VAN NATTA'S
WORKERS' COMPENSATION REPORTER
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Oregon Workers' Compensation Board
Attn.: Roger Pearson
2601 25th St. S.E.
Salem, OR 97302

VAN NATTA'S

WORKERS' COMPENSATION REPORTER

VOLUME 53

(Pages 1367-END)

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

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

OCTOBER-DECEMBER 2001

"In a minute there is time
For decisions and revisions
Which a minute will reverse."

--T.S. Eliot, *The Love Song of J. Alfred Prufrock*

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53 Van Natta ____ (2001)

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CORRECTED ORDER ON REVIEW
Willner, Wren, et al., Claimant Attorney
VavRosky, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) held that the Hearings Division lacked jurisdiction over his hearing request regarding a "post-ATP" Determination Order and penalties and attorney fees; (2) found that the Determination Order was void; and (3) directed the self-insured employer to issue an Own Motion Notice of Closure. Claimant contends that this matter must be remanded to the ALJ for a hearing regarding permanent disability. On review, the issues are jurisdiction, remand, and potentially, permanent and temporary disability, penalties and attorney fees. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin by summarizing the procedural history of the claim. Claimant compensably injured his low back in 1982. The claim was closed by a September 6, 1984 Determination Order that awarded temporary disability and 10 percent unscheduled permanent disability. (Ex. 2). Pursuant to a 1987 stipulation, the parties agreed that: (1) claimant's compensable back condition had aggravated; (2) claimant was awarded an additional 10 percent unscheduled permanent disability; and (3) claimant would be referred for "whatever vocational assistance to which he is administratively entitled." (Ex. 3-5).

In a 1988 decision, the Director concluded that claimant was not eligible for vocational assistance. A Hearings Division referee reversed the Director's decision and found claimant eligible for vocational assistance. (Ex. 3-6). On Board review, we reversed the referee's decision and reinstated the Director's order. *Richard A. Colclasure,* 42 Van Natta 2454 (1990). The Court of Appeals affirmed our order, but the Supreme Court reversed and remanded. *Colclasure v. Wash. County School Dist. No. 48-J,* 317 Or 526 (1993).

On June 28, 1994, following remand by the Supreme Court, we found that the Director's decision denying vocational assistance violated former OAR 436-120-040. (Exs. 3; 4). *Richard A. Colclasure,* 46 Van Natta 1246, *on recon* 46 Van Natta 1667 (1994). As a result of our order, claimant received vocational services and successfully participated in an authorized training program (ATP). Claimant began working as a hotel clerk/night auditor on September 14, 1998. Vocational services ended on November 14, 1998 with completion of the ATP. (Exs. 7; 8).

On April 19, 1999, claimant's attorney wrote to the employer's attorney inquiring about claim closure following the ATP. (Ex. 9). An October 31, 2000 Determination Order awarded temporary disability benefits from September 15, 1997 through September 14, 1998. Claimant requested reconsideration. The request was denied on the ground that reconsideration was not mandatory for claims in which the worker was medically stationary on or before July 1, 1990. Claimant was directed to refer his appeal from such a closure to the Hearings Division.

Claimant requested a hearing from the Determination Order seeking additional permanent and temporary disability, penalties and attorney fees. Reasoning that claimant's aggravation rights had expired in September 1989, the ALJ concluded that entitlement to any additional compensation fell within the Board's "Own Motion" authority under ORS 656.278. Relying on *Stanley W. Talley,* 53 Van Natta 214 (2001), the ALJ held that the Determination Order was void and the Hearings Division lacked jurisdiction over the issues raised by claimant's hearing request. The ALJ also directed the employer to issue a Notice of Closure. Claimant requested Board review of the ALJ's order.

On review, claimant asserts that his entitlement to vocational assistance arose out of a "dry aggravation" in 1987, prior to the expiration of claimant's aggravation rights. Claimant argues that because his entitlement to vocational assistance arose prior to the expiration of his aggravation rights, this matter is not within the Board's Own Motion jurisdiction. Claimant asserts that this matter should be remanded to the ALJ to address permanent disability.

The employer contends that claimant's aggravation rights expired prior to the ATP and that, under the *Talley* holding, the ALJ's decision is correct. In addition, the employer argues that claimant's request for vocational services did not toll the five year aggravation period and that claimant's aggravation rights continued to run and had expired by the time claimant began his ATP. On this basis, the employer argues that claimant is not entitled to a hearing to challenge the closure of the claim.

This case presents unique facts. Claimant's request for vocational services was made in 1987, prior to the expiration of his aggravation rights. Because of the litigation process, claimant's entitlement to vocational assistance was not finally determined until 1994. The vocational assistance was not completed until 1998.

We find the *Talley* case distinguishable for the following reasons. In *Talley*, after the claimant's aggravation rights had expired, the carrier voluntarily reopened the claim for an ATP. Following completion of the ATP, the carrier issued a Notice of Closure under ORS 656.268 with appeal rights. We held that because the claimant's aggravation rights had expired, any additional compensation fell under the Board's "Own Motion" authority pursuant to ORS 656.278. We reasoned that, because the benefits voluntarily provided to the claimant were vocational assistance benefits, and because the Board's "Own Motion" jurisdiction does not extend to vocational assistance, neither the Hearings Division nor the Board had jurisdiction over the carrier's Notice of Closure issued under ORS 656.268. We noted in a footnote that, under OAR 438-012-0055, the carrier was required to issue a Notice of Closure of Own Motion claim with appeal rights.

Here, in contrast to *Talley*, the request for vocational benefits in this case was initiated well before the expiration of claimant's aggravation rights. Claimant's disabling claim was first closed on September 6, 1984. Thus, his 5-year aggravation rights expired on September 6, 1989. In 1987, pursuant to the parties stipulation, claimant sought vocational assistance. That request was denied in 1988. Thereafter, claimant appealed that decision and continued to pursue his entitlement to vocational benefits which culminated in his eventual award of such services.

Under such circumstances, we find the present situation distinguishable from *Talley*. We conclude, given the unique facts of this case, that claimant's request for vocational services was perfected prior to the expiration of his aggravation rights. The parties continued to pursue the litigation over claimant's entitlement to vocational services until the Director's 1988 denial of benefits was ultimately and finally overturned on remand. The ATP that claimant completed in 1998 was based on claimant's 1987 request for vocational services. Because that request was made and the litigation regarding that request was begun prior to the expiration of claimant's aggravation rights, we conclude that this matter does not fall within the Board's "Own Motion" jurisdiction. Rather, we conclude that the closure of the claim was proper under ORS 656.268(9) and that we have jurisdiction over the closure.[1]

We now turn to the motion for remand. 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).

Here, because claimant's claim became medically stationary prior to July 1, 1990, the reconsideration procedure created in 1990 does not apply. *See* Or Laws 1990 (Special Session), ch. 2, section 54(3).[2] Because the ALJ concluded that the Hearings Division lacked jurisdiction over this

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[1] We note that if we agreed with the employer that this matter fell within our "Own Motion" jurisdiction, a carrier could limit the type of benefits available to a worker on claim closure merely by continuing vocational assistance appeals until after the worker's aggravation rights had expired, even if the request for those benefits was initiated well before the expiration of the 5-year aggravation period.

[2] Section 54(3), provided in relevant part that: "Amendments by this 1990 Act to ... ORS 656.268(4), (5), (6), (7) and (8) ... shall apply to all claims which become medically stationary after July 1, 1990."

matter, a hearing was not held regarding the issues raised in claimant's hearing request. Under such circumstances, claimant is entitled to a hearing regarding the issues raised in his hearing request. Accordingly, we conclude that the record is not sufficiently developed. Thus, we find a compelling basis to remand to the ALJ.

Accordingly, the ALJ's order dated May 4, 2001 is vacated. This case is remanded to ALJ Mongrain with instructions to reopen the record and conduct further proceedings consistent with this order. Those proceedings may be conducted in any manner that the ALJ deems achieves substantial justice. Thereafter, the ALJ shall issue a final appealable order reconsidering those issues raised at hearing.[3]

IT IS SO ORDERED.

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[3] 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.

In the Matter of the Compensation of
RICHARD A. COLCLASURE, Claimant
Own Motion No. 01-0176M
OWN MOTION ORDER
Willner, Wren, et al., Claimant Attorney
VavRosky, et al., Defense Attorney

Reviewing panel: Members Biehl and Haynes.

Claimant requests review of the self-insured employer's May 15, 2001 Notice of Closure which purported to close his claim with an award of temporary total disability from September 15, 1997 through September 14, 1998. We vacate the Notice of Closure.

Claimant asserts that the employer's May 15, 2001 Own Motion Notice of Closure is a nullity and argues that the October 31, 2000 Determination Order is the "correct and only closure order appropriate in this case. Based on the following reasoning, we agree.

On today's date, we issued our order in WCB Case No. 99-05436. Specifically, we determined that, given the unique facts of this case, claimant's request for vocational services was perfected prior to the expiration of his 5-year "aggravation rights." Specifically, we reasoned that claimant's authorized training program (ATP), which was completed in 1998, was based on his 1987 request for vocational services. Because that request was made and the litigation was begun prior to the expiration of claimant's "aggravation rights," we concluded that the "post-ATP" claim closure did not fall within the Board's "Own Motion" jurisdiction. Instead, we concluded that the closure of the claim by Determination Order was proper under ORS 656.268(9).

In light of our decision in WCB Case No. 99-05436 (which is incorporated by this reference), the employer's May 15, 2001 Own Motion Notice of Closure did not "close" any "reopened" Own Motion claim. Thus, the employer's May 15, 2001 Own Motion Notice of Closure is vacated as a nullity.

IT IS SO ORDERED.

In the Matter of the Compensation of
VIRGIL L. MATHIA, Claimant
WCB Case No. 00-08839
ORDER ON RECONSIDERATION
Floyd H. Shebley, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of our September 7, 2001 order that affirmed the Administrative Law Judge's (ALJ's) order that awarded an assessed attorney fee pursuant to ORS 656.382(1).[1]

On reconsideration, SAIF first contends that we misinterpreted 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." (O&O at 4). SAIF argues that the ALJ did not specifically reference "[on claimant's contention that SAIF unreasonably refused to close claimant's new medical condition claim,]" as we had stated in our initial order. (Order on Review at 2, 3). Rather, SAIF contends that the ALJ's statement should be interpreted to mean that it did not contest entitlement to a fee under ORS 656.382(1) only if claimant prevailed on his theory that there had been an "unreasonable resistance to compensation." We disagree with SAIF's contention.

Although the ALJ's order did not specifically contain the words bracketed in our initial order, the context of the order is supportive of our interpretation of the ALJ's statement. In this regard, we note that, after describing SAIF's concession, the ALJ did not engage in any analysis of whether SAIF's actions constituted an "unreasonable resistance to compensation." Instead, directly after stating that "SAIF does not dispute that claimant is entitled to a fee pursuant to ORS 656.382(1) should claimant prevail," the ALJ proceeded to determine the amount of the fee pursuant to OAR 438-015-0010(4). (O&O at 4). For that reason, the ALJ's statement and the context of that statement support a conclusion that SAIF had conceded entitlement to a fee under ORS 656.382(1) if claimant prevailed on the underlying "claim processing" issue (already determined by the ALJ in favor of claimant); *i.e.*, that SAIF had unreasonably refused to close claimant's new medical condition claim.

Secondly, SAIF argues that we misinterpreted its argument on review regarding ORS 656.382(1). SAIF contends that it argued that it had not "resisted the payment of compensation" consistent with the language of ORS 656.382(1). However, our initial order affirming the attorney fee was narrowly directed at SAIF's concession at hearing, not at its contentions on Board review. In other words, we acknowledge that SAIF contends *on review* that its conduct did not result in a resistance to the payment of compensation. Nonetheless, our decision is based on a conclusion that SAIF did not advance such a challenge at hearing, nor did it contest the ALJ's statement regarding its position at hearing. In light of such circumstances, we will not consider the challenge on review. We continue to adhere to that reasoning on reconsideration.

Finally, SAIF contends that an ALJ's attorney fee award can be challenged on review even though the amount of the fee was not challenged at hearing, citing *Arthur C. Collier*, 53 Van Natta 191 (2001).

In *Arthur C. Collier*, an ALJ awarded the claimant attorney fees totaling $7,000 under ORS 656.386(1) for his attorney's efforts in setting aside two compensability denials. A carrier requested Board review, contending that the attorney fees awarded were excessive. The claimant argued that, because he did not request a specific attorney fee at hearing, the carrier was not entitled to object to the amount of the fees on review. We rejected the claimant's argument, reasoning that attorney fees were an issue at hearing, and the carrier timely requested review of the ALJ's order. Therefore, we held that the issue of the *amount* of attorney fees was properly before us. 53 Van Natta at 192, 193. *Collier* thus involved an entirely different issue than that which is presented here. It did not involve a *concession of entitlement* to an attorney fee at hearing and is distinguishable.

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[1] ORS 656.382(1) provides, in pertinent part:

"If an insurer or self-insured employer refuses to pay compensation due under an order of an Administrative Law Judge, board or court, or otherwise unreasonably resists the payment of compensation, * * * the employer or insurer shall pay to the claimant or the attorney of the claimant a reasonable attorney fee as provided in subsection (2) of this section."

Accordingly, we withdraw our September 7, 2001 order. On reconsideration, as supplemented herein, we adhere to and republish our September 7, 2001 order. The parties' rights of appeal shall begin to run as from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRIAN K. DANIELS, Claimant
WCB Case No. 01-00034
ORDER ON REVIEW
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Marshall's order that found that his claim for permanent partial disability benefits for his thoracic condition was barred by issue preclusion. On review, the issue is issue preclusion.

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

On review, claimant requests that we address various federal and state constitutional arguments regarding 1995 legislative changes to ORS 656 Chapter 656 that prevented him from testifying about the extent of his permanent partial disability. However, as the ALJ explained, because claimant did not appeal the Board's May 25, 1999 Order on Review that ultimately affirmed a July 17, 1998 Order on Reconsideration that awarded no permanent disability for the thoracic condition, that order is final. Therefore, claimant may not relitigate the permanent disability issues decided by that order. That bar on relitigation includes considering the constitutional arguments that claimant currently raises at Hearing and on Review.[1]

ORDER

The ALJ's order dated June 11, 2001 is affirmed.

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[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
LLOYD CARLTON, Claimant
WCB Case No. 00-06066
SECOND ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorney
Schwabe, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The insurer has requested reconsideration of that portion of our September 13, 2001 Order on Reconsideration that affirmed an Administrative Law Judge's (ALJ) order that awarded a $4,000 attorney fee for the insurer's unreasonable discovery violation. In reaching our conclusion, we determined that, although the ALJ had jurisdiction to consider claimant's request for temporary disability, the ALJ was not authorized to award temporary disability in light of claimant's failure to timely seek reconsideration of a Determination Order that had declined to reclassify a nondisabling claim as disabling. The insurer asserts that our order contradicts the Board's prior decision of *Jay Pitman*, 45 Van Natta 1782 (1993).[1] After considering the insurer's arguments, we continue to adhere to our prior order with the following supplementation.

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.[2] Although we determined that the ALJ lacked authority to consider the reclassification issue, we nonetheless concluded 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. Contrary to the insurer's assertion, our prior order is not contradicted by *Pitman*.

In *Pitman*, the claimant began missing work after his claim had been accepted as nondisabling. The employer did not commence payment of temporary disability but did seek a Determination Order regarding the disabling/nondisabling status of the claim. Thereafter, the claimant requested a hearing seeking temporary disability. Reasoning that the "actual issue" was claim classification, and considering that the Department had not yet issued its Determination Order, the Board held it did not have original jurisdiction to consider whether the claim was disabling or nondisabling.[3] *Pitman*, 45 Van Natta at 1784.

Here, unlike *Pitman*, we do not view the "actual issue" as only "claim classification." Rather, the issues also included temporary disability, medical services, penalties, and attorney fees. Thus *Pitman* is distinguishable. In any event (as explained below), to the extent that *Pitman* is inconsistent with *Alfredo Martinez*, 49 Van Natta 67 (1997) and its progeny, *Pitman* has been disavowed sub silentio.

Subsequent to *Pitman*, the Board issued its decision in *Martinez*. There, the claimant requested a hearing (rather than reconsideration) seeking entitlement to temporary disability for a time period not included in a Notice of Closure. The carrier requested dismissal of claimant's request for hearing for "lack of jurisdiction." Relying on *SAIF v. Roles*, 111 Or App 597, 601 *rev den*, 314 Or 391 (1992) (a tribunal has subject matter jurisdiction if it has the authority to make an inquiry into the dispute), we reasoned that entitlement to temporary disability was "a matter concerning a claim," and concluded that the Hearings Division/Board retained jurisdiction over the temporary disability issue pursuant to ORS 656.283(1). *Martinez*, 49 Van Natta at 68. Consequently, we declined to dismiss the request for hearing for "lack of jurisdiction."

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[1] On September 17, 2001, claimant filed a petition for judicial review of the Board's September 13, 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); *Duane A. Ferren*, 53 Van Natta 1016 (2001); *Marietta Z. Smith*, 51 Van Natta 731 fn 1 (1999).

[2] The reimbursement for prescriptions and mileage, as well as the unreasonable claim processing issues were resolved before the hearing through the parties' stipulated settlement.

[3] The Board also noted it lacked jurisdiction to determine entitlement to temporary disability. *Pitman*, 45 Van Natta at 1783.

We further concluded that, under the circumstances presented, an award of temporary disability may result in an overpayment. Relying on *Lebanon Plywood v. Seiber*, 113 Or App 651 (1992) (entitlement to temporary disability pursuant to ORS 656.210 and 656.212 is determined at the time of claim closure), we reasoned that the Hearings Division/Board lacked authority to create such an overpayment. *Martinez*, 49 Van Natta at 68-69. Consequently, we reversed the ALJ's award of temporary disability benefits. In doing so, we specifically noted that the Hearings Division/Board's lack of authority to award temporary disability did not divest the Hearings Division/Board of jurisdiction over the dispute. *Martinez*, 49 Van Natta at 68.

Consistent with our holding and rationale in *Martinez*, our decisions in *Carmen Mendoza*, 51 Van Natta 1986 (1999) and *Roberta F. Bieber*, 49 Van Natta 1541 (1997) are based on a lack of *authority* to award temporary disability benefits, as opposed to a lack of *jurisdiction* to consider the issue. Thus, in accordance with the reasoning expressed in those decisions, we continue to hold that the ALJ in this case retained jurisdiction over the temporary disability issue and, as such, was authorized to award an attorney fee for the insurer's discovery violation.

Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our September 13, 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
MAZOUZ A. FATTOM, Claimant
WCB Case No. 01-00545
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) reduced claimant's scheduled permanent disability award for loss of use or function of the right hand from 18 percent (27 degrees), as awarded by an Order on Reconsideration, to zero; and (2) reduced claimant's unscheduled permanent disability award for a low back injury from 27 percent (86.4 degrees), as awarded by the Order on Reconsideration, to 15 percent (48 degrees). On review, the issues are scheduled and unscheduled permanent disability. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Scheduled Permanent Disability

We adopt and affirm the ALJ's conclusion and reasoning regarding this issue.

Unscheduled Permanent Disability/Adaptability

With regard to unscheduled permanent disability, the only dispute concerns the adaptability factor. The ALJ concluded that claimant's adaptability factor should be 2, instead of 6, as found by the Order on Reconsideration. This modification resulted in a reduction in claimant's unscheduled award from 27 to 15 percent.

In reaching his conclusion regarding claimant's adaptability, the ALJ reasoned that, although claimant's regular work was heavy, he was not able to perform heavy work for a period exceeding five years prior to the closure of his claim due to modification of his job because of a previous compensable

injury. Based on this reasoning, the ALJ concluded that the Order on Reconsideration improperly concluded that claimant's base functional capacity (BFC) was heavy. Instead, the ALJ found that claimant's BFC should be medium.

Claimant argues that, under the disability rating standards, the BFC must be determined by use of the DOT strength category for the most physically demanding job performed in the five years prior to claim closure. On this basis, claimant argues that, in determining the BFC, the ALJ was required to use the strength category from the DOT. We agree.

Pursuant to OAR 436-035-0310(4) (WCD Admin. Order 98-055), Base Functional Capacity (BFC) is the most current of:

> "(a) The highest strength category assigned in the DOT for the most physically demanding job that the worker has successfully performed in the five (5) years prior to date of issuance. When a combination of DOT codes most accurately describes a worker's duties, the highest strength for the combination of codes shall apply; or
>
> "(b) A second-level physical capacity evaluation as defined in OAR 436-010-0005 and 436-009-0020(30) performed prior to the date of the on-the-job injury; or
>
> "(c) For those workers who do not meet the requirements pursuant to OAR 436-035-0300(3), and who have not had a second-level physical capacity evaluation performed prior to the on-the-job injury or disease, their prior strength shall be based on the worker's job at the time of injury.
>
> "(d) Where a worker's highest prior strength has been reduced as a result of an injury or condition which is not an accepted Oregon workers' compensation claim the Base Functional Capacity shall be the highest of:
>
> "(A) The job at injury; or
>
> "(B) A second-level physical capacities evaluation as defined in OAR 436-010-0005 and 436-009-0020(27)(a)(b) performed after the injury or condition which was not an accepted Oregon workers' compensation claim but before the current work related injury."

Based on the language of the rule, the BFC must be determined based on the DOT strength category for the most physically demanding job that the worker has successfully performed in the five years prior to date of closure, or on a second-level physical capacity evaluation performed prior to the injury, unless the worker's highest prior strength has been reduced as a result of an injury or condition which is not an accepted Oregon workers' compensation claim.[1]

Here, because claimant's highest prior strength was reduced by a previous *compensable* injury, the ALJ was not permitted to use the actual job at injury that claimant was performing to determine claimant's BFC. Instead, because there is no second-level physical capacities evaluation performed prior to the date of the injury, the DOT strength category determines the BFC.

The DOT for the job claimant was performing in the five years prior to closure was for the job of medical equipment repairer (DOT 639.281-022). The strength category for this DOT code is heavy. Thus, pursuant to OAR 436-035-0310(4)(a), the Order on Reconsideration correctly determined that claimant's BFC was heavy. *See Timothy M. Morris*, 51 Van Natta 969 (1999) (the standards require that the BFC be determined by the DOT).

The ALJ determined that claimant's residual functional capacity (RFC) was medium/light, relying on Dr. Rosenbaum, claimant's attending physician at the time of claim closure. Dr. Rosenbaum released claimant to work with restrictions of no lifting more than 50 pounds with some additional restrictions including pushing, pulling, lifting and carrying. (Ex. 19). Dr. Rosenbaum indicated that the physical

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[1] There is no contention that claimant did not meet the SVP training time requirements of OAR 436-035-0300(3). Thus, OAR 436-035-0310(4)(d) does not apply.

capacities form filled out by Dr. Stephens, claimant's previous attending physician, contained reasonable modifications. (Ex. 22). These included occasional bending, squatting, climbing and twisting and no crawling, occasional lifting of 26 to 50 pounds and regular lifting of 11 to 25 pounds. (Ex. 20). We find no persuasive reason not to defer to Dr. Rosenbaum's opinion regarding claimant's impairment. *See Weiland v. SAIF*, 64 Or App 810 (1983) (we generally defer to the treating physician absent persuasive reasons to the contrary). Based on this evidence, we agree with the ALJ that claimant's RFC is medium/light. Thus, comparing claimant's BFC of heavy and his RFC of medium/light, we conclude that claimant's adaptability factor is 4 pursuant to OAR 436-035-0310(6).

The age (1) and education (2) values are added to equal 3. *See* OAR 436-035-0280(4). This number is multiplied by the adaptability factor of 4 to equal 12. OAR 436-035-0280(6). This is added to claimant's impairment value of 9 to equal 21 percent unscheduled permanent disability. OAR 436-035-0280(7).

Because our order results in increased compensation, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 ercent of the increased compensation created by the order (the 6 percent difference between the ALJ's 15 percent award and our 21 percent award) not to exceed $6,000. ORS 656.386(2); OAR 438-015-0055(2). In the event that all or any part of this compensation resulting from this order has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane A. Volk*, 46 Van Natta 681, *on recon* 46 Van Natta 1017 (1994), *aff'd on other grounds Volk v. America West Airlines*, 135 Or App 565 (1995), *rev den* 322 Or 645 (1996).

ORDER

The ALJ's order dated April 24, 2001 is modified in part. In lieu of the Order on Reconsideration's and ALJ's award of unscheduled permanent disability, claimant is awarded 21 percent (67.20 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation awarded by this order (the 6 percent difference between the ALJ's 15 percent award and our 21 percent award) not to exceed $6,000, payable directly to claimant's counsel. In the event that all or any part of this compensation has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in *Jane Volk*. The remainder of the order is affirmed.

October 3, 2001 Cite as 53 Van Natta 1375 (2001)

In the Matter of the Compensation of
MARK W. GOLDEN, Claimant
WCB Case No. 01-00768
ORDER ON REVIEW
Willner, et al., Claimant Attorney
Sather, 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: (1) set aside its "de facto" denial of claimant's low back injury claim; and (2) assessed a penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability and penalties.

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

The ALJ set aside the insurer's denial of claimant's low back injury claim, finding that a preponderance of the evidence established that an alleged lifting incident on October 10, 2000 was the major contributing cause of claimant's lumbosacral strain and resulting need for treatment and disability under ORS 656.005(7)(a)(B). Among the insurer's contentions on review is that the medical opinions of Drs. Rosenbaum and Williams were based on an inaccurate history. *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). Specifically, the insurer argues that those physicians were unaware that claimant did not completely recover from noncompensable low back surgery on February 14, 2000. The insurer cites testimony from claimant's coworkers (Tenenholz and McClure) that claimant had continuing difficulties after the February 2000 low back surgery with good days and bad days and continued low back pain and limping. (Trs. 44, 52).

Dr. Rosenbaum reported a history that, after the February 2000 surgery, claimant returned to work in 10 days but had residual stiffness in the low back as well as some numbness in the left leg with prolonged standing. (Ex. 15-1). At hearing, claimant testified he had soreness in the back after the surgery where the incision was made, but no pain. (Tr. 11). Claimant also testified that, post-operatively, he would experience residual numbness in the left leg after prolonged standing. (Tr. 17). Having compared claimant's testimony with the history Dr. Rosenbaum received, we conclude that they are sufficiently compatible.

Dr. Williams received a history that claimant was relieved of back and lower extremity pain after his operation in February 2000 and was not having chronic back and left lower extremity pain. (Ex. 25-2). Again, this was reasonably consistent with claimant's testimony that the surgery relieved his pain.

We recognize that the testimony of Tenenholz and McClure indicates that claimant was perhaps having more difficulty than he testified to or told the physicians. However, claimant's testimony indicates that he was not symptom free after the February 2000 surgery. Moreover, claimant did return to regular work after the February 2000 surgery and did not seek medical treatment between the February 14, 2000 surgery and October 17, 2000, after the disputed lifting incident.

Having reviewed this record, we are not persuaded that claimant had significant medical problems in the period after the surgery and before the October 10, 2000 lifting incident. Moreover, we are persuaded that Drs. Rosenbaum and Williams had a sufficiently accurate understanding of claimant's medical history such that their medical opinions should not be discounted on this basis.

The insurer also argues that those doctors were not aware of claimant's deer and elk hunting activities shortly before the alleged October 2000 injury. While neither doctor was informed of those activities, the record does not establish that claimant was injured or experienced any physical problems as a result of his hunting activity. Thus, we conclude that the physicians' lack of knowledge of this activity does not render their opinions unpersuasive.

In conclusion, we agree with the ALJ's decision to set aside the "de facto" denial. Accordingly, we affirm.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,998, 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 counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 27, 2001 is affirmed. For services on review, claimant's attorney is awarded as assessed fee of $1,998, to be paid by the insurer.

In the Matter of the Compensation of
JESUS ROJAS, Claimant
WCB Case No. 00-05788
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Scott Monfils, Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Biehl. Member Biehl dissents.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the self-insured employer's denial of his injury claim for a low back condition; and (2) declined to assess penalties 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.

The ALJ first determined that the employer's denial encompassed both legal and medical causation. The ALJ then found that claimant had failed to establish the occurrence of an injurious work event. Consequently, the ALJ upheld the denial.

The express language of the employer's July 27, 2000 denial stated that "[b]ased upon the information in our file, we are hereby denying your claim on the grounds that your work activity at [the employer] was neither a material nor the major contributing cause of your low back condition * * *." (Ex. 18). Under such circumstances, we find that the denial denied both legal and medical causation. *See Arthur A. Conner*, 52 Van Natta 649 (2000) (denial on the basis that the injury was not "caused by," nor did it "arise out of" claimant's employment sufficiently denied legal and medical causation).

The dissent argues, based on a sparse colloquy at hearing, that the parties agreed to limit the issue to "medical causation." (Tr. 2). However, after reviewing the entire transcript, it is readily apparent that the parties proceeded to present, without objection as to relevance, testimony directed almost entirely at the issue of legal causation; *i.e.*, whether claimant sustained an on-the-job injury on June 16, 2000.[1]

"Parties to a workers' compensation proceeding may, by express or implicit agreement, try an issue that falls outside the express terms of a denial." *Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990); *Shawn K. Flohr*, 52 Van Natta 1346 n1 (2000); *see Gary M. Emmerson*, 49 Van Natta 1080 (1997).

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[1] *See, e.g.*, Tr. 7:

"Q: [By claimant's counsel] Okay. When did you notice you had any symptoms in your back?

A: [By claimant] It was on the 16th of June, the same day that I was injured.

Q: Okay, but approximately what time?

A: It would've been that time, about from 12:30-12:30.

Q: Okay. And did you tell anyone that you had back pain at that time?

A: Yes, the person that was on the side of me.

Q: Okay. And who was that person?

A: His name was Rafael."

And *see* Tr. 13:

"Q: [By employer's counsel] [Claimant,] doesn't [the employer] have a rule that you are supposed to report injuries right away if they happen at work?

A: [By claimant] Yes, I did know that, but I did not report.

Q: When you claim you injured yourself on June 16th you did not tell any of your supervisors about an injury, did you?

A: No."

Thus, assuming for the sake of argument that the parties' opening statements could be interpreted as an indication that "legal causation" of claimant's injury claim was not disputed, the parties' subsequent presentation of evidence bearing directly on the legal causation issue (without objection from either party) supports a conclusion that the parties agreed to litigate the issue.

On the merits of the compensability dispute, we adopt and affirm the ALJ's reasoning and conclusion that claimant has not met his burden of proving that he was injured at work. We likewise agree with the ALJ's decision not to assess a penalty for unreasonable claim processing. Consequently, we affirm the ALJ's order.

ORDER

The ALJ's order dated March 29, 2001 is affirmed.

Board Member Biehl dissenting.

I disagree with the majority's conclusion that claimant failed to establish the compensability of his low back condition. Therefore, I respectfully dissent.

Claimant contends that: (1) the employer's denial did not encompass "legal "causation;" and (2) the parties expressly agreed to limit the litigation to medical causation. Thus, claimant asserts that the denial cannot be upheld on the basis that he had failed to establish "legal causation."[1] I agree.

Carriers are bound by the express language contained in their denials. *See Tattoo v. Barrett Business Services*, 118 Or App 348 (1993). Here, the employer expressly denied that claimant's work activities were the cause of his low back condition. The employer did not expressly deny that claimant was involved in potential causal work activities; *i.e.*, pulling lumber from the green chain. Thus, while the express terms of the employer's denial denied that claimant's work activities caused his low back condition (medical causation), the language of the denial did not challenge that claimant was engaged in potentially causal work activities (legal causation). Consequently, I conclude that the employer's denial did not encompass legal causation.

The majority relies on *Arthur A. Conner*, 52 Van Natta 649 (2000), to conclude that the employer's denial encompassed both legal and medical causation. In *Conner*, the claimant argued that a denial stating the "injury was not caused by your employment, nor did it arise out of your employment" encompassed only the issue of "course and scope" (legal causation). There, however, the Board specifically noted that the express issue at hearing was "compensability," not "course and scope." *Id.* Reasoning that "compensability" includes "medical causation," the Board rejected the claimant's argument. *Id.* Here, unlike *Conner*, the issue at hearing was "medical causation," not "compensability." Additionally, unlike *Conner*, the employer's denial did not use the term "arise out of." Rather, it simply stated that claimant's "work activity" did not cause his low back condition. Consequently, I find *Conner* distinguishable.

In any event, even if I found *Conner* controlling, I would find (from the parties' express statement of the issues to the ALJ) that the "legal causation" issue was "waived." In *Clifford D. Cornett*, 51 Van Natta 1430 (1999), we held that a penalty issue raised in the pleadings had been waived when the claimant's counsel expressly stated that compensability and responsibility were the only issues. Here, like *Cornett*, the employer's counsel expressly agreed that the only issues were medical causation, penalties, and attorney fees. (Tr. 2). Consequently, considering the "totality of the circumstances," even if I assume that the denial encompassed "legal causation," I conclude the employer waived that issue. *See Wright Schuchart Harbor v. Johnson*, 133 Or App 680, 688 (1995), *on remand Connie M. Johnson*, 48 Van Natta 239 (1996) (whether a "waiver" has occurred must be ascertained from the "totality of the circumstances"); *Valerie Barbeau*, 49 Van Natta 1189, 1190 (1997) (carrier waived its right to assert a medical causation defense when carrier's attorney expressly agreed that the only issues were timeliness, penalties, and attorney fees).

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[1] "Legal causation" is established by showing that a claimant engaged in potentially causal work activities; whether those work activities caused claimant's condition is a question of "medical causation." *See Harris v. Farmer's Co-Op Creamery*, 53 Or App 618, 621 (1981); *Gary W. Emmerson*, 49 Van Natta 1080, 1081-2 (1997).

Having concluded that "legal causation" was not a viable issue at hearing, I further conclude that, it was fundamentally unfair for the ALJ to uphold the denial of claimant's low back condition based on claimant's failure to prove "legal causation." *See Terry Hickman*, 48 Van Natta 1073 (1996) (to decide a case on a basis different than what was litigated at the hearing is fundamentally unfair). Consequently, I disagree with the ALJ's decision to go beyond the express issue (medical causation) presented by the parties for resolution. *See generally Birrer v. Principal Financial Group*, 172 Or App 654 (2001).

The majority concludes that because claimant presented testimony directed toward "legal causation," he thereby implicitly agreed to litigate an issue otherwise outside the express terms of the denial. While I agree that claimant testified at some length about the onset of his symptoms, I view that testimony as necessary to establish medical causation, not as an implicit agreement to litigate "legal causation." The opinions of Drs. Grady and McColl rest, in part, on a history that claimant's back pain began during his work activities. (Exs. 30; 31). Consequently, claimant's testimony regarding the onset of back pain at work was necessary to show that the medical opinions of Drs. Grady and McColl were based on complete information. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions based on incomplete information are not persuasive).

Without such testimony, the opinions of Drs. Grady and McColl lack the foundation to link claimant's condition to his work on the "green chain." In other words, without claimant's testimony (like that set forth by the majority in footnote 1) about the onset of his back pain, the opinions of Drs. Grady and McColl are legally insufficient to establish compensability. In these circumstances, I cannot understand how the majority concludes that claimant's testimony about the onset of his back pain constitutes an implied agreement to litigate an issue that was clearly beyond the parties' express statement of the issues to the ALJ.[2]

I turn to the merits of compensability. The record contains the opinions of two physicians, Drs. Grady and McColl, regarding the cause of claimant's low back condition.[3] Both physicians opined that claimant's work activity on the green chain was the major contributing cause of his low back pain and herniated disc condition. (Exs. 30; 31). Their opinions are not contested. Consequently, I conclude that claimant has established compensability of his low back condition.

I now address claimant's request for penalties. Under ORS 656.262(11)(a), if a carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount up to 25 percent of the amount then due. Here, the uncontested medical evidence established that claimant's work activity on the green chain was the major contributing cause of his low back pain and herniated disc condition. Nonetheless, the employer denied compensability only on "medical causation" grounds. Under these circumstances, I conclude that the employer had no legitimate doubt as to the compensability of claimant's low back condition. *See International Paper Co. v. Huntley*, 106 Or App 107 (1991); *Brown v. Argonaut Ins.*, 93 Or App 588, 591 (1988). Consequently, the insurer unreasonably refused to pay compensation under the terms of ORS 656.262(11)(a).

Accordingly, I would reverse the ALJ's order, set aside the employer's denial, remand the claim to the employer for processing according to law, and award claimant a 25 percent penalty pursuant to ORS 656.262(11)(a) based upon compensation due as of the date of hearing.

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[2] I am particularly troubled by the majority's comment that evidence it characterizes as "directed almost entirely at the issue of legal causation" was presented without "objection as to relevance." Pursuant to ORS 656.283(7), an ALJ "is not bound by common law or statutory rules of evidence[.]" Consequently, ALJs (when faced with a relevancy objection) usually admit the evidence, and consider the objection as "going to the weight" of the proffered evidence. As a further consequence, practitioners in this forum voice objections much less frequently than in court. I also note that objections (regardless of the forum) disrupt the flow of information to the fact finder. Such disruptions (although legally supportable) can have a negative effect in the mind of the fact finder. Consequently, whether in this forum or in court, practitioners (as part of the trial strategy) must balance the legal correctness of an objection against any negative effect such objection may have on the fact finder. As a result, practitioners do not usually object to evidence that does little harm to the cause being presented. In other words, if the proffered evidence "does not hurt," the party against whom the evidence is offered does not object to it. In light of all this, I believe the majority reads too much into testimony that was presented without objection.

[3] Dr. McColl was the initial treating physician. Dr. Grady took over claimant's care after Dr. McColl changed clinics.

In the Matter of the Compensation of
TERRY A. WOOLFOLK, Claimant
Own Motion No. 01-0214M
OWN MOTION ORDER

Reviewing Panel: Members Biehl and Haynes.

The self-insured employer has submitted claimant's request for temporary disability compensation for an upper extremity condition. Claimant's aggravation rights have expired.

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

The employer initially agreed that claimant met the necessary criteria for reopening under the Board's Own Motion authority pursuant to ORS 656.278. Consequently, the employer recommended reopening of the claim.

Thereafter, the employer submitted a medical report from Dr. Dodds, claimant's attending physician. Reporting that claimant's current condition continued to improve, Dr. Dodds recommended deferral of the recommended surgery for at least six weeks.

Finally, the employer submits a September 2001 chart note from Dr. Dodds. Reporting that "it seems still reasonable to defer consideration of operative intervention at this point," Dr. Dodds states that claimant is "in agreement with this assessment." Claimant has not challenged Dr. Dodds' reports or the employer's representations.[1]

In light of these circumstances, the record does not establish that claimant currently requires surgery or hospitalization. As a result, even assuming that claimant's current condition is causally related to his compensable injury, we are not presently authorized to grant his request to reopen the claim.

Accordingly, we deny the current request for Own Motion relief. *Id.* Claimant's entitlement to medical expenses under ORS 656.245 is not affected by this order.

IT IS SO ORDERED.

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[1] We note that the employer acknowledges its continuing obligation to process any future Own Motion claim arising from a surgery and/or hospitalization regarding claimant's compensable condition.

In the Matter of the Compensation of
TAMARA S. HILL, Claimant
WCB Case Nos. 00-09714, 00-07668 & 00-05330
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Johnson, Nyrburg & Andersen, Defense Attorney

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

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the insurer's denial of her aggravation claim for a right knee condition; (2) upheld the insurer's partial denial of her "new medical condition" claim for patellofemoral instability, inferior surface tear of the posterior horn of the medial meniscus, post-traumatic chondromalacia, anterior cruciate ligament shrinkage/medial retinacular reefing and chronic synovitis; and (3) affirmed an Order on Reconsideration that did not award any permanent disability. The insurer cross-requests review of that portion of the ALJ's order that awarded interim compensation from June 30, 2000 through July 28, 2000, and from September 1, 2000 through March 8, 2001. On review, the issues are aggravation, compensability, interim compensation and extent of permanent disability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the second paragraph on page 3, we change the first sentence to: "Claimant returned to Dr. Cook on July 16, 1999." In the second paragraph on page 4, we change the date in the second sentence to "February 5, 1998." In the fourth paragraph on page 4, we change the date in the first sentence to "June 11, 1998." On page 4, after the first sentence of the fifth paragraph, we add the following: "Dr. Sedgewick diagnosed anterior cruciate ligament laxity, patellofemoral pain and malalignment."

CONCLUSIONS OF LAW AND OPINION

We adopt and affirm the portions of the ALJ's order pertaining to extent of permanent disability, scope of acceptance and compensability.

Perfection of Aggravation Claim/Interim Compensation

The ALJ found that the information from Dr. Cook in June 2000 that authorized time loss and explained that claimant's work limitations precluded her work as a flagger was sufficient to require the insurer to pay interim compensation. The ALJ awarded interim compensation from June 30, 2000 through July 28, 2000, and from September 1, 2000 through March 8, 2001.

The insurer argues that claimant failed to perfect the aggravation claim and, therefore, she is not entitled to interim compensation. According to the insurer, the information from Dr. Cook did not establish that claimant had sustained an "actual worsening" or that her condition was attributable to the original accepted injury.

Claimant responds that she met all the requirements to perfect an aggravation claim, including written medical evidence from Dr. Cook establishing that she had suffered a worsened condition attributable to the compensable injury.

We briefly review claimant's right knee problems. On December 1, 1994, claimant had surgery for a right knee lateral meniscal tear and anterior cruciate ligament (ACL) disruption. (Ex. A).[1] On January 13, 1995, an ACL reconstruction was performed. (Ex. B).

On March 19, 1996, claimant, a flagger, compensably injured her right knee when she had to jump out of the way of a car. (Ex. 2). On November 4, 1996, a stipulation and order was approved in which the parties agreed that the insurer would accept a right knee strain related to the March 1996 injury. (Exs. 6, 7).

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[1] Our citations refer to the exhibit file for WCB Nos. 00-05330 and 00-09714.

Claimant continued to have right knee problems and she requested authorization for arthroscopic surgery and a possible lateral retinacular release. (See Ex. 11). On January 14, 1998, the insurer denied a claim for post reconstruction of the right knee ACL, interior knee pain and her current need for surgery. (Ex. 9). The denial was amended to include chondromalacia of the patella. (Ex. 10). Claimant requested a hearing on the denials. On February 24, 1998, a stipulation and order was approved in which the insurer authorized the proposed surgery and claimant's requests for hearing were dismissed with prejudice. (Ex. 11). No additional conditions were accepted.

On March 5, 1998, Dr. Cook performed an arthroscopy with partial medial meniscectomy, patellar shave and lateral retinacular release. (Ex. 12). He diagnosed traumatic chondromalacia patella and posterior horn tear of the medial meniscus. (*Id.*)

Dr. Sedgewick performed additional right knee surgery on December 1, 1998, which was described as arthroscopic ACL shrinkage and medial retinacular reefing and a chondroplasty intracondylar notch to the femur, along with a distal tubercle transfer. (Ex. 14). He diagnosed anterior cruciate ligament laxity, patellofemoral pain and malalignment. (*Id.*)

The insurer issued an updated notice of acceptance at closure on February 23, 2000, which referred to the accepted condition as a right knee strain. (Exs. 21, 25). Dr. Cook agreed that claimant was medically stationary as of December 30, 1999. (Ex. 22). A March 27, 2000 Notice of Closure did not award any permanent disability. (Ex. 23).

On April 5, 2000, Dr. Cook reported that claimant did not need further surgery and she was medically stationary. (Ex. 24). He explained, however, that in order to perform productively, she needed a modified work environment involving no prolonged standing, crawling, stooping, kneeling and squatting. (*Id.*) He felt her work should be largely sedentary.

On June 16, 2000, claimant's attorney submitted Dr. Cook's time loss authorizations to the insurer. (Ex. 26). Dr. Cook indicated on June 16, 2000 that claimant was unable to work until further notice. (Ex. 27). One week later, claimant's attorney filed an aggravation claim, submitting an aggravation claim form, a June 16, 2000 letter from Dr. Cook and chart notes from July 16, 1999 to June 16, 2000. (Ex. 28). The aggravation claim form signed by Dr. Cook said claimant was restricted to light duty and was to avoid repetitive standing, climbing, walking, stooping, kneeling and squatting. (Ex. 28-2). Dr. Cook's June 16, 2000 letter stated:

> "[Claimant] has been back to her usual job as a flagger for the last three weeks. This is in clear violation of medical recommendations that she avoid prolonged standing, walking, kneeling, squatting, stopping, and climbing. It is my opinion that she should either be retrained for more sedentary work, or further attempt at surgery be considered, although that would be the last option.
>
> "At any rate, I do not feel that the job as a flagger is acceptable for her considering her current knee status. I hope this information is of benefit in reopening her claim or in otherwise having her status reevaluated." (Ex. 28-3).

Dr. Cook's June 16, 2000 chart note explained:

> "Claimant has been back to flagging for the last three weeks, and as a result, her knee is sore and swollen. This is definitely outside the restrictions that we recommended. After having reviewed her IME and taking her current history, it is my opinion that she is faced with three options. Number one, if the guidelines outlined for avoiding repetitive standing, climbing, walking, stooping, kneeling, and squatting are ignored, she will either be faced with additional surgery and/or disability evaluation and vocational training for sedentary work." (Ex. 28-4).

Claimant's attorney wrote to the insurer on July 14, 2000, again requesting time loss benefits for claimant. (Ex. 28A). The insurer responded that it had requested clarification from Dr. Cook, but had not yet received a response. (Ex. 28B). On July 26, 2000, Dr. Cook wrote to the insurer, explaining:

> "After concluding her care with Dr. Sedgewick, [claimant] returned to my office in mid-July of 1999 stating that overall, her knee condition was unimproved. We discussed treatment options at that time.

> "In May of 2000, she attempted to return to her work as a flagger, and after three weeks, she presented to my office on the 16th of June with a painful, swollen knee.
>
> "With a chronic knee problem, she had been placed on restrictions that included avoidance of uninterrupted standing, kneeling, squatting, excessive walking, and in other words, limitations would exclude her functioning as a flagger.
>
> "It is, therefore, my opinion that she has an exacerbation of her previous condition, and that until some more sedentary work is found, she should be provided with time-loss.
>
> "I am uncertain as to her current status. I feel that, as stated above, her condition was caused by uninterrupted standing, and I feel that that is what interrupted her previously-medically-stationary status.
>
> "The options of treatment are to: (A) Re-evaluate her knee arthroscopically and revise anything that may improve knee function. (B) To modify her work environment to one that is more sedentary, or, alternatively, to accept her current condition and determinant degree of disability." (Ex. 29).

ORS 656.273(6) provides that the first installment of interim compensation in an aggravation claim shall be paid no later than the 14th day after the subject employer has notice or knowledge of medically verified inability to work resulting from a compensable worsening under ORS 656.273(1).

In *Stapleton v. Liberty Northwest Ins. Corp.*, 175 Or App 618 (2001), the court explained that, for an aggravation claim to be perfected, ORS 656.273 requires a claimant to contact the insurer in a timely manner, to provide the 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).[2]

The critical issue in this case is whether the written medical evidence was sufficient to establish that claimant had suffered a worsening condition "attributable to the compensable injury[,]" pursuant to ORS 656.273(3). Claimant argues that it is, noting that Dr. Cook's aggravation claim referenced the correct claim number for the accepted condition and the correct date of injury for the compensable condition. (Ex. 28-2). Claimant also relies on Dr. Cook's notation that the information he was providing was to benefit in "reopening her claim." (Ex. 28-3). Claimant relies in particular on the following portion of Dr. Cook's June 26, 2000 letter[3] to the insurer:

> "It is, therefore, my opinion that she has an exacerbation of her previous condition, and that until some more sedentary work is found, she should be provided with time-loss." (Ex. 29).

According to claimant, Dr. Cook's attribution of the "exacerbation" to claimant's "previous condition" is more than sufficient to trigger the insurer's obligation to commence interim compensation payments.

Although Dr. Cook attributed claimant's painful and swollen knee to her work, ORS 656.273(3) requires the written medical evidence to show that the worsening condition is "attributable to the compensable injury." Dr. Cook did not explain that claimant's compensable right knee strain had worsened. As the foregoing medical reports demonstrate, claimant had several noncompensable

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[2] ORS 656.273(3) provides:

> "A claim for aggravation must be in writing in a form and format prescribed by the director and signed by the worker or the worker's representative. The claim for aggravation must be accompanied by the attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury."

[3] We note that the insurer does not specifically argue that the July 26, 2000 letter from Dr. Cook did not "accompany" the aggravation claim. For purposes of our analysis, we assume, without deciding, that the July 26, 2000 "clarification" letter may be considered. *Compare Teri Caouette*, 52 Van Natta 767 (2000) (the aggravation claim form was not "accompanied by" a medical report establishing a worsened condition attributable to the compensable injury).

problems with her right knee, in addition to the accepted right knee strain. Neither of claimant's two most recent right knee surgeries were performed for a right knee strain. Dr. Cook diagnosed traumatic chondromalacia patella and posterior horn tear of the medial meniscus in connection with the March 5, 1998 surgery. (Ex. 12). Dr. Sedgewick, who was assisted by Dr. Cook during claimant's December 1, 1998 surgery, diagnosed anterior cruciate ligament laxity, patellofemoral pain and malalignment. (Ex. 14). On April 5, 2000, Dr. Cook said that claimant was medically stationary. (Ex. 24, *see* Ex. 22).

In Dr. Cook's July 26, 2000 letter to the insurer, he referred to claimant's "chronic knee problem" and indicated she could not perform her regular work. (Ex. 29). Although he said claimant had an "exacerbation of her previous condition," he did not explain whether the "previous condition" was the accepted right knee strain or one of the noncompensable conditions, including chondromalacia patella, medial meniscus tear, anterior cruciate ligament laxity, patellofemoral pain or malalignment. We find that Dr. Cook's reports are insufficient to establish that the "previous condition" was the accepted right knee strain. Instead, his July 26, 2000 letter leads to the opposite conclusion. Dr. Cook said that one alternative was to "accept her current condition and determinant degree of disability" (Ex. 29), which indicates that claimant's "current condition" had not yet been accepted.

We conclude that the reports from Dr. Cook for the aggravation claim are not sufficient to establish that claimant had suffered a worsened condition "attributable to the compensable injury." *See Amador R. Gallardo*, 52 Van Natta 487 (2000) (because the medical opinion could indicate the claimant's symptoms were due to a cause other than the compensable injury, the aggravation claim was not perfected); *Susan R. Foster*, 49 Van Natta 2026 (1997) (physician's chart notes did not establish that the claimant's symptoms were due to her prior compensable injury). Therefore, we conclude that claimant is not entitled to interim compensation and we reverse the ALJ's award of interim compensation.

ORDER

The ALJ's order dated April 27, 2001 is reversed in part and affirmed in part. The portion of the ALJ's order that directed the insurer to pay interim compensation from June 30, 2000 through July 28, 2000 and from September 1, 2000 through March 8, 2001, is reversed. Claimant's "out-of-compensation" attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

October 5, 2001 Cite as 53 Van Natta 1384 (2001)

In the Matter of the Compensation of
CARLA S. PEDERSON, Claimant
WCB Case No. 98-05528
ORDER ON REVIEW
Terrall & Terrall, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

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

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

Claimant alleges that she injured her neck and right knee during a fall at work on December 9, 1997. (Exs. 1, 2, 5). The fall was not witnessed. (Tr. 40).

The day of the alleged incident, claimant sought medical treatment from Dr. Moore. (Ex.1). Dr. Moore noted tenderness in claimant's paraspinal muscles, decreased range of cervical motion, and an abrasion on claimant's right knee. (*Id.*) Dr. Moore diagnosed cervical strain and right knee contusion. (*Id.*)

On December 15, 1997, claimant was seen by Dr. Brunswick. (Ex. 6). Dr. Brunswick noted cervical muscle tenderness and decreased range of cervical motion. (*Id.*) Dr. Brunswick diagnosed both cervical strain and knee contusion, and reported that according to claimant, the knee contusion "isn't even a bother any more." (*Id.*)

On December 18, 1997, claimant was seen by Dr. Traina.[1] (Ex. 7). Dr. Traina diagnosed cervical strain and noted decreased cervical range of motion for flexion and rotation. (*Id.*) Dr. Traina referred claimant to physical therapy. (*Id.*)

On April 9, 1998, the employer arranged for claimant to be evaluated by Dr. Telew, a psychiatrist.[2] (Ex. 20-1). Dr. Telew diagnosed malingering. (Ex. 20-6).

On May 12, 1998, the employer denied the claim. Claimant requested a hearing.

The ALJ found that claimant had fallen at work on December 9, 1997. The ALJ determined, based on the findings of Drs. Moore, Brunswick, and Traina, that claimant had injured her neck and right knee as a result of the work incident. Consequently, the ALJ set aside the employer's denial of claimant's cervical and right knee conditions.[3]

On Board review, the employer contends that the opinions of Drs. Moore, Brunswick, and Traina are insufficient to establish the compensability of claimant's cervical strain and right knee contusion. In particular, the employer asserts that the doctors' findings of decreased range of motion, lack of flexion, tightness, and tenderness are "subjective." Consequently, the employer argues that the medical record lacks "real" objective findings sufficient to establish a compensable injury.[4]

In accordance with *SAIF v. Lewis*, 170 Or App 201 (2000), *rev allowed* 331 Or 692 (2001) (requirement of objective findings not satisfied by reports of symptoms not presently verifiable by the physician), we address the question of whether a physician's reference to "decreased range of motion" and abrasion establish that 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; Lewis*, 170 Or App at 212.

Here, claimant's reduced ranges of motion are physical findings that were measured by Drs. Moore, Brunswick, and Traina. As such, claimant's reduced ranges of motion constitute objective findings. *See Patricia A. Waldo*, 53 Van Natta 539 (2001). Additionally, claimant's right knee abrasion (noted by Dr. Moore) is an objective finding because it was "observable." Thus, the claims for "cervical strain" and "right knee contusion" are supported by objective findings. *See* ORS 656.005(19).

The employer asserts that Dr. Telew's opinion regarding claimant's "malingering" negates the findings of Drs. Moore, Brunswick, and Traina. We note, however, that Dr. Telew's opinion is in relation to claimant's alleged memory loss, not in relation to claimant's cervical strain or her right knee contusion. (Ex. 20). Moreover, Dr. Telew did not doubt that claimant had been injured at work, nor did he expressly question the findings of Drs. Moore, Brunswick, and Traina. (Ex. 20-5). Consequently, we reject the employer's argument.

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[1] Dr. Moore, Brunswick, and Traina are in the same clinic.

[2] Dr. Telew was asked to evaluate claimant's complaints of memory loss allegedly the result of the fall at work.

[3] The ALJ also concluded that claimant had failed to establish the compensability of post-concussion syndrome. The parties do not challenge that portion of the ALJ's order.

[4] We acknowledge the employer's assertion that because claimant did not mention a neck or knee injury on the 801 form (Exhibit 5), she apparently did not believe that she had injured those body parts in the fall at work. We note, however, that the 801 form is not signed by claimant; the only signature on the 801 form is from the employer's representative. (Ex. 5). Additionally, we note that the 827 form, which claimant did sign, indicates "injured knee." (Ex. 2). No testimony was produced on this issue. In light of this, we are not persuaded that the description of the body part affected contained on the 801 form can be attributed to claimant. Moreover, the contemporaneous medical records document objective findings of injury to claimant's neck and right knee. Consequently, we reject the employer's argument.

The employer further contends that the March 3, 1999 evaluation performed by Dr. Hartman (another attending physician) casts doubt on the findings of Drs. Moore, Brunswick, and Traina. Like Dr. Telew, Dr. Hartman was not concerned with claimant's cervical strain or right knee contusion; rather he was primarily concerned with postconcussion syndrome. (Exs. 18; 24A-7). On examination, he noted no evidence of embellishment and no residual loss of cervical range of motion. (Ex. 24A-8). Dr. Hartman explained that such a finding would be consistent with the resolution of a cervical strain that had occurred about three months earlier. (*Id.*) Because Dr. Hartman does not expressly challenge the findings of Drs. Moore, Brunswick, and Traina, and because he reported that his evaluation of claimant's cervical spine was not inconsistent with their findings, we reject the employer's argument.

Accordingly, we agree with the ALJ that claimant has established the compensability of her neck and right knee conditions.

ORDER

The ALJ's order dated March 21, 2001, as reconsidered May 9, 2001, is affirmed.

October 5, 2001 Cite as 53 Van Natta 1386 (2001)

In the Matter of the Compensation of
MARK E. SNYDER, Claimant
WCB Case No. 00-08379
ORDER ON REVIEW (REMANDING)
Schneider, et al., Claimant Attorney
VavRosky, et al., Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found claimant had not established extraordinary circumstances beyond his control to justify his failure to appear at a scheduled hearing; and (2) dismissed claimant's hearing request regarding the self-insured employer's "current condition" denial. On review, the issues are postponement and dismissal. We vacate and remand.

FINDINGS OF FACT

Claimant requested a hearing on a "current condition" denial. A hearing was scheduled for June 5, 2001, at 9:00 A.M.[1] At the time and place specified for hearing, attorneys for claimant and the employer appeared. Claimant was not present.

Claimant's attorney had no explanation for claimant's absence, but indicated that claimant's testimony might not be necessary as medical causation was the disputed issue. (Tr. 1). When the ALJ specifically asked if claimant's attorney wished to proceed in claimant's absence, claimant's attorney requested a "continuance." (*Id.*) The employer objected and moved for dismissal of the request for hearing. (Tr. 1-2).

The ALJ decided to issue a dismissal order indicating that claimant could have his hearing request reinstated upon a showing of good cause for failing to appear. (Tr. 2). Thereafter, claimant filed an affidavit stating that he had overslept the morning of the hearing after being up most of the previous night resolving a dispute with his fiancee. The affidavit further stated that claimant had not abandoned his claim and he requested that the matter be reset for hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant's case should not be postponed pursuant to OAR 438-006-0081 and issued an Order of Dismissal. Claimant requested Board review.

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[1] The case was originally set for hearing on February 6, 2001, but postponed at claimant's request in order for claimant to obtain different legal counsel.

Claimant acknowledges that oversleeping does not establish extraordinary circumstances to warrant the postponement of the hearing. Nonetheless, citing *Richard Ensinger*, 51 Van Natta 956 (1999), claimant asserts that the case should be remanded for hearing based on the exhibits submitted prior to the hearing and any witnesses who were prepared to testify at the scheduled hearing. We agree.

OAR 438-006-0071(2) provides:

> "Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the Administrative Law Judge shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

OAR 438-006-0071 does not provide authority for dismissal of a hearing request for failure of a claimant to appear at hearing if claimant's attorney appears on his or her behalf. *See Darius McKellips*, 51 Van Natta 2047 (1999); *Richard Ensinger*, 51 Van Natta at 956. Thus, we disagree with the ALJ's dismissal of the request for hearing. We turn to how the hearing should be conducted on remand.

We have previously held that the procedure for the hearing on remand in cases such as this one depends on whether or not a postponement should have been granted. *Ensinger*, 51 Van Natta at 957. If a postponement should have been granted, then the hearing should be conducted as any other hearing. If, however, a postponement should have been denied, then no exhibit may be received which was not submitted in connection with the prior hearing and no witness, including claimant, may testify if that witness was not available to testify at the prior hearing.

Here, we agree with the ALJ that the circumstances described in claimant's affidavit did not warrant postponement. Although the sequence of events that led to claimant's failure to appear involved complications in his personal life, he essentially overslept. Even assuming that claimant's mistake in oversleeping was due to a good faith expectation that he would be awakened in time to appear at the hearing, the fact remains that claimant was aware of the importance of arriving to attend the hearing at the appropriate time or to notify his counsel or the ALJ of his situation in advance of the hearing. Consequently, the effect of this decision is that claimant has waived his right to testify at the hearing. *Ensinger*, 51 Van Natta at 957.

The employer asserts that claimant's counsel waived the right to present any evidence by declining to proceed in claimant's absence. Contrary to the employer's assertions, claimant's attorney indicated that claimant's testimony might not be necessary and sought a continuance. (Tr. 1). Because waiver is "the intentional relinquishment of a known right" that must be plainly and unequivocally manifested, we conclude, under the circumstances presented here, that claimant's attorney did not waive the right to proceed in claimant's absence. *See Anthony L. St. Julien*, 53 Van Natta 300 (2001).

Having concluded that claimant's attorney did not waive the right to proceed with the hearing, we vacate the ALJ's order and remand for further development of the record based on the exhibits submitted for presentation at the scheduled June 5, 2001 hearing, as well as any witnesses who were present to testify at that hearing. ORS 656.295(5).

Accordingly, we vacate the ALJ's order and remand to ALJ Peterson. The ALJ shall determine what exhibits should be received, but no exhibits shall be admitted that were not prepared for submission as evidence at the June 5, 2001 hearing. Nor shall any witness, including claimant, be permitted to testify who was not prepared to testify at the prior hearing. These proceedings may be conducted in any manner that the ALJ determines achieves substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

ORDER

The ALJ's order dated June 21, 2001 is vacated. This case is remanded to ALJ Peterson for further proceedings consistent with this order.

In the Matter of the Compensation of
NICHOLAS P. WART, Claimant
WCB Case No. 01-00776
ORDER ON REVIEW
Schneider, et al., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Meyers and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that declined to award an assessed attorney fee pursuant to ORS 656.386(1). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

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

On November 7, 2000, claimant filed a claim for a work related back strain with the employer. The date of injury was listed as November 1, 2000.

Claimant failed to respond to a written request from the SAIF Corporation's claims adjuster to telephone her to arrange an interview within two weeks so that she could obtain information to process claimant's claim. Thereafter, the claims adjuster requested that the Department suspend claimant's benefits for failure to cooperate.

On January 2, 2001, the Department issued a notice to claimant and SAIF that notified the parties that: (1) claimant had failed to cooperate in the investigation of his claim; and (2) claimant's compensation would be suspended five working days after the date of the notice unless the Department received a response as directed in the notice.

On January 12, 2001, after the Department received no response to its January 2, 2001 notice, it issued an Order Suspending Compensation Pursuant to ORS 656.262(15). As part of that order, SAIF was authorized to deny claimant's claim for "non-cooperation" if claimant did not cooperate for an additional 30 days after the Department's January 2, 2001 notice. On February 1, 2001, SAIF issued a "non-cooperation" denial.

Claimant, *pro se* at the time, requested a hearing regarding the January 12, 2001 order suspending compensation. That request was received by the Board on January 29, 2001. On March 23, 2001, claimant retained counsel.

At the April 26, 2001 hearing, claimant's attorney raised issues of "Denial orders" dated January 12, 2001 and February 1, 2001. (Tr. 1). After SAIF's attorney noted that SAIF's February 1, 2001 "non-cooperation" denial had never been appealed, claimant's attorney stated that it was "now" being appealed. (Tr. 2).

At hearing, claimant's attorney contended that SAIF's "non-cooperation" denial was void because claimant had cooperated with SAIF's investigation. (Tr. 6). SAIF's attorney contended that claimant continued to fail to cooperate in that he still had not contacted the claims adjuster to arrange an interview. (Tr. 5-7).

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed the Department's January 12, 2001 Order Suspending Compensation in its entirety. The ALJ also set aside SAIF's February 1, 2001 "non-cooperation" denial as void because it issued before the expiration of the statutory 30-day period following the Department's notice that found that claimant had failed to cooperate.[1] Those issues are not contested on review.

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[1] ORS 656.262(15) provides, in part, that "[i]f the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate."

Claimant requested reconsideration of the ALJ's order, raising the issue of entitlement to an assessed attorney fee under ORS 656.386(1). Although reasoning that claimant's attorney was entitled to a "reasonable attorney fee" pursuant to ORS 656.386(1), the ALJ concluded that such a fee should be set at zero. Claimant requested Board review.

Preliminary Matter

In his appellant's brief, claimant states that "[e]nclosed is a copy of a June 21, 2001 letter indicating the claim was accepted" and requests that we either take administrative notice of that document or remand the matter to the ALJ with instructions to admit the document into the Hearings record. However, no document was attached to claimant's brief. In addition, SAIF challenges claimant's request for administrative notice or remand.

There are limitations on both administrative notice and remand for admission of new evidence. In this regard, as a general rule, the Board may take administrative notice of a fact that is "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." ORS 40.065(2). In addition, we may remand a case to the ALJ if we find that the case has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). To merit remand for consideration of additional evidence, it must be clearly shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Claimant makes no argument that his request for administrative notice or remand meets the above limitations. In any event, because we conclude that the admission of any subsequent acceptance will not alter our ultimate decision regarding the ORS 656.386(1) attorney fee issue, we need not address claimant's "administrative notice" or "remand" request.

Attorney Fee

On review, SAIF contends that claimant is not entitled to an assessed attorney fee under ORS 656.386(1) because the "non-cooperation" denial does not qualify as a "denied claim" under ORS 656.386(1)(b)(A). In making this argument, SAIF points to a statement in the "non-cooperation" denial that it was "not a denial on the merits."

ORS 656.386 provides, in relevant part:

> "(1)(a) * * * * * In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall allow a reasonable attorney fee. * * * * *
>
> "(b) For purposes of this section, a 'denied claim' is:
>
> "(A) A claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or *otherwise does not give rise to an entitlement to any compensation*[.]" (Emphasis added).

SAIF's "non-cooperation" denial stated, in part, that "[p]ursuant to ORS 656.262(15), OAR 436-060-0135 and the January 12, 2001 Order suspending compensation, *we deny your claim.*" (Ex. 8, emphasis added). It also contained denial appeal rights, which began with the phrase "[i]f you think this *denial* is not right[.]" (*Id.*, emphasis added). Thus, the clear language of the "non-cooperation" denial indicates that the document was a denial.

Moreover, although the "non-cooperation" denial also stated that it was not a denial on the merits, that statement does not take it out of the realm of a "denied claim" under ORS 656.386(1)(b)(A). As quoted above, ORS 656.386(1)(b)(A) defines a "denied claim" in terms of a carrier's refusal to pay compensation on a claim either on the grounds that it is not compensable on the merits or on the

grounds that it "otherwise does not give rise to an entitlement to any compensation." SAIF's "non-cooperation" denial falls within the latter category. In other words, by issuing the "non-cooperation" denial, SAIF was refusing to pay compensation on claimant's back injury claim on the grounds that he failed to cooperate with its investigation of his claim.

In addition, as quoted above, SAIF stated that it was denying claimant's claim pursuant to ORS 656.262(15),[2] which provides that if a worker does not cooperate for an additional 30 days after the Director's notice, the carrier "may deny the claim because of the worker's failure to cooperate." The statute also provides that, after issuance of a "non-cooperation" denial, certain requirements must be met by the worker or the worker will not be granted a hearing on the merits of the claim and "the worker's claim for injury shall remain denied." ORS 656.262(15). Thus, if the "non-cooperation" denial is not set aside, it becomes a final denial of claimant's claim for injury.

Given all of these factors, we find that SAIF's "non-cooperation" denial represented a "denied claim" under ORS 656.386(1)(b)(A). Furthermore, because the ALJ found that the "non-cooperation" denial was void (a decision that has not been contested on review) claimant finally prevailed against the denial at hearing. Therefore, claimant is entitled to a reasonable assessed attorney fee under ORS 656.386(1). *See Jodie M. Dubose*, 50 Van Natta 1631 (1998) (Board awarded assessed attorney fee for prevailing over a "non-cooperation" denial, rejecting the carrier's argument that a "non-cooperation" denial issued under ORS 656.262(15) did not qualify as a "denied claim" under ORS 656.386(1)), *rev'd on other grounds SAIF v. Dubose*, 166 Or App 642 (2000), *rev allowed* 331 Or 692 (2001).

SAIF argues that the "non-cooperation" denial was not timely appealed and, therefore, claimant's attorney was not instrumental in overturning the denial. However, as the ALJ concluded (and SAIF does not dispute that conclusion), the "non-cooperation" denial was void. It is not necessary to determine whether claimant "timely" requested a hearing on the "non-cooperation" denial because the denial was void and, thus, without legal effect. *See Knapp v. Weyerhaeuser*, 93 Or App 670, 674 (1988), *rev den* 307 Or 326 (1989) (a claimant need not request a hearing within 60 days from a denial which had "no basis in law;" therefore, the ordinary time limitation in ORS 656.319(1)(a) did not apply to foreclose the claimant's hearing request from the invalid denial); *Patricia A. Waldo*, 53 Van Natta 536 (2001); *Richard J. James*, 52 Van Natta 1677 (2000) (a denial issued in response to a withdrawn claim is null and void, without legal effect, and invalid *ab initio*; therefore, failure to request a hearing on such a denial does not preclude a claimant from subsequently reasserting the claim).

SAIF also argues that claimant is not entitled to an assessed attorney fee because overturning the "non-cooperation" denial did not result in any benefits to claimant. Instead, SAIF argues, the action that occurred as a result of the denial being overturned is that SAIF was required to investigate the claim and determine whether it should be accepted or denied. In support of this argument, SAIF cites *William C. Becker*, 47 Van Natta 1933 (1995). We disagree with SAIF's argument and find *Becker* distinguishable.

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[2] ORS 656.262(15) provides:

"If the director finds that a worker fails to reasonably cooperate with an investigation involving an initial claim to establish a compensable injury or an aggravation claim to reopen the claim for a worsened condition, the director shall suspend all or part of the payment of compensation after notice to the worker. If the worker does not cooperate for an additional 30 days after the notice, the insurer or self-insured employer may deny the claim because of the worker's failure to cooperate. The obligation of the insurer or self-insured employer to accept or deny the claim within 90 days is suspended during the time of the worker's noncooperation. After such a denial, the worker shall not be granted a hearing or other proceeding under this chapter on the merits of the claim unless the worker first requests and establishes at an expedited hearing under ORS 656.291 that the worker fully and completely cooperated with the investigation, that the worker failed to cooperate for reasons beyond the worker's control or that the investigative demands were unreasonable. If the Administrative Law Judge finds that the worker has not fully cooperated, the Administrative Law Judge shall affirm the denial, and the worker's claim for injury shall remain denied. If the Administrative Law Judge finds that the worker has cooperated, or that the investigative demands were unreasonable, the Administrative Law Judge shall set aside the denial, order the reinstatement of interim compensation if appropriate and remand the claim to the insurer or self-insured employer to accept or deny the claim."

As explained above, the "non-cooperation" denial is a "denied claim" under ORS 656.386(1); *i.e.*, it is a "claim for compensation" that SAIF refused to pay on the ground that it "otherwise does not give rise to an entitlement to any compensation." In order to be entitled to an attorney fee under ORS 656.386(1), the statute requires that the claimant prevail against a "denied claim," as that term is defined in the statute. Here, claimant has done that.

In *Becker*, the claimant initially made an occupational disease claim, but withdrew that claim before the statutory period for investigating the claim had run. Nevertheless, after the claimant withdrew the claim, the carrier issued a "denial." We found that a denial issued in the absence of a claim was a nullity and without effect. We also found that under ORS 656.386(1), the claimant had to prevail over a "denied claim" to be entitled to attorney fees. Because the claimant had withdrawn his claim, he did not prevail over a "denied claim," and he was not entitled to an attorney fee award under ORS 656.386(1).

Here, unlike *Becker*, claimant did not withdraw his claim. At the time of the "non-cooperation" denial, claimant's back injury claim remained viable. *Compare 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). Therefore, here, a "denied claim" existed and claimant prevailed over that denial.

Accordingly, based on the above reasoning, we find that claimant is entitled to a reasonable attorney fee under ORS 656.386(1) for prevailing over the "non-cooperation" denial at hearing.[3] After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the "non-cooperation" denial is $500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the denial issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. Claimant is not entitled to an attorney fee for services at hearing or on review devoted to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 461 (1986); *Amador Mendez*, 44 Van Natta 736 (1992).

ORDER

The ALJ's order dated May 16, 2001, as reconsidered on June 4, 2001, is reversed in part and affirmed in part. That portion of the order that declined to award an assessed attorney fee is reversed. For services at hearing regarding the "non-cooperation" denial, claimant's attorney is awarded a fee of $500, payable by the SAIF Corporation. The remainder of the ALJ's order is affirmed.

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[3] The availability of a "386(1)" attorney fee is dependent on whether the carrier elects to issue a "non-cooperation" denial. ORS 656.262(15) does not require the carrier to issue such a denial; it provides that "the insurer or self-insured employer *may* deny the claim because of the worker's failure to cooperate." (Emphasis added.) If the carrier elects to issue a "non-cooperation" denial, and the worker later prevails over the denial, the carrier would be liable for an attorney fee. If, on the other hand, the carrier elects not to issue a "non-cooperation" denial, a "386(1)" attorney fee would not be available, and the Director's suspension of the payment of compensation would remain in effect until the worker reasonably cooperates with the claim investigation. *See Jodie M. Dubose*, 50 Van Natta at 1634 fn 6.

In the Matter of the Compensation of
LYNN E. FISHER, Claimant
WCB Case Nos. 00-06199 & 00-04004
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.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) found that the Hearings Division did not have jurisdiction to determine whether the SAIF Corporation's claimed offset was properly before the Appellate Unit; (2) authorized SAIF's offset for allegedly overpaid temporary disability compensation; and (3) declined to assess a penalty for SAIF's allegedly unreasonable claim processing and allegedly unauthorized offset. On review, the issues are jurisdiction, offset, claim processing and penalties. We affirm.

FINDINGS OF FACT

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

On October 20, 1998, SAIF accepted claimant's claim for disabling cervical and lumbar disc herniations. (Ex. 2). SAIF opened claimant's claim for payment of temporary disability compensation effective May 14, 1998. On November 23, 1998, SAIF referred claimant for a vocational training eligibility evaluation. (Ex. 20). The vocational training evaluators were in the process of clarifying medical information when, on February 10, 1999, claimant wrote a letter stating: "I have retired and I am going to decline any further vocational services." (Exs. 3, 4).

On April 7, 1999, SAIF issued a Notice of Ineligibility for Vocational Assistance based on claimant's February 10, 1999 letter declining vocational services. (Ex. 5). On June 18, 1999, SAIF petitioned the Director for authorization to reduce claimant's temporary disability benefits to zero for failure to engage in vocational rehabilitation. (Ex. 8).

On June 24, 1999, the Director issued an Order Denying Reduction of Benefits Pursuant to ORS 656.325(4). (Ex. 0E). The order concluded that reduction of benefits under ORS 656.325(4) could be considered only after the claim had been closed and benefits awarded under ORS 656.268. SAIF initially requested a hearing with the Board's Hearings Division from that order, but subsequently withdrew its hearing request and requested that the hearing be dismissed without prejudice. The Board ultimately affirmed an Opinion and Order that dismissed SAIF's hearing request without prejudice. *See Lynn E. Fisher*, 52 Van Natta 1492 (2000).

Claimant became medically stationary on February 9, 2000. On March 1, 2000, SAIF issued a Notice of Closure that awarded 47 percent unscheduled permanent disability and temporary disability benefits from May 14, 1998 through February 9, 2000, with the exception of the period from December 29, 1998 through January 17, 1999 (no temporary benefits were awarded for that period). (Ex. 12). The notice also alleged that SAIF had incurred an overpayment of benefits in the amount of $2,215.80.

In a March 31, 2000 letter to claimant and his attorney, SAIF provided notice of an overpayment of $26,158.43, based on claimant's refusal to participate in vocational services for the period from April 8, 1999 (the date of SAIF's Notice of Ineligibility for Vocational Assistance) through February 9, 2000. (Ex. 15).

Claimant requested reconsideration of the March 1, 2000 closure from the Workers' Compensation Appellate Review Unit, raising issues regarding the rating of permanent disability, temporary disability dates, and offset. (Ex. 15A). Regarding the offset issues, claimant contested SAIF's assertion that it was entitled to offsets for the periods from December 29, 1998 through January 17, 1999, and from April 8, 1999 through February 9, 2000. (Ex. 15A-2).

On April 17, 2000, SAIF petitioned the Director pursuant to ORS 656.325(4) for a reduction in temporary disability compensation from February 10, 1999 to February 10, 2000 for claimant's failure to participate in a vocational rehabilitation program. (Ex. 16). In an April 18, 2000 letter to the Director, claimant objected to SAIF's petition. (Ex. 17).

On April 24, 2000, SAIF submitted a Supplemental Reconsideration Request in which it requested "permission to offset any overpayments as allowed by law." (Ex. 17A).

In a May 1, 2000 letter to the Director entitled "Petition for Reduction of Benefits," SAIF raised several points in support of its April 17, 2000 Petition for Reduction of Benefits. (Ex. 19). SAIF also noted that claimant had requested reconsideration of the March 1, 2000 closure. SAIF requested that "this overpayment issue be considered at reconsideration and [claimant's] benefits be reduced accordingly." (Ex. 19).

A July 10, 2000 Order on Reconsideration increased the permanent disability award to 53 percent and awarded claimant temporary disability benefits for the entire period from April 15, 1998 through February 9, 2000, based on the attending physician's authorization. (Ex. 21). The Order on Reconsideration also noted that modifications made in claimant's compensation might affect the compensation that had become due and payable. Accordingly, the order declined to affirm the $2,215.80 overpayment alleged in SAIF's Notice of Closure. In addition, the order noted that a March 31, 2000 letter from SAIF to claimant indicated an overpayment of $26,158.43, although the amount of the additional request was "not on the face of the 3-01-00 Notice of Closure." Finally, the order directed SAIF to recalculate the amount of compensation due and payable and to notify the parties of the results. After recalculation, the order authorized SAIF to deduct any overpaid temporary disability and/or previously paid permanent disability against any unpaid permanent disability in accordance with the law. (Ex. 21-4, -5).

In an August 4, 2000 letter, SAIF notified claimant that it was recovering an overpayment of $22,250.09 out of future disability benefits, based on his failure to participate in vocational services for the period from April 8, 1999 through February 9, 2000. (Exs. 23, 24). SAIF indicated that it calculated this amount by deducting the additional temporary disability awarded by the Order on Reconsideration ($3,908.34) from the $26,158.43 alleged overpayment due to "failure to participate in voc[ational] services." (Ex. 24-1). SAIF began to offset claimant's compensation.

On August 7, 2000, claimant requested a hearing on the Order on Reconsideration, raising the issues of offset, improper claim processing, penalties and attorney fees. Instead of a hearing, the parties submitted the matter based on the documentary record and written closing arguments.

In a September 12, 2000 letter, the Sanctions Unit addressed SAIF's April 17, 2000 "Petition for Reduction of Benefits." (Ex. 26). The Sanctions Unit notified SAIF that it lacked jurisdiction over the alleged overpayment for claimant's failure to participate in vocational services because the alleged overpayment had been incorporated within the July 10, 2000 Order on Reconsideration, which had been appealed to the Hearings Division. (*Id.*)

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

Reasoning that neither party requested a hearing from the July 10, 2000 Order on Reconsideration, the ALJ found that the reconsideration order had become final by operation of law. Thus, the ALJ determined that the Hearings Division was without authority to determine whether the offset issue was properly before the Appellate Unit. Nevertheless, because the offset issue was actually addressed by the Order on Reconsideration, and claimant's hearing request challenged SAIF's actions subsequent to the reconsideration order, the ALJ concluded that the Hearings Division had jurisdiction to determine whether SAIF's actions subsequent to the order were proper. Based on the following reasoning, we find that the Hearings Division and the Board have jurisdiction over the offset issue.

Contrary to the ALJ's holding and SAIF's argument on review, claimant timely requested a hearing regarding the July 10, 2000 Order on Reconsideration.[1] In that request for hearing, claimant raised the issues of improper offset, improper claims processing, unauthorized offset, penalties, and

[1] In his reply brief, however, claimant states that he is not challenging the Order on Reconsideration, but only SAIF's designation of overpaid temporary disability benefits.

attorney fees. Based on claimant's timely hearing request that specifically challenged the offset issue, we have jurisdiction over that issue, including determining whether the offset issue was properly before the Appellate Unit.[2]

Offset of Overpaid Temporary Disability Benefits

As summarized in the above findings of fact, this case presents a complex procedural history regarding the issue of offset of allegedly overpaid temporary disability benefits. Both at hearing and on review, claimant essentially argues that the offset issue was not properly before the Appellate Unit. Alternatively, claimant argues that the July 10, 2000 Order on Reconsideration is insufficient to serve as the Director's authorization to offset any overpaid temporary disability benefits under ORS 656.325(4) and OAR 436-060-0105(13). SAIF counters that the offset issue was properly before the Appellate Unit and the Order on Reconsideration sufficiently serves as the Director's authorization to offset the overpayment under the above statute and rule. Based on the following reasoning, we agree with SAIF.

ORS 656.325(4) provides:

> "When the employer of an injured worker, or the employer's insurer determines that the injured worker has failed to follow medical advice from the attending physician or has failed to participate in or complete physical restoration or vocational rehabilitation programs prescribed for the worker pursuant to this chapter, the employer or insurer may petition the director for reduction of any benefits awarded the worker. Notwithstanding any other provision of this chapter, if the director finds that the worker has failed to accept treatment as provided in this subsection, the director may reduce any benefits awarded the worker by such amount as the director considers appropriate."

OAR 436-060-0105(13) provides:

> "The Director may reduce any benefits awarded the worker under ORS 656.268 when the worker has unreasonably failed to follow medical advice, or failed to participate in a physical rehabilitation or vocational assistance program prescribed for the worker under ORS chapter 656 and OAR chapter 436. Such benefits shall be reduced by the amount of the increased disability reasonably attributable to the worker's failure to cooperate."

First, we find that the offset issue was properly before the Appellate Unit during the reconsideration process. Pursuant to ORS 656.325(4), SAIF petitioned the Director for reduction of any benefits awarded claimant. Although the Director found that SAIF's initial petition for reduction of benefits was premature because it was made before claim closure and, thus, before any award under ORS 656.268, SAIF again petitioned for such relief after claimant's claim was closed under ORS 656.268 with an award of permanent disability compensation. Specifically, after the March 1, 2000 claim closure, on April 17, 2000, SAIF petitioned the Director pursuant to ORS 656.325(4) for reduction in temporary disability from February 10, 1999 to February 10, 2000 for claimant's failure to participate in a vocational rehabilitation program. (Ex. 16). In an April 18, 2000 letter to the Director, claimant objected to SAIF's petition, arguing that SAIF's attempt to cut off time loss from April 1999, before claimant was medically stationary and before his claim was closed, was "improper and without merit." (Ex. 17).

In a May 1, 2000 letter to the Director, SAIF responded to claimant's April 18, 2000 letter, raising several points supporting its April 17, 2000 petition. (Ex. 19). SAIF explained that new facts, *i.e.*, its March 1, 2000 claim closure, made its request for reduction of benefits timely and mature for the Director's decision. SAIF also noted that claimant had requested reconsideration of the March 1, 2000 claim closure. SAIF requested that "this overpayment issue be considered at reconsideration and the benefits be reduced accordingly." (*Id.*) Finally, SAIF requested an early decision, noting that pending the Director's decision, it was paying out the permanent disability compensation on a monthly basis.

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[2] In the alternative, pursuant to ORS 656.704(1) and (3), we would have jurisdiction of claimant's challenge to SAIF's offset of alleged overpaid temporary disability benefits. This is apparently the jurisdiction referred to in the ALJ's order. Subject to limitations not applicable here, ORS 656.704(1) and (3) provide that the Hearings Division and the Board have jurisdiction over "matters concerning a claim," which are defined as "matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3)(a). Claimant's objection to SAIF's claimed offset of any allegedly overpaid temporary disability compensation concerns a worker's right to receive compensation or the amount thereof. Therefore, the offset issue is a "matter concerning a claim" and, as such, is within the Hearings Division's and our jurisdiction.

Thus, the issue of SAIF's petition for reduction of benefits under ORS 656.325(4) was before the Director during the reconsideration process. Both parties addressed the overpayment/offset issue and presented their written positions during the reconsideration process.[3] (Exs. 16, 17, 19). Based on the above evidence, we find that, in accordance with ORS 656.325(4), SAIF petitioned the Director for reduction of any benefits awarded claimant for failure to participate in or complete a prescribed vocational rehabilitation program.

The question remains, however, whether the Director granted SAIF's petition by means of the July 10, 2000 Order on Reconsideration. Based on the following reasoning, we find that the Director granted SAIF's requested relief.

The Order on Reconsideration addressed the temporary disability issue, in part, by finding that claimant was medically stationary on February 9, 2000, and noting that evidence showed that claimant "retired from the workforce effective 2-10-00 [*sic*]." (Ex. 21-2). The order addressed the overpayment/offset issue in a section entitled "OTHER" and stated:

> "The worker's temporary disability and permanent partial disability have been modified which may affect the compensation due and payable. Therefore, the overpayment amount of $2,215.80 as noted on the NOTICE OF CLOSURE dated March 1, 2000 is not affirmed. We also find a letter dated 3-31-00 from SAIF to the work [*sic*] indicating an overpayment of $26,158.43, an amount which is not on the face of the 3-01-00 Notice of Closure. The insurer shall recalculate the amount of compensation due and payable and notify the parties of the results. After recalculation, recovery of any resulting overpayment is authorized." (Ex. 21-4).

The "order" language of the Order on Reconsideration is identical to the above quoted language with the following exceptions: (1) the third sentence of the above paragraph is not included in the order language; and (2) the last sentence of the above paragraph is replaced with the following sentence in the order language: "After recalculation, deduction of overpaid temporary disability and/or previously paid permanent disability from any unpaid permanent disability is approved in accordance with the law." (Ex. 21-5).

Claimant argues that the reconsideration order is inadequate as a decision under ORS 656.325(4) because it does not contain any findings regarding whether claimant "unreasonably" failed to participate in a vocational assistance program. In support of this argument, claimant cites several cases involving the failure of workers to undergo *medical treatment*, to which the courts and the Board have applied a "reasonableness" standard. *Nelson v. EBI Companies*, 296 Or 246, 250 (1984); *Reef v. Willamette Industries*, 65 Or App 366 (1983) (court held that under ORS 656.325(2), the claimant may not be denied benefits if he reasonably refuses treatment that is "reasonably essential to promote recovery"); *Sharon S. Webster*, 46 Van Natta 2438 (1994) (applied ORS 656.325(1)(a) and determined that failure to attend examination not unreasonable); *Paul F. Weigel*, 44 Van Natta 44 (1992) (refusal to undergo proposed surgery not unreasonable). These cases are distinguishable because they involve interpretation of other statutes and/or failure to undertake medical treatment, not vocational services.

In addition, as quoted above, neither ORS 656.325(4) nor OAR 436-060-0105(13) provides that the failure to participate in a prescribed vocational rehabilitation program must be "unreasonable" for the Director to reduce benefits. Although OAR 436-060-0105(13) provides a "reasonableness" standard for failure to follow *medical advice*, it does not provide that same standard for failure to participate in a prescribed vocational assistance program. Pursuant to ORS 656.325(4) and OAR 436-060-0105(13), simply failing to participate in or complete a prescribed vocational rehabilitation program allows the carrier to petition for and the Director to grant a reduction of any benefits awarded the worker.

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[3] Claimant contends that, if the Order on Reconsideration is determined to be the Director's order authorizing reduction of benefits under ORS 656.325(4), he was deprived of a reasonable opportunity to defend against SAIF's attempt to reduce his benefits. We disagree. As summarized above, during the reconsideration process, claimant had the opportunity (and availed himself of that opportunity) to defend against SAIF's attempt to reduce his benefits via the petition for reduction of benefits under ORS 656.325(4). Furthermore, claimant had the opportunity (and availed himself of that opportunity) to request a hearing on the Order on Reconsideration.

Claimant also argues that no vocational assistance program was "prescribed" for him under ORS chapter 656 and OAR chapter 436. Thus, claimant contends that neither ORS 656.325(4) nor OAR 436-060-0105(13) would apply to authorize an offset of any alleged overpayment of temporary disability benefits. We disagree.

An insurer is required to contact a worker with an accepted disabling claim to begin the eligibility determination within five days of the insurer's receipt of a medical or investigative report sufficient to document a need for vocational assistance, including medical verification of projected or actual permanent limitations due to the injury. OAR 436-120-0320(1)(b). Claimant was receiving vocational services in the form of an eligibility evaluation when he retired from the work force and declined further vocational services. (Exs. 4, 20-1). Because the eligibility evaluation stage is the initial phase of the vocational rehabilitation process, the evaluation is necessarily encompassed within the term "prescribed vocational rehabilitation program." Furthermore, by retiring from the work force and declining further vocational services, claimant failed to participate in or complete the prescribed vocational rehabilitation program.

Claimant argues that the Order on Reconsideration does not represent a determination by the Director that claimant's benefits are to be reduced or the amount of such reduction. We disagree.

Although the Director's handling of the offset issue under ORS 656.325(4) in the Order on Reconsideration is conclusory, the order finds that claimant retired from the work force, mentions the March 31, 2000 letter in which SAIF notifies claimant of overpaid temporary disability in the amount of $26,158.43 for failure to participate in vocational services, and directs SAIF to recalculate the amount of compensation due as awarded by the order and deduct any overpaid temporary disability and/or previously paid permanent disability from any unpaid permanent disability. In other words, the Director authorized deduction of the entire overpayment of temporary disability benefits. Thus, contrary to claimant's arguments, the Director specifically approved SAIF's petition for reduction of benefits under ORS 656.325(4). This interpretation is supported by the Sanctions Unit's September 12, 2000 letter stating that it lacked jurisdiction over SAIF's April 17, 2000 "Petition for Reduction of Benefits" because the overpayment was incorporated in the July 10, 2000 Order on Reconsideration that had been appealed to the Hearings Division. (Ex. 26).

Claimant correctly contends that the Order on Reconsideration only authorizes deduction of overpaid temporary disability benefits "in accordance with the law." However, claimant argues that such authorization does not permit reduction of benefits by the $26,158.43 overpayment sought by SAIF.[4] We disagree.

Claimant must be in the work force to be entitled to temporary disability. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989). Claimant was in the work force when he was disabled; therefore, he is entitled to temporary disability during the periods authorized by his attending physician and while he remained in the work force.

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[4] Claimant also argues that his benefits should not have been reduced by the full amount of alleged overpayment of $26,158.43, contending that, if he had completed a vocational rehabilitation program, at best, vocational assistance might have placed him in a minimum wage job. However, ORS 656.325(4) does not provide for any apportionment of damages when a worker fails to participate in or complete a prescribed vocational rehabilitation program. Although OAR 436-060-0105(13) provides that "benefits shall be reduced by the amount of the increased disability reasonably attributable to the worker's failure to cooperate[,]" a rule may not add language that is not in the applied statute.

In any event, because claimant retired from the work force before completing the eligibility process, there is no evidence in the record regarding claimant's potential for earnings following completion of a vocational rehabilitation program. The report claimant cites in support of his argument for some sort of apportionment of damages actually refers to his earning potential at his current level of disability *without* vocational services. (Ex. 20).

More importantly, as explained below, SAIF has complied with the Director's order to offset the overpayment "in accordance with the law."

As of February 10, 1999, claimant retired and declined further vocational services. (Ex. 4). Claimant does not contend that he remained in the work force after his February 10, 1999 retirement. Nevertheless, SAIF does not request an offset of temporary disability benefits from the date of retirement. Instead, it requested and received an offset of temporary disability benefits from April 8, 1999, the day after its Notice of Ineligibility for Vocational Assistance, through February 9, 2000. (Exs. 21, 23, 24).

In the alternative, even if the "vocational reduction" issue was not encompassed within the Order on Reconsideration, we would still be authorized to address the overpayment/offset issue. In other words, the Order on Reconsideration awarded temporary disability for a specific time period. To receive entitlement to such benefits, claimant must be in the work force during that time period.

In closing the claim by means of a Notice of Closure, SAIF awarded temporary disability benefits and asserted an overpayment. Thereafter, by virtue of claimant's appeal, the Notice of Closure was subject to the "reconsideration" process, including temporary disability awards granted therein, as well as the accompanying offset/overpayment issues. In addition, during the reconsideration proceeding, SAIF submitted its audit letter, further clarifying its claim for an overpayment/offset. In other words, claimant's entitlement to temporary disability (including his withdrawal from the work force) and SAIF's accompanying overpayment/offset request exist even if its earlier request for reduction of benefits for failure to participate in vocational services had not been made or acted upon.

Therefore, assuming without deciding that the Order on Reconsideration did not address the "vocational reduction" issue (and we find that it likely did based on references to SAIF's letter and comments in the order, as addressed above) the Hearings Division and the Board still have authority over the overpayment/offset issue because the order addressed temporary disability entitlement (which necessarily includes "work force" issues), overpayment, and offset. Moreover, as addressed above, because claimant is entitled to temporary disability only while he remained in the work force, he has received an overpayment of temporary disability benefits that SAIF is entitled to offset.

Penalty

Because we find that SAIF properly petitioned and received an order from the Director authorizing a reduction of benefits under ORS 656.325(4), we do not find SAIF's actions unreasonable. Therefore, no penalty is appropriate.

ORDER

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

October 8, 2001 Cite as 53 Van Natta 1397 (2001)

In the Matter of the Compensation of
JOHN B. RILEY, Claimant
Own Motion No. 01-0261M
OWN MOTION ORDER OF ABATEMENT
Welch, et al., Claimant Attorney
Employers Insurance of Wausau, Insurance Carrier

Reviewing Panel: Members Haynes and Biehl.

Claimant requests reconsideration of our September 20, 2001 Own Motion Order, that affirmed the carrier's June 28, 2001 Notice of Closure.

In order to allow sufficient time to consider the motion, we withdraw our order and implement the following briefing schedule. Claimant is granted 21 days from the date of this order to file his opening argument, including supporting documents. The insurer's response must be filed within 21 days of the mailing date of claimant's submission. Claimant has 14 days from the date of the insurer's response to submit his reply. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM C. MILLER, Claimant
WCB Case No. 00-07800
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Randy Rice, Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's "de facto" denial of claimant's disc protrusion at L5-S1. 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, a truck driver and dispatcher, had two prior surgeries to the L5-S1 level in the 1980's. On February 12, 2000, claimant was driving his truck when he was involved in a work-related collision with a pick-up truck. That evening, claimant sought treatment at a hospital emergency room for pain in the region of the shoulder blades, lower back, both hips laterally with some radiation of pain down into his legs extending from the posterior thigh to the heels in a sciatic distribution. Claimant indicated he had been bothered off and on by some pain and intermittent numbness since his two prior L5-S1 surgeries, but the pain was not as severe as that following the motor vehicle accident. A lumbar strain with sciatica was diagnosed. (Ex. 5).

Claimant filed a claim for the injury that was accepted by the insurer as a nondisabling cervical and lumbar strain. Claimant received treatment from Mr. Freeman, PAC, following the injury. Dr. Michels, D.C., became claimant's attending physician on June 7, 2000. An MRI dated June 16, 2000 revealed prior laminectomy at L5-S1 and a recurrent large disc protrusion at L5-S1 centrally and producing left-sided neural foraminal encroachment. (Ex. 26).

Dr. Michels referred claimant to Dr. Brett, a neurologist. Dr. Brett, who became claimant's attending physician, opined that the February 12, 2000 injury caused a pathologic worsening resulting in further disc protrusion and annular injury at L5-S1 and increased left S1 radiculitis/pain. (Ex. 27-2).

In a July 6, 2000 letter, claimant's attorney requested that the insurer amend its acceptance to include "disc protrusion at L5-S1 centrally with left-sided neural foraminal encroachment." (Ex. 29). Claimant filed a hearing request contesting a "de facto" denial of the L5-S1 disc condition on October 17, 2000.

The ALJ found the opinions of claimant's treating physicians, Dr. Brett and Dr. Michels, insufficiently persuasive to establish compensability of claimant's L5-S1 disc condition. In this regard, the ALJ concluded that the opinions of Drs. Brett and Michels did not persuasively show that the injury was the major contributing cause of claimant's L5-S1 disc condition under the weighing analysis required by *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995) (determining the major contributing cause involves an evaluation of the relative contribution of different causes of an injury or disease and deciding which is the primary cause).

Based on the medical evidence in this record, ORS 656.005(7)(a)(B) is applicable in determining compensability. Accordingly, claimant must show that the injury is the major contributing cause of his 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). To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to his need for treatment and disability for the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). Four medical experts have addressed claimant's L5-S1 disc condition.

Dr. Baker, orthopedic surgeon, examined claimant on behalf of the insurer. He opined that claimant's disc condition at L5-S1 probably preexisted the February 12, 2000 motor vehicle accident. He based this opinion on the fact that claimant was slowly returning to his pre-injury status with no significant symptoms different from those that were present prior to his accident. Dr. Baker opined that the February 12, 2000 injury caused soft tissue cervical and lumbar muscular strains that had subsided and that any residual impairment was related to degenerative change in both the cervical and lumbar areas. (Ex. 33).

In response to Dr. Baker, Dr. Brett noted that claimant's MRI showed a recurrent disc herniation centrally and to the left at L5-S1 in the setting of degenerative change and moderate intervertebral disc space narrowing. Dr. Brett opined that there had probably been a pathological worsening with further injury to the annulus centrally and to the left at L5-S1 with increased disc protrusion resulting in increased symptoms as a direct result of the February 12, 2000 injury. Dr. Brett felt that the injury was the major contributing factor to claimant's worsened condition. (Ex. 38A).

Dr. Michels, a chiropractic physician, opined that the February 12, 2000 accident is the major contributing cause of claimant's current spinal complaints and disability. (Ex. 40).

Dr. Murray, a neurologist, reviewed claimant's medical records on behalf of the insurer. Dr. Murray noted that claimant had ongoing symptoms of left lower extremity pain and paresthesias preceding the February 12, 2000 accident. Dr. Murray noted that following the accident, in March 2000, claimant had significant reduction of pain and nearly full functional recovery. Dr. Murray indicated that the fact that claimant did not relate a subjective history of lower extremity symptoms in March 2000 argued strongly in favor of a cervical/lumbar strain without evidence of acutely recurrent disk protrusion at L5-S1 with neural foraminal encroachment and nerve root irritation at S1.

Dr. Murray further stated that:

> "Other reasons to support the lack of radiculopathy/nerve root involvement include the clinical pattern of his symptom progression. This claimant was nearly asymptomatic in March of 2000, without complaints of lower extremity symptoms, and did not relate in the clinical record any intervening reinjury to his low back. His symptoms related to [Dr. Michels] were nonspecific and there was no correlating objective evidence to support a progressive neurologic event in the lumbosacral region. In addition, the clinical pattern of progressive radiculopathy secondary to disk protrusion with nerve root compression from neural foraminal encroachment over the course of an 11-month period of time would most likely reveal a clinical pattern of greater symptoms progression than this claimant presents with. In addition, there are no objective changes in his neurologic examination form his preinjury status. The objective neurologic deficits that are present, in my opinion, are secondary to the postoperative events occurring in 1992 from his prior L5-S1 disk herniation." (Ex. 41-7).

Dr. Murray indicated that she concurred with Dr. Baker that claimant's L5-S1 disk protrusion most likely preexisted the February 12, 2000 injury and was symptomatically exacerbated. Dr. Murray indicated that it was not uncommon for postoperative disk protrusions to occur on a slow, progressive, long-term basis without significant neurologic deficit and that this, in her opinion, was what occurred with claimant. Dr. Murray concluded that, given the mechanism of injury, with very little trauma sustained to the lumbosacral area and no evidence of axial loading of the spinal column, the February 12, 2000 accident resulted only in soft tissue cervical and lumbar strains. (Ex. 41-7).

In response to Dr. Murray's report, Dr. Brett noted that claimant was doing reasonably well prior to his accident and that although he had some occasional and intermittent left leg complaints, they would radiate only as far as the knee and likely represented referred pain rather than true radicular pain. Dr. Brett opined that there was a very significant impact and trauma in the February 12, 2000 accident, that claimant had immediate worsening of his low back discomfort and then the development of radicular pain into both legs, extending into the left leg distally below the knee representing true radicular pain into the left leg and referred pain into the right leg. Dr. Brett stated that simply because claimant did not have a progressive neurologic deficit did not mean that there was no pathological worsening caused by the February 2000 accident. Dr. Brett concluded that claimant had a combined condition and a "weak shell." However, Dr. Brett stated that claimant's injury was "at least a material contributing factor to his pathologic worsening. In fact, in my opinion, this was the major contributing factor in all medical probability." (Ex. 42-2).

Although the ALJ found that Dr. Brett's views were more concordant with claimant's credible testimony, he also concluded that Dr. Brett's explanation was insufficient under *Dietz*. 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 do not find persuasive reasons not to defer to Dr. Brett (whose opinion is supported by that of Dr. Michels). As the ALJ noted, Dr. Brett's history was most consistent with claimant's testimony. In addition, Dr. Brett was aware of claimant's prior L5-S1 surgeries and his symptoms prior to the February 12, 2000 accident. Based on his opinions, he engaged in the weighing analysis required by *Dietz* and considered the contribution of claimant's prior L5-S1 surgeries as well as the contribution from the February 12, 2000 injury. Dr. Brett concluded that the injury was the major cause of claimant's disability and need for treatment. In addition, Dr. Brett responded to the opinions of both examining physicians.

Dr. Murray performed only a record review and never examined claimant. Moreover, Dr. Murray believed that little trauma was sustained to the lumbosacral area, which is not consistent with claimant's testimony regarding the severity of the accident.

Based on this record, we find no persuasive reason not to rely on Dr. Brett's opinion. Accordingly, we conclude that the "de facto" denial should be set aside.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the 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 on review is $4,700, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated April 27, 2001 is reversed. The "de facto" denial is set aside and the claim is remanded to the insurer for processing in accordance with law. For services at hearing and on review, claimant's attorney is awarded $4,700, payable by the insurer.

In the Matter of the Compensation of
GEMMA ZON, Claimant
WCB Case No. 00-04080
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Bostwick, et al., Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Haynes. Member Haynes dissents.

The self-insured employer request review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of claimant's injury/occupational disease for a right shoulder condition. On review, the issue is compensability.

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

We do not adopt the first sentence of the final paragraph of the ALJ's "Ultimate Findings of Fact." With that modification, we now proceed with our supplementation of the ALJ's order.

The ALJ set aside the employer's denial of claimant's right shoulder condition, finding that claimant had sustained her burden of proving that the disputed condition was compensable. In so doing, the ALJ first rejected claimant's argument that her right shoulder condition was compensable as an occupational disease. However, the ALJ determined that the right shoulder condition was compensable under an accidental injury theory. The ALJ reasoned that the period of time in which claimant alleged her right shoulder injury occurred (operating a machine for one and one-half days while performing a special project) was sufficiently discrete to be considered an injury claim. Moreover, because the medical evidence did not establish that work activity combined with a preexisting condition, the ALJ applied a material contributing cause standard to the compensability determination.

The ALJ then noted the discrepancy between claimant's description of the work activity that allegedly caused the right shoulder condition, diagnosed by her attending physician, Dr. Gardner, as a right shoulder strain, and that of a supervisor, Ms. Tobin. Finding no reason to question the truthfulness of either witness, the ALJ, nevertheless, found claimant's version of events to be the more accurate of the two. Turning to an evaluation of the medical evidence, the ALJ concluded that Dr. Gardner's opinion established that claimant's work activities over one and one-half days caused a need for treatment and disability and, therefore, that the claim was compensable.

On review, the employer contends that the medical opinions of an examining physician, Dr. Thompson, and of a physician, Dr. Yarusso, who reviewed medical records, are more persuasive than Dr. Gardner's opinion. The employer asserts that Dr. Gardner relied on an inaccurate history concerning the amount of time claimant spent working at machine in light of Ms. Tobin's testimony that claimant spent, not 12 hours at the machine as claimant alleged, but rather three to four hours. The employer also notes Ms. Tobin's testimony that claimant's duties were not very strenuous, requiring only and one-half pounds of force to operate the machine. Contrasting Ms. Tobin's "crystal clear understanding and recollection" of the project in which claimant allegedly sustained her injury with what it describes as claimant's "vague, hesitant and clearly inconsistent" testimony, the employer argues that Tobin's testimony is more reliable and supports the conclusions of Drs. Thompson and Yarusso that claimant's work activity in February 2000 did not result in a right shoulder sprain.

We first turn to the credibility issue. Like the ALJ, we are troubled by the discrepancy between claimant's version of events leading to her alleged injury and that of Ms. Tobin. Having reviewed this record, we agree, however, with the ALJ that claimant has given consistent histories to the medical providers. We also recognize that the ALJ is in a superior position to evaluate the credibility of claimant based on attitude and demeanor. *See Sherri L. Williams*, 51 Van Natta 75, 77 (1999). The ALJ expressly stated that she did not believe that claimant was fabricating this episode. Moreover, the ALJ noted that it was possible that Ms. Tobin was remembering a different project. After carefully considering the evidence and the employer's arguments, we agree with the ALJ's assessment of this issue and find that Dr. Gardner had a materially accurate history on which to base her opinion.

Turning to the medical evidence, we first acknowledge the employer's argument that the ALJ should have applied the major contributing cause standard of ORS 656.005(7)(a)(B). However, we need not definitively decide whether the medical evidence establishes a "combined condition." That is, we conclude that, under either a material or major contributing cause standard, Dr. Gardner's opinion satisfies claimant's burden of proof.

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 give greater weight to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983); *Darwin B. Lederer*, 53 Van Natta 974 (2001) (discussing impact of *Dillon v. Whirlpool Corp.*, 172 Or App 484 (2001) on the general policy of deferring to the attending physician's opinion).

Having reviewed this record, we conclude that there are no persuasive reasons not to give greater weight to the attending physician's opinion. Dr. Gardner issued a series of reports in which she evaluated the various potential casual factors and responded to the medical evidence from Drs. Thompson and Yarusso. Dr. Gardner also reviewed the videotape of claimant's job activities that was shown to Drs. Thompson and Yarusso. Based on her evaluation of the causation issue, Dr. Gardner concluded that claimant's work activity was the major contributing cause of claimant's right shoulder condition and need for treatment and disability. (Ex. 38). Although the employer contends that Drs. Thompson and Yarusso have superior expertise in evaluating causation issues such as this, we find that Dr. Gardner's opinion is well reasoned and based on an accurate history. Moreover, we find no reason to conclude that she lacks the qualifications to express a cogent opinion in this case. Thus, we find Dr. Gardner's opinion is persuasive.

Accordingly, we conclude that claimant has satisfied her burden of proof. Therefore, we agree with the ALJ's decision setting aside the employer's denial.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). The employer objects to claimant's attorney's request for an assessed fee of $2,400, arguing that it is excessive.

In deciding whether the requested fee is appropriate, we consider the factors in OAR 438-015-0010(4), which includes time devoted to the case, the complexity of the issues, the value of the interest involved, the skill of the attorneys, the nature of the proceedings, the benefits secured, and the risk that an attorney's efforts may go uncompensated. *See Schoch v. Leupold & Stevens,* 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable). Claimant's attorney devoted 16 hours to the compensability issue on appeal and submitted a 21 page brief, of which 20 pages were devoted to the compensability issue. The compensability issue concerned whether claimant sustained a compensable right shoulder injury or occupational disease. As compared to typical compensability cases, the compensability issue here was of above average complexity. Because claimant's right shoulder claim has been found compensable, she is entitled to workers' compensation benefits. The interest involved and the benefits secured for claimant are significant. The attorneys involved in this matter are skilled litigators with substantial experience in worker's compensation law. Finally, considering the conflicting testimony and medical evidence, there was a risk that claimant's counsel's efforts might have gone uncompensated. No frivolous issues or defenses have been presented on review.

Consequently, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $2,400, 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, his counsel's representation of time devoted to the brief, and the employer's objections), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated February 7, 2001 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $2,400, to be paid by the employer.

Board Member Haynes dissenting.

The majority affirms the ALJ's order setting aside the self-insured employer's denial of claimant's injury/occupational disease claim for a right shoulder condition. In so doing, the majority concludes that the attending physician, Dr. Gardner, had an accurate history of claimant's work activities and that her opinion was sufficiently persuasive to satisfy claimant's burden of proof under either a material or major contributing cause standard.

Based on my review of this record, however, I cannot agree that claimant's description of the work activities that allegedly caused her right shoulder condition is accurate. Thus, I conclude that Dr. Gardner's opinion is not based on an accurate history and is, therefore, not persuasive. Because of this, I would find that claimant's right shoulder claim is not compensable and must respectfully dissent.

I first address the burden of proof. It is apparent from this record that claimant had a four-year history of right shoulder symptoms prior to the one-and-one-half day period of work activity in February 2000 that claimant alleges caused her right shoulder condition. Dr. Gardner's initial chart note records such a history. (Ex. 7). The ALJ correctly concluded that this preexisting condition "combined" with claimant's work activity on the development project in February 2000. Therefore, under ORS 656.005(7)(a)(B), claimant must prove that her work activity during this project was the major contributing cause of her disability and need for treatment.

I next address the credibility issue. I agree with the employer that the supervisor's (Ms. Tobin's) testimony regarding the nature of the development project that allegedly caused claimant's right shoulder condition was more persuasive than claimant's. While I believe each witness was honest, Ms. Tobin's testimony that claimant rotated to other workstations and did not spend more than three or four hours at the machine that allegedly caused her condition was more specific and detailed and, hence, was more reliable.

Ms. Tobin clearly described the work activity in which claimant was engaged at the time of the alleged injury and testified that performing a job without rotation is never done. (Trs. 30-75). Ms. Tobin further testified that she knew the engineer working on the development project was aware of the

project's purpose and specifically recalled claimant rotating from job to job. (Tr. 45). Ms. Tobin explained that the force necessary to operate the machine that allegedly caused claimant's injury was minimal. (Tr. 49). Contrary to the majority's and the ALJ's suggestion, there is nothing in the record to indicate that Ms. Tobin was recalling a different development project.

Thus, I find Ms. Tobin's testimony more reliable than claimant's and supports the conclusions of Drs. Thompson and Yarusso that claimant's work activities in February 2000 did not result in a right shoulder sprain. Moreover, because I believe that Dr. Gardner had a materially inaccurate history of claimant's work activity (*i.e.*, incorrectly believed that claimant worked for 12 hours straight on the same machine), it follows that her opinion is less persuasive. *See Miller v. Granite Construction Company*, 28 Or App 473 (1977) (medical opinions based on an inaccurate history are entitled to little weight).

In addition to the above deficiency in her medical opinion, Dr. Gardner clearly lacked the expertise of Drs. Yarusso and Thompson. Dr. Thompson is an orthopedist experienced in performing shoulder surgeries and examinations. Dr. Yarusso is an occupational medicine expert specializing in evaluation of workers' compensation injuries and assessing ergonomics of workstations in relation to injury prevention. In contrast, the qualifications of Dr. Gardner are unknown. While her letterhead indicates she is a medical doctor, Dr. Gardner's experience in orthopedics, occupational medicine or ergonomics is not apparent from the record. In light of this, I conclude that Drs. Thompson and Yarusso have a decided edge in qualifications in comparison to Dr. Gardner.

Accordingly, given the inaccurate history of claimant's work activities on which Dr. Gardner relied, as well the superior expertise of Drs. Yarusso and Thompson, I disagree with the ALJ's conclusion that the medical evidence proves that claimant's work activities were the major contributing cause of the right shoulder condition. Instead, I would find the medical opinions of Drs. Thompson and Yarusso establish that the preexisting right shoulder condition is the major factor in claimant's right shoulder condition and need for treatment. Because the majority concludes otherwise, I respectfully dissent.

In the Matter of the Compensation of
JIMMY L. GRAZIER, Claimant
WCB Case No. 99-09893
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorney
Jerry Keene, Defense Attorney

On May 23, 2001, we abated our May 8, 2001 order affirming an Administrative Law Judge's (ALJ's) order that: (1) denied claimant's motion to reopen the record for consolidation with another case arising from a claim that he had filed with the Department regarding the noncomplying status of Mr. Swain; (2) found that claimant was not a subject worker of Swain Construction, Inc.; and (3) upheld the SAIF Corporation's denial of claimant's neck injury claim. 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, the parties agree that SAIF's denial "shall be approved" and that claimant's request for hearing "shall be dismissed with prejudice."

We have approved the settlement, thereby resolving the parties' dispute. Accordingly, on reconsideration, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARVIN W. CROSS, Claimant
WCB Case No. 00-07401
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Meyers, Bock, and Biehl. Member Biehl dissents.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Fitzwater's order that: (1) admitted Exhibit A; (2) determined that the SAIF Corporation properly ceased payments of temporary total disability on June 21, 2000; and (3) declined to assess a penalty for SAIF's allegedly unreasonable claim processing. Subsequent to briefing, claimant moved for remand for the admission of additional evidence and the opportunity for further cross-examination of the employer. On review, the issues are remand, evidence, temporary disability, and penalties.

We adopt and affirm the ALJ's order, with the following supplementation to respond to claimant's request for remand and arguments on review regarding the temporary disability issue.

Remand

Claimant has submitted a document entitled "Activity Timeline," dated Tuesday, May 23, 2000, the date of claimant's injury, which he alleges came from the truck that he was driving on the day of his accident. Claimant requests remand for admission of the document and for the purpose of cross-examining the employer regarding this document.

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 the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, claimant has not established that the document that he has submitted was unavailable with due diligence at the time of the hearing. *See Robert A. Wilson*, 52 Van Natta 2225 (2000). Moreover, the issue at hearing was whether claimant's employment was terminated for violation of a work rule or other disciplinary reasons. *See* ORS 656.325(5)(b). The employer testified that he fired claimant for driving at an excessive speed, based on the presence of skid marks at the accident site. According to claimant, the "Activity Timeline" casts doubt on the credibility of the employer's testimony at hearing.

To the extent that claimant is contending that the employer's termination of claimant's employment was unreasonable or unjustified, this is not an issue within the purview of workers' compensation law. *See Kenneth A. Meyer*, 50 Van Natta 2302 (1998). In addition, in light of the 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, conclude that the case has not been improperly, incompletely or otherwise insufficiently developed. Accordingly, remand is not warranted. ORS 656.295(5).

Evidence

At hearing, claimant objected to the admission of Exhibit A, a copy of the employer's return to work policy, on the basis that it was not timely submitted under OAR 438-007-0015(2). In response, among other arguments, SAIF contended that it had obtained and provided the policy to claimant on January 4, 2001, the day before hearing. (Tr. 2).

The ALJ admitted the document, and provided claimant with the opportunity to continue the hearing to cure any material prejudice. *See* OAR 438-007-0018(4). Claimant declined a continuance.

On review, claimant contends that the employer's "Early Return to Work Policy" was a "document pertaining to the claim" that should have been disclosed. We need not address this issue, however, because, as explained below, even if the exhibit was not considered, the record supports a conclusion that the employer had a written policy of offering modified work to injured workers.

Temporary Disability

The issue at hearing was whether SAIF properly ceased payment of temporary disability under ORS 656.325(5)(b), which requires that the employer have a written policy of offering modified work to injured workers. The employer testified at hearing that, as of the date that claimant was injured, it had a written return to work policy in force. (Tr. 29). The ALJ found that this testimony satisfied the statutory requirement, even though claimant was not aware of the policy during his employment.

On review, claimant observes that the employer did not provide the written return to work policy until shortly before the hearing, that the document was not dated or signed, and that it was not clear who prepared the policy. Moreover, claimant notes that there was no evidence that claimant or any other employee knew the policy existed. Under these circumstances, claimant contends that the record does not establish the existence of a written return to work policy.

Claimant's contentions notwithstanding, we conclude that the record, without consideration of the document itself, does establish the existence of a written return to work policy. The employer credibly testified that the policy was in effect at the time of claimant's injury and that he knew this because he had previously returned injured workers back to work.[1] (Tr. 29). In light of such testimony, we agree with the ALJ that the requirement under ORS 656.325(5)(b) that the employer have a written policy of offering modified work to injured workers has been satisfied. *See, e.g., Christine M. Mulder*, 50 Van Natta 521 (1998).[2]

Claimant also contends that the description of the modified job that Dr. Wilson, the attending physician, approved was legally insufficient because it failed to adequately describe the modified work at issue. (Ex. 1A). The ALJ rejected this argument because the job description explained the job duties, location, physical requirements and the required safety equipment. The ALJ observed that, unlike OAR 436-060-0030(5) pertaining to ORS 656.268(4)(c), the job description under OAR 436-060-0030(6) (which implements ORS 656.325(5)(b)) does not have to provide the duration of the modified job and its hours. Thus, the ALJ found that the job description notified Dr. Wilson of the physical tasks to be performed and that Dr. Wilson concluded that the employment appeared within claimant's capabilities. We agree with the ALJ's reasoning.

Claimant's employment was terminated for violating a work rule or other disciplinary reasons; *i.e*, driving at excessive speed. Thus, ORS 656.325(5)(b) is the governing statute. Under ORS 656.325(5)(b), an employer may discontinue paying temporary total disability benefits and begin paying temporary partial disability benefits when the worker has been terminated for disciplinary reasons or violation of a work rule and the attending physician approves work in a modified job that would have been offered to the worker had he remained employed. Because this case falls under ORS 656.325(5)(b), the applicable administrative rule is OAR 436-060-0030(6).[3] *See, e.g., Michael J. Benson*, 51 Van Natta 866

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[1] Although the evidence establishes that claimant did not know of this policy (Tr. 11, 15), claimant's testimony does not prove that the policy did not exist on June 21, 2000, the date that SAIF ceased payment of TTD, in light of the employer's credible testimony directly addressing the existence of the written modified-work policy.

[2] Noting some troubling aspects of the employer's testimony, the dissent contends that the record does not establish that the employer had a written return to work policy. While we acknowledge the dissent's concerns, we are nevertheless persuaded after reviewing the hearing testimony that the employer had a written policy of offering modified work.

[3] OAR 436-060-0030(6) provides in pertinent part:

"Pursuant to ORS 656.325(5)(b), the insurer shall cease paying temporary total disability compensation and start paying temporary partial disability compensation under section (2) as if the worker had begun the employment when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had not been terminated from employment for violation of work rules or other disciplinary reasons, under the following conditions:

"(a) The employer has a written policy of offering modified work to injured workers;

"(b) *The insurer* has written documentation of the hours available to work and the wages that would have been paid if the worker had returned to work in order to determine the amount of temporary partial disability compensation under section (2);

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

"(d) The attending physician agrees the employment appears to be within the worker's capabilities." (Emphasis added.)

(1999); *Kenneth A. Meyer*, 50 Van Natta 2302 (1998), *on recon* 51 Van Natta 319 (1999). This rule requires that the attending physician be notified by the employer or insurer of the physical tasks to be performed by the injured worker, and agrees that the employment appears to be within the worker's capabilities. OAR 436-060-0030(6)(c) and (d). The rule does not require that the modified job description the attending physician approves include the hours to be worked or the wages to be paid. Instead, the insurer must have that information. OAR 436-060-0030(6)(b). In this case, the record establishes that SAIF had the required information. (Ex. 1B).

Consequently, we find that the record establishes that the insurer had "written documentation of the hours available to work and the wages that would have been paid" within the meaning of OAR 436-060-0030(6)(b). Finally, we agree with the ALJ that the attending physician was notified of the physical tasks to be performed by the worker and agreed that the employment "appear[ed] to be within the worker's capabilities." (Ex. 1A); OAR 436-060-0030(6)(c) and (d); *see Deanna L. Rood*, 49 Van Natta 285, 286 (1997).

In conclusion, having reviewed this record, we agree with the ALJ's finding that SAIF properly ceased payment of temporary disability under ORS 656.325(5)(b) and OAR 436-060-0030(6). Therefore, we affirm.

ORDER

The ALJ's order dated February 5, 2001 is affirmed.

Board Member Biehl dissenting.

After review of the record, I would find that the employer's "Early Return-to-Work Policy" was a "document pertaining to a claim" under OAR 438-007-0015(5) and (6)[1] because it is a document relevant

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[1] A "claim" is a "written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6). "Compensation" includes "all benefits, including medical services, provided for a compensable injury to a subject worker or the worker's beneficiaries by an insurer or self-insured employer pursuant to this chapter." ORS 656.005(8). Among the benefits included for injured workers are temporary total and temporary partial disability benefits. *See* ORS 656.210. OAR 438-007-0015 provides in pertinent part:

> "(5) For the purpose of this rule, "documents pertaining to the claim(s)" or any variation thereof means documents and recordings, whether written or electronic or in any other form, which consist of the following items applicable to the workers' compensation claim:
>
> "(a) Medical and vocational reports, including any correspondence to and from the medical and vocational experts who provide the reports or who agree to testify on behalf of the party sending correspondence;
>
> "(b) Official forms and notices required by ORS Chapter 656, the Workers' Compensation Division or the Workers' Compensation Board, as they relate to the claim(s);
>
> "(c) Investigative statements, including a party's statement, and investigative summaries;
>
> "(d) Correspondence to and from the Workers' Compensation Division and the Workers' Compensation Board; and
>
> "(e) Upon specific request, records of all compensation paid, payroll records, records or statements of wages earned by the claimant, and copies of bills from medical and vocational service providers rendering treatment or services to the claimant.
>
> "(6) After the disclosure required by this rule, either the claimant or the insurer may request further specific discovery of other factual documents relevant and material to an issue raised by the Request for Hearing or the Response thereto, or any other issue which thereafter arises and is subject to the jurisdiction of the Workers' Compensation Board. Any dispute regarding the discoverability of such further documents shall be resolved by the Administrative Law Judge assigned to the hearing.
>
> " * * * * * .
>
> "(8) It is the express policy of the Board to promote the full and complete discovery of all relevant facts and expert opinion bearing on a claim being litigated before the Hearings Division, consistent with the right of each party to due process of law. Failure to comply with this rule shall, if found to be unreasonable, be considered delay or refusal under ORS 656.262(11) and may result in the imposition of penalties and attorney fees, exclusion of evidence and/or continuance of a hearing subject to OAR 438-006-0091."

and material to the issue of claimant's entitlement to temporary total or temporary partial disability benefits, which was raised in his request for hearing. *See* ORS 656.325(5)(b)[2] and ORS 656.268(4)(c).

However, even assuming that the ALJ's evidentiary ruling was proper, I would still not find the document persuasive evidence that the employer had an "Early Return to Work" policy in place at the time of claimant's employment.

As the majority observes, the employer testified that the "Early Return to Work" policy was in effect at the time of claimant's May 2000 accident. However, there is no documentary evidence in the record that supports his testimony. First, the employer testified that he did not formulate the policy (Tr. 28), which indicates to me that the employer itself did not have a policy to return employees to work. Second, the employer testified that he has no one in his office who deals with workers' compensation matters and, instead, relied on the Association of Oregon Loggers (*id.*), which further indicates to me that the policy was that of the Association rather than the employer. Third, the employer testified that the document entitled "Early Return to Work" policy was generated by the Association of Oregon Loggers, not the employer (*id.*), which reinforces my conclusion. Fourth, the document itself was undated and unsigned, and the employer was unable to say when it was adopted by his company. (Tr. 29) Finally, claimant was not aware of any "Early Return to Work" policy on the part of the employer, although he had been hired as a log truck driver by the employer and had worked for him for over a year. (Tr. 5, 15).

In sum, based on the employer's testimony that the "Early Return to Work" document was generated by someone other than the employer, and the employer's failure to make such a policy known to claimant at any time during his term of employment, I would conclude that the employer itself had no policy in place at the relevant times. Consequently, I would find that the requirement under ORS 656.325(5)(b) that the employer have a written policy of offering modified work to injured workers, has not been met, and that the employer had no authority to cease paying temporary total disability compensation in this case.

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[2] ORS 656.326(5)(b) provides:

"If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed, *provided that the employer has a written policy of offering modified work to injured workers.* (Emphasis added).

October 9, 2001 Cite as 53 Van Natta 1407 (2001)

In the Matter of the Compensation of
CHRISTINA M. CARRILLO, Claimant
WCB Case No. 00-08120
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorney
Cummins, Goodman, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

On September 20, 2001, we abated our September 7, 2001 order that 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 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 "will be affirmed in its entirety" and that she will not take any further workers' compensation benefits on behalf of the denied claim.

We have approved the settlement, thereby resolving the parties' dispute.[1] Accordingly, on reconsideration, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] Pursuant to OAR 438-009-0010(2)(g), a settlement must include a list of medical service providers who shall receive reimbursement in accordance with ORS 656.313(4), including the specific amount each provider shall be reimbursed, and the parties' acknowledgment that this reimbursement allocation complies with the reimbursement formula prescribed in ORS 656.313(4)(d). When no unpaid medical bills are in the carrier's possession on the date the settlement terms are agreed on, the "list" and "acknowledgment" requirements of OAR 438-009-0010(2)(g) are inapplicable. *See Robert E. Wolford*, 46 Van Natta 522 (1994).

Here, the agreement provides that the employer agrees to pay outstanding and unpaid bills in the amount of $574. Elsewhere, however, the agreement includes the parties' acknowledgment that there are no outstanding medical bills subject to reimbursement pursuant to ORS 656.248 and consistent with ORS 656.313. Thus, in granting this approval, we have interpreted the aforementioned provisions as the parties' representation that there were no outstanding medical bills for claimant's cervical condition in the employer's possession on the date the terms of the settlement terms were agreed on. Thus, the agreement is approvable.

October 9, 2001 Cite as 53 Van Natta 1408 (2001)

In the Matter of the Compensation of
DAVID A. JACKSON, Claimant
Own Motion No. 01-0114M
OWN MOTION ORDER
Bischoff, Strooband & Ousey, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Reviewing Panel: Members Haynes and Biehl.

On April 30, 2001, we referred claimant's Own Motion request to the Hearings Division. We took this action because litigation concerning the responsibility for his current condition was pending before the Hearings Division. (WCB Case No. 01-03201).

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

On July 18, 2001, Administrative Law Judge (ALJ) Hazelett issued an Order of Dismissal, dismissing claimant's pending hearing request. (WCB Case No. 01-03201). That order has not been appealed.

Thereafter, the Board's staff directed a letter to the parties regarding the effect of the ALJ's July 18, 2001 order on this pending Own Motion matter. In response, claimant announced that the insurer had accepted responsibility for claimant's current condition under a 2001 claim and that he is "no longer in need" of Own Motion benefits because he has sustained a "new injury" which was being processed under a different claim number. The insurer does not challenge claimant's representations.

In light of such circumstances, we conclude that claimant's current condition (which formed the basis for the Own Motion request) is being processed as a "new injury" claim. Consequently, claimant's current condition is considered unrelated to his January 1989 compensable injury. Thus, we are without authority to reopen claimant's 1989 claim. ORS 656.278(1)(a).

Accordingly, claimant's request for Own Motion relief under his 1989 claim is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
PATRICIA J. LATAL, Claimant
WCB Case No. 00-04009
ORDER ON RECONSIDERATION
Martin L. Alvey, Claimant Attorney
Scheminske, et al., Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

On September 6, 2001, we withdrew our August 7, 2001 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. We took this action to consider claimant's request for reconsideration. Having received the self-insured employer's response, we proceed with our reconsideration.

Claimant asserts that our interpretation of the opinions from two physicians (Drs. Spady and Smith) was erroneous. In particular, claimant contends that the doctors' opinions are based on a "major contributing cause" analysis rather than (as we had interpreted) a "precipitating cause" analysis. Thus, claimant argues that she has established the compensability of her "consequential" low back condition.

We begin with a discussion of Dr Smith's opinion. As found in our prior order, 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 pre-existing degenerative condition" and "*is not related in any way to her left shoulder injury.*" (Ex. 39-7; 42) (emphasis added). We also found that subsequent to his concurrence with Drs. Gripkoven and Reimer, 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; 60-8). Thus, Dr. Smith has given two opinions that are inconsistent with each other.

Assuming, for the sake of argument, that Dr. Smith's ultimate opinion regarding the cause of claimant's low back symptoms is based on a "major contributing cause" analysis, we agree with the ALJ's conclusion that Dr. Smith did not explain the reason for changing his earlier opinion that claimant's low back condition was not related to her work injury. Without such an explanation, Dr. Smith's change of opinion is 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). Furthermore, our order adopted the ALJ's order that contained considerable reasoning regarding Dr. Smith's opinion. Nonetheless, in response to claimant's motion, we offer the following additional comment.

In his chart note of March 9, 1999, Dr. Smith noted that one month after the shoulder surgery, claimant was progressing well, until her improvement was slowed by a "superimposed back problem which occurred when she lurched suddenly to protect her young child" from falling out of bed. (Ex. 60-23). Dr. Smith reported that claimant had twisted her low back and was having "mechanical lumbar symptoms." (*Id.*) In his deposition, Dr. Smith indicated that that particular event was sufficient to cause the symptoms for which he treated claimant, and sufficient to cause a disc bulge or herniation. (Ex. 60-16; 60-17).

As noted by the ALJ, Dr. Smith did not offer any explanation of how or why claimant's left shoulder injury and/or surgery was the major contributing cause of claimant's "consequential" low back condition. (O&O p. 7). Consequently, Dr. Smith's opinion is insufficient to carry claimant's burden of proof. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995) (determination of major contributing cause involves evaluation of the relative contribution of different causes and deciding which is the primary cause).

We turn to Dr. Spady's opinion. Dr. Spady first stated: "The degenerative process may be a preexisting condition but without the forceful injury while at work that radiculopathy and back pain may very well have never occurred." (Ex. 44A). Later, Dr. Spady opined:

> "[T]he hard surgical bed and or movement during surgery most likely was the major contributor to herniation. Since she needed the surgery, to get better for her shoulder injury, I would say there is a direct relationship to her back problems and her injury recovery." (Ex. 56).

Dr. Spady's two opinions appear to be inconsistent. The first opinion suggests that claimant's back condition was caused by the same force that caused her compensable shoulder injury. In contrast, his subsequent opinion indicates that that claimant's back problem (disc herniation) occurred during the surgery for the shoulder condition. Dr. Spady did not offer an explanation for his apparent change of opinion. As a result, his opinion is unpersuasive. *Blakely*, 89 Or App at 656.

Moreover (assuming that the disc herniation occurred during the shoulder surgery), Dr. Spady did not discuss the relative contributions of claimant's movement during surgery and her preexisting degenerative process in producing the disc herniation. Without such a discussion, his opinion regarding the cause of the disc herniation is insufficient to meet claimant's burden of proof. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 7, 2001 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

October 9, 2001 Cite as 53 Van Natta 1410 (2001)

In the Matter of the Compensation of
GINA E. LAMERE, Claimant
WCB Case No. 00-08813
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Hornecker, Cowling, et al., Defense Attorney

Reviewing Panel: Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim; and (2) declined to award a penalty for an allegedly unreasonable denial. On review, the issues are aggravation and penalties.

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

Even assuming that one or more of claimant's compensable conditions worsened, we are not persuaded that such worsening was "more than waxing and waning of symptoms of the condition(s) contemplated by the previous permanent disability award." *See* ORS 656.273(8); *Gary R. Platt*, 52 Van Natta 1102 (2000) (Aggravation not proven where medical evidence failed to establish worsening greater than contemplated by the previous permanent disability award); *Patricia J. Sampson*, 45 Van Natta 771, *aff'd mem*, 125 Or App 338 (1993) (same). (*See* Exs. 79, 80).

ORDER

The ALJ's order dated May 29, 2001 is affirmed.

In the Matter of the Compensation of
JOHN L. ANDERSON, Claimant
WCB Case Nos. 00-06476 & 00-04825
ORDER ON REVIEW
Doblie & Associates, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewing Panel: Haynes, Meyers, Bock, Phillips Polich and Biehl. Members Phillips Polich and Biehl dissent.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that found claimant's claim was prematurely closed. On review, the issue is premature closure. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the fourth paragraph on page 2, we change the last word in the third sentence to "condition."

CONCLUSIONS OF LAW AND OPINION

The employer accepted a disabling chest wall strain resulting from claimant's August 13, 1999 injury. (Exs. 18, 64). In the course of treating claimant, a CT scan was performed that showed a lesion on the right lung. (Ex. 13). Claimant was referred to Dr. Donnelly, who requested authorization to perform surgery to determine the nature of the lesion. (Ex. 46). He performed surgery on December 6, 1999, which involved a right lower lobectomy and excision of mediastinal mass. (Ex. 50). The subsequent pathology revealed a mixed tissue mass with no indication it was secondary to trauma. (Ex. 62).

On January 24, 2000, Dr. Yarusso, claimant's attending physician, performed a closing examination. (Ex. 62). He reported that claimant was medically stationary from the August 13, 1999 industrial episode, but not with respect to the December 6, 1999 diagnostic surgery. (Exs. 62, 67). Dr. Donnelly agreed that, as of February 3, 2000, claimant was not yet medically stationary from surgery. (Ex. 68).

A Notice of Closure issued on February 3, 2000, and claimant requested reconsideration, contending that the claim was prematurely closed. (Ex. 65A2). Claimant argued that, because he had not yet recovered from the diagnostic lobectomy, closure was premature. (Exs. 65A2, 65A3). Dr. Thompson performed a medical arbiter examination on May 11, 2000. (Ex. 66).

The employer subsequently agreed to pay for the diagnostic lobectomy. (Ex. 67A). The employer indicated it was paying for the services as diagnostic in nature, since the "underlying cause for [claimant's] discomfort was a mass that was unrelated to his workers' compensation injury." (*Id.*) A June 22, 2000 Order on Reconsideration affirmed the Notice of Closure. (Ex. 69). Claimant requested a hearing.

The ALJ relied on *Brooks v. D & R Timber*, 55 Or App 688 (1982), and found that claimant's condition was not medically stationary because he was expected to improve from the effects of the compensable diagnostic procedure. The ALJ reasoned that, because the diagnostic procedure was compensable, claimant should not be deemed medically stationary until he has recovered from the effects of that surgery.

On review, the employer acknowledges that the diagnostic surgery is compensable. *See* ORS 656.245(1)(c)(H). The employer contends, however, that there is no statutory authority to delay the closure date when claimant's accepted injury is medically stationary. Relying on *Thomas A. Hutcheson*, 46 Van Natta 354 (1994), the employer argues that the existence of a noncompensable condition that is

not medically stationary at the time of claim closure does not preclude a finding that claimant's *compensable* condition is medically stationary.[1]

ORS 656.268(1)(a) provides that a carrier shall close the worker's claim, as prescribed by the Director, and determine the extent of the worker's permanent disability, provided the worker is not enrolled and actively engaged in training, when the worker has become medically stationary and there is sufficient information to determine permanent impairment. An injured worker is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). OAR 436-035-0035(1) (WCD Admin. Order No. 97-065) provides that a worker's "compensable condition" shall be determined to be medically stationary when the attending physician or a preponderance of medical opinion declares the worker either "medically stationary," "medically stable," or uses other language meaning the same thing.

Although claimant relies on *Brooks v. D & R Timber*, 55 Or App at 688, and *Counts v. International Paper Co.*, 146 Or App 768 (1997), the issue in those cases was compensability of the claimant's diagnostic procedure. *See also Mohr v. Barrett Business Services*, 168 Or App 579 (2000); *Roseburg Forest Products v. Langley*, 156 Or App 454 (1998). That is not at issue here because the employer agrees that claimant's diagnostic surgery is compensable. Instead, the issue is premature closure, which was not addressed in the aforementioned court cases.

In determining whether a claim was prematurely closed, the issue is whether the claimant's accepted chest wall strain was medically stationary on the date of the February 2000 closure, without considering subsequent changes in his condition. *See Scheuning v. J.R. Simplot & Company*, 84 Or App 622, 625, *rev den* 303 Or 590 (1987); *Alvarez v. GAB Business Services*, 72 Or App 524, 527 (1985).

In *James L. Mack*, 50 Van Natta 338 (1998), we concluded that a determination of whether a claim has been prematurely closed must focus only on those conditions accepted at the time of closure. We reach the same conclusion in this case.

At the time of closure, the employer had accepted a chest wall strain. (Ex. 64). Dr. Yarusso, claimant's attending physician, performed a closing examination on January 24, 2000. (Ex. 62). He reported that claimant's range of motion to his neck, shoulder, elbows and wrists were within normal limits and claimant was medically stationary from the August 13, 1999 industrial episode. (Ex. 62-2). On the other hand, Dr. Yarusso found that claimant was not yet medically stationary as a result of recovery from the December 6, 1999 diagnostic surgery. (Exs. 62, 67). Similarly, Dr. Donnelly agreed that, as of February 3, 2000, claimant was still recovering from that surgery and was not yet medically stationary. (Ex. 68). He indicated that claimant's recovery from the surgery would take three to four months. (*Id.*)

Dr. Thompson performed a medical arbiter examination on May 11, 2000. (Ex. 66). He said that many of the findings were invalid and the current findings were not directly related to the accepted condition. (Ex. 66-6).

In sum, we find no medical evidence to establish that claimant's compensable chest wall strain was reasonably expected to materially improve from medical treatment, or the passage of time, as of the February 3, 2000 Notice of Closure. Although the employer agreed to pay for the December 6, 1999 diagnostic surgery, it did not accept any additional conditions. *See* ORS 656.262(10). Thus, the issue of whether claimant's noncompensable lung lesion was medically stationary at the time of claim closure is not relevant to a determination of whether the claim was prematurely closed. *See, e.g., Vicky L. Woodard*, 52 Van Natta 796 (2000); *James L. Mack*, 50 Van Natta at 338. Consequently, we reverse the ALJ's order.

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[1] In *Hutcheson*, the claimant had a compensable lumbar strain. In arguing that the claim was prematurely closed, the claimant relied on medical opinions that focused on his noncompensable degenerative disc condition and L4-5 disc herniation, and did not specifically address the status of the compensable lumbar strain. Because those medical opinions did not distinguish between the compensable and noncompensable conditions, we found they were entitled to little weight. 46 Van Natta at 355. We concluded that the lumbar strain claim was not prematurely closed, reasoning that the proper inquiry was whether any material improvement could reasonably be expected to the claimant's compensable condition, from either medical treatment or the passage of time. We said that the fact that a worker has a noncompensable condition that was not medically stationary at the time of claim closure did not preclude a finding that the worker's compensable condition was medically stationary. *Id.*

ORDER

The ALJ's order dated March 13, 2001 is reversed in part and affirmed in part. The February 3, 2000 Notice of Closure and the June 22, 2000 Order on Reconsideration are reinstated and affirmed. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

Board Members Phillips Polich and Biehl dissenting.

The majority finds that the issue of whether claimant's noncompensable lung condition was medically stationary at the time of claim closure is not relevant to a determination of whether the claim was prematurely closed. Because the majority incorrectly frames the issue and, ultimately, misapplies the law, we respectfully dissent.

Unlike the majority, the ALJ properly analyzed this case. The ALJ relied on *Brooks v. D & R Timber*, 55 Or App 688 (1982), which held that, although the claimant's exploratory surgery ultimately served only to discover the existence of a noncompensable condition, it was still compensable because the surgery was initially performed because of the work-related, compensable injury. *Id.* at 692. Thus, if diagnostic services are necessary to determine the cause or extent of a compensable injury, the tests are compensable whether or not the condition that is discovered as a result of them is compensable. *Counts v. International Paper Co.*, 146 Or App 768, 771 (1997).

Here, the employer accepted a disabling chest wall strain resulting from claimant's August 13, 1999 injury. (Exs. 18, 64). In the course of treating claimant, a CT scan showed a lesion on the right lung. (Ex. 13). Dr. Donnelly was unable to determine whether claimant had a lung lesion or a tear in the diaphragm without performing surgery. (Ex. 46). On December 6, 1999, Dr. Donnelly performed a right lower lobectomy and excision of mediastinal mass. (Ex. 50). Because of the location of the lesion, the surgery was a major one and Dr. Donnelly anticipated that claimant's recovery from the surgery itself would take three to four months. (Ex. 68). The pathology revealed a mixed tissue mass with no indication it was secondary to trauma. (Ex. 62). The employer subsequently agreed to pay for the diagnostic lobectomy. (Ex. 67A).

There is no dispute that claimant's December 1999 diagnostic surgery was compensable. Nevertheless, the employer closed the claim on February 3, 2000, despite the fact that claimant had not yet recovered from the diagnostic surgery. The ALJ correctly determined that that claimant should not be deemed to be medically stationary until he has recovered from the effects of the compensable diagnostic procedure.

ORS 656.005(17) provides that an injured worker is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." As claimant points out, the "improvement" in ORS 656.005(17) is not restricted to compensable medical conditions; rather, it may include compensable diagnostic tests. Whether a carrier has prematurely closed a claim depends on whether the claimant was medically stationary on the date of closure, without consideration of subsequent changes in his condition. *See Schuening v. J.R. Simplot & Company*, 84 Or App 622, 625, *rev den* 303 Or 590 (1987). Because claimant was expected to improve from the effects of the compensable diagnostic procedure, his claim was prematurely closed. The majority violates ORS 174.010 by imposing a requirement that is not in the statute.

Finally, the cases discussed by the majority are distinguishable and do not support the conclusion reached by the majority. Although the employer relies on *Thomas A. Hutcheson*, 46 Van Natta 354 (1994), the ALJ correctly distinguished that case. In *Hutcheson*, the claimant had a compensable lumbar strain and a noncompensable preexisting degenerative disc condition. The claimant subsequently had surgery for an L4-5 disc condition, he continued to have back pain and further surgery was recommended. The claimant argued that the claim had been prematurely closed. The claimant's physicians had focused on the claimant's noncompensable preexisting degenerative disc condition, with an emphasis on the L4-5 disc herniation, but we found that the compensable lumbar strain had not been prematurely closed. Here, in contrast, claimant was recovering from a compensable diagnostic procedure. Claimant was *not* receiving treatment for a noncompensable, preexisting condition, as in *Hutcheson*.

The majority cites *James L. Mack*, 50 Van Natta 338 (1998), asserting that a determination of whether a claim has been prematurely closed must focus only conditions accepted at the time of closure. In *Mack*, however, the additional conditions at issue were accepted *after* claim closure. In that situation, we reasoned that the proper procedure was to remand the later accepted conditions to the carrier for processing. Thus, any future disputes after claim closure could be resolved in this forum. Here, unlike *Mack*, claimant's diagnostic procedure was at issue *before* the Order on Reconsideration issued. Based on the majority's disposition of this case, there is no forum for the resolution of this case. The majority's conclusion is fundamentally unfair.

The majority also relies on *Vicky L. Woodard*, 52 Van Natta 796 (2000), asserting that the issue of whether claimant's noncompensable lung lesion was medically stationary at the time of claim closure is not relevant to a determination of whether the claim was prematurely closed. In *Woodward*, although the case related to premature closure, the primary issue was the scope of acceptance. The carrier had accepted bilateral ankle sprains and, after closure, the claimant was treated for left ankle arthralgia. We found that left ankle arthralgia was not the same as the accepted bilateral ankle strains and, therefore, the medically stationary status of the arthralgia condition was irrelevant to the premature closure determination.

The present case does not involve a scope of acceptance issue. Instead, the issue is whether claimant is medically stationary from a compensable diagnostic procedure that revealed a noncompensable lung condition. This situation is distinguishable from *Woodward* because the medically stationary status of claimant's diagnostic procedure is relevant in this case.

In sum, contrary to the majority's analysis, the issue is whether claimant was reasonably expected to improve from a compensable diagnostic procedure; *not* whether he was expected to improve from a noncompensable lung condition. The majority asks the wrong question and reaches the wrong result. Consequently, we dissent. The ALJ's order finding that the claim was prematurely closed should be affirmed.

In the Matter of the Compensation of
DENISE A. JAMISON, Claimant
WCB Case Nos. 01-00323 & 00-07884
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewing Panel: Members Meyers and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order that: (1) upheld the self-insured employer's aggravation denial of claimant's low back condition; and (2) upheld the employer's denial of claimant's lumbar strain/sprain injury claim. On review, the issues are aggravation and compensability. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except that we correct the date of "January 23, 2000" in the last paragraph to "January 23, 2001."

CONCLUSIONS OF LAW AND OPINION

Aggravation

Claimant has an accepted nondisabling claim for lumbar strain that was accepted in March 2000. (Ex. 32). On September 7, 2000, claimant's treating physician filed a "Notice of Aggravation." (Ex. 45). In response, the employer denied the claim for aggravation on January 23, 2001. (Ex. 65). The ALJ upheld the denial after finding an absence of evidence that the accepted condition had worsened.

On review, claimant asserts that she "had no burden of perfecting an aggravation claim" because "she lost time from work due to the accepted injury." Citing ORS 656.277(1), claimant argues that the "aggravation denial should be reversed as a matter of law and the insurer ordered to reclassify the accepted claim as disabling."

Under ORS 656.277(1), a worker's request for reclassification of a claim must be submitted to the carrier and the carrier shall respond within 14 days if the request is within one year after the date of acceptance. If such a request is made more than one year after the date of acceptance, the request "shall be made pursuant to ORS 656.273 as a claim for aggravation[.]" ORS 656.277(2).

Here, claimant's "Notice of Aggravation" was filed within one year of the date of acceptance. Under ORS 656.277(1), however, claimant was limited to submitting only a request for reclassification. Consequently, claimant's aggravation claim was procedurally invalid.[1] Additionally, because the employer's denial was in response to a procedurally invalid claim, its denial is also procedurally invalid.

In sum, having found that claimant's aggravation claim and the employer's denial should be set aside as procedurally invalid, we vacate that portion of the ALJ's order addressing aggravation.

Compensability

On June 22, 2000, claimant tripped and fell; the employer accepted a nondisabling claim for multiple contusions. The ALJ concluded that claimant did not prove that she sustained a compensable lumbar strain from the June 22, 2000 accident. In challenging this conclusion, claimant relies on the opinion of her treating physician, Dr. Weller.

Dr. Weller first examined claimant on August 21, 2000, and diagnosed "acute and chronic low back pain." (Ex. 43-4). Dr. Weller also noted that the "presence of the lumbosacral strain and sacroiliac dysfunction appear[,] based on [claimant's] * * * history[,] to be related to this most recent injury in June." (*Id.*)

When Dr. Weller examined claimant on November 14, 2000, she diagnosed a "lumbosacral strain injury which is now resolved." (Ex. 61-1). After noting the presence of degenerative disc disease that was not related to the work injury, Dr. Weller stated that "the work injury combined with her pre-existing degenerative condition to cause the current symptoms and need for treatment." (*Id.*)

In an accompanying report, Dr. Weller stated that "the ongoing need for treatment is also a result of this combined injury with the slip and fall incident on June 22nd being the major cause." (Ex. 62). Dr. Weller based this opinion on claimant's "history as provided to me that she had no significant radicular symptoms in the immediate period prior to this incident." (*Id.*)

Dr. Neary, who also treated claimant, noted that claimant's back condition "was triggered by her accident in June[.]" (Ex. 53-2).

Neither Dr. Weller nor Dr. Neary support claimant's argument on review that her January and June 2000 accidents "combined to cause her disability." Rather, both physicians identify only the June 22, 2000 accident. Furthermore, based on Dr. Weller's opinion, we agree with the ALJ that the appropriate statute for determining compensability is ORS 656.005(7)(a)(B).[2]

The remaining medical opinion is from the examining panel of Dr. Fuller, orthopedic surgeon, and Dr. Bell, neurologist. The panel found that claimant exhibited pain behavior and subjective magnification and determined that there was "no objective pathology relating to the 06/22/00 event."

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[1] We further note that we lack jurisdiction if we considered claimant's aggravation claim as a request for reclassification. *See* ORS 656.277(1) (providing that the worker first may seek review of the carrier's classification by the Department).

[2] For the same reason, we find no merit to claimant's assertion that she need only "show that her injury caused a material worsening of her preexisting condition." Furthennore, although not explicitly argued on review, we find no medical opinion in the record that would justify applying the last injurious exposure rule.

(Ex. 47-8). The panel further reported that the "major cause of [claimant's] ongoing expanded subjective complaints possibly is psychogenic in origin, since her physical examinations have been negative for discopathy since June 2000." (*Id.* at 9). With regard to its conclusion that there was no evidence of a strain resulting from the June 2000 accident, the panel reviewed claimant's initial examination on June 23, 2000 with Dr. Halpert, who did not diagnose a lumbar strain. (*Id.*)

Dr. Fuller provided a subsequent report after reviewing additional records. Dr. Fuller compared claimant's examinations with Dr. Halpert, Dr. Neary and Dr. Weller and found "arbitrary changes in presentation." (Ex. 63-2). According to Dr. Fuller, the panel found that claimant's "subjective complaints were not valid [because] these changed without logic from examiner to examiner." (*Id.*) Thus, Dr. Fuller continued to conclude that there was "no objective finding of a discopathy or a disc herniation, or discogenic event resulting from the 06/22/00 exposure." (*Id.*)

Finally, Dr. Halpert concurred with a report stating that "it is not possible to state that the June 22, 2000 incident caused a separate lumbar strain or sprain in relation to the June 22, 2000 injury." (Ex. 64-1).

Like the ALJ, we find that Dr. Weller's opinion is not sufficiently persuasive to carry claimant's burden of proof. First, Dr. Weller did not respond to Dr. Fuller's finding that claimant's complaints were not consistent. The panel's finding of symptom magnification was corroborated to some extent by Dr. Neary, who reported that claimant "has a lot of personal issues which are no doubt complicating her recovery" and also "has some fairly significant family problems[.]" (Ex. 40-1). Dr. Weller also provides little explanation for her opinion in that she only points to the lack of symptoms during the immediate period before the accident. In light of the complex nature of claimant's condition, which includes her previous injuries and preexisting degenerative condition, we find Dr. Weller's opinion to be conclusory.

Moreover, Dr. Weller had limited contact with claimant. She did not examine claimant until August 21, 2000, two months after the accident. Because she was on maternity leave, Dr. Weller did not see claimant again until November 14, 2000, three months later. Thus, we find that Dr. Weller had a very limited opportunity to become familiar with claimant's condition.

In a similar vein, the physician who examined claimant the day after the June 22, 2000 incident indicated that he could not state that claimant had sustained a lumbar strain or sprain from the accident. Because Dr. Halpert saw claimant so soon after the accident, we find that he was in a better position to evaluate claimant's condition than Dr. Weller, who did not examine claimant until two months later.

For these reasons, we are not persuaded by Dr. Weller's opinion. Dr. Neary indicated only that the June 2000 accident "triggered" claimant's back condition, which we also find inadequate to prove that the compensable injury was the major contributing cause of the claimant's need for treatment and disability. In sum, claimant did not carry her burden of proving compensability under ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated May 9, 2001 is vacated in part and affirmed in part. That portion of the order addressing aggravation is vacated. Claimant's "Notice of Aggravation" and the employer's denial of aggravation are set aside as procedurally invalid. The remainder of the order is affirmed.

In the Matter of the Compensation of
LAURIE D. LINN, Claimant
WCB Case No. 00-07621
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Bruce A. Bornholdt (Saif), 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) Kekauoha's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

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

We first correct the ALJ's reference to "hyperthyroidism" to "hypothyroidism."

In finding that claimant did not carry her burden of proof, the ALJ found that examining hand surgeon, Dr. Button, provided a more persuasive opinion than claimant's treating surgeons, Dr. Layman and Dr. Swanson. Claimant contends that Dr. Button relied on an inaccurate history in that he underestimated claimant's computer use and, thus, his opinion is not reliable.

In rendering his first report, Dr. Button relied on a history from claimant that she used the computer 60 to 70 percent. (Ex. 10-1). In a later report, relying on claimant's recorded statement to SAIF, Dr. Button indicated that claimant produced only one page per work day. (Ex. 17-1).

Claimant told Dr. Swanson that 75 percent of her work day was on the computer. At hearing, she testified that, although the time fluctuated, seven to eight hours of a ten hour work day was a "fair estimate" of her computer use. (Tr. 10). This would correspond to using the computer 70 to 80 percent of the work day.

Although it appears that Dr. Button underestimated claimant's computer use in his second report, his understanding of claimant's computer use in his first report did not materially differ from claimant's testimony at hearing. In that report, Dr. Button stated that "etiology was multi-factorial" and in particular explained how symptoms were provoked by computer use without constituting the major contributing cause of the condition. (Ex. 10-4). Dr. Button's second report was in response to additional information and indicated that he adhered to the opinion in his first report. (Ex. 17-1).

Because Dr. Button's first report relied on an accurate history and provided a well-reasoned explanation for discounting computer use as the major contributing cause, we agree with the ALJ regarding Dr. Button's opinion. Moreover, along with lacking a biomechanical explanation for attributing claimant's computer use (as noted by the ALJ), the opinions of Drs. Layman and Swanson were deficient in other respects.

First, Dr. Layman's initial report supporting compensability noted only that it was "well recognized that repetitive use of the hands with activities such as computer entry work and writing are significant factors related to carpal tunnel syndrome," without explaining why *claimant's* particular computer use and writing caused her condition. Dr. Layman's second report was similarly conclusory by simply stating that he considered all potentially causative factors, including work activities, age, gender, and obesity, and found that work activities were the major contributing cause. (Ex. 19-1).

Dr. Swanson's report contained similar conclusory language. (Ex. 21-1). Furthermore, in response to Dr. Button's point that the fact that claimant's symptoms were more severe in her nondominant hand was not consistent with attributing her condition to her work, Dr. Swanson merely responded by stating that this factor was of "little concern" because he had seen many patients "with their worst symptoms in their non-dominant hand." (*Id.*)

In short, because Dr. Button provided a well-reasoned explanation for his opinion and the treating physicians' opinions were conclusory, the medical opinions, at best, are in equipoise. As such, claimant did not carry her burden of proof. *See* ORS 656.802(2).

ORDER

The ALJ's order dated May 25, 2001 is affirmed.

October 10, 2001 Cite as 53 Van Natta 1418 (2001)

In the Matter of the Compensation of
KATHY L. KELLINGTON, Claimant
WCB Case No. 01-00215
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorney
Cummins, Goodman, et al., Defense Attorney

Reviewing Panel: Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) found that the self-insured employer's amended notice of acceptance of a "combined" condition was valid; and (2) upheld the employer's denial of claimant's "current" low back condition. On review, the issues are claim processing and compensability.

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

On October 20 1999, claimant reported back pain following "more than usual lifting" at work. (Exs. 1; 2). The employer initially accepted the claim as a "low back strain." (Ex. 17).

On November 13, 2000, the employer amended its acceptance to: "low back strain combined with non-work related degenerative changes, scoliosis and an unstable right sacroiliac joint." (Ex. 54). Thereafter, the employer denied claimant's "current" low back condition for the reason that the October 1999 work injury was no longer the major cause of her disability or need for treatment. (Ex. 55). Claimant requested a hearing.

The ALJ determined that the amended Notice of Acceptance (accepting a "combined" condition) was valid. Reasoning that the amended Notice of Acceptance was valid, the ALJ concluded that the "current " condition denial (based on a "combined" condition) was procedurally valid. On the merits, the ALJ determined that claimant had failed to establish the compensability of her "current" low back condition. Consequently, the ALJ upheld the employer's "current" condition denial of claimant's low back condition.

Claimant asserts the practical effect of the employer's amended Notice of Acceptance is a revocation of the employer's previous unequivocal acceptance of "low back strain" followed by an acceptance of "low back strain combined with non-work related degenerative changes, scoliosis and an unstable right sacroiliac joint" (a diminishment of the previously accepted condition). Reasoning that such a "revocation" of the initial acceptance was not the result of "later obtained evidence," claimant reasons that the employer's amended Notice of Acceptance is an impermissible "back-up" denial under the terms of ORS 656.262(6)(a).

ORS 656.262(6)(a) provides in pertinent part: "If the insurer or self-insured employer accepts a claim * * * , and later obtains evidence that the claim is not compensable * * *, the insurer or self-insured employer may revoke the claim acceptance and issue a formal denial, * * * ." Here, the employer did not revoke acceptance of the claim nor challenge the compensability of claimant's injury. Rather, the employer amended the condition accepted; *i.e.*, from a "low back strain" to a "low back strain combined with" various conditions. The amended Notice of Acceptance is not a "back-up" denial. Because the employer's amended Notice of Acceptance did not deny the compensability of the claim, ORS 656.262(6)(a) does not apply.

Alternatively, claimant contends that her 1999 accepted "low back strain" merged with her 1996 "low back strain." Claimant asserts, therefore, that under ORS 656.308(1) all medical services and disability involving the 1996 condition must be processed as part of the new 1999 work injury.[1]

[1] Claimant makes this argument in support of her contention that the "degenerative" conditions are not "preexisting" because they did not "preexist" the 1996 injury.

ORS 656.308(1) applies when a "new" compensable injury includes the "same condition" previously accepted. *See, e.g., Sanford v. Balteau Standard/SAIF Corp.*, 140 Or App 177, 186 (1996); *Timothy A. Vinton*, 53 Van Natta 979, 982 (2001). A new compensable injury "involves the same condition" when the new injury encompasses, or has as part of itself, the prior compensable injury. *Multifoods Specialty Dist. v. McAtee*, 164 Or App 654, 662 (1999). Consequently, claimant's argument hinges on whether the 1999 work injury "encompassed or had as part of itself," the prior compensable low back strain from the 1996 injury.

Although both the 1996 and 1999 injuries involve "low back strain" conditions, the medical record indicates that the 1996 condition became stationary without permanent impairment on December 10, 1996. (Exs. OH; OJ). Moreover, the medical record indicates that between December 10, 1996, and October 19, 1999, claimant did not require medical treatment for "low back strain." (Exs. OH; 1). More importantly, none of the medical opinions in this record suggest that the 1996 and 1999 injuries involve the same condition. In any event, the "degenerative" conditions were not accepted in 1996 or thereafter (under the 1996 claim). Consequently, we conclude ORS 656.308(1) does not apply.

Having concluded that neither ORS 656.262(6)(a) nor ORS 656.308(1) apply, we agree with the ALJ that the amended Notice of Acceptance is valid.[2]

Regarding the compensability of claimant's "current" condition, we adopt and affirm the reasoning of the ALJ.

ORDER

The ALJ's order dated May 2, 2001 is affirmed.

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[2] Claimant further asserts that even if the amended Notice of Acceptance is not invalid as a "back-up" denial, it is otherwise invalid because there is no medical evidence of any "preexisting condition" (other than the 1996 compensable injury) with which the 1999 work injury could combine. Contrary to claimant's assertions, the medical record establishes that claimant has degenerative disc disease, and a congenital thoracolumbar scoliosis. (Exs. 45-7; 50-5; 56-6). Moreover, the medical evidence establishes a "combining" of the preexisting conditions and the 1999 work injury. (Exs. 53-3; 56-8). Consequently, we reject claimant's argument.

Board Member Phillips Polich specially concurring.

I agree with the outcome reached by the lead opinion, and find it consistent with my discussion of the statutory language of ORS 656.262(6)(c) in my dissent in *Jeff E. White*, 53 Van Natta 220, 222 (2001) and my special concurrence in *John J. Shults*, 53 Van Natta 383, 387 (2001). Here, unlike either *White* or *Shults*, the insurer's acceptance of a "combined" condition did not occur on the same day as the subsequent "current condition" denial. Thus, here, unlike *White* or *Shults*, there is no question that the insurer's denial was procedurally valid. Consequently, both *White* and *Schults* are distinguishable.[1] For these reasons, I specially concur.

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[1] In *White*, the carrier's "combined" condition acceptance and the "current condition" denial occurred on the same day and in the same document. In *Shults*, the acceptance and denial were separate documents, but the documents issued on the same day with denial issued later in time.

In the Matter of the Compensation of
FLOYD D. BLASER, Deceased, Claimant
WCB Case No. 99-10052
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Meyers. Member Meyers dissents.

The self-insured employer requests review of Administrative Law Judge (ALJ) Howell's order that: (1) reinstated claimant's[1] survivor's benefits; and (2) assessed a 5 percent penalty for the employer's allegedly unreasonable delay in accepting or denying the claim. On review, the issues are entitlement to survivor's benefits and penalties.

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

For the reasons given by the ALJ, we agree that *Peters v. R.A. Briggs and Sons*, 10 Or App 310 (1972), requires reinstatement of claimant's survivor's benefits. As found by the ALJ, claimant's voidable marriage was seasonably annulled on the basis of fraud by a court of general jurisdiction. Thus, for the reasons set forth in the ALJ's order, we disagree with the dissent's assertions that claimant's marriage was not seasonably annulled. In this regard, we agree with the ALJ's conclusion that claimant took action to leave the marriage immediately upon discovering the fraud. The voidable marriage was then annulled by the court. We likewise agree with the ALJ that the employer cannot collaterally attack the judgment of annulment. However, even assuming that the employer could collaterally challenge the judgment, we are persuaded that the record establishes that claimant's consent to the marriage was obtained through fraud. Under such circumstances, we are in agreement with the ALJ's analysis.[2]

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

ORDER

The ALJ's order dated March 19, 2001 is affirmed. For services on Board review, claimant's attorney is awarded $1,500, payable by the employer.

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[1] The "claimant" in this matter is the widow of the deceased worker.

[2] The employer argues that *Peters* was decided "long before" the Court set forth its opinion in *PGE v. BOLI*, 317 Or 606, 610-12 (1993). The employer also argues that at the time *Peters* was issued in 1972, the workers' compensation law was to be liberally construed, whereas ORS 656.012(3) now requires that the law be interpreted in an impartial and balanced manner. We conclude, however, that *Peters* remains good law and is consistent with *PGE*. In this regard, under the *PGE* analysis, the first level of review is to examine the text and context of the statute. Included within the context of a statute is case law interpreting the statute. *Gaston v. Parsons*, 318 Or 247 (1994). Except for changes in the amount of benefits, ORS 656.204(2)(a) remains materially unchanged. Had the legislature disagreed with the Court's interpretation of the statute, it could have amended the statute. Thus, we are persuaded that the *Peters* decision is part of the context of the statute that is considered under the first level of the *PGE* analysis.

Board Member Meyers dissenting.

I disagree with the majority's decision to adopt the ALJ's order reinstating claimant's survivor's benefits. The main basis for my disagreement is that I find the facts of *Peters v. Briggs & Sons*, 10 Or App 310, 315 (1972), the case relied upon by the ALJ and the majority, to be distinguishable from the facts of the present case. Thus, I do not believe that the holding in the *Peters* case requires reinstatement of claimant's survivor's benefits.

In *Peters*, the claimant was the widow of a worker killed in an industrial accident. The claimant remarried in Nevada but separated immediately following the wedding ceremony. The marriage was never consummated and the claimant returned to her home in Oregon. Nine days later, she filed suit for annulment on grounds of fraud and was granted a default decree of annulment. The carrier advised the claimant that her remarriage had terminated her right to survivor's benefits pursuant to ORS 656.204(2)(a) and offered her a statutory lump sum payment.[1] The claimant requested a hearing contending that she had not remarried within the meaning of ORS 656.204(2) and was entitled to continue receiving benefits.

The court held that the logical meaning of "remarriage" as contemplated by ORS 656.204(2) is a valid and subsisting marriage and that it was the intention of the legislature that a widow would lose her rights to benefits only if she subsequently contracts a "valid and subsisting marriage." The court concluded that it followed that the claimant did not lose her widow's benefits where her voidable remarriage was "seasonably annulled" by a court of competent jurisdiction.

In contrast to *Peters*, the present case involves a marriage that was annulled after 10 years. Thus, I agree with the employer that, unlike the marriage in *Peters*, which was immediately annulled following the ceremony and was never consummated, the marriage in the present case was not "seasonably" annulled, but was a valid and subsisting marriage for 10 years prior to the annulment.

Under such circumstances, I conclude that this case is factually distinguishable from the situation in *Peters*.

In addition, I agree with the employer's contention that claimant was aware of the "fraud" committed by Heintz, who she married in 1989, well prior to the annulment and took no steps to leave the marriage until 1998. In this regard, claimant learned of Heintz' attempts to regain his membership in the Baha'i faith as early as 1991. (Ex. 27-21). Based on this knowledge, claimant knew at that time that Heintz did not intend to give up practicing his faith. Instead of taking steps to leave the marriage upon first learning of Heintz' attempts to regain his membership in the church, claimant stayed in the marriage for 10 years. Under such circumstances, I would conclude that claimant's remarriage was "valid and subsisting" and that, under *Peters*, claimant would not be entitled to reinstatement of her survivor's benefits.

I also agree with the employer's argument that this proceeding is not bound by the finding in the annulment decree that the marriage was induced by fraud. As the employer asserts, it was not a party to the decree. Under such circumstances issue preclusion does not apply. Additionally, I do not believe that the employer is collaterally attacking the decree by contending, in this separate workers' compensation proceeding, that claimant knew of the fraud before 1998 and took no action. This information is relevant in determining whether the remarriage was "valid and subsisting" under *Peters* and is not an attack on the annulment judgment itself.

Finally, from a public policy standpoint, the majority decision should not stand. Interpreting the majority's decision in the most positive light, the majority would hold that a poor choice in selecting a new marriage partner would become the responsibility of the workers' compensation system. It is difficult to imagine this was ever contemplated by any legislature, and public policy should dictate otherwise.

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[1] The current version of ORS 656.204(2)(a) provides: "If the worker is survived by a spouse, monthly benefits shall be paid in an amount equal to 4.35 times 66-2/3 percent of the average weekly wage to the surviving spouse until remarriage. The payment shall cease at the end of the month in which the remarriage occurs." The version of the statute that applied at the time of the *Peters* decision provided:

> "(2) If the workman is survived by a spouse, $110 per month shall be paid to the surviving spouse until remarriage. The payment shall cease at the end of the month in which the remarriage occurs * * * (c) Upon remarriage, a widow shall be paid $2,500 as final payment of her claim, but the monthly payments for each child shall continue as before * * *."

Current ORS 656.204(3)(a) provides that: "Upon remarriage, a surviving spouse shall be paid 36 times the monthly benefit in a lump sum as final payment of the claim, but the monthly payments for each child shall continue as before."

A less positive interpretation is that this marriage failed because the wife did not convert to her husband's religion. This marriage is not unlike other marriages that end due to irreconcilable differences. Here, that irreconcilable difference is religion. In light of the value of the workers' compensation benefits being claimed, this is a divorce couched in the legal fiction of an annulment.

Finally, from a fiscal standpoint, the financial impact of this decision is beyond any legislative intent. The self-insured employer, having appropriately paid all benefits due, closed its claim. Now, some 10 years after the fact, without having reserved for such a contingency, the self-insured employer (and possibly its reinsurer) and the Retro Reserve Fund are all faced with a liability not remotely anticipated. The majority decision would pave the financial way for insurers, reinsurers, and the Retro Reserve Fund never to be able to close their claims, even when the surviving spouse has remarried, not to mention the rating of such obscure contingencies by carriers and rating organizations.

Because I believe there is no legal nor rational basis for reinstatement of survivor's benefits after claimant's 10 year marriage, I would reverse. Because no benefits would be due, it follows that no penalty may be assessed.

In the Matter of the Compensation of
WILLIAM J. DWYER, JR., Claimant
WCB Case Nos. 00-05572 & 00-05571
ORDER ON REVIEW
Cole, et al., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that: (1) upheld the SAIF Corporation's denials of his current low back condition; and (2) found that claimant's 1999 medical services were not related to his accepted claims. On review, the issues are compensability and medical services.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated May 31, 2001 is affirmed.

Board Member Phillips Polich dissenting.

By adopting the ALJ's order, the majority finds that SAIF's denials of claimant's "combined condition" were procedurally valid and SAIF is not required to pay for claimant's 1999 physical therapy treatment. Because I disagree with both conclusions, I respectfully dissent.

At hearing, claimant argued that SAIF's October 25, 2000 "current condition" denials were procedurally invalid because he had never filed a claim for a combined condition and because SAIF had never accepted a combined condition. The ALJ (and the majority) conclude that: (1) a carrier can issue a "combined condition" denial any time it feels the medical situation compels such a denial even if claimant has not filed a new condition claim or requested acceptance of a combined condition; and (2) in a closed claim, a carrier may issue a combined condition denial without ever having formally accepted a combined condition. I disagree, particularly with the second issue.

Claimant has two accepted low back injuries. On November 22, 1995, he injured his low back lifting a heat pump. SAIF accepted a disabling lumbar strain. (Ex. 3). The claim was closed on June 19, 1996 without an award of permanent disability. (Ex. 13).

On July 24, 1998, claimant sustained a back injury while delivering parts to a customer. An August 3, 1998 lumbar MRI showed disc desiccation and reactive end plate changes at L4-5 with modest posterior bulging. (Ex. 19). Dr. Kitchel interpreted the MRI as showing severe degenerative change at

L4-5. (Ex. 23). On August 17, 1998, SAIF wrote to Dr. Kitchel, asking, among other things, whether claimant had a preexisting condition, whether it had combined with the July 24, 1998 work exposure, and what was the major contributing cause of his condition and need for treatment. (Ex. 24). Dr. Kitchel replied that claimant had preexisting lumbar degenerative disc disease and the July 1998 work injury was the major contributing cause of his current pain and need for treatment. (Ex. 26). Shortly thereafter, SAIF accepted only a disabling low back strain. (Exs. 27, 29). A December 9, 1998 Notice of Closure did not award any permanent disability. (Ex. 30).

In late September 1999, claimant sought medical treatment from Dr. Pugsley for low back pain. (Ex. 31-2). She diagnosed recurrent lumbar radicular pain and recommended physical therapy and medication. (*Id.*) In December 1999, Dr. Fuller, who examined claimant on behalf of SAIF, reported that claimant's back pain had resolved and he continued to perform his regular work without restriction. (Ex. 37-3).

On October 25, 2000, SAIF issued two denials of claimant's "current condition," each referring to one of claimant's injury dates. Regarding the 1995 injury, SAIF stated:

> "We continue to monitor the process of your recovery from your November 22, 1995 occupational injury. Our most recent information indicates that your current condition is no longer compensable for the following reason(s):
>
> "Your claim was originally accepted for lumbar strain. Information in your claim file also indicates that beginning on or after November 22, 1995, your injury and/or accepted condition(s) have combined with one or more preexisting conditions including: lumbar degenerative disc disease.
>
> "However, a combined condition is compensable only so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability and need for treatment of the combined condition. Medical information indicates that on or about September 29, 1999, and thereafter, your accepted injury is no longer the major contributing cause of your combined condition. Accordingly, SAIF hereby denies your combined condition or and after September 29, 1999." (Ex. 53B).

SAIF issued a similar denial with respect to the July 24, 1998 injury. (Ex. 53A).

On review, SAIF argues that the October 25, 2000 denials were procedurally and factually correct. According to SAIF, a denial of a combined condition issued after claim closure is not procedurally improper. For the following reasons, I disagree.

It is first necessary to address 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 accepted a lumbar strain resulting from the November 22, 1995 injury. (Ex. 3). The claim was closed on June 19, 1996 without an award of permanent disability. (Ex. 13).

Similarly, SAIF specifically accepted a low back strain related to the July 24, 1998 injury, despite the fact that Dr. Kitchel had reported that claimant had a preexisting degenerative condition at L4-5. (Exs. 26, 27). On December 9, 1998, SAIF issued an updated notice of acceptance at closure, again referring to the accepted condition as a low back strain. (Ex. 29). SAIF closed the claim on December 9, 1998, without an award of permanent disability. (Ex. 30).

Thus, SAIF accepted a lumbar strain resulting from the November 1995 injury and a low back strain related to the July 1998 injury. There is no evidence that SAIF accepted a combined condition related to either claimant's November 1995 or July 1998 injury. *See Johnson v. Spectra Physics*, 303 Or 49, 58 (1987) (acceptance of a claim includes only those injuries or conditions specifically accepted in writing pursuant to ORS 656.262(6)). This is not a situation in which SAIF simultaneously accepted and denied a combined condition in one document, or in separate documents issued on the same day. *Compare John J. Shults*, 53 Van Natta 383 (2001); *Jeff E. White*, 53 Van Natta 220 (2001). Because there was no acceptance of a combined condition before SAIF issued denials of claimant's "combined condition," the provisions of ORS 656.262(6)(c) and (7)(b) do not apply. *See Blamires v. CleanPak Systems, Inc.*, 171 Or App 163 (2000); *Croman Corp. v. Serrano*, 163 Or App 136 (1999).

Furthermore, because SAIF has not accepted a "combined condition," it cannot deny either claim on the basis that claimant's accepted injury is no longer the major contributing cause of his combined condition. *See Dale E. Holden*, 53 Van Natta 197 n1 (2001) (because the carrier had not accepted a

combined condition, it could not deny the claim on the basis that the claimant's preexisting patellofemoral malalignment condition had combined with his compensable chondromalacia). In addition, because SAIF did not attempt to revoke its prior acceptance of either the low back strain or the lumbar strain, ORS 656.262(6)(a) does not apply. *See Jan L. Cox*, 53 Van Natta 731 n1 (2001). I would therefore set aside SAIF's October 25, 2000 denials as procedurally invalid.

Regarding claimant's medical services claim, the ALJ and the majority conclude that SAIF was not required to pay for claimant's 1999 physical therapy treatment. I disagree.

Instead, I agree with claimant that SAIF should be held responsible for reimbursement of all medical treatment, including physical therapy, that it is materially required by the accepted injury conditions. In a deposition, Dr. Pugsley agreed that physical therapy was appropriate treatment for a soft tissue muscle strain, but does not treat underlying degenerative disc disease in anything more than a symptomatic fashion. (Ex. 54-10). Under ORS 656.245, any material relationship to the injury is sufficient to require SAIF to pay for the physical therapy. The majority errs by concluding that SAIF is not required to pay for claimant's 1999 medical care.

In the Matter of the Compensation of
DAVID S. HAMBLIN, Claimant
WCB Case No. 01-01094
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Hitt, et al., Defense Attorney

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that affirmed an Order on Reconsideration that awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of claimant's left hip and 6 percent (9 degrees) scheduled permanent disability for loss of use or function of claimant's right hip. On review, the issue is extent of scheduled permanent disability.

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

The employer argues that the medical arbiter's report does not support a permanent disability award, because the medical arbiter found "no objective basis for a permanent medical disability rising out of the accepted conditions." (Ex. 41-3).[1] However, considering the arbiter's correct understanding of claimant's compensable injuries, his valid bilateral hip range of motion measurements, and the absence of non-injury related causes for claimant's reduced hip range of motion, we are not persuaded by the employer's argument. *See Patrick J. Callow*, 53 Van Natta 1181 (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 $800, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 22, 2001 is affirmed. For services on review, claimant is awarded an $800 attorney fee, payable by the self-insured employer.

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[1] The employer also relies on the arbiter's specific comments regarding the cause of claimant's "activity intolerance" and "partial loss of ability to use his hip[s]." We do not find these comments helpful in evaluating the cause of claimant's valid hip range of motion measurements, because they do not address *range of motion*. (*See* Ex. 41-3-4).

In the Matter of the Compensation of
JENNIFER A. KOSCHNICK, Claimant
WCB Case No. 00-06833
ORDER ON REVIEW
Welch, et al., Claimant Attorney
Gene L. Platt, Defense Attorney

Reviewing Panel: Members Meyers, Bock, and Biehl. Member Biehl dissents.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's denial of claimant's right ankle injury claim. On review, the issue is whether claimant's injury arose out of and in the course and scope of her employment.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated May 4, 2001 is affirmed.

Board Member Biehl dissenting.

The facts of this case are undisputed: Claimant is a police officer who is on call 24 hours a day. She usually works from 6 p.m. until 6 a.m. However, claimant often performs work duties after 6 a.m., including paperwork and briefing the next shift. In addition, claimant and other officers customarily call the work dispatcher when they arrive home after work and that phone call signals the end of the officer's watch--the technical end of the shift.

Claimant wears a work uniform that includes boots, a heavy belt, a bullet resistant vest, a portable radio, a hand gun, a baton and a spray canister. The items she carries weigh about 20 pounds. She also carries a shotgun in her patrol car. According to the employer's policy, police officers may not leave their shotguns in unattended patrol vehicles. Therefore, when an officer takes a patrol car home, he or she must remove the gun from the vehicle.

On May 28, 2000, at about 6 a.m., claimant completed some paperwork at the Sheriff's office, briefed the next shift, then drove her patrol car home. She got out of the car, removed her shotgun from the trunk, and began walking toward her house. (She also picked up her newspaper from the ground near the car). As she walked, claimant adjusted the muzzle of the shotgun upward. After a few steps, claimant stepped on uneven ground in her lawn and felt a snapping and/or popping sensation and severe pain in her right ankle. She fell to the ground.

Claimant sought medical treatment and filed a workers' compensation claim which the insurer denied.

The majority upholds the insurer's denial, finding the evidence of a work-connection minimal at best. I would find the causal relationship between claimant's work and her injury sufficient to warrant compensation under Oregon Workers' Compensation Law.

For an injury to be compensable under ORS Chapter 656, it must "arise out of" and occur "in the course of the employment." ORS 656.005(7)(a). The "arising out of" prong of the compensability test requires that a causal link exist between the worker's injury and the employment. *Robinson v. Nabisco, Inc.*, 331 Or 178, 185 (2000). The requirement that the injury occur "in the course of the employment" concerns the time, place, and circumstances of the injury. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 525-526 (1996).

Although there are two parts of a unitary "work-connection" test, the fundamental inquiry is whether the relationship between the injury and the employment is sufficiently close that the injury should be compensable. *Robinson*, 331 Or at 185 (2000); Krushwitz, 323 Or at 526. The unitary work-connection test does not supply a mechanical formula for determining whether an injury is compensable. Rather, we evaluate the relevant factors on a case by case basis to determine whether the

circumstances of a claimant's injury are sufficiently connected to employment to be compensable. *Robinson*, 331 Or at 185.[1]

Claimant's injury must satisfy both prongs of the work-connection test to some degree; neither is dispositive. *Id.* at 186; *Krushwitz*, 323 Or at 531. However, if many facts support one element of that test, fewer facts may support the other. *Robinson*, 331 Or at 186; *Redman Industries, Inc. v. Lang*, 326 Or 32, 35 (1997).

I would find that the evidence supporting the "in the course of" element of the work-connection test is strong. It is undisputed that claimant was on call 24 hours a day and she regularly performed work duties beyond her 12 hour shift. It is also undisputed that it was claimant's and other officers' practice to call the dispatcher from home after work and this call technically signaled the end of the officer's "watch." On May 28, 2000, however, claimant had not called in to signal the end of her watch when she was injured. Considering the nature of claimant's work, particularly her on call status, the regular practice of calling to end the shift, and the fact that claimant had not made that call when she was injured, I would find that these facts weigh heavily in favor of a work connection. Moreover, the circumstances of the injury indicate that claimant was following the employer's rule against leaving the shotgun in the unattended patrol car when she fell: She was carrying the shotgun from the car to her house. This activity, including its time and place, was not only anticipated by the employer, it was required by the employer's work rules. Accordingly, because the time, place and circumstances of the injury are clearly work related, I would find that claimant has satisfied the "in the course of element" of the work connection test with unequivocal evidence. *See Robinson*, 331 Or at 189 ("An injury occurs 'in the course of' employment if it takes place within the period of employment, at a place where a worker reasonably may be expected to be, and while the worker reasonably is fulfilling the duties of the employment or is doing something reasonably incidental to it.").

I would find the "arising out of" prong of the work connection test similarly satisfied. An injury arises out of employment if the employment exposes him to some risk from which the injury originates. *Robinson*, 331 Or at 186; *Fred Meyer, Inc. v. Hayes*, 325 Or 592 (1997); *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994).

Here, the risk of a fall while walking on uneven ground was a risk for claimant every day, on and off work. Considering claimant's on call status, and the fact that her watch had not ended, I would find the risk of falling on her own lawn *at least* a neutral risk (one neither purely personal to claimant nor purely employment related. Moreover, as noted, claimant was following work rules at the time of her injury (removing the shotgun from the patrol car) and she was therefore acting within the boundaries of her work when she was injured. Under these circumstances, I believe the location of the injury is much less important than the other factors for this "on call" police officer. Because claimant has satisfied both elements of the unitary work connection test, I am satisfied that a sufficient causal link exists between claimant's injury and a risk connected with employment to justify the conclusion that claimant's injury arose out of employment under ORS 656.005(7)(a).

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1 " 'The statutory phrase "arising out of and in the course of employment" must be applied in each case so as to best effectuate the socio-economic purpose of the Worker's Compensation Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer. 1 *Larson, Workmen's Compensation Law*, section 2.20."' *Robinson*, 331 Or at 185.

In the Matter of the Compensation of
PAUL M. MURPHY, Claimant
WCB Case No. 00-02262
ORDER ON REVIEW
Juli Hall, Claimant Attorney
William J. Blitz, Defense Attorney

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

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's injury claim for a thoracic strain. 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 concerning the thoracic strain. 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 $1,155, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 19, 2001 is affirmed. For services on review concerning claimant's thoracic strain, claimant's attorney is awarded $1,155, payable by the insurer.

Board Member Meyers dissenting.

In adopting the ALJ's order, the majority finds this claim compensable based on the ALJ's "medical" opinion that claimant sustained a thoracic strain. Because the medical evidence is insufficient to support that conclusion, I respectfully dissent.

Claimant was compensably injured on April 23, 1999, when he was struck by a heavy cable and choker while working for the employer as a choker setter. The insurer initially accepted a cervical contusion. (Ex. 4). On January 31, 2000, claimant's attorney requested that the employer amend the acceptance to include a cervical strain, thoracic and back strain and contusions, post-traumatic headaches and a right arm bruise. (Ex. 7A). The insurer accepted a cervical strain and post-traumatic headaches. (Ex. 8). Claimant requested a hearing regarding the insurer's *de facto* denial, raising issues of compensability of a thoracic strain and contusion, and a right arm bruise. (Tr. 3, 4).

The ALJ upheld the denial of the right arm bruise, but found that claimant had sustained a thoracic strain. The ALJ reasoned that, based on the location claimant was struck, and in view of "objective" examination findings in April and May 1999 of swelling and palpation tenderness in the muscles of the thoracic strain, the "back muscle" strain diagnosed by Dr. Carter necessarily included the thoracic spine. The ALJ found that Dr. Glassman had concluded in his deposition that the findings described by Dr. Givens would "require" consideration of a diagnosis of thoracic strain. The ALJ concluded that the insurer's acceptance should be expanded to include a thoracic strain.

The insurer argues that the medical evidence is insufficient to establish that claimant sustained a thoracic strain as a result of the April 1999 injury. Instead, the insurer asserts that the medical evidence confirms that claimant had a cervical strain and post-traumatic headache, which have already been accepted.

Claimant contends that the claim for a thoracic strain is supported by objective medical findings and by his unchallenged testimony regarding the nature of the injury and ensuing pain complaints, which should not be disregarded because the physicians did not apply the label "thoracic strain."

Because this case involves a complicated situation, expert medical evidence is required to prove causation. *See Barnett v. SAIF*, 122 Or App 279 (1993). Generally, a claimant need not prove a specific diagnosis if he or she proves that the symptoms are attributable to work. *See Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992). Here, however, the issue is whether the insurer incorrectly omitted a thoracic strain from its notice of acceptance, *see* ORS 656.262(6)(d), and, therefore, claimant must establish that he sustained a thoracic strain.

In *Benz v. SAIF*, 170 Or App 22, 25 (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 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"). Although claimant relies on numerous medical records to support his argument that there were objective findings of a thoracic strain, the Board is not free to reach its conclusion about whether claimant sustained a thoracic strain. Rather, the Board must rely on medical evidence to reach that conclusion. *See also SAIF v. Brown*, 177 Or App 113 (2001) (the Board's stated reason for saying that the opinions were based on complete information was not supported by any medical opinion).

Claimant relies on Dr. Carter's findings to establish a thoracic strain. One week after the work injury, Dr. Carter reported that claimant had "some tenderness of his paraspinous muscles in his lumbar as well as thoracic area[.]" (Ex. B). He diagnosed "muscle strain of back[.]" (*Id.*) On May 5, 1999, Dr. Carter reported that claimant had neck stiffness, back pain and headaches, and he found some tenderness of his trapezius muscles bilaterally. (Ex. C). He diagnosed a muscular headache. (*Id.*) One week later, Dr. Carter found that claimant had tenderness in his neck muscles, as well as his upper back and trapezius muscles. (Ex. E). He diagnosed a neck and back strain with resultant headaches. (*Id.*)

The issue is whether claimant had a thoracic strain. In contrast, Dr. Carter diagnosed a neck and back strain, with headaches. The Board is not an agency with specialized medical expertise and I cannot reasonably infer from Dr. Carter's findings that claimant had a thoracic strain. *See Benz v. SAIF*, 170 Or App at 25; *SAIF v. Calder*, 157 Or App at 227-28. Dr. Carter's reports are insufficient to establish that the insurer incorrectly omitted a thoracic strain from the notice of acceptance. *See* ORS 656.262(6)(d).

The only other medical evidence that arguably supports the conclusion that claimant had a thoracic strain is from Dr. Glassman, who first examined claimant on June 16, 1999, almost two months after the April 23, 1999 injury. He reported that most of claimant's pain was in the "interscapular" area, and he diagnosed a cervical strain and headache. (Ex. 1). He recommended medication and physical therapy "to include cervical stretching, cervical mobilization and modalities." (Ex. 1-2). Dr. Glassman later concurred with a report from Drs. Neumann and Denekas, who had diagnosed a cervical strain and post-traumatic headaches related to the April 23, 1999 injury. (Exs. 5, 6). On December 1, 1999, Dr. Glassman determined that claimant's cervical strain and headaches had resolved and he was medically stationary, without permanent impairment. (Ex. 7).

In June 2000, claimant's attorney wrote to Dr. Glassman, asking whether claimant had suffered an injury to his upper back and, if so, what would be the medical diagnosis. (Ex. 9). Dr. Glassman responded that the diagnosis was a "cervical strain." (Ex. 9-2).

In a deposition, Dr. Glassman reiterated that his primary diagnosis was a cervical strain, based on his evaluation of claimant. (Ex. 10-9, -21). Dr. Glassman was asked to review Dr. Givens' April 27, 1999 chart note that found claimant had "diffuse swelling over the paraspinal muscles on the right-hand side of his back from about T5 all the way down to L1." (Exs. A-2, 10-10, -11). Claimant's attorney and Dr. Glassman then engaged in the following colloquy:

> "Q. [Claimant's attorney] What would you conclude as a physician in taking a look at that report?
>
> "A. [Dr. Glassman] I would - well, I don't know if I would would conclude anything without the opportunity to conduct an objective examination.
>
> "Q. All right. So -
>
> "A. So let me preface that by saying, in other words, I would examine the patient before I could conclude anything on that. Just looking at this, I would think that it could be any one of a number of things -
>
> "Q. Okay. Let's -
>
> "A. - actually a thoracic strain, spasms. Am I answering your question?
>
> "Q. Yeah, you are. A thoracic strain or possibly a lumbar strain?
>
> "A. Those are the things that would come to mind.

"Q. Okay. And I understand you weren't there and you didn't conduct the examination. But assuming that Dr. Givens made these objective findings, what we've talked about would indicate a thoracic strain or a lumbar strain or some associated problem?

"A. Well, again, I hate to put words in Dr. Givens' mouth. So I would be hesitant to say. If I had those findings, I might think of thoracic strain." (Ex. 10-11, -12).

Thus, Dr. Glassman testified that he was reluctant to reach any conclusions about another physician's findings without an opportunity to conduct an objective examination. (Ex. 10-11). He was hesitant to put words in Dr. Givens' mouth, but he said that, given his findings, he "might" think of thoracic strain. (Ex. 10-12). In *Gormley v. SAIF*, 52 Or App 1055, 1060 (1981), the court found that the doctors' use of the words "could," "can," "it is reasonable to assume" and "we would like to assume" militated against a finding of medical causation in terms of probability. The court concluded that, because the claimant could not prove more than just the possibility of a causal connection, she failed to carry her burden of proof. I reach a similar conclusion in this case. Dr. Glassman's opinion merely supports a conclusion that it was *possible* that claimant sustained a thoracic strain as a result of the April 1999 work injury. Consequently, Dr. Glassman's opinion is insufficient to meet claimant's burden of proof. Because there are no other medical opinions that establish that claimant sustained a thoracic strain as a result of the April 1999 work injury, I would reverse the ALJ's order. The majority errs by concluding otherwise.

In the Matter of the Compensation of
FRED R. TRIBUR, Claimant
Own Motion No. 01-0282M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Black, Chapman, et al., Claimant Attorney
Argonaut Ins. Co., Insurance Carrier

Reviewing panel: Members Biehl and Haynes.

Claimant requests review of the insurer's July 25, 2001 Own Motion Notice of Closure that closed his claim with an award of temporary disability compensation from February 6, 2001 through March 25, 2001. The insurer declared claimant medically stationary as of July 5, 2001. Asserting that the Own Motion closure is "inappropriate," claimant contends that "the claim should be processed pursuant to ORS 656.262 and 268."

FINDINGS OF FACT

On December 7, 1976, claimant sustained a compensable left knee injury, which the insurer accepted as a nondisabling injury. Claimant's aggravation rights expired five years later, on December 7, 1981.

On February 6, 2001, claimant underwent an arthroscopic debridement of his left knee performed by Dr. Freudenberg, his treating physician. On February 13, 2001, we issued an Own Motion Order authorizing the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant underwent the proposed surgery. The insurer was also directed to close the claim pursuant to OAR 438-012-0055 when claimant was medically stationary. That Own Motion Order was not appealed.

On July 5, 2001, Dr. Freudenberg examined claimant and declared him medically stationary. He noted that claimant remained released for his regular work.

On July 25, 2001, the insurer issued an Own Motion Notice of Closure that closed the claim with an award of temporary disability benefits from February 6, 2001 through March 25, 2001, and declared claimant medically stationary as of July 5, 2001.

On September 4, 2001, claimant requested that the Board in its Own Motion capacity review the insurer's Own Motion Notice of Closure, contending that his claim should be processed pursuant to ORS 656.262 and 656.268.

CONCLUSIONS OF LAW

Claimant requests that the Board, in its Own Motion authority, review the insurer's July 25, 2001 "Notice of Closure Board's Own Motion Claim." He contends that the Own Motion closure is inappropriate and that the claim should be processed under ORS 656.262 and 656.268 pursuant to *Johansen v. SAIF Corporation*, 158 Or App 672 (1999).[1] Claimant makes no argument regarding the merits of the insurer's closure.

To begin, we have subject matter jurisdiction in our Own Motion capacity to review the July 25, 2001 closure. Our reasoning for this conclusion is expressed in *John R. Graham*, 51 Van Natta 1740 (1999), 51 Van Natta 1746 (1999), and *Craig J. Prince*, 52 Van Natta 108 (2000). In *Graham*, we held that a "new medical condition" claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c), even if the original claim is in the Board's Own Motion jurisdiction. 51 Van Natta at 1745.

Furthermore, in *Prince*, we determined that the Board's authority under its "Own Motion" capacity is strictly limited by the provisions of ORS 656.278 and that those provisions do not include the authority to direct a carrier to process a claim under ORS 656.262(7)(c). We explained that the issue of whether the claim should be processed under ORS 656.262(7)(c) is a "matter concerning a claim," and under ORS 656.283, any party "may at any time request a hearing on any matter concerning a claim." 52 Van Natta at 111. Therefore, where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *Id.*

Finally, we have subject matter jurisdiction in our Own Motion capacity to review a carrier's Own Motion Notice of Closure. Specifically, where a claimant's aggravation rights have expired on the initial injury claim and the condition worsened requiring surgery, we are authorized to reopen the claimant's claim pursuant to ORS 656.278(1)(a) and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. We also have subject matter jurisdiction in our Own Motion capacity to review the carrier's subsequent closure of that claim. *See SAIF v. Ledin*, 174 Or App 61 (2001); *see also Paul E. Smith*, 52 Van Natta 730 (2000); *Robert A. Olson*, 52 Van Natta 1540 (2000).

Here, the record is undeveloped regarding the question of whether claimant has initiated a "new medical condition" claim or a new condition that has been found compensable after claim closure. In any event, the *Ledin*, *Graham*, and *Prince* rationale is equally applicable. In other words, there is no dispute that claimant's aggravation rights have expired on his initial injury claim. Furthermore, claimant's condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the February 13, 2001 Own Motion Order that authorized the reopening of claimant's claim pursuant to ORS 656.278(1)(a) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review the insurer's subsequent closure of that claim.[2] Therefore, we proceed with that review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 65.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at the date of closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the July 25, 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

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[1] We interpret claimant's assertion that his claim should be processed pursuant to ORS 656.262 and 656.268 to mean that he has a "new medical condition" which requires different claim processing.

[2] We have previously explained, where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *See Prince*, 52 Van Natta at 111. In other words, claimant's relief, if any, regarding his request for claim processing under ORS 656.262(7)(c) and 656.268 lies with the Hearings Division, not the Board in our Own Motion jurisdiction.

(1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Here, the only medical evidence regarding the medically stationary issue is provided by claimant's attending physician, who opined that claimant was medically stationary as of July 5, 2001. That is the date the insurer declared claimant's condition medically stationary when it closed the claim.

Claimant makes no argument that he was not medically stationary at the time of closure, nor does he argue that his medically stationary date was incorrect. He also does not contest the temporary disability compensation award. Instead, claimant's argument is procedurally based; *i.e.*, he argues that this particular closure of this Own Motion claim should not be processed under the Board's Own Motion jurisdiction. Because we have rejected that argument and claimant raises no substantive arguments, we affirm the insurer's July 25, 2001 Own Motion Notice of Closure in its entirety. *See Harold G. Magnum*, 52 Van Natta 1824 (2000); *John P. Adkins*, 52 Van Natta 708 (2000).

Accordingly, the insurer's July 25, 2001 Own Motion Notice of Closure is affirmed.

IT IS SO ORDERED.

October 16, 2001 Cite as 53 Van Natta 1431 (2001)

In the Matter of the Compensation of
MAUREEN BRYANT, Claimant
WCB Case No. 00-08805
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

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

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

Claimant argues on review that the ALJ erred in analyzing claimant's claim as an occupational disease rather than an injury. Based on this record, however, we conclude that whether claimant's claim is analyzed as an injury or a disease, compensability has not been established.

Claimant has a prior claim for a low back strain in 1997. The denial of this claim was not appealed and became final by operation of law.

Dr. Poulson, claimant's attending physician, diagnosed chronic recurrent lumbosacral strain with a likely degenerative disc. (Ex. 14-2). Dr. Poulson indicated that he did not believe that claimant's work exposure was the major contributing cause of her recurrent "LS" strain. He further indicated that the condition appeared to have combined with her low back condition from 1997. (Ex. 18). Dr. Poulson later stated that this combination was the major cause of claimant's problem. (Ex. 22).

Dr. Dutton, D.C., indicated that claimant's work was the major contributing cause of her lumbosacral strain. However, Dr. Dutton was unable to say that claimant's degenerative changes were not responsible for her current low back condition. (Ex. 20).

Dr. Freeman, D.C., opined that claimant's work was the major contributing cause of claimant's strain. (Ex. 21-2). He did not feel that claimant's degenerative changes were responsible for claimant's condition.

After reviewing this medical evidence, we find it insufficient to establish compensability of claimant's condition as either an occupational disease or an injury. In this regard, we find the opinions

of Dr. Freeman and Dr. Dutton unpersuasive because neither doctor discussed whether the 1997 strain contributed to claimant's low back condition. In addition, neither Dr. Freeman nor Dr. Dutton addresses Dr. Poulson's opinion. Under such circumstances, regardless of whether the claim is analyzed as an injury or disease, we find the medical opinions of Drs. Dutton and Freeman inadequately reasoned and insufficiently explained. Accordingly, we conclude that the medical evidence does not establish compensability.

ORDER

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

In the Matter of the Compensation of
SCOTT E. TAYLOR, Claimant
WCB Case No. 00-07159
ORDER ON REVIEW
Lavis & DiBartolomeo, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Haynes and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that upheld the SAIF Corporation's denial of his injury/occupational disease claim for a bilateral shoulder 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 compensability of claimant's bilateral shoulder condition, diagnosed as calcific tendonitis. In so doing, the ALJ determined that the claim should be analyzed as an occupational disease and that the claim was not compensable because the medical evidence from the attending physician, Dr. Keizer, and a radiologist who reviewed medical records, Dr. Young, did not establish that claimant's work activity as a truck driver pathologically worsened claimant's preexisting calcific tendonitis. *See* ORS 656.802(2)(b).

On review, claimant contends that the ALJ incorrectly analyzed the claim as an occupational disease and that, instead, the claim should be viewed as one for an industrial injury because his condition arose during a discrete period of work activity. *See Valtinson v. SAIF*, 56 Or App 184 (1982). Further, claimant asserts that Dr. Keizer's opinion establishes the compensability of his bilateral shoulder condition, regardless of whether the claim is characterized as an injury or occupational disease.

For the following reasons, we conclude that Dr. Keizer's opinion is not persuasive. Therefore, we conclude that claimant failed to sustain his burden of proof on either an injury or occupational disease theory. We reason as follows.

The cause of claimant's bilateral shoulder 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 that 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).

Dr. Keizer authored the only opinion that supports compensability, stating that claimant's work activity was the major contributing cause of his calcific tendonitis. (Ex. 23-1). In his deposition, however, Dr. Keizer testified that his opinion was based on subjective information from claimant on when his pain developed. (Ex. 26-6). Dr. Keizer specifically noted that claimant "felt that it was related

to the ongoing work that he was doing." (Ex. 26-7). Dr. Keizer conceded that he did not have any idea of how long claimant worked for the employer, that he did not inquire into the specifics of claimant's work activities, and that he did not know what claimant did off the job. (Ex. 26-10, 16). Dr. Keizer described his reasoning as follows:

> "So, I mean, I don't know what kind of work he was doing or exactly what would cause this to flare up. But it flared up about the same time that he began work. And I--to me, there may be something that he's doing that we don't know what caused it to flare up. Maybe it wasn't even at work. I don't know.
>
> "But all I can say is that it occurred at the same time that he was at work. And he is stating that since he has been at work doing that kind of work, he's had problems with his shoulder." (Ex. 26-13).

Having reviewed Dr. Keizer's testimony, we conclude that his opinion is not well reasoned because it was based on incomplete information. Dr. Keizer conceded that he did not know the specifics of claimant's work or anything about off-the-job activity. Moreover, Dr. Keizer's opinion was based on a temporal relationship between the reported onset of symptoms and the commencement of claimant's employment. Medical opinions based solely on a temporal relationship are generally not persuasive. *See Allie v. SAIF*, 79 Or App 284 (1987); *Vicki F. Brown*, 51 Van Natta 1961 (1999) (treating doctor's opinion inadequately explained and unpersuasive because it was based on the temporal relationship between the claimant's work and her symptoms, without explaining why work contributed more than undisputed preexisting condition). Finally, because he relied on a temporal relationship analysis, Dr. Keizer did not weigh the relative contribution of the various potential causes of claimant's bilateral shoulder condition.

For all these reasons, we do not find Dr. Keizer's opinion persuasive. It, therefore, follows that it cannot satisfy claimant's burden of proof under either an injury or occupational disease theory. Accordingly, we conclude that the ALJ properly upheld SAIF's denial.

ORDER

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

October 16, 2001 Cite as 53 Van Natta 1433 (2001)

In the Matter of the Compensation of
DARCIE A. HOWARD, Claimant
WCB Case No. 00-08666
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the SAIF Corporation's denial of her combined condition claim for a fibromyalgia condition.[1] On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

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

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[1] At hearing, claimant contended that her fibromyalgia condition was compensable as either a "combined" or "consequential" condition. *See* ORS 656.005(7)(a)(A) and (B). However, on review, claimant contends only that the condition is compensable as a "combined condition."

In the Matter of the Compensation of
JENNY L. BOYDSTON, Claimant
WCB Case No. 97-03081
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that declined to award additional temporary disability benefits. On review, the issue is temporary disability.

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

Claimant compensably injured her right middle finger in September 1994.[1] (Exs. 6; 7; 9; 13). In December 1996, the claim was closed by Determination Order with an award of scheduled permanent disability, but no award of temporary disability. (Ex. 14). Claimant requested reconsideration seeking an award of temporary disability. (Ex. 15).

A February 27, 1997 Order on Reconsideration awarded temporary disability from February 12, 1995 through February 28, 1995. (Ex. 17-2). Claimant requested a hearing seeking additional temporary disability.

The ALJ determined that Dr. Ballard (attending physician) released claimant to regular duty work on February 28, 1995. The ALJ determined that Dr. Ballard's February 1997 "retroactive" temporary disability authorization (from February 28, 1995 to October 15, 1996) was ineffective pursuant to ORS 656.262(4)(g). Finding no contemporaneous authorization of temporary disability by Dr. Ballard or any other physician in the record, the ALJ concluded that claimant had failed to establish entitlement to additional temporary disability. Consequently, the ALJ affirmed the February 1997 Order on Reconsideration.

Claimant acknowledges that Dr. Ballard released claimant to regular duty work on February 28, 1995. Nonetheless, claimant contends that Dr. Ballard's subsequent chart notes, together with his February 1997 opinion establish an entitlement to additional temporary disability. We disagree.

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."

ORS 656.262(4)(g) applies to claims in open status and at the time of claim closure. *See Menasha Corporation v. Crawford*, 332 Or 404, 416 (2001).

Here, Dr. Ballard's February 1997 opinion authorizes temporary disability for a period of time more than 14 days prior to its issuance. Consequently, pursuant to ORS 656.262(4)(g), to the extent that the "retroactive" authorization extends for a period in excess of 14 days from its issuance, the authorization is ineffective and does not establish entitlement to temporary disability.

Dr. Ballard released claimant to regular work on February 28, 1995. Based on our review of Dr. Ballard's subsequent chart notes from February 28, 1995 to October 15, 1996, we find no contemporaneous authorization of temporary disability. Accordingly, we agree with the ALJ that claimant is not entitled to additional temporary disability.

ORDER

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

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[1] The accepted condition was "right middle finger contusion." (Exs. 9; 13).

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 1435-1492 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH NOVEMBER 9, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, OCTOBER-DECEMBER 2001.

In the Matter of the Compensation of
JASON B. BERRINGTON, Claimant
Own Motion No. 01-0323M
OWN MOTION ORDER
Welch, et al., Claimant Attorney

Reviewing panel: Members Haynes and Biehl.

The self-insured employer has submitted a request for temporary disability compensation for claimant's left knee condition. Claimant's aggravation rights have expired. The employer recommends reopening for 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 the worker is actually hospitalized or undergoes outpatient surgery. *Id.*

Here, on August 14, 2001, Dr. Hoppert, claimant's attending physician, recommended left knee surgery. Thus, we conclude that claimant's compensable condition worsened requiring surgery.

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

With its recommendation form, the employer submitted medical reports from Dr. Hoppert, which demonstrate that claimant was in the work force at the time of the current disability. On April 11, 2001, Dr. Hoppert noted that claimant "is still driving a truck." He further noted that claimant was released to full duty as a truck driver. On June 26, 2001, Dr. Hoppert reported that claimant could "continue his work as a truck driver." On July 11, 2001, Dr. Hoppert noted that claimant "may continue working with the knee splint on so long as the patella is not overtly painful." Finally, on August 14, 2001, Dr. Hoppert reported that claimant could continue "working as a work driver."

Based on these reports, we conclude that claimant was in the work force at the time of his current worsening.[1] *See Ralph A. Schultz*, 52 Van Natta 762 (2000); *John R. Kennedy*, 50 Van Natta 837 (1998). Accordingly, we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, the 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. However, claimant's attorney has stated that he wishes to limit his fee to $200. In light of claimant's attorney's position, the attorney fee is limited to a maximum of $200.

IT IS SO ORDERED.

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[1] The "date of disability" for the purpose of determining whether claimant is in the work force, under the Board's Own Motion jurisdiction, is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to August 14, 2001, when his condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

In the Matter of the Compensation of
JUDY A. RICHTER, Claiman
WCB Case No. 00-06991
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Employers Defense Counsel, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's occupational disease claim for a left elbow condition. On review, the issue is compensability.

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

Claimant was a school bus driver for about 20 years. (Tr. 15). In the fall of 1999, claimant began to notice pain in her left arm, for which she eventually sought medical treatment from Dr. Lundsgaard in June 2000. (Tr. 49; Ex. 2). The condition was diagnosed as left elbow epicondylitis. (Ex. 2-1). Thereafter, claimant filed a claim for her left elbow condition. (Ex. 3).

The insurer denied the claim. (Ex. 5). Claimant requested a hearing.

The ALJ, relying on the opinion of Dr. Lundsgaard (attending physician), concluded that claimant had established the compensability of the left elbow condition. Consequently, the ALJ set aside the insurer's denial. To establish the compensability of her left elbow epicondylitis condition as an occupational disease, claimant 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 left elbow 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); *Barnett v. SAIF*, 122 Or App 279, 282 (1993).

Dr. Lundsgaard was the only physician that offered an opinion regarding causation. According to Dr. Lundsgaard, claimant's left elbow lateral epicondylitis was caused by repetitive microtrauma resulting from her work activities as a school bus driver. (Exs. 11; 12-6; 12-12). In rendering his opinion, Dr. Lundsgaard considered claimant's work history, claimant's work activities including the daily safety check of the bus (operating emergency windows and doors), driving, opening the door at each stop, and cleaning the bus. Dr. Lundsgaard also considered claimant's non-work activities. Dr. Lundsgaard's opinion is complete and well reasoned. Accordingly, we find it persuasive. *See Somers v. SAIF*, 77 Or App 259, 263, (1986).

The insurer contends that Dr. Lundsgaard's opinion is not persuasive because it is based on an inaccurate history. In particular, the insurer asserts that Dr. Lundsgaard was under the mistaken belief that claimant's symptoms began about two months before she first consulted with him, when in fact claimant's symptoms began about a year and a half earlier. However, when specifically asked if the duration of claimant's symptoms would change his opinion as to causation, Dr. Lundsgaard indicated that such a change in history would not change his ultimate opinion. (Ex. 12-13). Consequently, we reject the insurer's argument.

The insurer also contends that Dr. Lundsgaard did not weigh the contribution of other potential causes. Dr. Lundsgaard indicated that claimant's left elbow condition was multifactorial. (Ex. 12-6). However, contrary to the insurer's assertions, Dr. Lundsgaard considered claimant's off-work activities,

a prior medical problem with claimant's right arm, and a possible history of moving furniture.[1] (Ex. 10-2). Additionally, Dr. Lundsgaard ruled out arthritis as a cause based on x-ray and bone scan testing. (Exs. 12-15). Consequently, we conclude that Dr. Lundsgaard did weigh other potential causes in rendering his ultimate opinion.

Finally, the insurer suggests that: (1) Dr. Lundsgaard's opinion is based on possibilities, not probabilities; and (2) Dr. Lundsgaard did not state an opinion in terms of "major contributing" cause. In particular, the insurer asserts that Dr. Lundsgaard's answer to a hypothetical question (in which he indicated that the major cause was not clear) posed by the insurer's counsel during a deposition supports its contention. First, we note that, before rendering his ultimate opinion, Dr. Lundsgaard had been expressly asked to state his opinion in terms of probabilities. (Ex. 10-3). Additionally, he was expressly asked if claimant's work activities were the major contributing cause of her left lateral epicondylitis. (*Id.*) Because Dr. Lundsgaard affirmatively answered the "major contributing cause" question, we conclude that his opinion is sufficient to carry claimant's burden of proof. (Ex. 11). *See Liberty Northwest Insurance Corp. v. Cross*, 109 Or App 109, 113 (1991); *McClendon v. Nabisco Brands, Inc.*, 77 Or App 412, 417 (1986) (use of "magic words" not necessary to establish medical causation). Moreover, we note that the hypothetical question posed by the insurer's counsel did not accurately describe claimant's activities either on or off the job. Under such circumstances, Dr. Lundsgaard's answer to the inaccurate hypothetical question is not probative. Consequently, we reject the insurer's assertion.[2]

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

ORDER

The ALJ's order dated May 25, 2001 is affirmed. For services on review, claimant's attorney is awarded a $1,200 attorney fee, payable by the insurer.

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[1] Dr. Lundsgaard indicated in his deposition that claimant had mentioned elbow pain in relation to moving from one residence to another. (Ex. 12-8). He did not record claimant's remarks and could not remember with any specificity what claimant had said. (*Id.*) Claimant testified that she had packed boxes in preparation for the move, but had not moved any thing. (Tr. 31). Claimant's testimony was supported by Roy Palmer, a neighbor, who testified that he and claimant's relatives moved claimant's furniture and boxes. (Tr. 5). Consequently, to the extent that claimant may have participated in lifting items in changing residences, we conclude that Dr. Lundsgaard was aware of that activity and considered it in rendering his ultimate opinion.

[2] In support of its argument, the employer cites both *James R. Andrews*, 53 Van Natta 255 (2001) and *Devin D. Cole*, 50 Van Natta 191 (1998). In *Andrews*, we determined that a treating physician's ultimate causation opinion which failed to explain how the claimant's work activities put stress on the lateral epicondyle was conclusory and less persuasive than other medical opinions in the medical record. 53 Van Natta at 256. Here, unlike *Andrews*, there are no opposing medical opinions. Moreover, unlike *Andrews*, there are no medical opinions expressly stating that claimant's work activities would not put enough force or stress on the lateral epicondyle to cause lateral epicondylitis. Consequently, Andrews is distinguishable.

In *Cole*, we determined that a treating physician's opinion regarding causation was not persuasive because it was primarily based on a temporal relationship and because it failed to consider previous injuries to the same body part. 50 Van Natta at 192. Here, unlike *Cole*, Dr. Lundsgaard's opinion is not primarily based on a temporal relationship between a single event and the onset of claimant's symptoms. Moreover, unlike *Cole*, claimant's left arm was not previously injured. (Tr. 29, 49). Consequently, *Cole* is distinguishable.

In the Matter of the Compensation of
GREGG R. SWANSON, Claimant
WCB Case No. 00-06895
ORDER ON REVIEW
Brad L. Larson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

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

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

In upholding SAIF's denial, the ALJ found that claimant had not met his burden of proving major contributing cause through the opinion of his treating physician, Dr. Labby. We agree with the ALJ's ultimate decision, but supplement the order to clarify the standard of proof in this occupational disease claim.

In an occupational disease context, claimant must prove that work activities were the major contributing cause of the claimed condition. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000). In addition, the medical evidence from Dr. Laycoe, who examined claimant at the request of SAIF, establishes that claimant's right wrist osteoarthritis condition was a "preexisting condition."[1] (Ex. 6-4). Claimant's claim for right wrist osteoarthritis is thus "based on" a worsening of this preexisting condition. ORS 656.802(2)(b). For that reason, claimant must prove that his employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. *Id.*; *Joy A. Kosta*, 53 Van Natta 1205 (2001).

We agree with SAIF that there is no such proof of a "pathological worsening" of claimant's right wrist condition in the record. Dr. Laycoe recognized that claimant's work activity provoked symptoms in his right wrist, but concluded that the work activity was not the "primary factor" in causing the condition and did not cause a worsening or change in claimant's degenerative conditions revealed on x-ray. (Ex. 6-4). In contrast, Dr. Labby identified claimant's work activity as the major contributing cause of claimant's right wrist condition based on the timing and location of his symptoms (greater on the right). (Exs. 8, 11). However, Dr. Labby did not state that claimant's work had "pathologically worsened" his combined osteoarthritis condition.

Accordingly, we need not address claimant's arguments that Dr. Labby's opinion satisfies his burden of proving "major contributing cause" or that Dr. Laycoe's opinion is unpersuasive in light of *Bronco Cleaners v. Velazquez*, 141 Or App 295 (1996). SAIF's denial was properly upheld.

ORDER

The ALJ's order dated May 18, 2001 is affirmed.

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[1] Dr. Labby also acknowledged that claimant "may well have had some preexisting arthritis in his hand and wrist." (Ex. 11).

In the Matter of the Compensation of
GARRETT W. CRAWFORD, Claimant
WCB Case No. 98-03327
ORDER ON REMAND
Stebbins & Coffey, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

This matter is before the Board on remand from the Supreme Court. *Menasha Corp. v. Crawford*, 332 Or 404 (2001). The court has affirmed the Court of Appeals decision, 164 Or App 174 (1999), that reversed our prior order, *Garret W. Crawford*, 51 Van Natta 1 (1999), that affirmed the ALJ's order that: (1) awarded claimant additional temporary disability benefits from October 20, 1995 through September 30, 1997; (2) awarded claimant's attorney an "out-of-compensation" attorney fee; and (3) declined to award claimant a penalty for unreasonable claim processing.

In *Crawford*, we concluded that the lack of a contemporaneous authorization of time loss from claimant's attending physician (as required by *former* ORS 656.262(4)(f), now subsection (g)), did not preclude claimant's entitlement to "substantive" temporary disability following the closure of his claim. The Court of Appeals reversed our decision, citing *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999).

The Supreme Court has affirmed the Court of Appeals decision. In doing so, the Court discussed *Bundy*, in which the court had concluded that the reference in ORS 656.262(4) to ORS 656.268 was intended to limit the award of "retroactive" time loss to 14 days, regardless of whether the claim was open or was pending closure. The *Crawford* Court echoed that reasoning and similarly held that the "14-day" retroactive limitation applied to the issue of claimant's entitlement to additional temporary disability. 332 Or at 416. Consequently, the Court has remanded for further proceedings.

Here, the record contains no contemporaneous temporary disability authorization from an attending physician for the time period from October 20, 1995 through September 30, 1997. On October 20, 1995, Dr. Davis released claimant to regular work. (Ex. 11-2). On December 1, 1997, Dr. Bert stated that he believed claimant was unable to work from October 1995 until his surgery on September 30, 1997. (Ex. 29). However, pursuant to the Court's holding, such retroactive authorization of temporary disability (greater than 14 days) is insufficient. 332 Or at 416. *See former* ORS 656.262(4)(f). Claimant is thus not entitled to temporary disability for that period of time. *See also Linda K. Holcomb*, 51 Van Natta 933 (1999).

Accordingly, on reconsideration of our prior order, the ALJ's September 3, 1998 order is reversed in part and affirmed in part. The ALJ's award of additional temporary disability, as well as an "out-of-compensation" attorney fee, are reversed. The ALJ's order is otherwise affirmed.[1]

IT IS SO ORDERED.

[1] Because claimant's compensation has ultimately been reduced as a result of the employer's request for Board review, we rescind the $1,500 attorney fee awarded in our prior order pursuant to ORS 656.382(2).

In the Matter of the Compensation of
JOSEPH P. GATTO, Claimant
WCB Case No. 01-01014
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

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

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

Claimant has been a warehouseman for 35 years. (Tr. 11). A large part of his job activities involved loading and unloading trucks which required repeated bending and lifting with his knees. (Tr. 15). His job also required considerable walking on concrete floors. (Tr. 18).

In 1997, claimant began to notice sharp pain on the inside of his left knee cap. (Tr. 13). Sometime latter, he developed the same type of pain in his right. knee. (*Id.*) Ultimately, he had three surgeries on each knee. (*Id.*).

In August 2000, claimant filed an occupational disease claim for his bilateral knee condition. (Ex. 26). SAIF denied the claim. (Ex. 30) Claimant requested a hearing.[1]

The ALJ determined that Dr. Edelson's (attending physician) opinion was the only opinion in the record supporting compensability. Concluding that Dr. Edelson's opinion was insufficient to meet claimant's burden of proof, the ALJ upheld SAIF's denial.

Claimant seeks to establish the compensability of bilateral knee conditions, as an occupational disease. Therefore, he must prove that his work activities are the major contributing cause of the disease itself, not just the major contributing cause of the disability or treatment associated with it. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).

Dr. Edelson opined that claimant's work activity was the major contributing cause of claimant's disability and need for treatment for his bilateral knee conditions. (Ex. 33). He did not opine that claimant's work activity was the major contributing cause of claimant's bilateral knee condition itself. Consequently, Dr. Edelson's opinion is not sufficient to carry claimant's burden of proof. ORS 656.802(2)(a); *Foster*, 52 Van Natta at 178.

Claimant asserts that, as a whole, Dr. Edelson's report (Exhibit 33) supports a conclusion that Dr. Edelson was discussing the major cause of the bilateral knee condition itself rather than the major cause of the disability and need for treatment of the condition. Dr. Edelson used the word "cause" in three separate sentences in his report; in each sentence it is used in conjunction with the word "treatment." (Ex. 33). Such use of the word "cause" supports only the conclusion that Dr. Edelson is of the opinion that claimant's work was the major cause of his need for treatment. Consequently, we reject claimant's assertion.

Claimant also asserts that, based on the stipulation of the parties, there are no alternative causes contributing to claimant's knee conditions. (Appellant's Brief, p. 6). In other words, claimant contends there is only one possible cause for claimant's bilateral knee condition; *i.e.*, his work. During opening statement, SAIF's counsel agreed that there were no preexisting conditions and "this is strictly an occupational disease claim under ORS 656.802(2)(a)." (Tr. 8). Contrary to claimant's assertions, such a stipulation does not mean that there are not possible alternative causes for the disputed condition. Rather, such a stipulation means that claimant need not meet the burden of proof imposed by ORS 656.802(2)(b). Consequently, we reject claimant's argument.

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[1] Claimant sought to establish the compensability of multiple meniscus tears and osteoarthritis in both knees. (Tr. 5).

Accordingly, we agree with the ALJ that, on this record, claimant's bilateral knee condition is not compensable.

ORDER

The ALJ's order dated June 4, 2001 is affirmed.

October 19, 2001 Cite as 53 Van Natta 1441 (2001)

In the Matter of the Compensation of
GEORGE L. GRANT, Deceased, Claimant
WCB Case No. C012301
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Preston, Bunnell & Stone, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

On September 27, 2001, the Board received the parties' claim disposition agreement (CDA) and amended CDA in the above-captioned matter. Pursuant to that amended agreement, in consideration of the payment of a stated sum, claimant (the beneficiaries of the deceased worker) 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 amended CDA provides that "[t]he parties stipulate and agree that [the decedent] was medically stationary as of March 12, 2001, and that [the decedent] was permanently and totally disabled effective that date."

It is well settled that CDAs are not designed for purposes of claim processing. *See, e.g., Kenneth D. Chalk*, 48 Van Natta 1874 (1996); *Kenneth R. Free*, 47 Van Natta 1537 (1995). Here, however, we do not interpret the CDA as a Board order granting permanent total disability. Rather, we interpret the provision as the parties' explanation regarding the basis for the consideration to be paid under the CDA.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $23,801.20, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
BRIAN KASSOFF, Claimant
WCB Case No. 01-01305
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that dismissed claimant's request for hearing for failure to appear at hearing. Claimant also requests remand. On review, the issues are propriety of the dismissal order and remand. We vacate and remand.

FINDINGS OF FACT

Claimant requested a hearing from the insurer's denial of his claim. He did not appear on May 14, 2001, the date of the scheduled hearing.

When the hearing convened, the insurer moved to dismiss claimant's request for hearing and claimant's attorney moved to postpone the hearing. The ALJ took both motions under advisement and issued an Order to Show Cause, instructing claimant to explain his failure to appear at the hearing.

On May 29, 2001, claimant submitted an affidavit explaining that he was aware that the hearing had been set for May 14, 2001, but he thought that date fell on Wednesday, rather than Monday, and that was why he failed to appear at the Monday hearing. The insurer responded to claimant's affidavit.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's mistaken belief that the May 14, 2001 hearing date fell on a Wednesday, rather than a Monday, did not constitute "good cause" for his failure to appear at the hearing. Therefore, the ALJ dismissed claimant's request for hearing. Claimant requested Board review.

Claimant argues that his failure to appear at the hearing was not "unjustified" and extraordinary circumstances justified postponement or continuation of the hearing. Claimant also argues that the ALJ abused his discretion by not specifically ruling on the motion to postpone the hearing. In addition, claimant requests remand to "complete the record pursuant to ORS 656.295(5). We remand.

OAR 438-006-0071(2) provides:

> "Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the Administrative Law Judge shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

OAR 438-006-0071 does not provide authority for dismissal of a hearing request for failure of a claimant to appear at hearing if the claimant's attorney appears on his or her behalf. *See Mark E. Snyder*, 53 Van Natta 1386 (2001); *Darius McKellips*, 51 Van Natta 2047 (1999); *Richard Ensinger*, 51 Van Natta at 956. Consequently, we disagree with the ALJ's dismissal of the request for hearing. We turn to how the hearing should be conducted on remand.

We have previously held that the procedure for the hearing on remand in cases such as this one depends on whether or not a postponement should have been granted. *Ensinger*, 51 Van Natta at 957. If a postponement should have been granted, then the hearing should be conducted as any other hearing. If, however, a postponement should have been denied, then no exhibit may be received which was not submitted in connection with the prior hearing and no witness, including claimant, may testify if that witness was not available to testify at the prior hearing.

Here, we agree with the ALJ that the circumstances described in claimant's affidavit did not warrant postponement. Claimant's mistake regarding the day (but not the date) of the hearing was avoidable by referring to a calendar. As such, it was not an "extraordinary circumstance" justifying postponement under OAR 438-006-0081. Moreover, claimant was (or should have been) aware of the importance of arriving to attend the hearing at the appropriate time. Consequently, the effect of this decision is that claimant has waived his right to testify at the hearing. *Ensinger*, 51 Van Natta at 957.

Consequently, we vacate the ALJ's order and remand for further development of the record based on the exhibits submitted for presentation at the scheduled May 14, 2001 hearing, as well as any witnesses who were present to testify at that hearing.

Accordingly, we vacate the ALJ's order and remand to ALJ Spangler. The ALJ shall determine what exhibits should be received, but no exhibits shall be admitted that were not prepared for submission as evidence at the May 14, 2001 hearing. Nor shall any witness, including claimant, be permitted to testify who was not prepared to testify at the prior hearing. These proceedings may be conducted in any manner that the ALJ determines achieves substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

ORDER

The ALJ's order dated June 19, 2001 is vacated. The case is remanded to ALJ Spangler, for further proceedings consistent with this order.

October 23, 2001 Cite as 53 Van Natta 1443 (2001)

In the Matter of the Compensation of
JOHN K. HARKNESS, Claimant
WCB Case No. 97-08467
ORDER OF ABATEMENT
Gayle A. Shields, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Claimant requests reconsideration of our September 28, 2001 Second Order on Remand that: (1) modified our Order on Remand to award claimant's attorney $17,082 for services performed before the Hearings Division, Board and court; (2) awarded claimant's attorney a $1,500 fee for services on remand; and (3) declined to award $240 in court costs.

Claimant contends that the attorney fee should be increased to $21,822. Specifically, she argues that the $17,082 in fees awarded by the Court of Appeals was for services "after the Board's first Order on Review was issued" and did not include time for services before the ALJ and the Board (or reviewing SAIF's petition for Supreme Court Review). Claimant requests $3,000 for services at hearing and $1,500 for services before the Board on remand. She also requests $240 in costs awarded by the court.

In order to further consider this matter, we withdraw our September 28, 2001 order. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Claimant's reply must be filed within 14 days from the date of mailing of SAIF's response. In submitting their respective positions, the parties are asked to discuss what the $17,082 attorney fee awarded by the Court of Appeals represents, including any written materials they previously filed with the court. After receiving the parties' responses, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
PHYLLIS C. MAAS, Claimant
WCB Case No. 00-03231
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Fitzwater's order that: (1) upheld the SAIF Corporation's denial of claimant's back and neck injury claim; and (2) declined to award a penalty based on the allegedly untimely denial of that claim. On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated May 22, 2001 is affirmed.

Board Member Phillips Polich concurring.

While I agree with the lead opinion that, for the reasons explained by the ALJ, claimant failed to establish compensability of her back and neck injury claim and, therefore, is not entitled to a penalty for the SAIF Corporation's untimely denial of that claim, I again find myself compelled to address the penalty issue by means of a concurrence. *See Barbara A. Hasse*, 53 Van Natta 771 (2001).

Here, the work incident occurred on June 4, 1999. On June 8, 1999, claimant sought treatment with Dr. Evans, her chiropractor, and filed a claim by means of an 827 form. (Ex. 2). On August 2, 1999, the employer submitted an 801 form to SAIF, reporting its version of the work incident. (Ex. 4). On August 16, 1999, claimant treated with Dr. Wilson, M.D., who filed another 827 form reporting the June 4, 1999 incident. (Ex. 5).

The first evidence of any claim processing activity by SAIF is a September 7, 1999 letter that submitted questions to Dr. Coulter, M.D., regarding an upcoming medical examination arranged by SAIF. (Ex. 8). That examination occurred on September 23, 1999. (Ex. 9). On October 9, 1999, Dr. Wilson concurred with Dr. Coulter's report, which did not support compensability. (Ex. 11). There is no further claim processing activity in the record until March 22, 2000, when SAIF denied the claim. (Ex. 12).

Pursuant to ORS 656.262(6), the carrier is required to accept or deny a claim within *90 days* after the employer has notice or knowledge of the claim. Here, SAIF denied the claim more than *nine months* after the employer had notice of the claim. It appears that SAIF's first claim processing activity did not occur until the 90-day period to timely accept or deny the claim had almost expired. SAIF provides no reason for its failure to abide by ORS 656.262(6).

Yet, despite the untimeliness of SAIF's denial, there is no basis for the assessment of either a penalty under ORS 656.262(11)(a) or an attorney fee under ORS 656.382(1). A penalty may be assessed under ORS 656.262(11)(a) if there were "amounts then due" between the date when the acceptance or denial should have issued and the date the acceptance or denial actually issued. *Melody L. Rivers*, 48 Van Natta 2089 (1996); *Jeffrey D. Dennis*, 43 Van Natta 857 (1991). Because the claim is not compensable and there were no amounts due at the time of SAIF's unreasonable delay, there is no basis for a penalty. *See Wacker Siltronic v. Satcher*, 103 Or App 513 (1990). In addition, 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, since the claim is not compensable and there were no unpaid amounts due, there is no unreasonable resistance to payment of compensation and no assessed attorney fee is available under ORS 656.382(1).

Thus, under the current state of law, a carrier may disregard statutory claim processing requirements without being subject to any penalty for its unreasonable action.[1] Nevertheless, a denial is not a mere formality. Instead, it is a legal document that notifies the parties of the status of the claim at that point in time and notifies a claimant of his or her right to request a hearing. Moreover, an untimely denial may result in problems for the claimant in gathering evidence to support his or her claim. Furthermore, other problems may be created by an untimely denial. For example, here, claimant was negatively affected by SAIF's delay in that she continued to accrue medical bills for treatment of her back condition during this extended delay period. In addition, the medical provider apparently provided ongoing services assuming that the claim would be accepted. If SAIF had issued a timely denial, claimant may have made other arrangements for her medical treatment.

Given the statutory mandate requiring acceptance or denial of a claim within 90 days and the legal significance of such a document, SAIF's failure to comply with that mandate should result in some penalty. That said, I acknowledge that, under the circumstances of this case, the current state of law does not provide for such a remedy.

[1] In contrast, pursuant to ORS 656.265, an injured worker is held to strict reporting requirements, including definitive timelines, in reporting work injuries to the employer. An injured worker is not permitted to grant himself or herself an "extension" of the statutory timeline within which to report an injury. Likewise, a carrier should not be permitted to grant itself an "extension" of the statutory timeline within which to process a claim.

October 24, 2001 Cite as 53 Van Natta 1445 (2001)

In the Matter of the Compensation of
JEANNE M. KLAGGE, Claimant
WCB Case No. 01-01820
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Alice M. Bartelt (Saif), 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) Peterson's order that awarded no unscheduled permanent disability, whereas an Order on Reconsideration had awarded 16 percent (51.20 degrees). On review, the issue is unscheduled permanent disability.

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

The ALJ reduced the Order on Reconsideration award of 16 percent unscheduled permanent disability for claimant's accepted right shoulder, cervical, thoracic and lumbar strains to zero. The ALJ noted that, although the medical arbiter reported loss of range of motion findings in the right shoulder and thoracic, cervical and lumbar spines, he also stated that claimant had "recovered from her shoulder, cervical thoracic and lumbar strains." (Ex. 41). The ALJ also noted that claimant's attending physician, Dr. Ward, had also found loss of range of motion, but had stated that he believed the ranges of motion he documented were within normal limits for claimant. (Ex. 37-4). Dr. Ward indicated that there was no permanent impairment due to the compensable injury. *Id.*

On review, claimant argues that the fact that she has recovered does not mean that she does not have impairment. SAIF argues that, in light of the medical arbiter's statement that claimant had recovered, the arbiter's report cannot be read to mean that claimant's loss of range of motion is due to the compensable conditions.

Based upon this record, we are not persuaded that the medical arbiter's report establishes that claimant has permanent impairment related to the compensable conditions. Read in conjunction with the attending physician's opinion, we are persuaded that the most reasonable interpretation of the arbiter's report is that claimant's documented loss of range of motion is related to something other than the compensable strain injuries. Accordingly, we affirm the ALJ's order.

ORDER

The ALJ's order dated June 8, 2001 is affirmed.

In the Matter of the Compensation of
KEVIN W. KOPSA, Claimant
WCB Case No. 01-01645
ORDER ON REVIEW
Safeco Legal, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

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

FINDINGS OF FACT

On February 22, 2001, claimant signed a retainer agreement employing his then-attorney of record to represent him in connection with his workers' compensation claim. A provision of that retainer agreement stated that "[Claimant] authorizes Attorneys to sign [claimant's] name and in all other respects to act for [claimant]."

On February 28, 2001, claimant's attorney requested a hearing on claimant's behalf contesting the insurer's partial denial of claimant's injury claim for a cervical disc condition. A hearing was scheduled for May 22, 2001.

On May 21, 2001, claimant's attorney wrote to the Hearings Division and withdrew the request for hearing. The ALJ issued an Order of Dismissal.

On June 28, 2001, claimant's attorney requested Board review of the ALJ's May 21, 2001 dismissal order. Claimant's attorney resigned as attorney of record on July 24, 2001.

On August 16, 2001, claimant submitted a letter to the Board requesting that: (1) the dismissal order be set aside; and (2) requesting remand for consideration of "newly discovered evidence." Claimant asserted that his claim had been dismissed "because test results were unavailable" to his "present doctors."

CONCLUSIONS OF LAW AND OPINION

The ALJ dismissed claimant's hearing request. Thus, the sole issue before us is whether claimant's hearing request should have been dismissed. Based on the following reasoning, we adopt and affirm the ALJ's dismissal order.

Where a claimant signs a retainer agreement employing an attorney and giving that attorney authority to act on the claimant's behalf, a dismissal order issued in response to that attorney's withdrawal of the hearing request is appropriate. *Donald J. Murray*, 50 Van Natta 1132 (1998); *Robert S. Ceballos*, 49 Van Natta 617 (1997).

Here, claimant makes no argument as to why the dismissal order was not appropriate. Nor does he challenge his then-attorney's authority to withdraw the request for hearing. *Cf. Silverio Frias, Sr.*, 49 Van Natta 1514 (1997) (Board vacated ALJ's dismissal order and remanded to the ALJ to determine if the attorney was authorized to withdraw the request for hearing). Under these circumstances, we find no reason to alter the dismissal order. *Eva F. Gutierrez*, 51 Van Natta 2028 (1999); *William A. Martin*, 46 Van Natta 1704 (1994).

Claimant asserts that "newly discovered" evidence "warrants" a hearing. We interpret claimant's assertion as a motion to remand. We may remand to the ALJ for the taking of further evidence if we determine that the record has been improperly, incompletely, or otherwise insufficiently developed. ORS 656.295(5). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Here, other than indicating that certain medical tests were previously unavailable, claimant has offered no explanation regarding the nature of the medical tests in question, or how the test results would likely effect the outcome of this case; *i.e.*, the ALJ's decision to dismiss claimant's hearing request based on his attorney's withdrawal of the request. Phrased another way, even if we assume the previously unavailable test results concern claimant's disability, we are unable to conclude that the newly discovered evidence is reasonably likely to affect the outcome of the case. Accordingly, we do not find a compelling reason to remand.[1] *Compton v. Weyerhaeuser Co.*, 301 Or at 646.

ORDER

The ALJ's order dated May 30, 2001 is affirmed.

[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 the Matter of the Compensation of
ROBERT RICE, Claimant
Own Motion No. 01-0277M
OWN MOTION ORDER
Bischoff, Strooband & Ousey, Claimant Attorney
Kemper Insurance, Insurance Carrier

Reviewing panel: Members Haynes and Biehl.

The insurer submitted claimant's request for temporary disability compensation for his right knee condition. Claimant's aggravation rights have expired. The insurer's Own Motion recommendation neither recommended reopening nor denying claimant's request, but, rather, it indicated: "no recommendation." On page two of the recommendation form, the insurer agreed that: (1) surgery and/or hospitalization was required for claimant's current condition; (2) claimant's current condition was causally related to his compensable condition; (3) it is responsible for claimant's current condition; (4) proposed surgery and/or hospitalization was appropriate for his compensable condition; and (5) claimant was in the work force at the time of his current disability.

In response, claimant requests that we direct the insurer to reopen the claim and assess a penalty for an unreasonable delay in processing his Own Motion claim for temporary disability compensation.

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

On April 11, 2001, Dr. Chamberlain, claimant's attending physician, recommended that claimant undergo surgical repair of his right knee. On April 19, 2001, Dr. Chamberlain submitted a request for pre-certification of a "revision of the right total knee." This request was sent by facsimile to the insurer and received on that same day.

Claimant underwent an insurer-arranged medical examination (IME) on June 19, 2001. The IME examiner concluded that claimant required an arthroscopy for his right knee condition. On August 8, 2001, Dr. Chamberlain concurred with the IME's recommendation.

In its recommendation, the insurer agrees that the proposed surgery is appropriate treatment for claimant's compensable condition. Additionally, the insurer agrees that claimant's current condition is causally related to his compensable injury and that it is responsible for his current condition. Finally, the insurer agrees that claimant was in the work force at the time of the current disability.[1]

Therefore, we are persuaded that claimant's compensable injury has worsened requiring surgery. Accordingly, we authorize the reopening of the claim to provide temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

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

OAR 438-012-0030(1) provides that a carrier is required to submit a written recommendation to the Board as to whether the claim should be reopened or denied within 90 days after receiving an Own Motion claim. This rule is mandatory, not permissive. Moreover, the carrier is required to submit a timely Own Motion recommendation regardless of whether the carrier has resolved any compensability or responsibility issues associated with the claim. *See Mark A. Vichas*, 52 Van Natta 634 (2000) (Board found the carrier's failure to submit a timely Own Motion recommendation unreasonable regardless of fact that the carrier had raised compensability issues in a denial and questioned the reasonableness and necessity of the surgery).

A carrier is deemed to have notice of an Own Motion claim upon receipt of any document that reasonably notifies the carrier that claimant's compensable injury requires surgery or hospitalization. *See* OAR 438-012-0020(3)(b).

Here, by an April 19, 2001 pre-certification surgery request, Dr. Chamberlain announced that claimant's right knee condition required surgery. The insurer received, by facsimile, Dr. Chamberlain's request on April 19, 2001. Notwithstanding its receipt of this reasonable notification that claimant's compensable condition required surgery, the insurer did not submit its recommendation to the Board until September 4, 2001, well beyond the 90-day period following claim filing. Under these circumstances, we find the insurer's failure to timely process claimant's Own Motion claim to be unreasonable.

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

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

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, 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] We acknowledge that the insurer expressly states "no recommendation" on its Own Motion recommendation. Nonetheless, in light of its responses to the aforementioned statements, we conclude that, in effect, the insurer recommended reopening of the Own Motion claim.

In the Matter of the Compensation of
CHARLES B. BAKER, Claimant
WCB Case No. 00-08118
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

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

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

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact with the exception of the "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable low back injury on September 28, 1998. SAIF accepted his claim for lumbar strain on January 7, 1999. (Ex. 15). On March 8, 1999, SAIF issued a Notice of Closure finding claimant's condition medically stationary with no permanent disability. (Ex. 20).

On April 24, 2000, claimant sought treatment with Dr. Minogue for low back pain, worse in the past three to four months. (Ex. 23). Dr. Minogue noted "probable muscle spasm in the right SI joint area and above." (Ex. 23-2). Dr. Minogue filed a request to reopen claimant's claim for aggravation, which was denied by SAIF. (Exs. 24, 32).

On September 7, 2000, Dr. Schilperoort examined claimant at the request of SAIF. (Ex. 30). Dr. Schilperoort's impression was that claimant's accepted lumbar strain had resolved "long ago." (Ex. 30-5). He also diagnosed scoliosis, probably asymptomatic, and minor diffuse degenerative changes, primarily at L3-4, possibly symptomatic. (*Id.*) Dr. Schilperoort found no "objective pathological worsening" of claimant's accepted condition. (Ex. 30-7).

ORS 656.273(1) provides that a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition. *SAIF v. Walker*, 330 Or 102 (2000). ORS 656.273(1) requires proof of two specific elements in order to establish a worsened condition: (1) "actual worsening" and (2) a compensable condition. *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995). Both elements must be satisfied in order to establish a "worsened condition resulting from the original injury." For the following reasons, we find that claimant has not met his burden of proving that his compensable lumbar strain condition has worsened.

Here, SAIF accepted claimant's claim for lumbar strain only. (Ex. 15). The medical evidence in the record reveals that claimant also suffers from low back degenerative disk disease and possibly from a myofascial pain syndrome. (Exs. 30-6, 33, 34-13).

Claimant's treating physician, Dr. Minogue, ultimately could not determine whether claimant's lumbar strain condition had worsened, as opposed to another condition. Dr. Minogue originally stated that "[claimant] has ongoing, current muscular-type pain in the right lower lumbar spine that is related to his original injury two years ago." (Ex. 31-1). However, in a "post-hearing" deposition, Dr. Minogue admitted that he did not know if claimant's lumbar strain condition was worse. (Ex. 34-17). He stated that claimant's current low back pain could have been caused by the September 1998 compensable injury, but "not necessarily." (Ex. 34-18) Dr. Minogue also stated that claimant's findings were consistent with worsening of his back problems, "whatever his back problems are." (Ex. 34-17).

Medical opinion phrased in terms of possibilities, instead of medical probability, does not meet claimant's burden of proof. *Gormley v. SAIF*, 52 Or App 1055 (1981). *See Jennifer L. Porter*, 53 Van Natta 1081 n3 (2001); *Ted L. Golden*, 51 Van Natta 55, 56 (1999) ("could have" and "may have" indicate only possibility not medical probability). Thus, claimant has not met his burden of proof through Dr. Minogue.

In contrast, Dr. Schilperoort, the only other physician to address the issue of whether claimant sustained a worsening of his compensable lumbar strain condition, attributed claimant's current symptoms and need for treatment solely to his low back "degenerative changes." (Ex. 30-7). Dr. Schilperoort also specifically concluded that claimant had experienced no "objective pathological worsening" of his accepted condition. (*Id.*)

Based on the above, we find that claimant has failed to meet his burden of proving that his compensable lumbar strain condition has worsened since closure. Accordingly, we reverse the ALJ's order and assessed attorney fee award.

ORDER

The ALJ's order dated May 29, 2001 is reversed. SAIF's denial is reinstated and upheld. The ALJ's assessed attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

Because I agree with the ALJ's interpretation of Dr. Minogue's opinion, I respectfully dissent.

The majority reverses the ALJ on the narrow ground that claimant did not meet his burden of proving that his compensable lumbar strain condition had worsened through Dr. Minogue. I believe that a more reasonable reading of Dr. Minogue's opinion establishes the compensability of claimant's aggravation claim, especially on a "material contributing cause" basis. Dr. Minogue has treated claimant on several occasions since July 10, 2000. (Ex. 24). As to the issue of aggravation, Dr. Minogue first stated that claimant's continuing "muscular-type pain" was related to his original injury. (Ex. 31-1). His comments in the "post-hearing" deposition reinforced that position. (Ex. 34-17, -18). I agree with the ALJ that, by stating that claimant's current low back pain was "not necessarily" related to his September 1998 compensable injury, Dr. Minogue merely recognized that he could not determine that to be the case *with certainty*. Of course, proof to a "certainty" is not required, only to a "reasonable degree of medical probability." *See Kathryn R. Loney*, 53 Van Natta 1189 n3 (2001).

I find no persuasive reasons not to defer to claimant's treating physician Dr. Minogue in this case. Therefore, I respectfully dissent.

In the Matter of the Compensation of
CHARLES HAMMOND, Claimant
WCB Case No. 01-00498
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

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

We adopt and affirm the ALJ's order with the following changes and supplementation. In the first paragraph on page 2, we change the date in the last sentence to "December 7, 2000." On page 3, we change the last date in the ultimate findings of fact to "November 14, 2000."

The employer contends that the ALJ erred in finding that claimant was credible. The ALJ found that, based on claimant's demeanor and manner while testifying, he was a credible witness. Although not statutorily required, the Board generally defers to the ALJ's credibility determination when it is based on the ALJ's opportunity to observe the witnesses. *See Erck v. Brown Oldsmobile*, 311 Or 519, 526 (1991). When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). On *de novo* review, we agree with the ALJ's determination that claimant was a credible witness.

On page 4 of the ALJ's order, we replace the first two full paragraphs with the following discussion.

The employer argues that claimant failed to present persuasive medical evidence to establish that he suffered a compensable injury. According to the employer, Dr. Lepard's opinion is not persuasive because he only had a history of claimant's two work incidents in November 2000. The employer also contends that Dr. Balme's opinion on causation is not persuasive because his medical opinion is directly contradicted by the facts in the case.

Claimant testified that he first injured his right knee on September 11, 2000, when he was climbing down a ladder at work. (Tr. 5, 14-15). He reported the incident to his supervisor, who recorded it on claimant's time sheet. (Tr. 5, Ex. A). Claimant did not seek medical treatment at that time.

Claimant injured his right knee a second time on November 7, 2000, when he was climbing into a bin to rearrange some wood. (Tr. 6-7, 20-21). He told Mr. Evans, group manager, about his injury. (Tr. 9, 16, 77-78; Ex. 00-1). Claimant injured his knee again on November 14, 2000, after he climbed out of a bin after fixing a belt. (Tr. 7, 26-29). He told Mr. Hirengen, his supervisor, about the third incident. (Tr. 9, 29; Ex. 1).

Claimant sought medical treatment on November 15, 2000 from Dr. Lepard. (Tr. 29, Ex. 6). The nurse's report referred to right knee pain "inj x 3" and indicated that claimant had originally twisted and fallen from a ladder. (Ex. 5). Dr. Lepard reported that claimant hyperextended his right knee "a couple of weeks ago while getting off a ladder[.]" (Ex. 6). Dr. Lepard said claimant had a "second similar injury shortly thereafter, and yesterday twisted it somehow." (*Id.*) Although Dr. Lepard did not have a correct understanding of the timing of claimant's first injury, he was aware that the first incident involved a ladder and that claimant had two other right knee injuries. Dr. Lepard did not provide a report regarding causation.

Claimant was referred to Dr. Balme, who examined him on December 13, 2000. Dr. Balme reported that claimant twisted his right knee on September 11, 2000 when he fell out of a sorter bin. (Ex. 14). In a December 27, 2000 report, Dr. Balme again referred to the date of injury as September 11, 2000, and said that claimant "would have been unemployable from the date of his injury[,]" except for very sedentary work. (Ex. 15A). In another report, Dr. Balme said that claimant's torn ligament and meniscus were related to his September 11, 2000 injury. (Exs. 18, 19).

In a later concurrence letter from claimant's attorney, Dr. Balme was informed about the details of claimant's three work injuries and he agreed that the mechanisms of those injuries were consistent with causing an ACL tear and medial meniscus tear.[1] (Ex. 20). Dr. Balme agreed that the injuries were the major cause of claimant's right knee condition. (Ex. 20).

Dr. Balme provided the only medical opinion on causation. Although he initially had an incomplete history regarding only claimant's September 2000 injury, he was subsequently informed about claimant's two right knee injuries in November 2000.

The employer argues that Dr. Balme's December 27, 2000 opinion that claimant was "unemployable" because of his September 2000 injury is directly contradicted by the facts and, therefore, his opinion is not persuasive. Dr. Balme's December 27, 2000 report was based on incomplete information. However, Dr. Balme was later provided with more complete information and we rely on his concurrence report to conclude that claimant has established that his work injuries were a material cause of his right knee condition.

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

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[1] We note that the concurrence letter to Dr. Balme refers to the dates of injury as September 9, 2000, November 7, 2000 and November 14, 2000. (Ex. 20). The record indicates the first incident occurred on September 11, 2000. Despite the minor date discrepancy, the concurrence report accurately describes the three incidents involving claimant's right knee.

ORDER

The ALJ's order dated April 25, 2001 is affirmed. For services on review, claimant's attorney is awarded $2,000, payable by the self-insured employer.

In the Matter of the Compensation of
JOSE L. MARTINEZ, Claimant
WCB Case No. 01-00403
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Phillips Polich. Member Phillip Polich concurring in part and dissenting in part.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) upheld the SAIF Corporation's denial of his aggravation claim for a lumbar strain; (2) upheld SAIF's denial of claimant's current condition; and (3) upheld SAIF's denial of claimant's L4-5 disc herniation. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated May 11, 2001 is affirmed.

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

I agree with the majority's decision to affirm the portion of the ALJ's order that upheld SAIF's denial of claimant's L4-5 disc herniation condition. However, I respectfully dissent from the majority's decision to affirm the ALJ's order upholding SAIF's denials of claimant's aggravation claim and current condition.

As to claimant's aggravation claim, SAIF accepted a lumbar strain condition in 1999 that was closed without an award of permanent disability on February 18, 2000. (Ex. 12). ORS 656.273(1) provides:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings."

Absent persuasive reasons to the contrary, we generally defer to the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, there are no reasons not to defer to the opinion of claimant's treating physician, Dr. Becker. Dr. Becker agreed with the statement that "there has been an actual worsening of [claimant's] condition post-closure of his claim in which he was awarded zero (0) permanent partial disability. While [claimant] did have some symptoms on closure, those symptoms have worsened at the present time and it is your opinion that the objective findings indicate an actual worsening of his compensable condition in the low back." (Ex. 33-3). In addition to symptomatic worsening, Dr. Becker detailed objective findings of worsening including an "involuntary list" and failure to reverse lumbar lordosis. (Ex. 32-2).

Dr. Becker's opinion is more than sufficient to establish an aggravation claim under *SAIF v. Walker*, 330 Or 102 (2000) (evidence of a symptomatic worsening may prove an aggravation claim if a physician concludes based on objective findings (which may incorporate claimant's symptoms) that the underlying condition has worsened). Dr. Becker has examined claimant on several occasions over the relevant time period before and since closure. I would defer to his opinion.

As to the compensability of claimant's current low back condition, I would similarly defer to Dr. Becker. I agree with Dr. Becker's analysis that claimant's need for treatment leaves a clear "paper trail" back to his compensable 1999 injury. (Ex. 32-2). In making this statement, Dr. Becker correctly considered that claimant had a prior, 1995 low back injury that had improved "90 percent" at the time of his 1999 injury. (*Id.*) In fact, claimant had not required treatment for a year prior to his February 1999 injury. In addition, Dr. Becker stated that the new injury in 1999 is responsible for claimant's radicular symptoms on the right, not present before the injury. (*Id.*) These right-sided symptoms have been recorded consistently in the record since claimant's 1999 injury. (*See* Exs. 4, 7-12, 14, 18, 24).

For these reasons, I respectfully dissent in part.

In the Matter of the Compensation of
ANDREA ALLIN, Claimant
WCB Case No. 00-02161
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorney
Scheminske, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's injury claim for a right eye condition. On review, the issues are course and scope of employment and compensability.

We adopt and affirm the ALJ's order with the following supplementation. We write only to address the employer's argument that the ALJ erred in concluding that claimant's right eye injury arose out of and in the course and scope of her employment.

On November 23, 1999, claimant, who lives in Central Point, Oregon, was in Vancouver, Washington to attend an employment-related training program the following day. The trip, including airline transportation and hotel accomodations, was paid by the employer. Claimant arrived at the hotel approximately 9:30 pm. (Tr. 7). After dinner, she fell asleep watching television. (Tr. 8). When she awoke, she forgot that she had already removed her contact lenses, and she scratched her right eye while trying to remove the non-existent contact lens. (*Id.*) Her eye was painful and she did not sleep well that night. (*Id.*) Because her right eye was still bothering her the next day, she did not wear a contact lens in that eye. (Tr. 9).

Claimant attended the seminar, but her eye was painful and watery. About 3:30 pm., one of the trainers drove claimant to a local emergency room, where she was told she had a scratch on her cornea. (Tr. 9-10). She was treated with drops that numbed her eye, given a prescription, and told to fill it as soon as she arrived in Medford. (Tr. 10-11). Claimant's flight was scheduled to leave at 5:30 pm on November 24, 1999, and she planned to arrive in Medford about 6:30 pm. (Tr. 10-11). The flight was delayed until about midnight and claimant did not arrive in Medford until about 1:00 am. (Tr. 13, 14). She arrived home about 2:00 am. (Tr. 15). When she got home, she attempted to fill the prescription by calling about seven local pharmacies, without success. (Tr. 15, 21).

The next morning (Thanksgiving day), claimant awoke in severe pain and asked a friend to drive her to a local emergency room. (Tr. 17). She was referred to Dr. Paden, who diagnosed a pseudomonas corneal ulcer and impending perforation of the globe. (Ex. 4A). Claimant was transferred to the Oregon Health Sciences Center, where she was hospitalized for about four days. (Tr. 17-18). Without a prompt referral, claimant would have lost the sight in her right eye. (Ex. 4A). Claimant was off work for one month. (Tr. 18).

The ALJ found that claimant was a traveling employee and the treatment and disability related to her right eye injury arose out of and in the course of her employment.

On review, the employer argues that, even though claimant injured her eye at the time and place of her employment-related trip, the circumstances of the injury (injuring an eye when attempting to remove a contact lens) were purely personal and did not connect her injury to her employment. The employer contends that claimant failed to prove that she injured her eye due to a risk that arose during activities necessitated by her travel.

Both parties assert, and we agree, that claimant was a "traveling employee." Claimant's attendance was compensated and her travel to and attendance at the training program accomplished the employer's business purpose.

In *Savin Corp. v. McBride*, 134 Or App 321, 324 (1995), the court held that a person who has the status of a traveling employee is *continuously* within the course and scope of employment while traveling, except when it is shown that the person has "engaged in a distinct departure on a personal errand." *See also Proctor v. SAIF*, 123 Or App 326, 330 (1993). The court has relied on the general rule governing the compensability of injuries to traveling employees, which is stated in 2 Larson, *Workers' Compensation Law*, section 25.01 (2001):

> "Employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Thus, injuries arising out of the necessity of sleeping in hotels or eating in restaurants away from home are usually compensable." (Footnote omitted).

In *McBride*, the court explained that when travel is part of the employment, "the risk of injury during activities necessitated by travel remains an incident to the employment," even though the employee may not actually be working when the injury occurs. 134 Or App at 324 (quoting *PP & L v. Jacobson*, 121 Or App 260, 263 (1993)). In determining whether a traveling employee's injury is compensable, we consider whether the activity that resulted in the injury was reasonably related to the employee's travel status. *McBride*, 134 Or App at 325; *Proctor v. SAIF*, 123 Or App at 330; *Slaughter v. SAIF*, 60 Or App 610, 616 (1982).

Here, we agree with the ALJ that claimant's activity in attempting to remove her contact lens did not constitute a "distinct departure on a personal errand." At the time of the injury, claimant was engaging in a reasonable activity, and the activity that resulted in the injury to her right eye was reasonably related to her travel status. *See McBride*, 134 Or App at 325-26 (the claimant's personal bank business required a diversion of a few blocks from her route home and it took about five minutes; the claimant's personal errand was not so unrelated to her travels as to be excluded from the "broad scope" of coverage for traveling employees).

Although the employer argues that claimant was not injured while she was grooming herself to go to work or a work-related activity, she was grooming herself before going to sleep, in order to be prepared for the training session the next day. That activity was reasonably related to her travel status. Because claimant was a traveling employee, we do not agree with the employer that it was necessary for her to be grooming herself immediately before a work-related activity in order for the injury to be compensable. Rather, we agree with claimant that being in a hotel and having to engage in normal personal hygiene activities is expected and reasonably related to her status as a traveling employee whose employment-related travel required overnight accomodations.

In *Proctor v. SAIF*, 123 Or App at 332, the court examined whether the claimant's activity had a work connection and whether it violated employer directives or was so inconsistent with the purpose of the trip as to constitute an abandonment of employment or such a deviation that would lead to the conclusion that the claimant was no longer in the course of employment. The court explained that a traveling employee is expected to satisfy physical needs, including relaxation. *Id.* at 330-31.

Here, claimant watched television to relax after her journey and she fell asleep while doing so. After she woke up, she forgot that she had removed her contact lens and she scratched her right eye while attempting to remove the non-existent contact lens. Claimant's activity of attempting to remove her contact lens did not violate any of employer's directives and it was not inconsistent with the business trip's purpose. We conclude that claimant's right eye injury was reasonably related to her travel status and, therefore, we agree with the ALJ that the injury arose out of and in the course of her employment.

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

ORDER

The ALJ's order dated June 11, 2001 is affirmed. For services on review, claimant's attorney is awarded $2,000, payable by the employer.

In the Matter of the Compensation of
VINCENTE R. CENTENO, Claimant
WCB Case Nos. 01-02175, 01-02174 & 00-09204
ORDER DENYING MOTION TO DISMISS
Sather, Byerly & Holloway, Defense Attorney
Steven T. Maher, Defense Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant, *pro se*, has requested Board review of Administrative Law Judge (ALJ) Davis' September 26, 2001 Order of Dismissal. Asserting that claimant's requests for hearing were properly dismissed, Liberty Northwest Insurance Corporation (Liberty) and Wausau Insurance Companies (Wausau) seek dismissal from this appeal. The motions are denied.

FINDINGS OF FACT

On September 26, 2001, in response to claimant's attorney's August 27, 2001 letter withdrawing claimant's hearing requests, the ALJ issued an order dismissing claimant's requests for hearing regarding his claims with Liberty, Wausau and Royal and SunAlliance. On October 16, 2001, the Board received claimant's request for review of the ALJ's order.[1] On October 18, 2001, the Board mailed a computer-generated letter to the insurers' counsels acknowledging the request for review.

CONCLUSIONS OF LAW AND OPINION

Liberty and Wausau move to dismiss claimant's request for review as it pertains to them on the basis that they were each "dismissed" from these proceedings by virtue of the ALJ's dismissal order. Based on the following reasoning, we deny the insurers' requests.

Liberty and Wausau do not contend that claimant's request for review was procedurally defective. In other words, the insurers do not assert that claimant untimely filed his request for Board review or failed to serve the parties with copies of his request.

In any event, the record establishes that claimant's request was timely filed and that the parties received timely notice of his appeal. *See* ORS 656.289(3); ORS 656.295(2). Specifically, claimant's request for review was received by the Board on October 16, 2001, which is within 30 days of the ALJ's September 26, 2001 order.

The record does not indicate that claimant provided the other parties with copies of his request for review. Nevertheless, the Board's "computer-generated" letter acknowledging claimant's request for review was mailed to the parties' attorneys on October 18, 2001, well within 30 days of the ALJ's September 26, 2001 order. Our conclusion of timely notice is further confirmed by the fact that, again within 30 days of the ALJ's order, Liberty and Wausau each requested to be dismissed from this appeal.

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[1] The record does not indicate that claimant's attorney has formally withdrawn from representation. Claimant filed the October 7, 2001 request for review himself.

Under such circumstances, we conclude that Liberty and Wausau received timely actual notice of claimant's request for review of the ALJ's order. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47, 51 (1985); *Tsegaye Addisu*, 53 Van Natta 792 n1 (2001). Thus, we are authorized to examine the propriety of the ALJ's decision to dismiss claimant's hearing requests. *See Alexander Toniatti*, 51 Van Natta 736 (1999); *Elvia H. Hillner*, 49 Van Natta 567, *on recon* 49 Van Natta 584 (1997).

In conclusion, regardless of whether the insurers' arguments regarding the propriety of the dismissal order ultimately are determined to have merit, because we retain jurisdiction to consider claimant's request for Board review of the ALJ's order, final resolution of their arguments must await completion of the briefing schedule and our formal review. Consequently, we deny the insurers' motions to dismiss. The briefing schedule shall continue as previously implemented. Thereafter, we will proceed with our review.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRANCISCA CORTEZ, Claimant
WCB Case No. 00-06677
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

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

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for right wrist, arm, and shoulder overuse conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working as a medical records assistant in 1995. (Tr. 11). The purpose of that job was to retrieve medical charts (for the next day's appointments) and file medical charts for providers and others in the medical clinic and to file loose papers in the charts. (Tr. 100). Claimant's work day was equally split between retrieving charts and filing loose papers into charts.[1] (Tr. 36). The number of charts per day claimant was required to handle varied from approximately twenty to more than seventy. (Tr. 101). The weight of the charts varied, with the larger charts weighing up to three to four pounds. (Tr. 91).

Sometime in 1997, claimant's job was changed to receptionist (with the same employer). (Tr. 13). The receptionist job involved retrieving medical charts (for walk-in patients without appointments), typing, and hand writing of receipts, appointment records, telephone messages, and insurance information. (Tr. 51-52; 107).

In 1996 claimant began to notice pain in her right wrist and elbow. (Tr. 43; Ex. 1). The pain was worse when she was working and using her arm. (Ex. 1). The pain progressed such that claimant sought medical attention from Dr. Thomas in February 1999. (*Id.*) Dr. Thomas diagnosed tendinitis of the right wrist and elbow. (*Id.*) Those conditions were accepted in February 1999. (Exs. A; 2A). One month later the insurer also accepted tendinitis of the right hand.[2] (Ex. 3).

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[1] In order to file loose papers in the medical chart, claimant would first have to retrieve the chart from the record storage area.

[2] The various tendinitis conditions were accepted as nondisabling conditions. (Exs. 2A, 3).

Claimant continued to treat with Dr. Thomas until March 2000, when she was seen by Dr. Box.[3] (Ex. 5; Tr. 60). Dr. Box concluded that claimant's right wrist and elbow tendinitis was continuing and further concluded that claimant had an element of cervicothoracic strain. (Ex. 6-1). Dr. Box started a treatment plan of manipulation and massage, prescribed home exercise, continued claimant on light duty work, and referred claimant to Dr. Verzosa for evaluation. (*Id.*)

On May 1, 2000, Dr. Verzosa became the attending physician. (Ex. 7). Upon examination, Dr. Verzosa noted swelling in the PIP joint of claimant's right middle finger as well as swelling of her right elbow extensors and flexors. (Ex. 8-3). Dr. Verzosa opined that claimant was suffering from chronic overuse injury of the right upper trapezius, involving cervicothoracic area, arm, elbow, wrist, and hand secondary to repetitive use of the arm at work. (*Id.*) Dr. Verzosa referred claimant to Dr. Puziss for an orthopedic evaluation.[4] (Ex. 8-4).

Dr. Puziss diagnosed overuse syndrome of the right upper extremity, and noted objective evidence of atrophy and loss of right dominant grip and pinch strength, which he opined correlated well with her clinical and subjective findings. (Ex. 9-2; 9-3). Dr. Puziss referred claimant to Dr. Long for nerve conduction studies.[5] (*Id.*)

On July 31, 2000, the insurer denied claimant's "current" right wrist, elbow, arm, shoulder, upper trapezius and neck conditions. (Ex. 17). Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on the opinions of Drs. Thomas, Box, Verzosa, Puziss, and Long, and concluded that claimant had established the compensability of her "current" overuse conditions of the right wrist, arm, and shoulder. Applying the occupational disease claim standard under ORS 656.802(1)(a), the ALJ set aside the insurer's denial of those conditions.

The insurer notes the accepted claim for right wrist tendinitis has been in nondisabling status for more than one year. Therefore, the insurer contends claimant must prove a "worsening" of that condition. *See* ORS 656.273(4)(b). Asserting that claimant has not attempted to prove a worsening of the wrist tendinitis condition, the insurer argues that its denial of that condition should be upheld.

We begin by determining whether claimant's "current" right wrist condition is the same condition as the previously accepted "right wrist tendinitis" condition. Dr. Thomas, the initial attending physician, diagnosed claimant's wrist condition as "tendinitis." (Ex. 1). Dr. Box diagnosed a continuation of right wrist "tendinitis." (Ex. 6-1). Dr. Verzosa described claimant's right wrist condition as a "chronic overuse injury," but did not use the term "tendinitis."[6] (Ex. 8-3). Neither Dr. Puziss nor Dr. Long used the term "tendinitis" in describing claimant's right wrist condition. (Exs. 9; 11).

Additionally, we note that no physician in this record opined that claimant's "current" right wrist condition is the "same" as the previously accepted wrist "tendinitis" condition. Moreover, Drs. Bald and Farris opined that the accepted "tendinitis" condition had resolved. (Ex. 24-11). After considering these medical opinions, we conclude that the record does not persuasively establish that claimant's "current" right wrist condition is the same condition as the previously accepted "tendinitis" condition. Accordingly, we reject the insurer's assertion that the applicable standard is ORS 656.273.

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[3] On February 25, 2000, Dr. Thomas placed claimant on three weeks of light duty work. (Ex. 4-2).

[4] Claimant continued to treat with Dr. Verzosa through September 26, 2000. (Ex. 18).

[5] Dr. Long determined that claimant had a mild median nerve compression in the right palm that was atypical for carpal tunnel syndrome. (Ex. 11-7).

[6] Drs. Bald and Farris (insurer-arranged examiners) acknowledge that tendinitis is a type of overuse condition. (Ex. 27-15).

We now turn to the compensability of claimant's "current" right wrist, arm and shoulder conditions. To establish the compensability of those overuse conditions as occupational diseases, claimant must prove that her work activities are the major contributing cause of those conditions. ORS 656.802(2)(a). To satisfy the "major contributing cause" standard, claimant must establish that her work activities contributed more to the claimed conditions 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 current 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).

Drs. Thomas, Box, Verzosa, Puziss, and Long have all opined that the major contributing cause of claimant's "current" overuse conditions is her repetitive arm movement associated with her work duties. (Exs. 20; 21; 22; 23; 26). As explained by Dr. Verzosa, claimant's repetitive reaching and writing strained the arm muscles with reactive inflammation, eventually affecting the tendons producing "tendinitis." (Ex. 23-4).

In contrast, Drs. Bald and Farris (insurer-arranged examiners) opined that claimant's accepted conditions had resolved and that her "current" conditions were of a "nonphysiologic basis," unrelated to her work activities. (Ex. 24-8).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Drs. Bald and Farris base their opinions that claimant's "current" conditions are "nonphysiologic" (of psychological origin) largely upon their understanding that claimant's work was not repetitive. (Ex. 24-11). Because claimant's supervisor testified that claimant's work activities as both a medical records assistant and a receptionist involved repetitive arm motions, we conclude that Drs. Bald and Farris did not have an accurate understanding of claimant's job tasks. (Tr. 104-105; 115). Consequently, we find the opinion of Drs. Bald and Farris unpersuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

Unlike Drs. Bald and Farris, Dr. Verzosa based her opinion on photos of claimant performing her job functions. (Ex. 23-2). The photos (Exhibit 25) were verified as accurately depicting claimant's job tasks by claimant's supervisor. (Tr. 101-102). Additionally, Dr. Verzosa's opinion was based upon her own review of the medical records and her examinations of claimant. Finding no persuasive reason to do otherwise, we consider Dr. Verzosa's opinion, as supported by the opinions of Drs. Thomas, Box, Puziss, and Long, persuasive.[7] Consequently, we conclude that claimant has established the compensability of her "current" right wrist, arm, and shoulder conditions.[8]

We acknowledge the insurer's argument that all of claimant's doctors were under the mistaken impression that some of the medical charts claimant handled weighed up to 25 pounds. While some of claimant's counsel's letters to claimant's doctors erroneously reported the maximum weight of the

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[7] We acknowledge the insurer's argument that Dr. Verzosa's opinion is not persuasive because she has "no good explanation for [claimant's] ongoing pain." However, the insurer has taken Dr. Verzosa's comments out of context. The wording relied upon by the insurer is contained in the assessment section of Dr. Verzosa's May 12, 2000 chart note and reads as follows: "The patient presently appears frustrated due to lack of good explanation of her ongoing pain." (Ex. 10-1). Thus to the extent that Dr. Verzosa's statement can be interpreted as referring to a lack of understanding of the medical problem, it is clear that Dr. Verzosa was discussing claimant's lack of understanding (not Dr. Verzosa's lack of understanding). Moreover, we note that the May 12, 2000 chart note was written about seven months prior to Dr. Verzosa's ultimate opinion, in which she stated that work was the major cause of claimant's condition. (Ex. 23). Consequently, we reject the insurer's argument.

[8] There is no medical opinion in this record indicating that claimant's "current" conditions involve the preexisting conditions. Therefore, ORS 656.802(2)(b) is not applicable. *See Shawn J. Stevens*, 53 Van Natta 1008 (2001).

medical charts, the doctors' opinions as a whole focused more on claimant's arm movements than the weight of selected charts. Moreover, the photos of claimant, which Dr. Verzosa reviewed, accurately show the size and type of the medical charts in question. Under these circumstances, we conclude that claimant's doctors, particularly Dr. Verzosa, had an accurate understanding of claimant's work activities.

Finally, the insurer argues that the opinions of Drs. Thomas, Box, Puziss, and Long are not persuasive because they do not explain why claimant's problems developed two years after she stopped work as a medical records assistant and began work as a receptionist. We note, however, that claimant and claimant's supervisor both testified that claimant's work as receptionist (claimant's job after the medical records assistant job) also involved repetitive arm motions, some of which were the same as those performed by claimant in the medical records assistant job. Because claimant performed the receptionist job continuously from 1997 until she was placed on light duty in June 2000, we do not find the doctors' alleged failure to explain why claimant's problems developed after she became a receptionist significant. Consequently, we reject the insurer's argument.

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 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 $1,200 attorney fee, payable by the insurer.

In the Matter of the Compensation of
BONNIE L. IMEL-HOWER, Claimant
Own Motion No. 99-0189M
OWN MOTION ORDER ON RECONSIDERATION
Sather, Byerly & Holloway, Defense Attorney

Reviewing panel: Members Biehl and Haynes.

On September 25, 2001, we abated our August 29, 2001 Own Motion Order of Dismissal, in response to claimant's request for reconsideration. Having received the self-insured employer's response, we proceed with our reconsideration.

In our August 29, 2001 Own Motion Order of Dismissal, we dismissed claimant's January 26, 2001 request for review of the employer's August 21, 2000 Notice of Closure. We took this action because claimant's request for review was untimely and the closure was final by operation of law. In doing so, we found that claimant had not established good cause for her failure to file the request within the appeal period allowed by Board rule.

As noted in our prior order, in order to be considered, a request for review must be filed with the Board within 60 days from the date of mailing of the notice of closure, or within 180 days after the mailing date if claimant can establish good cause for the failure to file the request within 60 days. *See* OAR 438-012-0060(1). The standard for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized by ORCP 71B(1) and *former* ORS 18.160. *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666 (1986); *see also Brown v. EBI Companies*, 289 Or 455 (1980). Lack of due diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). Claimant has the burden of proving good cause. *Id.*

On reconsideration, claimant contends that her request for review of the closure was untimely because she was "between attorney's [*sic*]," and that it is difficult to find an attorney to "take an 'old injury' case." Additionally, claimant states that she had relied on her assumption that her prior attorney was going to represent her, but found out that was not the case after the appeal period had expired.

Claimant does not contend that she did not understand the appeal rights outlined in the August 21, 2000 Notice of Closure nor does she provide evidence supporting a conclusion that she was physically or mentally incapable of conducting her personal business affairs. Under these circumstances, we conclude that claimant's failure to timely file the request for review was due to her lack of diligence, which does not qualify as good cause.[1] Therefore, we conclude that claimant has not met her burden of proving "good cause" for her untimely request for review of the employer's closure, and continue to deny that request. *See John J. Wiseman*, 52 Van Natta 1666 (2000) (no "good cause" for untimely request for hearing where the claimant made no effort to confirm his assumption that a partial denial was somehow being handled by his former attorney); *Kathryn C. Loeks*, 50 Van Natta 1359 (1998) (no "good cause" for untimely request for review of carrier closure where there was no evidence that the claimant misunderstood appeal rights and the claimant contended busy life prevented her from timely filing request).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 29, 2001 order in its entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] We note that OAR 438-012-0065(3) provides that "[n]otwithstanding section (2) of this rule, in extraordinary circumstances the Board may, on its own motion, reconsider any prior Board order." However, this record presents no "extraordinary circumstances" to support the Board's reconsideration of its prior order. *See Larry P. Karr*, 48 Van Natta 2182 (1996); *Jay A. Yowell*, 42 Van Natta 1120 (1990). Instead, as discussed above, claimant's failure to timely file the request for review was due to her lack of diligence.

In the Matter of the Compensation of
PAMELA J. McKINEY, Claimant
WCB Case No. TP-98008
THIRD PARTY ORDER ON REMAND
Stebbins & Coffey, Claimant Attorney
Mannix, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

This matter is before the Board on remand from the Court of Appeals. *McKiney v. Cardinal Services*, 176 Or App 358 (2001). The court has reversed our prior order, *Pamela J. McKiney*, 50 Van Natta 2385 (1998), that had held that AIG Claim Services (AIG) was entitled to a share of the proceeds from claimant's third party settlement. Citing *Rash v. McKinstry Co.*, 331 Or 665 (2001), the court has remanded for reconsideration.

In *Rash*, the Supreme Court determined that an insurer's lien against a claimant's third party recovery is a "matter[] * * * potentially arising out of claims within the meaning of ORS 656.236(1)(a)." Consequently, because the insurer's third party lien was not mentioned in the parties' Claim Disposition Agreement (CDA), the *Rash* Court concluded that the insurer's lien was "resolved," or extinguished by the CDA.

Here, as in *Rash*, the CDA did not refer to AIG's third party lien. Under such circumstances, we conclude that AIG's lien was extinguished by the CDA. *See* ORS 656.236(1)(a); *Rash*, 331 Or at 665.

Accordingly, on reconsideration of our December 21, 1998 order, we hold that it is not "just and proper" for AIG to receive a share of claimant's third party settlement proceeds. *See* ORS 656.593(3).

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN RANDALL, Claimant
WCB Case No. 98-09289
ORDER OF DISMISSAL
Peter O. Hansen, Claimant Attorney
Meyers, Radler, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that affirmed the Workers' Compensation Division's (WCD's) nonsubjectivity determination under ORS 656.740(2) which found that claimant was not a subject worker. We dismiss for lack of appellate jurisdiction.

FINDINGS OF FACT

On November 2, 1998, the WCD issued an order finding claimant to be an independent contractor and not a subject worker pursuant to ORS 656.027(7). Claimant requested a hearing from the WCD's order. *See* ORS 656.740(2). On July 2, 2001, on behalf of the Director under ORS 656.740(5), the ALJ issued an order affirming the WCD's order. However, the order contained no statement regarding the parties' rights of appeal. On July 24, 2001, claimant requested Board review of the order.

CONCLUSIONS OF LAW AND OPINION

An order that contains incorrect or no appeal language is not final. *See Oldham v. Plumlee*, 151 Or App 402 (1997); *Callahan v. Employment Division*, 97 Or App 234 (1989); *Delbert Shay*, 52 Van Natta 1924, *on recon* 52 Van Natta 2020 (2000). Because the ALJ's order lacked a "notice of appeal" statement, it is not a final order. We lack appellate jurisdiction over the ALJ's non-final order. *See Shay*, 52 Van Natta 2020. Therefore, we dismiss claimant's request for review.

Because we have no appellate jurisdiction over the ALJ's order, we likewise are not authorized to remand the case to the ALJ. Nonetheless, because the ALJ's order is not final, we could return the record to the ALJ to consider the issuance of another order containing the correct Notice of Appeal rights. *See Delbert Shay*, 52 Van Natta at 2021. For the following reasons, it is unnecessary to return the case to the ALJ.

Subsequent to claimant's request for Board review, the ALJ issued an Order of Abatement, a Corrected Opinion and Order, and a Second Corrected Opinion and Order. In the initial Corrected Opinion and Order, any dissatisfied party was advised to seek Board review, rather than to petition the Court of Appeals for judicial review. Because the sole issue at hearing appears to be confined to the "subject worker" question arising out of the WCD's "nonsubjectivity" determination, such a notice seems to conflict with ORS 656.740(5). *See Delbert Shay*, 52 Van Natta 2020. However, the ALJ's Second Corrected Opinion and Order does include a "notice of appeal" statement directing the parties to the Court of Appeals, which does appear to comply with ORS 656.740(5). In light of such circumstances, returning the case to the ALJ for the issuance of a corrected order is not warranted.

IT IS SO ORDERED.

In the Matter of the Compensation of
CAROL A. SHEESLEY, Claimant
WCB Case No. 00-07888
ORDER ON REVIEW
Swanson, Lathen, et al., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that set aside its denial of claimant's injury claim for an L4-5 disc condition. On review, the issue is compensability.

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

The ALJ set aside SAIF's denial, finding that the medical opinion of claimant's surgeon, Dr. Brett, established that claimant's May 18, 2000 work injury, accepted as a lumbosacral and thoracic strain, was also the major contributing cause of an L4-5 disc protrusion. *See* ORS 656.005(7)(a)(B). Claimant contends on review that the ALJ erred in relying on Dr. Brett's opinion. We disagree.

Dr. Brett opined that claimant's diagnosis was of an annular injury and focal disc protrusion on the right at L4-5 with right L5 nerve root impingement as a direct result of her work activities on or about May 18, 2000. According to Dr. Brett, while claimant had some "minor" preexisting and asymptomatic degenerative change in her low back, claimant's injury and work activity were the major contributing factor to her disc herniation and need for treatment. (Ex. 31).

One reason the ALJ cited for relying on Dr. Brett's opinion is that he reviewed actual MRI studies and performed surgery at L4-5. *See Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 701 (1988). SAIF argues that Dr. Brett gave his causation opinion prior to performing surgery and, thus, that his opinion should not be considered persuasive on the basis that he performed surgery.

SAIF is correct that Dr. Brett's causation opinion was given prior to performing surgery. Nevertheless, Dr. Brett's "pre-surgery" opinion (based on actual review of MRI studies) that claimant had an L5 nerve root impingement was verified by his findings at surgery. In his surgical report, Dr. Brett specifically noted his surgical finding that claimant had right L5 nerve root impingement within the foramen and lateral recess. (Ex. 34-1). Such findings reinforce Dr. Brett's causation opinion rendered prior to claimant's surgery.

Accordingly, we agree with the ALJ's decision to set aside SAIF's denial. Thus, we affirm.

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

ORDER

The ALJ's order dated June 27, 2001 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF.

In the Matter of the Compensation of
LAURA J. GOLDEN, Claimant
WCB Case No. 00-06840
ORDER ON REVIEW
John C. Dewenter, Claimant Attorney
Julie Masters (Saif), Defense Attorney

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

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that awarded temporary disability from November 11, 1998 through July 4, 2000. Claimant cross-requests review of that portion of the ALJ's order that awarded an "out-of-compensation" attorney fee. On review, the issues are temporary disability and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recounting the pertinent facts. Claimant injured her right shoulder in June 1993, a claim SAIF initially accepted as a nondisabling right shoulder strain. In February 1995, claimant was enrolled in a managed care organization (MCO) for her accepted claim. (Ex. 7). She began treating with Dr. Adams, a chiropractor, in May 1997. (Ex. 15).

In October 1997, Dr. Adams recommended that claimant's work hours be restricted due to symptoms in her right shoulder, neck and upper back. (Ex. 19). In December of that year, claimant began working half-time and Dr. Adams filed an aggravation claim on her behalf, which SAIF denied on June 1, 1998. In the meantime, Dr. Adams authorized half-time work in May 1998. (Ex. 32).

On August 28, 1998, claimant requested that SAIF accept, under the June 1993 claim, myofascial pain syndrome, fibromyalgia, cervical strain and thoracic strain. (Ex. 35B). Action on claimant's request was deferred.

On November 3, 1998, SAIF notified claimant that Dr. Adams was no longer a member of the MCO provider panel and that, if claimant required treatment for accepted conditions, she would have to change doctors and seek treatment from an MCO-authorized medical provider. (Ex. 38). Claimant, however, continued to treat primarily with Dr. Adams, who continued to restrict claimant to half-time work.

On November 24, 1998, SAIF denied the claim for the "new medical conditions." (Ex. 38B). That denial was partially set aside with respect to the myofascial and fibromyalgia conditions by a prior ALJ's November 10, 1999 order. (Ex. 43-11). After it requested Board review, SAIF withdrew the appeal. (Ex. 44A).

Claimant requested, on April 18, 2000, that SAIF pay temporary disability for the period of half-time work since December 1997. (Ex. 45). On June 20, 2000, SAIF again advised claimant that Dr. Adams was not a member of the MCO provider panel. (Ex. 45B). Claimant sought treatment from another chiropractor on July 5, 2000.

Claimant requested a hearing seeking payment of temporary disability from November 11, 1998 to July 4, 2000.

The ALJ awarded claimant the requested temporary disability. The ALJ reasoned that, under ORS 656.262(4)(i), SAIF was entitled to terminate temporary disability for the accepted right shoulder strain seven days after its November 3, 1998 notice to claimant that she needed to seek treatment from an MCO authorized provider other than Dr. Adams. The ALJ further reasoned, however, that the circumstances were different for the new myofascial pain syndrome and fibromyalgia conditions. According to the ALJ, claimant was not subject to the MCO contract for these conditions and, thus, SAIF's notice did not apply to these conditions and could not provide a basis for SAIF to decline to pay temporary disability under the "new medical condition" claims. Concluding that nothing had occurred after the November 3, 1998 notice that gave SAIF the right to terminate temporary disability prior to July 5, 2000, the ALJ determined that claimant was entitled to temporary disability for the disputed period.

On review, SAIF contends that, once Dr. Adams was no longer an MCO doctor and claimant was notified of this, Dr. Adams was not an attending physician who could authorize temporary disability. Therefore, SAIF asserts that the ALJ incorrectly awarded temporary disability during the disputed period. For the following reasons, we agree.

ORS 656.262(4)(a) and (h) provide that temporary disability compensation shall be paid if authorized by the "attending physician." ORS 656.005(12)(b) provides, in part:

> "Except as otherwise provided for workers subject to a managed care contract, 'attending physician' means a doctor or a physician who is primarily responsible for the treatment of a worker's compensable injury[.]"

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."

ORS 656.245(4)(a) provides, in part:

> "Those workers who are subject to the [managed care organization] contract shall receive medical services in the manner prescribed in the contract. * * * A worker becomes subject to the contract upon the worker's receipt of actual notice of the worker's enrollment in the managed care organization, or upon the third day after the notice was sent by regular mail by the insurer or self-insured employer, whichever event first occurs.* * * Insurers or self-insured employers who contract with a managed care organization for medical services shall give notice to the workers of eligible medical service providers and such other information regarding the contract and manner of receiving medical services as the director may prescribe."

Here, claimant was subject to the MCO contract beginning in 1995. (Ex. 7). Dr. Adams was her attending physician under the contract until November 1998, when SAIF notified claimant that it had been informed by the MCO that Dr. Adams was no longer an MCO provider. Neither claimant nor the ALJ dispute that, as of November 1998, Dr. Adams was no longer claimant's attending physician under the MCO contract. The essential dispute in this case is what effect that fact has on Dr. Adams' ability to authorize temporary disability for the period in dispute. The ALJ reasoned that claimant was subject to the MCO contract only for the accepted right shoulder strain condition and that, therefore, the removal of Dr. Adams from the list of MCO providers did not affect her status as attending physician for the initially unaccepted new medical conditions, which, according to the ALJ, were not subject to the MCO contract.

We do not find this reasoning persuasive. Under ORS 656.245(4)(a), it is the "worker" who becomes subject to the MCO contract upon receipt of actual notice of MCO enrollment.[1] Thus, it is the worker, not the claim or specific conditions within a claim, that becomes enrolled in the MCO. In this instance, the record establishes that claimant became enrolled in the MCO in 1995 and was not subsequently removed from enrollment. Therefore, during the period in dispute, claimant was subject to the MCO contract.

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[1] The dissent cites legislative history to support its contention that, once a claim is denied, the legislature intended to allow the injured worker complete freedom to treat with whomever he or she wishes and that, after the denial is overturned, to provide for payment of temporary disability even if the authorizing physician was not MCO-approved. We do not find the dissent's position persuasive. First, there is no need to resort to legislative history because the statutory scheme is unambiguous. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 611 (1993). ORS 656.245(4)(b)(D) only requires payment of *medical services* from non-MCO sources after a claim is determined to be compensable. If the legislature had intended to include temporary disability, it could easily have said so. Moreover, even if we considered the legislative history the dissent cites, it appears directed to an initial claim, not to a new medical condition claim where there is already an accepted claim.

Pursuant to ORS 656.262(4)(i), an insurer may unilaterally suspend payment of all compensation to a worker enrolled in a MCO if the worker continues to seek care from an attending physician not authorized by the MCO more than seven days after the mailing of notice by the insurer. Here, claimant continued to seek care from an attending physician, Dr. Adams, after receiving notice that Dr. Adams was no longer an authorized attending physician. Therefore, SAIF was within its rights to terminate temporary disability under that statute.

As support for this conclusion, we note that ORS 656.245(2)(b) specifically provides that "a medical service provider who is not an attending physician cannot authorize the payment of temporary disability compensation." Because Dr. Adams was no longer an attending physician after SAIF's November 1998 notice, Dr. Adams could not authorize temporary disability during the period in dispute.

Subsequent to the ALJ's order, we decided a case in which the issue was whether a physician who did not qualify as a primary care physician with an MCO could authorize temporary disability. We determined that the physician could not. *See William I. Sergeant*, 53 Van Natta 231, 236 (2001). Likewise, in this case, Dr. Adams did not qualify as an attending physician with the MCO during the period in dispute. Like the physician in *Sergeant*, Dr. Adams could not authorize temporary disability in this case.[2]

In conclusion, we find that claimant is not entitled to the disputed temporary disability. Thus, we reverse that portion of the ALJ's order.[3]

ORDER

The ALJ's order dated January 8, 2001 is reversed in part and affirmed in part. That portion of the ALJ's order that awarded temporary disability is reversed. The ALJ's "out-of-compensation" attorney fee award is also reversed. The remainder of the ALJs' order is affirmed.

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[2] Claimant notes SAIF's concession that her medical treatment with Dr. Adams was compensable as a result of its eventual acceptance of the new medical conditions. *See* ORS 656.245(4)(b)(D) (requiring payment of medical services obtained from non-MCO sources after a claim is finally determined to be compensable); *SAIF v. Reid*, 160 Or App 383 (1999) (applying that statute to "new medical condition" claims). Claimant argues that it makes no sense that his medical treatment may be paid for but not his authorized temporary disability. Claimant's contention notwithstanding, payment of workers' compensation benefits must be authorized by statute. As the above discussion demonstrates, SAIF was under no legal obligation to pay the disputed temporary disability because those benefits must be authorized by an attending physician. Because Dr. Adams did not qualify as an attending physician under the MCO contract because of her removal from the MCO provider panel, claimant is not entitled to the disputed temporary disability. *See Sergeant*, 53 Van Natta at 236.

[3] Given our disposition of the case, we need not address the issues raised by claimant's cross-request for review.

Board Member Phillips Polich dissenting.

The majority reverses the ALJ's order awarding temporary disability from November 11, 1998 through July 4, 2000. In so doing, it concludes that the attending physician, Dr. Adams, could not authorize temporary disability during the period in dispute because she did not qualify as an attending physician with the managed care organization (MCO). Because I disagree with this conclusion, I respectfully dissent.

The ALJ's decision on this issue was well-reasoned and should be affirmed. For the accepted right shoulder condition, SAIF was entitled to terminate temporary disability under ORS 656.262(4)(i) seven days after SAIF mailed claimant the November 3, 1998 notice that she needed to seek any additional treatment from an MCO-authorized provider, rather than Dr. Adams. However, as to the myofascial and fibromyalgia conditions, those were claims for "new medical conditions" that arose after SAIF's initial acceptance of the claim for a right shoulder strain. *See Johansen v. SAIF*, 158 Or App 672 (1999).

While only an attending physician may authorize temporary disability on a claim under ORS 656.245(2)(b)(B), the MCO's authority to designate an attending physician, in my view, only applies to workers who are subject to the MCO contract. Under ORS 656.245(4)(a), a worker is only subject to an MCO contract for an "accepted condition." That statute provides that "[workers] subject to the [MCO] contract include those who are receiving medical treatment for an accepted compensable injury or occupational disease."

Here, claimant's myofascial pain syndrome and fibrosis, which caused her disability, were not accepted conditions until January 27, 2000, when the Board dismissed SAIF's request for review of the prior ALJ's order that required SAIF to accept the myofascial and fibrosis conditions. Therefore, claimant was not subject to the MCO contract with respect to those conditions until that time. Thus, I agree with the ALJ that it is the "claim" that is subject to the MCO contract, not the injured worker.[1]

The question then arises whether anything happened after the new medical conditions claim was accepted to terminate temporary disability prior to July 5, 2000. I agree with the ALJ that nothing did because claimant still did not become subject to the provisions of the MCO contract until SAIF notified her that she was enrolled in the MCO concerning those conditions. That did not occur until June 20, 2000. Because claimant stopped treating with Dr. Adams within seven days of the June 20, 2000 letter, SAIF could not terminate benefits based on that letter. Because nothing else occurred between June 20, 2000 and July 4, 2000 that authorized suspension of benefits, the ALJ correctly concluded that claimant was entitled to temporary disability to that date.

Given this analysis, I must conclude that the majority errs in reversing the ALJ's order. It makes no sense that claimant has a right to have her treatment for the new medical conditions paid for under ORS 656.245(4)(b)(D,) but not her temporary disability. Not recognizing the latter right to temporary disability greatly reduces the impact of the former right to have medical treatment paid for after a claim is accepted.

The majority cites *William I. Sergeant*, 53 Van Natta 231 (2001), as support for its decision. However, that case did not involve denied or newly-accepted medical conditions. Thus, I would find the facts of that case distinguishable from those present in this case.

In conclusion, I believe the ALJ correctly determined that claimant was entitled to temporary disability during the disputed period. Because of this, I disagree with the majority's decision to reverse the ALJ's order. Thus, I dissent.

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[1] The comments of Representative Mannix during the discussions of the MCO provisions of Senate Bill 369 (1995) support my view. There, Representative Mannix stated: "Now, when the denial goes out, the worker is then released from the obligation to treat with the Managed Care Organization and can treat wherever the worker wants, if that denial is later overturned so the claim is compensable, wherever that care was, that still has to be paid for, too." Representative Mannix later stated: "If the claim is accepted, no problem. But if the claim is denied, then the worker knows that the worker is free to go elsewhere." (Tape recording, Senate Labor and Government Operations meeting jointly with House Labor on January 30th, 1995, Tape 45, Side A). Having reviewed these comments, I believe it was the legislature's intent to allow an injured worker complete freedom to treat with whomever he or she wished once a claim is denied. Once that denial is overturned, as it was in this case, the legislature also intended that medical treatment and temporary disability be paid for even if the attending physician was not MCO-approved.

In the Matter of the Compensation of
SUSANNA A. BURKS, Claimant
WCB Case Nos. 01-01199 & 00-06607
ORDER ON REVIEW
Philip Emerson, Claimant Attorney
VavRosky, MacColl, Olson, et al., Defense Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) found that SAIF had denied compensability of claimant's occupational disease claim for a right wrist condition; and (2) awarded claimant an assessed fee of $3,500, to be shared equally by SAIF and Reliance National Insurance Co. (Reliance). On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's right wrist condition was compensable and that SAIF was responsible for her condition. The ALJ determined that both SAIF and Reliance had denied compensability, explaining that, in closing arguments, SAIF had relied on Reliance's denial to put compensability at risk. The ALJ then split claimant's $3,500 attorney fee award for services concerning compensability equally between SAIF and Reliance.

On review, SAIF argues that it denied only responsibility, not compensability, and that the ALJ erred in assessing an attorney fee against it. SAIF asserts that Reliance is liable for the entire attorney fee award. According to SAIF, the ALJ incorrectly found that SAIF had relied on Reliance's denial to put compensability at risk. Instead, SAIF argues that in closing argument, SAIF's trial counsel stated that SAIF, which had limited its denial to responsibility, would receive the benefit of Reliance's compensability denial should the ALJ find the condition unrelated to work. (Appellant's br. at 2). SAIF insists that at no time did its attorney raise compensability on behalf of SAIF.

On the other hand, Reliance argues that the ALJ correctly found that SAIF had relied upon Reliance's denial to place compensability at issue, and it contends that there is no evidence to the contrary. Reliance asserts that, because SAIF denied compensability and was found responsible for claimant's condition, SAIF is responsible for the entire attorney fee award.

On review, the parties disagree as to whether or not SAIF denied compensability in closing arguments. In its reply brief, SAIF requests that the Board transcribe the closing arguments to determine what SAIF's trial counsel actually stated. Although closing arguments were recorded (*see* Tr. 39), no party has requested that they be transcribed. We interpret SAIF's reply brief to request that the closing arguments be ordered and transcribed at the Board's expense.

We decline to bear the expense of the transcription costs for the closing arguments. There is no requirement that closing arguments at hearing be recorded and/or transcribed. *See, e.g., Charles T. Brence*, 39 Van Natta 704 (1987). Furthermore, it is a long-standing Board policy that closing arguments are not transcribed at the Board's expense unless requested by the ALJ. *See Albert W. Vanslyke*, 42 Van Natta 2811 (1990), *aff'd Vanslyke v. Fred Meyer, Inc.*, 108 Or App 493 (1991). The ALJ did not order a transcript of the closing arguments in this case. Under these circumstances, the closing arguments would be considered part of the hearing record only if a party obtains a transcript of the closing argument and submits it as part of the hearing record. *See Roberto Rocha-Barrancas*, 48 Van Natta 1462 (1996) (the claimant's submission of transcribed closing arguments obtained at his expense were included in the record and considered on review). Because none of the parties have submitted a transcript of closing arguments, we proceed with our review based on the record before us.

On July 14, 2000, SAIF denied responsibility of claimant's right wrist condition, asserting that another employer or insurer was responsible for her condition. (Ex. 9). SAIF did not oppose the designation of a paying agent pursuant to ORS 656.307. (*Id.*) At hearing, SAIF's attorney agreed that SAIF did not oppose a "307" order and denied only responsibility. (Tr. 4). SAIF's attorney said that SAIF would rely on the language of its denial. (Tr. 5).

Although Reliance relies on the ALJ's finding that SAIF changed its position in closing argument and said that it was relying on the denial of Reliance to put compensability at risk, there is no evidence in the record to support that conclusion. Consequently, we agree with SAIF that there is no evidence that SAIF contested compensability of claimant's right wrist condition.

In conclusion, Reliance denied compensability and responsibility and SAIF denied only responsibility. Although SAIF is responsible for claimant's right wrist condition, Reliance is liable under ORS 656.386(1) for the attorney fee awarded at hearing. *See Safeway Stores, Inc. v. Hayes*, 119 Or App 319 (1993) (court upheld assessment of fee under *former* ORS 656.386(1) against carrier that necessitated the claimant's participation to establish the compensability of the claim, even though that carrier was not ultimately responsible); *Terry J. Rasmussen*, 51 Van Natta 1287 (1999). We therefore modify the ALJ's order to find that Reliance is responsible for paying a $3,500 attorney fee to claimant's counsel.

ORDER

The ALJ's order dated June 11, 2001 is modified in part and affirmed in part. Reliance is responsible for paying the entire $3,500 attorney fee award to claimant's counsel. The remainder of the ALJ's order is affirmed.

November 2, 2001 Cite as 53 Van Natta 1468 (2001)

In the Matter of the Compensation of
TRAVIS H. WILLIAMS, Claimant
WCB Case Nos. 00-09281 & 00-09198
ORDER ON REVIEW
Coughlin, Leuenberger & Moon, Claimant Attorney
James B. Northrop (Saif), Defense Attorney
Sheridan & Levine, Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

PAULA Insurance, on behalf of Dash W. Bar Ranch, requests review of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of responsibility for claimant's right hip injury claim; and (2) upheld the SAIF Corporation's denial of responsibility, issued on behalf of Pine Creek Ranch, for the same condition. On review, the issue is responsibility.

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

Claimant is the son of Dash W. Bar Ranch's owner and its sole employee. Pine Creek Ranch is a neighboring ranch with two employees. It has long been the practice of Dash W. Bar and Pine Creek to loan each other their employees during times of increased work. On November 1, 2000, Pine Creek asked Dash W. Bar for claimant's help weighing calves. Claimant was injured during this activity. Dash W. Bar/Paula and Pine Creek/SAIF both denied responsibility for claimant's injuries.

The ALJ concluded, based on the "loaned servant" doctrine and *Newport Seafood v. Shine*, 71 Or App 119 (1984), that claimant was an employee of Dash W. Bar Ranch, Paula's insured. *Shine* holds that a determination of an employment relationship focuses first on the claimant's perspective. In the present case, the ALJ looked to claimant's perspective and concluded that, because claimant believed he was an employee of the general employer, Dash W. Bar, Dash W. Bar was claimant's employer and was responsible for claimant's injuries. Absent an express contract dealing with such situations, we are constrained to follow *Shine*.

ORDER

The ALJ's order dated April 12, 2001 is affirmed.

In the Matter of the Compensation of
DAVID M. DURANT, Claimant
WCB Case No. 00-09432
ORDER ON REVIEW
Jensen, et al., Claimant Attorney
Hoffman, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order affirming an Order on Reconsideration that awarded no scheduled permanent disability for a right hamstring condition. On review, the issue is extent of scheduled permanent disability.

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

Claimant sustained multiple injuries as a result of a work-related fall, including an accepted right hip strain. The claim was closed by Notice of Closure in December 1999 that awarded 9 percent unscheduled permanent disability for injury to claimant's low back and 38 percent scheduled permanent disability for injury to the left thumb. Claimant requested reconsideration that resulted in a medical arbiter's examination on March 31, 2000. Dr. Filarski, the medical arbiter, reported that claimant had a right hamstring muscle mass deformity, for which loss of strength was "4/5" and which Dr. Filarski related to the accepted hip strain.

On July 20, 2000, an Order on Reconsideration awarded 13 percent scheduled permanent disability for injury to claimant's right leg (hip) as a direct medical sequelae of the original accepted conditions.

On August 11, 2000, the insurer formally accepted the right hamstring condition pursuant to a stipulation approved by an ALJ on July 12, 2000. That same day, the insurer reopened and closed the claim for the newly accepted right hamstring condition, awarding no additional permanent disability. Claimant requested reconsideration of the insurer's closure notice.

Another medical arbiter's examination occurred on October 5, 2000. This time, the medical arbiter (Dr. Anderson) rated claimant's loss of strength in the right leg as "2/5." The November 20, 2000 Order on Reconsideration declined to award additional scheduled permanent disability for the right hamstring condition, noting that the condition had been previously rated in the July 20, 2000 reconsideration order. Claimant requested a hearing, seeking an increased scheduled permanent disability award for the right leg based on Dr. Anderson's 2/5 muscle strength rating.

The ALJ declined to award additional permanent disability and affirmed the November 20, 2000 reconsideration order. In so doing, the ALJ held that claimant must prove a worsening of the right hamstring condition in order to receive additional scheduled permanent disability. Determining that the record did not demonstrate such a worsening, the ALJ concluded that claimant was not entitled to additional scheduled permanent disability.

On review, claimant contests the ALJ's determination that claimant was required to prove a worsening of the newly accepted right hamstring condition in order to receive increased permanent disability based on Dr. Anderson's medical arbiter's examination. We disagree.

OAR 436-035-0007(9)(c) requires redetermination of the extent of permanent disability under certain limited circumstances if a claim has multiple compensable conditions that are either newly accepted since the last arrangement of compensation and/or that have actually worsened. *See, e.g., Clara J. Scurlock*, 52 Van Natta 1926 (2000). If a condition is unchanged or improved, there shall be no redetermination, and, if a condition has not actually worsened, the impairment value shall continue to be the same impairment values that were established at the last arrangement of compensation. OAR 436-035-0007(9)(c); *Eliseo Roman*, 53 Van Natta 273, 274 (2001).

Based on the applicable administrative rule, claimant is not entitled to a redetermination of scheduled permanent disability, if his right hamstring condition is unchanged, improved, or has not actually worsened. OAR 436-035-0007(9)(c). Claimant does not contend, and the record does not establish, that claimant's right hamstring condition has either changed or worsened since the July 2000

reconsideration order. In light of this, the ALJ correctly determined that claimant is not entitled to additional scheduled permanent disability based on Dr. Anderson's medical arbiter's report. Accordingly, we affirm.

ORDER

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

November 5, 2001 Cite as 53 Van Natta 1470 (2001)

In the Matter of the Compensation of
CARLOS MELENDEZ, Claimant
WCB Case Nos. 00-01205, 99-06183 & 99-07492
ORDER ON RECONSIDERATION
Mitchell & Guinn, Claimant Attorney
Sheridan, et al., Defense Attorney

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

On September 26, 2001, we withdrew our August 31, 2001 order that 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). We took this action to consider the insurer's motion for reconsideration.

In our prior order, we determined that an attending physician's chart note and billing for treatment of "mechanical back pain with preexisting degenerative disc disease" was insufficient, in and of itself, to constitute a claim for such a condition. Consequently, in the absence of claimant's "clear request" for "formal written acceptance" of "mechanical back pain with preexisting degenerative disc disease," we concluded that, under the particular circumstances presented, the insurer's "current" condition denial (which we found, as a factual matter, was based on the "unclaimed" condition) was procedurally invalid. Accordingly, we affirmed the ALJ's order setting aside the denial.

The insurer requests that we reconsider our prior order because "it flies in the face" of normal claim processing by preventing "insurers from clarifying what conditions they are responsible for." The insurer also requests that we reconsider our prior attorney fee award.

ORS 656.262(7)(a) requires a worker to "clearly request formal written acceptance" of any new medical condition after claim acceptance. Here, we determined that claimant had not made such a request for "mechanical back pain with preexisting degenerative disc disease." Therefore, the insurer was not obligated to either accept or deny that particular condition. In such circumstances, a denial based on an "unclaimed" condition, is procedurally invalid.

Contrary to the insurer's contention, we are not holding that all "current" condition denials are impermissible. Rather, we have only determined that this particular "current" condition denial, which the record establishes was based on an "unclaimed" condition is impermissible.[1] Moreover, nothing in our decision prevents a carrier from seeking clarification from claimant or claimant's counsel if the carrier is in doubt over a "claim" for a new medical condition. Accordingly, we adhere to our prior reasoning regarding the procedural validity of the insurer's "current" condition denial in this particular case.

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[1] The record supports a conclusion that claimant's "current" condition is "mechanical back pain with preexisting disc disease," a condition unrelated to the accepted condition of "thoracic strain." Thus, under these particular circumstances, this "current" condition denial is procedurally invalid because that condition was "unclaimed."

We turn to the attorney fee issue. ORS 656.386(1) provides that claimant is entitled to an attorney fee for prevailing over a "denied" claim. Here, because we determined that the insurer's denial was procedurally invalid; *i.e.*, it was issued in the absence of a "claim," claimant has not prevailed over a "denied claim." In other words, the legal predicate for an award of attorney fees under ORS 656.386(1) does not exist. *See Stephenson v. Meyer*, 150 Or App 300 (1997); *Donna M. Virnig*, 52 Van Natta 2191 (2000) (an assessed attorney fee is not authorized where the claimant has not made a "claim" within the meaning of ORS 656.005(6)). Consequently, the ALJ's assessed attorney fee award is reversed.

On reconsideration, as supplemented and modified herein, we adhere to and republish our August 31, 2001 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 5, 2001 Cite as 53 Van Natta 1471 (2001)

In the Matter of the Compensation of
ANN B. MILLER, Claimant
Own Motion No. 01-0203M
OWN MOTION ORDER
Welch, et al., Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewing panel: Members Haynes and Biehl.

The SAIF Corporation has submitted claimant's request for temporary disability compensation for a left hip condition. Claimant's aggravation rights have expired. Assuming that the managed care organization (MCO) approves the proposed surgery and claimant submits "proof of earnings," SAIF agrees that claimant meets the necessary criteria for reopening under the Board's Own Motion authority pursuant to ORS 656.278.

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

On April 30, 2001, Dr. Baskin, claimant's attending physician, recommended that claimant undergo left hip surgery. On October 22, 2001, SAIF acknowledged that the MCO had precertified the surgery as medically necessary and appropriate. Under such circumstances, we are persuaded that claimant's compensable injury has worsened requiring surgery.[1]

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

Here, in response to SAIF's position, claimant has submitted copies of her paystubs for the period between May 1 and June 15, 2001. These paystubs also reflect "year-to-date" earnings, which demonstrate that claimant was working prior to her current disability; *i.e.*, April 30, 2001. Based on

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[1] In reaching this conclusion, we note that SAIF had announced that, in the event the MCO approved the proposed surgery, it would not oppose reopening of the claim. Considering SAIF's October 22, 2001 announcement that the MCO had precertified the proposed surgery, we interpret SAIF's position to be supportive of claimant's request for claim reopening.

claimant's submission, we find that she was in the work force at the time of her current worsening, which requires surgery.[2]

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

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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[2] The "date of disability" for the purpose of determining whether claimant is in the work force, under the Board's Own Motion jurisdiction, is the date she enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish she was in the work force is the time prior to April 30, 2001 when her condition worsened requiring that hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331.

November 5, 2001 Cite as 53 Van Natta 1472 (2001)

In the Matter of the Compensation of
DANIEL L. REGNART, Claimant
WCB Case No. 00-05983
ORDER ON REVIEW
Raymond Bradley, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) declined to reopen the record for the admission of an additional medical report and for the taking of claimant's testimony; and (2) upheld the SAIF Corporation's denials of claimant's occupational disease claim for knee, wrist and back conditions. On review, the issues are the ALJ's procedural rulings and compensability.[1]

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

Claimant requested a hearing from SAIF's denials of his claims for knee, wrist and back conditions. A hearing was set for March 29, 2001. Claimant's attorney appeared at the hearing, but claimant did not. Claimant's attorney chose to proceed on the written record. (Tr. 2). On April 25, 2001, the ALJ issued an order upholding SAIF's denials.

On May 9, 2001, claimant, through his attorney, filed a Motion of Abatement of the April 25, 2001 order. In that motion, claimant requested that the record be reopened for an additional medical report and for an affidavit explaining "good cause" for his failure to appear at the hearing. On May 10, 2001, the ALJ abated the April 25, 2001 order and provided claimant 14 days in which to file an affidavit regarding good cause and an explanation why the proposed additional report could not have been produced at the time of hearing. Claimant did not provide the information within the allotted time.

On May 30, 2001, SAIF requested that the April 25, 2001 order be reinstated due to claimant's failure to timely produce the requested documentation. On June 4, 2001, the Hearings Division received claimant's May 30, 2001 affidavit, contending that he did not appear at the hearing because he was "misinformed" as to the date of the hearing by his attorney. On June 27, 2001, the ALJ issued an Order on Reconsideration adhering to his former order. Claimant timely requested Board review of the ALJ's orders.

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[1] By letter of October 1, 2001, claimant's attorney requested a copy of claimant's May 30, 2001 affidavit. However, in subsequent briefing received by the Board, claimant's attorney referenced the affidavit. Accordingly, we consider claimant's attorney's request to be moot.

Initially, we note that claimant's non-appearance at the hearing does not mandate dismissal of the hearing request. *Jose Arisqueta-Martinez*, 42 Van Natta 2072 (1990); *Mark A. Wiitala*, 42 Van Natta 196 (1990). Claimant's attorney can thus proceed on the record without claimant's testimony, an option his attorney expressly chose at hearing. (Tr. 2).

Here , after the ALJ's initial order issued, claimant moved for abatement of the order to provide an explanation of good cause for his failure to appear and to offer an additional medical report. The ALJ then abated the initial order on May 10, 2001 and allowed claimant 14 days, or until May 24, 2001, in which to provide the information. Claimant's response to the ALJ was received on June 4, 2001. Claimant has not provided a reason for failing to respond within the ALJ's expressly mandated 14-day "abatement" period. In those circumstances, we are not inclined to remand. *See Janis L. Eames*, 52 Van Natta 1303 n1 (2000); *Enrique Torralba*, 52 Van Natta 357 n1 (2000).

In any event, even if claimant had timely responded to the ALJ's abatement order and we were to consider the affidavit, it would not change the result. Claimant's explanations for his failure to appear focus on the alleged inadequacies of his counsel, for which accusations we are not the proper forum. *See Franklin D. Casteel*, 44 Van Natta 1464 (1992); *Diane E. Sullivan*, 43 Van Natta 2791 (1991). Moreover, claimant's explanations for his failure to appear at hearing do not amount to "extraordinary circumstances" justifying postponement or continuance of the hearing. OAR 438-006-0071(2). The Hearings Division mailed a Notice of Hearing to claimant on January 18, 2001, informing him of the date and time of the hearing. Claimant does not contend that he did not receive that notice.

As to the request to reopen the record for the admission of an additional medical report, claimant's attorney did not request a continuance to obtain such a report at hearing. Claimant did not offer the report or proffer an argument as to the admissibility of any such report within 14 days of the ALJ's abatement order. Claimant has also never offered an explanation why the report could not have been obtained at the time of the hearing. In those circumstances, we cannot find that the report was unobtainable with due diligence at the time of the hearing. We therefore decline to remand for the admission of the additional medical report. *See Timothy D. Gaines*, 53 Van Natta 100 (2001).

Finally, we adopt and affirm the ALJ's order on the issue of compensability.

ORDER

The ALJ's order dated April 25, 2001, as reconsidered on June 27, 2001, is affirmed.

November 5, 2001 Cite as 53 Van Natta 1473 (2001)

In the Matter of the Compensation of
BYRON M. STEINMAN, Claimant
Own Motion No. 99-0120M
OWN MOTION ORDER
Lavis & Dibartolomeo, Claimant Attorney
Hoffman, et al., Defense Attorney

Reviewing panel: Members Haynes and Biehl.

The self-insured employer submitted claimant's request for temporary disability compensation for his low back condition. Claimant's aggravation rights have expired. The employer recommended against reopening contending, among other grounds, that the proposed surgery was inappropriate treatment for claimant's compensable condition.

In August 1998, Dr. Grew, claimant's attending physician, recommended low back surgery. The parties eventually submitted the medical services dispute to the Medical Review Unit (MRU) of the Workers' Compensation Division. On December 3, 1999, we postponed action on the Own Motion matter pending the outcome of the medical services dispute.

On February 24, 2000, the MRU issued an Administrative Order, which found that the proposed surgery recommended by Dr. Grewe was appropriate medical treatment for claimant's compensable injury. (TX 00-033). The employer requested a contested case hearing appealing the MRU's decision.

On May 9, 2001, a Proposed and Final Contested Case Hearing Order upheld the MRU's decision that the proposed surgery was appropriate treatment for claimant's compensable condition. The order was not appealed, and has become final by operation of law.

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.*

Following the resolution of the medical services dispute, we requested the parties' positions regarding the effect the Director's order had on claimant's Own Motion request. Claimant responded that the Director's conclusion that the proposed surgery was appropriate treatment for his compensable condition authorizes the Board "to allow for temporary total disability *should* [claimant] choose to undergo surgery." (Emphasis supplied.)

The employer argues that although the proposed surgery was found to be appropriate treatment for claimant's compensable surgery, there is "no evidence in this case that claimant has either been hospitalized or sought outpatient services." Therefore, the employer "objects" to the issuance of an order reopening claimant's claim until such time that claimant actually undergoes treatment "pursuant to the statute, for conditions that are related to any compensable claims."

Here, Dr. Grewe recommended surgery in August 1998. The dispute over the appropriateness of the recommended surgery was resolved more than four months ago. Nonetheless, the record does not demonstrate that claimant has pursued that option or that surgery is still being contemplated. The most current medical records in the Own Motion file are from 1998. In addition, claimant apparently does not contest the employer's contention that he is not currently planning surgery. In this regard, claimant's position is that the Board has authority to reopen his claim "should [he] choose to undergo surgery."

In light of claimant's assertion that he would be entitled to Own Motion benefits should he "choose" to undergo surgery and the employer's unrebutted contention that claimant has not pursued the surgery option, the record does not establish that claimant *currently* requires surgery or hospitalization. Consequently, we cannot authorize the payment of temporary disability benefits at this time. ORS 656.278(1)(a).

In reaching this conclusion, we note that by virtue of the Director's order, the employer remains responsible for the surgery proposed by Dr. Grewe in 1998. Should claimant require the proposed surgery at a future time, he may request reopening of his claim to provide temporary disability compensation at that time.

Accordingly, the current request for Own Motion relief is denied. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BUCK SCHAFFER, Claimant
WCB Case No. 01-00580
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that awarded an assessed attorney fee pursuant to ORS 656.386(1). On review, the issue is attorney fees.

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

The ALJ awarded an assessed fee pursuant to ORS 656.386(1) for claimant's counsel's efforts in setting aside a "denied claim" without necessity of a hearing based on claimant's request for acceptance of an omitted condition under ORS 656.262(6)(d). In concluding that claimant's counsel was entitled to an assessed fee, the ALJ reasoned that SAIF both expressly and *de facto* denied claimant's request for acceptance of a thoracic sprain condition under ORS 656.262(6)(d).[1]

On review, SAIF contends that it never expressly denied the thoracic condition and, moreover, that it did not *de facto* deny the omitted condition claim because it responded to the claim on January 10, 2000, within 30 days of the claim. According to SAIF, its response pursuant to ORS 656.386(1)(b)(B) and 656.262(6)(d) was such that no attorney fee should have been assessed. As support for its position, SAIF cites *Mary Egbert*, 52 Van Natta 1457 (2000), and *Latoy E. Hamilton*, 51 Van Natta 724 (1999).

We do not decide whether SAIF initially denied the thoracic strain claim on the express ground that the condition for which compensation was claimed was not compensable or otherwise did not give rise to entitlement to any compensation. *See* ORS 656.386(1)(b)(A). That is, we agree with the ALJ that SAIF did not adequately respond within 30 days of the omitted condition claim and, therefore, that SAIF's claim processing resulted in a "denied claim" under ORS 656.386(1)(b)(B). In reaching this conclusion, we distinguish both *Egbert* and *Hamilton*.

ORS 656.386(1)(b)(B) provides that a "denied claim" is a claim for compensation made pursuant to ORS 656.262(6)(d) to which the carrier does not respond within 30 days. ORS 656.262(6)(d) requires that once the claimant has properly communicated an objection to any Notice of Acceptance, the carrier has 30 days to respond. However, the statute does not require the carrier to accept or deny a condition within 30 days of an objection, only that the carrier is obligated to revise or to "make other written clarification in response."

Here, claimant's attorney provided the proper written communication to SAIF. SAIF's claims examiner responded as follows on January 10, 2001 to claimant's attorney's December 14, 2000 request for acceptance of the thoracic strain:

> "I am reviewing the issue and will contact you as soon as possible. Please note, I have a call into your office to discuss [claimant's] claim. I will be out of the office a few days returning on January 16. I would appreciate your call as soon as possible on or after that date." (Ex. 39).

In *Egbert*, the claimant requested that the carrier accept shoulder conditions that were omitted from its acceptance notice. Within 30 days of the claimant's request, 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. The claimant contended that the carrier's letter did not qualify as a timely response because it was neither an amendment of its acceptance nor a written clarification. We rejected that contention and found that the carrier's response qualified as a "written clarification" under ORS 656.386(1)(b)(B). We further concluded that because the carrier's claim processing was timely, the claimant's attorney was not entitled to an assessed attorney fee for prevailing over an alleged *de facto* denial. 52 Van Natta at 1458.

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[1] The request for acceptance of the thoracic sprain condition was made on December 14, 2000. The condition was eventually accepted on March 12, 2001. (Ex. 15A).

In *Hamilton*, we found no "denied claim" for purposes of ORS 656.386(1)(b)(B) because the employer responded to the claimant's claim for compensation within the 30-day period. There, the claimant requested acceptance of a "L5-S1 facet dysfunction, L5-S1 disk bulge/protrusion/herniation condition" on June 12, 1998. In its July 10, 1998 response, the employer revised the notice of acceptance (to include L5-S1 facet dysfunction) and clarified its position with regard to the disc diagnoses. The employer asserted that the previously accepted disc bulge encompassed the disc protrusion diagnosis, and explained that it was seeking further information from a physician regarding the disc herniation diagnosis. Although the employer did not specifically accept a L5-S1 disc herniation as a distinct condition until it received clarification from a physician, we held that its July 10, 1998 clarification and response to the claimant's request complied with the processing requirements of ORS 656.262(6)(d) and 656.386(1)(b). 51 Van Natta at 725.

In this case, unlike *Egbert* (where 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), SAIF did not state that it was gathering information, only that it was "reviewing the issue." Moreover, SAIF did not state that it would make a decision on claimant's claim by a certain date. Therefore, in contrast to our conclusion in *Egbert*, we find in this case that SAIF's January 10, 2001 response to claimant's omitted condition claim does not constitute "written clarification" under ORS 656.262(6)(d).

In addition, we find *Hamilton* distinguishable. In that case, the employer asserted that the previously accepted disc bulge encompassed the disc protrusion diagnosis and explained that it was seeking further information from a physician regarding the disc herniation diagnosis. Here, in contrast, SAIF made no assertion that its previous acceptance encompassed the thoracic strain condition or that it was seeking further information from a physician.

Having reviewed SAIF's January 10, 2001 response, we agree with the ALJ that it was neither directly responsive to the request for acceptance, nor was it definite about the information required to make a determination of its liability. It also did not state a definite time in which it would make a decision. Thus, we agree with the ALJ that SAIF's response does not constitute a "written clarification" as required by ORS 656.262(6)(d). Because of this, we further conclude that there was a "denied claim" for the purposes of ORS 656.386(1)(b)(B).

Because the thoracic claim was eventually accepted, and because there is no dispute that claimant's attorney was instrumental in obtaining a rescission of a denial prior to a decision by an ALJ, the ALJ properly concluded that a reasonable attorney fee should be allowed under ORS 656.386(1). Accordingly, we affirm.[2]

ORDER

The ALJ's order dated May 25, 2001 is affirmed.

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[2] Claimant is not entitled to an attorney fee for services on review devoted to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

Board Member Haynes concurring.

I agree that SAIF's January 10, 2001 response to claimant's objection to its Notice of Acceptance was insufficient written clarification under ORS 656.262(6)(d) and that, therefore, there was a "denied claim" within the meaning of ORS 656.386(1)(b)(B). I write separately to summarize my understanding of what constitutes a "written clarification" under ORS 656.262(6)(d) and to give carriers some guidance so that they may know how to respond to objections to acceptance notices.

While the legislature has not provided a definition of what constitutes "written clarification," several cases, including this one, have explained what this Board requires from a carrier in order to satisfy the statute. As this case illustrates, a carrier must do more than write a letter stating that it is reviewing the issue and would like to discuss the matter. Under *Mary Egbert*, 52 Van Natta 1457 (2000), and *Latoy E. Hamilton*, 51 Van Natta 724 (1999), a carrier may satisfy the requirement of "written clarification" by stating in writing that it is gathering information to determine compensability, by giving

a certain date by which a decision on acceptance or denial will be made, or by advising that a previous acceptance has encompassed the condition for which an omitted-condition claim has been made. A carrier may also assert that the claimed condition constitutes merely symptoms of the accepted condition, rather than a separate medical condition or diagnosis. *See Kris Henriksen*, 51 Van Natta 401 (1999). Of course, the carrier may also simply issue a denial in response to the claim.

The point of these cases, I believe, is that the carrier's response must be directly responsive to a claimant's request for acceptance. Here, because SAIF's response to claimant's omitted-condition claim was insufficient under our cases to constitute "written clarification," I agree with the lead opinion's holding that SAIF denied the omitted-condition claim *de facto*. Thus, I also believe that the ALJ properly assessed an attorney fee under ORS 656.386(1).

November 5, 2001 Cite as 53 Van Natta 1477 (2001)

In the Matter of the Compensation of
VINCENT B. SWEENEY, Claimant
Own Motion No. 01-0287M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

Reviewing panel: Members Haynes and Biehl.

The SAIF Corporation has submitted a request for temporary disability compensation for claimant's low back condition. Claimant's aggravation rights have expired. SAIF opposes the authorization of the payment of temporary disability compensation, questioning whether claimant has demonstrated that he was in the workforce.

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

On June 28, 2001, claimant underwent a L5-S1 microdiscectomy. Thus, we conclude that claimant's compensable condition worsened requiring surgery.

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

With its recommendation form, SAIF submitted an August 24, 2001 medical report from Dr. Johnson, claimant's treating physician, which demonstrates that claimant was in the work force at the time of the current disability. Dr. Johnson reported that claimant was examined one-month following his surgery and was doing well. He noted that claimant was not taking any pain medication and had returned to work. Dr. Johnson further noted that claimant was "back at work already." Finally, Dr. Johnson noted that there was no specific work release, but that claimant "went back on his own accord."

Based on the references included in Dr. Johnson's reports, (and in the absence of contrary evidence), we are persuaded that claimant was in the work force at the time of his current worsening. *See Ralph A. Schultz*, 52 Van Natta 762 (2000); *John R. Kennedy*, 50 Van Natta 837 (1998). Accordingly, we authorize the reopening of claimant's claim for SAIF to provide temporary total disability compensation beginning June 28, 2001, the date claimant was hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
LYNDA L. BOSWELL, Claimant
WCB Case No. 00-07055
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Reinisch, MacKenzie, Healey, et al., 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) Myzak's order that set aside its partial denial of claimant's injury 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 "Finding of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured her back when she slipped and fell at work on August 2, 1999.[1] (Ex. 1). A May 1, 2000 Notice of Closure closed the claim without an award of permanent disability.

In June 2000, claimant requested that the insurer amend its acceptance to include "injuries to the lateral collateral and medial collateral ligamentous complexes of the right knee." (Ex. 69). The insurer declined to accept those conditions. (*Id.*) Claimant requested a hearing.

The ALJ found that claimant was a credible witness and determined that in the August 2, 1999 fall at work, claimant twisted her right knee under her left leg. The ALJ also determined that claimant began to experience right knee pain upon her return to weight bearing work in October 1999. Relying on the opinion of Dr. Malloy (attending physician), the ALJ concluded that claimant had established the compensability of her right knee condition. Consequently, the ALJ set aside the insurer's partial denial of the right knee condition.

Because of possible alternate causes for claimant's 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).

On March 30, 2000, claimant was evaluated (at the insurer's request) by Drs. Scheinberg and Denekas. Examination of claimant's right knee revealed: (1) a +1 effusion; (2) the right knee was warmer than the left knee; and (3) a 5 degree loss of motion in extension. (Ex. 50-5; 50-6). Based on claimant's history of a temporal relationship between the August 2, 1999 injury and the right knee pain and swelling, Drs. Scheinberg and Denekas concluded that the August 2, 1999 work incident was the major cause of claimant's right knee problem. (Exs. 50-7; 50-8).

Dr. Malloy, the attending physician, using a "check-the-box" form, concurred with the opinion of Drs. Scheinberg and Denekas. (Ex. 54-2).

Later, Drs. Scheinberg and Denekas changed their opinion regarding causation. (Exs. 67; 68). Claimant asserts that the doctors' change of opinion is not adequately explained, and thus their March 2000 opinion supports the compensability of claimant's right knee condition. We disagree.

Drs. Scheinberg and Denekas indicated that their March 2000 opinion had been based on a mistaken understanding that claimant's knee pain began immediately following the August 1999 work injury. (Exs. 70-11; 71-5; 71-6). According to Dr. Scheinberg, while "slip and fall" accidents can result in damage to the ligaments of the knee, such injuries are associated with the immediate onset of knee pain. (Ex. 71-5). He further indicated that there was "no way" the August 1999 work event could account for claimant's knee pain, if the pain did not begin until three months later. (Ex. 71-8). Rather, he opined that claimant's rheumatoid arthritis "would be the most likely cause" of such knee pain. (*Id.*)

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[1] The insurer accepted "contusion to buttocks and low back." (Ex. 29).

In their initial report dated March 30, 2000, Drs. Scheinberg and Denekas related claimant's right knee condition to the August 2, 1999 work incident based on the temporal relationship between claimant's right knee symptoms and the incident. In doing so, the physicians were not aware that claimant's right knee symptoms began in October, two months after the August 1999 work incident. After becoming aware of the correct history, Drs. Scheinberg and Denekas withdrew their opinion relating the right knee condition to the August 1999 work incident.

Under such circumstances, the only opinion arguably supporting compensability is that of Dr. Malloy. Dr. Malloy's concurrence with the March 2000 opinion of Drs. Scheinberg and Denekas was in the form of a "check-the-box" type concurrence. Dr. Malloy did not offer any other explanation or opinion regarding the cause of claimant's right knee condition. In light of its conclusory nature and its apparent reliance on an inaccurate history, we conclude that Dr. Malloy's unexplained concurrence is insufficient on its own to establish the compensability of claimant's right knee condition.[2] *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, based on this record, we conclude that claimant's right knee condition is not compensable.

ORDER

The ALJ's order dated June 15, 2001 is reversed. The insurer's partial denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[2] We need not determine whether a material contributing cause standard or the major contributing cause standard applies to this claim. Under either standard, the medical evidence is insufficient to meet claimant's burden of proof.

In the Matter of the Compensation of
LARRY L. KADEN, Claimant
WCB Case No. 00-08309
ORDER OF DISMISSAL
Jerry Keene, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Otto's order that dismissed his request for hearing. Contending that it did not receive timely notice of claimant's appeal, the self-insured employer seeks dismissal of claimant's motion to dismiss. We grant the motion.

FINDINGS OF FACT

On May 1, 2001, the ALJ issued a Dismissal Order that dismissed claimant's request for hearing for failure to appear at hearing. Copies of the ALJ's order were mailed to claimant, the employer, its claim processing service and their attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for review must be mailed to the other parties within the 30-day appeal period.

On May 14, 2001, the Hearings Division received a letter from claimant that did not indicate that copies were provided to the employer, its claim processor, or its attorney. The ALJ's order was neither abated nor reconsidered.

Claimant's letter was eventually forwarded to the Board. The letter was treated as a request for Board review. On October 29, 2001, the Board mailed its computer-generated letter to all parties acknowledging claimant's letter as a request for review.

On October 30, 2001, the employer moved to dismiss claimant's request for Board review. The employer's counsel stated that the Board's acknowledgement letter represented the employer's first notice of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

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

Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983). The failure to timely file and serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992), except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47, 51 (1985); *Argonaut Insurance Co. v. King*, 63 Or App at 853.

Here, the 30th day after the ALJ's May 1, 2001 order was May 31, 2001. The record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's "request for review" within the statutory 30-day period.[1] Rather, based on the employer's submission (Motion to Dismiss), the other parties' first notice apparently occurred when its counsel received a copy of the Board's October 29, 2001 letter acknowledging claimant's request for review. Under such circumstances, notice of claimant's appeal was untimely. *Stella T. Ybarra*, 52 Van Natta 1252 (2000).

Consequently, we conclude that notice of claimant's request was not provided to the other parties within 30 days after the ALJ's May 1, 2001 order.[2] Therefore, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. *See* ORS 656.289(3); 656.295(2); *Sherry A. Gomes, on recon*, 52 Van Natta 2022, 2023 (2000).

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

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] For purposes of this review, we have assumed, without deciding, that claimant's letter to the ALJ constitutes a request for Board review.

[2] In the event that claimant can establish that he provided notice of his request for Board review to the other parties to the proceeding within 30 days after the ALJ's May 1, 2001 order, he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Because our authority to reconsider this order expires within 30 days after the date of this order, claimant must file his submission as soon as possible.

In the Matter of the Compensation of
ANITA DIAZ, Claimant
WCB Case Nos. 00-04188 & 00-01243
ORDER ON REVIEW
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's lumbar strain condition; and (2) upheld the insurer's denial of claimant's claims for L3-4 and L5-S1 disc bulges, cervical and thoracic sprain/strains, right shoulder post traumatic arthropathy, and mild right temporomandibular joint syndrome. Claimant also requests an opportunity to present witnesses. We treat claimant's request as a motion to remand. On review, the issues are extent of unscheduled permanent disability, compensability, and remand.[1]

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

We may remand a case to the ALJ for further evidence taking if we determine that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). In addition, to merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986); *Bernard L. Osborn*, 37 Van Natta 1054, 1055 (1985), *aff'd mem*, 80 Or App 152 (1986).

We conclude that claimant has not established that additional testimony was unobtainable with due diligence at the time of the hearing. In this regard, we note that claimant's attorney mentioned the possibility of witnesses other than claimant testifying, specifically claimant's family members who were present. However, this testimony was never offered. No objection was made to the closure of the record and there was no request for a continuance to obtain testimony. Moreover, lay witness testimony would not likely alter our decision on the merits, because the extent of permanent disability and compensability issues require expert evidence for their resolution. Accordingly, we deny the motion for remand. *See Philip G. Michael*, 46 Van Natta 519 (1994).

ORDER

The ALJ's order dated April 10, 2001 is affirmed.

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[1] We note that claimant is unrepresented. Because she is unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. She may contact the Workers' Compensation Ombudsman 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
JOSE DE LA TORRE, Claimant
WCB Case No. 00-05548
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) upheld the SAIF Corporation's denial of his injury claim for L4-5 and L5-S1 herniated discs; and (2) declined to award additional temporary disability. Claimant requests remand for the submission of an additional medical report. On review, the issues are remand, compensability and temporary disability.

We adopt and affirm the ALJ's order with the following supplementation. We write only to address claimant's request for remand for consideration of a July 5, 2001 MRI report that purportedly shows a "rent" or tear in his annulus at the L5-S1 disc.[1] Claimant contends that the MRI was not obtainable at the time of the hearing and the evidence is reasonably likely to affect the outcome of his case "since no physician provided an opinion based on the existence of a torn annulus that might have contributed to claimant's herniated disc condition." (Claimant's br at 3).

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 n 3 (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's July 5, 2001 MRI report fits the first criteria in that it concerns his disability. Nevertheless, even if we assume that the report at issue was not "obtainable" at hearing, we find that, for the following reasons, the report offered by claimant is not reasonably likely to affect the outcome of the case.

SAIF correctly asserts that there is no medical evidence that indicates that any "rent" or tear in the annulus of claimant's L5-S1 disc was related to the January 3, 2000 work injury. To the contrary, Dr. Farris explained that annular fissures are common and are part of the degenerative process. (Ex. 57-27). She also testified that a ruptured annulus would not cause irritation because it was not near enough to the nerve root to irritate it. (*Id.*) Similarly, although Dr. Seres reported there was a possibility of an annulus tear at L4-5 (rather than L5-S1), he said that could be degenerative in nature. (Ex. 59-11). We conclude that claimant's proposed evidence is not reasonably likely to affect the outcome of the case. Consequently, we find no compelling reason to remand.

ORDER

The ALJ's order dated May 25, 2001 is affirmed.

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[1] We note that claimant did not submit a copy of the July 5, 2001 MRI report for purposes of our review concerning the remand issue.

In the Matter of the Compensation of
RICHARD E. HALFERTY, Claimant
WCB Case No. 00-08751
ORDER ON REVIEW
Fox & Olson, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Biehl, Bock, and Haynes. Member Haynes dissents.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Thye's order that affirmed an Order on Reconsideration that awarded 21 percent (31.5 degrees) scheduled permanent disability for loss of use or function of the left leg. On review, the issue is extent of scheduled permanent disability.

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

On May 13, 1999, claimant fractured his left leg and suffered a crush injury to his left foot. SAIF accepted left tibial and fibular disphyseal fractures with dorsal angulation, and a crush injury of the left foot. (Exs. 8, 13).

A May 23, 2000 Notice of Closure awarded 5 percent scheduled permanent disability for loss of use or function of claimant's left foot, based on decreased sensation. (Ex. 20). Claimant requested reconsideration, arguing that he had a leg length disparity. (Ex. 21). Dr. Sacamano performed a medical arbiter examination on September 7, 2000. (Ex. 23).

An October 19, 2000 Order on Reconsideration awarded a total of 21 percent (31.5 degrees) scheduled permanent disability for loss of use or function of the left leg. Among other things, the award included a 5 percent value for leg length discrepancy pursuant to OAR 436-035-0230(2).[1] (Ex. 27-4). SAIF requested a hearing.

The ALJ relied on the medical arbiter evaluation and determined that claimant had a 3/8 inch loss of length of the left tibia as a result of the compensable injury. Applying OAR 436-035-0230(2), the ALJ concluded that claimant was entitled to 5 percent for loss of leg length as a result of the injury. Consequently, the ALJ affirmed the Order on Reconsideration.

On review, SAIF contends that the ALJ erred by concluding that OAR 436-035-0230(2) did not require that the shortened leg be shorter than the contralateral leg. In support of its position, SAIF asserts that WCD Bulletin 239 requires a comparison between the injured shortened leg and the uninjured contralateral leg. For the reasons set forth below, we disagree with SAIF's contention.

WCD Bulletin 239 is intended for use by physicians. (Bulletin No. 239, p 1). Its purpose is to explain to physicians what medical information is needed for disability. (*Id.*) Unlike OAR chapter 436, division 035, the purpose of Bulletin 239 is not to establish standards for rating permanent disability. OAR 436-035-0002. Consequently, contrary to SAIF's assertion, a worker's disability is established by application of OAR chapter 436, division 035, not application of Bulletin 239.[2]

Moreover, we note that while Bulletin 239 (in the general provisions section) expressly asks the evaluating physician to report "range of motion" or "grade of laxity" in the contralateral joint, Bulletin 239 does not expressly request the reporting of contralateral leg measurements in the specific section dealing with "leg length discrepancy." (Bulletin No. 239, p. 6 & A-3). Therefore, even if Bulletin 239

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[1] The only dispute at hearing and on review pertains to the 5 percent award for a leg length discrepancy.

[2] Citing *Jenna Larson*, 48 Van Natta 1278 (1996), SAIF asserts that Bulletin 239 has "the force of law." In *Larson*, the issue was whether a specific bulletin of the Director should have been promulgated as a rule under the APA. *Larson* was not a "disability standards" case. Consequently, *Larson* is distinguishable. Moreover, pursuant to ORS 656.283(7) and 656.295(5) the ALJ and Board are mandated to apply the "standards." Bulletin 239 is not the "standard."

established the standards for rating disability, the express language of Bulletin 239 does not require that leg length discrepancy be determined by comparison to the contralateral leg. In the absence of such an express requirement, we decline SAIF's invitation to insert such a requirement into Bulletin 239.[3]

Accordingly, we conclude that claimant was entitled to a 5 percent value for leg length discrepancy.[4]

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

ORDER

The ALJ's order dated April 3, 2001 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by SAIF.

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[3] We also note that the medical arbiter expressly reported claimant's right tibeal plateau (contralateral leg) measured 16-3/8 inches while claimant's left tibeal plateau measured 16 inches. (Ex. 23-4). Thus, the medical arbiter apparently did compare claimant's injured left leg to his uninjured right leg. Consequently, even if we interpreted Bulletin 239 as SAIF suggests, we would still conclude that claimant is entitled to a 5 percent value for leg length discrepancy.

[4] We disagree with SAIF's assertion that the ALJ's decision is inconsistent with *Joslin A. McIntosh*, 46 Van Natta 2445 (1994). In that case, the claimant argued that she had sustained a shortening of the left femoral neck, which necessarily resulted in an overall shortening of the left leg, and she asserted that the impairment was not covered by the standards. We were not persuaded that the claimant had a shortening of the left femoral neck. We referred to a medical opinion that said "[t]here is slight shortening of the femoral neck, but this may be rotational projection also." Nevertheless, the same physician found that the claimant's leg lengths were equal at 37-1/2 inches. Under those circumstances, we were not persuaded that the claimant was entitled to a rating for length discrepancy of the injured leg. In addition, we found that, even assuming that the claimant had a shortened femoral neck, such impairment was addressed by *former* OAR 436-35-230(2) and, therefore, remand under ORS 656.726(3)(f)(C) was not warranted.

Unlike *McIntosh*, where we were not persuaded that the claimant had a shortening of the left femoral neck, we find that the medical arbiter's report persuasively establishes that claimant has a 3/8 inch shortening of the left tibial shaft. Indeed, the ALJ expressly found that SAIF did not dispute that claimant lost 3/8 inch from his tibial shaft as a result of his injury. On review, SAIF does not contend otherwise.

Board Member Haynes dissenting.

The majority rejects SAIF's argument that WCD Bulletin 239 requires a comparison between the injured shortened leg and the uninjured contralateral leg and it affirms the ALJ's conclusion that claimant was entitled to a 5 percent scheduled disability award for loss of leg length. Although I agree that SAIF's argument concerning Bulletin 239 is not persuasive, I rely on a different reasoning. Furthermore, I disagree with the majority's conclusion that claimant's shortening of the left tibial shaft is ratable under OAR 436-035-0230(2). I offer the following alternative analysis.

The ALJ concluded that claimant was entitled to 5 percent for loss of leg length as a result of the injury. The ALJ reasoned that the leg length measurement requirements in Workers' Compensation Division (WCD) Bulletin 239 were inconsistent with OAR 436-035-0230(2). The ALJ found that the discrepancy occurred as a result of claimant's fractured tibia, and the loss of length was in the foot, not the "leg" as defined in OAR 436-035-0130. Nevertheless, the ALJ determined that OAR 436-035-0230(2) indicated that a length change due to the injury, whether a result of injury to the upper or lower leg, is entitled to a permanent disability award (assuming it is 1/4 inch or greater), and the rule did not require a comparison with the contralateral leg.

SAIF argues that the ALJ erred in finding that claimant was entitled to a scheduled permanent disability award of 5 percent for a leg length discrepancy. According to SAIF, because the medical evidence indicates that claimant's leg lengths are symmetrical, when measured consistent with Bulletin 239, claimant is not entitled to an award for leg length discrepancy.

Dr. Sacamano performed a medical arbiter examination on September 7, 2000. He measured claimant's leg lengths, explaining: "Leg lengths are symmetrical, measured from the anterior spine to the medial malleolus, but the tibial measurement from the medial malleolus to the medial tibial plateau is 16-3/8 inches right and 16 inches left." (Ex. 23-4). He diagnosed, among other things, "[p]osttraumatic shortening, left tibia, secondary to [left fracture of tibia and fibula shaft diaphysis]." (Ex. 23-5). In response to the question that asked him to "[d]escribe any leg length discrepancies in inches from the anterior superior iliac spine to the distal medial malleolus[,]" Dr. Sacamano responded: "There is leg length discrepancy, with 3/8-inch shortening of the left tibial shaft." (Ex. 23-7).

On September 18, 2000, an Appellate Review Specialist wrote to Dr. Sacamano, asking for clarification:

> "Please clarify why the worker's *overall* leg lengths are equal when the worker has a shortened tibia. Does the worker have a leg length discrepancy as described in the attached copy of OAR 436-035-0230(1)? Please confirm that the measurements for leg length were taken from the anterior superior iliac spine to the distal medial malleolus." (Ex. 24; emphasis in original).

On September 18, 2000, Dr. Sacamano responded:

> "The greater the distance of measurement, the more variables affect the value; i.e., femoral lengths, pelvic asymmetry, et cetera. The reported 3/8" discrepancy is due to the work injury." (Ex. 25).

The question is whether claimant's situation is addressed by the standards for rating permanent disability. I begin by reviewing the pertinent statute and rules. ORS 656.214(2) provides, in part:

> "When permanent partial disability results from an injury, the criteria for the rating of disability shall be permanent loss of use or function of the injured member due to the industrial injury. The worker shall receive $454 for each degree stated against such disability in subsections (2) to (4) of this section as follows.
>
> "* * * * *
>
> "(c) For the loss of one leg, at or above the knee joint, 150 degrees, or a proportion thereof for losses less than a complete loss.
>
> "(d) For the loss of one foot, 135 degrees, or a proportion thereof for losses less than a complete loss."

Thus, ORS 656.214(2)(c) provides that the loss of a "leg" is at or above the knee joint. OAR 436-035-0130(1) provides that the "leg" begins with the femoral[1] head and includes the knee joint. In contrast, OAR 436-035-0130(2) provides that the "foot" begins just distal to the knee joint and extends just proximal to the metatarsophalangeal joints of the toes.

OAR 436-035-0230(2) provides, in part:

> "The following ratings are for length discrepancies of the injured leg. However, loss of length due to flexion/extension deformities are excluded. The rating is the same whether the length change is a result of an injury to the foot or to the upper leg[.]"

The rule provides an impairment value of 5 percent for a 1/4 to 1/2 inch "leg" discrepancy.

Here, the WCD medical arbiter questions provided to Dr. Sacamano asked him to "[d]escribe any leg length discrepancies in inches from the anterior superior iliac spine to the distal medial malleolus." (Ex. 22-2). The medical arbiter questions noted that "[o]nly those methods described in the AMA's Guides to the Evaluation of Permanent Impairment, 3rd Edition (Revised), copyright 1990 and Director's Bulletin 239 may be used to measure and report impairment." (Ex. 22-3).

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[1] "Femoral" relates to the femur or thigh. Stedman's Electronic Medical Dictionary, v. 4.0 (1998).

I first address SAIF's argument that, because the medical evidence indicates that claimant's leg lengths are symmetrical, when measured consistent with Bulletin 239, claimant is not entitled to an award for leg length discrepancy.

The Director's Bulletin 239 provides that leg length discrepancy is measured "in inches from the anterior superior iliac spine to the distal medial malleolus." WCD Bulletin 239, at 15 (July 15, 1998). The "anterior superior iliac spine" is defined as the "anterior extremity of the iliac crest, which provides attachment for the inguinal ligament and the sartorius muscle." *Stedman's Electronic Medical Dictionary*, v.4.0 (1998); *see SAIF v. Calder*, 157 Or App 224, 227 (1998) (Board may rely on medical dictionaries to define medical terms). "Iliac" pertains to the "ilium," which is "broad, flaring portion of the hip bone, distinct at birth but later becoming fused with the ischium and pubis; it consists of a body, which joins the pubis and ischium to form the acetabulum and a broad thin portion, called the ala or wing." *Id.* "Medial malleolus" is defined as "the process at the medial side of the lower end of the tibia, forming the projection of the medial side of the ankle." *Id.* "Tibia" is the "medial and larger of the two bones of the leg, articulating with the femur, fibula, and talus[,]" or the shin bone. *Id.* "Distal" is "[s]ituated away from the center of the body, or from the point of origin; specifically applied to the extremity or distant part of a limb or organ." *Id.*

Thus, based on the medical dictionary definitions, WCD Bulletin 239 requires leg length discrepancy to be measured from the "anterior superior iliac spine," which is essentially the iliac crest or hip bone, to the "distal medial malleolus," which is at the lower end of the tibia (shinbone), by the ankle. That measurement, however, is inconsistent with ORS 656.214(2)(c), which provides that the loss of a "leg" is at or above the knee joint, and OAR 436-035-0130(1), which provides that the "leg" begins with the femoral head and includes the knee joint.

Because the measurements in WCD Bulletin 239 for leg length discrepancy are inconsistent with ORS 656.214(2)(c) and OAR 436-035-0130(1), I am not persuaded by SAIF's argument that relies on Bulletin 239.

The WCD medical arbiter questions noted that the methods described in the "AMA's Guides to the Evaluation of Permanent Impairment, 3rd Edition (Revised), copyright 1990" may also be used to measure and report impairment. (Ex. 22-3). OAR 436-035-0007(7) provides that "[e]xcept as otherwise required by these rules, methods used by the examiner for making findings of impairment shall be the methods described in the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Edition, Rev.** 1990, and shall be reported by the physician in the form and format required by these rules." (Bold in original). However, the ALJ found, and I agree, that the 3rd edition of the "AMA Guides" did not include a guideline for measuring loss of leg length.[2]

I turn to the administrative rules to determine if claimant is entitled to a rating for the undisputed 3/8 inch shortening of his left tibial shaft. OAR 436-035-0230(2) provides, in part:

> "The following ratings are for length discrepancies of the injured leg. However, loss of length due to flexion/extension deformities are excluded. The rating is the same whether the length change is a result of an injury to the foot or to the upper leg[.]"

Although OAR 436-035-0230(2) provides that the length change may be the "result" of an injury to the foot or to the upper leg, the rule expressly provides that the ratings are "for length discrepancies of the injured *leg*." (Emphasis supplied). That rule provides ratings for length discrepancies of the injured "leg," but it does not define "leg." As discussed above, ORS 656.214(2)(c) provides that the loss of a "leg" is at or above the knee joint, and OAR 436-035-0130(1) provides that the "leg" begins with the femoral head and includes the knee joint. In contrast, under OAR 436-035-0130(2), the "foot" is measured from the knee joint to the toes. Thus, OAR 436-035-0230(2) provides a rating for length discrepancies of the femoral head to the knee joint only, not for any length discrepancies of the "foot."

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[2] I note that the 4th edition of the "AMA Guides" includes a section on limb length discrepancy, but it does not apply here and, in any event, is not particularly helpful to this case. The 4th edition provides, in part:

> "Measuring lower-extremity length by tape measure, or determining the iliac crest level when the subject is standing has at least a 0.5- to 1-cm variance and is difficult in a patient with pelvic angulation, knee flexion contracture, or significant ankle edema. For this reason, teleroentgenography is recommended for estimating these impairments, which are classified in Table 35 * * *."

Although Dr. Sacamano found that claimant's leg lengths were symmetrical, when measured from the anterior spine to the medial malleolus (Ex. 23-4), that measurement is inconsistent with the "leg," as defined in ORS 656.214(2)(c) and OAR 436-035-0130(1). Based on my interpretation of OAR 436-035-0230(2), there is no evidence that claimant has a "leg" length discrepancy that is ratable pursuant to that rule. Consequently, the majority errs by affirming the ALJ's order. I dissent.

In the Matter of the Compensation of
LYNN A. WOLFER, Claimant
WCB Case No. 01-00610
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that increased claimant's unscheduled permanent disability award for a cervical condition from 25 percent (80 degrees), as awarded by an Order on Reconsideration, to 29 percent (92.8 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant injured his neck at work on November 5, 1999. Dr. Gallo performed a C5-6 laminectomy/discectomy on January 12, 2000. Claimant's claim was closed by a Notice of Closure that awarded 25 percent unscheduled permanent disability for claimant's cervical condition, based in part on July 17, 2000 reduced range of motion findings ratified by Dr. Gallo.

Claimant requested reconsideration and Dr. Cronin performed a medical arbiter's examination. He measured claimant's cervical range of motion as follows: 20 degrees flexion, 38 degrees extension, 34 degrees right lateral flexion, 58 degrees right rotation, and 64 degrees left rotation. (Ex. 9-1).

Dr. Cronin questioned the validity of these measurements because claimant's motion was significantly more restricted than the prior measurements indicated and "[a] single mid to low cervical disc level is responsible for only a small amount of motion." (*Id.* at 2). Further reasoning that claimant's range of motion was "significantly more limited than I would expect to see based on a single level disc herniation successfully treated," Dr. Cronin opined that 50 percent of claimant's reduced range of motion was due to his accepted condition and 50 percent was related to his preexisting C6-7 degenerative disease. (*Id.* at 3).

Based on Dr. Cronin's report, a December 22, 2000 Order on Reconsideration affirmed the Notice of Closure's award of 25 percent unscheduled permanent disability. Claimant requested a hearing.

The ALJ found Dr. Cronin's "50% reduction" to claimant's range of motion measurements "inappropriately arbitrary," and concluded that the measurements should be rated at "full value."[1] SAIF requested Board review.

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[1] The ALJ found no evidence that range of motion like claimant's "never occurs with a single level disc herniation" and no evidence that claimant had cervical complaints or diminished range of motion before his work injury. Further finding that Dr. Cronin did not explain where he "came up with the 50 percent reduction figure," the ALJ concluded that the reduction was inappropriately arbitrary. We disagree, as explained herein.

The sole issue on review is the proper rating for claimant's cervical impairment--specifically, his range of motion. We reinstate the Order on Reconsideration award, based on the following reasoning.

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.

In *SAIF v. Alton*, 171 Or App 491 (2000), the court explained claimant's burden of proof in the context of establishing entitlement to permanent disability benefits, citing ORS 656.266. The court also noted that the claimant must meet his or her burden by a preponderance of the medical evidence. *Id.* 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 [] 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).

As noted in *Alton*, the Board is not an agency with specialized medical expertise and our findings must be based on a preponderance of medical evidence in the record. *Id.* at 497; *Calder*, 157 Or App at 228. We may not reach medical conclusions on our own, absent such evidence. *Benz v. SAIF*, 170 Or App 22, 26 (2001); *see Leora Mitchell*, 53 Van Natta 1018, 1022 (2001). Based on these principles, we reach the following conclusions.

First, we rely on the medical arbiter's opinion, because there is no preponderance of medical evidence establishing a different level of impairment.[2] Second, based on the arbiter's uncontradicted

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[2] In fact, Dr. Cronin's opinion regarding the contribution of claimant's noncompensable preexisting degeneration is uncontradicted.

opinion, we find that only 50 percent of claimant's diminished cervical range of motion results from his compensable condition. Consequently, claimant's cervical impairment is properly rated based on 50 percent of the medical arbiter's measurements and we reinstate the Order on Reconsideration to that effect. *See Javier Urzua*, 53 Van Natta 648 (2001) (impairment not rated where attending physician and medical arbiter found it nonexistent or inconsistent with work injury).

ORDER

The ALJ's order dated June 29, 2001 is reversed. The Order on Reconsideration's award of 25 percent (80 degrees) unscheduled permanent disability is affirmed. The ALJ's "out-of-compensation" attorney fee award is reversed.

November 8, 2001 Cite as 53 Van Natta 1489 (2001)

In the Matter of the Compensation of
RICHARD L. MINARD, Claimant
WCB Case No. 00-06656
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
David L. Jorling, 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) Menashe's order that upheld the self-insured employer'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. *See Yung Thompson*, 50 Van Natta 2401 (1998) (although doctor supporting claim weighed the claimant's susceptibility, he did not explain why work contributed more to the claimant's condition); *see also Cresencia Green*, 50 Van Natta 47 (1998) (where persuasive medical evidence indicated that the claimant's anatomy amounted to a predisposition that contributed to her condition, it was a "preexisting condition" under ORS 656.005(24)).

ORDER

The ALJ's order dated June 18, 2001 is affirmed.

In the Matter of the Compensation of
NORVIN R. ZACARIAS, Claimant
WCB Case No. 00-01248
ORDER ON RECONSIDERATION
Willner, Wren, et al., Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

On October 10, 2001, we abated our September 10, 2001 order that adopted and affirmed the Administrative Law Judge's order upholding the SAIF Corporation's denial of claimant's occupational disease claim for a right indirect inguinal hernia condition. We took this action to consider claimant's motion for reconsideration. Having received SAIF's response, we proceed with our reconsideration.

The ALJ upheld SAIF's denial of claimant's hernia claim, finding that this was an occupational disease claim involving a preexisting congenital defect (and, quite likely, a preexisting hernia) that "combined" with claimant's work activities. The ALJ then reasoned that, under those circumstances, claimant had to prove that his work activities were the major contributing cause of the "combined condition" and of a pathological worsening of the preexisting disease. *See* ORS 656.802(2)(b). The ALJ then focused on claimant's argument that only an examining physician, Dr. Heinonen, properly analyzed the claim as one for an occupational disease and that his deposition testimony supported compensability.

The ALJ rejected claimant's argument, finding that, even if all other medical evidence was disregarded, Dr. Heinonen's opinion was not sufficient to satisfy claimant's burden of proof. In so doing, the ALJ stated that: "Ultimately, Dr. Heinonen cannot state for sure when the hernia developed, but as I view his opinion, he feels it is more likely than not that it preexisted claimant's employment." (O&O p. 5).

Claimant contends that the ALJ's finding that claimant had a preexisting hernia was not supported by Dr. Heinonen's testimony.[1] Thus, claimant asserts that he does not have to prove compensability of his occupational disease claim under the more stringent requirements of ORS 656.802(2)(b).

Having reviewed this record once more, we conclude that the ALJ correctly determined that claimant's hernia probably preexisted his employment. Dr. Heinonen testified that claimant's hernia had been there "a long time." (Ex. 12-18). At another point, Dr. Heinonen stated:

> "I mean I'm not trying to be argumentative, but I mean he could have had this for ten years. I mean here's a man who has had a huge inguinal hernia for probably a long period of time and he doesn't go to a doctor. He could have had a small hernia for ten years * * *." (Ex. 12-13).

Viewing Dr. Heinonen's testimony as a whole, we agree with the ALJ's finding that claimant's hernia probably preexisted his employment. Regardless, however, of whether that is, in fact, true, the medical evidence, not only from Dr. Heinonen, but from other physicians as well, support the ALJ's finding that claimant had a preexisting congenital defect. (Exs. 9-1, 9-2, 12-10, 12-15, 12-22, 12A-2, 13-2). Moreover, the medical evidence establishes that this preexisting condition combined with claimant's work activities to produce the inguinal hernia. (Exs. 9-1, 11-3, 12-15). Thus, the ALJ correctly concluded that there was a "combined condition," even assuming that the inguinal hernia did not preexist claimant's employment. Under such circumstances, we find that the ALJ properly applied the

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[1] Noting that claimant had not submitted an appellant's brief on review, SAIF moves to strike claimant's request for reconsideration on the grounds that the reconsideration request amounts to an appellant's brief in "disguise" that should not be considered by the Board. We deny SAIF's motion. A party is allowed to request reconsideration of a Board order. Accordingly, we have considered claimant's arguments regarding the alleged defects in our order that adopted and affirmed the ALJ's order. *See Dan A. Sturtevant*, 49 Van Natta 1482 (1997).

compensability standards of ORS 656.802(2)(b). When those standards are applied, we are not persuaded that claimant established a compensable occupational disease claim because Dr. Heinonen did not opine that work activity was the major contributing cause of the "combined condition" or of a pathological worsening of the preexisting disease. (Ex. 12-16, 17).

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 10, 2001 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

November 9, 2001 Cite as 53 Van Natta 1491 (2001)

In the Matter of the Compensation of
JEFFERY D. WETMORE, Claimant
WCB Case No. 00-05901
ORDER ON REVIEW
James W. Moller, Claimant Attorney
Wallace, Klor & Mann, Defense Attorney
G. Joseph Gorciak III, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's aggravation claim for a low back condition; and (2) set aside its denial of claimant's injury claim for bulging discs at L4-5 and L5-S1. In his brief, claimant argues that the ALJ should not have considered Exhibit 33 as *prima facie* evidence. On review, the issues are evidence, aggravation and compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the last paragraph beginning on page 1 and continuing on page 2, we replace the fourth sentence with the following:

> "Claimant was found to be medically stationary on August 6, 1999 and he was released to regular work. (Ex. 6). His treating physician at the time found no permanent impairment. (*Id.*)"

After the second full paragraph on page 2, we add the following paragraph:

> "In July 2000, Drs. Schilperoort and Williams examined laimant on behalf of the insurer. (Ex. 33). They found that claimant's lumbar strain had resolved. (Ex. 33-6, -7). Their only explanation for claimant's continued pain was that his preexisting degenerative changes were symptomatic. (Ex. 33-6)."

In the last sentence beginning on page 2, we change the sentence to refer to "Drs. Schilperoort and Williams."

Evidence

Relying on OAR 438-007-0005(3), claimant argues that the ALJ should not have considered Exhibit 33, a report from Drs. Schilperoort and Williams, as *prima facie* evidence of the opinions contained therein.

ORS 656.283(7) provides that an 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 evidence. *See, e.g, Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the 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).

OAR 438-007-0005(3) provides, in part:

> "Medical, surgical, hospital and vocational reports offered by the insurer or self-insured employer will also be accepted as *prima facie* evidence provided the insurer or self-insured employer agrees to produce the medical and vocational expert(s) for cross-examination upon request of the claimant. The reports of any medical or vocational expert who has refused to make herself or himself available for cross-examination shall be excluded from the record unless good cause is shown why such evidence should be received."

Claimant argues that the insurer failed to make Drs. Schilperoort and Williams available for cross-examination and, therefore, their report should not be accepted as *prima facie* evidence. In response, the insurer contends that claimant's attorney did not continue his request for a deposition and claimant's argument regarding Exhibit 33 is therefore moot.

The record does not support a conclusion that either Dr. Schilperoort or Dr. Williams "refused" to make himself available for cross-examination. On November 7, 2000, claimant's attorney requested depositions of Drs. Schilperoort and Williams. (Ex. 36A). At hearing, claimant's attorney asserted that, because the insurer had not made those physicians available for cross-examination, Exhibit 33 should not be admitted. (Tr. 1). The insurer's attorney did not object to claimant's request for depositions. (Tr. 2). She explained that the parties had been discussing other matters and she did not understand that the depositions were critical. (*Id.*) The insurer's attorney said that the practicality of scheduling such depositions was usually subject to more serious discussions and she had not been specifically requested by claimant's attorney to make the arrangements. (Tr. 3). Claimant's attorney agreed generally with the custom and practice indicated by the insurer's attorney. (*Id.*) The ALJ received Exhibit 33 into evidence subject to claimant's right to cross-examine the physicians. (Tr. 3, 4). On February 9, 2001, claimant's attorney withdrew the request to depose Drs. Schilperoort and Williams. Because there was no refusal by Drs. Schilperoort or Williams to submit to cross-examination and claimant withdrew his request for cross-examination, we find no abuse of discretion by the ALJ in considering Exhibit 33.

Attorney Fee

Claimant's attorney is entitled to an assessed fee for services on review regarding aggravation and compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,300, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's uncontested request), the complexity of the issue, and the value of the interest involved.[1]

ORDER

The ALJ's order dated June 6, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,300, payable by the insurer.

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[1] Claimant's attorney requested a $1,500 attorney fee for services on review, asserting that he spent 10 hours preparing the brief. Because a portion of those services were devoted to the unsuccessful evidentiary issue, we have reduced the attorney fee to $1,300.

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UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 1493-1552 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH NOVEMBER 30, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, OCTOBER-DECEMBER 2001.

In the Matter of the Compensation of
DEANNA L. WHETSTINE, Claimant
WCB Case No. 00-02871
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Cummins, Goodman, et al., Defense Attorney

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

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's injury claim for a stress fracture and consequential complex regional pain syndrome/reflex sympathetic dystrophy. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the first paragraph of the findings of fact on page 2, we replace the second and third sentences with the following:

> "On June 11, 1999, claimant sought treatment from Ms. Pylkki, physician's assistant, who found a moderate amount of ecchymosis and swelling about the anterior portion of the lower leg. (Ex. 1). She explained that the x-rays were negative for any fractures and diagnosed a severe contusion of the right lower leg. (*Id.*)"

In the second paragraph on page 2, we change the last sentence to read: "On July 12, 1999, Dr. Peterson reported that claimant may have a neuroma of the saphenous nerve or possible RSD; it was also possible that claimant had some internal derangement of the knee. (Ex. 18)."

In the the first paragraph on page 3, we change the first sentence to read: "Drs. Woodward and Williams examined claimant on September 28, 1999, on behalf of the employer. (Ex. 39)."

On page 6, we replace the first full paragraph with the following:

> "Dr. Williams and Farris concurred with the reports from Drs. Ochoa, Glass and Young. (Exs. 106, 111). Dr. Woodward reviewed the reports from Drs. Ochoa and Young and agreed with most of their conclusions. (Ex. 107)."

We do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant was injured on June 10, 1999, when dirt gave out beneath her right foot and her right shin fell on a 10 inch pipe. (Exs. 1, 4). The employer accepted a bone contusion of the right tibia. (Ex. 37). In September 1999, claimant's attorney asked the employer to amend its acceptance to include a stress fracture of the right tibia. (Ex. 38). Three months later, claimant's attorney asked the employer to amend the acceptance to include right lower extremity complex regional pain syndrome/reflex sympathetic dystrophy, incomplete fracture of the right proximal tibia, and saphenous nerve entrapment compression neuropathy. (Ex. 59).

In October 2000, the employer modified its acceptance to include a "disabling bone contusion, right tibia and a non-disabling saphenous nerve contusion condition combined with a preexisting mental condition." (Ex. 105). On November 6, 2000, the employer issued a partial denial on the ground that the major contributing cause of claimant's combined condition had become the non-work-related preexisting mental condition. (Ex. 108). In addition, the employer denied compensability of the stress fracture of the right tibia, right lower extremity complex regional pain syndrome/reflex sympathetic dystrophy, incomplete fracture of the right proximal tibia, and saphenous nerve entrapment compression neuropathy. (*Id.*) The employer stated that, to the extent those conditions existed, they were not sufficiently related to claimant's work activities or the June 10, 1999 incident to be compensable. (*Id.*) Claimant requested a hearing.

The ALJ relied on the opinion of Dr. James to find that claimant sustained a stress fracture as a direct result of the June 10, 1999 injury. The ALJ also relied on Dr. James' opinion to find that the compensable injury was the major contributing cause of claimant's complex regional pain syndrome/reflex sympathetic dystrophy. On the other hand, the ALJ found that the medical evidence was insufficient to establish compensability of saphenous nerve compression neuropathy. Finally, the ALJ concluded that the medical evidence failed to establish that claimant's compensable injury was the major contributing cause of the combined condition denied by the employer; *i.e.*, disabling bone contusion, right tibia and a non-disabling saphenous nerve contusion condition combined with a preexisting mental condition. (*See* exs. 105, 108).

Stress Fracture

The employer contends that the ALJ erred in relying on the opinion of Dr. James to determine that claimant sustained a stress fracture as a result of the June 1999 injury. The employer argues that Dr. James does not have expertise in diagnostic radiology and the contrary medical opinions, particularly that of Dr. Young, are much more persuasive.

Claimant relies on Dr. James' interpretation of the x-rays and the July 1999 bone scan to establish that she had a stress fracture. She acknowledges that Dr. James is not a radiologist, but she asserts that his readings of an incomplete fracture were never flatly contradicted. For the following reasons, we are not persuaded by Dr. James' opinion that claimant sustained a stress fracture in her right leg as a result of the June 10, 1999 injury.

Claimant initially sought treatment on the day after the injury from Ms. Pylkki, physician's assistant, who found a moderate amount of ecchymosis and swelling about the anterior portion of the lower leg. (Ex. 1). She explained that the x-rays were negative for any fractures and diagnosed a severe contusion of the right lower leg. (*Id.*) Five days later, claimant was examined by Dr. Korpa, who found that the x-rays were negative and diagnosed a hematoma. (Ex. 5).

Claimant was referred to Dr. James, orthopedist, in July 1999. He reviewed her previous x-rays and found no obvious fractures. (Ex. 13). He took new x-rays, however, and thought claimant had an incomplete fracture of the proximal tibial cortex. (*Id.*) He diagnosed "incomplete fracture of her proximal right tibia, nondisplaced." (*Id.*)

On July 11, 1999, claimant sought treatment in the emergency department because of pain. Dr. Minser reported that x-rays showed no obvious fracture. (Ex. 16). Dr. Lewis interpreted an x-ray of claimant's right lower leg as follows:

> "No bony articular or soft tissue abnormalities are definitively seen. Despite the history of possible prior fracture, a definite displaced fracture is not appreciable. Toward the fibular head, one could query incomplete and minimal lucency along the lateral cortical aspect. The ankle joint is not optimally centered on the film, but again a definitive displaced fracture is not identified." (Ex. 17).

An MRI of claimant's right knee showed some degenerative changes. (Ex. 21).

On July 23, 1999, Dr. James recommended a bone scan, explaining:

> "If the bone scan is positive, then I think we are going to have to continue to treat that as a stress fracture. If the bone scan is negative, then we are going to have to look at this as possibly a soft tissue problem, though I find no evidence of neuroma along the saphenous nerve or the infrapatellar branch of the saphenous nerve today. She does complain of some numbness over the area of swelling which could just be due to the contusion in the proximal leg which is below the level of the infrapatellar branch of the saphenous nerve. At this point, I really do not think she is RSD since her symptoms really have been present almost since the time of her injury." (Ex. 23-2).

A July 28, 1999 bone scan was interpreted by Dr. Fennell as showing "[v]ery minimal increased flow and blood pool activity to the right proximal tibia region." (Ex. 24). He said this may be related to hyperemia from a soft tissue abnormality, but there was no scintigraphic evidence for underlying bone pathology. (*Id.*) Dr. Fennell explained that the delayed images of the bones revealed very minimal focal increased activity in the proximal tibias bilaterally, but that appearance was *not* typical for a stress fracture. (*Id.*)

Despite Dr. Fennell's interpretation, Dr. James reviewed the bone scan and found that it showed "uptake along the medial tibial metaphyseal area proximally compatible with either a severe contusion of the periosteum or more than likely she does have an incomplete fracture of the proximal tibia metaphyseal area." (Ex. 25). He did not explain why he felt claimant had a fracture, rather than a severe contusion.

Dr. James placed claimant's right leg in an immobilization cast from August 18, 1999 to September 29, 1999. (Exs. 33, 109). In late September 1999, Dr. James said that x-rays showed that claimant's fracture had healed, but she was still tender over the infrapatellar branch of the saphenous nerve. (Ex. 40). He diagnosed saphenous nerve entrapment compression neuropathy. (*Id.*) In December 1999, Dr. James diagnosed reflex sympathetic dystrophy. (Ex. 54). In early January 2000, Dr. James explained that claimant's bone scan was "not negative though could be considered equivocal." (Ex. 64).

Dr. James' finding that claimant had a fracture of the proximal right tibia was inconsistent with the initial reports from Ms. Pylkki, physician's assistant, Dr. Korpa, Dr. Minser, as well as Dr. Lewis, who provided a radiology report stating that a displaced fracture was not appreciable. (Exs. 1, 5, 16, 17).

Furthermore, Dr. James' interpretation of claimant's July 1999 bone scan is inconsistent with Dr. Fennell's interpretation, as well as that of Dr. Young, radiologist, who reviewed claimant's records on behalf of the employer. Dr. Young reviewed the July 1999 bone scan and said there was a minimal increase in blood flow and blood pool activity in the right knee, which probably represented increased blood flow to an area of soft tissue injury or other hyperemic soft tissue. (Ex. 103-2). He explained that the "tracer uptake is normal in the bones strongly suggesting that there are no destructive bony lesions or stress fractures." (*Id.*) Dr. Young said the mild tracer uptake may be seen in cases of soft tissue hyperemia or contusion. (Ex. 103-3). He also reviewed the July 1999 right knee MRI and found no bone contusion or evidence of stress fractures. (Ex. 103-2). Dr. Young concluded that the July 1999 bone scan and right knee MRI excluded the diagnosis of stress fracture and bone contusion. (Ex. 103-4).

Claimant had another bone scan of the right lower extremity on May 4, 2000. (Ex. 82). Dr. Jackson, radiologist, interpreted the results:

> "*Findings have changed since the prior study of July. At that time no evidence was seen of a fracture or healing fracture but the uptake was almost completely normal.* Now the patient shows, on the delayed images, diffusely increased activity in the visualized portion of the lower extremity though not in the pelvis, and slightly increased static uptake on the flow study. This picture could represent a reflex sympathetic dystrophy appearance." (Ex. 82; emphasis supplied).

Dr. Young reviewed claimant's May 2000 bone scan and found that blood pool and delayed images showed moderate increase and diffuse and patchy uptake involving the distal femur and proximal tibia, and that non-focality was inconsistent with the diagnosis of a stress fracture. (Ex. 103-2). He explained that this unilateral uptake surrounding a joint was frequently seen in cases of disuse or atypical osteoporosis. (*Id.*) Dr. Young said this was not the appearance of a healed or healing stress fracture. (Ex. 103-4). Furthermore, he found that the June 2000 right knee MRI showed findings of marrow edema, which was frequently seen in cases of disuse osteoporosis or atypical osteoporosis. (*Id.*)

Dr. Young's opinion that claimant did not have a stress fracture resulting from the June 10, 1999 injury is supported by the opinions of Drs. Williams and Woodward (Exs. 39-6, 57-2, 106, 107), Dr. Farris (Ex.111), and Drs. Ochoa and Bell. (Ex. 94-17, -18, -40). Drs. Ochoa and Bell explained that the increased uptake in the July 1999 bone scan was compatible with hyperemia related to soft tissue abnormality, which was known to be present in claimant. (Ex. 94-18). They said the May 2000 bone scan findings were non-specific and could be explained on the basis of disuse. (Ex. 94-40).

Dr. James is the only physician who diagnosed a stress fracture. Although Drs. Grant, Goodwin and O'Sullivan relied on Dr. James' opinion regarding the stress fracture, there is no evidence that they personally reviewed the x-rays or bone scans and independently diagnosed a stress fracture. (Exs. 51, 67, 85, 91). In addition, there is no evidence that they reviewed the contrary medical reports from Drs. Young, Williams, Woodward, Ochoa and Bell. Under these circumstances, the opinions of Drs. Grant, Goodwin and O'Sullivan regarding claimant's stress fracture are entitled to little weight.

When the medical evidence is divided, we give more weight to those medical opinions that are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). We may give greater weight to the opinion of the treating physician, depending on the record in each case. *See Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001). Here, however, we find that the causation dispute involves expert analysis rather than expert external observations. Under those circumstances, Dr. James' status of treating physician confers no special deference. *See Allie v. SAIF*, 79 Or App 284 (1986); *Hammons v. Perini Corp.*, 43 Or App 299 (1979).

We conclude that the opinion of Dr. Young, as supported by Drs. Korpa, Minser, Lewis, Fennell, Jackson, Williams, Woodward, Farris, Ochoa and Bell, is well-reasoned and establishes that claimant did not sustain a stress fracture as a result of the June 10, 1999 work injury. In contrast, Dr. James' opinion is conclusory and lacks adequate explanation, particularly since his findings are inconsistent with the radiologists (Drs. Lewis, Fennell, Jackson and Young) who reviewed claimant's x-rays and bone scans. Dr. James acknowledged that the July 1999 bone scan was "equivocal." (Ex. 64). We conclude that the medical evidence is insufficient to establish compensability of a stress fracture of claimant's right leg. We therefore reverse that portion of the ALJ's order.

Regional pain syndrome/Reflex sympathetic dystrophy

The ALJ found that claimant sustained a right lower extremity complex regional pain syndrome/reflex sympathetic dystrophy (CRPS/RSD), and the major contributing cause of that condition was her compensable injury.

The employer argues that the medical evidence is insufficient to establish that claimant has CRPS/RSD or that the work injury was the major contributing cause of that condition. We agree with the employer that claimant's CRPS/RSD is properly analyzed as a consequential condition. Under ORS 656.005(7)(a)(A), a consequential condition is a separate condition that arises from the compensable injury. *Fred Meyer, Inc. v. Evans*, 171 Or App 569, 573 (2000). In order to establish her CRPS/RSD condition as a consequential condition of the compensable injury, claimant must prove that the compensable injury is the major contributing cause of that condition.

Claimant relies on the opinions of Drs. James, Grant and Goodwin to establish compensability of her CRPS/RSD condition. On July 23, 1999, Dr. James did not believe claimant had RSD "since her symptoms really have been present almost since the time of her injury." (Ex. 23-2). Dr. James initially diagnosed an incomplete fracture of the proximal right tibia, but later diagnosed saphenous nerve entrapment compression neuropathy in late September 1999. (Exs. 13, 40). Dr. James first diagnosed RSD and CRPS on December 15, 1999, after reviewing a report from Dr. Grant. (Ex. 54).

In a later concurrence letter from claimant's attorney, Dr. James agreed that claimant's June 10, 1999 injury had caused a right leg stress fracture and saphenous nerve contusion and she developed CRPS/RSD as a consequence of those conditions. (Ex. 102). He agreed that the original injury to the saphenous nerve and stress fracture was the major cause of the consequential CRPS/RSD. (*Id.*)

The primary problem for claimant in proving compensability of the CRPS/RSD condition is that the medical opinions she relies on, from Drs. James, Grant and Dr. Goodwin, are based on an understanding that claimant sustained a stress fracture as a result of the June 1999 injury.

In diagnosing right lower extremity CRPS/RSD on December 3, 1999, Dr. Grant relied on Dr. James' diagnosis of a stress fracture. (Ex. 51). He explained that, based on his electrodiagnostic evaluation, he could delineate no specific neurophysiologic abnormalities to correlate with claimant's symptoms. (Ex. 51-3). Nevertheless, he relied on claimant's symptoms to diagnose CRPS/RSD. (*Id.*)

Dr. Goodwin also diagnosed CRPS/RSD. (Ex. 67). In reaching his conclusion, he relied on a history that claimant had a stress fracture as a result of the June 1999 work injury. (Exs. 67-1, -5, 91-1). He explained that the diagnosis of CRPS was "very commonly associated with stress fractures." (Ex. 67-5).

As discussed earlier, we have determined that the medical evidence is insufficient to establish that claimant had a stress fracture resulting from the June 10, 1999 work injury. Under these

circumstances, the medical opinions relying on the fact that claimant had a stress fracture to diagnose CRPS/RSD are not persuasive. We conclude that the opinions of Drs. James, Grant and Dr. Goodwin, who diagnosed CRPS/RSD, are not persuasive because they are based on inaccurate understanding of claimant's June 10, 1999 injury. In addition, there are several medical opinions disputing the diagnosis of CRPS/RSD from Drs. Ochoa, Williams, Woodward, Glass and Farris. (Exs. 57, 94, 95, 106, 107, 111). We conclude that the medical evidence is insufficient to establish compensability of CRPS/RSD.

ORDER

The ALJ's order dated May 21, 2001 is reversed in part and affirmed in part. The employer's denials of claimant's stress fracture and complex regional pain syndrome/reflex sympathetic dystrophy are reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
ANITA M. BRITTAIN, Claimant
WCB Case No. C012496
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, Moore, et al., Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

On October 19, 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 her compensable injury. We approve the proposed disposition.

The proposed agreement provides for total proceeds of $23,950. Absent extraordinary circumstances, attorney fees in claim disposition agreements are limited to 25 percent of the first $17,500, plus 10 percent of any amount in excess of $17,500. OAR 438-015-0052(1). Thus, in accordance with OAR 438-015-0052(1), and absent extraordinary circumstances, claimant's attorney fee cannot exceed $5,020. The proposed agreement, however, provided for an attorney fee of $5,025, and did not provide any extraordinary circumstances justifying the excessive fee. On October 24, 2001, we asked the parties to either reduce the extraordinary attorney fee or provide the extraordinary circumstances justifying the fee. On November 1, 2001, we received the parties' addendum correcting the attorney fee to $5,020.[1]

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $5,020, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

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[1] We offer no comment regarding claimant's counsel's references to a resignation agreement or any issues arising therefrom, other than to emphasize that our approval pertains solely to the parties' CDA and does not extend to any other agreement (proposed or otherwise) involving the parties. *See, e.g., Karen A. Vearrier,* 42 Van Natta 2071 (1990) (disapproving a CDA that purported to release the claimant's rights to reemployment).

In the Matter of the Compensation of
JIM E. HUNT, Claimant
WCB Case Nos. 01-00536 & 99-07272
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

The self-insured employer requests reconsideration of our October 23, 2001 order that affirmed the Administrative Law Judge's (ALJ) order that increased claimant's unscheduled permanent disability award from 19 percent (60.8 degrees), as awarded by an Order on Reconsideration, to 35 percent (112 degrees).

In affirming the ALJ's order, we declined to consider the employer's "claim preclusion" argument because the issue was not raised at hearing. On reconsideration, the employer contends that it raised its "claim preclusion" argument in closing arguments to the ALJ and that we should therefore consider the issue. The employer cites to certain passages of the recorded closing arguments. However, we have previously held that we will not consider an issue raised for the first time during closing argument. *See Phillip L. Shores*, 49 Van Natta 341 (1997); *Edward A. Rankin*, 41 Van Natta 1926 (1989), *on recon* 41 Van Natta 2133 (1989).

In any event, the Supreme Court, in *Drews v. EBI*, 310 Or 134 (1990), recognized that a valid statute or rule could provide an exception to claim preclusion. "A final determination is not conclusive, when, by provision of a statute or valid rule of the body making the final determination, that determination does not bar another action or proceeding on the same transactional claim." 310 Or at 141 (citing Restatement (Second) of Judgments sec. 20(1)(c)(1982)). *See Evangelical Lutheran Good Samaritan Society v. Bonham*, 176 Or App 490 (2001).

Here, the ALJ increased claimant's unscheduled permanent disability award based on an adjustment in claimant's social and vocational "factors" (Specific Vocational Preparation (SVP) and Base Functional Capacity (BFC)). The ALJ adjusted claimant's BFC from "medium" to "heavy" and his SVP from 7 to 3. The employer contends that, because claimant did not specifically challenge the SVP and BFC values after his claim was first closed[1], he is now barred by principles of claim preclusion from challenging those factors after closure of his aggravation claim. We disagree.

ORS 656.273(1) provides that "[a]fter the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury."

OAR 436-035-0007(9)(c) provides:

> "If a claim has multiple compensable conditions which are either newly accepted since the last arrangement of compensation and/or which have actually worsened, the extent of permanent disability *shall* be redetermined." (Emphasis added).

By statute and rule, then, claimant is entitled to have the extent of his permanent disability (including social and vocational "factors") redetermined after an "actual worsening" of his condition; *i.e.*, a compensable aggravation claim. His request for hearing from the December 18, 2000 Order on Reconsideration (after closure of his aggravation claim) is therefore not barred by principles of claim preclusion.

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[1] On October 8, 1997, a prior ALJ approved a stipulated settlement increasing claimant's unscheduled permanent disability to 11 percent. (Ex. 13). Through that stipulation, claimant agreed that his request for hearing from the July 7, 1997 Order on Reconsideration in relation to the initial closure (including all issues "raised or raisable" regarding the claim closure) could be dismissed. (*Id.*) The July 7, 1997 Order on Reconsideration found that claimant was entitled to a SVP value of 7 and a BFC of "medium/light." (Ex. 10-2).

Accordingly, we withdraw our October 23, 2001 order. As supplemented herein, we adhere to and republish our October 23, 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
ROBERT E. KOBS, Claimant
WCB Case No. 00-07562
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Atwood & Associates, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that: (1) affirmed an Order on Reconsideration that awarded 1 percent (1.5 degrees) scheduled permanent disability for loss of use or function of claimant's right forearm (wrist); and (2) denied claimant's request for remand for a second medical arbiter's examination. On review, the issues are remand and extent of scheduled permanent disability.[1]

FINDINGS OF FACT

Claimant worked for the employer as its Public Works Supervisor. He filed a claim for right carpal tunnel syndrome, which the employer accepted.

Dr. Collada performed a right carpal tunnel release on May 17, 1999. A May 26, 2000 Notice of Closure ultimately closed the claim with no permanent disability award. Claimant requested reconsideration and a medical arbiter was appointed.

The medical arbiter found "5/5" strength in claimant's right wrist flexors and extensors and "very mild" decreased right wrist range of motion (palmar flexion). The arbiter described his findings as valid.

A September 11, 2000 Order on Reconsideration awarded 1 percent scheduled permanent disability for claimant's decreased right wrist range of motion. Claimant requested a hearing regarding the reconsideration order. On October 23, 2000, the medical arbiter responded to an inquiry from the Appellate Review Unit and explained how he measured claimant's grip strength and range of motion.

CONCLUSIONS OF LAW AND OPINION

Remand

We adopt and affirm the ALJ's opinion on this issue, with the following supplementation.[2]

Claimant requests remand to the Director for adoption of a temporary rule to address his disability, specifically reduced right forearm strength and range of motion. Alternatively, claimant requests remand for a second medical arbiter's examination.[3] Claimant's requests are denied, for the following reasons.

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[1] Claimant also argues that the ALJ erred in refusing to admit proposed Exhibit R41A, a letter written by claimant to the Workers' Compensation Division. We do not address the propriety of the ALJ's evidentiary ruling, because the result would be the same if the document was admitted.

[2] However, we rely on *Corrine L. Birrer*, 53 Van Natta 678 (2001), rather than *Corrine L. Birrer*, 51 Van Natta 163 (1999), because the court reversed the 1999 decision on the same day that the ALJ's order issued in this case. *See Birrer v. Principal Financial Group*, 172 Or App 654 (2001).

[3] Alternatively, claimant contends that his claim was prematurely closed. We do not address this argument because the issue was not raised on reconsideration or before the ALJ.

First, the Director specifically found that claimant's disability was addressed by the standards. (Ex. R41-2). Second, the standards do address the disability in question--strength and range of motion. (*See id.*) Therefore, remand for adoption of a temporary rule or rules is not authorized under ORS 656.726(3)(f)(C). *See Barbara F. Cooper*, 52 Van Natta 2241 (2000).

Claimant's request for remand for a second arbiter's examination is also denied, because we lack authority to remand on this basis. *See Melody R. Ward*, 52 Van Natta 241 (2000) (no statutory authority for remand to the Director for clarifying report from a medical arbiter who allegedly mistakenly reported claimant's loss of strength). Moreover, a remedy such as remanding to the ALJ (to await an additional arbiter's report) is inappropriate here because neither the arbiter nor the Director indicates that the existing arbiter's report is incomplete. *Compare, Corrine L. Birrer*, 53 Van Natta at 682 (2001) (remand appropriate where arbiter acknowledged that his previous report was incomplete for purpose of rating the claimant's condition).

Extent of Scheduled Permanent Disability

We adopt the ALJ's opinion on this issue, with the following supplementation.

We agree with the ALJ that the medical arbiter's right wrist range of motion measurements were valid and that the preponderance of medical evidence does not establish a different level of impairment. Accordingly, we also agree that the reconsideration order properly rated claimant's range of motion based on those measurements.[4]

We also agree with the ALJ that the medical arbiter properly measured claimant's strength under the standards and no preponderance of the medical evidence establishes a different level of impairment. *See Jose I. Rios*, 52 Van Natta 1552 (2000). Consequently, claimant is not entitled to an impairment rating for lost strength. Under these circumstances, we agree with the ALJ that the Order on Reconsideration correctly determined claimant's permanent disability. *See Gene L. Grenz*, 53 Van Natta 268, 270 fn 1 (2001) (not all impairment results in impairment value under "standards").

ORDER

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

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[4] Claimant argues that the medical arbiter's measurements are invalid because the results varied more than allowed under the Workers' Compensation Division Bulletin No. 239 (July 15, 1998). Therefore, claimant contends that the arbiter's measurements should not be the basis for his impairment rating. The employer responds that the cited bulletin applies only to spinal range of motion measurements. We agree. Moreover, even though some of the arbiter's range of motion measurements did not accurately represent claimant's impairment (as the arbiter explained), we are persuaded that the reconsideration order relied on valid measurements because the arbiter explained why those measurements better represented claimant's impairment. (Ex. R43-1-2; Ex. R40-4); *see, e.g., Gerardo Zuniga*, 53 Van Natta 1039 (2001) (where validity criterion not met, but physician determines the findings are valid, findings not used to rate permanent disability unless physician provides a "written rationale, based on sound medical principles, explaining why the findings are valid.").

In the Matter of the Compensation of
RICHARD D. CARROLL, Claimant
WCB Case Nos. 00-09212 & 00-04718
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Cavanagh & Zipse, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

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

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

The ALJ set aside the insurer's denial based on the opinion of Dr. Karasek. On review, the insurer contends that Dr. Karasek's opinion is not persuasive because it does not properly consider claimant's history of symptoms and relies on a "temporal" analysis. We disagree.

The parties agree that this is a "combined condition" case subject to the major contributing cause standard. ORS 656.005(7)(a)(B). Claimant must prove that his compensable work injury is the major contributing cause of his disability or need for treatment for his combined L5-S1 disc disruption condition. *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997). Where the medical evidence is divided, we rely on those medical opinions that are well reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

Here, we agree with the ALJ that Dr. Karasek represents the most persuasive opinion in the record. Dr. Karasek, a consulting neurologist, concluded that claimant's compensable April 20, 1998 injury was the major cause for claimant's need for treatment for his internal disc disruption at L5-S1. (Ex. 116). In reaching his opinion, Dr. Karasek recognized and evaluated the contribution of claimant's preexisting low back "degradation" changes. (*Id.*)

We find particularly persuasive that, as the ALJ observed, Dr. Karasek is the only physician to have evaluated claimant's condition in light of discogram and post-discogram CT scan studies. (Ex. 119). For that reason, we find that Dr. Karasek's opinion rests on the most complete information. *Somers v. SAIF*, 77 Or App at 263. Dr. Karasek also persuasively rebutted Dr. Schilperoort's opinion that disc disruptions could not be traumatic in nature and referenced several pieces of medical literature in support of his position. (Ex. 119).

Contrary to the insurer's contention, Dr. Karasek's opinion does not rely solely on a temporal or "precipitating cause" analysis. *See Dietz v. Ramuda*, 130 Or App 397, 400-402 (1994), *rev den* 302 Or 35 (1986) (the fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or need for treatment). As we explained above, Dr. Karasek also considered the effect of claimant's preexisting degradation changes. (Ex. 116). Based on a discogram and post-discogram imaging studies demonstrating a posterior tear in the L5-S1 disk, Dr. Karasek reasoned that claimant's April 1998 injury caused the internal disc disruption. (Ex. 119).

The insurer contends that Dr. Karasek's opinion that the 1998 injury caused the internal disc disruption is not consistent with claimant's history of primarily thoracic symptoms after the 1998 injury. However, in addition to thoracic pain, claimant also suffered from low back pain and symptoms into the buttocks and upper thigh after the April 1998 injury. (*See* Exs. 83, 94-97).

Finally, we agree with the ALJ that Dr. Schilperoort's opinion is unpersuasive because it relies on a "but for" analysis. *See Delvin W. Vandetta*, 53 Van Natta 217 (2001). Dr. Schilperoort, who examined claimant pursuant to ORS 656.325(1), reasoned that "[s]ince it appears as though degenerative disc disease is required for the identification of internal disc disruption, these findings would appear, therefore, in major part based on degenerative changes." (Ex. 117-1).

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

ORDER

The ALJ's order dated June 12, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

November 16, 2001 Cite as 53 Van Natta 1502 (2001)

In the Matter of the Compensation of
VERN L. HAHN, Claimant
WCB Case No. 99-10172
ORDER ON REVIEW
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Howell's order that upheld the insurer's denial of his injury claim for a mid back condition. On review, the issue is compensability.

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

In July or August of 1990, claimant felt a pop and crack in his spine while working. (Tr. 8;16). Claimant notified his supervisor of the incident, but did not miss any work time. (Tr. 9).

Claimant's first medical treatment after the 1990 work incident was in November 1994, when he was seen by Dr. Bassinger. (Ex. 1). Dr. Bassinger recorded a medical history of: (1) "pain mid-back 1 year;" and (2) motor vehicle accident in 1986 resulting in some injury to claimant's back and left arm, but not requiring treatment after 1986. (*Id.*) Dr. Bassinger diagnosed "chronic back pain, moderate osteoarthritis." (*Id.*).

Claimant's next medical treatment was from Dr. Hansen-Smith in January and February of 1996, following a slip and fall at work. (Ex. 4-1). The diagnosis was elbow effusion and thoracic strain. (*Id.*) Claimant next saw Dr. Hansen-Smith in January 1997 for complaints of chest pain. (Ex. 4-2). Claimant also reported a history of mid-back pain dating back to the 1990 work incident. (*Id.*)

Claimant next saw Dr. Hansen-Smith for his back pain in November 1998 and in February 1999. (Exs. 7 & 9). Thereafter, claimant filed a claim, alleging that the 1990 work incident had caused his mid-back condition. (Ex. 10).

The insurer denied the claim. (Ex. 11). Claimant requested a hearing.

The ALJ determined that resolution of the cause of claimant's mid-back condition was a complex medical problem. Finding no medical opinion in the record that causally related claimant's mid-back condition to the 1990 work incident, the ALJ concluded that claimant had failed to establish the compensability of his mid-back condition. Consequently, the ALJ upheld the insurer's denial.

To establish that his mid-back condition is compensable, claimant must prove that the 1990 work incident was a material contributing cause of the disability or need for treatment of the mid-back condition. *See* ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992). Because of possible alternative causes (1986 auto accident, 1990 work incident, osteoarthritis, and 1996 slip and fall) of claimant's mid-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); *Barnett v. SAIF*, 122 Or App 279 (1993).

The only medical opinion in this record regarding the cause of claimant's mid-back condition is from Dr. Woodward. (Ex. 13). Dr. Woodward was unable to attribute claimant's mid-back condition to the 1990 work incident. (Ex. 13-8). Consequently, based on this record, claimant's mid-back condition is not compensable.[1]

ORDER

The ALJ's order dated April 27, 2000 is affirmed.

[1] It appears that claimant is not clear as to what medical evidence he needs to present to establish a compensable claim. Inasmuch as claimant is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. He may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

WORKERS' COMPENSATION OMBUDSMAN
DEPT OF CONSUMER & BUSINESS SERVICES
350 WINTER ST NE
SALEM OR 97301
Telephone: 1-800-927-1271

In the Matter of the Compensation of
JACK RILEY, Claimant
WCB Case No. 00-09155
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) dismissed his request for hearing from the insurer's "non-cooperation" denial for failure to request an expedited hearing under ORS 656.291; (2) affirmed the Workers' Compensation Division's (WCD's) order suspending claimant's compensation; and (3) upheld the insurer's "*de facto*" denial of claimant's occupational disease claim for a binaural hearing loss condition. On review, the issues are dismissal, claim processing, and potentially, compensability.

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

On page five, paragraph three of the ALJ's order, we replace "The October 3, 2000 Order Denying Suspension of Compensation is upheld" with "The October 25, 2000 Order Suspending Compensation is affirmed."

Claimant filed a claim for a binaural hearing loss condition. After claimant did not appear for a scheduled examination under ORS 656.325(1), the insurer requested suspension of his compensation. On October 25, 2000, WCD issued an Order Suspending Compensation pursuant to ORS 656.262(15). (Ex. 9). On December 6, 2000, claimant requested a hearing, listing as issues "*de facto*" denial, "Director's order 10/15/00 [*sic*]," and attorney fees. (Ex. 10). The hearing request did not seek an expedited hearing nor was the box checked on the request form that pertained to an expedited hearing.

On December 8, 2000, the insurer issued a claim denial based on claimant's asserted non-cooperation with claim processing. (Ex. 11). On February 1, 2001, claimant requested a hearing from the December 8, 2000 denial, listing as issues "12/8/00 denial, compensability/complete claim denial," (as well as attorney fees) and noting that the request for hearing should be consolidated with the prior request for hearing. (Ex. 12).

The consolidated hearing was convened and the record closed on March 1, 2001. The ALJ dismissed claimant's request for hearing for failure to request an expedited hearing, upheld the insurer's *de facto* denial of claimant's claim for a hearing loss condition, and affirmed the WCD's order suspending claimant's compensation.

In *SAIF v. Dubose*, 166 Or App 642 (2000), *rev allowed* Or 692 (2001) the court held that the ALJ had no authority to set aside the carrier's "noncooperation" denial where the claimant failed to request an expedited hearing by indicating "worker noncooperation ORS 656.262(15)" as an issue on the request for hearing. The court reasoned that ORS 656.262(15) unambiguously requires an expedited hearing for challenging a denial based on the worker's noncooperation and places the burden on the worker to make a request for an expedited hearing. *Id.*

In *Lewis v. Cigna Ins. Co.*, 174 Or App 531 (2001), the carrier requested suspension of the claimant's benefits when the claimant failed to attend a scheduled examination under ORS 656.325(1) and refused to cooperate with a deposition. After the claimant did not comply with a WCD order suspending his compensation, the carrier issued a claim denial based on the claimant's alleged noncooperation. The claimant requested a hearing from the denial and the WCD's orders, but did not specifically designate "worker noncooperation ORS 656.262(15)" as an issue.[1] Therefore, the hearing was not scheduled on an expedited basis. *Id.* at 534, 535.

At hearing, the carrier moved to dismiss the claimant's request for hearing. The ALJ denied the carrier's motion and we affirmed. The court held that we erred in denying the carrier's motion to dismiss the claimant's request for hearing. *Id.* at 537. The court applied *Dubose* and reasoned that, in the absence of a request for an expedited hearing under ORS 656.262(15), the ALJ and the Board lacked authority to consider the claimant's challenge to the carrier's noncooperation denials. *Id.*

Here, claimant failed to request an expedited hearing from the insurer's "non-cooperation" denial, as required by ORS 656.262(15). In those circumstances, the ALJ properly dismissed claimant's hearing request. ORS 656.262(15), ORS 656.291(1); *Lewis*, 174 Or App at 537; *Dubose*, 166 Or App at 650.

On review, claimant contends that, although he did not check the box for "worker non-cooperation" on his Request for Hearing form (*see* Ex. 12), he nevertheless requested an Expedited Hearing at the close of the hearing. Although claimant raised this issue in his "Request to Abate and Reconsider" the ALJ's initial order, the hearing transcript does not include such a request. However, even assuming that claimant made such a request at hearing, we agree with the ALJ's reasoning that, at least in these circumstances, an initial "ordinary" request for hearing cannot later be "amended" at hearing and thereby transformed into an "expedited" hearing request.[2] Such a process would run contrary to the statute and the Board's rules, as well as the policy expressed in *Dubose*. *See* OAR 438-013-0010(1) (a request for hearing concerning a denial under ORS 656.262(15) *shall* be referred to the Expedited Claims Service); *Dubose*, 166 Or App at 642 (court focused on the obligation of the claimant to mark the appropriate "worker non-cooperation" box on the request for hearing form).

We also reject claimant's argument that the March 1, 2001 hearing was held within 30 days of his February 1, 2001 request for hearing from the insurer's December 8, 2000 "non-cooperation" denial (*see* Ex. 12), and was therefore properly deemed an "expedited" hearing request. *See* OAR 438-013-0025 (requiring that "expedited" hearings be set within 30 days of the request).

Initially, we note that the February 1, 2001 hearing request was a "supplemental" hearing request in which claimant merely requested that the additional issue of the December 8, 2000 denial ("compensability/complete claim denial") be consolidated with the already scheduled March 1, 2001 hearing. *See* Ex. 12; OAR 438-006-0065(2) ("any request for hearing pertaining to the same claim or claimant as that of a pending hearing request should also recite whether the hearing request should be consolidated with a pending hearing request or be separately scheduled for hearing."). Claimant did not request that the supplemental request for hearing be separately scheduled (for an "expedited" hearing).

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[1] The claimant did, however, check the box marked "Other" on the request for hearing, and referenced "ORS 656.262 (11, 14 & 15) *et al.*" 174 Or App at 534, 535 n1.

[2] OAR 438-006-0036 allows for the amendment of "issues" not previously raised up to the date of the hearing, not for a recharacterization of the request for hearing.

More importantly, the February 1, 2001 request for hearing failed to designate "Worker noncooperation ORS 656.262(15)" as an issue, as required by ORS 656.262(15) and *Dubose*. 166 Or App at 648. Therefore, although the hearing was held within 30 days of the February 1, 2001 supplemental request for hearing, the hearing was not held as an "expedited" hearing. OAR 438-013-0010 provides that a request for hearing shall be referred to the Expedited Hearing Service if, among other reasons, "the request involves a denial under ORS 656.262(15) for a worker's failure to cooperate in a claim investigation." OAR 438-013-0010(1)(c). The focus of the rule is on the issues selected in the request for hearing. Checking the box for worker noncooperation triggers the case to be assigned to the Expedited Hearing Service. Such a request at hearing or "post hearing" is thus insufficient to designate the hearing as an "expedited" hearing.

For all of these reasons, claimant's request for hearing was properly dismissed. Accordingly, we do not reach the validity of the insurer's "non-cooperation" denial or WCD's Order Suspending Compensation.[3]

Finally, we agree with the ALJ that, having not first requested an expedited hearing under ORS 656.262(15) and ORS 656.291(1), claimant was precluded from proceeding on the merits of the compensability issue. *See* ORS 656.262(15).

ORDER

The ALJ's order dated March 27, 2001, as reconsidered on May 9, 2001, is affirmed.

[3] In light of our disposition of the issues on this basis, we need not address claimant's Constitutional arguments based on the Privileges and Immunities clauses of the Oregon and United States Constitutions. Claimant's arguments on this issue focus on the Constitutional validity of the insurer's "non-cooperation" denial as applied to an "out-of-state" claimant. However, as we explained above, because claimant failed to request an expedited hearing, we are not authorized to address the validity of the denial.

November 16, 2001 Cite as 53 Van Natta 1505 (2001)

In the Matter of the Compensation of
ROBERT RICE, Claimant
Own Motion No. 01-0277M
OWN MOTION ORDER OF ABATEMENT
Bischoff, Strooband, et al., Claimant Attorney
Kemper Insurance Co., Insurance Carrier

Reviewing Panel: Members Biehl and Haynes.

Claimant requests reconsideration of our October 24, 2001 Own Motion Order in which authorized the reopening of his claim to provide temporary disability compensation beginning the date claimant is hospitalized for surgery. Specifically, claimant seeks an assessed attorney fee pursuant to ORS 656.382(1).

In order to allow sufficient time to consider the motion, we abate our order. The insurer 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
TERRY R. MYERS, Claimant
WCB Case Nos. 00-07268, 00-07267 & 00-01987
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Liberty Northwest Insurance Corporation requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its responsibility denial of claimant's current low back condition; and (2) upheld the SAIF Corporation's responsibility denial of the same condition.[1] On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the second full paragraph on page 2, we change the first sentence to read: "In April 1995, Dr. Brandenburg reported that claimant's low back pain was slowly improving and he had intermittent radiation to his leg. (Ex. 26)." In the last sentence of the same paragraph, we change the citations to "(Exs. 32A, 34, 35A)." We do not adopt the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The issue in this case is responsibility for claimant's current low back condition. Claimant has three accepted low back injury claims. SAIF accepted two low back injuries in 1984. On January 9, 1984, claimant injured his back while working for SAIF's insured. (Ex. 1). SAIF accepted the claim, but did not refer to a specific condition. (Ex. 2). A May 15, 1984 Determination Order awarded only temporary disability. (Ex. 3).

On December 28, 1984, claimant injured his low back while helping lift a truck clutch assembly. (Ex. 4). In February 1985, SAIF accepted the claim, but did not refer to a specific condition. (Ex. 5). Claimant had treatment for low back pain and radicular complaints following the December 1984 injury and a CT scan in April 1985 showed some mild bulging. (*See* Ex. 53-2). Claimant was declared medically stationary in late 1985, but his condition aggravated in 1987 and the claim was reopened for a work-hardening program. (*Id.*)

In January 1988, claimant sought treatment from Dr. Dunn for persistent low back and left leg symptoms. (Ex. 6). Dr. Dunn diagnosed a herniated disc at L5-S1. (Ex. 12). He performed an L5-S1 microdiskectomy on December 2, 1988 and removed an extruded fragment. (Ex. 13). SAIF subsequently indicated that it had accepted a lumbar strain and "December 2, 1988 L5-S1 microlumbar diskectomy" resulting from the December 1984 injury. (Ex. 47).

Claimant continued to have low back and left leg problems after the 1988 surgery. By October 1995, however, claimant's condition had improved and he was back to work. (Ex. 26).

On September 25, 1997, while working for Liberty's insured, claimant injured his low back when he was moving a heavy sliding door. (Exs. 28, 29, 30). After the September 1997 incident, claimant experienced pain in the same area of his back where he had pain before, but it was greater in intensity and constant. (*See* Ex. 53-3). Dr. Chandler initially suspected a recurrent disc herniation. (Exs. 32A, 34, 35A).

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[1] Claimant cross-requested review, arguing that he is entitled to an attorney fee under ORS 656.386(1) for Liberty's rescission of its compensability denial. The attorney fee issue was resolved through our approval of claimant's and Liberty's stipulation. Our October 31, 2001 Interim Order is incorporated into this order by this reference.

Liberty and SAIF issued denials and a hearing was held before ALJ Mills regarding compensability and responsibility. In a November 4, 1999 order, ALJ Mills reasoned that claimant's condition after the 1997 incident was essentially the same as the condition that was accepted by SAIF arising from the 1984 injury and, therefore, ORS 656.308(1) applied. (Ex. 53-4). ALJ Mills found that the medical evidence established that claimant's preexisting condition combined with the 1997 incident to cause or prolong disability and a need for treatment. ALJ Mills reviewed the medical opinions and determined that claimant did not have any new disc pathology or spine pathology; rather, all the doctors agreed that claimant sustained simply a new strain injury. (Ex. 53-5). ALJ Mills concluded that claimant's 1997 strain was the major cause of his disability and need for treatment, at least for a period of time. (*Id.*) Therefore, ALJ Mills determined that Liberty was responsible for claimant's new injury after the 1997 incident. On November 16, 1999, Liberty accepted a disabling lumbar strain. (Ex. 54).

Claimant continued to experience low back and left leg pain. On January 21, 2000, Liberty issued a current condition denial, asserting that claimant's accepted lumbar strain had resolved and his current need for treatment was unrelated to the accepted condition. (Ex. 59). SAIF also denied responsibility for claimant's current condition. (Exs. 62, 63). Claimant requested a hearing.

The ALJ found that ALJ Mills' November 4, 1999 decision that ORS 656.308 was applicable and that claimant had sustained a new compensable injury in the form of a strain combined with a preexisting condition was necessarily a conclusion that the new compensable injury in 1997 "involved" the same condition previously accepted by SAIF. The ALJ reasoned that ALJ Mills' conclusion was "res judicata." The ALJ noted that the injury accepted by SAIF included a strain and a lumbar disc injury. The ALJ determined that claimant's 1997 compensable injury with Liberty included an element of injury to the same disc injured and accepted by SAIF, as well as the strain accepted by SAIF, and concluded that Liberty remained responsible for claimant's current condition.

Liberty argues that the ALJ failed to properly apply ORS 656.308. Liberty points out that ALJ Mills found that claimant's 1997 injury was "simply a lumbar strain," and Liberty accepted that condition. Liberty asserts that ALJ Mills did not find that claimant had a disc injury as a result of the 1997 injury. According to Liberty, under ORS 656.308, responsibility shifts only for the "same condition." Because claimant did not sustain a disc injury in 1997, Liberty contends that responsibility for the disc condition did not shift to Liberty.

On the other hand, SAIF argues that responsibility for claimant's back condition shifted forward to Liberty under ORS 656.308(1) and cannot shift back to SAIF. SAIF relies on ALJ Mills' November 4, 1999 decision and the ALJ's analysis.

To resolve this dispute, we must determine whether issue or claim preclusion applies and whether ORS 656.308(1) applies. The ALJ found that ALJ Mills' November 4, 1999 decision regarding the application of ORS 656.308(1) was "res judicata" to this case. In other words, in the present case, the ALJ found that, because ALJ Mills found that ORS 656.308(1) applied to the previous litigation, ORS 656.308(1) necessarily applies to the dispute at issue in this case; *i.e.*, compensability of claimant's current condition. We disagree with the ALJ's analysis.

For the following reasons, we find that neither issue nor claim preclusion applies to the current condition denial in this case. Issue preclusion precludes future litigation on a subject issue only if the issue was "actually litigated and determined" in a setting where its determination was essential to the final decision reached. *Drews v. EBI Companies*, 310 Or 134, 139 (1990). In contrast, claim preclusion does not require actual litigation of an issue of fact or law, nor that the determination of the issue be essential to the final result. *Id.* at 140. Claim preclusion requires the opportunity to litigate, as well as finality. *Id.*

Here, the issue of claimant's current low back condition was not litigated at the prior hearing on July 30, 1998. Instead, the issues at the prior hearing were compensability of and responsibility for claimant's September 1997 low back injury. (Ex. 53). ALJ Mills determined that the 1997 injury was simply a new strain and claimant did not have any new disc or spine pathology. (Ex. 53-5). On the other hand, Dr. Dunn, claimant's current treating physician, said that claimant's current low back condition is related to annular damage, epidural fibrosis and stenosis. (Exs. 59D, 68). Compensability of claimant's *current* back condition was not "actually litigated" at the prior hearing and there was no opportunity to do so. Thus, neither issue nor claim preclusion apply to the present proceeding.

The next question is whether ORS 656.308(1) applies to this case. Under ORS 656.308(1), an employer remains responsible for future compensable medical services and disability relating to the compensable condition "unless the worker sustains a new compensable injury involving the same condition."

In *Barrett Business Services v. Morrow*, 164 Or App 628, 636 (1999), the court held that ORS 656.308(1) applies only when the original compensable injury and the second injury involve the same condition. The court explained that a new compensable injury "involves the same condition" when the new compensable injury encompasses, or has as part of itself, the prior compensable injury. *Id.* at 631. In that circumstance, all further medical treatment and disability compensably related to the prior compensable injury become the responsibility of the subsequent employer and are to be processed as a part of the new injury claim. *Id.* In *Morrow*, there was no dispute that the claimant's new compensable strain was the same condition previously accepted by the carrier. *Id.* at 632. In that case, responsibility for the claimant's preexisting strain shifted to the second carrier. *Id.*

In the present case, we must determine whether ORS 656.308(1) applies. Claimant has three compensable back claims. The most recent back claim involved claimant's September 1997 injury while working for Liberty's insured. After litigation, ALJ Mills found that claimant had sustained a strain injury and Liberty accepted a disabling lumbar strain. (Exs. 53, 54). We first compare the most recent low back claim (Liberty's lumbar strain) to claimant's current low back condition to determine whether his current condition "involves the same condition."

We find no medical evidence indicating that claimant's current low back condition is a lumbar strain. After the prior litigation, claimant continued to have pain in his low back and left leg. (Exs. 54A, 55, 56). Claimant was referred to Dr. Dunn in December 1999. (Ex. 56). Dr. Dunn diagnosed a postoperative laminectomy with epidural fibrosis and probable discogenic pain and he recommended an MRI. (Ex. 56-3). In a later report, Dr. Dunn agreed that the major contributing cause of claimant's current condition and need for treatment was his 1984 back injury and subsequent surgery, not the 1997 lumbar strain. (Ex. 65). In a deposition, Dr. Dunn explained that some of claimant's current pain was discogenic from annular damage and some was from epidural fibrosis, as well as stenosis. (Ex. 68-10, -31).

Dr. Schilperoort examined claimant on December 28, 1999 on behalf of Liberty. He reported that claimant's lumbar strain secondary to the September 1997 episode had resolved. (Exs. 57-5, -6, 58). In a later report, he explained that the September 1997 strain would have resolved by December 1997. (Ex. 58-2).

Dr. Wilson examined claimant in November 2000 on behalf of SAIF. He explained that if claimant's September 1997 accident had just caused a lumbar strain, that would have resolved within a couple of months. (Ex. 64-8).

We find no medical evidence that establishes that claimant's current back condition involves the same condition as the compensable 1997 lumbar strain for which Liberty was responsible. The medical evidence does not establish that the 1997 lumbar strain is "within" or "part of" the current low back condition. Rather, the reports from Drs. Dunn, Schilperoort and Wilson establish that claimant's September 1997 lumbar strain has resolved and that claimant's current condition is discogenic and fibrositic. Because there is no persuasive evidence that the current low back condition "involves" the 1997 lumbar strain, ORS 656.308(1) does not apply to that compensable back condition. *See Multifoods Specialty Dist. v. McAtee*, 164 Or App 654, 663 (1999) (although the claimant's lumbar strain combined with the earlier accepted degenerative condition, it was not one "involving" the previously accepted degenerative condition because there was no evidence that the strain had the previously accepted condition within or as a part of itself; therefore, the claimant's new injury did not involve the same condition previously subject to an accepted claim), *rev allowed* 332 Or 305 (2001).

We next examine SAIF's back claims to determine if claimant's current low back condition "involves the same condition." SAIF's most recent claim involves a December 28, 1984 low back injury. (Ex. 4). In February 1985, SAIF accepted the claim, but did not refer to a specific condition. (Ex. 5). Claimant had treatment for low back pain and radicular complaints following the December 1984 injury and a CT scan in April 1985 showed some mild bulging. (See Ex. 53-2). In January 1988, claimant

sought treatment from Dr. Dunn for persistent low back and left leg symptoms. (Ex. 6). Dr. Dunn diagnosed a herniated disc at L5-S1 and performed an L5-S1 microdiskectomy on December 2, 1988. (Ex. 13). SAIF later explained that it had accepted a lumbar strain and "December 2, 1988 L5-S1 microlumbar diskectomy" resulting from the December 1984 injury. (Ex. 47).

For the following reasons, we find that the preponderance of medical evidence establishes that claimant's current low back condition "involves the same condition" as the L5-S1 disc condition accepted by SAIF.

In December 1999, Dr. Dunn diagnosed a postoperative laminectomy with epidural fibrosis and probable discogenic pain. (Ex. 56-3). He reported that claimant's MRI had been compared with the previous MRI and showed L5-S1 epidural fibrosis, stenosis and nerve root irritation, some of which had improved since 1997. (Ex. 59D). On December 6, 2000, Dr. Dunn agreed that the major contributing cause of claimant's current condition and need for treatment was his 1984 back injury and subsequent surgery, not the 1997 lumbar strain. (Ex. 65).

In a deposition, Dr. Dunn said that some of claimant's current pain was discogenic from annular damage and some was from epidural fibrosis, as well as stenosis. (Ex. 68-10, -31). He explained that epidural fibrosis was scarring after the surgery, which was 100 percent related to the surgery for the 1984 injury. (Ex. 68-8, -31). Dr. Dunn testified that claimant had annular damage and disc damage from the 1984 injury. (Ex. 68-18, -22, -25). He felt the same disc had "flared up" as a result of the 1997 injury and that injury had caused some disc damage. (Ex. 68-26, -27, -32). Dr. Dunn concluded that the major contributing cause of claimant's need for continuing medical treatment was the 1984 injury. (Ex. 68-18, -19).

The other medical reports discussing claimant's current low back condition also indicate his condition is related to the L5-S1 disc condition. Dr. Schilperoort found that claimant's current condition was strictly related to his preexisting L4-5 and L5-S1 degenerative spine changes. (Ex. 57-5, -6). Dr. Wilson listed three possibilities for the etiology of claimant's current condition: (1) the preexisting disc herniation with surgery and scar formation; (2) something happened on September 25, 1997 that was not showing on the imaging studies; and (3) possible psychosocial factors. (Ex. 64-6).

Based on Dr. Dunn's opinion, as supported by Drs. Schilperoort and Wilson, we find that claimant's current low back condition is related to the L5-S1 disc and "involves the same condition" as his compensable L5-S1 disc condition with SAIF. Under ORS 656.308(1), SAIF remains responsible for future compensable medical services and disability relating to the compensable condition unless claimant sustains a new compensable injury involving the same condition. Although claimant sustained a "new compensable injury" in 1997, the previous ALJ found that claimant did not have any new disc pathology or spine pathology; rather, he sustained simply a new strain injury. (Ex. 53-5). Therefore, a lumbar strain was found compensable, but not an L5-S1 disc condition. Under these circumstances, SAIF remains responsible for claimant's low back condition.

Alternatively, even if ORS 656.308(1) does not apply, SAIF would be responsible for claimant's current low back condition under *Industrial Indemnity Co. v. Kearns*, 70 Or App 583 (1984). In that case, the court held that:

> "Where there are multiple accepted injuries involving the same body part, we will assume that the last injury contributed independently to the condition now requiring further medical services or resulting in additional disability, and the employer/insurer on the risk at the time of the most recent injury has the burden of proving that some other accepted injury last contributed independently to the condition which presently gives rise to the claim for compensation; *e.g.*, that its accepted injury caused only symptoms of the condition or involved a different condition affecting the same body part." *Id.* at 585-86 (internal quotations omitted).

Whether successive injuries involved the same "body part" under *Kearns* is a question of fact. *Sisters of Providence v. Ridenour*, 162 Or App 467, 470-71 (1999). The law does not require a certain minimum level of specificity to a "body part" for purposes of applying the *Kearns* presumption. *Id.* at 471. In *Ridenour*, the court rejected the carrier's argument that *Kearns* did not apply because the current disputed condition involved a herniated nucleus pulposus at L4-5, whereas the previous compensable condition involved the "low back."

Here, there is no evidence that claimant's last injury with Liberty's insured (lumbar strain) contributes to the condition now requiring further medical treatment. Thus, as the carrier with the last accepted injury, Liberty has rebutted the *Kearns* presumption. On the other hand, the medical evidence establishes that claimant's injury with SAIF contributes to his current low back condition. SAIF accepted a lumbar strain and "December 2, 1988 L5-S1 microlumbar diskectomy" resulting from the December 1984 injury. (Ex. 47). As we discussed earlier, Dr. Dunn, claimant's treating physician believed that the major contributing cause of claimant's current condition and need for treatment was his 1984 back injury and subsequent surgery. (Exs. 65, 68). Therefore, we conclude that SAIF is responsible for claimant's current low back condition. Consequently, we set aside SAIF's responsibility denial and uphold Liberty's denial of claimant's current low back condition.

ORDER

The ALJ's order dated May 31, 2001 is reversed. SAIF's responsibility denial of claimant's current low back condition is set aside and the claim is remanded to SAIF for processing according to law. Liberty's responsibility denial is reinstated and upheld. SAIF is responsible for the ALJ's $1,000 attorney fee award, to be paid to claimant's counsel.

November 19, 2001 Cite as 53 Van Natta 1510 (2001)

In the Matter of the Compensation of
EUGENE L. TUBRA, Claimant
Own Motion No. 66-0480M
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 January 18, 1955 dental condition. SAIF recommends reopening of this claim under our Own Motion for the provision of medical treatment to tooth #7 and additional dental treatment for claimant's compensable teeth #7 and #8 conditions. 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.

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
CANDY BARTEL, Claimant
WCB Case No. 00-03185
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Reinisch, MacKenzie, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) awarded claimant additional temporary disability; and (2) awarded a $4,500 attorney fee for claimant's counsel's services in prevailing over the employer's denial of claimant's depression condition. On review, the issues are temporary disability and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant was compensably injured on March 17, 1996.[1] (Ex. 9).

In November 1998, after being released for modified work by Dr. Gulick, the attending physician, claimant sought modified work from the employer. (Tr. 12). No modified jobs were available. (*Id.*)

The employer paid temporary total disability (TTD) benefits until April 19, 2000. (Tr. 11; Ex. 129). On January 8, 2001, when claimant began a vocational program, the employer resumed TTD payments.

Claimant requested a hearing seeking temporary disability benefits from April 19, 2000 to January 8, 2001.

The employer asserts that upon claimant's release to modified work, her temporary disability benefits were changed from (TTD) to temporary partial disability (TPD). Reasoning that *former* ORS 656.212(2) limits the aggregate payments of TPD to a period not exceeding two years, the employer contends that it properly ceased payments of temporary disability on April 19, 2000.

Claimant responds that *former* ORS 656.268(3) required the employer to continue TTD benefits until the occurrence of one of the four events enumerated therein. Reasoning that none of the four enumerated events had yet occurred, claimant asserts that the employer improperly ceased paying temporary disability. For the reasons stated below, we agree with claimant.

We previously addressed the applicability of the two year time period limiting the payment of TPD in *Sharon A. Gambrel*, 46 Van Natta 1881 (1994). There, the claimant had been released for and accepted modified work in April 1989. Pursuant to ORS 656.212, the carrier ceased paying TPD in April 1991. The claimant continued to work in a modified capacity through July 1993 when the employer withdrew the modified job offer.[2] The claimant requested a hearing seeking reinstatement of temporary total disability as of the date that the employer withdrew the modified job offer.

In affirming the ALJ's award of TTD, we concluded that because the claim was in open status, and because the claimant had not returned to modified work after the employer withdrew its modified job offer, the carrier was required to reinstate the payment of TTD. 46 Van Natta at 1883. In other

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[1] The claim was initially closed by a December 7, 1998 Determination Order. (Ex. 93). A February 26, 1999 Order on Reconsideration rescinded the Determination Order. (Ex. 97). At the time of the hearing, the claim was in open status.

[2] The claimant's employer in 1993 was not the employer at injury.

words, we concluded that although the carrier had been authorized to terminate TTD (and begin paying TPD) pursuant to *former* ORS 656.268(3) when the claimant began modified work, that circumstance no longer existed when the employer withdrew its modified job offer. *Id.* Thus, the carrier was required to reinstate the payment of TTD.

We find the facts of this case analogous to those in *Gambrel*. Here, although claimant was able to perform modified work, the employer did not offer modified employment. In fact, the employer expressly advised claimant that no such modified work was available. Applying the *Gambrel* rationale, we conclude that because the employer did not offer claimant modified employment, the employer was not authorized pursuant to *former* ORS 656.268(3) to cease paying TTD and begin payments of TPD. In other words, under the circumstances here, the two year time period limiting the payment of TPD has not yet commenced. Accordingly, we conclude that *former* ORS 656.212(2) is not applicable.

Our conclusion is consistent with OAR 436-060-0030(4) & (5) (WCD Admin Order No. 96-070), which require a carrier to continue paying TTD (and not begin paying TPD) until the worker either (1) begins some type of wage earning employment; or (2) fails to begin (after a written offer from the employer) wage earning employment which was authorized by the attending physician. Here, the circumstances set forth in OAR 436-060-0030(4) & (5) that authorize a carrier to terminate TTD and begin paying TPD *never* materialized. Consequently, claimant was entitled to receive TTD on April 19, 2000 and thereafter. Accordingly, we affirm the ALJ's order awarding additional temporary disability benefits from April 19, 2000 to January 8, 2001.

The employer argues that the ALJ's $4,500 attorney fee award was excessive, because claimant developed no medical evidence for the hearing regarding the employer's denial of her depression condition. Claimant responds that the ALJ's fee award was appropriate, considering that claimant's depression condition was sufficiently complex, the benefit to claimant, the value of the claim, and the time devoted to the case.

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 depression condition. The hearing lasted about two hours and 15 minutes not including closing arguments. The transcript consists of 31 pages. Claimant called the two witnesses who testified at hearing. The record consists of about 130 exhibits spanning a 4-year time period. No depositions were taken. The case involved issues of factual, medical, and legal complexity, that are comparable with disputed mental conditions that are generally submitted to his forum. The claim's value and the benefits secured are significant, especially considering claimant's disabling depression 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 the claim.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $4,500 is a reasonable attorney fee for services at the hearings level. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the hearing 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 temporary disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding that issue is $1,750, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the temporary disability issue (as represented by claimant's

respondent's brief, his counsel's request, and the employer's objection), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review devoted to the ALJ's attorney fee award. *See Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated March 8, 2001 is affirmed. For services on review, claimant is awarded a $1,750 attorney fee, payable by the self-insured employer.

November 20, 2001 Cite as 53 Van Natta 1513 (2001)

In the Matter of the Compensation of
JAMES BURROWS, JR., Claimant
WCB Case No. 00-08690
ORDER ON REVIEW
Gatti, Gatti, et al., Claimant Attorney
Garrett, Hemann, et al., Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Fitzwater's order that: (1) upheld the self-insured employer's denial of his current neck condition; and (2) declined to assess penalties or attorney fees for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated July 13, 2001 is affirmed.

Board Member Phillips Polich concurring.

I agree with the lead opinion that, for the reasons explained by the ALJ, claimant failed to establish compensability of his current neck condition. I write separately to express my concerns about this case.

It is apparent that claimant seriously injured his neck as a result of the January 13, 2001 work incident. Nevertheless, because he has a preexisting cervical disc disease and case law broadly defines a "combined condition" under ORS 656.005(7)(a)(B), claimant's burden of proof is high. *See Luckhurst v. Bank of America*, 167 Or App 11 (2000); *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999). Unfortunately for claimant, the medical evidence in this case is insufficient to sustain his burden of proof.

In the Matter of the Compensation of
CHARLES D. COCHRAN, Claimant
WCB Case No. 00-07183
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its partial denial of claimant's injury claim for a low back condition; and (2) awarded an $8,000 attorney fee pursuant to ORS 656.386(1). 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

Claimant was compensably injured in August 1997 when he fell through an attic, landing on a ceiling joist. (Ex. 17; Tr. 14). The claim was accepted as a lumbar strain.[1] (Ex. 26). The claim was closed in October 1997 without an award of permanent disability. (Ex. 29).

Following the August 1997 work event, claimant experienced low-grade back pain that was aggravated by activity, but relieved with rest. (Tr. 20). Claimant eventually came under the care of Dr. Potter, who diagnosed grade I spondylolisthesis L5-S1. (Ex. 57). Claimant requested acceptance of the spondylolisthesis condition.

SAIF declined acceptance of the spondylolisthesis condition. (Ex. 62A). Claimant requested a hearing.

The ALJ relied on the opinion of Dr. Potter and concluded that claimant had established the compensability of his spondylolisthesis condition. Consequently, the ALJ set aside SAIF's denial. The ALJ also awarded an $8,000 attorney fee pursuant to ORS 656.386(1).

Claimant seeks to establish the compensability of his L5-S1 spondylolisthesis as a consequential condition of the August 1997 work injury. In order to establish the compensability of his spondylolisthesis condition as a "consequential" condition of his compensable injury, claimant must prove that the compensable injury is the major contributing cause of the spondylolisthesis 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 spondylolisthesis condition and deciding which is the primary cause. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Dr. Potter explained that claimant incurred a pars fracture as a result of the 1997 work injury when he fell through a ceiling and landed on a beam. (Ex. 66-37; 66-38). According to Dr. Potter, the force caused when claimant impacted the beam was applied to the facet joints between L5 and S1, levering the facet joints against the vertebral body through the pars, thus causing the fracture. (Ex.66-39). Dr. Potter further explained that in such a fracture, the muscles attached to the spinous process (posterior to the fracture) constantly move the fracture site. (Ex. 66-43; 66-44). As a result, the fracture does not heal, and "callous" rather than bone forms at the fracture site, eventually causing a "traumatic" L5-S1 spondylolisthesis. (Ex. 66-44). Based on claimant's history, his findings of "callous" during

[1] Claimant also injured his left knee. (Ex.26). The knee injury is not in issue.

surgery, the radiology studies, and his experience in operating on between 100 and 150 pars fractures, Dr. Potter opined that the major contributing cause of claimant's L5-S1 spondylolisthesis was the work injury of August 1997. (Ex. 64; 66-36). Because Dr. Potter's opinion is based largely upon his actual surgical observations, his opinion is entitled to great weight.[2] *See Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 701 (1988).

Drs. Young and Williams (SAIF-arranged examiners) each opined that claimant's spondylolisthesis condition was most likely due to degenerative changes or was congenital in nature. (Exs. 46-6; 62-4). Dr. Williams based his opinion on a statistical analysis that congenital spondylolisthesis is "more common" than traumatic spondylolisthesis. (Ex. 46-7). Because Dr. Williams' opinion is grounded more on statistical analysis and less on factors personal to claimant than is the opinion of Dr. Potter, we find it less persuasive than Dr. Potter's opinion. *See Brian Mottaz*, 53 Van Natta 802, 803 (2001) (medical evidence grounded in statistical analysis is generally not persuasive because it is not sufficiently directed to the claimant's particular circumstances); *Yolanda Enriquez*, 50 Van Natta 1507 (1998); *Steven H. Newman*, 47 Van Natta 244, 246 (1995).

Dr. Young's opinion is based on a belief that traumatic L5-S1 spondylolisthesis cannot occur in conjunction with pars fracture. (Ex. 62-4; 64B-8). Dr. Young relied on medical literature (Deposition Exhibits 1 & 2) to support his opinion. Dr. Potter did not agree with Dr. Young, and explained that the medical literature on which Dr. Young relied does not exclude pars fracture as a cause of traumatic L5-S1 spondylolisthesis. Rather, the medical literature relied on by Dr. Young merely categorized pars fracture spondylolisthesis as Type IIC spondylolisthesis instead of Type IV spondylolisthesis. (Ex. 66-37). Based on our review of Deposition Exhibits 1 & 2, we conclude that, in context, Dr. Potter's explanation regarding the medical literature is more persuasive. (Depo Ex. 1, p 85; Depo Ex 2, p 207). Because Dr. Young's opinion appears to rest on incomplete or inaccurate information, his opinion is not persuasive.

In conclusion, finding no persuasive reason to do otherwise, we defer to Dr. Potter's opinion and conclude that claimant has established the compensability of his spondylolisthesis condition. *See Weiland v. SAIF*, 64 Or App 810 (1983).

SAIF argues that the ALJ's $8,000 attorney fee award was excessive and suggests that a $4,500 fee award is sufficient. Claimant responds that the ALJ's fee award was appropriate, considering the value of the claim and the highly technical nature of the medical evidence.

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 L5-S1 spondylolisthesis condition. The hearing lasted about two hours and 40 minutes not including closing arguments. The record consists of about 66 exhibits, including the depositions of two doctors. Claimant's attorney submitted a statement of services indicating 25 hours of time spent through the hearing.

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 significant, especially considering that claimant required 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 SAIF's vigorous challenge.

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[2] SAIF contends that Dr. Potter's opinion is not persuasive because it rests on the mistaken belief that claimant had been unable to consistently work for two years, rather, than as claimant testified, that he was able to work by self-limiting his activity level. Dr. Potter did initially misunderstand claimant's ability to work. (Ex. 38). However, during his deposition, Dr. Potter was given the correct history and indicated that such a history is not inconsistent with a traumatic injury. (Ex. 66-12). Consequently, we reject SAIF's assertion.

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $6,500 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 fee request, and SAIF's objections), the abov average complexity of the issue, the value of the interest involved, 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). Claimant's attorney has requested $3,000 for services on Board review. SAIF contends that $1,500 is appropriate.

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

The issue on review is compensability of claimant's L5-S1 spondylolisthesis as a consequence of his August 1997 work injury. The record consists of 38 pages of transcript and 66 exhibits, including the depositions of two doctors and 30 pages of medical literature. Claimant submitted a 19 page respondent's brief.

The medical issues presented in this compensability dispute, when compared to compensability disputes generally presented to this forum, are of above average complexity. The value of the claim and the benefits secured are significant. The parties' respective counsels presented their positions in a thorough and professional manner. No frivolous issues or defenses were presented. Finally, considering the conflicting medical opinions and the stringent standard for establishing compensability of consequential condition claims, there was a significant risk that claimant's counsel's efforts might have gone uncompensated.

After considering claimant's counsel's statement of services, and SAIF's response, and applying the factors set forth in OAR 438-015-0010(4), we conclude that $2,500, payable by SAIF, is a reasonable attorney fee under ORS 656.382(2) for services on Board review regarding the compensability issue. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief, claimant's counsel's statement of services, and SAIF's response), the complexity of the issue, and the value of the interest involved. We note that claimant is not entitled to an attorney fee for services devoted to the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated June 4, 2001 is modified in part and affirmed in part. In lieu of the ALJ's attorney fee award for services at the hearing, claimant's attorney is awarded a $6,500 attorney fee payable by SAIF. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded a $2,500 attorney fee, payable by SAIF.

In the Matter of the Compensation of
STEPHEN G. LUTES, Claimant
Own Motion No. 01-0316M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

Reviewing panel: Members Biehl and Haynes.

Claimant requests review of the self-insured employer's August 21, 2001 Notice of Closure, which closed his claim with an award of temporary disability compensation from January 2, 2001 through August 16, 2001. The employer declared claimant medically stationary as of August 16, 2001. Claimant contends that he is entitled to additional temporary disability because he was not medically stationary when the employer closed his claim. Having received the parties' submissions and respective positions, we proceed with our review.[1]

FINDINGS OF FACT

On January 2, 2001, claimant underwent a compensable fusion of the right talonavicular joint, performed by Dr. Daines, claimant's former attending physician. On January 10, 2001, we authorized the payment of temporary disability compensation beginning the date claimant was hospitalized for the proposed surgery. On May 17, 2001, Dr. Daines noted that x-rays showed one of the screws had broken and a CT scan clearly showed a nonunion through the talonavicular joint. As a result, Dr. Daines recommended a re-fusion of the talonavicular joint of claimant's right foot.

On July 11, 2001, Dr. Daines opined that claimant was not medically stationary. Diagnosing a nonunion in claimant's right foot, Dr. Daines continued to recommend the re-fusion surgery. Without the recommended surgery, Dr. Daines did not consider claimant's condition to be medically stable. Dr. Daines further noted that the recommended surgery was for curative purposes. The employer received this report on July 30, 2001.

On August 6, 2001, the employer advised claimant that it had not been "able to substantiate medical treatment since May 17, 2001." The employer further notified claimant that if it did not hear from claimant by August 20, 2001, it would "assume that [he has] completely recovered and will proceed with closure of the claim."

Dr. Roser, a new attending physician, saw claimant on August 10, 2001. Concluding that claimant was "not at maximal medical improvement," Dr. Roser reported that claimant required right ankle surgical reconstruction, noting that the talonavicular fusion had gone into "nonunion with broken hardware." Dr. Roser forwarded this report to the employer by facsimile on August 13, 2001.

In an August 16, 2001 "check-the-box" letter, Dr. Daines agreed to the employer's question: "Would you agree that until the surgery is done, [claimant] is medically stationary? (Put another way, would you agree that there will be no further improvement in [claimant's] condition until the surgery has been done?)."

Relying on Dr. Daines' "check-the-box" response, the employer issued its Notice of Closure on August 21, 2001, declaring claimant medically stationary as of August 16, 2001.

In a September 25, 2001 chart note, Dr. Roser reiterated that claimant required further surgery and noted that claimant was willing to proceed with the surgery. Claimant underwent the proposed surgery on October 2, 2001.

On October 17, 2001, the employer submitted another Own Motion recommendation form, which included a copy of Dr. Roser's August 10, 2001 chart note recommending further surgery. The employer recommended claim reopening.

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[1] On January 10, 2000, we issued an Own Motion Order, which reopened claimant's 1978 claim for the provision of temporary disability compensation. (Own Motion Case No. 99-0460M). The employer issued its August 21, 2001 Notice of Closure for that claim.

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 August 21, 2001 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 employer relies on the "check-the-box" letter from Dr. Daines and its contention that claimant had not sought medical treatment since May 2001. However, before and after the August 21, 2001 closure, claimant's attending physicians (Drs. Daines and Roser) opined that claimant's condition was not medically stationary. These assessments were based on the proposition that claimant required a re-fusion of his right ankle 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 do not find Dr. Daines' August 16, 2001 "check-the-box" response persuasive. Dr. Daines' August 16, 2001 concurrence is insufficiently explained to overcome his prior opinion that claimant's condition was not medically stationary. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (unexplained change of physician's opinion found unpersuasive). Furthermore, Dr. Roser, undertook claimant's treatment prior to the closure and continued to opine that claimant still required the surgery that was first recommended in May 2001. Dr. Roser's opinion was based on a complete examination of claimant and objective diagnostic evidence.

Under such circumstances, the medical record does not support a conclusion that claimant's condition was medically stationary when the employer closed the claim on August 21, 2001. Therefore, we conclude that the closure was premature.

We are likewise not persuaded by the employer's contention that claimant's condition was medically stationary because of a failure to seek further treatment. The record demonstrates that claimant sought treatment with Dr. Roser on August 10, 2001, ten days prior to the expiration of the deadline set forth by the employer in its August 6, 2001 letter to claimant. A chart note from this examination was sent by facsimile to the employer on August 13, 2001, eight days prior to the issuance of its August 21, 2001 closure. Claimant's willingness to proceed with the surgery is further confirmed by Dr. Rosen's September 25, 2001 chart note.

Consequently, we conclude that claimant's condition was not medically stationary when the employer closed his claim. Accordingly, we set aside the Notice of Closure as premature and remand the claim to the employer for further processing in accordance with law. When appropriate, the claim shall be closed by the employer pursuant to OAR 438-012-0055.[2]

IT IS SO ORDERED.

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[2] In light of our finding that the claim was prematurely closed, we have dismissed the October 17, 2001 Own Motion reopening request in a separate order. (WCB Case No. 01-0324M).

In the Matter of the Compensation of
GAYLE "JOE" R. MOORE, Claimant
WCB Case No. 01-00760
ORDER ON REVIEW
Kryger, et al., Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

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

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Martha Brown's order that set aside its denial of claimant's "new medical condition" claim for a cervical 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 compensably injured his neck during a motor vehicle accident on the job on December 3, 1999. SAIF accepted claimant's claim for a "cervical sprain/strain." (Ex. 7). The claim was closed by a March 7, 2000 Notice of Closure awarding no permanent disability. (Ex. 13). Eventually, claimant was awarded nine percent unscheduled permanent disability. (Ex. 42).

The ALJ set aside SAIF's denial of claimant's "new medical condition" claim for a C6-7 disc extrusion based on the opinion of a consulting neurosurgeon, Dr. Ono.[1] On review, SAIF contends that Dr. Ono's opinion is insufficient to meet claimant's burden of proof. Specifically, SAIF contends that the ALJ erroneously concluded that claimant did not suffer from a preexisting condition that combined with his compensable injury. We agree.

A "preexisting condition" is:

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

Here, the preponderance of medical evidence proves that claimant suffered from preexisting cervical degenerative conditions that combined with his compensable injury to contribute to his disability or need for treatment. 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 rely on the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983).

Here, we find no reasons not to defer to claimant's treating physician, Dr. Neuburg, on the issue of whether claimant suffers from a "preexisting condition." A cervical spine x-ray taken on the date of claimant's December 3, 1999 injury was originally interpreted on the Form 827 (First Medical Report) and by the emergency room physician, Dr. Pliskin, as being "negative." (Exs. 1, 2-1). However, on April 20, 2000, Dr. Neuburg described the same x-ray as indicating degenerative changes at C6-7. (Ex. 16). On May 16, 2000, Dr. Neuburg then described the x-ray as revealing "disc space narrowing and lipping" at C6-7. That same date, Dr. Neuburg stated that claimant suffered from preexisting conditions of degenerative disk disease and degenerative joint disease at C6-7. (Exs. 18, 19). On May 25, 2000, an MRI scan showed "marked" degenerative disease at C6-7. (Ex. 20). On May 31, 2000, Dr. Neuburg assessed claimant's condition as "status post neck strain with underlying preexisting previously asymptomatic degenerative disc disease of the spine." (Ex. 21).

Dr. Young, a neurologist who examined claimant on referral from Dr. Neuburg, found that claimant suffered from degenerative disc disease at C6-7, which was "preexisting by x-ray report." (Ex. 22). Another x-ray taken on June 8, 2000 demonstrated degenerative disc disease at the C5-6 level with narrowing and spurring at C6-7. (Ex. 24). On June 20, 2000, Dr. Neuburg stated that claimant's treatment had been directed at a combination of "waxing and waning" (from the neck strain), but that

[1] The ALJ referred to Dr. Ono as a neurologist. The record establishes that Dr. Ono was a neurosurgeon.

claimant's symptoms had been primarily secondary to his degenerative disc disease and degenerative joint disease. (Ex. 27). Finally, on October 25, 2000, Dr. Young stated that claimant "clearly" had preexisting degenerative disc disease at C6-7, and that the predominant factor in his current condition was the preexisting disease. (Ex. 42A).

In contrast, Dr. Ono stated in answer to questions posed by claimant's counsel that he did not find definite preexisting conditions "from [claimant's] history" at the time of his initial examination. (Ex. 42B). However, in view of the extensive evidence of preexisting degenerative disc disease and degenerative joint disease detailed above, we do not find Dr. Ono's opinion on this issue persuasive. In this regard, we also note that Dr. Ono stated he did not find any preexisting conditions "from [claimant's] history." (*Id.*) We interpret that phrase to indicate merely that *claimant* had told Dr. Ono that he had no prior injuries or symptomatic preexisting conditions, which is consistent with his testimony. (Tr. 7, 8). However, Dr. Ono did not reconcile his opinion with the x-rays and MRI reports described above, nor with Dr. Neuburg and Dr. Young's interpretations of those studies.

In addition, based on Dr. Neuburg and Dr. Young's opinions, we find that claimant's preexisting degenerative cervical conditions "combined with" his compensable neck strain to cause his disability and need for treatment. (*See* Exs. 21, 27). *See Luckhurst v. Bank of America*, 167 Or App 11 (2000) (a combined condition means two conditions that "merge or exist harmoniously"); *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654 (1999). In particular, Dr. Young stated that claimant's treatment represented a "combination of waxing and waning" (since the neck strain claim was closed) but "primarily symptoms due to his degenerative disk disease and degenerative joint disease of the lower cervical spine." (Ex. 27). Accordingly, claimant must prove that his compensable injury was the major contributing cause of his disability or need for treatment of his combined cervical condition. ORS 656.005(7)(a)(B).

Where proof by "major contributing cause" is necessitated, persuasive medical opinion must evaluate the relative contribution of different causes of claimant's condition and determine which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Dr. Ono represents the only medical opinion supportive of claimant's claim for a C6-7 disc extrusion condition. However, Dr. Ono's conclusory statement that claimant's December 1999 compensable injury was the major contributing cause of his disc extrusion condition does not compare or weigh the potential effect of claimant's preexisting cervical degenerative conditions. (Ex. 42B). In those circumstances, claimant has not met his burden of proof. ORS 656.266. We therefore need not compare the relative persuasiveness of countervailing medical opinions in the record.

Accordingly, we reverse the portion of the ALJ's order setting aside SAIF's denial of the cervical condition. The ALJ's assessed attorney fee award will also be reversed.

ORDER

The ALJ's order dated May 15, 2001 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the SAIF Corporation's January 23, 2001 denial of claimant's new medical condition claim for a C6-7 disc extrusion is reversed. The aforementioned portion of SAIF's January 23, 2001 denial is reinstated and upheld. The ALJ's assessed attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Phillips Polich dissenting.

I agree with the majority that claimant's burden of proof in this matter is by "major contributing cause." Despite one "normal" x-ray just after the accident, there is abundant evidence of preexisting degenerative conditions in claimant's cervical spine, necessitating evaluation of this case as a "combined condition" pursuant to ORS 656.005(7)(a)(B). However, on the medical evidence, I would still affirm the ALJ's reliance on Dr. Ono's opinion and set aside SAIF's denial of claimant's claim for the cervical condition. Accordingly, I respectfully dissent.

Dr. Ono concluded that claimant's December 3, 1999 work injury, when he was rear-ended by a tow truck at relatively high speed, was the major contributing cause of his cervical disc extrusion. (Ex. 42B). As the ALJ reasoned, Dr. Ono, a neurosurgeon who examined claimant on several occasions, is the only physician whose opinion incorporates claimant's unrebutted testimony that he had never experienced symptoms in, nor sought treatment for, his neck before this on-the-job injury. (*Id.*)

I agree with the ALJ that the remainder of the medical opinion in the record fails to adequately consider this important factor and is therefore unexplained and unpersuasive. Although Dr. Young,

who examined claimant only once, recognized that claimant did not have any prior symptoms, I would not rely on his conclusory opinion that the "predominant factor" in claimant's condition was preexisting disease. (Ex. 42A).

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
SAMUEL B. VAUGHN, Claimant
WCB Case No. 00-04989
ORDER ON REVIEW
Cole, Cary, et al., Claimant Attorney
Cummins, Goodman, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Fitzwater's order that upheld the self-insured employer's denial of his injury claim for back, right shoulder and elbow conditions. On review, the issue is compensability.

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

Claimant, a maintenance worker, alleged that he was injured after being "belly bumped" by his temporary supervisor, Mr. Woods. Concluding that claimant was not a credible witness, the ALJ found first that claimant had not established that he suffered an injury in the course and scope of his employment. ORS 656.005(7)(a). Alternatively, the ALJ found that claimant's claim was barred because he was an "active participant" in the alleged assault under ORS 656.005(7)(b)(A). For the following reasons, we agree with the ALJ's finding that claimant was not a credible witness, and therefore that claimant did not prove that he sustained a compensable injury. We thus need not resolve the issue of whether claimant was an "active participant" in an assault.

We ordinarily defer to the ALJ's "demeanor-based" credibility findings. *International Paper v. McElroy*, 101 Or App 61 (1991); *Robert P. Sale*, 53 Van Natta 559 (2001). Here, we find no reasons not to defer to the ALJ's demeanor-based finding that claimant did not credibly testify that he sustained an on-the-job injury. (O&O at 4). In this regard, we find persuasive that claimant did not seek medical treatment for more than a month after his alleged injury on March 9, 2000. (*See* Ex. 2).

In addition, claimant did not report his alleged injury to police chief Hudson, whom claimant and Woods both sought out just after their March 9, 2000 confrontation and the alleged injury. (Tr. 82, 85, 86). Claimant also neglected to mention the alleged injury to Hudson during a telephone call later that day in which claimant asserted that Woods had been involved in an altercation in a bar in California and that Woods' son possessed illegal fireworks or explosives. (Tr. 86). It was not until the following morning (March 10, 2000) that claimant reported an alleged injury from the previous day in a telephone call to Hudson. (Tr. 87). Given claimant's acknowledged and repeated history of "whistleblowing" regarding the employer's alleged safety violations, we find that claimant likely would have reported his injury to Hudson during at least one of his conversations with him on March 9, 2000, if it had in fact occurred. (*See* Tr. 17, 89).

Finally, we find no reasons not to defer to the ALJ's demeanor-based credibility finding in favor of Woods' testimony denying that a "belly-bumping" incident occurred on March 9, 2000. (Tr. 63). In reaching this conclusion, we note that Hudson corroborated in significant part Woods' testimony regarding the sequence of events during the week of the alleged incident.

For these reasons, we agree with the ALJ that claimant has not proved that he suffered an injury in the course and scope of his employment on March 9, 2000. ORS 656.005(7)(a). The employer's denial was properly upheld.

ORDER

The ALJ's order dated July 18, 2001 is affirmed.

In the Matter of the Compensation of
GLENNA D. BULLOCK, Claimant
WCB Case No. 01-00113
ORDER ON REVIEW (REMANDING)
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Peterson's order that dismissed her 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 3, 2001. Claimant failed to appear. The SAIF Corporation moved to dismiss claimant's request for hearing.

On April 24, 2001, the ALJ issued an Order of Dismissal dismissing claimant's request for hearing and providing notice of the right to request Board review. The order also contained a paragraph providing that claimant's request for hearing could be "subject to reinstatement" if claimant submitted a written request to do so within 15 days of the order.

On May 1, 2001, the Hearings Division received a letter from claimant stating that she "[did] not agree with the finding in this matter." The ALJ did not abate or reconsider the Dismissal Order. Claimant's letter was eventually acknowledged as a request for Board review.

CONCLUSIONS OF LAW AND OPINION

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 37, 38 (2001). 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 "reinstatement" order, as described above, on April 24, 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 May 1, 2001, claimant filed a response to the ALJ's order, within the requisite 15-day "reinstatement" period, asserting that she did not agree with "the finding in this matter." We thus interpret claimant's letter as a motion to postpone the April 3, 2001 hearing. *See Michael E. Davis*, 53 Van Natta 1059 (2001); *Brent Harper*, 50 Van Natta at 500.

We may remand a case 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-Reinstatement/Dismissal order" 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); *Michael E. Davis*, 53 Van Natta at 1060.

Accordingly, the ALJ's April 24, 2001 dismissal order is vacated and this matter is remanded to ALJ Peterson. Following further development of claimant's explanations for failing to appear at the scheduled hearing (including SAIF's response), the ALJ shall determine whether claimant's non-appearance was justified and constituted extraordinary circumstances beyond her control. The development of the record may be made in any manner that the ALJ deems achieves substantial justice. 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.

IT IS SO ORDERED.

In the Matter of the Compensation of
CAROL M. HALEY, Claimant
Own Motion No. 01-0231M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE

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

Claimant requests review of the self-insured employer's "June 8, 2000" [*sic*][1] Notice of Closure, which closed her claim with an award of temporary disability compensation from May 22, 1998 through March 31, 2001. The employer declared claimant medically stationary as of March 31, 2001.

Claimant requests review of the closure, contending that: (1) she continues to experience "considerable and constant pain;" (2) her attending physician continues to treat her for her pain; (3) her *left hip* has "not been repaired;" and (4) she requires additional treatment in the form of ultrasound therapy.

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

The propriety of the closure turns on whether claimant was medically stationary at the time of the June 8, 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 order to be medically stationary, all compensable conditions must be medically stationary. *Rogers v. Tri-Met*, 75 Or App 470 (1985); *Gerald D. Duren*, 49 Van Natta 722 (1997); *Paul E. Voellar, on recon* 42 Van Natta 1962 (1990).

Typically, there are only two issues to be raised when a claimant requests review of an insurer's closure of his or her claim. The most commonly raised issue is an assertion by the claimant that he or she was not medically stationary at claim closure. A second issue less frequently raised is an assertion by the claimant that he or she is entitled to additional temporary disability compensation during the time the claim was open, although there is no dispute that the claimant was medically stationary at claim closure.

Here, claimant requested review because she continues to experience pain and her doctor has recommended further treatment. We interpret claimant's request for review as a challenge to both the medically stationary issue and the temporary disability compensation issue. The evidence in the record supports the conclusion that, although claimant was medically stationary at the time of closure, she is entitled to additional temporary disability compensation until she became medically stationary.

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[1] Because of the dates listed for claimant's temporary disability awards, we find that the Notice of Closure contained a clerical error regarding its mailing date. Therefore, rather than June 8, 2000, we are persuaded that the Notice of Closure was mailed June 8, 2001.

In its May 18, 1998 Own Motion recommendation form, the employer identified the accepted conditions as claimant's "left knee" and "left hip." It further identified the "current" condition for which Own Motion benefits were being requested as claimant's *left knee*. Regarding claimant's left hip, there is no indication that, during the time the claim was in "reopened" status, claimant sought treatment for any left hip condition nor is there any indication that her left hip condition was not medically stationary at claim closure. Rather, the only references in the record regarding claimant's left hip before claim closure were chart notes in January 1999 and November 2000, which reported that claimant's left hip exhibited full range of motion. No treatment for claimant's left hip condition was recommended on either occasion. On this record, claimant has not established that her left hip was not medically stationary at claim closure.

Regarding claimant's left knee condition, on May 15, 2001, Dr. Tennant, claimant's attending physician, opined that claimant's left knee condition was medically stationary. He noted that claimant still had "some discomfort," but was much better than before her operation. Dr. Tennant did not foresee any future surgical treatment and reported that claimant "probably reached maximal improvement one year after her surgery." Based on Dr. Tennant's May 2001 opinion, the employer issued its June 8, 2001 closure.

Following a July 16, 2001 examination, Dr. Tennant reported that claimant had complaints of left knee pain. He further noted that radiographic evaluation was "unremarkable." Dr. Tennant diagnosed "stable status post left knee arthroplasty with residual pain." Dr. Tennant did not "think [claimant was] medically stationary at this point in time." Dr. Tennant also examined claimant's left hip. He found that she had complete range of motion and radiographic evaluation showed that the "hip joint [was] well maintained," and although there was a slight irregularity of the femoral head, it also looked "good." Dr. Tennant offered to inject the hip with a cortisone shot but claimant refused. Recommending physical therapy, Dr. Tennant advised claimant to return in the fall.

Dr. Tennant reexamined claimant on September 11, 2001. At that time, he diagnosed "status post knee arthroplasty with continued pain of unknown origin." He prescribed some anti-inflammatories and scheduled claimant for a four to six week follow-up. Dr. Tennant did not comment on claimant's "medically stationary" status. Also, Dr. Tennant made no comments regarding claimant's left hip condition.

In her request for review, claimant contends that she has continued pain, requires additional treatment in the form of ultrasound therapy and her "left hip" has not been "repaired." Dr. Tennant's opinion expressed in the July and September 2001 chart notes demonstrate that claimant required additional treatment following claim closure.

However, we find Dr. Tennant's July and September 2001 chart notes do not focus on claimant's left knee and left hip conditions at the time of the June 8, 2001 closure. Rather, Dr. Tennant's July and September 2001 opinion focuses on claimant's current need for treatment,[2] not her condition when her claim was closed. As such, they indicate "post-closure" developments, which are not relevant to the pivotal question of whether claimant's left knee and left hip conditions were medically stationary at the time of the June 2001 claim closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987) (evidence that was not available at the time of closure may be considered to the extent the evidence addresses the condition at the time of closure).

Finally, even if we were to conclude that Dr. Tennant's July and September 2001 opinion relates to claimant's left knee and left hip conditions at closure, he recommended that claimant undergo physical therapy and prescribed anti-inflammatories. In other words, there is no recommendation for further curative treatment. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. *See Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation that further or ongoing medical treatment would "materially improve" claimant's compensable condition at claim closure. *Lois Brimblecom*, 48 Van Natta 2312 (1996).

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[2] In this regard, Dr. Tennant's July 2001 chart note stated that claimant was not medically stationary "at this point in time."

In May 2001 Dr. Tennant opined that claimant's left knee condition was medically stationary. He further reported that he did not foresee any future surgical treatment. Finally, he opined that claimant had "probably reached maximal improvement one year after her surgery."[3] Although in his July 2001 report Dr. Tennant opined that claimant was not medically stationary, that opinion does not focus on claimant's conditions at the time of the June 8, 2001 closure. Furthermore, Dr. Tennant does not change his May 2001 opinion that claimant's left knee condition was medically stationary at that time. Thus, based on this uncontroverted medical evidence, we find that claimant's conditions were medically stationary on the date her claim was closed.[4]

We proceed to address the issue of entitlement to additional temporary disability compensation. As previously noted, the employer's Notice of Closure terminated claimant's temporary disability effective March 31, 2001. Yet, the record does not demonstrate that claimant was medically stationary prior to May 15, 2001. The only medical record prior to the May 15, 2001, is Dr. Tennant's January 2001 chart note, which reported continued pain and scheduled claimant for a follow-up visit. Additionally, following claimant's March 2000 surgery, Dr. Tennant first released claimant to sedentary work as of May 15, 2001.

On this record, we find that claimant was disabled due to her compensable injury until May 15, 2001, and, thus, entitled to temporary disability benefits until that time. *See Frank L. Bush*, 48 Van Natta 1748 (1996). Therefore, we modify the employer's Notice of Closure to award claimant additional temporary disability compensation from April 1, 2001 through May 15, 2001.

Accordingly, we modify the employer's June 8, 2001 Notice of Closure to award claimant temporary disability compensation from May 22, 1998 through May 15, 2001, when her left knee condition became medically stationary. The Notice of Closure is affirmed in all other respects.

IT IS SO ORDERED.

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[3] Claimant underwent two surgeries on her left knee. On May 22, 1998, claimant underwent a left knee arthroscopic partial medial meniscectomy. On March 31, 2000, claimant underwent a left knee arthroplasty.

[4] 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
DIRK K. CARNEY, Claimant
WCB Case No. 01-02257
ORDER ON REVIEW (REMANDING)
Charles L. Lisle, Claimant Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Poland'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 June 19, 2001. Although claimant's attorney appeared at the hearing, claimant failed to appear. Claimant's attorney elected not to proceed in claimant's absence. The insurer moved to dismiss claimant's request for hearing.

On July 25, 2001, the ALJ issued an Order of Dismissal dismissing claimant's request for hearing. The order also contained a "Show Cause" order that notified claimant of his right:

"within twenty (20) days after the mailing date of this order, to request in writing that the undersigned ALJ reconsider this dismissal. **Any request for reconsideration must be received by the Board before the expiration of the 20 day period.** In the request for reconsideration, claimant must show good cause why this matter should not be dismissed." (Emphasis in original).

On August 14, 2001, the Hearings Division received claimant's letter that offered reasons for his failure to appear at the June 19, 2001 hearing and requested that he be granted a new hearing. Claimant's letter was eventually acknowledged as a request for Board review.

CONCLUSIONS OF LAW AND OPINION

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 37, 38 (2001). 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 July 25, 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 August 14, 2001, claimant filed a response to the ALJ's order, within the requisite 20-day period. Because claimant's submission provided reasons for his failure to appear at the hearing, we interpret claimant's letter as a motion to postpone the June 19, 2001 hearing. *See Michael E. Davis*, 53 Van Natta 1059 (2001); *Brent Harper*, 50 Van Natta at 500.

We may remand a case 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, 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); *Michael E. Davis*, 53 Van Natta at 1060.

Accordingly, the ALJ's July 25, 2001 dismissal order is vacated and this matter is remanded to ALJ Poland. 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 achieves substantial justice. 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.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN K. HARKNESS, Claimant
WCB Case No. 97-08467
THIRD ORDER ON REMAND
Gayle A. Shields, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

On October 23, 2001, we abated our September 28, 2001 Second Order on Remand that: (1) modified our Order on Remand to award claimant's attorney $17,082 for services performed before the Hearings Division, Board and court; (2) awarded claimant's attorney a $1,500 fee for services on remand; and (3) declined to award $240 in court costs. We took this action to consider claimant's contention that the attorney fee should be increased. Having received SAIF's response and claimant's reply, we proceed with our reconsideration.

Claimant requested reconsideration of our Second Order on Remand, arguing that the attorney fee should be increased to $21,582[1]. Specifically, she argues that the $17,082 in fees awarded by the Court of Appeals was for services "after the Board's first Order on Review was issued" and did not include time for services before the ALJ and the Board (or reviewing SAIF's petition for Supreme Court Review). Claimant requests $3,000 for services at hearing and $1,500 for services before the Board on remand.

On reconsideration, SAIF contends that the attorney fee award in our Second Order on Remand is "more than adequate." Relying on ORS 656.388(1), SAIF argues that the Board has the authority to revise the court's attorney fee award in the event claimant prevails on remand, as is the case here. SAIF notes that it objected to claimant's attorney fee request before the Court of Appeals on the basis that both the hourly rate and the time claimed was excessive. SAIF asserts that the court reduced claimant's attorney's hourly rate, but did not address its objection to the time expended on the case. On reconsideration, SAIF renews its objections to claimant's fee request.

We begin by reviewing the procedural posture of the attorney fee issue. SAIF has submitted copies of documents provided to the court regarding claimant's attorney fee request. In claimant's petition to the court, she requested attorney fees of $18,980 and $334.52 in costs. Claimant's petition stated, in part:

> "These amounts are in addition to fees and penalties awarded by the Administrative Law Judge in the Opinion and Order, which Appellant will ask the Workers' Compensation Board to reinstate on remand, and fees for appearing before the Board."

Claimant's attorney submitted an affidavit that detailed her services from November 4, 1998 through December 15, 2000.[2] The Board's Order on Review issued on October 16, 1998, *John K. Harkness*, 50 Van Natta 2055 (1998), and the court issued *Harkness v. SAIF*, 171 Or App 329 (2000), on December 6, 2000. Thus, claimant's counsel's affidavit referred only to her services before the Court of Appeals.

SAIF objected to claimant's petition for attorney fees, arguing that her request was premature and the amount requested was excessive. After claimant replied to SAIF's objections, the Court of Appeals issued an Order Allowing Attorney Fees on March 13, 2001, which provided:

> "Petitioner's petition for attorney fees is allowed in the amount of $17,082. The award of fees is based on a reasonable hourly rate of $180 and a 50 percent reduction of the hourly rate for time spent on this case and *Blamires v. Clean Pak Systems, Inc.*, A103926."

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[1] Although claimant initially requested an attorney fee of $21,822, she subsequently changed the request to $21,582 and no longer requests $240 in costs awarded by the court.

[2] Claimant's affidavit also included time spent helping to prepare a brief in *Blamires v. Clean Pak Systems, Inc.*

On March 19, 2001, SAIF filed a motion to amend the Order Allowing Attorney Fees, requesting that the court's order reflect that the attorney fee determined by the court was conditioned on the ultimate outcome of the case and should be awarded by the Board only if claimant prevails on remand. Claimant did not oppose SAIF's motion to amend. On May 11, 2001, the Court of Appeals issued an Order Granting Motion to Amend Order Allowing Attorney Fees, stating that claimant "is allowed attorney fees in the amount of $17,082, contingent on petitioner prevailing on remand."

On June 4, 2001, the court issued an appellate judgment awarding claimant, among other things, attorney fees in the amount of $17,082 "contingent on petitioner prevailing on remand."

In the meantime, SAIF submitted a petition for review to the Supreme Court, which was denied on March 20, 2001. *Harkness v. SAIF*, 331 Or 692 (2001).

After reviewing the aforementioned documents, we find that the attorney fee of $17,082 awarded by the Court of Appeals was only for claimant's counsel's services before the Court of Appeals and did not include her services at hearing or before the Board. Claimant's attorney also asserts that the $17,082 fee did not include her services for reviewing SAIF's petition for Supreme Court Review. Under these circumstances, we withdraw our Second Order on Remand and modify our Order on Remand as follows.

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 acknowledge SAIF's challenge to the court's attorney fee award for services on judicial appeal. Even if we assume, without deciding, that we have the authority to modify the court's attorney fee award, after considering the factors set forth in OAR 438-015-0010(4), we find that a $17,082 award represents a reasonable fee for claimant's counsel's services performed before the court.

In addition to the attorney fees previously awarded by the ALJ ($3,000), and the $17,082 fee awarded by the Court of Appeals, we award a reasonable carrier-paid attorney fee for claimant's counsel's services before the Board and court following the Court of Appeals' opinion. 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, as well as considering SAIF's objections to claimant's attorney fee request, we find that a reasonable fee for claimant's attorney's services before the Board and court following the Court of Appeals' opinion 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 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).

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 $21,582, payable by SAIF.

Accordingly, 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.

In the Matter of the Compensation of
PATRICIA J. HURD, Claimant
WCB Case No. 00-09221
ORDER ON RECONSIDERATION
Schneider, et al., Claimant Attorney
Meyers, et al., Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests reconsideration of our July 25, 2001 Order on Review that remanded this matter to the Administrative Law Judge (ALJ) for further proceedings. Contending that our order lacks sufficient findings of fact, is erroneous as a matter of law, is not supported by substantial evidence and demonstrates an abuse of discretion, claimant argues that our decision remanding to the ALJ was incorrect.

In our original order, we determined that the employer was entitled to amend its November 29, 2000 denial of claimant's current low back condition (which asserted a major contributing cause defense) based on a February 15, 2001 letter in which its counsel stated that the employer was denying claimant's current condition on *both* major and material contributing cause grounds. Finding that this conclusion raised the issue of whether claimant would be entitled to a continuance of the hearing in order to respond to the "new issue" raised by employer's counsel's letter, we remanded the case to the ALJ to allow claimant the opportunity to respond to the material causation issue and, if claimant made such a motion, for the ALJ to decide whether a continuance was appropriate.

Claimant asserts that our order contains no explicit finding that the February 15, 2001 actually amended the employer's denial of claimant's current condition and, further, that the issue of the amended denial was not properly raised before the ALJ. We do not find claimant's contentions persuasive.

While claimant argues that, for various reasons, the February 15, 2001 letter did not constitute a valid amendment of the November 2000 denial, such a focus is too narrow. As noted in our previous order, 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. Therefore, regardless of whether the February 15, 2001 correspondence effectively amended the employer's denial, the employer was free to raise additional issues under the Board's rules.

In light of the above rules, which freely allow for expansion of the issues to be litigated, we conclude that the February 15, 2001 letter did raise a material contributing cause issue prior to the March 6, 2001 hearing. That letter, written by employer's counsel to claimant's attorney, copied to the ALJ and admitted as an exhibit, recounted the discussion of the issues between the parties. The letter specifically noted that the employer continued to deny claimant's current condition on the basis of compensability. The letter further explained that the grounds for the denial was that the August 30, 1999 injury was "not the major or at least material contributing cause to the condition and treatment in October 2000." (Ex. 27). Under these circumstances, the ALJ should have addressed the issue of whether claimant's current condition was materially related to the compensable injury.[1]

We now proceed to the issue of a continuance. Our original order remanded to the ALJ in order to give claimant the opportunity to request a continuance. In her request for reconsideration, however, claimant expressly declines a remand, conceding that a remand for consideration of a continuance is inappropriate. In light of this concession, and the fact that the record is sufficiently developed for review, we address the compensability of claimant's current low back condition under a material contributing cause standard.

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[1] Claimant cites *Kenneth L. Devi*, 49 Van Natta 108 (1997) in support of her argument that the employer did not raise an amended denial theory at hearing. We do not find *Devi* controlling. Unlike that case, where we held that the claimant did not timely raise the issue of claim preclusion on the record, in this case the February 15, 2000 letter expressly framed the issues for litigation by stating that the employer denied claimant's current condition on both material and major contributing cause grounds. Thus, we find that the employer timely raised the material cause issue.

Dr. Arbeene, an examining physician, concluded that, while claimant had sustained a low back strain resulting from the original compensable injury, such strains heal within four to six weeks. Moreover, Dr. Arbeene opined that, beginning October 4, 2000, the compensable low back strain was neither the major or material contributing cause of claimant's complaints or need for treatment. (Ex. 28-2). Dr. Andersen, the attending physician, attributed claimant's current condition primarily to degenerative or psychological factors. Dr. Arbeene opined that claimant's August 30, 1999 low back strain would have resolved by November 18, 1999. (Ex. 29-2). There are no opposing medical opinions asserting that claimant's current low back condition is materially related to the original compensable injury. Thus, we conclude that the record does not establish that claimant's current low back condition is compensable.

Based on this finding, it necessarily follows that the employer's denial was substantively correct and hence not unreasonable. Moreover, as a result of our decision, there are no amounts "then due" and, therefore, nothing on which to base a penalty and no compensation to have been unreasonably resisted. *See* ORS 656.262(11)(a) and ORS 656.382(1).

Accordingly, on reconsideration of our July 25, 2001 order, the ALJ's March 14, 2001 order is reversed.[2] The employer's denial is reinstated and upheld. The ALJ's penalty assessment and attorney fee award are reversed. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

[2] Board member Phillips Polich continues to find that remand to the ALJ is the legally correct disposition of this case. However, in light of claimant's position that a remand is inappropriate, she has addressed the merits of the case and agrees with the majority's disposition of this matter.

In the Matter of the Compensation of
DANIEL S. RAYLE, Claimant
WCB Case No. 00-06347
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorney
Reinisch, MacKenzie, Healey, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's injury claim for right cervical C7 radiculopathy. 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). The employer objects to claimant's attorney's request for an assessed fee of $3,000, arguing that it is excessive and should not exceed $1,500.

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

Claimant's attorney devoted 8.18 hours to the compensability issue on review and submitted a 9-page brief. The issue on review was whether claimant's right cervical C7 radiculopathy was compensable. As compared to typical compensability cases, the compensability issue here was of above average complexity. Because claimant's C7 radiculopathy condition has been found compensable, he is entitled to workers' compensation benefits. The interest involved and the benefits secured for claimant are significant. The attorneys involved in this matter are skilled litigators with substantial experience in

workers' compensation law. In light of the conflicting medical evidence, there was a risk that claimant's counsel's efforts might have gone uncompensated. No frivolous issues or defenses have been presented on review.

In reviewing claimant's attorney's statement of services, we note that, although claimant's attorney addresses each of the factors under OAR 438-015-0010(4), he includes efforts and expenditures related to developing the hearing record, rather than focusing only on his services on review. Claimant did not object to the sufficiency of the attorney fee awarded by the ALJ.

Under these circumstances, and after considering the factors set 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 compensability is $1,750, 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, his counsel's representation of time devoted to the brief, and the employer's objections), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 10, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,750, payable by the employer.

November 27, 2001 Cite as 53 Van Natta 1531 (2001)

In the Matter of the Compensation of
FRED R. TRIBUR, Claimant
Own Motion No. 01-0282M
OWN MOTION ORDER DENYING RECONSIDERATION
Black, Chapman, et al., Claimant Attorney
Argonaut Ins. Co., Insurance Carrier

Reviewing Panel: Members Biehl and Haynes.

On October 15, 2001, we issued an Own Motion Order Reviewing Carrier Closure that affirmed the insurer's July 25, 2001 Notice of Closure. In that order, we concluded that we had subject matter jurisdiction in our Own Motion capacity to review the insurer's closure of claimant's left knee injury claim that previously had been reopened under our Own Motion jurisdiction. We found that the unrebutted opinion of claimant's attending physician established that his left knee injury claim was medically stationary at claim closure.

In addition, we explained that the undeveloped state of the Own Motion record regarding any new medical condition claim was not relevant to the issue before us. Relying on *Craig J. Prince*, 52 Van Natta 108, 111 (2000), we explained that the Board's authority under its "Own Motion" capacity is strictly limited by the provisions of ORS 656.278 and that those provisions do not include the authority to direct a carrier to process a claim under ORS 656.262(7)(c). However, the issue of whether the claim should be processed under ORS 656.262(7)(c) is a "matter concerning a claim," and under ORS 656.283, any party "may at any time request a hearing on any matter concerning a claim." 52 Van Natta at 111.

Therefore, where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *Id.* In other words, we explained that claimant's relief, if any, regarding his request for claim processing under ORS 656.262(7)(c) and 656.268 was with the *Hearings Division*, not the Board in our Own Motion jurisdiction under ORS 656.278.

On reconsideration, claimant contends that the insurer has accepted a new medical condition (degenerative arthritis of the left knee) and disputes the insurer's processing of that new medical condition claim. As explained our October 15, 2001 order, if claimant disputes the processing of his new medical condition claim, his dispute is within the Hearings Division's jurisdiction, not the Board's Own Motion jurisdiction. Because claimant's contention was adequately addressed in our October 15, 2001 order, the request for reconsideration is denied.

In conclusion, we adhere to our October 15, 2001 Own Motion Order Reviewing Carrier Closure. The parties' rights of appeal shall continue to run for the date of our October 15, 2001 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LAURA K. ALANDER, Claimant
WCB Case No. 00-06993
ORDER ON REVIEW
Reinisch, MacKenzie, Healey, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the insurer's denial of her occupational disease claim for stress-related chest pain and mental disorders. With her reply brief, claimant also submits an additional medical report.[1] We treat such a request as a motion for remand. On review, the issues are remand and compensability.

We adopt and affirm the ALJ's order with the following supplementation on the "remand" issue.

Our review must be based on the record certified to us. *See* ORS 656.295(5). Consequently, we treat claimant's request to admit an additional medical record on review as a motion to remand to the ALJ for the taking of additional evidence. *Tamara J. Fleshman*, 52 Van Natta 1918 (2000); *Judy A. Britton*, 37 Van Natta 1262 (1985).

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 the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, there is no evidence that the medical records claimant would submit for the first time on review were unavailable with due diligence at the time of the hearing. *See Tamara J. Fleshman*, 52 Van Natta at 1918. Moreover, in light of the existing documentary and testimonial evidence already present in the record, we find that consideration of this additional evidence would not likely affect the outcome. *See Compton v. Weyerhaeuser Co.*, 301 Or at 646. Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Accordingly, it does not merit remand. ORS 656.295(5).

ORDER

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

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[1] We acknowledge the insurer's "Objection to Supplemental Arguments" directed at claimant's additional submissions filed after completion of the briefing schedule. However, in light of our order affirming the ALJ, and our denial of remand, we need not address the employer's motion.

In the Matter of the Compensation of
LAURA J. DECKER, Claimant
WCB Case No. 00-07600
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of her occupational disease claim for a bilateral 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

The ALJ upheld SAIF's denial of claimant's claim for bilateral carpal tunnel syndrome (CTS), finding that claimant had not met her burden of proof through Dr. Jewell, a consulting physician. On review, claimant contends that Dr. Jewell's opinion is persuasive. Based on the following reasoning, we agree.

To establish her CTS condition as an occupational disease, claimant must prove that her work activities are the major contributing cause of the condition. ORS 656.802(2)(a). Due to the presence of a potentially-contributory preexisting hypothyroid condition, this case represents a complex medical question, for which expert medical evidence is required. *Barnett v. SAIF*, 122 Or App 279 (1993).

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

Here, claimant's treating physician is Dr. Fletchall. Dr. Fletchall concurred with the report of Dr. Tsai, who performed an insurer-arranged medical examination (IME).[1] (Exs. 9, 11). Dr. Tsai concluded that claimant's hypothyroidism condition was a "major overwhelming contributing factor" in causing her CTS condition. (Ex. 9-12). However, for the following reasons, we agree with the ALJ that Dr. Tsai's opinion (and, it follows, Dr. Fletchall's opinion) is unpersuasive.

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[1] We note that the ALJ used the term "CME" or "Compulsory Medical Examination" when referring to a medical examination conducted pursuant to ORS 656.325. This reference likely arises from appellate decisions such as *Robinson v. Nabisco*, 331 Or 178 (2000), *Wantowski v. Crown Cork and Seal*, 175 Or App 609 (2001), *Maddux v. SAIF*, 175 Or App 603, 606 n2 (2001), and *Curry Educational Service District v. Bengtson*, 175 Or App 252, 255 n2 (2001), which use the term "compelled medical examination" when describing such an examination. This Board has generally used the phrase "insurer-arranged medical examination" or "[an examination] at the request of [the employer/insurer/carrier]" when discussing such examinations. *See, e.g., Pamela L. Darling*, 53 Van Natta 1110, *on recon*, 53 Van Natta 1202 (2001); *Carolyn F. Weigel*, 53 Van Natta 1200 (2001); *Karen L. Arms*, 53 Van Natta 1114 (2001).

Effective January 1, 2002, another examination has been added to the statutorily "compelled" medical examinations conducted under ORS 656.325. This examination is initiated at the worker's request following the filing of a hearing request from a denial that is based on a report of a carrier-arranged medical examination under subsection (1)(a) with which the worker's attending physician has not concurred. *See* ORS 656.325(1)(b).

In light of such circumstances, when referring to such examinations in an order, this Board will describe these two types of statutorily-compelled medical examinations in the following manner: (1) for examinations initiated by a self-insured employer, insurer, claim administrator, claim processing agency, or other carrier, these examinations will be referred to as "insurer-arranged medical examinations" (IMEs); and (2) for examinations initiated by a worker, these examinations will be referred to as "worker-requested medical examinations" (WMEs).

Dr. Davies, an endocrinologist who treated claimant for her hypothyroid condition, persuasively rebutted Dr. Tsai's conclusion that the hypothyroidism caused her CTS condition. Dr. Davies described claimant's condition as "exceptionally mild." (Ex. 15-17). Dr. Davies explained that Dr. Tsai had apparently confused claimant's condition with the more severe condition of myxedema. (Ex. 15-3). Dr. Jewell also disagreed with Dr. Tsai's correlation of claimant's CTS condition with her hypothyroidism. (Ex. 13-2).

The only remaining medical opinion on causation is that of Dr. Jewell. Dr. Jewell concluded that claimant's work activities were the major contributing cause of her CTS condition. (Ex. 13). Dr. Jewell specifically discussed and then eliminated any off-work activities or "preexisting conditions" (including the hypothyroid condition) as causes of claimant's CTS condition. (Ex. 13-2). Nevertheless, the ALJ found Dr. Jewell's opinion to rest on an inaccurate history, and therefore to be unpersuasive.

First, the ALJ found that Dr. Jewell assumed a history of a more sustained repetitive hand motion than was supported by the record. (Ex. 13). However, we find that Dr. Jewell's history of claimant's performing "repetitive-type hand and arm motions" including "data entry and filing," as well as "counter work, answer[ing] telephone calls" and "10-key work for numerical entries on her computer keyboard" is accurate and supported by the remainder of the evidence. (Ex. 13-1). Dr. Jewell also reviewed a letter from claimant's counsel which accurately summarized the proportionate time claimant spent with each work activity. (Ex. 12-1). In particular, Dr. Jewell found claimant's "repetitive-type hand and arm motions in a palm-down ergonomic pattern on the keyboard" to be causative of her CTS condition.[2] (Ex. 13-2). Specifically, claimant's testimony and the "workload tracking" reports in Exhibit 2 detail all of the above activities. (Ex. 2; Tr. 5-7).

Although the ALJ faulted Dr. Jewell for describing the "palm-down" activity as being performed for "many hours at a time," the work tracking reports support the fact that claimant was required to perform data entry for up to five hours in a day. (Exs. 2-17, 13-2). We are persuaded that Dr. Jewell relied on a substantially accurate history in this regard.

The ALJ also found that Dr. Jewell's history of "nocturnal paresthesias" was not supported by claimant's testimony or by the history recorded by Dr. Tsai. (Ex. 13-1). However, claimant testified that she wore wrist splints at night, and that the splints relieved her symptoms. (Tr. 21). That testimony is reasonably consistent with Dr. Jewell's history of "nocturnal paresthesias." In any event, even if Dr. Jewell's history is inaccurate on this particular point, we do not find it to be sufficiently material to his opinion on causation to entirely discount the opinion. *See Gale F. Farrester*, 53 Van Natta 176, *on recon* 53 Van Natta 315 (2001).

Finally, the ALJ found that Dr. Jewell's opinion was conclusory in nature and therefore unpersuasive. However, as detailed above, Dr. Jewell adequately explained his opinion by describing the contribution of claimant's "palms-down" work activity to her CTS condition. (Ex. 13-2). Moreover, Dr. Jewell discussed but discounted claimant's hypothyroid condition and off-work activities.[3] (*Id.*)

In sum, we find Dr. Jewell's opinion to persuasively establish claimant's bilateral CTS condition as an occupational disease. ORS 656.802(2)(a). Accordingly, we reverse the ALJ's order and set aside SAIF's denial.

Finally, claimant's attorney is entitled to an assessed attorney fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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[2] We acknowledge SAIF's contention that this portion of Dr. Jewell's opinion was couched in possibilities; *i.e.*, "*could* produce the carpal tunnel syndrome." (emphasis added) (Ex. 13-2). However, Dr. Jewell's ultimate opinion on "major contributing cause" was not based on possibilities. (*Id.*)

[3] We therefore disagree with SAIF's contention that Dr. Jewell's opinion rests on a "precipitating cause" analysis as prohibited by *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

ORDER

The ALJ's order dated June 6, 2001, as corrected on June 8, 2001, is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded $5,500, payable by SAIF.

In the Matter of the Compensation of
BONNIE M. PRICE, Claimant
Own Motion No. 01-0284M
OWN MOTION ORDER

Reviewing panel: Members Haynes and Phillips Polich.

The self-insured employer submitted claimant's request for temporary disability compensation for her left arm condition. Claimant's aggravation rights have expired. Although the employer does not dispute that claimant was in the work force at the time of disability, it recommends against reopening the claim, contending that claimant does not meet the requirements of ORS 656.278(1)(a) on two grounds. First, the employer contends that claimant is not entitled to Own Motion relief because the treatment she underwent (surgical implantation of a spinal cord stimulator) was performed on an outpatient basis and did not require inpatient surgery or overnight hospitalization. Second, the employer contends that the treatment was for pain management, not for curative purposes, and thus does not entitle claimant to Own Motion relief. Based on the following reasoning, we find that claimant meets the requirements of ORS 656.278(1)(a).

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

We have defined "surgery" as an invasive procedure undertaken for a curative purpose, which is likely to temporarily disable the worker. *Fred E. Smith*, 42 Van Natta 1538 (1990). A claimant need not undergo *inpatient* surgery or hospitalization requiring an overnight stay to qualify for temporary disability compensation under the Board's Own Motion jurisdiction. ORS 656.278(1)(a) explicitly states that a worsening of the compensable injury requiring "either inpatient or outpatient surgery or other treatment requiring hospitalization" allows the Board to "authorize the payment of temporary disability from the time the worker is actually hospitalized or undergoes outpatient surgery." Because the language of the statute is written in the disjunctive, meeting any one of the listed requirements is sufficient. *See Roy G. Wells*, 49 Van Natta 1557 (1997) (ORS 656.278(1) does not require that a claimant both undergo outpatient surgery and be hospitalized as an inpatient; invasive procedure resulting in temporary disability sufficient); *Gary L. Dobbins*, 49 Van Natta 88 (1997) (outpatient surgery that was invasive and resulted in temporarily disabling the claimant satisfied ORS 656.278(1)(a)).

Here, claimant underwent outpatient surgery to treat her compensable left upper extremity reflex sympathetic dystrophy. On July 11, 2001, Dr. Kahn, claimant's attending physician, implanted a "temporary device" (dual cervical epidural spinal cord stimulator electrodes) to treat claimant's ongoing and unrelenting left upper extremity pain. This procedure included: (1) placement of cervical epidural

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[1] ORS 656.278(1)(a) provides, in relevant part, that the Board:

"may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

electrodes; (2) sharp and dull dissection to enable anchoring of the electrode catheters; (3) creation of a tunnel to the left infrascapular region and development of a pocket using sharp and dull dissection and electrocautery; and (4) wound coverage with multiple sutures. The purpose of this "temporary device" was to determine the effectiveness of such treatment for claimant. This procedure was performed on an outpatient basis.

On July 24, 2001, Dr. Kahn performed outpatient surgery to implant a permanent spinal cord stimulator in claimant's upper back. This procedure involved: (1) incisions in the left upper back at C4 and T1-T2 using sharp & dull dissection to open a pocket; (2) using a tunneling device electrode extensions were carrier from the ventral to the dorsal wound; (3) implantation of an impulse generator; and (4) wound coverage with multiple sutures.

We find that these procedures are invasive and qualify as outpatient surgery under ORS 656.278(1)(a). However, that is not the end of our inquiry. In this regard, the employer also contends that the outpatient surgery did not qualify for Own Motion relief under ORS 656.278(1)(a) because it was for pain relief, rather than for curative purposes. We disagree.

As noted above, the Board has defined surgery as an invasive procedure undertaken for a curative purpose, which is likely to temporarily disable the worker. *Fred E. Smith*, 42 Van Natta at 1538. The basis for including "curative purpose" in the definition of surgery is to satisfy the statutory requirement of "a worsening of a compensable injury," which is one of the prerequisites of our authority to reopen a claim for Own Motion relief. ORS 656.278(1)(a); *Earl Prettyman*, 46 Van Natta 891 (1994).

Under normal circumstances, the need for curative surgery for the compensable condition indicates a worsening of that condition. On the other hand, the need for diagnostic tests requiring surgery or hospitalization does not necessarily indicate a worsening of the compensable condition. *See Phillip E. Hager*, 43 Van Natta 2291 (1991) (diagnostic surgery to determine status of compensable condition that revealed no worsening of compensable condition did not entitle the claimant to benefits under ORS 656.278(1)(a)). Based on the following reasoning, we find that there was a worsening of claimant's compensable injury that required outpatient surgery.

In a May 8, 2001 chart note, Dr. Kahn diagnosed a "complex regional pain syndrome of [claimant's] left upper extremity since 1984 when she was injured on the job." He noted that claimant had disabling pain in her left shoulder, left forearm, and left elbow as a result of the compensable injury and was "currently disabled and unable to work." He also reported that claimant underwent sympathetic blocks and intravenous bier blocks without long term relief. Dr. Kahn commented that claimant had developed a tremor of her left arm at rest that was steadily worsening. The physician noted that claimant was placed on medical leave in June 2000, and had attempted to return to work in January 2001, but was only able to work half-time about a month before becoming disabled again. Dr. Kahn reported that a TENS unit was not effective and biofeedback was initially used, but was no longer effective. Dr. Kahn recommended that claimant undergo the implantation of a spinal cord stimulator as a "covered benefit based on medical necessity."

At the request of the employer, Dr. Spencer, M.D., reviewed claimant's medical record. In a June 6, 2001 report, Dr. Spencer noted that claimant had a chronic pain syndrome that was refractory to aggressive medical management that had included medications (including narcotics), stellate blocks, sympathectomies, multiple arm surgeries, physical therapy, and chiropractic care. He concluded that claimant was a good candidate for implantation of a spinal cord stimulator and that such medical treatment was medically appropriate. He further opined that there was no "cure" for claimant's "illness," but that the proposed treatment "offers the greatest potential for reduction of pain and improved functionality."

As noted above, claimant underwent two outpatient surgical procedures. First, on July 11, 2001, claimant underwent surgical implantation of a temporary device to determine whether the treatment would be effective for her. Following this procedure, claimant's condition improved, including pain-free intervals and total abatement of her tremors and involuntary jerking movements, which were "both components of Complex Regional Pain Syndrome." As a result of this improvement, Dr. Kahn sought authorization to implant a permanent device. Following the July 24, 2001 permanent surgical implant, Dr. Kahn noted that claimant's left hand "appears normal now" having lost the previous edema and discoloration.

In an August 9, 2001 report, Dr. Kahn noted that the majority of claimant's neuropathic pain in her left arm had been controlled with the dorsal column stimulator. He concluded that with this improvement, claimant might be able to return to work at a half-time level as soon as November 2001.

On October 12, 2001, Dr. Puziss, claimant's treating orthopedist since 1992, concurred with Dr. Kahn's assessment. Dr. Puziss noted that, before implantation of the neurostimulator, claimant had been in so much pain that she could not work. Specifically, Dr. Puziss concluded that claimant's "compensable injury made it impossible for her to obtain and perform any kind of work for which she was qualified between June 2000 and October 31, 2001." However, he noted that, following the implantation of the neurostimulator, claimant's pain level dramatically improved and that she would be released to half time work at her regular job in November 2001.

Based on the unrebutted opinions of Drs. Kahn, Spencer and Puziss, we conclude that the record establishes that the need for the surgical procedure was caused by a worsening of claimant's compensable condition. Prior to undergoing the implantation of the stimulator, Dr. Kahn reported that claimant was "disabled and unable to work" due to her compensable condition. In addition, Dr. Kahn opined that, despite attempts at several non-invasive modalities, claimant's compensable condition was progressively worsening. Thus, we find that claimant's condition worsened to the extent that she underwent an invasive procedure that resulted in temporary disability, which qualifies as "surgery" under ORS 656.278. *See Fred E. Smith*, 42 Van Natta at 1538; *Barry M. Brown*, 53 Van Natta 346 (2001) (worsening of compensable condition resulted in need for surgical implantation of spinal cord stimulator); *Vera Tannenbaum*, 52 Van Natta 1962, *on recon* 52 Van Natta 2109 (2000) (worsening of compensable condition resulted in need for surgical implantation of morphine pump); *Durwood McDowell*, 47 Van Natta 2370 (1995) ("worsening" requiring hospitalization under ORS 656.278(1)(a) found where the claimant's condition worsened to extent that pain could only be managed by treating the compensable condition during inpatient hospitalization). Under such circumstances, we conclude that authorization of temporary disability compensation is appropriate.

Accordingly, we authorize the reopening of claimant's 1984 injury claim for the employer to provide temporary disability compensation beginning July 11, 2001, the date claimant underwent the first outpatient surgery. When claimant's condition is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

November 28, 2001 Cite as 53 Van Natta 1537 (2001)

In the Matter of the Compensation of
RONALD J. WADDELL, Claimant
WCB Case No. 01-01203
ORDER ON REVIEW
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the SAIF Corporation's denial of his occupational disease claim for a bilateral thumb condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.[1]

ORDER

The ALJ's order dated July 11, 2001 is affirmed.

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[1] We note that claimant objects to the fact that closing arguments were not recorded or transcribed. Claimant was represented at hearing and he does not dispute his former attorney's authority to act on his behalf. To the extent claimant is arguing about alleged inadequacies on the part of his former attorney, the Workers' Compensation Board is not the proper forum for litigating the adequacy of legal representation. *See, e.g., Maybelle M. Werner*, Van Natta 2076 (2000).

In the Matter of the Compensation of
ALEXA PROVENCIO, Claimant
WCB Case No. 01-00345
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) found that claimant's argument concerning her adaptability factor did not arise out of an Order on Reconsideration that awarded 14 percent (44.8 degrees) unscheduled permanent disability for a right shoulder injury; and (2) declined to award additional permanent disability. In her brief, claimant moves for acceptance of her appellant's brief on the ground that it was untimely filed due to extraordinary circumstances. On review, the issues are the procedural motion, jurisdiction and, potentially, extent of unscheduled permanent disability.

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

Procedural Motion

Claimant filed a motion for extension of the briefing schedule. Because the motion was filed after the due date for claimant's brief, we interpret her request as a motion for waiver of the Board's rules. *See* OAR 438-011-0020(3); OAR 438-011-0030.

Claimant asserts that she did not request an extension of the briefing schedule in a timely manner because the request for appeal was not properly docketed, in error. The insurer responds that claimant's calendaring error does not constitute "extraordinary circumstances" sufficient to waive the filing requirements.

Under OAR 438-011-0030, a motion to waive the rules may be allowed if the Board finds that extraordinary circumstances beyond the control of the moving party justify such action. In previous cases, we have held that clerical errors and calendaring errors do not constitute extraordinary circumstances beyond the control of the moving party. *E.g., Peter A. Roy*, 52 Van Natta 2075 (2000); *Antonina Gnatiuk*, 50 Van Natta 976 (1998).

Here, claimant did not file a request for briefing extension within the requisite time period. After considering the parties' positions (including the insurer's opposition), we do not consider claimant's counsel's docketing error to constitute an extraordinary circumstance beyond the control of the requesting party. *See, e.g., James W. Petrie*, 52 Van Natta 936 (2000). Consequently, we reject claimant's appellant's brief as untimely. In any event, our consideration of the brief would not change our ultimate disposition of the case.

Jurisdiction and Extent of Unscheduled Permanent Disability

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated June 19, 2001 is affirmed.

In the Matter of the Compensation of
CINDY L. RAMSEY, Claimant
WCB Case Nos. 00-05411 & 00-02043
ORDER ON REVIEW
Welch, et al., Claimant Attorney
Reinisch, et al., Defense Attorney
Cavanagh & Zipse, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Farmers Insurance Group (Farmers), on behalf of MAACO Auto Paint & Body (MAACO), requests review Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS); and (2) upheld Firemans Fund Insurance Company's denial, on behalf of Earl Scheib, Inc., of the same condition. Farmers also argues that the ALJ erred in declining to admit testimony of Mr. Dalicub, one of claimant's co-workers. On review, the issues are evidence, compensability, and responsibility.

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

The hearing on this matter convened on September 12, 2000. The ALJ continued the hearing to allow the parties to take Dr. Brown's deposition, obtain payroll records, and take the testimony of James Brown, one of claimant's co-workers. The hearing convened again on April 16, 2001. At that time, Farmers offered the testimony of Mr. Dalicub, another of claimant's co-workers. Claimant objected to admission of Mr. Dalicub's testimony. (*See* 2Tr. 1-5, 22-24). The ALJ declined to admit the disputed evidence. Farmers contends that the ALJ erred in this regard.

The ALJ has broad discretion with regard to the admissibility of evidence at hearing. *Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. *Jesus M. Delatorre*, 51 Van Natta 728 (1999); *James D. Brusseau II*, 43 Van Natta 541 (1991). Specifically, when an ALJ leaves the record open for a limited purpose, it is within the ALJ's discretion to exclude evidence that does not comport with that purpose. *Clifford L. Conradi*, 46 Van Natta 854 (1994). Here, the record remained open for specific purposes and the ALJ did not abuse his discretion in refusing to admit evidence beyond those purposes. *See David W. Keller*, 52 Van Natta 1559 (2000).

Finally, we agree with the ALJ that the claim is compensable and Farmers is responsible, because claimant's work for MAACO was the major contributing cause of her bilateral CTS and the major contributing cause of a pathological worsening of her preexisting left CTS. (*See* Ex. 35-35-40).

Claimant's attorney is entitled to an assessed fee for services on review. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,100, payable by Farmers. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and her counsel's undisputed statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated May 10, 2001 is affirmed. For services on review, claimant is awarded a $2,100 attorney fee, payable by Farmers Insurance Group, on behalf of MAACO.

In the Matter of the Compensation of
FRANCIS J. SIMON, Claimant
WCB Case Nos. 00-09678, 00-09677, 00-06748 & 00-03168
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Julie Masters (Saif), Defense Attorney
Reinisch, MacKenzie, Healey, et al., Defense Attorney
Thaddeus J. Hettle, Defense Attorney

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

The SAIF Corporation, on behalf of Abella Masonry (SAIF/Abella), requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's occupational disease claim for bilateral overuse syndrome condition. SAIF, on behalf of Clem Fleck (SAIF/Clem Fleck), cross-requests review of that portion of the ALJ's order that set aside its denial of responsibility for claimant's right carpal tunnel syndrome condition. SAIF, on behalf of Haines Masonry (SAIF/Haines), cross-requests review of that portion of the ALJ's order that set aside its denial of compensability of claimant's consequential condition claim for left wrist arthritis.[1] On review, the issues are compensability and responsibility. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except for the second paragraph concerning claimant's 1972 activities.

CONCLUSIONS OF LAW AND OPINION

Claimant worked for many years as a brick mason. The ALJ found that claimant proved compensability of his conditions of bilateral overuse, right carpal tunnel syndrome, and left wrist arthritis. The ALJ further found that SAIF/Abella was responsible for the bilateral overuse condition, SAIF/Clem Fleck was responsible for the right carpal tunnel syndrome condition, and SAIF/Haines was responsible for the left wrist arthritis condition. All of those parties challenge the ALJ's conclusions.

Compensability of Bilateral Overuse Condition

In arguing that claimant did not prove compensability of the bilateral overuse condition, SAIF/Abella asserts that there is no persuasive evidence that claimant has such a condition. Claimant relies on the ALJ's order finding that the "opinions of Drs. Smith, Gritzka, and Puziss collectively establish the compensability of claimant's bilateral overuse syndrome, right carpal tunnel syndrome, and left degenerative arthritis wrist condition."

When claimant saw Dr. Cooper on November 24, 1997, Dr. Cooper noted "overuse syndrome." (Ex. 6). Claimant, however, did not return to see Dr. Cooper until January 29, 1999; Dr. Cooper at that time diagnosed possible left carpal tunnel syndrome and chronic left shoulder discomfort. (Ex. 7). Claimant continued seeing Dr. Cooper through May 2000. Dr. Cooper did not diagnose overuse syndrome.

Claimant first saw Dr. Smith in consultation with Dr. Cooper and was examined by him several times thereafter. (Ex. 12). As Dr. Smith explained in his deposition, he diagnosed traumatic arthritis of the left wrist and carpal tunnel syndrome of the left wrist. (Ex. 40A-4, 40A-8). Thus, Dr. Smith also did not diagnose overuse syndrome.

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[1] SAIF/Haines also "anticipated" that SAIF/Abella and SAIF/Clem Fleck would request review of that portion of the ALJ's order that found that claimant timely filed his occupational disease claims for right carpal tunnel syndrome and joined in their arguments. Because those parties did not contest the ALJ's conclusions concerning claimant's timely filing of his claim, we disregard SAIF/Haines' arguments concerning that issue.

Examining neurologist, Dr. Farris, attributed claimant's symptoms to a possible peripheral neuropathy condition. (Ex. 16-6). Dr. Gritzka, an orthopedic surgeon who reviewed the medical record at claimant's attorney's request agreed with Dr. Smith that claimant had right carpal tunnel syndrome and left wrist arthritis. (Ex. 44).

Only Dr. Puziss, who examined claimant at his attorney's request, diagnosed bilateral overuse syndrome, as well as right carpal tunnel syndrome, and traumatic arthritis of the left wrist. (Ex. 27-4). He explained that the overuse condition "is due to [claimant's] work given that he has worked for the past twenty [years] as a brick mason, working heavily and very repetitively[.]" (Ex. 32). Dr. Puziss further stated that the "overuse would be superimposed upon the old scaphoid fracture, which because of the fracture and continued use, he has a traumatic and degenerative arthritis. The overuse syndromes ultimately cause some degeneration of the nerves in his wrist, thus causing carpal tunnel syndrome on the right." (*Id.*)

Because none of claimant's treating physicians, including Dr. Cooper and Dr. Smith, nor Dr. Farris and Dr. Gritzka, found that claimant had "overuse syndrome," we conclude that the preponderance of medical evidence does not establish that claimant had an "overuse syndrome." Thus, we conclude that claimant did not establish the compensability of a bilateral overuse syndrome condition. *See* ORS 656.005(7)(a).

Responsibility for Carpal Tunnel Syndrome

Relying on the opinions of Drs. Smith, Puziss, and Gritzka over that of Dr. Farris, the ALJ found that claimant showed that his work activities performing masonry were the major contributing cause of his right carpal tunnel syndrome. With regard to responsibility, the ALJ found that claimant first received medical services for his condition while working for SAIF/Abella but, based on evidence showing that claimant's work at SAIF/Clem Fleck contributed to a pathological worsening, further concluded that responsibility shifted to SAIF/Clem Fleck. SAIF/Clem Fleck asserts that there is insufficient medical evidence that its work activity pathologically worsened claimant's condition and, thus, responsibility remains with SAIF/Abella. SAIF/Abella responds that initial responsibility is with SAIF/Clem Fleck and that responsibility does not shift to its employment.

Dr. Puziss reported that claimant's masonry work was the major contributing cause of his right carpal tunnel syndrome. (Ex. 27-4). He explained that claimant probably "had some carpal tunnel disease sometime before his work at Clem Fleck Masonry but his major symptoms occurred after working there about four months." (*Id.*) Dr. Smith concurred with Dr. Puziss' report. (Ex. 38).

During a deposition, Dr. Smith indicated that claimant's masonry work was the major contributing cause of his condition. (Ex. 40A-10). He also stated that the condition would have "accumulated for an indefinite period of time prior to March '99 when [claimant] began to experience physical symptoms." (*Id.* at 26). With regard to claimant's examination in November 1997, Dr. Smith found it "reasonable" that claimant's symptoms were consistent with carpal tunnel syndrome. (*Id.* at 34). According to Dr. Smith, a report of worsening symptoms indicated that the condition had worsened. (*Id.* at 36-37).

Finally, Dr. Gritzka agreed that claimant's masonry work was the major contributing cause of his carpal tunnel syndrome. (Ex. 44-3).

Because claimant does not have an accepted claim for right carpal tunnel syndrome and the medical evidence attributes the condition to claimant's entire work history, we apply the last injurious exposure rule to determine responsibility. *See SAIF v. Yokum*, 132 Or App 18, 24 (1994); *Bennett v. Liberty Northwest Ins. Corp.*, 128 Or App 71, 75 n. 1 (1994).

The last injurious exposure rule provides that, where a worker establishes that an occupational disease is caused when two or more carriers are at risk, the last employment providing the potentially causal conditions is deemed responsible for the disease. *Boise Cascade Corp. v. Starbuck*, 296 Or 238 (1984). The onset of disability is the "triggering date" for determining which employment is the last potentially causal employment. *Bracke v. Baza'r*, 293 Or 239, 248 (1982). 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, 213 (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).

Here, according to Dr. Smith, claimant's symptoms when he sought treatment from Dr. Cooper on November 27, 1997 were consistent with carpal tunnel syndrome. Dr. Puziss also thought that claimant had developed the condition before his work at Clem Fleck, which began in January 1999. Based on this evidence, we find that claimant first sought treatment for his right carpal tunnel syndrome condition on November 27, 1997. Because claimant worked for SAIF/Abella at that time, it is presumptively responsible for the condition.

Responsibility for claimant's carpal tunnel syndrome shifts to a later employment if the "later employment contributed independently to the cause or worsening" of the condition. *MacMillan Plumbing v. Garber*, 163 Or App 165, 170 (1999), *see Bracke v. Baza'r*, 293 Or at 250 (once assigned, responsibility may shift forward if later work activities "contribute to the cause of, aggravate, or exacerbate the underlying disease").

Because the medical evidence implicates all of claimant's masonry work, we find proof that claimant's masonry work after his employment with SAIF/Abella independently contributed to his right carpal tunnel syndrome. In this respect, Dr. Smith indicated that claimant's condition would have accumulated before March 1999. Because claimant began working for SAIF/Clem Fleck in January 1999, we conclude that its employment independently contributed to a worsening of claimant's condition. Thus, we agree with the ALJ that responsibility shifts to SAIF/Clem Fleck.

Compensability of Left Wrist Arthritis

Relying on claimant's testimony, the ALJ found that claimant compensably injured his left heel and left wrist in 1972 while working for SAIF/Haines. Furthermore, based on medical evidence showing that a left wrist fracture was the major contributing cause of claimant's left wrist arthritis, the ALJ concluded that claimant proved compensability under ORS 656.005(7)(a)(A).

On review, SAIF/Haines continues to assert that the record lacks evidence that it accepted a left wrist fracture in 1972 and also argues that claimant's testimony is not sufficiently reliable to prove such an acceptance. Thus, according to SAIF/Haines, claimant did not prove that a "compensable injury" was the major contributing cause of his left wrist arthritis condition.

We agree with SAIF/Haines that the record lacks any contemporary documentary evidence that SAIF/Haines accepted a left wrist fracture. A Form 801 provides that claimant fractured his left heel on July 23, 1972 when he fell from a ladder and this claim was accepted. (Ex. 1). There also is some evidence of an injury on October 23, 1973. (Ex. 1A). The record lacks any medical evidence that claimant was treated for a left wrist fracture.

In November 1997, claimant told Dr. Cooper that "he recalled having fractured [his left] wrist in 1972." (Ex. 6). In January 1999, claimant told Dr. Cooper that he sustained a "traumatic fracture of the left wrist in the distant past[.]" (Ex. 7).

A few months later, Dr. Gibbs reported that claimant "broke both of his wrists in an on-the-job fall in 1975." (Ex. 10-1). Similarly, Dr. Smith noted that claimant's "left wrist had a fracture in about 1975 following a fall from 20 feet." (Ex. 12-1). Claimant told Dr. Farris that "around 1971 or 1972 he was at work when he fell 26 feet and thinks that he recalls fracturing both wrists and one of his heels as well as fracturing his tailbone." (Ex. 16-3). In an April 2000 Form 801, claimant wrote that he "fell 26' and then 14' in 1976 - ? & fractured or broke my left wrist." (Ex. 20). Claimant provided similar information on a Form 827 but dated the incident as 1973-74. (Ex. 24).

In July 2000, Dr. Puziss reported that claimant "fell from a height of about 25 feet" about 20 years ago and sustained a left wrist fracture. (Ex. 27-2). Dr. Puziss further noted that claimant "fell again from a height of 14 feet, again probably refracturing his left wrist and the left heel." (*Id.*)

At hearing, claimant testified that he "thought" he broke his heel and left wrist, "but from what the records have indicated," he "guessed" he just broke his wrist. (Tr. 38). Claimant also stated that he received medical treatment at that time for his left wrist. (*Id.*) Moreover, according to claimant, he broke his wrist a second time about a year later during another work accident. (*Id.* at 39). Although acknowledging that he gave a different history to Dr. Farris, claimant explained that he had "recollected everything, talking to my mom and everybody[.]" (*Id.* at 48).

The ALJ found that claimant's "manner and demeanor of testifying" was "credible, straightforward, and forthright," and his explanation for prior inconsistent histories was "understandable and plausible." 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 witness's testimony, we are equally qualified to make our own determination of credibility. *Coastal Farm Supply v. Hultberg*, 94 Or App 282 (1987). Here, based on the substance of the record, we do not find claimant's testimony concerning the 1972 and 1973 injuries to be sufficiently reliable that he proved that he fractured his left wrist while working for SAIF/Haines.

First, as noted above, the documentary record shows only that SAIF/Haines accepted a left heel fracture from a 1972 fall. Furthermore, claimant gave inconsistent histories to the physicians. Claimant dated the injury as 1971, 1972, 1973, 1975, and 1976, and "about 20 years ago" or 1980. In describing his injuries, claimant at times limited it to a left wrist fracture and other times included both wrists, the left heel and the tailbone. Finally, claimant first cited a single incident without relating it to work activities, then said the incident was at work, and later reported fracturing the left wrist during two work injuries.

In short, we find claimant's inconsistent reporting as showing that his recollection of the 1972 and 1973 injuries is unreliable. Because the record also is devoid of any evidence that SAIF/Haines accepted a left wrist fracture or that claimant at any time sought medical treatment for such a condition, we conclude that claimant failed to prove a compensable left wrist fracture injury with SAIF/Haines.

The medical evidence supporting compensability relied on a history that claimant sustained a left wrist fracture and such condition was the major contributing cause of claimant's current arthritis. (Exs. 27-5, 35, 40A-4, 44-4). Because we find that claimant did not prove the accuracy of this history by establishing that he sustained a wrist fracture while working with SAIF/Haines, we find these medical opinions unpersuasive. Thus, claimant did not prove compensability. *See* ORS 656.005(7)(a)(A).

Attorney Fee

Claimant is entitled to an attorney fee for his counsel's services on Board review. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by SAIF/Clem Fleck. In reaching this conclusion, we have particularly considered the time devoted to the denial issues (as represented by claimant's briefs), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated April 20, 2001 is reversed in part and affirmed in part. That portion of the order setting aside SAIF/Abella's denial of claimant's bilateral overuse syndrome condition claim is reversed. SAIF/Abella's denial is reinstated and upheld. That portion of the order setting aside SAIF/Haines' denial of claimant's left wrist arthritis condition is reversed. SAIF/Haines' denial is reinstated and upheld. The ALJ's attorney fee awards assessed against SAIF/Abella and SAIF/Haines are reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by SAIF/Clem Fleck.

In the Matter of the Compensation of
ABDERRAHIM NAJJAR, Claimant
WCB Case No. 00-06870
ORDER ON REVIEW
Mark D. Sherman, Claimant Attorney
Meyers, et al., Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's claim for a left knee injury. The employer has also moved to strike claimant's respondent's brief as untimely. On review, the issues are compensability and the motion to strike. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We summarize those findings as follows.

Claimant worked for the employer's grocery store as a janitor. Claimant's injury occurred when he chased a suspected shoplifter from the employer's parking lot to an area off the employer's premises. In the course of this chase, claimant fell and injured his left knee.

Immediately prior to his injury, claimant had been off duty for several hours and had returned to the employer's premises to do personal shopping. Claimant was in the company of Mr. Johnson, also an off-duty co-employee. Mr. Johnson had bought a six pack of beer at the store and claimant and Mr. Johnson sat in Mr. Johnson's car drinking beer. At some point, claimant and Johnson got out of the car and were in front of the store speaking with two females. Wilson Lee, the head clerk at the employer's store, came out of the front door in pursuit of the shoplifting suspect. Mr. Lee observed claimant and Johnson and called to them and then began running after the suspect. Claimant and Johnson heard Lee call and interpreted this as a request for assistance. Claimant and Johnson continued to run and passed Lee. Lee stopped the chase once he left the employer's premises. Claimant and Johnson continued the chase approximately one block from the store when claimant fell and injured his left knee.

At the time of claimant's injury, Wilson Lee was on duty and was pursuing the shoplifting suspect as part of his official duties. In his position as head clerk, Mr. Lee assumed the management of the store in the absence of the store manager. At the time of claimant's injury, the employer had a policy that prohibited employees from pursuing a fleeing shoplifter off the employer's premises. The employer also had a policy prohibiting employees from accusing or assisting in making detentions of suspected shoplifters unless the employees had been designated in writing to do so and had received special training. Claimant had been apprised of the employer's policies regarding shoplifters. Dealing with shoplifters was not an activity that was expressly included in claimant's job. However, prior to claimant's injury, supervisory personnel had solicited and/or accepted claimant's assistance in confronting shoplifters and the employer had never disciplined or dissuaded claimant from engaging in such activities.

The employer denied claimant's claim on August 16, 2000, on the ground that the injury did not occur in the course and scope of employment.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike Respondent's Brief

The employer filed a motion to strike the respondent's brief as untimely. We need not resolve this matter because whether or not claimant's brief is considered, the result of this case would be the same.

Course and Scope

The ALJ concluded that claimant was in the course and scope of employment when his left knee injury occurred. The ALJ reasoned that the injury arose out of work because the injury occurred after claimant responded to a directive from Mr. Lee, who claimant regarded as his "boss." The ALJ further

noted that Lee had supervisory authority at the store in the absence of the manager and assistant manager. The ALJ concluded that, in requesting claimant's assistance, Mr. Lee was acting on behalf of the employer and that the employer thereby accepted the risk that claimant would be injured. On this basis, the ALJ concluded that the injury bore a causal relationship to work; *i.e.*, arose out of employment.

The ALJ further concluded that claimant's injury also satisfied the "in the course of" (or time, place and circumstance) prong of the unitary work-connection test. In reaching this conclusion, the ALJ acknowledged that claimant was off-duty at the time of the incident and also acknowledged that chasing shoplifters was not part of claimant's job. However, the ALJ relied on testimony from the store manager, Mr. Kelly, that off-duty employees sometimes performed work activity at the request of supervisors and were paid for the additional work. The ALJ also relied on the fact that, although the employer had a policy against chasing shoplifters off-premises and although claimant was not authorized under the employer's policy to deal with shoplifters, he had done so in the past and the employer's supervisors had accepted claimant's assistance.

ORS 656.005(7)(a) provides that a "'compensable injury' is an accidental injury * * * arising out of and in the course of employment[.]" There are two elements in determining whether the relationship between the injury and the employment is sufficient to establish compensability of the injury: (1) "arising out of employment" tests the causal connection between the injury and the employment; and (2) "in the course of employment" concerns the time, place, and circumstances of the injury. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994).

The phrases "arising out of" and "in the course of" are two elements of a single inquiry into whether an injury is work-related. *Norpac Foods*, 318 Or at 366; *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596 (1997). This is called the unitary "work-connection" test. Under that test, both elements must be satisfied to some degree; however, they need not be met to the same degree. *Id.* Neither element is dispositive; rather, we consider all the circumstances to determine if the claimant has satisfied the work-connection test. *Norpac Foods*, 318 Or at 366, 369. When the factors supporting one element are many, the factors supporting the other may be minimal. *Redman Industries, Inc. v. Lang*, 326 Or 32, 35 (1997).

Here, considering all of the circumstances surrounding claimant's injury, we are not persuaded that it arose out of the course and scope of employment. In this regard, the "course of" element (time, place and circumstances of the injury) is completely absent. Claimant was not working when the injury occurred. He had been drinking beer in the parking lot and talking to girls with another off-duty co-worker who worked at another store. In addition, when the injury occurred, claimant was doing something that was not part of his job as a janitor (chasing a suspected shoplifter off premises). Moreover, the injury did not occur on the employer's premises (claimant had chased the shoplifter off-premises against the employer's explicit written policy). In short, claimant was not in the course of employment (the time, place and circumstances of his job) when the injury occurred.

Based on this evidence, we are not persuaded that the "course of" employment prong of the test has been satisfied even slightly. In addition, we conclude that the "arising out of element" is weak at best. The only evidence that the ALJ found to support a causal connection between the injury and claimant's work was that he considered Mr. Lee to be the boss and Lee gave him a "directive" to chase the alleged shoplifter. The record contains no evidence that Lee gave claimant any "directive" to chase the shoplifting suspect. Mr. Lee stated that he called to claimant and Johnson and said their first names. (Tr. I, 55). He further indicated that he did not ask the men to help him or to chase the alleged shoplifter. (Tr. I, 58, 74). The whole incident occurred within 10 or 15 seconds. (Tr. I, 74).

Mr. Johnson testified that when he chased the suspect, he did not know he was chasing an alleged shoplifter. (Tr. II 47). Johnson testified that the neighborhood surrounding the store was a dangerous one and he made a decision on his own time to chase the person to help Mr. Lee. (Tr. II 46). Based on the testimony of the witnesses at hearing, it has not been established that Mr. Lee "directed" claimant or Mr. Johnson to pursue the alleged shoplifter. Thus, the causal connection between claimant's employment and his knee injury is minimal at best.

We find that the "in the course of" employment element is missing and the "arising out of" element is weak. Considering all of these factors, we are not persuaded that claimant's injury arose out of the course and scope of employment.

ORDER

The ALJ's order dated May 26, 2001 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

November 29, 2001 Cite as 53 Van Natta 1546 (2001)

In the Matter of the Compensation of
ROBERT F. SHERWOOD, Claimant
WCB Case No. 01-01449
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that upheld the SAIF Corporation's denial of claimant's claim for a current low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order, with the following supplementation. *See Darren Wilcoxen*, 52 Van Natta 58 (2000) (claim fails where supporting medical evidence irreconcilable); *Gary D. Baxter*, 50 Van Natta 634 (1998) (Where doctor did not explain the material inconsistencies between his various opinions, his opinion "as a whole" was unpersuasive because it lacked adequate explanation for those variations).

Claimant contends that prior litigation precludes the present ALJ's analysis of Dr. Grewe's opinion. SAIF objects to this argument, contending that we should not address it because claimant raises it for the first time on review.

We need not resolve SAIF's procedural challenge to claimant's argument because, assuming for the sake of argument that our prior order does have preclusive effect, the result would be the same. We base this conclusion on the following reasoning.

In our prior order, issued February 22, 2001, we adopted an ALJ's order finding that claimant failed to prove that a March *1998* work incident was the major contributing cause of his then-current low back condition. (*See* Exs. 51, 53). We reached this conclusion in part because we found Dr. Grewe's opinion supporting the claim insufficient to prove major causation.

Thus, the prior litigation established the "law of the case" as of October 4, 2000, the date of the prior hearing. In other words, the prior litigation determined that the *1998* work incident was not the major contributing cause of claimant's condition. However, the prior litigation did not actually or necessarily determine the issue in the present case; *i.e.*, whether claimant's 1985 injury was the major contributing cause of his condition as of the May 16, 2001 hearing.

Moreover, our prior order found that Dr. Grewe's September 1, 2000 opinion, (Ex. 50), merely established that claimant's *1998* work incident was a factor that precipitated his then current condition. We do not see how that finding bears on the same doctor's opinion regarding the *1985* injury's causal contribution to claimant's current condition. Under these circumstances, we conclude that the prior litigation does not aid claimant's cause in the present matter.

ORDER

The ALJ's order dated June 19, 2001 is affirmed.

Board Member Phillips Polich concurring.

I write separately to acknowledge claimant's mathematical argument regarding the relative "percent contributions" of his several injuries. Although the argument is interesting, it is insufficient to prove the claim-absent persuasive supporting expert evidence. There is no such supporting evidence in this case. Accordingly, because I agree that Dr. Grewe's various causation opinions are irreconcilable, I also agree that the claim must fail.

November 30, 2001 Cite as 53 Van Natta 1547 (2001)

In the Matter of the Compensation of
PAULA E. COULTAS-PETERSON, Claimant
WCB Case Nos. 00-04054 & 98-08887
ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Meyers, Radler, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) upheld the self-insured employer's denial of claimant's aggravation claim; and (2) upheld its denial of claimant's claims for costrochondritis, left hip bursitis, left knee tendinitis, and left shoulder strain/tendinitis. On review, the issues are aggravation and compensability.

We adopt and affirm the ALJ's order.[1]

ORDER

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

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[1] We note that the ALJ used the term "CME" or "Compulsory Medical Examination" when referring to a medical examination conducted pursuant to ORS 656.325. This reference likely arises from appellate decisions such as *Robinson v. Nabisco*, 331 Or 178 (2000), *Wantowski v. Crown Cork and Seal*, 175 Or App 609 (2001), *Maddux v. SAIF*, 175 Or App 603, 606 n2 (2001), and *Curry Educational Service District v. Bengtson*, 175 Or App 252, 255 n2 (2001), which use the term "compelled medical examination" when describing such an examination. This Board has generally used the phrase "insurer-arranged medical examination" or "[an examination] at the request of [the employer/insurer/carrier]" when discussing such examinations. *See, e.g., Pamela L. Darling*, 53 Van Natta 110, *on recon*, 53 Van Natta 1202 (2001); *Carolyn F Weigel*, 53 Van Natta 1200 (2001); *Karen L. Arms*, 53 Van Natta 1114 (2001).

Effective January 1, 2002, another examination has been added to the statutorily "compelled" medical examinations conducted under ORS 656.325. This examination is initiated at the worker's request following the filing of a hearing request from a denial that is based on a report of a carrier-arranged medical examination under subsection (1)(a) with which the worker's attending physician has not concurred. See ORS 656.325(1)(b).

In light of such circumstances, when referring to such examinations in an order, this Board will describe these two types of statutorily-compelled medical examinations in the following manner: (1) for examinations initiated by a self-insured employer, insurer, claim administrator, claim processing agency,' or other carrier, these examinations will be referred to as "insurer-arranged medical examinations" (IMEs); and (2) for examinations initiated by a worker, these examinations will be referred to as "worker-requested medical examinations" (WMEs).

In the Matter of the Compensation of
JAMIE B. DAVIS, Claimant
WCB Case Nos. 01-01083 & 00-03934
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
Cummins, Goodman, et al., Defense Attorney
Employers Defense Counsel, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that upheld Liberty Northwest Insurance Corporation's (on behalf of Springfield School District) denial of his injury claim for a back condition.[1] On review, the issue is compensability.

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

ORDER

The ALJ's order dated June 11, 2001 is affirmed.

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[1] After requesting review, claimant withdrew his challenge to that part of the ALJ's order that upheld the current condition denial of Royal and SunAlliance Insurance Company, on behalf of Ecklund Industries.

[2] We note that the ALJ used the term "CME" or "Compulsory Medical Examination" when referring to a medical examination conducted pursuant to ORS 656.325. This reference likely arises from appellate decisions such as *Robinson v. Nabisco*, 331 Or 178 (2000), *Wantowski v. Crown Cork and Seal*, 175 Or App 609 (2001), *Maddux v. SAIF*, 175 Or App 603, 606 n2 (2001), and *Curry Educational Service District v. Bengtson*, 175 Or App 252, 255 n2 (2001), which use the term "compelled medical examination" when describing such an examination. This Board has generally used the phrase "insurer-arranged medical examination" or "[an examination] at the request of [the employer/insurer/carrier]" when discussing such examinations. *See, e.g., Pamela L. Darling*, 53 Van Natta 1110, *on recon*, 53 Van Natta 1202 (2001); *Carolyn F. Weigel*, 53 Van Natta 1200 (2001); *Karen L. Arms*, 53 Van Natta 1114 (2001).

Effective January 1, 2002, another examination has been added to the statutorily "compelled" medical examinations conducted under ORS 656.325. This examination is initiated at the worker's request following the filing of a hearing request from a denial that is based on a report of a carrier-arranged medical examination under subsection (1)(a) with which the worker's attending physician has not concurred. *See* ORS 656.325(1)(b).

In light of such circumstances, when referring to such examinations in an order, this Board will describe these two types of statutorily-compelled medical examinations in the following manner: (1) for examinations initiated by a self-insured employer, insurer, claim administrator, claim processing agency, or other carrier, these examinations will be referred to as "insurer-arranged medical examinations" (IMEs); and (2) for examinations initiated by a worker, these examinations will be referred to as "worker-requested medical examinations" (WMEs). *See Laura J. Decker*, 53 Van Natta 1533 (2001).

In the Matter of the Compensation of
RODNEY L. PLANCK, Claimant
WCB Case Nos. 00-05099 & 00-04851
ORDER ON REVIEW
Sather, Byerly & Holloway, Defense Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant, *pro se*, requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) upheld Liberty Northwest Insurance Company's (Liberty) denial, on behalf of Taylor Lumber and Treating Company (Taylor Lumber), of claimant's aggravation and occupational disease claims for his current low back condition; and (2) upheld Royal and Sun Alliance's (Royal) denial, on behalf of the same employer, of claimant's "new injury" and occupational disease claims for the same condition. Royal cross-requests review of that portion of the ALJ's order that set aside its denial of claimant's "new injury" claim for cervical and thoracic strain conditions. On review, the issues are compensability and responsibility. We reverse in part and affirm in part.[1]

FINDINGS OF FACT

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

Claimant began working for Taylor Lumber in June 1995. He fell at work and sustained a compensable low back strain under Liberty's coverage in December 1997. Royal came on the risk in October 1998.

Claimant did not seek treatment for his low back for 17 months after September 1998. He continued working, with low back pain that came and went. (Tr. 12, 14; Ex. 47).

By June 1999 claimant worked almost exclusively as a forklift operator. His regular work involved driving a forklift to and from the employer's sawmill in the lumber yard. Beginning February 7, 2000, claimant performed his regular work and the work of a co-worker. The latter involved driving a forklift backward down a gravel road across railroad tracks to the employer's planer. To do this, claimant twisted in the forklift seat to look backward as he drove.

Between June 1999 and February 2000, claimant worked in this "looking backward" position about 5 percent of the time. (Tr. 36). Beginning February 7, 2000, claimant worked in that position at least 50 percent of the time. (Tr. 39; *see* Tr. 26).

Around February 11, 2000, claimant experienced pain from his neck to his low back. On February 14, 2000, he sought medical treatment from Dr. Toliver. Claimant has not worked since that date. Although claimant's cervical and mid back pain subsided, his low back pain persisted.

CONCLUSIONS OF LAW AND OPINION

Cervical and Thoracic Strains

We adopt and affirm the ALJ's opinion on this issue and conclude, based on Dr. Toliver's opinion, that claimant's work for the employer on or about February 11, 2000 caused his subsequent cervical and thoracic strains. Therefore, these initial injury claims are compensable under ORS 656.005(7)(a) and Royal is responsible. (*See* Exs. 39, 59, 67-54, -57). *See Hewlett-Packard Co. v. Toy*, 174 Or App 275, 279 (2001) (doctor's reproducible findings constituted "objective findings").

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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

Lumbar Condition

The ALJ analyzed claimant's claim for annular tears at L4-5 and L5-S1 as an occupational disease and upheld the insurers' denials. We analyze the claim as an injury and find it compensable, based on Dr. Toliver's opinion.

Dr. Toliver examined claimant's low back once in September 1998 and treated him regularly beginning in February 2000. The doctor had a materially accurate and complete history regarding claimant's activities on and off work. Thus, Dr. Toliver was in a particularly good position to evaluate the nature and etiology of claimant's condition. *See Kienow's Food Stores, Inc. v. Lyster*, 79 Or App 416, 421 (1986) (opinion by physician who examined the claimant before and after an injury is persuasive). He initially diagnosed cervical, thoracic, and lumbar strains, based on claimant's history of driving a forklift backward at work, twisting his back in a position awkward for his spine. (*See* Exs. 67-17-18, -52-53).

Later, an MRI revealed mild degeneration and annular tears at L4-5 and L5-S1. Dr. Toliver opined that the tears were the likely cause of claimant's low back symptoms and forklift driving was the primary cause of the condition. Dr. Toliver also opined that forklift driving on February 11, 2000 was the primary reason claimant sought treatment on February 14, 2000.[2] (Exs. 67-10, -14, -16-20, -28-29, -31; *see also id.* at 50).

Dr. Toliver considered and evaluated claimant's prior low back problems, the nature of his work generally and the awkward forklift driving from February 7-11, 2000, in particular. (*See* Exs. 55-2-3, 67-7, 67-58). He explained that claimant's 1997 injury made him vulnerable to re-injury and fork lift driving generally probably caused wear and tear on claimant's spine. (*See* Ex. 59). Dr. Toliver acknowledged that he could not determine exactly when claimant's annular tears happened. However, the doctor reasoned that claimant's torn annulae represented traumatic injury, consistent with claimant's February 7-11, 2000 work activities --but not consistent with his occasional off-work activities, such as repairing cars. (*See* Exs. 67-23, -32-33). Further considering most forklifts' suspension and claimant's ergonomics in early February 2000, Dr. Toliver concluded that the latter work was the major contributing cause of claimant's current condition.[3] (*See* Ex. 67-56-59).

In our view, Dr. Toliver's opinion is well-reasoned and based on an accurate and complete history. (*See* Exs. 55, 67-19-20, -40).[4] We find no persuasive reason to discount Dr. Toliver's opinion.[5] Therefore, we rely on it in evaluating the nature and etiology of claimant's condition. The question becomes whether that opinion is sufficient to carry claimant's burden of proving compensability. We conclude that it is, based on the following.

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[2] The fact that *claimant* relates his current condition to the 1997 injury does not undermine Dr. Toliver's opinion relating it to work activities during the second week of February 2000. *See Benz v. SAIF*, 170 Or App 22, 27 (2000).

[3] We acknowledge that Dr. Toliver stated that he did not believe that claimant had a "new injury" in February 2000 and he initially described claimant's February 2000 condition as an "exacerbation" of his prior problems. (*See* Exs. 54a, 59, 67-25-26). Nonetheless, considering the doctor's opinion as a whole and claimant's clinical course, we find that claimant *did* have a new injury in February 2000. *See Robert S. Jessiman*, 51 Van Natta 744, 746 (1999) (where symptoms, diagnosis and cause of the condition changed materially in 1997, new condition medically distinct from prior condition).

[4] Royal argues that Dr. Toliver's opinion is unpersuasive, because it changed without explanation. Specifically, Royal contends that the doctor relied on an understanding that claimant drove a forklift on uneven ground for 8 hours a day, then stated that the roughness of the ground or the amount of driving time would not affect his causation opinion. We read Dr. Toliver's opinion differently. In our view, the doctor relied on an accurate history that claimant's work in early February 2000 differed significantly from his prior work, in that claimant spent at least half of his work time in February 2000 in an awkward injurious position-on a forklift with stiff suspension. (*See id.*, Tr. 39; *see also* Tr. 36). (Royal does not challenge this history.)

[5] We agree with the ALJ that the examiners' causation opinions are not persuasive, as the ALJ explained. *See Jessiman*, 51 Van Natta at 745 (1999) (where doctor did not mention that the claimant first injured his back at work when he was 32 or address the fact that he had no prior back problems and the claimant continued to perform physically demanding work activities, opinion that the work "does not appear" to have altered or contributed to low back condition inadequately explained and unpersuasive).

To determine whether claimant's low back condition is a disease or an injury, we must examine whether the symptoms of the condition were sudden or gradual in onset. *See Weyerhaeuser Co. v. Woda*, 166 Or App 73, 81, *rev den* 330 Or 361 (2000). An injury need not be instantaneous. However, "an *injury* based on repetitive trauma must develop within a discrete, identifiable period of time due to specific activity." *LP Company v. Howard*, 118 Or App 36, 40 (1993); *see Mathel v. Josephine County*, 319 Or 235, 240 (2000) (compensable injuries under ORS 656.005(7) are "events," whereas occupational diseases under ORS 656.802 are "ongoing states of the body or mind").

Here, Dr. Toliver agreed that it was "fairly accurate" to say that claimant had a discrete incident in 1997 (when he fell at work) and a gradual onset of symptomatology in 2000. (Ex. 67-23). However, he later explained that the 2000 symptoms occurred over "a couple day time frame" and, in that sense, they were "sudden, as opposed to gradual[,]" but *he* would not classify "sudden onset as being something transpiring over one or two days, or even several."[6] (*Id.* at 40-41).

Here, as in *Donald Drake Co. v. Lundmark*, 63 Or App 261 (1983), *rev den* 296 Or 350 (1984), claimant's low back claim is for repetitive trauma and his severe (2000) symptoms arose over a discrete time period (between February 7, 2000 and February 11, 2000). Accordingly, the claim is properly considered an injury under ORS 656.005(7)(a).[7] *Lundmark*, 63 Or App at 266 (claim properly analyzed as an injury were the claimant's back trouble coincided precisely with jolting of a faulty loader).

In addition, because claimant had a preexisting low back condition that combined with his February 2000 work exposure, he is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B).[8]

Based on Dr. Toliver's persuasive opinion, we conclude that claimant has carried his burden of proving that his forklift work on or about February 11, 2000 was the major contributing cause of his need for medical treatment on February 14, 2000. (*See* Ex. 61-2). We turn to the question of whether responsibility for claimant's condition rests with Royal's insured.

ORS 656.308 does not apply because claimant's current condition (torn L4-5 and L5-S1 annulae) is not the same condition as the accepted condition (a lumbosacral strain) under Liberty's 1997 claim.[9]

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[6] The doctor did *not* have a history that claimant's symptoms increased gradually. (Ex. 67-42.)

[7] *See Howard* 118 Or App at 38 (claim analyzed as a "new injury" even though the claimant had continuing symptoms from a prior work injury).

[8] Dr. Toliver explained that claimant was "prone" to have degenerative disc disease because of the nature of his job. He opined:

> "I would have to conclude that there's a combination of events here. Number one, he had an instigating event in December of '97. He had a subsequent event in February of 2000 that brought this to the forefront again. But he's had, more than likely, repetitive trauma to his back." (Ex. 58).

Based on this analysis, we find that claimant had a preexisting condition under ORS 656.005(24) and that condition combined with claimant's early February 2000 work activities to cause his torn annulae. (*See* Ex. 59). *See Luckhurst v. Bank of America*, 167 Or App 11, 16 (2000) ("[i]n order for there to be a 'combined condition,' there must be two conditions that merge or exist harmoniously"). Therefore claimant is subject to the major contributing cause standard of proof under ORS 656.005(7)(a)(B). *See Jonna M. Moore*, 52 Van Natta 1984-85 (2000).

[9] ORS 656.308(1) applies only where there is an earlier accepted claim and a later injury involves the same condition as did the earlier accepted claim. *Sanford v. Balteau Standard*, 140 Or App 177, 181 (1996); *SAIF v. Yokum*, 132 Or App 18 (1994). In this context, a "new injury involves the same condition as the earlier accepted injury when it has the earlier compensable injury within or as part of itself." *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999).

Here, although claimant's 1997 accepted lumbosacral strain rendered him "prone" to disc degeneration and/or herniation, the medical evidence does not indicate that claimant's current torn annulae condition has the 1997 strain within or as part of itself. (*See* Ex. 59). Therefore, ORS 656.308 does not apply to the responsibility determination.

In any event, we would reach the same result under ORS 656.308(1), based on Toliver's persuasive opinion that claimant's early February 2000 work was the major contributing cause of claimant's need for treatment for his compensable torn annulae. *See James A. Hoyt*, 52 Van Natta 346, 349 n.2 (2000).

Therefore, responsibility is assigned to Royal, the carrier on the risk when claimant sustained his second low back injury.[10]

Claimant is entitled to an attorney fee for his counsel's services at hearing regarding the compensability of his low back claim. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding that issue is $3,000, payable by Royal. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant is also entitled to an attorney fee under ORS 656.308(2)(d) for prevailing against Royal's responsibility denial. Considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorney's services related to the responsibility issue at hearing is $1,000, payable by Royal. *See* ORS 656.308(2)(d).

Finally, we note that there were no attorney services on review.

ORDER

The ALJ's order dated May 30, 2001 is reversed in part and affirmed in part. That portion of the order that upheld that portion of EBI/Royal's denial regarding claimant's low back condition is reversed. The low back denial is set aside and the claim is remanded to Royal for processing according to law. The remainder of the ALJ's order is affirmed. For services at hearing regarding the compensability of and responsibility for the low back condition, claimant's "hearing" counsel is awarded a $4,000 attorney fee, to be paid by Royal.

[10] Liberty is not responsible for claimant's condition, because claimant's injury under Royal's coverage independently contributed to his subsequent condition. *See Hoyt*, 52 Van Natta at 349 n.4 (2000).

November 30, 2001 Cite as 53 Van Natta 1552 (2001)

In the Matter of the Compensation of
BONNIE L. IMEL-HOWER, Claimant
Own Motion No. 99-0189M
OWN MOTION ORDER OF ABATEMENT
Sather, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant requests reconsideration of our October 31, 2001 Own Motion Order on Reconsideration that dismissed her request for Board review of the self-insured employer's Notice of Closure. In reaching our conclusion, we found that claimant had not established good cause for her failure to timely file an appeal from the employer's closure notice. Describing the difficulties she encountered in retaining an attorney, claimant seeks reconsideration of our decision.

In order to allow sufficient time to consider the motion, we abate our order. The employer 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 is also granted an opportunity to reply. To be considered, that reply must be filed within 14 days from the date of mailing of the employer's response. 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
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UPDATE PAGES

ENCLOSED ARE *VAN NATTA'S* PAGES 1553-1612 WITH WORKERS' COMPENSATION BOARD ORDERS THROUGH DECEMBER 13, 2001. THESE PAGES SHOULD BE INSERTED INTO YOUR CURRENT *VAN NATTA'S* BINDER, VOLUME 53, OCTOBER-DECEMBER 2001.

In the Matter of the Compensation of
SHIRLEY J. PIERCE, Claimant
WCB Case No. 00-07117
ORDER ON REVIEW
Willner, et al., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

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

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that set aside its denial of her occupational disease claim for a positive tuberculosis (TB) test. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant began working in November 1998 for the employer, a group home, as a life enrichment specialist. In April 2000, claimant sought medical treatment for a cough. As a precaution, claimant was given a skin (PPD) test for TB, which was positive. Claimant filed a claim for TB.

SAIF denied the claim on August 24, 2000, on the ground that the alleged TB did not arise out of and in the course of employment. Claimant requested a hearing from the denial.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's denial, concluding that claimant had proved that her positive TB test arose out of and in the course of employment. In reaching this conclusion, the ALJ relied on the medical opinion of Dr. Darby, the attending physician, who opined that claimant's work exposure was the major factor in her becoming TB positive.

On review, SAIF contends that claimant failed to prove that she was exposed to TB during her employment and, therefore, that her claim is not compensable under *Rhonda L. Hittle*, 47 Van Natta 2124 (1995) and *Tamara Hergert*, 45 Van Natta 1707 (1993). We agree.

Claimant has the burden to prove the compensability of her occupational disease claim by a preponderance of the evidence. ORS 656.266. She must prove that her work activities are the major contributing cause of the disease. 656.802(2)(a). Because causation of claimant's condition presents a complex medical question, expert medical opinion is necessary to establish causation. *See Uris v. Compensation Department*, 247 Or 420 (1967).

The issue in this case is whether Dr. Darby's opinion is sufficient to establish the necessary causal relationship between claimant's positive TB test and her work exposure. We conclude that it is not.

Dr. Darby testified that claimant's work exposure was the major contributing cause of claimant becoming TB positive. (Ex. 7-24). However, there is no documented evidence that claimant was actually exposed on the job to a person with infectious TB. Claimant's former coworker, Ms. Curran, tested PPD positive for TB, but would not have been the source of a TB infection because she did not have a positive chest x-ray, which the medical evidence indicates is required before TB can be considered infectious. (Ex. 6-8).

SAIF's investigation report notes a statement by Ms. Curran that two male residents at the care facility had positive skin tests with negative chest x-rays. Claimant testified, however, that all residents and personnel tested negative at the care facility. (Tr. 8). Thus, claimant's own testimony casts doubt on the reliability of the hearsay statement in the investigation report. Nevertheless, even assuming that the investigation report accurately reported that two residents had positive skin tests, the fact that their chest x-rays were negative rules them out as a potential source of TB infection.

Moreover, Dr. Darby based his opinion that claimant was exposed to TB at work on a statistical analysis. (Ex. 6-11).[1] Not only is Dr. Darby's statistical analysis unpersuasive, Dr. Darby admitted that,

[1] Dr. Darby testified that: "It's statistical. If the probability of being PPD positive is one in 10,000 and you have two people in the same place, same time are positive, you know, statistically it starts to get real unlikely that would happen randomly. It's possible." (Ex. 6-30).

when he stated that it was medically probable that claimant's exposure came at work, what he was really doing was ruling out other likely exposures by engaging in deductive reasoning; *i.e.*, because it was not proven that claimant's exposure to active TB was due to other causative agents, the positive TB test must have been caused by the work environment. (Ex. 6-11, 25). Dr. Darby's opinion is inadequate to establish more than a possible exposure at work.[2]

Consequently, claimant has failed to prove compensability by a preponderance of the evidence.[3] ORS 656.266; *Lenox v. SAIF*, 54 Or App 551 (1981) (claimant must prove claim by preponderance of the evidence); *Gormley v. SAIF*, 52 Or App 1055 (1981) (a possibility of a causal relationship is insufficient to meet a claimant's burden of proof). Accordingly, we reverse the ALJ's decision setting aside SAIF's denial of claimant's occupational disease claim for TB exposure.

ORDER

The ALJ's order dated May 21, 2001 is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[2] In both *Hergert* and *Hittle* we held that claims for TB exposure were not compensable because neither claimant could prove actual exposure to the disease at work. *Hittle*, 47 Van Natta at 2125; *Hergert*, 45 Van Natta at 1707. Like the claimants in *Hittle* and *Hergert*, claimant here also has not affirmatively proved any exposure to TB in the course of her employment, only the increased risk of exposure due to her employment in health care, which is insufficient to prove compensability under *Hittle* and *Hergert*.

[3] The dissent cites *Moore v. Douglas County*, 92 Or App 255 (1988) as support for its argument that claimant established a compensable occupational disease claim. We believe that *Moore* is distinguishable. In that case, unlike here, there was a specific incident of exposure to a disease (a needle prick incident). Moreover, in *Moore*, the record established that inmates and staff had infectious Hepatitis B that could be spread by accidental needle prick. However, in this case, the record does not prove exposure to infectious TB. Under these circumstances, we continue to conclude that claimant's claim is not compensable. *See George E. Duarte, Jr.*, 53 Van Natta 387, 388 (2001) (where there was no documented evidence that the claimant was exposed on the job to a person infected with TB, the claimant failed to prove compensability).

Board Member Phillips Polich dissenting.

The majority finds that claimant failed to prove the compensability of her occupational disease claim for a positive tuberculosis (TB) test. In so doing, the majority determines that the medical opinion of Dr. Darby is unpersuasive because he relied on statistical analysis and deductive reasoning. Moreover, the majority reasons that claimant failed to affirmatively prove exposure to TB, noting that the record does not contain evidence of exposure to an infectious case of TB.

In contrast to the majority, I would conclude that Dr. Darby's opinion is more than sufficient to establish medical causation. Moreover, I would find that this case is similar to *Moore v. Douglas County*, 92 Or App 255 (1988), a case where the claimant proved a compensable occupational disease claim for hepatitis B. For these reasons, I dissent.

First, Dr. Darby's deposition testimony makes a compelling case for compensability. Dr. Darby testified that virtually all patients that turn TB positive are employees within the medical field who take care of patients. (Ex. 7-10). Claimant is just such a health care worker who tested TB positive. Dr. Darby also testified that, given the lack of exposure to sources outside of claimant's employment, the fact that two people (claimant and Ms. Curran) who worked at the same facility became PPD positive means that there is "extremely high probability" that work exposure was the cause of the positive PPD test. (Ex. 7: 22-28). While the majority faults Dr. Darby's reasoning for being based solely on statistics and deductive reasoning, Dr. Darby explained that is "the only reasoning that would be available in a situation like this." (Ex. 7-31).

Having reviewed Dr. Darby's testimony, I conclude that it satisfies claimant's burden of proving a compensable occupational disease. Moreover, I find this case controlled by *Moore*.

In that case, the claimant worked as a nurse in a correctional facility where a number of inmates and staff had hepatitis A and B. The claimant accidentally pricked herself with a needle, which the evidence indicated was a common source of exposure to hepatitis B. The claimant developed symptoms of the disease within the incubation period. The claimant's physician opined that health professionals were a higher risk of contracting hepatitis B and that the claimant's history, occupation and exposure to individuals who were potential carriers of the disease made it "only logical to assume that [the claimant] did contract her hepatitis at her place of employment."

Reversing the Board's order affirming the ALJ's order denying compensation, the *Moore* court determined that this opinion was sufficient to satisfy to satisfy the claimant's burden of proof. The court noted the uncontroverted evidence that the claimant regularly came into contact with bodily fluids of inmates who were potential sources of hepatitis, that inmates and staff had the disease, that the needle prick incident was a potential means of contracting the virus, and that the claimant's symptoms appeared during the incubation period. Significantly, the court noted that there was no off-work exposure. *Moore*, 92 Or App at 258.

In this case, like *Moore*, there is no evidence of off-work exposure to TB. Like the physician's opinion in *Moore*, Dr. Darby also opined that claimant here was at high risk of contracting TB because she was in the medical profession. Moreover, as was true of the claimant in *Moore* who came into contact with sources of the hepatitis disease, claimant in this case also came into contact with a coworker (Curran) who was a potential source of TB. Finally, the medical evidence is even stronger in this case than it was in *Moore*, where the physician did not use magic words and could only state that it was "only logical to assume." By contrast, in this case, Dr. Darby definitively opined that work exposure was the major contributing cause of claimant's positive PPD test and provided compelling testimony (as noted above) detailing the reasons for so concluding. Thus, the medical evidence is much stronger here than it was in *Moore*, where somewhat equivocal medical evidence was still held sufficient to satisfy the claimant's burden of proof.

Accordingly, I conclude that a finding of compensability is the only just conclusion in this case from both a legal and factual standpoint. The majority errs by denying this claimant a compensable workers' compensation claim. Because of this, I dissent.

December 4, 2001 Cite as 53 Van Natta 1555 (2001)

In the Matter of the Compensation
O. C. PITTMAN, Claimant
WCB Case No. 00-06413
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Herman's order that reduced claimant's scheduled permanent disability for loss of use or function of his right arm from 5 percent (9.6 degrees), as awarded by an Order on Reconsideration, to 1 percent (1.92 degrees).[1] On review, the issue is scheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In February 1999, claimant filed a claim for injury to his right shoulder. (Ex. 1). SAIF denied the claim. A prior ALJ's order set aside the denial and remanded the claim to SAIF for processing. (Ex. 4). SAIF accepted "cervical strain, trapezius stain and right shoulder tendonitis." (Ex. 10).

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[1] The ALJ's order contains a typographical error. The ALJ's order awarded 1 percent scheduled permanent disability for loss of use or function of the right arm, but listed the degrees associated with such an award as 3.2 degrees. (O&O. 5). 1 percent of the arm equates to 1.92 degrees. ORS 656.214(2)(a).

The claim was closed in May 2000, without an award of permanent disability. (Ex. 11). Claimant requested reconsideration.

Dr. Gripekoven performed a medical arbiter evaluation. (Ex. 13). Relying on Dr. Gripekiven's evaluation, an August 22, 2000 Order on Reconsideration awarded 5 percent scheduled permanent disability (chronic condition impairment) for loss of use or function of the right arm. (Ex. 14). SAIF requested a hearing.

The ALJ determined that the medical arbiter's evaluation persuasively established that claimant was significantly limited in the repetitive use of his right arm due to adhesive capsulitis, a direct medical sequelae of the accepted conditions. Consequently, the ALJ concluded that claimant was entitled to impairment for a chronic condition pursuant to OAR 436-035-0010(5). The ALJ further determined, based on the medical arbiter's evaluation, that the chronic condition should be apportioned, 20 percent to the accepted condition and 80 percent to a preexisting condition. Accordingly, the ALJ reduced the Order on Reconsideration's award of scheduled permanent disability from 5 percent to 1 percent.

Claimant's disability is determined as of the date of the Order on Reconsideration. ORS 656.283(7). Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14) (WCD Admin Order No. 98-055). Where a preponderance of evidence establishes a different level of impairment, the impairment is established by the preponderance of evidence.[2] (*Id.*)

Here, Dr. Gripekoven, the medical arbiter, reviewed claimant's medical records and performed a medical exam. As a result, Dr. Gripekoven opined that claimant was "partially limited in the ability to repetitively use his right arm in the elevated position due to adhesive capsulitis of the right shoulder." (Ex. 13-7). Dr. Gripekoven explained that:

> "The adhesive capsulitis and loss of motion in [claimant's] shoulder is a secondary reaction to the accepted tendinitis, but also the pain reaction from the degenerative disc disease. Pain has led to dysfunction, splinting, and loss of motion, which has gone on to an adhesive capsulitis and loss of range of motion." (*Id.*)

SAIF asserts that "adhesive capsulitis" is not an accepted condition. Citing *Julio C. Garcia-Caro*, 50 Van Natta 160 (1998), SAIF argues that, in the absence of such acceptance, claimant is not entitled to any permanent disability resulting from that condition. We disagree.

In *Garcia-Caro*, we found no relevant medical evidence that the claimant's loss of cervical range of motion was a direct medical sequelae of the right shoulder tendinitis. 50 Van Natta at 163. Consequently, in the absence of an accepted cervical condition, we concluded that *former* ORS 656.268(16) (now subsection (14)) did not apply to provide for the rating of the claimant's cervical impairment. (*Id.*)

Here, unlike *Garcia-Caro*, we find that Dr. Gripekoven's analysis persuasively links claimant's limitation to repetitively use his right arm in an elevated position to the cervical/trapezius strains and right shoulder tendinitis. Thus, *Garcia-Caro* is distinguishable. Consequently, we conclude that claimant's limitation to repetitively use his right arm is a "direct medical sequelae" of his strain/tendinitis conditions, and because it has not been specifically denied, is to be rated in accordance with ORS 656.268(14).[3] *See Melinda I. Hale*, 53 Van Natta 617 (2001) (cold intolerance condition ratable as "direct medical sequelae" of accepted carpal tunnel syndrome).

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[2] This 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).

[3] "Direct medical sequela" means a condition that originates or stems from the compensable injury or disease which contributes to the worker's overall disability or need for treatment and is the result of the original injury or disease. OAR 436-035-0005(5).

ORS 656.268(14) provides: "Conditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied."

OAR 436-035-0010(5) provides that:

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

"* * * * *

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

We have previously held that a worker is not entitled to a scheduled impairment award for a chronic condition of the arm where the medical evidence did not identify any symptoms causing loss of function of the arm as distinguished from the shoulder. *See Vikki A. Cuellar*, 52 Van Natta 1679, 1682 (2000); *Richard O. Burke*, 50 Van Natta 1177 (1998). Here, Dr. Gripekoven attributed claimant's inability to repetitively use this right arm to adhesive capsulitis and loss of motion in the right shoulder. Dr. Gripekoven did not identify any other symptoms or conditions that limited claimant's use of the right arm. Consequently, we conclude that claimant is not entitled to impairment for a chronic condition of the arm under the terms of OAR 436-035-0010(5).

ORDER

The ALJ's order dated July 17, 2001 is reversed. In lieu of the ALJ's order and Order on Reconsideration scheduled permanent disability awards, claimant is awarded no scheduled permanent disability for the right arm.

In the Matter of the Compensation of
MARK H. RESSLER, Claimant
WCB Case No. 01-01669
ORDER ON REVIEW
Brad L. Larson, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

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

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that determined that claimant's claim was prematurely closed. On review, the issue is premature claim closure. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of the final paragraph on page two. We now summarize those facts and make additional findings as necessary.

Claimant sustained a compensable left ankle injury on May 30, 2000, diagnosed as a left lateral malleolar fracture. On June 13, 2000, Dr. Van Anrooy performed an open reduction and internal fixation of the displaced left ankle fracture.

Dr. Higgins became claimant's attending physician on September 6, 2000. Dr. Higgins performed a closing examination on October 9, 2000, in which he expressly stated that claimant's condition was medically stationary. Claimant, however, reported ongoing pain and that he had tried to wear leather boots but found that pressure over the medial aspect of the ankle caused too much pain. Dr. Higgins acknowledged claimant's continuing symptoms and noted that, if, over the next two months, claimant did not have a diminution in medial tenderness, he might be a candidate for "hardware removal," with the goal of reducing to whatever extent possible some of the medial tenderness. (Ex. 12).

On December 11, 2000, the claim was closed by Notice of Closure that determined that claimant was medically stationary on October 9, 2000 and awarded 8 percent scheduled permanent disability for loss of use or function of the left ankle. (Ex. 19).

Two days after the closure, on December 13, 2000, claimant returned to Dr. Higgins, who reiterated that he would consider hardware removal but could give no assurance that claimant's pain would be measurably improved. Claimant indicated that he wished to undergo the procedure. (Ex. 21).

On January 22, 2001, Dr. Higgins reported that claimant was scheduled for surgery on January 25, 2001 to remove pins from the medial malleolus. According to Dr. Higgins, this was the only treatment that carried any prospect of decreasing claimant's pain. Dr. Higgins added, however, that "my overwhelming sense is that these screws are not responsible for the majority of [claimant's] current pain." (Ex. 22).

After Dr. Higgins removed two screws from the medial malleolus as planned, claimant requested reconsideration of the closure notice, contending that the claim was prematurely closed. (Ex. 25).

On February 5, 2001, Dr. Higgins once again examined claimant's left ankle. Claimant was still symptomatic. Dr. Higgins once more declared claimant's condition medically stationary, noting that he had previously done so in October 2000. According to Dr. Higgins, "his sentiments remained unchanged." (Ex. 26).

On February 22, 2001, an Order on Reconsideration issued that rejected claimant's contention that the claim was prematurely closed and affirmed the December 11, 2000 Notice of Closure in all respects. (Ex. 27). Claimant requested a hearing, solely contending that his claim was prematurely closed.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that the claim had been prematurely closed despite Dr. Higgins express statement on October 9, 2000 that claimant's condition was medically stationary. The ALJ reasoned that there was a reasonable expectation of improvement in the left ankle condition at the time of closure by reason of the surgery that Dr. Higgins proposed in the event that claimant's symptoms did not improve.

On review, the insurer contends that the ALJ's decision was incorrect because the uncontroverted evidence from Dr. Higgins indicated that claimant was medically stationary when the claim was closed. The insurer further asserts that the surgery that was ultimately performed was merely "palliative" and does not mean that claimant was not medically stationary at the time of claim closure. For the following reasons, we find the insurer's contentions persuasive.

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 December 11, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

In this case, the attending physician, Dr. Higgins, expressly stated that claimant's left ankle condition was medically stationary at the time the claim was closed. There was no contrary opinion. Granted, claimant was still experiencing symptoms and eventually underwent a medical procedure in which two screws were removed from the medial malleolus. However, the term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation that further or ongoing medical treatment would "materially improve" claimant's compensable condition at claim closure. ORS 656.005(17); *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Here, given Dr. Higgins' express statement on October 9, 2000 that claimant was medically stationary, we do not find a reasonable expectation that further medical treatment would materially improve claimant's left ankle condition. Indeed, Dr. Higgins' subsequent reports indicate the screws in claimant's ankle were not primarily responsible for his pain and that surgical removal would likely result at most in minor pain reduction.[1]

Accordingly, we conclude that Dr. Higgins' uncontroverted medical opinion that claimant's left ankle condition was medically stationary on October 9, 2000 establishes that claimant's condition was medically stationary prior to claim closure. Moreover, the medical evidence shows that subsequent surgery was performed in attempt to effect modest pain reduction and was palliative, not curative, in nature. Therefore, we disagree with the ALJ's finding that the claim closure was premature. Thus, we reverse.

ORDER

The ALJ's order dated June 18, 2001 is reversed. The December 11, 2000 Notice of Closure is reinstated and affirmed. The Order on Reconsideration is affirmed in its entirety. The ALJ's attorney fee award is also reversed.

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[1] Evidence that was not available at the time of closure may still be considered to the extent the evidence addresses the condition at the time of closure. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). In this case, we consider Dr. Higgins' "post-closure" reports to be addressing claimant's condition at the time of closure because the record does not establish that his condition materially changed after claim closure. *See Rodney Sullivan*, 52 Van Natta 1394, 1395, *on recon* 52 Van Natta 1964 (2000) (Inasmuch as the record did not suggest that the claimant's condition changed between a January 2000 claim closure and a physician's March 2000 report, that physician's March 2000 opinion addressed the claimant's condition at claim closure); *Edward D. Riggs*, 52 Van Natta 93 (2000) (physician's opinion found to address the claimant's condition at closure where it was written two weeks after carrier closure and there was no evidence that the claimant's condition had changed in that interval).

Board Member Phillips Polich dissenting.

The majority finds that claimant's left ankle condition was medically stationary prior to claim closure and that, therefore, his claim was not prematurely closed. Because I disagree with the majority's finding, I respectfully dissent.

The majority correctly observes that Dr. Higgins stated on October 9, 2000 that claimant's condition was medically stationary. However, I believe that it is appropriate under the circumstances of this case to look beyond that statement to determine whether claimant's left ankle condition was, in fact, medically stationary prior to claim closure.

In Dr. Higgins' October 9, 2000 report, it is clearly documented that claimant was still experiencing significant symptoms, so much so that claimant was unable to wear leather boots and commented that his ankle hurt all the time. (Ex. 9). Dr. Higgins noted that, if claimant did not have diminution in medial tenderness over the next two months, he would be a reasonable candidate for removal of screws. Given these comments, it seems to me that, if there was reason to assess the need for screw removal in two months, claimant's condition could not be medically stationary until that assessment was made. This is especially true given the significant symptoms claimant was experiencing.

Accordingly, I would conclude that, despite Dr. Higgins' conclusion that claimant's left ankle condition was medically stationary prior to claim closure, the medical evidence as a whole does not indicate that condition was, in fact, medically stationary. For this reason, I disagree with the majority's conclusion that the ALJ improperly set aside the claim closure as premature. Thus, I dissent.

In the Matter of the Compensation of
PAMELA J. SARTIN, Claimant
WCB Case No. 00-05902
ORDER ON REVIEW
Welch, et al., Claimant Attorney
Hornecker, Cowling, et al., Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denials of her discogenic disease at L4-5 and her current low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the second full paragraph on page 3, we change the first date in the first sentence to "October 10, 2000." In the same paragraph, we change the date of claimant's fusion surgery in line 9 to "March 2000."

L4-5 Discogenic Disease

The ALJ found that the medical evidence failed to prove the existence of an L4-5 disc injury. Alternatively, if there was such a disc injury, the ALJ found that the medical evidence was insufficient to establish that it was related, either in material or major part, to the work injury. The ALJ rejected the causation opinion of Dr. Dunn, claimant's treating physician, because he had an inaccurate history of claimant's ongoing low back symptoms between 1991 and 1998.

On review, claimant contends that the medical evidence establishes the existence of an L4-5 discogenic condition. We disagree, based on the following reasoning.

We agree with the ALJ that claimant failed to establish medical causation. Dr. Dunn's opinion on causation is not persuasive because he did not have an accurate history of claimant's back symptoms between May 1991 and October 1998. When he examined claimant on October 14, 1998, Dr. Dunn reported that she had done "relatively well with ongoing intermittent pain until two months ago" when she was lifting a box at work and felt something pop. (Ex. 35-1). Dr. Dunn referred to a similar history in October 2000, explaining that although he had not seen claimant for seven years before October 1998, she related that "she had done well over the years with some intermittent, ongoing pain" until the August 1998 injury. (Ex. 66-2).

We find that Dr. Dunn's understanding of claimant's back symptoms is not accurate. Instead, the medical records indicate claimant had serious low back and leg symptoms before Dr. Dunn saw her in October 1998.

In January 1994, Dr. Narus reported that claimant's low back and left leg pain had worsened in the past year and she also had pain radiating into the right sacroiliac joint. (Ex. 11-3). He recommended an MRI, which showed desiccation at L4-5, desiccation and a slight disc bulge at L5-S1, and minimal facet arthropathy at L4-5 and L5-S1. (Exs. 12-2, 13).

In April 1994, Dr. Melnyk diagnosed a flare of fibromyalgia and Dr. Sampson diagnosed left hip trochanteric bursitis. (Exs. 15, 16). In May 1994, claimant's pain was more severe and included the right sacroiliac joint. (Ex. 16-2). In June 1994, Dr. Sampson noted that claimant had been evaluated by three other physicians without much success. (Ex. 16-3). In July 1994, Dr. Peterson reported that a bone scan showed increased uptake at the L4-5 level on the right, compatible with facet joint disease. (Ex. 18-1). He diagnosed "[s]ymptomatic facet joint inflammatory process right L4-5" and recommended a facet joint block. The injections did not provide any benefit. (Ex. 19).

In April 1996, Dr. Bates reported that claimant had significant fibromyalgia, which included bilateral leg pain. (Ex. 22-1). He recommended a pain center. Dr. Krohn provided a rheumatology consultation in May 1996. Dr. Krohn reported that, although claimant had been off work for 30 days, she had not noticed much improvement in her symptoms, which included chronic back pain. (Ex. 23-1). Dr. Krohn diagnosed fibromyalgia and depression, and noted that claimant was a "very difficult therapeutic challenge." (Ex. 23-2).

On June 3, 1996, Dr. Bates reported that claimant "has reached a decision in her life that she is going to attempt to get permanently disabled, expects she will not be working much longer due to the chronicity of her pain." (Ex. 24). He indicated he wrote a letter regarding her disability. (*Id.*) In January 1997, Dr. Bates said claimant had significant low back, leg, arm and upper back pain whenever she did repetitive work. (Ex. 26).

In October 1997, claimant sought treatment from Dr. Konecne for left lumbar pain radiating to the knee and she was diagnosed with an acute lumbar strain. (Ex. 27). Claimant continued to treat with Dr. Narus for symptoms that included chronic low back pain. (Ex. 28).

There is no evidence that Dr. Dunn had an opportunity to review claimant's medical records between 1991 and 1998. As indicated by the foregoing medical reports, Dr. Dunn's understanding that claimant had done "relatively well with ongoing intermittent pain" until August 1998 was not accurate. Because Dr. Dunn did not have an accurate understanding of claimant's previous symptoms, we agree with the ALJ that his opinion is not persuasive.

In addition, we are not persuaded by Dr. Dunn's causation opinion regarding the L4-5 disc condition because it lacks adequate explanation. Dr. Dunn's comment in October 2000 that claimant's injury was the "straw that broke the camel's back" (Ex. 66-4), indicates that he relied on a "precipitating cause" analysis, which is not sufficient to establish compensability. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (although a work event may precipitate symptoms or need for treatment, that does not necessarily mean that it was the major contributing cause of the condition or its need for treatment). We agree with the ALJ that the medical evidence is insufficient to establish compensability of the L4-5 discogenic disease.

Current Low Back Condition

The employer also issued a denial of claimant's "current condition," contending that, pursuant to ORS 656.262(6)(c), claimant's current condition was "no longer related in any material or major way to any compensable combination conditions or claims." (Ex. 64).

Claimant contends that the ALJ failed to discuss compensability of her current low back condition and focused only on the L4-5 discogenic disease. She also raises several additional arguments concerning the current condition denial.[1]

We agree with the employer that the ALJ decided that claimant did not meet her burden of proving compensability of the L4-5 condition *or* her current condition. The ALJ concluded that Dr. Dunn's history was insufficient to prove that claimant's compensable injury was a material or the major contributing cause of a disc injury, or the disability from or need for treatment of a combined condition involving a preexisting disc condition.

We supplement the ALJ's order with the following. We begin by reviewing the procedural posture of the "current condition" issue. On August 17, 1998, claimant injured her low back after lifting a parcel at work. (Ex. 46-2). She had an extensive history of back pain before the injury. (*Id.*) The employer denied the claim on the grounds of medical and legal causation, and claimant requested a hearing. (Ex. 40).

On April 15, 1999, a prior ALJ set aside the employer's denial. (Ex. 46). The prior ALJ applied the major contributing cause standard of proof under ORS 656.005(7)(a)(B), and found the claim compensable based on Dr. Dunn's opinion. The Board affirmed the ALJ's order. (Ex. 50). On October 27, 1999, the employer accepted a nondisabling lumbar strain resulting from the August 17, 1998 injury. (Ex. 51).

Claimant continued to experience low back symptoms, along with radiation down both legs. (Exs. 53, 55). On March 6, 2000, Dr. Dunn performed surgery at L4-5. (Ex. 57-2). His diagnosis was degenerative disc disease with discogenic pain at L4-5. (*Id.*)

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[1] The employer contends that several of claimant's arguments on review should not be considered because they were not first raised at hearing. We need not address the employer's contentions because, for the reason expressed below, the consideration of claimant's arguments do not effect the ultimate outcome of this case.

On March 31, 2000, claimant's attorney requested that the employer accept "discogenic disease at L4-5" as a result of the August 17, 1998 injury. (Ex. 58A). The employer denied compensability of discogenic disease at L4-5, and issued an alternative "current condition" denial pursuant to ORS 656.262(6)(c). (Exs. 62, 64).

On review, claimant contends that, as a matter of law, her entire low back condition was compensable as a result of the prior litigation. She argues that there was an acceptance of a general low back condition as a result of the prior litigation orders, despite the fact that the employer's notice of acceptance referred only to a lumbosacral strain.

The scope of an acceptance is a question of fact. *See, e.g., Columbia Forest Products v. Woolner*, 177 Or App 639 (2001); *SAIF v. Dobbs*, 172 Or App 446, 451, *adhered to as mod on recons* 173 Or App 99 (2001).

In *Woolner*, the primary issue was whether an employer may issue a preclosure denial under ORS 656.262(7)(b) for a "combined condition" if its earlier acceptance did not expressly identify the claim as one for a combined condition. In that case, the carrier had accepted a claim for "multi-directional instability, right shoulder and cervical strain," and issued a preclosure current condition denial that denied compensability because the work injury was no longer the major contributing cause of that condition and need for treatment. *Woolner*, 177 Or App at 641-42.

The claimant argued, among other things, that the carrier's acceptance did not state explicitly that it accepted a combined condition, and its denial based on a combined condition under ORS 656.262(7)(b) was therefore improper as a matter of law. The court rejected the claimant's argument that "magic words" of "combined condition" were necessary to signify the acceptance of a combined condition. *Id.* at 646.

Further, the court held that, although ORS 656.262(6)(a) provides that a notice of acceptance shall "specify what conditions are compensable[,]" it does not mandate the use of any particular descriptive label making explicit that two or more conditions have combined. *Id.* at 647. The court explained:

> "It is true that the acceptance in this case did not expressly inform claimant that the preexisting condition--multidirectional instability--was not being accepted outright and that it was only compensable as part of a combined condition. *See Multifoods Specialty Distribution v. McAtee*, [164 Or App 654, 661 (1999)], *rev allowed* 332 Or 305 (2001) (holding that acceptance of a combined condition is not an outright acceptance of a preexisting condition that has combined with a work-related injury or condition). However, the notice *did* apprise claimant of the nature of the compensable conditions covered by the acceptance and, therefore, offended no legal requirement that has been brought to our attention. Accordingly, we conclude that a notice of acceptance that fails to employ the specific words 'combined condition' is not--for that reason alone--insufficient as a matter of law to constitute an acceptance of a combined condition for purposes of ORS 656.262(7)(b)." *Id.* at 647 (emphasis in original; footnote omitted).

Here, the prior ALJ applied the major contributing cause standard of proof under ORS 656.005(7)(a)(B) to decide compensability of claimant's August 17, 1998 injury. (Ex. 46-4). The prior ALJ found that claimant's injury had combined with her preexisting back condition, based on Dr. Dunn's comment that claimant's injury had "initiated" her pain, and Dunn's subsequent observation that one of her problems was "[d]iscogenic pain, probably L5-S1" aggravated by her August 17, 1998 fall, and "sacroiliac strain," aggravated by the same incident. (Ex. 46-3, -4). The prior ALJ relied on Dr. Dunn's opinion and concluded that claimant had established legal and medical causation. (Ex. 46-6). The employer's denial was set aside and the claim was "remanded to the employer for acceptance and provision of all appropriate benefits." (Ex. 46-7).

After the Board affirmed the ALJ's order, the employer accepted a lumbar strain resulting from the August 17, 1998 injury. (Ex. 51). The employer's failure to expressly accept a "combined condition" does mean that it did not accept a "combined condition." *See Woolner*, 177 Or App at 646 ("magic words" of "combined condition" are not necessary to signify the acceptance of a combined condition). Based on the prior ALJ's findings, we conclude that the employer accepted a "combined condition" of a lumbar strain with preexisting discogenic pain at L5-S1 and sacroiliac strain. (Ex. 46).

Nevertheless, as the court explained in *Woolner*, the acceptance of a combined condition is *not* an outright acceptance of preexisting conditions that have combined with a work-related injury. *See McAtee*, 164 Or App at 661. In other words, although we find that the employer accepted a "combined condition" of a lumbar strain with preexisting discogenic pain at L5-S1 and sacroiliac strain, that does not constitute an outright acceptance of the preexisting conditions. *See also Mitchell D. Joy*, 50 Van Natta 824, 825 (1998); *Karen S. Carman*, 49 Van Natta 637 (1997).

Rather, it is the "combined condition" that is accepted, and only to the extent that the work injury was the major contributing cause of disability or the need for treatment of the combined condition. *McAtee*, 164 Or App at 662. Thus, for purposes of analyzing compensability of the current condition denial, we review the medical evidence to determine whether the compensable injury is the major contributing cause of claimant's current disability or need for treatment.

We find no medical evidence that claimant continues to suffer from a lumbar strain. After claimant's fusion surgery, Dr. Dunn diagnosed degenerative disc disease with discogenic pain at L4-5. (Ex. 57). Dr. Dunn explained that the reason claimant's symptoms persisted so long was because of a discogenic source. (Ex. 66-4). Similarly, Dr. Woodward found that the lumbar strain had resolved. (Ex. 54-14), as did Drs. Farris, Morton and Courogen. (Exs. 56-6, 61-11).

In addition, the medical evidence does not indicate that claimant's current condition is related to a sacroiliac strain or discogenic pain at L5-S1. Dr. Farris reported that claimant's sacroiliac strain had resolved "long ago." (Ex. 56-6). As discussed above, Dr. Dunn referred to claimant's current low back condition as related to discogenic pain at L4-5, not L5-S1. (Exs. 57, 66). Indeed, Dr. Dunn's postoperative diagnosis was degenerative disc disease with discogenic pain at L4-5. (Ex. 57).

In any event, for the reasons discussed earlier, we agree with the ALJ that claimant failed to establish medical causation of her current low back condition because he did not have an accurate history of claimant's back symptoms between May 1991 and October 1998. We conclude that the medical evidence is insufficient to establish that claimant's work injury is the major contributing cause of disability or the need for treatment of the combined condition.

Furthermore, we find that claimant's arguments concerning issue preclusion are not persuasive. On review, claimant contends that the employer's arguments in this case are the same arguments it made at the time of the previous litigation. According to claimant, the employer cannot relitigate these issues and, absent a change of circumstances, the doctrine of issue preclusion bars litigation of compensability of her current low back condition because it is the same condition previously litigated.

For the following reasons, we do not agree with the underlying premise of claimant's argument; *i.e.*, that her current low back condition is the "same condition" previously litigated.

Based on the prior ALJ's findings, we conclude that the employer accepted a "combined condition" of a lumbar strain with preexisting discogenic pain at L5-S1 and sacroiliac strain. After the record closed after the last hearing, Dr. Dunn's reports indicated that claimant had, among other things, degenerative disc disease at L4-5 and L5-S1 with mild stenosis at L4-5, and spondylolisthesis of L4 on L5. (Ex. 45). Dr. Dunn reviewed a July 1999 MRI and referred to the finding of "[i]ntradural right L4 and L5 root enhancement, which is suspicious for neuritis." (Exs. 48, 49). After performing surgery in March 2000, Dr. Dunn diagnosed degenerative disc disease with discogenic pain at L4-5. (Ex. 57). He later explained that claimant had an annular tear at L4-5 and discogenic pain at that level. (Ex. 66-3). Based on these medical reports, we are not persuaded by claimant's argument that her current low back condition is the "same condition" previously litigated.

Finally, claimant argues that the opinions from Drs. Woodward, Morton and Courogen are contrary to the "law of the case." We find that it is not necessary to address claimant's law of the case argument because, whether or not we discount any medical opinions for being inconsistent with the law of the case, *see Kuhn v. SAIF*, 73 Or App 768 (1985), we would reach the same result. In other words, we agree with the ALJ that the medical evidence supporting claimant's position is insufficient to establish compensability.

ORDER

The ALJ's order dated February 26, 2001 is affirmed.

In the Matter of the Compensation of
ROBERT W. SMITH, Claimant
WCB Case No. 00-09340
ORDER ON REVIEW
Welch, et al., Claimant Attorney
Craig A. Staples, 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 insurer's denial of claimant's occupational disease claim for a bilateral hearing loss condition. On review the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, 82 years of age at the time of hearing, was a long-time welder. His last Oregon employment was with the employer, Harbor Oil, through 1981. (Tr. 5, 12). He was exposed to loud noises throughout his working life. Claimant also has a history of exposure to noises in the military and, until 15 years ago, hunted and engaged in target shooting as hobbies. (Ex. 17B).

Claimant saw Dr. Lindgren for treatment for his hearing loss condition on one occasion in November 2000. (Ex. 17B). Dr. Lindgren concluded that claimant's work exposure was the major contributing cause of his hearing loss condition. (Exs. 17B, 20). Dr. Lindgren reasoned that claimant's overall hearing loss of 430 decibels (right) and 475 decibels (left) outweighed a 100-decibel presbycusis value derived from the Oregon Administrative Rules (the maximum value). (*Id.*) *See* OAR 436-035-0250.

Dr. Hodgson, an examining physician, took a complete history of claimant's work and off-work exposures and concluded that claimant's age-related hearing loss was the major contributing cause of his hearing loss condition. (Ex. 18-5). Dr. Hodgson used statistics from the American National Standards Institute (ANSI) study to derive an average presbycusis figure of 246 decibels for an 82 year-old man such as claimant. Dr. Hodgson reasoned that claimant's work-related hearing loss, when compared to the ANSI data, was less than 50 percent of the cause of his overall hearing loss condition. (Ex. 18-5).

Claimant filed claims for a bilateral hearing loss condition with several employers and insurers in 2000. These claims were denied, and claimant requested a hearing. At hearing, claimant dismissed all but the remaining employer and insurer from this proceeding.

In upholding the insurer's denial, the ALJ found Dr. Lindgren's analysis flawed based on our analysis in *Marvin H. Benz*, 53 Van Natta 266 (2001) (on remand). The ALJ observed that, in assessing compensability, Dr. Lindgren used presbycusis values taken from the Oregon Administrative Rules for rating permanent disability, OAR 436-035-0250, an analysis that we found unpersuasive in *Benz*. 53 Van Natta at 267.

On review, claimant first contends that we should revisit Benz in light of the Court of Appeals' decision in *RLC Industries v. Sun Studs, Inc.*, 172 Or App 233 (2001). We need not address claimant's argument, however, as we find Dr. Lindgren's opinion unpersuasive on alternative bases.

The compensability of claimant's hearing loss condition represents a complex medical question, which must be resolved with expert medical opinion. *Barnett v. SAIF*, 122 Or App 279, 282 (1992). 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 263 (1986). Absent persuasive reasons not to do so, we rely on the opinion of claimant's treating physician. *Weiland v. SAIF*, 63 Or App 810 (1983).

Here, we find persuasive reasons not to rely on the opinion of Dr. Lindgren. Initially, we note that Dr. Lindgren examined claimant on one occasion. Accordingly, Dr. Lindgren does not necessarily have greater familiarity with claimant's condition than Dr. Hodgson, who also examined claimant once, at the request of the insurer. Moreover, the cause of claimant's hearing loss condition involves expert analysis, rather than expert external observation. Thus, we are not inclined to give deference to Dr. Lindgren as treating physician. *See Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001) (greater weight to the opinion of the treating physician may be given by a factfinder, depending on the record of each case); *Deanna L. Whetstine*, 53 Van Natta 1493 (2001).

Moreover, Dr. Lindgren's opinion, while supportive of claimant's claim on the major contributing cause basis, is largely conclusory. (*See* Exs. 17B, 20). As such, we find it unpersuasive. *See, e.g. Carol A. Bryant*, 53 Van Natta 795, 796 (2001). In addition, Dr. Lindgren did not discuss claimant's decreased speech discrimination ability, which, Dr. Hodgson reasoned, implied a "nerve pathway" problem not affected by occupational noise exposure. (Ex. 18-5). For that reason, we find Dr. Lindgren's opinion less well-reasoned and complete than that of Dr. Hodgson.

On these alternate bases, we agree with the ALJ that Dr. Lindgren's opinion is unpersuasive and that claimant has not met his burden of proving a compensable hearing loss claim. ORS 656.266; ORS 656.802(2)(a). Accordingly, the denial was properly upheld.

ORDER

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

Board Member Phillips Polich dissenting.

I agree with claimant that he has established a compensable hearing loss claim based on the opinion of Dr. Lindgren. Therefore, I respectfully dissent.

Claimant is a longtime welder who worked in an extremely noisy environment for 35 years. He wore no hearing protection during his entire career. (Tr. 7). Claimant testified that, while he was working to chip off welds from tankers, the noise was so great that his ears would hurt and he would lose his sense of balance. (Tr. 7-8).

As to causation of claimant's severe sensorineural hearing loss condition, I would defer to the opinion of his treating physician, Dr. Lindgren. Dr. Lindgren has authored a well-reasoned opinion that properly considers all possible causes of claimant's hearing loss condition but concludes that his years of work exposure is the major contributing cause. (Exs. 17B, 20). Dr. Lindgren considered claimant's presbycusis (age-related hearing loss) and his off-work exposure (hunting and target shooting). (Ex. 17B-1).

The majority faults Dr. Lindgren opinion for being "conclusory." However, Dr. Lindgren's report, summarized above, demonstrates that she considered the effect of other causes of claimant's hearing loss and did not merely jump to an unsupported conclusion implicating claimant's work exposure. (Ex. 17B).

The majority is correct that Dr. Lindgren's failed to specifically address Dr. Hodgson's comments about a "nerve pathway" problem. However, Dr. Lindgren did describe claimant's hearing loss condition as "sensorineural," which in her opinion was "consistent with work related, noise induced hearing loss." (Ex. 17B-1). In my opinion, such reasoning is more than sufficient to carry claimant's burden of proof in this matter.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
JAVIER URZUA, Claimant
WCB Case No. 00-09652
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that declined to direct the SAIF Corporation to amend its acceptance of claimant's left shoulder strain to include rotator cuff impingement. On review, the issue is scope of acceptance.

We adopt and affirm the ALJ's order. *See Albert E. Killion*, 52 Van Natta 473 (2000) (medical evidence established that acceptance of right shoulder strain and rotator cuff tear reasonably apprised the claimant and medical providers of the nature of the compensable condition, including adhesive capsulitis and impingement syndrome).

ORDER

The ALJ's order dated June 18, 2001 is affirmed.

Board Member Phillips Polich dissenting.

The majority holds that SAIF's acceptance of a left shoulder strain "reasonably apprised" claimant and medical providers that the acceptance included rotator cuff impingement, as required by ORS 656.262(7)(a).[1] The issue is one of "notice": Whether the acceptance notified claimant and his medical providers that SAIF accepted not only a left shoulder strain, but also an impingement condition.

I believe the majority's affirmative answer is legally incorrect because it ignores the statute's requirement that the acceptance reasonably inform *claimant*, as well as medical providers, regarding the nature of the accepted condition. And I believe the majority's holding is factually incorrect, because the relevant evidence is equivocal at best.

First, there is no evidence that claimant understood (or should reasonably have understood), based on the acceptance, that SAIF had accepted his impingement condition. Nothing about the different diagnoses reasonably informed claimant, a lay person, that the different words the doctor used carried the same meaning. SAIF's defense should fail on this basis alone.

Second, Dr. Hanley provides the only relevant medical evidence and his statements are by no means clear. On one hand, the doctor agreed that the rotator cuff strain diagnosis was "encompassed" within the left shoulder strain diagnosis and rotator cuff strain, chronic rotator cuff impingement, and left shoulder strain diagnoses "are really all the same thing." On the other hand, Dr. Hanley also acknowledged that strains and impingement conditions have different medical definitions. (Ex. 15-13). In fact, even for Dr. Hanley, a shoulder strain diagnosis would only raise the "possibility" of rotator cuff impingement. (*Id.* at 14). And a person with a shoulder strain *might* have an impingement *or other* injury, such as a deltoid injury.[2] (*Id.* at 9-10). Although Dr. Hanley would appreciate the *possibility* of an impingement condition based on a shoulder strain diagnosis, he agreed that a family doctor might not appreciate the "full extent" of a patient's shoulder problem with only a strain diagnosis. (*Id.* at 11-13).

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[1] 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."

[2] The mere possibility of a diagnosis is insufficient to prove compensability. How can the mere possibility of condition be sufficient to expand an acceptance beyond its terms?

ORS 656.262(7)(a) imposes an objective standard of "reasonableness" not borne out by this record. Since it is undisputed that SAIF's acceptance would not reasonably apprise a family doctor regarding the nature and extent of claimant's condition, I would conclude that the acceptance offends the statute. Moreover, the acceptance clearly failed to apprise claimant that SAIF accepted *anything* other than a strain. Under these circumstances, SAIF should be required to amend its acceptance to include claimant's previously unaccepted left shoulder rotator cuff impingement condition. Accordingly, I must respectfully dissent.

In the Matter of the Compensation of
JAMES E. EBER, Claimant
Own Motion No. 01-0211M
OWN MOTION ORDER ON RECONSIDERATION

Reviewing panel: Members Biehl and Haynes.

On August 15, 2001, we withdrew our July 23, 2001 Own Motion Order, which denied claimant's request for Own Motion relief on the ground that he was not in the work force at the time of his current worsening.[1] We took this action to consider claimant's submissions regarding the work force issue. Having considered the self-insured employer's response and the parties' positions, we withdraw our prior order and replace it with the following order.

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

Claimant underwent surgery for his compensable knee condition on July 26, 2001. Thus, it is undisputed that claimant's compensable condition has worsened requiring surgery. However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Claimant was not working during the time prior to his July 2001 surgery. Claimant contends that he was in the work force under the third *Dawkins* criterion. In order to satisfy the third *Dawkins* criterion, claimant must establish both that: (1) he is willing to work; and (2) a work search is futile because of the work-related injury. Failure to prove either element results in a determination that claimant is not in the work force. Based on the following reasoning, we find that claimant was in the work force at the time of disability and, therefore, is entitled to temporary disability.

First, we address the "willingness" criteria of the third *Dawkins* criterion. Claimant submitted a July 25, 2001 statement asserting that he would have "still been the owner/operator of [his] auto body business * * * had [he] not been forced to sell [his] business due to [his] disability." He further states that he has been willing to seek employment, but has been unable to do so because of his compensable condition. Based on these unrebutted representations, we find that claimant was willing to work at the time of his current disability.

Next, we address the futility element of the third *Dawkins* criterion. Dr. Thomas, claimant's attending surgeon, reported that claimant returned to work as a manager in his own body shop

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[1] Claimant initially failed to respond to the employer's contention that he was not in the work force at the time of his current disability. On reconsideration, claimant submitted evidence regarding the work force issue.

following his compensable knee surgeries (which occurred in the 1980s), "but had to discontinue this line of work as a result of persistent pain and stiffness in his knees." Dr. Thomas further reported that claimant stated that "if he had knees that would cooperate that he would have continued working in this occupation for many years and it is his feeling that as a result of his deteriorated total knees that he has suffered wage loss[.]" These observations do not represent a medical opinion that it was futile for claimant to seek work at the time of his current worsening. Rather, they indicate that claimant ceased working as a manager of his auto body shop at some undesignated time as a result of knee complaints and, in claimant's estimation, was unable to continue to that line of work due to his knee condition.

Dr. Manley performed total knee replacement surgery on claimant's left knee in 1990 and his right knee in 1991. Dr. Manley stated that these surgeries were "directly related to an injury covered by workmen's compensation." Dr. Manley reported that, following these compensable surgeries, claimant was "totally disabled for his work and did not return to his previous occupation." Dr. Manley further opined that claimant's "disability was permanent and he was unable to return to any work after this surgery."

Although Dr. Manley noted that claimant was disabled from performing his previous occupation, he also opined that claimant was unable to return to any work following his knee replacement surgery. As the physician who performed these knee replacement surgeries, Dr. Manley is in a good position to evaluate claimant's ability to work following those surgeries.

We understand Dr. Manley's opinions as a whole to mean that, following the total knee replacement surgeries in 1990 and 1991, claimant was unable to perform any work due to his compensable bilateral knee condition. Therefore, based on Dr. Manley's opinion, we find that a work search was futile because of claimant's work-related injury. Thus, having established that he was willing to work at the relevant time but not seeking work because a work-related injury made such a work search futile, claimant has proved that he was in the work force at the time of disability.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning July 26, 2001, the date claimant underwent surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

December 6, 2001 Cite as 53 Van Natta 1568 (2001)

In the Matter of the Compensation of
PAULA E. COULTAS-PETERSON, Claimant
WCB Case Nos. 00-04054 & 98-08887
CORRECTED ORDER ON REVIEW
Mitchell & Guinn, Claimant Attorney
Meyers, Radler, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

It has come to our attention that our November 30, 2001 Order on Review contains a clerical error. Specifically, the order refers to the Administrative Law Judge (ALJ) as ALJ Podnar, whereas ALJ Hoguet issued the order.

To correct this oversight, we withdraw our November 30, 2001 order and replace "Podnar's" with "Hoguet's." Accordingly, as corrected herein, we republish our November 30, 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
DAVID R. LAMBIE, Claimant
Own Motion No. 01-0042M
OWN MOTION ORDER ON RECONSIDERATION
Vick & Conroyd, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewing panel: Members Biehl and Haynes.

On March 20, 2001, we authorized the reopening of claimant's February 7, 1995 low back injury claim for the payment of temporary disability compensation. Subsequently, we received information from the Workers' Compensation Division that raised a question regarding whether this claim is subject to our Own Motion authority under ORS 656.278. On April 6, 2001, we abated our order to allow the parties to respond to this jurisdiction issue. Having received the parties' responses, we proceed with our reconsideration.

FINDINGS OF FACT

On February 7, 1995, claimant sustained a compensable low back injury. On April 13, 1995, the SAIF Corporation accepted that claim for a nondisabling lumbar strain.

Subsequently, claimant filed a claim for a low back strain as a new injury occurring on August 15, 1995. Claimant's condition was later diagnosed as an L4-5 disc herniation. On September 22, 1995, SAIF denied the August 15, 1995 injury claim. Claimant requested a hearing on this denial. Thereafter, claimant alleged an aggravation of the February 7, 1995 injury claim. After SAIF failed to timely process the aggravation claim, claimant requested a hearing raising the issue of *de facto* denial of the aggravation claim. On February 22, 1996, SAIF reopened the February 7, 1995 injury claim for an L4-5 disc herniation.

On February 28, 1996, SAIF accepted the L4-5 disc herniation condition as part of the February 7, 1995 injury claim and changed the status of that claim from nondisabling to disabling.

On March 11, 1996, the parties entered into a stipulation to "settle all issue(s) raised or raisable at this time[.]" Specifically, the parties agreed that: (1) SAIF would reopen the February 7, 1995 injury claim for an L4-5 disc herniation as of February 22, 1996; (2) SAIF's September 22, 1995 denial of the August 15, 1995 new injury claim was upheld and became final; (3) claimant's attorney was allowed an assessed fee of $1,000 for prevailing on the denied claim; and (4) claimant's hearing request was dismissed with prejudice.

On November 8, 1996, SAIF issued a Notice of Closure that closed the claim and awarded temporary and permanent disability. Temporary total disability was awarded from September 29, 1995 through October 31, 1995, and temporary partial disability was awarded from November 1, 1995 through March 4, 1996. The Notice of Closure stated that claimant's "aggravation rights" would end on November 8, 2001.

On January 10, 2001, claimant was hospitalized for treatment of his low back condition. On January 15, 2001, claimant underwent surgery for that condition.

On February 1, 2001, SAIF submitted an Own Motion Recommendation Form, noting that it had voluntarily reopened claimant's claim and began paying temporary disability benefits as of January 10, 2001, the date of hospitalization.

By letter dated February 9, 2001, based on the November 8, 1996 Notice of Closure's statement that claimant's aggravation rights would end on November 8, 2001, the Board staff asked the parties' positions regarding whether the claim was within the Board's Own Motion jurisdiction. SAIF responded by submitting a copy of its April 13, 1995 Notice of Acceptance, noting that the claim was accepted as nondisabling and contending that claimant's "5-year aggravation right expired on April 13, 2000." Claimant did not respond to the Board's staff's inquiry.

On March 20, 2001, the Board issued an Own Motion Order authorizing SAIF to reopen claimant's claim pursuant to ORS 656.278(1)(a). Subsequently, the Board received information from the Workers' Compensation Division (WCD) that raised the issue of whether the claim was subject to the Board's Own Motion jurisdiction under ORS 656.278.

On April 6, 2001, the Board abated its March 20, 2001 Own Motion Order to allow the parties to respond to this jurisdiction issue.

CONCLUSIONS OF LAW AND OPINION

Claimant argues that, at the time his compensable low back condition worsened, his aggravation rights had not expired. Therefore, claimant argues, his claim should be processed as an aggravation claim under ORS 656.273, rather than an Own Motion claim under ORS 656.278.

We have jurisdiction to determine whether a claim comes within our Own Motion jurisdiction. *SAIF v. Reddekopp*, 137 Or App 102 (1995). The filing requirements of ORS 656.273 are jurisdictional. *SM Motor Co. v. Mather*, 117 Or App 176 (1992); *Timothy D. Beard*, 43 Van Natta 432 (1991); *Denise A. Robinson*, 42 Van Natta 2514 (1990). A claim for additional compensation made outside the time limits of ORS 656.273 is within the Board's Own Motion jurisdiction; *i.e.*, our Own Motion jurisdiction extends only to claims for worsened conditions that arise after the expiration of aggravation rights. *Miltenberger v. Howard's Plumbing*, 93 Or App 475 (1988).

At the time of claimant's February 7, 1995 injury, *former* ORS 656.273(4) provided:

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

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

Claimant argues that, notwithstanding application of *former* ORS 656.273(4), the statement in the November 8, 1996 Notice of Closure regarding expiration of his aggravation rights controls. Based on that statement, claimant argues that his aggravation rights expired on November 8, 2001, well after his low back condition worsened in January 2001. Claimant also contends that, because the November 1996 closure was made by a Notice of Closure that became final by operation of law, SAIF is bound by its statement regarding the expiration of aggravation rights. We disagree.

In *Miltenberger*, the court determined that an incorrect statement of aggravation rights on a Determination Order did not control whether the Board in its Own Motion capacity had jurisdiction over a claim. Instead, applying a prior version of ORS 656.273(4), the court held that that the statutory provisions regarding expiration of aggravation rights controlled. Under those provisions, the claimant's aggravation rights had expired before he filed his aggravation claim. On that basis, the court determined that the claim was within the Board's Own Motion jurisdiction.

Claimant argues that *Miltenberger* is distinguishable because that case involved a Determination Order, rather than a Notice of Closure. In support of his argument, claimant points out that a carrier is permitted to appeal a Determination Order but is not permitted to appeal its own Notice of Closure. We find this a distinction without a difference. In *Miltenberger*, as summarized above, the court's decision was based the *statutory requirements* regarding expiration of aggravation rights. The fact that claimant's aggravation claim was closed by a Notice of Closure rather than a Determination Order does not affect the statutory requirements regarding expiration of aggravation rights.

Furthermore, subject matter jurisdiction cannot be waived by the parties, the Board, or the court. *SM Motor Co. v. Mather*, 117 Or App at 180 (the time limitations for filing an aggravation claim are jurisdictional, and may not be waived by the parties or the court); *Bill D. Coleman*, 48 Van Natta 2154 (1996); *Daryl R. Gabriel, II*, 48 Van Natta 137 (1996); *see also Southwest Forest Ind. v. Anders*, 299 Or 205 (1985) (if the issue of jurisdiction is not raised by the parties, it is the fact-finder's duty to raise a want of jurisdiction on its own motion). In other words, a party's statement may not confer subject matter jurisdiction, which is conferred solely by statute. Therefore, we reject claimant's argument that the statement in the November 8, 1996 Notice of Closure regarding expiration of his aggravation rights controls.

Alternatively, claimant argues that his claim became disabling in the fall of 1995, although the nondisabling status of the claim did not "formally" change until February 28, 1996, when SAIF accepted the L4-5 disc herniation and changed the status of the claim from nondisabling to disabling. In support

of this argument, claimant notes that the Notice of Closure awarded temporary disability compensation beginning before one year passed from the February 7, 1995 date of injury. Therefore, claimant argues, his aggravation rights expire five years from the date of the November 8, 1996 Notice of Closure.

In making this argument, claimant ignores the statutory scheme regarding reclassification of nondisabling injury claims. Specifically, pursuant to *former* ORS 656.277, a claimant has one year from the date of injury in which to seek reclassification of his or her claim. If a request for reclassification is not made within the one-year time period, the claim cannot be reclassified except by making a claim for aggravation pursuant to ORS 656.273. *Former* ORS 656.277(1) and (2).[1] The court has held there are no exceptions, equitable or otherwise, to these statutory requirements. *Alcantar-Baca v. Liberty Northwest Insurance Corp.*, 161 Or App 49 (1999); *Shaw v. Paccar Mining*, 160 Or App 60 (1999).

Insofar as this record establishes, claimant made no request for reclassification of his claim within a year from the date of injury, although he filed an aggravation claim within that period. Claimant does not contend otherwise. In addition, the parties' March 11, 1996 stipulation did not mention any outstanding reclassification issue.

Here, the claim was initially accepted as nondisabling and remained in "nondisabling status" for more than a year after the date of injury. Therefore, under the terms of *former* ORS 656.273(4)(b), claimant had to file the aggravation claim within five years after the date of the February 7, 1995 injury, or by February 7, 2000. Inasmuch as claimant's 2001 claim was filed more than five years after the date of injury, claimant's request for benefits is within the sole jurisdiction of the Board under its Own Motion authority. ORS 656.278.

Having determined that we have subject matter jurisdiction, we proceed to address claimant's request for reopening his claim in our Own Motion jurisdiction. 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 hospitalization and surgery. Accordingly, we authorize SAIF to reopen the claim to provide temporary disability compensation beginning January 10, 2001, the date claimant was hospitalized for treatment of the compensable injury. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Accordingly, on reconsideration, as modified and supplemented herein, we adhere to and republish our March 20, 2001 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] *Former* ORS 656.277 provides, in part:

"(1) If within one year after the injury, the worker claims a nondisabling injury originally was or has become disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director of the Department of Consumer and Business Services for determination pursuant to ORS 656.268.

"(2) A claim that a nondisabling injury originally was or has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation."

In the Matter of the Compensation of
RHONDA A. FOSNOT, Claimant
WCB Case No. 00-04375
ORDER ON REVIEW
Daniel Snyder, Claimant Attorney
Reinisch, MacKenzie, Healey, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's injury claim for an L5-S1 disk herniation. In her brief, claimant contends that the insurer's appeal should be dismissed for lack of jurisdiction. On review, the issues are jurisdiction and compensability.

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

Jurisdiction

Claimant argues that the insurer's appeal should be dismissed for lack of jurisdiction. Claimant asserts that the insurer sent the original request for review to the Board, but argues that the only person served with a true copy of the request for review was claimant's attorney. Claimant contends that the insurer failed to mail copies of the request for review to claimant, the employer and the insurer. We deny the motion.

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

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(21). Attorneys are not included within the statutory definition of "party." *David K. Rowley*, 51 Van Natta 1853 (1999), *aff'd mem Rowley v. Masami Foods, Inc.*, 170 Or App 791 (2000). However, in previous cases, we have held that, in the absence of prejudice to a party, timely service of a request for review on the attorney for a party is sufficient compliance with ORS 656.295(2) to vest jurisdiction with the Board. *E.g., David K. Rowley*, 51 Van Natta at 1853; *Nancy C. Prevatt-Williams*, 48 Van Natta 242 (1996).

Here, the Board received the insurer's request for review of the ALJ's July 9, 2001 order on August 2, 2001. The request for review indicated that a certified true copy was mailed to claimant's attorney. In addition, the request for review indicated that copies were mailed to claimant's attorney and a representative of the insurer.

Claimant acknowledges that her attorney was served with a true copy of the request for review. She makes no argument that she was prejudiced by not receiving a copy herself. Accordingly, because timely mailing to a party's attorney (in the absence of prejudice to a party) is sufficient, we conclude that the insurer's timely service on claimant's counsel is adequate compliance with ORS 656.295(2). *See Rowley*, 51 Van Natta at 1854; *Prevatt-Williams*, 48 Van Natta at 243.

In a similar vein, the record does not support a conclusion that the employer was prejudiced by not receiving a copy of its insurer's attorney's request for review. In any event, we note that the Board's August 3, 2001 acknowledgment letter of the request for review indicates that copies of the acknowledgment letter were mailed to claimant, claimant's attorney, the employer, the insurer and the insurer's attorney. Under these circumstances, we find it more probable than not that all parties received actual notice of the insurer's request for Board review of the ALJ's July 9, 2001 order within the statutory 30-day period. *See, e.g., Prevatt-Williams*, 48 Van Natta at 243. Therefore, claimant's motion to dismiss is denied.

Compensability

We adopt and affirm the ALJ's order with the following supplementation. We write to address claimant's argument on review concerning compensability of her "current condition."

Claimant argues that, although the insurer's denial did not deny compensability of the L5-S1 disk herniation, the case was litigated "as if" the insurer had denied that condition. Claimant contends that Dr. Laycoe's opinion establishes compensability of the L5-S1 disk herniation and "current condition."

We need not decide whether the insurer's denial expressly denied an L5-S1 disk herniation because it is clear from the record that, in any event, the parties litigated that issue. (Exs. 64A, 64; Tr. 1, 3, 6; *see* written closing arguments). *See Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990). Indeed, the ALJ explained that the crux of the case was compensability of the L5-S1 disk herniation. (Opinion and Order at 5).

On review, claimant relies on Dr. Laycoe's opinion to establish compensability of her L5-S1 disk herniation *and* "current condition." She does not explain why, or if, her current condition is separate or different from her L5-S1 disk herniation. Dr. Laycoe examined claimant on March 24, 1999 and initially diagnosed a lumbosacral spine contusion and possible sciatica. (Ex. 32-4). He recommended an MRI to determine whether claimant actually had sciatica in her right leg. (Ex. 32-5). After Dr. Laycoe reviewed claimant's April 1999 MRI report, he opined that her disk herniation was the result of the June 22, 1998 injury. (Ex. 40). Thus, Dr. Laycoe's reports indicate that claimant had a lumbosacral spine contusion, which the insurer had already accepted, and an L5-S1 disk herniation, which is the subject of this litigation. Dr. Laycoe's reports do not indicate that claimant has a "current condition" that is separate or different from her L5-S1 disk herniation.

Claimant's attorney is entitled to an assessed fee for services on review concerning compensability of the L5-S1 disk herniation. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 9, 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
JERI L. HANSON, Claimant
WCB Case Nos. 00-02307 & 99-04706
ORDER DENYING MOTION TO DISMISS
Starr & Vinson, Claimant Attorney
Meyers, Radler, et al., Defense Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Springfield School District, requested review of Administrative Law Judge (ALJ) Fitzwater's order that: (1) set aside its responsibility denial of claimant's claim for a right shoulder condition; and (2) upheld Safeway's (a self-insured employer) denial of the same condition. Contending that all parties were not served with Liberty's request for review, Safeway has moved to dismiss the request for review. We deny the motion to dismiss.

FINDINGS OF FACT

On October 19, 2001, the ALJ issued an order setting aside Liberty's responsibility denial of claimant's right shoulder condition and upholding Safeway's responsibility denial. On November 9, 2001, Liberty mailed a request for review by certified mail to the Board. The request for review contained a certificate of service indicating that Liberty had served a copy of the request for review on claimant, claimant's attorney, and on Springfield School District. The request for review did not indicate that a copy had been served on Safeway or its attorney. The Board received the request for review on November 13, 2001.

On November 14, 2001, the Board mailed its computer-generated acknowledgment letter to the parties. The acknowledgment letter referenced a request for review received on November 13, 2001 and indicated that copies of the letter had been sent to claimant, claimant's attorney, Springfield School District, Liberty and its attorneys, and Safeway and its attorneys. On November 30, 2001, Safeway moved to dismiss the request for review for failure to serve all parties.

CONCLUSIONS OF LAW AND OPINION

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

The failure to timely serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or 47, 51 (1985); *Argonaut Insurance v. King*, 63 Or App at 852. "Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(21).

Here, the 30th day after the ALJ's October 19, 2001 order was Sunday, November 18, 2001. Therefore, the final day to perfect a timely appeal of the ALJ's order was Monday, November 19, 2001, the first business day following the expiration of the statutory 30-day appeal period. *See Anita L. Clifton*, 43 Van Natta 1921 (1991).

The Board's November 14, 2001 acknowledgment letter was mailed to all parties to the hearing within 26 days after the ALJ's order. Therefore, we conclude that it is more probable than not that all parties received actual notice of Liberty's request for Board review within the statutory 30-day period. *See Donald N. Vatore-Buckout*, 49 Van Natta 93 (1997); *Nancy C. Prevatt-Williams*, 48 Van Natta 242, 243 (1996); *Patricia A. Voldbaek*, 47 Van Natta 702 (1995). In fact, in its motion to dismiss, Safeway concedes that it received the Board's acknowledgment letter. In light of these circumstances, we are persuaded that the non-served party and/or its legal representative received actual notice of Liberty's appeal within the 30-day statutory period. *See Zurich Ins. Co. v. Diversified Risk Management*; 300 Or at 51; *Argonaut Insurance v. King*, 63 Or App at 852.

Safeway contends that the Board's acknowledgment letter is not sufficient to have provided it with "actual notice" of the request for review because it did not provide information such as which party had sought review, what order had been appealed, and what issues were being contested. Safeway relies on *Argonaut Insurance v. King* and *Mosley v. Sacred Heart Hospital*. We find *King* and *Mosley* distinguishable.

In *King*, the court held that the claimant's request for review from a referee's order was not perfected because the evidence established that the insurer received the Board's acknowledgment letter more than 30 days after the referee's order was mailed. ORS 656.295(2); 63 Or App 852, 853. The court did not state with particularity what information was required to constitute a party's "actual notice." Similarly, in *Mosley*, it was uncontraverted that all parties to the referee's order did not receive timely notice of the claimant's request for review. 113 Or App at 237. The court in *Mosley* therefore affirmed the Board's decision to dismiss the claimant's request for review. *Id.*

Moreover, we have repeatedly and specifically held that the Board's acknowledgment letter does constitute sufficient "actual notice" of an appeal, if received by all parties within 30 days of the date of mailing of the ALJ's order. *Donald Vatore-Buckout*, 49 Van Natta at 94; *Nancy C. Prevatt-Williams*, 48 Van Natta at 243.

Finally, Safeway cites to our decision in *Terri L. Walker*, 51 Van Natta 1471 (1999) for the proposition that a correctly identified ALJ order is an indispensable basis for our appellate review. However, our decision in *Walker* focused on the information contained *in the request for review*. 51 Van

Natta at 1471, 1472. Here, Liberty correctly identified the October 19, 2001 order in its November 9, 2001 request for review. Although the Board's acknowledgment letter did not identify the date of the ALJ's order, it did refer to the WCB case numbers that were listed on the ALJ's order. In light of such circumstances, we continue to conclude that a party's or its representative's receipt of such an acknowledgment letter establishes actual notice that the ALJ's order (which contains the cited WCB case numbers) has been appealed.

Accordingly, Safeway's motion to dismiss is denied. The briefing schedule shall continue as previously established. Thereafter, the case will be docketed for Board review.

IT IS SO ORDERED.

December 7, 2001 Cite as 53 Van Natta 1575 (2001)

In the Matter of the Compensation of
LAWRENCE JONES, Claimant
Own Motion No. 01-0195M
OWN MOTION ORDER DENYING RECONSIDERATION
Gilroy Law Firm, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

On September 13, 2001, we withdrew our July 9, 2001 Own Motion Order, which denied claimant's request for Own Motion relief on the ground that he was not in the work force at the time of his current worsening. We took this action to consider claimant's submissions regarding the work force issue.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if the party requesting reconsideration establishes good cause for the failure to file the request within 30 days. The standard for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized by ORCP 71B(1) and former ORS 18.160. *Anderson v. Publishers Paper Co.*, 78 Or App 513 517, *rev den* 301 Or 666 (1986); *see also Brown v. EBI Companies*, 289 Or 455 (1980). Lack of due diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). However, OAR 438-012-0065(3) also provides that "[n]otwithstanding section (2) of this rule, in extraordinary circumstances the Board may, on its own motion, reconsider any prior Board order." *See Larry P. Parker*, 48 Van Natta 2182 (1996); *Jay A. Yowell*, 42 Van Natta 1120 (1990).

Claimant apparently has his mail directed to his daughter's address, which is the address to which the Board's order was mailed. Claimant does not contend that the Board's order was misdirected. In addition, the return address provided on envelopes containing information submitted to the Board by claimant is the same address as claimant's daughter's address.

By letter dated August 20, 2001, and received by the Board on August 24, 2001, claimant's daughter requested reconsideration on behalf of claimant. Thus, claimant's request for reconsideration was received more than 30 days after the issuance of our July 9, 2001 Own Motion Order. In her letter, claimant's daughter stated that she received the Board's order the week of August 6, 2001 and noted that she was aware that claimant had 30 days from the date of the July 9, 2001 order to request reconsideration. In addition, claimant's daughter stated that, due to his "hand injury," claimant only checks his mail "about once every couple of weeks." Finally, she noted that claimant had not yet seen the Board's order.

We have held that a medical incapacity may establish good cause for failure to timely file a hearing request where the worker is sufficiently incapacitated during the relevant period following a denial to prevent him or her from seeking a timely hearing request. *See Patricia J. Mayo*, 44 Van Natta 2260 (1992); *Jerry M. McClung*, 42 Van Natta 400 (1990). In both *Mayo* and *McClung*, the claimants were essentially physically and/or mentally incapacitated due to medications, multiple surgeries, and hospitalizations until after the expiration of the appeal period.

However, the facts of this case do not rise to the level of medical incapacity that would satisfy the "good cause" standard. Although claimant's daughter asserts that claimant was unable to check his mail on a daily basis due to his "hand injury," no medical documentation has been provided to support that proposition nor to establish that claimant was physically incapable of mailing his request for reconsideration of our July 9, 2001 order within the required 30-day period (particularly when he had his mail directed to his daughter's address and she acknowledges that she received a copy of our order and was aware of the 30-day period). While we may empathize with claimant in that having a "hand injury" may be discomforting and debilitating, we do not find that this condition constitutes "good cause" for the untimely mailing of a request for reconsideration of our prior order.

In conclusion, claimant did not establish that he was physically or mentally incapable of conducting his personal business affairs, nor did he exercise due diligence in monitoring his mail. *See Ivan R. McDaniel, Jr.*, 51 Van Natta 967 (1999) (because claimant did not demonstrate due diligence in monitoring his mail, he could not rely on lack of actual knowledge of the denial to establish good cause for his untimely hearing request); *accord Geoff McClellan*, 50 Van Natta 43 (1998) (the claimant who failed to monitor his mail for correspondence concerning a claim could not establish that he failed to cooperate in the investigation of the claim for reasons beyond his control). Under these circumstances, we find that claimant's explanation for his untimely request for reconsideration does not constitute good cause.

Consequently, claimant's request for reconsideration is denied as untimely filed. Therefore, we decline to address his contentions that he remained in the work force at the time of his current worsened condition. Accordingly, our July 9, 2001 order is republished.[1]

IT IS SO ORDERED.

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[1] As noted in our prior order, if claimant has further questions, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. He may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

Department of Consumer & Business Services
Workers' Compensation Ombudsman
350 Winter St NE
Salem, OR 97301-3878

In the Matter of the Compensation of
EDDIE W. ROBINSON, Claimant
Own Motion No. 01-0359M
OWN MOTION ORDER
Welch, Bruun & Green, Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The SAIF Corporation has voluntarily reopened the claim pursuant to ORS 656.278 for claimant's low back condition. Claimant's aggravation rights have expired. SAIF asks the Board to authorize the reopening of the claim.

Claimant initially injured his low back on December 30, 1987, while working for the employer while insured by SAIF. SAIF accepted that claim for a herniated nucleus pulposis at L5-L6. On December 14, 2000, claimant sustained another low back injury while working for the same employer, still insured by SAIF. On January 12, 2001, SAIF accepted the December 14, 2000 injury as a disabling lumbar strain.

By separate letters dated November 8, 2001, claimant filed additional claims for his current low back condition with the same employer/same insurer. Specifically, claimant requested that SAIF: (1) expand its acceptance of the 1987 back injury claim to include left L4-5 and L5-S1 laminectomies; (2) expand its acceptance of the December 2000 back injury claim to include left L4-5 and L5-S1

laminectomies; and (3) accept the December 2000 injury as an occupational disease claim (Claim No. 7887966A). On November 20, 2001, SAIF issued a partial denial of the occupational disease claim.[1]

In *Leslie D. Marcum*, 50 Van Natta 2242 (1998), we authorized the 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 "occupational disease" claim and/or the December 2000 injury claim, SAIF has accepted "responsibility" under the 1987 Own Motion claim. Additionally, the language of ORS 656.307(1)(a) and OAR 438-060-0180 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 noted, SAIF is not contesting the compensability and/or responsibility of claimant's current low back condition as it relates to the 1987 Own Motion claim. Additionally, SAIF acknowledges that surgery is appropriate for the compensable condition. In fact, SAIF has voluntarily reopened the claim and requests 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 the "occupational disease" claim and/or the December 2000 injury claim. *Harold F. Schultz*, 53 Van Natta 1080 (2001). 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.* Based on the medical evidence, we find that claimant's compensable injury has worsened requiring surgery. We therefore have the authority to authorize the reopening of the claim for temporary disability compensation commencing July 24, 2001, the date claimant was hospitalized for the surgery. *Id.*

Accordingly, the record establishes that the reopening of the claim was appropriate.[2] When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); OAR 438-015-0080.

IT IS SO ORDERED.

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[1] On this record, it is not clear what action, if any, SAIF has taken regarding claimant's requests to expand its prior acceptances of the 1987 and 2000 low back injury claims.

[2] This conclusion is based on the presumption that SAIF, under the previously accepted condition described in the 1987 claim, will ultimately be held responsible for claimant's current condition. In the event that SAIF is ultimately found responsible for claimant's current condition under his "occupational disease" claim or as a "new medical condition" under the 1987 claim or the December 2000 injury claim, SAIF 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.

In the Matter of the Compensation of
ANDREA J. SPIES, Claimant
WCB Case No. 01-01592
ORDER ON REVIEW
Black, Chapman, et al., Claimant Attorney
Paul Louis Roess, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's aggravation claim for a low back condition. On review, the issues are the procedural propriety of the denial and aggravation.

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

Claimant was injured on January 7, 2000 while lifting concrete sacks at work. On May 15, 2000, the employer accepted "thoracic strain." On June 2, 2000, the employer issued a Notice of Closure closing the claim. On June 5, 2000, three days after claim closure, the employer issued an "Updated Notice of Acceptance at Closure" that accepted "lumbosacral strain."

Claimant's low back condition worsened and an aggravation claim was filed by Dr. Amstutz on October 18, 2000. (Ex. 13; 13A). An MRI dated October 25, 2000 showed a large herniated disc at L4-5 on the left. (Ex. 14). Dr. Amstutz performed an emergency left lumbar 4-5 laminotomy and disc excision with decompression of the nerve root on November 9, 2000. (Ex. 16). The employer denied an aggravation claim on January 24, 2001. (Ex. 19).

The ALJ concluded that the employer's June 5, 2000 Notice of Acceptance of a lumbosacral strain constituted a modified notice of acceptance and that claimant's lumbosacral strain condition had to be processed to closure before her aggravation rights could begin to run. The ALJ noted that the condition originally accepted on May 15, 2000 was a "thoracic strain." That condition was processed and the claim was closed on June 2, 2000. It was not until June 5, 2000 that a lumbosacral strain condition was accepted. Although the June 5, 2000 acceptance purported to include the lumbosacral strain condition in the June 2, 2000 claim closure, the ALJ reasoned that the only condition that had been accepted at the time of closure was "thoracic strain." The ALJ concluded that the employer's aggravation denial was procedurally invalid because the lumbosacral strain condition had to be processed to closure before a claim for aggravation of that condition could be claimed or denied. On this basis, the ALJ set aside the aggravation denial as procedurally invalid.

ORS 656.262(7)(c) provides, in part: "If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." Here, there was no evidence that a lumbosacral strain condition had been accepted by the employer prior to claim closure. In fact, the only condition accepted prior to closure was a thoracic strain condition. Three days after closure of the claim, the employer issued an acceptance of a "lumbosacral strain" condition. Because this condition was accepted, *i.e.*, found compensable after closure, the employer is obligated under ORS 656.262(7)(c) to reopen the claim for processing of that condition. *See Douglas G. Abbott*, 50 Van Natta 1156 (1998). Accordingly, we agree, for the reasons expressed above, that the lumbosacral strain claim must be processed and closed before either a valid aggravation claim or aggravation denial for that condition can be made.

ORDER

The ALJ's order dated June 22, 2001 is affirmed.

In the Matter of the Compensation of
JOSEPH M. WEBB, Claimant
WCB Case No. 01-03034
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Scheminske, et al., Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's right wrist injury claim; and (2) assessed a penalty for the employer's allegedly unreasonable denial. On review, the issues are course and scope and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's order with the following supplementation. We agree with the ALJ's application of the "increased danger rule" under the facts of this case. *See Cecil A. Green*, 53 Van Natta 664 (2001). We also provide the following alternative analysis.

Even if the "increased danger rule" is no longer viable, we find that claimant's right wrist injury arose out of and in the course of his employment, for the following reasons.

Claimant is a construction manager who occasionally inspects construction areas. On December 11, 2000, claimant was inspecting a ceiling remodel job in a counseling room and climbed on top of a table that was two-feet high in order to inspect the ceiling. When he stepped down from the table, his left knee buckled, which caused him to fall and fracture his right wrist when he landed on the floor.

Claimant testified that he has a preexisting problem with his left knee and was told that he has torn ligaments in the knee. (Tr. 8-9). Surgery for a ligament repair was recommended, but it was not required. (Tr. 12; Ex. 7A-4). Claimant said that his left knee buckles approximately once every four months. (Tr. 9). When his knee buckles, it usually drops him to the ground. (*Id.*) Claimant testified that the buckling of his left knee had always occurred either when he had stepped down or jumped down off of something; it had never happened when he was standing straight flat on the floor. (*Id.*)

The employer argues that claimant's left knee buckled because of an idiopathic condition and, therefore, claimant failed to sustain his burden of proving compensability. According to the employer, claimant's preexisting left knee instability, not the table or claimant's activity at the time of the injury, presented the increased risk.

In *Cecil A. Green*, 53 Van Natta at 666-67, the carrier made a similar argument; *i.e.*, that the claimant failed to sustain his burden of proof because his fall was "idiopathic."[1] We understood the carrier to be arguing that the claimant's risk was personal to him and was therefore noncompensable. *Id.* at 667. We discussed the risk analysis explained in Arthur Larson and Lex K. Larson, 1 *Larson's Workers' Compensation Law*, section 4 (2001); *i.e.*, risks distinctly associated with the employment, risks personal to the claimant and "mixed" risks.

In *Green*, the claimant argued that the fall that caused his head injury was initiated by a syncopal event caused by cardiac and circulatory conditions. The claimant asserted that the employment risks that led to his head injury included the presence of a sharp object on which he hit his head. We found that the circumstances did not clearly fit into either the purely "personal risk" or purely "employment risk" categories described by Larson. Instead, we determined that the claimant's injury

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[1] In *McTaggart v. Time Warner Cable*, 170 Or App 491, 496 n7 (2001), the court explained that idiopathic reasons are those that are peculiar to the claimant, rather than arising out of the work situation. *See also Phil A. Livesley Co. v. Russ*, 296 Or 25, 27 n1 (1983) ("idiopathic" refers to an employee's preexisting physical weakness or disease that contributes to the accident).

included components of both types of risk. We reasoned that the claimant's fall was caused by the beginning of a heart attack, which caused him to lose consciousness while at his workstation. The syncopal episode and beginning of a heart attack were personal to the claimant. On the other hand, we found that the head injury was caused by an employment risk; *i.e.*, the subdural hematoma was caused when the claimant struck his head on a sharp object. We found that the circumstances qualified as a "mixed risk," which is described by Larson as follows:

> "Another troublesome problem is that of mixed risks, in which a personal cause and an employment cause combine to produce the harm. The most common example is that of a person with a weak heart who dies because of strain occasioned by the employment. In broadest theoretical outline, the rule is quite simple. The law does not weigh the relative importance of the two causes, nor does it look for primary and secondary causes; it merely inquires whether the employment was a contributing factor. If it was, the concurrence of the personal cause will not defeat compensability." 1 *Larson's Workers' Compensation Law*, section 4.04 (footnotes omitted).

In *Green*, we concluded that the claimant's employment was a contributing factor in his head injury because it was caused when he struck his head on a sharp object, causing a subdural hematoma. We determined that the claimant's head injury arose out of his employment because the risk of injury originated from a risk to which the work environment exposed him.

We reach a similar conclusion in this case. As we discussed, the fall that caused claimant's right wrist injury occurred after his left knee buckled as he was stepping down from a table two-feet high. Claimant had climbed on the table to inspect a ceiling remodel job. We find that the buckling of claimant's left knee was personal to him. Claimant has a preexisting problem with left knee and he explained that his left knee buckles approximately once every four months. (Tr. 9).

On the other hand, the right wrist injury was caused by an employment risk because it occurred as he stepped down from the table. The only reason claimant was on the table was to inspect the ceiling remodel job. Claimant testified that his left knee buckles when he has stepped down or jumped down off of something, but it had never happened when he was standing straight flat on the floor. (Tr. 9-10). Thus, the fact that claimant was standing on a table and had to climb down created a risk that he would not have had if he was standing on the floor. We find that these circumstances qualify as a "mixed risk." We conclude that claimant's employment was a contributing factor in his right wrist injury because it was caused when he was stepping down from a two-foot high table. The fact that claimant's fall was initiated by the buckling of his left knee does not defeat compensability. Under these circumstances, we conclude that claimant's right wrist injury arose out of his employment because the risk of injury originated from a risk to which the work environment exposed him. *See Fred Meyer, Inc. v. Hayes*, 325 Or 592, 601 (1997).

Penalties

The ALJ found that the employer's denial was reasonable when issued, but became unreasonable after the Board issued *Cecil A. Green*, 53 Van Natta at 664. The ALJ assessed a 10 percent penalty against the employer.

The employer argues that, even after the Board issued *Green*, it had a legitimate doubt as to compensability. The employer contends that the situation in *Green* was distinguishable and it was reasonable for the employer to conclude that the counseling room did not present a situation that would justify application of the increased danger rule.

A carrier is liable for a penalty when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). In determining whether a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Id.* The carrier, however, has a continuing obligation to reassess the propriety of its denial in light of "post-denial" medical evidence. *Id.* at 592.

On March 8, 2001, the employer denied compensability on the basis that claimant's right wrist fracture was idiopathic in nature and did not arise out of, or in the course and scope of, his employment activities with the employer. (Ex. 8). We agree with the ALJ that, at the time the employer issued its denial, the employer had a legitimate doubt as to its liability.

On May 15, 2001, the Board issued *Cecil A. Green*, 53 Van Natta at 664. In that case, we held that the "increased danger" rule remained viable where the cause of a fall is idiopathic, and we agreed with the ALJ's application of that rule. *Id.* at 666. Alternatively, we found that the circumstances of the claimant's head injury qualified as a "mixed risk." We reasoned that the claimant's employment was a contributing factor in his head injury because it was caused when he struck his head on a sharp object, causing a subdural hematoma. *Id.* at 667.

In the present case, we find that the employer had a legitimate doubt as to whether the mechanism of claimant's right wrist injury constituted an "increased danger," and whether the circumstances of claimant's injury qualified as a purely "personal risk" to claimant. Consequently, we conclude that the employer's continuation of its compensability denial was not unreasonable under the circumstances presented in this case. Therefore, we reverse the ALJ's assessment of a penalty.

Claimant's attorney is entitled to an assessed fee for services on review concerning compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the course and scope issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services concerning the penalty issue. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

ORDER

The ALJ's order dated July 23, 2001 is affirmed in part and reversed in part. The portion of the ALJ's order that assessed a penalty for the employer's allegedly unreasonable denial is reversed. The remainder of the ALJ's order is affirmed. For services on review concerning compensability, claimant's attorney is awarded $1,000, payable by the employer.

December 11, 2001 Cite as 53 Van Natta 1581 (2001)

In the Matter of the Compensation of
BRIAN K. COUCH, Claimant
WCB Case Nos. 00-05839 & 00-01781
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney
Hornecker, Cowling, et al., Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Roseburg Forest Products (RFP), a self-insured employer, requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) set side its denial of claimant's L4-5 disc condition; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) denial of claimant's "new injury" claim for the same condition. On review, the issues are scope of review, compensability and, responsibility.

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

RFP argues that the ALJ erred in addressing compensability of the L4-5 condition, because the issue was not "advocated" at hearing. We disagree.

At the outset of the hearing, claimant's attorney stated that the first issue was "aggravation compensability/responsibility," referencing claimant's 1994 low back injury, which RFP previously accepted. (Tr. 5). Claimant's attorney stated that the second issue was "compensability/responsibility []under a new injury theory. The issues involve [claimant's] low back - in particular, the L4-5 and L5-S1 [discs]." (*Id.*). Neither Liberty nor RFP objected to claimant's description of the denied conditions or

the issues to be decided.[1] Therefore, we find that compensability of the L4-5 disc condition was properly before the ALJ.

That said, we specifically note RFP's concession that it remains responsible for claimant's accepted L5-S1 condition.[2] Thus, the only substantive issues on review are compensability of and responsibility for the L4-5 disc condition.

The ALJ set aside RFP's denial of the L4-5 condition, based on Dr. Bert's opinion that the 1994 accepted injury with RFP was the major contributing cause of claimant's current condition and need for treatment -- without contribution from claimant's later employment with Liberty's insured.[3] Considering RFP's concession that claimant's current L5-S1 condition remains compensably related to the accepted 1994 injury and Dr. Bert's persuasive opinion relating claimant's current need for treatment to that injury, we agree.[4] Consequently, claimant's L4-5 condition is compensable under ORS 656.005(7)(a) and RFP is responsible for it.[5] *See, e.g., Roseburg Forest Products v. Langley*, 156 Or App 454, 462-63 (1998) (employer obligated to pay for medical services for the purpose of determining the extent of the original compensable injury).

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

ORDER

The ALJ's order dated May 7, 2001 is affirmed. For services on review, claimant is awarded a $2,000 attorney fee, payable by RFP.

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[1] RFP explained that its denial was based in part on a contention that claimant's symptoms were due to a herniated disc at L4-5 (rather than the accepted L5-S1 condition). (*Id.* at 6). Liberty agreed generally with the issues described, commenting, "If it's L4-5, there's a serious question of compensability, as well as responsibility." (*Id.* at 6-7).

[2] As the ALJ explained, there is no denial of claimant's current condition at L5-S1 on causation grounds. And claimant has not contested the portion of the ALJ's order that upheld RFP's denial of claimant's aggravation claim for an allegedly worsened L5-S1 condition.

[3] We adopt the ALJ's evaluation of the contrary medical evidence, except we do not discount the opinions of Drs. Sullivan and Donahoo for being based solely on a temporal relationship between claimant's 1999 work activities and symptoms. Instead, we find these opinions unpersuasive because they are based on inaccurate histories. First, the doctors fail to rebut persuasive evidence establishing that claimant's recent supervisory work for Liberty's insured was not physical enough to cause or contribute to his condition. (*See* Exs. 43-4, 44; *compare* Exs. 45, 4,; Tr. 19, 23-25). We also discount these opinions to the extent that they are based on an inaccurate history that claimant's symptoms "began" in 1999. (*See id.*; Ex. 51-39; Tr. 28). And, although Dr. Schilperoort believes that claimant's current problems arise at L5-S1, he does not persuasively rule out an L4-5 contribution, because he dates the L4-5 disc condition to a time frame that encompasses the 1994 work injury. (*See also* Exs. 47-5-7, 50, 51-19).

[4] Ultimately, claimant's medical treatment may -- or may not include surgery at L4-5. (*See* Exs. 40, 42-11, 43-4, 44, 46A, 51-36-37). In any event, because claimant's current condition is compensable, RFP is responsible for medical services required to diagnose and treat the L5-S1 *and* L4-5 conditions. *See* ORS 656.245(1)(a); 656.245(1)(c)(H).

[5] We need not determine the "disability date" (the date of first medical treatment for the L4-5 condition), because responsibility ultimately rests with RFP in either event. That is, if responsibility for the L4-5 condition is presumptively assigned with Liberty (as the last work that could have contributed under the "last injurious exposure rule of assignment"), it would shift back to RFP, because the medical evidence establishes that claimant's prior exposure was the sole cause of the condition. Alternatively, if responsibility is presumptively assigned with RFP, it remains there, because the persuasive medical evidence indicates that claimant's exposure under Liberty's coverage did not cause or contribute to the condition. *See SAIF v. Paxton*, 154 Or App 259, 265 (1998) (where medical record established that the claimant sustained no hearing loss while employed by a particular employer, that employer not legally responsible).

In the Matter of the Compensation of
KENNETH T. CURRY, Claimant
WCB Case No. 00-08385
ORDER ON REVIEW
Sather, Byerly & Holloway, Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of his injury claim for a right arm condition. In his request for review, claimant objects to the hearing transcript as incomplete and raises several procedural arguments. On review, the issues are hearing procedure and compensability.

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

With regard to claimant's objection to the transcript as not containing the closing arguments, we note that the employer provided the Board with a copy of the closing arguments at hearing. That closing argument contains claimant's specific arguments to the ALJ regarding his contention that he was unable to hire counsel for the "post-hearing" deposition of Dr. Fleiss. Under such circumstances, claimant's contention regarding the inadequacy of the hearing transcript has been resolved.

On review, claimant also renews his argument that the Board's rules regarding the approval of fees for claimants' attorneys deprived him of his "right to counsel" under the United States Constitution. Claimant contends that it is fundamentally unfair that he is not able to hire an attorney on an hourly basis when a carrier may do so. We disagree.

Initially, we note that the "right to counsel" derives from Article I, Section 11 of the Oregon Constitution or from the Sixth Amendment to the United States Constitution, both of which apply solely to criminal proceedings. *Elkins v. Thompson*, 174 Or App 307 (2001); *McClure v. Maass*, 110 Or App 119, 125 (1991), *rev den* 313 Or 74 (1992). Thus, there is no such absolute "right" in workers' compensation proceedings. Nonetheless, injured workers are encouraged to be represented in formal hearings. OAR 438-006-0100.

Consistent with the aforementioned Board rule, prior to hearing, the Hearings Division sent claimant a letter in which he was "strongly urged to retain an attorney who is knowledgeable in workers' compensation law." Instead, claimant appeared at the hearing unrepresented. In addition, claimant was advised by the ALJ prior to beginning the hearing that he had the right to be represented by an attorney. (Tr. 1). Claimant acknowledged that advice from the ALJ, but again chose to proceed unrepresented. (Tr. 1, 2).[1]

Apparently, prior to the "post-hearing" deposition, claimant unsuccessfully attempted to hire an attorney. (Closing Argument at 1). Having chosen to initially proceed without representation until after the hearing and the presentation of evidence (except for a limited "post-hearing" deposition requested by claimant), it is understandable that the number of potential attorneys willing to accept such an assignment at such a late date in the hearing process was limited. Moreover, when requesting the "post-hearing" deposition, claimant did not alter his earlier position that he wished to proceed without an attorney. Under such circumstances, we are not persuaded that claimant was deprived of an opportunity to secure an attorney.

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[1] "[By the ALJ] Before we went on the record, I indicated to you that you could likely obtain the services of an attorney without incurring costs for attorney fees. Are you aware of that?

"[By claimant] I'm aware of your statement that - that that has been a supposed practice in this jurisdiction.

"* * *

"[By the ALJ] And you're aware of your right to be represented by an attorney if you choose to be?

"[By claimant] Yes, I'm aware of that.

"[By the ALJ] And is it your desire to proceed in this hearing representing yourself?

"[By claimant] I understand this, sir." - (Tr. 1, 2).

Claimant also raises an issue with the employer's ability to hire counsel on an hourly basis, as opposed to claimants. However, unless a statutory exception applies, corporations must be represented by counsel in any "action, suit or proceeding." ORS 9.320; *Cf. Allen Ehr*, 47 Van Natta 870 (1995) (claim disposition agreement (CDA) is not a "proceeding" requiring a corporation to be represented by an attorney). Claimants and other individuals, on the other hand, are not required by statute to retain an attorney and may remain unrepresented, an option claimant chose at the commencement of this proceeding (notwithstanding his "pre-hearing" acknowledgement that he could retain counsel before beginning the proceeding) and continued to exercise until the "post-deposition" closing arguments.

ORS 656.388(1) provides:

> "No claim or payment for legal services by any attorney representing the worker or for any services rendered before an Administrative Law Judge or the Workers' Compensation Board, as the case may be, in respect to any claim or award for compensation to or on account of any person, shall be valid unless approved by the Administrative Law Judge or board, or if proceedings on appeal from the order of the board with respect to such claim or award are had before any court, unless approved by such court."

Pursuant to this enabling statute and other statutory provisions, the Board's attorney fee rules are premised on a claimant's prevailing over a denial (ORS 656.386(1)) or establishing a carrier's unreasonable claim processing conduct (ORS 656.382(1)) (in which cases an attorney fee would be payable by the carrier) or on claimant receiving an increased temporary or permanent disability award (ORS 656.386(2)) in which case the fee would be payable out of claimant's compensation. *See* OAR 438-015-0003, *et seq.*

ORS 656.388(1) merely limits the situations in which claimants' attorneys may earn fees to those approved by the ALJ, Board, or court. Consistent with the statutory scheme, OAR 438-015-0010(4) takes into account that limitation by listing "the risk of going uncompensated" as a factor to be considered in setting the amount of a claimant's attorney's fee. OAR 438-015-0010(4)(g). Notwithstanding those limitations, the statute does not deprive claimants of the ability to retain counsel in the first instance. Indeed, as demonstrated by OAR 438-006-0100 and this record, retention of counsel by claimants is encouraged by the Board and its ALJs.

In conclusion, claimant's inability to retain an attorney does not establish that he was statutorily precluded from obtaining counsel. To the contrary, it merely underscores the significance of his "pre-hearing" decision to begin the proceedings without legal representation (even when advised of his opportunity to seek counsel).

Finally, we adopt and affirm the ALJ's order on the merits of the compensability issue.

ORDER

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

Board Member Phillips Polich specially concurring.

I concur in the Board's decision to uphold the employer's denial. However, I write separately to address claimant's valid concerns about obtaining counsel in this matter.

Under the "American rule," generally a private litigant pays for his or her own attorney (absent a statutory "fee shifting" provision). *See Mattiza v. Foster*, 311 Or 1 (1990). However, in our workers' compensation system, although corporations must obtain and pay for the services of a lawyer, a claimant cannot, at least through traditional means. What that means in a case such as this is that claimant, despite his earnest intention and effort to find and pay for an attorney, was unable to hire an attorney for a "post-hearing" deposition. Although the majority emphasizes that claimant was advised pre-hearing of his right to be represented, I do not believe that claimant, being *pro se* and foreign to our system, could have anticipated the necessity for such a deposition.

Secondly, the lead opinion explains that the Board takes into account the risk of going unrepresented in assessing the amount of a claimant's attorney fee, citing the Board rule. OAR 438-015-0010(4)(g). However, in my experience and opinion, that specific factor is rarely taken into account in actual practice.

Finally, in my experience and estimation, there has been no appreciable increase in the amount of attorney fees generally awarded by the Board in the past decade. This is despite the increased risk of going uncompensated due to multiple amendments to the Workers' Compensation Law in favor of employers and insurers and despite continuing increases in the cost of running a law practice and in the cost of living in general. Contingent fee representation at this marginal rate forces attorneys to choose their cases carefully and prevents claimants from hiring an attorney of their choice for litigation of close cases. All of these factors combine to work an inequity on claimants seeking representation in our forum.

For these reasons, I respectfully specially concur.

December 11, 2001 Cite as 53 Van Natta 1585 (2001)

In the Matter of the Compensation of
ALEJANDRO ESTOLANO, Claimant
WCB Case No. 00-07361
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorney
Ronald W. Atwood & Associates, Defense Attorney

Reviewing Panel: Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that declined to increase claimant's temporary total disability rate. On review, the issue is temporary total disability (TTD).

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

Claimant was compensably injured when he fell from a scaffold. He was paid TTD benefits based on an average weekly wage of $560.83. Claimant received $10 an hour for all hours he worked for the employer, including 96.5 hours that the parties stipulated was "arguably overtime." Claimant requested a hearing contending that his TTD rate should be $641.25 (based on a wage rate of $15 per hour (time and half) for the 96.5 hours worked that are "arguably overtime").

The ALJ concluded that there was no precedent for calculating a claimant's average weekly wage based on earnings greater than were actually received. The ALJ addressed claimant's argument that under a Bureau of Labor and Industries (BOLI) administrative rule, OAR 839-020-0030(3)(a)(A), claimant was entitled to a $15 per hour overtime wage rate. The ALJ stated that while claimant may be entitled to be recompensed consistent with the BOLI rule, there was no evidence in the record that such a determination had been made by BOLI. In the absence of a BOLI determination, the ALJ declined to modify claimant's TTD rate based on his "arguably overtime" hours.

On Board review, claimant asserts that pursuant to OAR 839-020-0030(3)(a)(A), his overtime rate should be $15 per hour. He argues that the $10 per hour rate for all hours worked is illegal. On this basis, claimant contends that his TTD rate should be recalculated based upon OAR 839-020-0030(a)(A). We disagree.

For workers, like claimant, who are paid on an hourly basis, the rate of TTD is governed by OAR 436-060-0025(5). That rule provides that the "rate of compensation" shall be computed based on "wages." "Wages" are "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident[.]" ORS 656.005(29).

OAR 436-060-0025(5)(f) requires that overtime earnings be included (in the TTD calculation) at the "overtime rate." The rule does not require a determination of whether a claimant's "overtime rate" is legally correct under BOLI rules.

Here, as previously noted, the parties have stipulated that claimant was paid at the rate of $10 per hour for all hours worked. Under such circumstances, the record supports a conclusion that the contract of hire in effect at the time of claimant's injury was $10 an hour for all of the hours he worked. Consequently, his TTD rate, for both regular and overtime hours, is based on a wage of $10 per hour.

This decision is consistent with our case precedent. In *Michael D. Wingo*, 48 Van Natta 2477 (1996), *aff'd Wingo v. SAIF*, 153 Or App 237 (1998), the claimant's modified employment was terminated because of his failure to pay union dues. When the carrier did not begin paying TTD, the claimant requested a hearing. In affirming the ALJ's determination that claimant had failed to establish entitlement to TTD, we noted that the claimant may well have a cause of action stemming from the manner in which his employment was terminated, but that the Board was not the appropriate forum for such an action.[1]

Similarly, in *Patricia K. Stodola*, 48 Van Natta 613 (1996), we affirmed an ALJ's determination that the claimant's entitlement to temporary disability ceased following the termination of her employment. In doing so, we confined our review to whether the claimant was terminated because of an inability to work due to the compensable injury. *Id.* at 614.

Thus, in previous cases, as in this one, we have declined to go beyond the confines of Chapter 656 concerning a workers' compensation claim to address the propriety of other employment or labor disputes. Here, the proper forum for claimant's argument that he is entitled to an overtime rate is BOLI.[2]

In conclusion, the record does not establish that BOLI has determined that claimant is entitled to an overtime wage rate of $15 per hour under OAR 839-020-0030(a)(A). Accordingly, we agree with the ALJ that claimant has not established that his TTD rate should be modified.

ORDER

The ALJ's order of June 22, 2001 is affirmed.

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[1] While we did determine, in *Wingo*, that the claimant's termination was "in violation of a normal employment standard," such a determination was required by an administrative rule applicable to the payment of temporary disability benefits. (*Former* OAR 436-60-030(11)(b)).

[2] A party in claimant's situation could seek resolution of the wage dispute through the procedures set forth in the BOLI rules. Once the dispute was resolved, the claimant could then seek recalculation of TTD based on any increased wages resulting from the wage dispute. If the carrier declined to recalculate TTD, the claimant could then seek a workers' compensation hearing regarding the TTD rate dispute.

Board Member Biehl dissenting.

I disagree with the majority's conclusion that claimant's TTD rate should be calculated using an overtime rate of $10 per hour instead of $15 per hour in accordance with OAR 839-020-0030(a)(A). Therefore, I respectfully dissent.

The majority correctly concludes that claimant's TTD rate is governed by OAR 436-060-0025. In reviewing cases to which OAR 436-060-0025 is applicable, we apply the methods prescribed by the Director in accordance with the intent of the legislature. *See SAIF v. Frias*, 169 Or App 345, 350 (2000).

In enacting ORS 653.010 *et seq.*, the legislature expressly stated an intent to "establish minimum wage standards." ORS 653.015. Based on that intent, the legislature provided that the Commissioner of the Bureau of Labor and Industries may issue rules prescribing "minimum conditions, excluding minimum wages, in any occupation as may be necessary for the preservation of the health of employees."[1] ORS 653.261(1). Pursuant to ORS 656.261(1), the Commissioner promulgated OAR 839-020-0030(3)(a)(A), which provides:

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[1] "Minimum wage" is set forth in ORS 653.025.

> "Where the employee is employed solely on the basis of a single hourly rate, the hourly rate is the 'regular rate'. For hours worked in excess of forty (40) hours in a work week the employee must be paid, in addition to the straight time hourly earnings, a sum determined by multiplying one-half the hourly rate by the number of hours worked in excess of forty (40)[.]"

Because wage standards established pursuant to ORS 653.015 *et seq.*, are *minimum* standards, and because temporary disability compensation calculated pursuant to OAR 436-060-0025 is to be based on a worker's wages in accordance with the "contract" in force at the time of the accident, I conclude that the legislature intended that the wages (which are the basis for temporary disability) provided by any such "contract" meet or exceed the minimum standards.

Here, claimant's "regular rate" is $10 per hour. During his pre-injury period of employment, claimant worked 96.5 hours of overtime. Pursuant to OAR 839-020-0030(3)(a)(A), his overtime rate is $15 per hour. The parties do not contend that any of the statutory exclusions to ORS 653.010 *et seq.*, apply to claimant. Consequently, applying OAR 436-060-0025 consistent with the minimum standards established by OAR 839-020-0030(3)(a)(A), I conclude that claimant's overtime rate, for purposes of calculating temporary disability, is $15 per hour.

Citing *Michael D. Wingo*, 48 Van Natta 2477 (1996), *aff'd Wingo v. SAIF*, 153 Or App 237 (1998), and *Patricia K. Stodola*, 48 Van Natta 613 (1996), the majority concludes that BOLI is the proper forum for determining claimant's entitlement to "an overtime rate." I disagree.

Here, the issue is not "disputed wages," as the majority suggests, but rather claimant's TTD rate. The proper forum for the determination of claimant's TTD rate is the Board, not BOLI. ORS 656.704(3). As discussed above, claimant's TTD rate is dependent on the "contract" in force at the time of claimant's injury. Thus, we have authority to determine claimant's wage under the "contract" for the purpose of establishing entitlement to temporary disability in the same manner as we have authority to examine the scope of a physician's license for the purpose of determining a claimant's right to receive compensation for medical treatment. *See Stiehl v. Timber Products*, 115 Or App 651, 654 (1992).

Moreover, both *Wingo* and *Stodola* distinguishable. Both cases concerned entitlement to TTD after employment had been terminated; they did not concern TTD rate. In deciding those cases, the Board determined that the respective claimants had left work for reasons unrelated to the compensable injury. Consequently, the Board concluded that the respective claimants had not established entitlement to TTD. 48 Van Natta at 2478; 48 Van Natta at 614. Accordingly, neither *Wingo* nor *Stodola* are applicable here.

For the reasons stated above, I would reverse the ALJ's order and direct the carrier to calculate claimant's average wage at $641.25. Because the majority reaches a different conclusion, I respectfully dissent.

In the Matter of the Compensation of
ARLEY GERTSON, Claimant
WCB Case No. 00-09532
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Sheridan Levine LLP, Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its compensability and responsibility denial of claimant's occupational disease claim for a bilateral elbow condition; and (2) awarded claimant a $4,500 attorney fee under ORS 656.386(1). On review, the issues are the scope of the insurer's denial, compensability, responsibility and attorney fees.[1]

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

The ALJ set aside the insurer's denial based on the opinion of claimant's treating physician, Dr. Butcher. On review, the insurer first contends that compensability was never at issue at hearing, and that therefore claimant was limited to a $1,000 attorney fee award on the responsibility issue. *See* ORS 656.308(2)(d). We disagree.

Initially, we note that the insurer's November 7, 2000 denial denied claimant's claim in part on the basis that "there is no specific evidence that supports that your employment with [the employer] is the major contributing cause of this condition." (Ex. 9). *See* ORS 656.802(2)(a). We have interpreted such "major contributing cause" language in a "disclaimer/claim denial" as denying compensability as well as responsibility. *See Bonnie A. Stafford*, 46 Van Natta 1452, 1454 (1994). Moreover, although it referenced "other potentially responsible insurers or self-insured employers," the insurer's denial was not labeled solely a "denial of responsibility." *Cf. Donald P. James*, 48 Van Natta 563, 565 (1996).

In *James*, the carrier issued a denial that included a caption stating that it was a "DENIAL OF RESPONSIBILITY," and notifying the claimant that the carrier had requested designation of a paying agent under ORS 656.307. 48 Van Natta at 565. In addition, the carrier did not contend at hearing that the claim was not compensable or that the claimant was not entitled to compensation. *Id.* In those circumstances, we concluded that the carrier's denial did not raise an issue of compensability. 48 Van Natta at 566.

Here, the insurer's denial did not contain such a caption. More importantly, the denial did not specify that the insurer had requested designation of a paying agent under ORS 656.307, and no ".307" order ever issued. *Cf. Donald P. James*, 48 Van Natta at 565; *Ray L. Bennett*, 47 Van Natta 866 (1995). Finally, at the beginning of the hearing, instead of conceding compensability or specifying that responsibility was the only issue, the insurer agreed with the ALJ's statement of the issues as including the November 7, 2000 denial and claimant's request for attorney fees "associated with that denial." (Tr. 1). In light of the specific wording of the insurer's written denial and the insurer's agreement with the ALJ's statement of the issues as including that denial, we find that the insurer denied compensability as well as responsibility.

Even assuming, as the ALJ acknowledged, that the insurer contested only responsibility by the time of its closing argument, we would reach this same conclusion. As we reasoned above, the insurer's November 7, 2000 denial included a denial of compensability. Conceding compensability at closing argument would amount only to a rescission of the insurer's compensability denial. In those circumstances, claimant's attorney would still be entitled to an attorney fee, because he was "instrumental in obtaining a rescission of the [compensability] denial prior to a decision by the Administrative Law Judge." *See* ORS 656.386(1). Accordingly, the ALJ properly awarded claimant an assessed attorney fee pursuant to ORS 656.386(1).

Finally, we adopt and affirm the ALJ's order on the merits of the compensability and responsibility issues and on the attorney fee awards granted under ORS 656.386(1) and ORS 656.308.

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[1] In its reply brief, the insurer moves to "strike" claimant's respondent's brief based on its allegedly "untrue arguments." However, inasmuch as the respondent's brief was timely filed, we deny the insurer's motion.

Although the insurer did not offer any specific arguments on the issue of compensability on review, by virtue of our *de novo* review authority over the ALJ's order, claimant's compensation was potentially at risk on Board review. Accordingly, claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on review. *Dennis Uniform Manufacturing v. Teresi*, 115 Or App 252, 253 (1992), *mod* 119 Or App 447 (1993).

After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the 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 under ORS 656.382(2) for services on review devoted to the responsibility and attorney fee issues. ORS 656.308(2)(d); *Dotson v. Bohemia*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated June 21, 2001 is affirmed. For services on review, claimant's attorney is awarded $800, payable by the insurer.

December 11, 2001 Cite as 53 Van Natta 1589 (2001)

In the Matter of the Compensation of
DAVID N. HOOD, Claimant
WCB Case No. 00-08724
ORDER ON REVIEW
Schneider, et al., Claimant Attorney
Sather, et al., Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) declined to award temporary disability benefits commencing February 8, 2000; and (2) declined to assess penalties and/or attorney fees for allegedly unreasonable claim processing. On review, the issues are temporary disability, penalties, and attorney fees.

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

On September 22, 1999, claimant filed a claim for a bilateral hand condition, which was ultimately diagnosed as carpal tunnel syndrome. (Ex. 2). The same day, the employer enrolled claimant in a Managed Care Organization (MCO) and advised him that although he could treat with a physician outside the MCO, time loss authorized by such a physician would not be payable. (Ex. 3A).

On January 18, 2000, the employer denied the claim. (Ex. 17). Claimant requested a hearing.

On February 18, 2000, claimant began treating with Dr. Thomas.[1] (Ex. 19A). On February 22, 2000, Dr. Thomas retroactively authorized temporary disability benefits commencing January 20, 2000.[2] (Ex. 21-1). Dr. Thomas continued to keep claimant off work until June 6, 2000, at which point he authorized light duty. (Exs. 21-2; 21-3; 24A; 25-1). Dr. Thomas continued to authorize light duty until November 20, 2000, when he once again took claimant off all work. (Exs. 25-2; 25C; 25E; 32-17).

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[1] Dr. Thomas is not a member of the employer's MCO. (Ex. 32-5).

[2] ORS 656.262(4)(g) provides in part: "No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize temporary disability more than 14 days from the date of issuance." Consequently, claimant seeks temporary disability beginning February 8, 2000, rather than January 20, 2000.

On August 16, 2000, a prior ALJ set aside the employer's denial, and ordered the employer to accept and process claimant's bilateral carpal tunnel syndrome. (Ex. 25). As a result, the employer accepted the claim on August 31, 2000. However, the employer did not pay any of the temporary disability authorized by Dr. Thomas.[3] (Ex. 25B). Claimant requested a hearing.

The ALJ reasoned that because Dr. Thomas was not a member of the employer's MCO, he did not qualify as claimant's attending physician. Consequently, the ALJ concluded that the temporary disability authorized by Dr. Thomas was not recoverable.

Subsequent to the ALJ's order, we decided *Laura J. Golden*, 53 Van Natta 1463 (2001). There, following its acceptance of the claimant's initial injury claim for a shoulder condition, the carrier enrolled her in a MCO. Some years later, the claimant sought acceptance of several "new medical conditions" under the original claim, which the carrier denied. During the same period, the carrier notified the claimant that her physician's affiliation with the MCO had ended and that she should seek treatment with a MCO-authorized physician. The claimant continued to receive treatment from the "non-MCO" physician, who authorized TTD. After contesting the denial and securing the carrier's acceptance of the "new medical conditions," the claimant sought recovery of the TTD benefits. Reasoning that the claimant, rather than the claim or medical condition, was subject to the MCO contract, we concluded, based on ORS 656.262(4)(i), ORS 656.245(2)(b), and *William I. Sergeant*, 53 Van Natta 231, 236 (2001) (physician who did not qualify as primary care physician with an MCO could not authorize temporary disability), that the former MCO physician could not authorize temporary disability.

Here, claimant was enrolled in an MCO. Claimant was advised that temporary disability authorized by a non-MCO physician was not payable. Claimant sought care from Dr. Thomas, a non-MCO physician. Based on these circumstances, we find *Golden* controlling. Consequently, for the reasons stated in *Golden* and *Sergeant*, we find that claimant is not entitled to the disputed temporary disability.

ORDER

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

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[3] Dr. Thomas stopped treating claimant on January 5, 2001, when he was notified by the employer that claimant needed to have an MCO physician. (Ex. 32-31).

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's order declining to award temporary disability from February 8, 2000 through January 5, 2001. In so doing, it relies on *Laura J. Golden*, 53 Van Natta 1463 (2001), to conclude that the attending physician, Dr. Thomas, could not authorize temporary disability during the period in dispute because he did not qualify as an attending physician with the managed care organization (MCO). For the reasons stated below, and consistent with my dissent in *Golden*, I disagree with this conclusion. Therefore, I respectfully dissent.

Under ORS 656.245(2)(a), the worker may choose an "attending physician" as defined by ORS 656.005(12)(b).[1] Notwithstanding ORS 656.245(2)(a), when a carrier contracts with an MCO, a worker subject to the contract shall receive medical services prescribed by the contract. ORS 656.245(4)(a). A worker becomes subject to an MCO contract upon receipt of actual notice of the worker's enrollment in the MCO, or the third day after the notice was mailed to the worker by the carrier, which ever event occurs first. *Id.* Under ORS 656.245(4)(b)(B), the worker's enrollment in an MCO may precede the carrier's acceptance or denial of the claim. Consequently, when a worker has notice, as defined by ORS 656.245(4)(a), of his/her enrollment in an MCO, the worker's choice of "attending physician" is prescribed by the MCO contract.

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[1] ORS 656.005(12)(b) provides in pertinent part:

"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:

"(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."

However, ORS 656.245(4)(b)(D) provides in material part: "If the claim is denied, the worker may receive medical services after the date of the denial from sources other than the managed care organization until the denial is reversed." The express language of ORS 656.245(4)(b)(D) does not limit the types of medical services that the worker can receive during the post denial period. Nor does the statute expressly limit who may provide the post denial medical services. The statute further provides that the reasonable and necessary post denial medical services are to be reimbursed (if the claim is finally determined to be compensable) pursuant to ORS 656.248 (the Director's rules) rather than the MCO contract rate.

ORS 656.005(12)(b) describes "attending physician" as the doctor or physician primarily responsible for the treatment of the worker's compensable injury. Consequently, when a worker (otherwise subject to an MCO contract) receives "post-denial" medical services outside the MCO, the doctor or physician primarily responsible for the worker's treatment during the post denial period is the "attending physician," if the claim is finally determined to be compensable.

Here, claimant was enrolled in an MCO before the claim was accepted. When the claim was denied, claimant sought medical care, as allowed by ORS 656.245(4)(b)(D), from Dr. Thomas. Claimant's bilateral hand condition was finally determined to be compensable on August 16, 2000. Dr. Thomas was the physician primarily responsible for claimant's treatment during the post denial period. Consequently, I conclude that Dr. Thomas was claimant's "attending physician" from February 18, 2000 until January 5, 2001.[2]

ORS 656.262(4)(a) provides that temporary disability compensation shall be paid if authorized by the "attending physician." Additionally, OAR 436-060-0020(11) requires a carrier to begin temporary disability payments pursuant to ORS 656.262, including retroactive periods, when a denied claim has been determined to be compensable. Having concluded that Dr. Thomas was the "attending physician" from February 8, 2000 through January 5, 2001, I further conclude that claimant is entitled to the temporary disability authorized by Dr. Thomas during that time period. Accordingly, I would reverse the ALJ's order and award claimant the temporary disability authorized by Dr. Thomas.

[2] Dr. Thomas is an orthopedic surgeon, and as such, satisfies the requirements imposed by ORS 656.005(12)(b)(A).

December 11, 2001 Cite as 53 Van Natta 1591 (2001)

In the Matter of the Compensation of
DEANNA L. WHETSTINE, Claimant
WCB Case No. 00-02871
ORDER OF ABATEMENT
Scott M. McNutt, Sr., Claimant Attorney
Cummins, Goodman, et al., Defense Attorney

Reveiwing Panel: Members Haynes, Bock, and Biehl.

Claimant requests reconsideration of our November 13, 2001 order that upheld the self-insured employer's denial of her injury claim for a stress fracture and complex regional pain syndrome/reflex sympathetic dystrophy. Specifically, claimant argues that the stress fracture condition should be analyzed under a material contributing cause standard, and that all other conditions should be analyzed as "combined conditions" pursuant to ORS 656.005(7)(a)(B).

In order to further consider this matter, we withdraw our November 13, 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 proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLARINDA S. KEYS, Claimant
WCB Case No. 00-08789
ORDER ON REVIEW
Scott M. Supperstein, Claimant Attorney
Steven T. Maher, Defense Attorney

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

The insurer requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) assessed a penalty under ORS 656.268(5)(d) based on its alleged failure to timely close claimant's claim; and (2) assessed an attorney fee under ORS 656.382(1) based on its allegedly unreasonable resistance to the payment of compensation. The insurer also contends that the ALJ lacked jurisdiction. Claimant requests review of those portions of the ALJ's order that: (1) found that claimant was not entitled to temporary disability from April 26, 2000 to December 1, 2000; and (2) found that claimant was not entitled to a penalty and related attorney fee based on the insurer's alleged failure to pay temporary disability. Claimant also alleges that he is entitled to an attorney fee under ORS 656.386(2). On review, the issues are jurisdiction and, potentially, temporary disability, penalties and attorney fees. We affirm in part, reverse in part, and vacate in part.

FINDINGS OF FACT

Claimant sustained a low back injury in June 1991 and the insurer accepted a lumbar strain. (Ex. 2). On July 29, 1993, the insurer issued a Notice of Closure that awarded only temporary disability. (Ex. 3). In December 1996, the insurer accepted an aggravation claim. (Ex. 4). A February 25, 1997 Determination Order awarded temporary disability and 5 percent unscheduled permanent disability. (Ex.5).

On September 11, 1999, claimant's attorney asked the insurer to modify its acceptance to include "right foot drop with radiculopathy and neurogenic bowel and bladder dysfunction." (Ex. 6). The insurer issued a modified notice of acceptance on October 14, 1999 for "lumbar strain, lumbar disc disorder, recurrent L5-S1 disc herniation, right foot drop with radiculopathy and neurogenic bowel/bladder dysfunction." (Ex. 7).

On May 19, 2000, the insurer issued a Notice of Closure for a "Board's Own Motion Claim" that awarded temporary disability from January 19, 1999 through April 25, 2000, and found claimant medically stationary on April 25, 2000. (Ex. 47). Claimant requested review of the Notice of Closure under the Board's Own Motion authority, asserting that she was not medically stationary when the insurer closed her claim and, therefore, she was entitled to additional benefits. The Board's August 15, 2000 Own Motion order found that claimant was medically stationary when her claim was closed and affirmed the Notice of Closure. (Ex. 54).

Claimant requested a hearing on November 20, 2000, asserting entitlement to temporary disability from April 26, 2000 "to present," a rating of scheduled and unscheduled permanent disability, and a penalty and attorney fee pursuant to ORS 656.262(11)(a).

On January 30, 2001, the insurer issued an updated Notice of Acceptance. (Ex. 67). The next day, a Notice of Closure awarded, among other things, temporary partial disability for April 3, 2000 through December 1, 2000, as well as unscheduled and scheduled permanent disability. (Ex. 68).

CONCLUSIONS OF LAW AND OPINION

At hearing, although conceding that the January 31, 2001 closure awarded the temporary disability initially sought in her November 2000 request for hearing, claimant argued that the compensation had not been paid. Thus, in response to the insurer's argument that the ALJ lacked jurisdiction because the sole issue was a penalty and related attorney fee, claimant contended that temporary disability continued to be at issue because she was seeking enforcement of the January 2001 Notice of Closure.

Without addressing the jurisdiction issue or acknowledging the January 31, 2001 Notice of Closure, the ALJ found that, because the record showed that claimant was medically stationary on April 25, 2000, she was not entitled to temporary disability after that date. Having found that claimant was not entitled to such benefits, the ALJ further found that the associated penalty issue under ORS 656.262(11) was "moot."

The ALJ further decided that claimant's November 20, 2000 request for hearing served as a "request to close the claim" and, because the insurer did not respond within 10 days as required by ORS 656.268(5)(b), it unreasonably failed to close the claim. Consequently, the ALJ assessed a penalty under ORS 656.268(5)(d) and also assessed an attorney fee under ORS 656.382(1) for the insurer's "unreasonable resistance to the payment of compensation."

Jurisdiction

On review, the insurer continues to argue that the ALJ lacked jurisdiction because the January 2001 Notice of Closure "mooted" the temporary disability sought by claimant in her November 2000 request for hearing and claimant did not seek reconsideration of the Notice of Closure.[1] According to the insurer, the only "viable" issues at hearing were penalties and the "ORS 656.382(1)" attorney fee issue.

Claimant responds that temporary disability is at issue because, at hearing, she sought enforcement of the temporary disability award. She also contends that the ALJ had jurisdiction because she raised issues involving the insurer's duty to process a claim under ORS 656.262(7)(c).

With claimant's request for hearing, she raised issues of temporary disability from April 26, 2000 "to present," a rating of scheduled and unscheduled permanent disability, and "[p]enalty and fees pursuant to ORS 656.262(11)(a)." After claimant requested a hearing, a January 31, 2001 Notice of Closure awarded, among other things, temporary disability from April 3, 2000 through December 1, 2000. At hearing, claimant relied on two additional statutes in asserting entitlement to penalties and fees: ORS 656.268(5)(d) and 656.382(1). (Tr. 1, 2). Claimant's attorney asserted that claimant was entitled to a 25 percent penalty, pursuant to ORS 656.268(5)(d), based on the permanent disability awarded in the January 31, 2001 Notice of Closure. (Tr. 8, 10, 11).

In addition, claimant's attorney asserted entitlement to an attorney fee under ORS 656.382(1) for the insurer's "unreasonable payment of compensation" related to the failure to pay time loss. (Tr. 8, 11). Claimant's attorney explained that there were two different problems: closing and payment of time loss, and he argued claimant was entitled to a 25 percent penalty for each of those problems. (Tr. 11). He also asserted that claimant was entitled to an attorney fee under ORS 656.382(1) for each of the problems. (*Id.*)

The insurer's attorney said there were two claims for penalties: one related to time loss pursuant to ORS 656.262(11)(a), and one based on the permanent disability award, pursuant to ORS 656.268(5)(d). (Tr. 16). The insurer's attorney argued that claimant was not entitled to a penalty under either statute. (Tr. 16- 22). The insurer's attorney also raised a jurisdictional argument, contending that time loss was not at issue and the only issues left were penalties and attorney fees. (Tr. 23).

ORS 656.262(11)(a) provides, in part:

> "If the insurer or self-insured employer unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim, the insurer or self-insured employer shall be liable for an additional amount up to 25 percent of the amounts then due. Notwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection."

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[1] Relying on ORS 656.268(5)(c), the insurer argues that claimant is barred from pursuing the time loss issue without having first sought reconsideration of the Notice of Closure. Under ORS 656.268(5)(c), a worker who *objects* to a Notice of Closure must first request reconsideration from the Director. Here, because claimant is not objecting to the Notice of Closure, we conclude that ORS 656.268(5)(c) does not apply.

Thus, under ORS 656.262(11)(a), the Director has "exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection." We have applied this statute in cases where, although initially involving more than the penalty issue, the additional matters subsequently were 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).

Here, claimant raised issues involving penalties and a penalty-related attorney fee under three statutes: ORS 656.262(11)(a), 656.268(5)(d) and 656.382(1). ORS 656.262(11)(a) provides that the Director's "exclusive jurisdiction" applies to "proceedings regarding solely the assessment and payment of the additional amount described in *this subsection.*" (Emphasis supplied). The phrase "this subsection" refers to ORS 656.262(11)(a). Thus, the Director has exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in ORS 656.262(11)(a). Here, in contrast, the proceedings also involve penalties under ORS 656.268(5)(d). Under these circumstances, the Director does not have exclusive jurisdiction over these proceedings.

Temporary Disability

The ALJ found that, based on the medical evidence, claimant was not entitled to temporary disability after April 25, 2000 because she was medically stationary on that date. Claimant challenges this portion of the ALJ's order.

The January 31, 2001 Notice of Closure awarded claimant temporary disability from April 3, 2000 through December 1, 2000. The issuance of the January 31, 2001 Notice of Closure eliminates the temporary disability issue. *See Alfredo Martinez*, 49 Van Natta 67, 69 (1997) (the Board does not have authority to impose a procedural overpayment by awarding temporary disability beyond the date determined by the closure notice). Furthermore, although claimant raises an issue of "enforcement" of the Notice of Closure, the record is insufficient to establish that any temporary disability awarded by the Notice of Closure was unpaid. Therefore, there is no temporary disability to be awarded and claimant is not entitled to an attorney fee under ORS 656.386(2).

Penalty and attorney fee for failure to pay temporary disability

Claimant also requests review of that portion of the ALJ's order that did not assess a penalty or an attorney fee for the insurer's alleged failure to pay the temporary disability awarded by the Notice of Closure.

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).

A January 31, 2001 Notice of Closure awarded, among other things, temporary partial disability from April 3, 2000 through December 1, 2000. (Ex. 68). The record is insufficient to establish that claimant was not paid the temporary disability benefits awarded by the January 31, 2001 Notice of Closure. Claimant did not testify at hearing, and there is no documentary evidence that establishes she was not paid the temporary disability award.

We acknowledge that claimant's attorney argued at hearing that time loss had not been paid, and, in a brief submitted shortly after the hearing, claimant argued that the ALJ's decision should include an order to pay the temporary disability owed. Claimant's arguments, however, do not constitute evidence and are not sufficient to establish that time loss was not paid.

Based on this record, we conclude that the evidence is insufficient to establish 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, e.g., SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 163 (1993); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991).

Penalty and attorney fee for late claim closure

The insurer objects to the ALJ's assessment of a penalty that was awarded on the basis that the insurer did not satisfy ORS 656.268(5)(b). That statute provides that the carrier must issue a notice of closure or refusal to close within 10 days "of receipt of a written request from the worker[.]" If the carrier closes or refuses to close the claim,

> "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 and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant." ORS 656.268(5)(d).

Thus, the statute has three requirements in order to assess a penalty under ORS 656.268(5)(d): (1) first, there must be closure or a refusal to close pursuant to section (5); (2) the "correctness" of the closure or refusal to close must be "at issue" in the hearing; and (3) a finding must be made at hearing that the closure or refusal to close was not reasonable.

Even assuming that claimant requested closure and the insurer's January 31, 2001 Notice of Closure was not issued within 10 days of any request, we find that not all of the requirements were satisfied for assessing a penalty under ORS 656.268(5)(d). As discussed above, we are not persuaded that the parties agreed to litigate an issue concerning enforcement of the Notice of Closure. Consequently, we conclude that claimant is not entitled to a penalty under ORS 656.268(5)(d). We therefore reverse that portion of the ALJ's order.

Finally, the insurer disputes the ALJ's assessment of an attorney fee under ORS 656.382(1). The ALJ found that the insurer's failure to comply with ORS 656.268(5)(b) requiring closure within 10 days of such a request was evidence of the unreasonableness of the resistance to the payment of compensation.

ORS 656.382(1) provides that, if a carrier "otherwise unreasonably resists the payment of compensation," the carrier shall pay a reasonable attorney fee. Claimant contends that she is entitled to an attorney fee because the insurer failed to properly close the claim pursuant to ORS 656.268(5)(b).

As discussed above, claimant is not entitled to a penalty under ORS 656.268(5)(d). Furthermore, we have concluded that the evidence is insufficient to establish that claimant was not paid the temporary disability benefits awarded by the January 31, 2001 Notice of Closure. Under these circumstances, we conclude that the evidence is insufficient to establish that there was any unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. We therefore reverse the portion of the ALJ's order that awarded a penalty-related attorney fee under ORS 656.382(1).

ORDER

The ALJ's order dated March 2, 2001 is affirmed in part, reversed in part, and vacated in part. Those portions of the ALJ's order that assessed a penalty under ORS 656.268(5)(d) and an assessed attorney fee under ORS 656.382(1) are reversed. That portion of the order that could be interpreted as modifying the January 31, 2001 Notice of Closure is vacated. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
EARL A. LEWIS, Claimant
WCB Case No. 01-02554
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that reduced his unscheduled permanent disability award for back and shoulder conditions from 15 percent (48 degrees), as awarded by Order on Reconsideration, to 9 percent (28.8 degrees). On review, the issue is unscheduled permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his back and right shoulder in November 1999. (Exs. 2, 3, 15). The claim was closed in October 2000 without an award of permanent disability. (Ex. 16). Claimant requested reconsideration. (Ex. 17).

Dr. Blake performed a medical arbiter evaluation. (Ex. 18). Relying on that evaluation, and Dr. Blake's subsequent clarification (Exhibit 20), the Appellate Review Unit (ARU) issued an Order on Reconsideration that awarded 15 percent (48 degrees) unscheduled permanent disability. (Ex. 22). The SAIF Corporation requested a hearing.

The ALJ determined that the medical arbiter's findings should be used to rate claimant's impairment. Relying on the medical arbiter's spinal range of motion form (Exhibit 18-4), the ALJ concluded that the medical arbiter's spinal range of motion findings for flexion and right lateral flexion were invalid, and as such, could not be used to rate impairment. Consequently, the ALJ reduced claimant's unscheduled permanent disability award from 15 percent to 9 percent. Claimant requested Board review. The sole issue on Board review is the validity of the medical arbiter's range of motion findings and any ratable impairment arising therefrom.

The medical arbiter's Spinal Range of Motion Form provides spaces for the arbiter to report range of motion findings, and a separate "yes" or "no" "check-the-box" entry (for each of the various spinal ranges of motion) for the arbiter to answer: "Are measurements within +/- 10% or 5 degrees (whichever is greater)?" Here, the medical arbiter's "check-the-box" response to the "+/- 10% or 5 degrees" inquiry for both flexion and right lateral flexion was "no." (Ex. 18-4).

Claimant contends that, contrary to the medical arbiter's "check-the-box" response, the reported range of motions findings are valid pursuant to the AMA Guides. In other words, claimant asserts that the medical arbiter's "check-the-box" validity response is inconsistent with his reported findings; *i.e.*, the range of motion findings are "within +/- 10% or 5 degrees" as set forth in the AMA Guides. Consequently, claimant asserts that the arbiter's range of motion findings for both flexion and right lateral flexion should be used to rate impairment.

OAR 436-035-0007(28) provides, in pertinent 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, unless the validity criterion for a particular finding is not addressed in this reference [.]" The AMA Guides set forth the following validity test regarding spinal ranges of motion:

> "Perform at least three measurements of each range of motion, and calculate the permitted variability (+/- 10% or 5 degrees) based on either the *maximum* or *median* motion values. That is, check to determine if all three measurements fall within reproducibility guidelines by varying less that 10% or 5 degrees from either the maximum or median value." (Emphasis in original). (AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990, p. 79)

Here, Dr. Blake reported his lumbar flexion measurements as follows: "32, 28, and 26." (Ex. 18-4). Although the reported measurements are not within 10% or 5 degrees of each other, or within 10% or 5 degrees of the "maximum" value (32), the reported measurements *are* within 10% or 5 degrees of the "median" value (28). Thus, the reported measurements appear valid pursuant to the express language of the AMA Guides validity test.

Dr. Blake reported the following measurements for claimant's right lateral flexion: "17, 13, 10." (Ex. 18-4). Like the reported measurements for lumbar flexion, the right lateral flexion measurements are not within 10% or 5 degrees of each other, or within 10% or 5 degrees the of "maximum" value (17), but *are* within 10% or 5 degrees of the "median" value (13). As with the flexion measurements, the right lateral flexion measurements appear valid pursuant to the express language of the AMA Guides validity test.

Turning to the body of Dr. Blake's report, we note that in describing his spinal range of motion findings, Dr. Blake opined: "These findings are considered valid." (Ex. 18-3). Dr. Blake also reported that his findings were due to the accepted condition. (Ex. 18-3). Consequently, because the disputed spinal range of motion findings appear to be valid within the express provisions of the AMA Guides validity test, and because Dr. Blake expressly stated that his findings were valid (Exs. 18-3; 18-6), we conclude that the disputed findings are valid.

Citing WCB Bulletin 239, SAIF contends that the disputed range of motion findings are invalid because they are not within 10% or 5 degrees of each other.[1] Based on the following reasoning, we disagree.

Contrary to SAIF's assertion, a worker's disability is established by application of OAR chapter 436, division 035, not application of Bulletin 239.[2] *See Richard E. Halferty*, 53 Van Natta 1483 (2001). OAR 436-035-0007(28) provides that validity shall be established according to the criterion noted in the AMA Guides. According to the AMA Guides (quoted above), range of motion findings are valid if all three measurements fall within 10% or 5 degrees from either the maximum or median value. AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990, p. 79. Therefore, because the medical arbiter's range of motion findings fall within 10% or 5 degrees of the median values, those findings are valid according to the AMA Guides.

Because the medical arbiter did not state that the findings were "invalid" (he only indicated they were not within 10% or 5 degrees of each other), we conclude that Dr. Blake's range of motion findings for flexion and right lateral flexion should be used to rate claimant's permanent impairment.[3] OAR 436-035-0007(14) (WCD Admin. Order No. 98-055). Based on each of those impairment findings, we reverse the ALJ's order, and affirm the March 8, 2001 Order on Reconsideration.

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 created by this order (the 6 percent difference between the ALJ's 9 percent unscheduled permanent disability award and our 15 percent unscheduled permanent disability award), not to exceed $6,000. ORS 656.386(2); OAR 438-015-0055(2).

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[1] The Bulletin provides in pertinent part: "When measuring spinal range of motion, the Department requires the examiner to take three consecutive measurements of mobility. These must fall within +/- 10% or 5 degrees (whichever is greater) of each other to be considered valid." (Bulletin 239, p. 7).

[2] Citing *Jenna Larson*, 48 Van Natta 1278 (1996), SAIF asserts that Bulletin 239 has "the force of law." In *Larson*, the issue was whether a specific bulletin of the Director should have been promulgated as a rule under the APA. *Larson* was not a "disability standards" case. Consequently, *Larson* is distinguishable. Moreover, pursuant to ORS 656.283(7) and 656.295(5), the ALJ and Board are mandated to apply the "standards." Bulletin 239 is not the "standard."

[3] In *Labor Force of Oregon v. Frierson*, 169 Or App 573, 577 (2000), 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." Here, unlike *Frierson*, the medical arbiter's impairment findings satisfy the AMA criteria. Thus, we need not address the second *Frierson* issue. Consequently, *Frierson* is distinguishable.

Claimant's attorney is also entitled to an assessed fee for services at hearing. ORS 656.382(2); *see Lorenzo K. Kimball*, 52 Van Natta 411, *on recon* 52 Van Natta 633 (2000). After considering the factors set 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 $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated July 2, 2001 is reversed. The March 8, 2001 Order on Reconsideration is affirmed. For services 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. For services at the hearing, claimant is awarded a $1,200 attorney fee, payable by SAIF.

In the Matter of the Compensation of
PERRY S. McKENZIE, Claimant
WCB Case Nos. 00-08363 & 00-04582
ORDER ON REVIEW
Kryger, et al., Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney
Reinisch, Mackenzie, Healey, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Kemper Insurance Company (Kemper), on behalf of Liberty Homes, requests review of Administrative Law Judge (ALJ) Black's order that: (1) set aside its denial of claimant's aggravation claim for a thoracic strain condition; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) denial, on behalf of Morton Alder Mills, of claimant's "new injury" claim for the same condition. On review, the issues are compensability, aggravation and, potentially, responsibility.

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

The ALJ found that claimant's "new injury" claim with Liberty was untimely. That finding is unchallenged on review. Consequently, the sole question on review is whether claimant has proven his aggravation claim with Kemper.

ORS 656.273(1) provides that a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition. *SAIF v. Walker*, 330 Or 102 (2000). ORS 656.273(1) requires proof of two specific elements in order to establish a worsened condition: (1) "actual worsening" and (2) a compensable condition. *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995).

Here, we find that claimant has proven his aggravation claim, based on the deposition opinion of Dr. Dreibelbis, claimant's long-time attending physician. Dr. Dreibelbis' opinion is based on a materially accurate and complete history.[1] She considered and evaluated identified off-work causes for claimant's current thoracic problems and explained her ultimate conclusion, as well as its development. (*See* Exs. 61-8, -10, -22, -26-28, -32-35). She also explained that claimant's thoracic condition[2] worsened

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[1] Dr. Dreibelbis is the only physician who acknowledged the seriousness of claimant's 1998 accepted injury with Kemper's insured. In this regard, we note that claimant's symptoms were so severe when Dr. Dreibelbis first examined him that she suspected that he might have fractured his spine. (*See also* Tr. 16, 18-22).

[2] We also find that claimant's current thoracic condition involves the "same condition" as the 1998 accepted thoracic strain, based on Dr. Dreibelbis' ultimate opinion that the 1998 strain probably did *not* resolve. (*See* Ex. 61-35). *See, e.g., MultiFoods Specialty Distribution v. McAtee*, 164 Or App 654, 661 (1999), *rev allowed* 332 Or 305, 27 P3d 1045 (2001) (new injury involves the same condition as the earlier accepted injury when it has the earlier compensable injury "within or as part of itself.")

in October 1999 and that Kemper's 1998 accepted injury is the major contributing cause of the worsened condition. (Exs. 61-13, -15, -38-39; *see also* Ex. 61-40). We find Dr. Dreibelbis' opinion persuasive and we rely on it.[3]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,475, payable by Kemper. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's uncontested request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 13, 2001 is affirmed. For services on review, claimant is awarded a $2,475 attorney fee, payable by Kemper Insurance Company.

[3] Kemper argues that it should escape liability because a work incident during Liberty's coverage and/or off-work contributors caused the current condition. However, based on claimant's credible testimony and Dr. Dreibelbis' persuasive opinion, we conclude that Kemper has not established that the major contributing cause of claimant's worsened condition was an injury outside the course and scope of employment or that a work incident during Liberty's coverage was the major contributing cause of the need for treatment or disability for claimant's current thoracic condition. Consequently, Kemper does not escape liability for claimant's thoracic strain condition under ORS 656.273(1) or 656.308(1).

In the Matter of the Compensation of
BENJAMIN G. SANTOS, Claimant
WCB Case No. 96-01407
ORDER ON REMAND
Schneider, et al., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes, Biehl, and Bock.

This matter is before the Board on remand from the Court of Appeals. *Santos v. Carryall Transport*, 163 Or App 414 (1999), *on recon* 171 Or App 467 (2000). The court reversed our prior order, *Benjamin G. Santos*, 49 Van Natta 1429 (1997), that held that claimant was barred from contending that he was entitled to the increased rate of unscheduled permanent disability set forth in *amended* ORS 656.214(6), because the issue was not raised at reconsideration. The court has remanded for recalculation of the amount of permanent partial disability (PPD), citing *Crowder v. Alumaflex*, 163 Or App 143 (1999). We proceed with reconsideration in light of the court's holding.

In *Crowder*, the court noted that the PPD rate did not increase until after the Order on Reconsideration had issued. The court held that the claimant was under no obligation to raise the rate issue at reconsideration and that ORS 656.283(7) did not prevent him from raising the issue at hearing. The court remanded for a determination of the claimant's award based consistent with the 1995 amendment to ORS 656.214(6). On remand, we affirmed the portions of the Administrative Law Judge's (ALJ) order that directed the insurer to pay the claimant's unscheduled PPD consistent with the increased rate in ORS 656.214(6). *Ferral C. Crowder*, 51 Van Natta 1991 (1999).

Consistent with *Crowder*, after reconsidering this matter, we affirm the ALJ's order that directed the SAIF Corporation to recalculate claimant's PPD award at the rate set forth in the 1995 amendment to ORS 656.214(6).

Finally, 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). That fee shall be as authorized under ORS 656.307(5), 656.308(2), 656.382 or 656.386. ORS 656.388(1).

Here, because we are affirming the ALJ's order, we likewise affirm the ALJ's "out-of-compensation" attorney fee award. Furthermore, because claimant petitioned the court for judicial review of our order and that appeal has ultimately resulted in an increased compensation award (the difference between our Order on Review and this order), claimant's counsel is also entitled to an "out-of-compensation" attorney fee for services before the court. That award shall equal 25 percent of the increased compensation awarded by this order (the difference between the compensation awarded by our prior order and this order). *See* ORS 656.386(2); ORS 656.388(1). However, the total "out-of-compensation" attorney fee awarded by the ALJ's order and this order shall not exceed $3,800 (as specified in claimant's attorney's retainer agreement).

Claimant prevailed at the hearing and SAIF requested Board review seeking disallowance or reduction in claimant's award of compensation. Following remand from the court, we have not disallowed or reduced the compensation awarded to claimant. Therefore, claimant's counsel is also entitled to an assessed attorney fee under ORS 656.382(2) for services before the Board in response to SAIF's unsuccessful request for Board review. *See* ORS 656.388(1). Under such circumstances, we award a reasonable attorney fee under ORS 656.382(2) for claimant's counsel's services before the Board.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on Board review is $2,000, payable by the SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent brief to the Board), 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 November 26, 1996, as reconsidered on February 5, 1997 is affirmed. For services before the Board, claimant's counsel is awarded a $2,000 insurer paid attorney fee, to be paid by the SAIF. For services before the court, claimant is awarded an "out-of-compensation" attorney fee equal to 25 percent of the increased compensation awarded by this order. However, the total "out-of-compensation" attorney fee awarded to claimant's counsel by the ALJ's order and this order shall not exceed $3,800.[1]

IT IS SO ORDERED.

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[1] Claimant seeks an insurer-paid attorney fee award for his counsel's services rendered before the court on appeal of our prior order. As support for the request, claimant refers to the court's concurring opinion.

We have declined claimant's request. In doing so, we note that the majority of the court in *Santos* stated that the concurrence's position "would not necessarily reflect the position of a majority of this court." Furthermore, as reasoned by the *Santos* majority, this situation may well represent a "gap" in the attorney fee statutes. Nonetheless, as explained by the *Santos* majority, the remedy for such a situation rests with the Legislature.

Finally, because the statutory scheme does not provide for an insurer-paid attorney fee award for claimant's counsel's services performed before the court, we have awarded an "out-of-compensation" attorney fee for those services. ORS 656.386(2).

In the Matter of the Compensation of
ROBERT DUBRAY, Claimant
WCB Case No. 99-02514
ORDER ON REMAND (REMANDING)
Ransom & Gilbertson, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

This matter is before the Board on remand from the Court of Appeals. *Dubray v. SAIF Corporation*, 175 Or App 112 (2001). The court has reversed our prior order that affirmed an Administrative Law Judge's (ALJ's) order that had declined to remand a claim to the Director for the promulgation of a temporary rule regarding claimant's condition. The court was unable to determine whether the ALJ's order (which we had adopted) was based on a conclusion that the Director had expressly addressed the question of the adequacy of the existing rules or whether the existing rules were adequate because they addressed claimant's permanent disability. Under such circumstances, the court concluded that it could not review the order. Consequently, the court remanded for reconsideration, stating that "the ALJ and the Board are to clarify the basis for the decision."

On remand, claimant moves for remand to the ALJ for interpretation of his prior order. Alternatively, claimant asserts that, although the ALJ found that the existing standards inadequately addressed his bilateral flat foot deformity condition, the ALJ mistakenly concluded that the Hearings Division lacked authority to remand the matter to the Director for the promulgation of a temporary rule. Consequently, claimant requests that the matter be remanded to the Director for the promulgation of a temporary rule.

SAIF contends that the ALJ found that the standards adequately addressed claimant's bilateral flat foot deformity condition and that the ALJ correctly determined (using the standards) the extent of claimant's permanent disability for that condition. Consequently, SAIF requests that we affirm the ALJ's order.

The Workers' Compensation Division (WCD) asserts that the ALJ determined that the Director had expressly found that the standards adequately addressed claimant's permanent disability.[1] Consequently, insofar as remand to the Director is concerned, WCD requests that we affirm that portion of the ALJ's order.

In remanding this case, the court has expressly mandated that the ALJ and the Board clarify the basis for the decision. Yet, in its current posture, this case is pending before the Board, not the ALJ. Therefore, the only way to fully comply with the court's directive is to remand to the ALJ to issue an Order on Reconsideration. In that way, should one of the parties disagree with the ALJ's decision, that party can seek Board review. In light of such circumstances, we conclude that it is appropriate to remand this matter to the ALJ. *See* ORS 656.295(5).

Accordingly, the ALJ's order dated March 16, 2000 is vacated and this matter is remanded to ALJ Johnson for further proceedings consistent with the court's decision and this order. Those proceedings may be conducted in any manner that the ALJ deems satisfies substantial justice. Following those proceedings, the ALJ shall issue a final appealable order.

IT IS SO ORDERED.

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[1] WCD participates in this case pursuant to ORS 656.726(4)(h).

In the Matter of the Compensation of
DAVID E. HEIDEN, Claimant
WCB Case No. 01-02015
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Ronald W. Atwood & Associates, 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) Podnar's order that awarded 8 percent (25.6 degrees) unscheduled permanent disability for claimant's low back condition. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his back on October 4, 1999. The employer accepted a disabling lumbar strain. (Exs. 7, 15).

In August 2000, Dr. Kirschner examined claimant on behalf of the employer. (Ex. 11). He found that claimant's lumbosacral strain had resolved. (Ex. 11-10, -14). Dr. Kirschner concluded that claimant's range of motion findings were considered "normal" for him. (Ex. 11-14). Dr. Calhoun, claimant's attending physician, concurred with Dr. Kirschner's report. (Ex. 12).

A September 28, 2000 Notice of Closure did not award any permanent disability. (Ex. 14). Claimant requested reconsideration. Dr. Peterson performed a medical arbiter examination on January 4, 2001. (Ex. 18).

A February 14, 2001 Order on Reconsideration affirmed the Notice of Closure. (Ex. 19).

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Peterson's opinion and found that claimant's sacroiliitis was a direct medical sequela of the accepted lumbar strain. The ALJ awarded 8 percent unscheduled permanent disability for reduced lumbar range of motion.

The employer argues that the ALJ erred in awarding unscheduled permanent disability for impairment due to sacroiliitis. The employer contends that the medical evidence did not clearly establish a sacroiliitis condition, or that it was caused by the accepted lumbar strain.

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).

Claimant's attending physician, Dr. Calhoun, concurred with the impairment findings of Dr. Kirschner, neurologist, who examined claimant on behalf of the employer. (Exs. 11, 12). Dr. Kirschner found that claimant's lumbosacral strain had resolved, and he said claimant's range of motion findings should be considered "normal" for him. (Ex. 11-10, -14). Dr. Kirschner diagnosed, among other things, degenerative disc disease, somatization disorder and possible underlying depression and conversion disorder. (Ex. 11-9). He found that there were multiple features of claimant's symptom history that were inconsistent and he questioned the validity of the history. (Ex. 11-10). Dr. Kirschner explained that claimant's examinations had repeatedly demonstrated no objective findings. (Ex. 11-11). He also said that claimant's chronic pain may represent an embellishment of discomfort related to preexisting degenerative disc disease. (Ex. 11-14).

The attending physician's opinion does not support an impairment rating for reduced range of motion. Based on the findings of Dr. Kirschner, as concurred with by Dr. Calhoun, a September 28, 2000 Notice of Closure did not award any permanent disability. (Ex. 14).

Claimant requested reconsideration and Dr. Peterson, neurologist, performed a medical arbiter examination. Dr. Peterson reported claimant's lumbar range of motion findings as 55 degrees flexion, 20 degrees extension, 18 degrees right lateral flexion and 10 degrees left lateral flexion. (Ex. 18-5). She diagnosed lumbar strain; status post C3-4 fusion; asymmetric disc protrusion T8-9, most likely related to 10/4/99 incident; signs and symptoms suggestive of peripheral neuropathy; and historical features "suggestive of myelopathy as is hyperreflexia." (Ex. 18-6).

Regarding claimant's lumbar range of motion, Dr. Peterson explained:

> "As noted, there are mild limitations in lumbar flexion and extension and more significant limitations in right and left lateral flexion. There is not significant degeneration in the lumbar spine. Therefore, I do not find this decreased range of motion attributable to a preexisting underlying degenerative condition. Lateral flexion is much more affected than forward flexion or extension, but may reflect sacroiliitis which, in this examiner's opinion, arises from the accepted condition of lumbar strain. Maximum midsacral motion is 40 degrees. Tightest straight leg raising is 45 degrees. Therefore, these values are found to be valid, according to established criteria." (Ex. 18-6).

Dr. Peterson was asked "[i]f the findings are due to the accepted conditions and due to other unrelated conditions, provide, based on your medical judgment, the percentage of the findings or the specific findings that are due to the accepted condition." (Ex. 18-7). She responded that claimant had hyperreflexia and the findings suggested a central lesion of the brain or spinal cord. (*Id.*) Dr. Peterson felt that claimant should be evaluated for hypothyroidism. (*Id.*) She believed that some of claimant's current symptoms could be explained on the basis of cervical myelopathy. (Ex. 18-6, -7). Dr. Peterson also discussed claimant's degenerative changes:

> "The degenerative change in the thoracic spine is not simply an age-related phenomenon as is the degenerative change in [claimant's] lumbar spine. Given the degenerative change as noted in the thoracic spine, it is unusual for it to be so focal at a given level and quite unusual for a disc bulge to be asymmetric, and I would therefore conclude that this is a post-traumatic finding, and feel it is consistent with the mechanism of injury sustained on 10/4/99. I therefore feel the thoracic condition is 100% attributable to the date of injury. The thoracic and lumbar strains should have resolved at this time. I believe that they have, and that the residual symptoms are due [to] a sacroiliitis as a result of the 10/4/99 incident." (Ex. 18-7).

ORS 656.268(14) provides that "[c]onditions that are direct medical sequelae to the original accepted condition shall be included in rating permanent disability of the claim unless they have been specifically denied." "Direct medical sequela" means a "condition which originates or stems from the compensable injury or disease that is clearly established medically." OAR 436-035-0005(5). We have determined that permanent disability caused by direct medical sequelae is limited to direct medical sequelae of *accepted condition(s)*, not the compensable injury. *See, e.g., Julio C. Garcia-Caro*, 50 Van Natta 160 (1998).

The employer contends that claimant's sacroiliitis was not "clearly established medically," as required in OAR 436-035-0005(5). The employer argues that Dr. Peterson's opinion suggests only the possibility that claimant's decreased lateral flexion "may reflect sacroiliitis." (Ex. 18-6). Further, the employer asserts that it is unclear from Dr. Peterson's report whether she attributes the sacroiliitis condition to the accepted condition or the accidental injury.

For the following reasons, we agree with the employer that the medical evidence is insufficient to establish that claimant is entitled to an 8 percent unscheduled permanent disability award for reduced range of motion.

Dr. Peterson stated that claimant's "[l]ateral flexion is much more affected than forward flexion or extension, but may reflect sacroiliitis[.]" (Ex. 18-6). Although she suggested that the lateral flexion "may" reflect sacroiliitis, she did include that condition in her diagnoses. Under these circumstances, Dr. Peterson's comment that claimant's reduced lateral flexion "may" reflect sacroiliitis indicates only the

possibility, not the probability, that claimant had that condition. We find that Dr. Peterson's equivocal comments about sacroiliitis, without diagnosing that condition, are insufficient to establish that the sacroiliitis is a "direct medical sequela" because it is not "clearly established medically," as required by OAR 436-035-0005(5).

Even if we assume that claimant has sacroiliitis, we agree with the employer that it is unclear from Dr. Peterson's opinion whether she attributes that condition to the accepted condition or to the injury. In the first part of her report, she said that claimant's sacroiliitis "arises from the accepted condition of lumbar strain." (Ex. 18-6). On the other hand, she explained that the lumbar strain had "resolved" and claimant's residual symptoms were due to a "sacroiliitis as a result of the 10/4/99 incident." (Ex. 18-7). Thus, Dr. Peterson said that the sacroiliitis was the result of the accepted lumbar strain *and* the work injury. Dr. Peterson's opinion is not sufficient to establish that claimant's sacroiliitis was the direct medical sequelae of the original accepted condition, rather than the compensable injury. Furthermore, Dr. Peterson did not explain how the sacroiliitis arose from a resolved lumbar strain.

We conclude that the medical evidence is insufficient to establish that claimant has sacroiliitis or that sacroiliitis was a direct medical sequelae of the accepted lumbar strain.[1] Under these circumstances, claimant is not entitled to an unscheduled permanent disability award for reduced lumbar range of motion. We therefore reverse the ALJ's order and reinstate the Order on Reconsideration.

ORDER

The ALJ's order dated June 22, 2001 is reversed. The September 28, 2000 Notice of Closure and February 14, 2001 Order on Reconsideration are reinstated and affirmed. The ALJ's attorney fee award is also reversed.

[1] Our holding, however, does not mean that a claim for the unaccepted conditions cannot be made and, if accepted or determined to be compensable, rated for permanent disability in the future. *See* ORS 656.262(6)(d), (7)(a).

In the Matter of the Compensation of
RAEMONA M. HOLCOMB, Claimant
WCB Case Nos. 01-03868 & 00-08486
ORDER ON REVIEW
Kryger, et al., Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Fitzwater's order that upheld the SAIF Corporation's denials of her claim for a right wrist condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND REASONING

The ALJ upheld SAIF's denial on the ground that the opinions of Drs. Dodds and Ferguson were unpersuasive because they did not explain how claimant's job duties caused her right wrist tendinitis. In addition, the ALJ concluded that Dr. Ferguson did not refer to the specific job duties he thought caused the condition.

On review, claimant argues, citing Exhibit 13A, that Dr. Ferguson identified claimant's x-ray duties as the cause of the tendinitis. In addition, claimant asserts that the opinions of Drs. Dodds and Ferguson establish that claimant's work activities are the major contributing cause of her tendinitis. On this basis, claimant argues that the denial should be set aside. SAIF asserts that Dr. Dodds' and Dr. Ferguson's opinions are unpersuasive because they do not identify the specific job duties that caused the condition.

To establish the compensability of an occupational disease claim, claimant 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 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). The causation issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 281 (1993).

Dr. Dodds, an orthopedic surgeon, diagnosed work-related bilateral wrist tendinitis and thoracic outlet syndrome that was unrelated to work. (Ex. 7). Dr. Dodds referred claimant to an occupational medicine specialist, Dr. Ferguson. Dr. Ferguson diagnosed bilateral upper extremity tendinitis from overuse and mild thoracic outlet syndrome related to work. (Ex. 9).

Claimant was examined by Dr. Baker, orthopedic surgeon, and Dr. Platt, neurologist, on behalf of SAIF. These physicians diagnosed right thoracic outlet syndrome that was not related to a work injury or work activities. Instead, the physicians concluded the condition was congenital/developmental in origin. (Ex. 10-6). Dr. Baker and Dr. Platt also diagnosed right wrist and hand pain of undetermined etiology with total absence of objective findings. (Ex. 10-7). The doctors concluded that they were not entirely certain of claimant's diagnosis and that it was difficult to ascribe a major contributing cause.

Dr. Dodds did not concur with the discussion and conclusions in the report of Drs. Baker and Platt. (Ex. 13). Dr. Dodds indicated that he believed wrist and hand tendinitis was a clinical diagnosis and was made on the basis of the patient's response to "palpatory examination." (Ex. 13-2). According to Dr. Dodds, true objective measures of tendinitis, even when clinically apparent, are often lacking. Dr. Dodds felt that claimant had ongoing bilateral wrist tendinitis attributable to her prior work exposure. (Ex. 13-2).

Dr. Ferguson examined claimant on November 30, 2000. Dr. Ferguson's assessment was of a work related injury resulting in tendinitis of the upper extremity and some shoulder abnormalities related to work in an extended and overhead position. Dr. Ferguson identified x-raying as the activity that caused claimant's condition, but noted that she now performed the activity infrequently. (Ex. 13A).

Claimant was examined by Dr. Jones, an orthopedist, on behalf of SAIF. Dr. Jones diagnosed thoracic outlet syndrome and vague hand and wrist paresthesias with no objective findings of tendinitis at the time of the examination. (Ex. 14-5). Dr. Jones agreed with the findings of Drs. Platt and Baker. He diagnosed thoracic outlet syndrome that was not work-related but might be congenital. (Ex. 14-6). Dr. Jones concluded that claimant's symptoms were either of unknown etiology or were related to possible thoracic outlet syndrome. (Ex 14-7).

Dr. Dodds deferred to Dr. Ferguson, claimant's attending physician, when asked about claimant's claim. However, he opined that claimant's apparent tendinitis was related to claimant's work activities since those activities were described by claimant as heavy and significantly repetitive. He felt that the type of manual activity described was consistent with producing an ongoing wrist tendinitis. Dr. Dodds reiterated that he did not think the thoracic outlet syndrome was work-related. (Ex. 15). Dr. Dodds reviewed Dr. Jones' report and indicated that he agreed with Dr. Jones' conclusions except with regard to wrist tendinitis. (Ex. 16).

Dr. Ferguson indicated that he diagnosed claimant's right wrist condition as upper extremity tendinitis. Dr. Ferguson agreed that, based on claimant's explanation of her job duties prior to the onset of her symptoms, claimant's repetitious flexion, extension, pronation and rotation of her right wrist probably caused friction along the tendons of the wrist. Dr. Ferguson indicated that this friction probably caused inflammation and swelling that resulted in her symptoms. According to Dr. Ferguson, the inflammation and swelling represented pathological changes in the right wrist that were directly caused by work activities. (Ex. 16A-3). Dr. Ferguson also concluded that claimant's work activities, as described in his August 22, 2000 chart note, were the major contributing cause of claimant's right wrist tendinitis. (Ex. 16A-4).

Dr. Ferguson's August 22, 2000 chart note described claimant's work over the past years as involving primarily handling of x-ray plates, doing a great deal of moving and flipping the plates, causing pain in the forearm, wrist, and numbness and tingling into the fingers and hands. (Ex. 9). The chart note also describes work in March of 1999 where claimant repetitively scooped a large amount of aluminum pellets with a small scoop.

In evaluating the medical evidence concerning causation, we generally give greater weight to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reason not to defer to Dr. Ferguson, whose opinion is supported by that of Dr. Dodds.

The ALJ discounted the opinions of Drs. Ferguson and Dodds by stating that they did not explain how claimant's work activities caused her tendinitis. In addition, the ALJ concluded that Dr. Ferguson did not identify the specific job duties that caused the condition. We disagree.

We find that Dr. Ferguson explained that repetitious flexion, extension, pronation and rotation of claimant's right wrist probably caused friction along the tendons of the wrist. He further explained that this friction probably caused inflammation and swelling that resulted in claimant's symptoms. The inflammation and swelling represented pathological changes in the right wrist that were directly caused by work activities. (Ex. 16A-3). Dr. Ferguson also indicated that claimant's work activities, as described in his August 22, 2000 chart note, were the major contributing cause of claimant's right tendinitis. (Ex. 16A-4). Dr. Ferguson's August 22, 2000 chart note described claimant's work as handling of x-ray plates, doing a great deal of moving and flipping the plates and repetitively scooping aluminum pellets.

Based on Dr. Ferguson's opinions in the record, we conclude that he explained how claimant's work caused the tendinitis condition and that he also identified the causal work activities: the x-ray activities and the scooping activities. Thus, we do not agree with the ALJ that Dr. Ferguson's opinion is conclusory with regard to the compensability of the tendinitis condition.[1] Moreover, Dr. Dodds' opinion supports that of Dr. Ferguson and concludes that claimant's work was consistent with producing wrist tendinitis.

Although the examining physicians, Drs. Platt, Baker and Jones did not diagnose tendinitis, they each examined claimant on only one occasion. Moreover, Drs. Platt and Baker expressed uncertainty about claimant's correct diagnosis. Dr. Dodds explained, however, that tendinitis was a clinical diagnosis based on palpatory exam and that true objective measures of tendinitis are often lacking. Dr. Ferguson indicated that he noted mild tenderness and discomfort over the volar wrist. These findings were consistent and reproducible. (Ex. 16A-4). Thus, we are persuaded that claimant had objective findings of right wrist tendinitis, and we find the opinion of Dr. Platt and Dr. Baker to be less persuasive than the opinions of the treating physicians, who had noted familiarity with claimant's wrist condition.

We likewise are not persuaded by the opinion of Dr. Jones. Although Dr. Jones stated that claimant's symptoms were inconsistent with tendinitis, he did not further explain this opinion.

Based on this record, we conclude that claimant has established compensability of an occupational disease claim for right wrist tendinitis. Accordingly, we conclude that the occupational disease denial should be set aside.[2]

Claimant's attorney is entitled to an assessed fee for services for hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $5,500, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the right wrist occupational disease 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 claimant's counsel might go uncompensated.

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[1] While we conclude that Dr. Ferguson's opinions, as supported by Dr. Dodds' opinions, are well reasoned regarding the right tendinitis condition, we agree with the ALJ that Dr. Ferguson's opinion does not establish compensability of a thoracic outlet syndrome. In this regard, Dr. Ferguson is the only medical expert who opined that claimant's thoracic outlet syndrome was compensable. Dr. Ferguson did not elaborate upon or explain his opinion. Accordingly, we agree with the ALJ that compensability of a thoracic outlet syndrome has not been established on this record.

[2] SAIF also issued a June 13, 2001 denial that claimant's right wrist condition was compensably related to an accepted cervical sprain/strain claim. (Ex. 18). Because there is no evidence that claimant's right wrist condition is related to a prior accepted claim, we agree with and affirm the portion of the ALJ's order upholding the June 13, 2001 denial.

ORDER

The ALJ's order dated July 13, 2001 is reversed in part and affirmed in part. SAIF's September 7, 2000 denial of her occupational disease claim for right wrist tendinitis is set aside and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $5,500, to be paid by SAIF. The remainder of the ALJ's order is affirmed.

December 13, 2001 Cite as 53 Van Natta 1607 (2001)

In the Matter of the Compensation of
MARTA J. HENRIKSEN, Claimant
WCB Case No. 00-04508
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Sather, et al., Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) CrummΘ's order that upheld the insurer's denial of claimant's injury claim for a left leg condition. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

Claimant is an educational assistant at an elementary school. Her ordinary work hours are 8:00 a.m. to 2:30 p.m., Monday through Friday. (Tr. 12, 13). Pursuant to an informal agreement among the school's staff, employees clean the staff room after work each day on a rotating weekly basis. The week of her injury, it was claimant's responsibility to clean the staff room. (Tr. 24). Claimant's ordinary route to the staff room after work was through an outdoor breezeway (a covered sidewalk). (Tr. 16, 22). The school's principal, Ms. Nice, testified that cleaning the staff room was "something that every staff member does" and that she had no "disagreement" with the arrangement. (Tr. 30, 31).

Due to an informal agreement between claimant and one of the teachers at the school, Ms. Willis, claimant transported Willis' son, Taylor (who attended the fifth grade at the school), to a day care facility after school. (Tr. 5). Claimant was not compensated for transporting Taylor. (Tr. 10). The employer was neither aware of, nor did it acquiesce in, this arrangement.

On the day of her injury, claimant completed her ordinary duties at 2:30 p.m. At that time, claimant met with Ms. Nice for a short work-related meeting until 2:40 p.m. Claimant then walked outside through a breezeway to find Taylor. She also planned to then proceed to the staff room to clean it and to pick up some personal belongings. (Tr. 15, 16). The staff room was located between the principal's office and the parking lot. (Tr. 22). When she spotted Taylor on the playground, he kicked a soccer ball in her direction. Claimant kicked the ball back to Taylor, mentioning that she used to play soccer as a child. (Tr. 16). Claimant then turned a corner, heading toward the staff room door, when Taylor, walking behind her, again kicked the ball in her direction. (*Id.*) The ball bounced off a wall. In attempting to stop the ball with her left foot, claimant rolled her foot over it and fractured her fibula. (Tr. 17).

CONCLUSIONS OF LAW AND OPINION

In upholding the insurer's denial, the ALJ found that claimant's injury was not compensable because it occurred during an activity primarily for personal pleasure under ORS 656.005(7)(b)(B). In addition, the ALJ found that the injury did not arise out of or in the course of claimant's employment. ORS 656.005(7)(a).

On review, claimant contends that the injury was not incurred during an activity primarily for personal pleasure and that it bears a sufficient relationship to her employment to be found compensable. We agree.

Under ORS 656.005(7)(b)(B), a "compensable injury" does not include any injury incurred while engaging in recreational activity primarily for the worker's personal pleasure. *See Julie A. Garcia*, 48 Van Natta 776 (1996); *Michael W. Hardenbrook*, 44 Van Natta 529, *aff'd mem Hardenbrook v. Liberty Northwest Insurance Corporation*, 117 Or App 543 (1992). However, the statute does not automatically exclude those recreational activities that have a close work nexus and are not performed "primarily" for the worker's personal pleasure. *Garcia*, 48 Van Natta at 776.

When ORS 656.005(7)(b)(B) applies, a statutory exclusion analysis must precede any unitary work connection analysis. *See Andrews v. Tektronix, Inc.*, 3223 Or 154, 161 n1 (1996); *William A. Rutten, Jr.*, 53 Van Natta 380 (2001); *Theodore A. Combs*, 47 Van Natta 1556, 1557 (1995).

"The proper inquiry under ORS 656.005(7)(b)(B) is, what is the primary purpose of the activity [at the time of the injury]?" *Kaiel v. Cultural Homestay Institute*, 129 Or App 471, 478 (1994). Here, we find that claimant's activity of stopping the soccer ball with her foot while walking to the staff room was not primarily for personal pleasure.

In reaching this conclusion, we find persuasive that, at the time of her injury, claimant had not yet completed the final task of her work day; *i.e.*, cleaning the staff room. Although this activity was not part of claimant's official job description and she was not paid for it, the employer knew of the agreement between the staff to clean the room on a rotating basis. (Tr. 30, 31). Furthermore, the record does not indicate that the employer disapproved of such an arrangement. Under such circumstances, we are persuaded that the employer acquiesced in the "room cleaning" activity.[1] *See generally Arthur E. Fredrickson*, 52 Van Natta 897 (2000); *Mark Hoyt*, 47 Van Natta 1046 (1995), *Elva McBride*, 46 Van Natta 282 (1994), *aff'd* 134 Or App 321 (1995) (the fact that the employer "acquiesced" in certain activity brought injury within course and scope of the claimant's employment).

The employer contends that claimant's activity of kicking the soccer ball with the student was a recreational activity not related to her job requirements. However, even assuming that is true, the evidence is that, at the exact time of her injury, claimant had turned away from kicking the soccer ball and was heading toward, and had almost reached, the staff room to perform her "room cleaning" duties. (Tr. 16). At that time, she reached out with her foot to stop the soccer ball after the student (walking behind her) had kicked it against the wall. (Tr. 17).

Importantly, there is no evidence that claimant intended to kick the ball back to the student; *i.e.*, to continue the "game" with him, when she attempted to stop the ball. Instead, claimant testified that she merely tried to stop the ball from bouncing out into a gravel area where garbage cans and a recycling can are kept. (Tr. 16). Therefore, although claimant had initially briefly departed from her direct route to the staff room to kick the soccer ball back to the student, she had then returned to her "room cleaning" duties when she was on her way to the staff room at the time that she injured her leg.

The insurer cites several "recreational activity" cases in which it alleges we have generally held the claimant's injuries not to be compensable. *See, e.g., Esther E. Edwards*, 44 Van Natta 1065 (1992); *Michael W. Hardenbrook*, 44 Van Natta 529 (1992). However, in each of these cases, the claimant was actively participating in recreational activity during either non-work time or during an unpaid lunch break.

In *Juan M. Zurita*, 46 Van Natta 993 (1994), *Elias Gonzalez*, 46 Van Natta 439 (1994), and *Troy D. Bjugan*, 45 Van Natta 1172 (1993), also cited by the insurer, the injuries arose from on-site basketball games during paid breaks and were held not to be compensable. However, the claimants in *Zurita*, *Gonzalez* and *Bjugan* were in the midst of participating in basketball games instead of returning to work-related duties (as claimant was) at the time of injury. Moreover, claimant's short detour to kick the soccer ball back to the student was far less involved than the more prolonged recreational activities described in the above cases.[2] For these reasons, we find that claimant's injury was not incurred while

[1] We find that the employer acquiesced in the activity by referencing Ms. Nice's acknowledgment that cleaning the staff room was something that "every staff member does" by informal agreement, and that she did not "disagree" with the agreement. (Tr. 30, 31).

[2] We note that claimant's route along the breezeway was apparently claimant's usual route to the staff room, or at least claimant's most direct route to the staff room after meeting with Ms. Nice. (Tr. 16, 22). In other words, she would have taken that route even if she did not have the additional purpose of locating the student. Moreover, after initially kicking the ball to the student, claimant had returned to her normal route to the staff room by turning the corner and heading to the staff room door.

engaging in an activity primarily for personal pleasure. Her claim is thus not barred by ORS 656.005(7)(b)(B).

We now proceed to the traditional analysis of whether claimant's injury arose out of and in the course of her employment. ORS 656.005(7)(a). The "arise out of" prong of the compensability test requires that a causal link exist between the worker's injury and his or her employment. *Krushwitz v. McDonald's Restaurant's*, 323 Or 520, 525-526 (1996); *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994). The requirement that the injury occur "in the course of" the employment concerns the time, place and circumstances of the injury. *Gilmore*, 318 Or at 366.

These two tests are two parts of a single "work-connection" inquiry; that is, whether the relationship between the injury and the employment is sufficient that the injury should be compensable. *Id.* Both prongs of the work connection test must be satisfied to some degree; neither is dispositive. *Krushwitz*, 323 Or at 531.

Here, the circumstances of claimant's injury are sufficiently connected to her employment to warrant compensability. Initially, we note that the fact that claimant's injury occurred after her official work hours is not dispositive. The term "in the course of" employment includes a reasonable period of time after work for the worker to leave the employer's premises. *Fred Meyer v. Hayes*, 325 Or 592, 598 (1997). In *Hayes*, the claimant was assaulted by a stranger in the employer's parking lot after her work shift and after she had spent several minutes shopping for personal items at the employer's grocery store. The Court found the claim compensable, agreeing with the Board's reasoning that the claimant's "brief personal deviation" after work was insufficient to sever the connection between the injury and her employment. *Hayes*, 325 Or at 601.

Here, claimant's injury occurred just minutes after she had left a meeting with the school's principal and was en route to an additional work-related obligation to clean the staff room. Based on the testimony of the principal, Ms. Nice, we find that claimant's activity of cleaning the staff room was acquiesced in by the employer. In these circumstances, we conclude that claimant's injury while traveling to that activity occurred in the course of her employment. The activity of kicking the soccer ball to the student amounted, at most, to a "brief personal deviation" in the midst of her journey. *Hayes*, 325 Or at 601. In addition, as we discussed above, at the time of her injury, claimant had resumed her normal route to the staff room. She had turned a corner and had almost reached the staff room door.

We next address whether claimant's injury "arose out of" her employment. That inquiry tests the causal connection between claimant's injury and a risk connected with her employment. *Hayes*, 325 Or at 601; *Krushwitz*, 323 Or at 525-526. We find that claimant's injury "arose out of" her employment because she was injured on the employer's premises while proceeding to the staff room to complete her final work-related obligation of the day. The task of cleaning the staff room was part of an informal agreement amongst her co-workers which was known to and acquiesced in by the employer. Traveling to that task through a breezeway (her normal route) at the time of her injury exposed claimant to the risk of being injured attempting to stop the soccer ball. *See Wilson v. State Farm Ins.*, 326 Or 413, 416 (1998).[3]

Finally, the insurer emphasizes claimant's non-work-related arrangement to transport the student to day care as a significant factor in claimant's injury. We do not consider this argument to be persuasive. As we reasoned above, claimant would have had to walk to the staff room through the same breezeway after meeting with Ms. Nice in any case. In addition, at the time of her injury, she had not yet begun transporting the student.

In conclusion, for all of the aforementioned reasons, claimant's injury bears a sufficient relationship to her employment to establish compensability. Accordingly, we reverse the ALJ's order and set aside the insurer's denial.

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[3] In *Wilson*, the Supreme Court held that a claimant who injured herself while "skip-stepping" around a corner in the workplace sustained an injury that arose out of her employment, even without evidence of a particular hazard on the employer's premises.

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 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 issues, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The ALJ's order dated July 16, 2001 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $5,000, payable by the insurer.

Board Member Haynes dissenting.

I agree with the ALJ that claimant's injury was incurred during an activity primarily for personal pleasure and that her injury does not have a sufficient work nexus to be found compensable. Therefore, I respectfully dissent.

The insurer, I believe, correctly summarized the issue here: "Whether claimant's after-hours soccer injury while playing with a child pursuant to a private, nonwork-related arrangement, is compensable." The majority fails to appreciate the true extent to which claimant had separated herself from any arguably work-related function during her recreational activity with that child (Taylor).

Claimant's injury did not arise out a risk of her employment. Her injury would not have occurred except for a personal decision to perform an ongoing favor for a teacher at her school, in addition to another personal decision to play soccer with that teacher's child.

As the insurer notes, playing soccer with the child had no connection to claimant's work. Claimant is an educational assistant. However, the child was not one of claimant's "students;" *i.e.*, he was not in one of claimant's "small groups." (Tr. 19). Claimant was not a soccer coach. (Tr. 22). Claimant's arrangement to transport the child to daycare was a purely private arrangement, in which the employer did not acquiesce.

Claimant's injury would never have occurred if it were not for the private, after work arrangement with a teacher to transport that teacher's son to daycare. If not for that arrangement, claimant would not have been in her exact position at the time of the injury. The evidence is that, even before engaging in the soccer game with the child, claimant had walked out to the breezeway with the specific purpose of locating him. (Tr. 16, 22). It was then that the child kicked the soccer ball to claimant, who became engaged with him, albeit briefly, in a "game" of soccer.

The majority finds that claimant had "extricated" herself from the soccer game at the exact time of her injury. However, that distinction ignores the larger picture that merely walking through the breezeway and kicking the ball with the child at that time of the day was a non-work-related activity. Claimant was not struck randomly by an errant soccer ball kicked by "just any" student. In addition, while walking along the breezeway, in addition to kicking the ball back and forth with the child, claimant shared with him that she had loved to play soccer as a child. (Tr. 16). In my view, the context of the encounter was purely recreational.

This case is analogous to several cases in which we have held that sports injuries on the employer's premises, even during paid work breaks, are generally not compensable because the activity was "primarily for the worker's personal pleasure." ORS 656.005(7)(b)(B). *See Juan M. Zurita*, 46 Van Natta 993 (1994); *Elias Gonzales*, 46 Van Natta 439 (1994); *Troy D. Bjugan*, 45 Van Natta 1172 (1993). Indeed, in my view, claimant's "after hours" soccer injury is even less deserving of compensability than a sports injury incurred during a paid work break.

Claimant was injured while playing soccer with a child after work - an activity that was "primarily for personal pleasure." ORS 656.005(7)(b)(B). In addition, I do not believe that claimant's injury "arose out of" or was "in the course of" her employment. For these reasons, I respectfully dissent.

In the Matter of the Compensation of
KEVIN A. JUHLIN, Claimant
WCB Case No. 01-02454
ORDER ON REVIEW
Allison Tyler, Claimant Attorney
Gilroy Law Firm, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

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

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

The employer challenges the ALJ's order, asserting that claimant is not credible. According to the employer, claimant's identification of the date on which the injury occurred was false, claimant demonstrated a shoulder disability to his supervisor before the claimed work-injury, and the accounts claimant provided to physicians concerning the manner in which the injury occurred were inconsistent.

The ALJ found claimant's testimony to be credible based upon his attitude, appearance and demeanor at hearing. (O & O at 4). We generally defer to the ALJ's demeanor-based credibility findings. *Erck v. Brown Oldsmobile*, 311 Or 510, 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.

The ALJ concluded that although claimant's recollection of the date of the work-related injury "may have been off by a day or so," the error or discrepancy was immaterial. In the context of this case, we agree.

Moreover, even if the precise date was material, evidence presented was sufficient to support the claim. Claimant testified that his shoulder injury occurred on January 8, 2001 when he was operating a chainsaw from the bucket of a 50' lift truck. The only other witness with first-hand information regarding claimant's activities on January 8th was his supervisor. The supervisor testified that although claimant regularly performed such work, he had not done so on that date.

The ALJ had an opportunity to evaluate the credibility and demeanor of both witnesses. Based upon claimant's demeanor, the ALJ determined that he was credible and his testimony generally reliable. No similar finding was made with respect to the supervisor. In light of such circumstances, the preponderance of the credible, persuasive evidence establishes that, more likely than not, claimant sustained a work-related shoulder injury on January 8, 2001.

A second factual dispute concerns the employer's assertion that claimant had a preexisting shoulder condition. Claimant denied that he suffered from anything more than occasional temporary soreness in both shoulders prior to January 8th. His supervisor testified that when claimant joined the work crew in early January, he demonstrated limited mobility in his shoulder. The supervisor was uncertain, but believed the condition displayed involved claimant's left shoulder. Although this factual dispute may also be resolved based upon the ALJ's demeanor-based credibility finding, we need not do so since the injury at issue involved claimant's right shoulder.

In addition, we agree with the ALJ's conclusion that, with the exception of a single chart note by the treating physician on January 23, 2001, claimant's medical histories to examining physicians are reconcilable. On the same day that a differing chart note was entered, the treating physician signed a report that described the work injury in terms consistent with the other histories. Under these circumstances, we conclude that any discrepancies in claimant's histories are insufficient to cause us to discount either claimant's treating physician's opinion or claimant's version of the relevant events.

Based on the above analysis, we defer to the ALJ's demeanor-based credibility finding in favor of claimant. Consequently, we conclude that claimant has satisfied his burden of proving that he sustained a work-related injury which was the major contributing cause of his need for medical treatment or disability for his right shoulder condition. *See* ORS 656.005(7)(a)(B).

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

ORDER

The ALJ's order dated July 20, 2001 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,400, to be paid by the self-insured employer.

In the Matter of the Compensation of
LAWANDA S. RICHEY, Claimant
WCB Case No. 00-07152
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of her occupational disease claim for a right shoulder condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order.[1]

ORDER

The ALJ's order dated July 10, 2001 is affirmed.

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[1] The ALJ referred to the medical examination conducted by Dr. Bald as a compelled medical examination (CME). For the reasons expressed in *Jamie B. Davis*, 53 Van Natta 1548 (2001), and *Laura J. Decker*, 53 Van Natta 1533 (2001), we refer to such an examination as an insurer-arranged medical examination (IME).

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In the Matter of the Compensation of
RICHARD S. HORTON, Claimant
Own Motion No. 01-0333M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Black, Chapman, et al., Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of the SAIF Corporation's September 12, 2001 Own Motion Notice of Closure that closed his claim with an award of temporary disability compensation from May 24, 2001 through September 4, 2001. SAIF declared claimant medically stationary as of September 5, 2001. Asserting that the Own Motion closure is "inappropriate," claimant contends that "the claim should be processed pursuant to ORS 656.262 and 656.268."[1]

FINDINGS OF FACT

On August 1, 1982, claimant sustained a compensable back injury, which SAIF accepted as a disabling injury. Claimant's 1982 claim was first closed on April 28, 1983. Thus, claimant's aggravation rights expired on April 28, 1988.

On May 24, 2001, claimant underwent a C6-7 laminectomy and disc excision bilaterally performed by Dr. Amstutz, his treating physician. On July 16, 2001, the Board issued an Own Motion Order authorizing the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant underwent the proposed surgery. SAIF was also directed to close the claim pursuant to OAR 438-012-0055 when claimant was medically stationary. That Own Motion Order was not appealed.

On September 5, 2001, Dr. Amstutz examined claimant and declared him medically stationary. He noted that claimant had a lifting limit of 25 pounds. Dr. Amstutz scheduled a follow-up visit in "three mo[nth]s or so."

On September 12, 2001, SAIF issued an Own Motion Notice of Closure that closed the claim with an award of temporary disability benefits from May 24, 2001 through September 4, 2001, and declared claimant medically stationary as of September 5, 2001.

On October 29, 2001, claimant requested that the Board in its Own Motion capacity review SAIF's Own Motion Notice of Closure, contending that his claim should be processed pursuant to ORS 656.262 and 656.268.

CONCLUSIONS OF LAW

Claimant requests that the Board, in its Own Motion authority, review SAIF's September 12, 2001 "Notice of Closure Board's Own Motion Claim." He contends that the Own Motion closure is inappropriate and that the claim should be processed under ORS 656.262 and 656.268 pursuant to *Johansen v. SAIF Corporation*, 158 Or App 672 (1999).[2] Claimant makes no argument regarding the merits of SAIF's closure.

To begin, we have subject matter jurisdiction in our Own Motion capacity to review the September 12, 2001 closure. Our reasoning for this conclusion is expressed in *John R. Graham*, 51 Van Natta 1740 (1999), 51 Van Natta 1746 (1999), and *Craig J. Prince*, 52 Van Natta 108 (2000). In *Graham*, we held that a "new medical condition" claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c), even if the original claim is in the Board's Own Motion jurisdiction. 51 Van Natta at 1745.

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[1] On July 16, 2001, we issued an Own Motion Order, which reopened claimant's 1982 claim for the provision of temporary disability compensation. (WCB Case No. 01-0175M). SAIF issued its September 12, 2001 Notice of Closure for that claim.

[2] We interpret claimant's assertion that his claim should be processed pursuant to ORS 656.262 and 656.268 to mean that he has a "new medical condition" which requires different claim processing.

Furthermore, in *Prince*, we determined that the Board's authority under its "Own Motion" capacity is strictly limited by the provisions of ORS 656.278 and that those provisions do not include the authority to direct a carrier to process a claim under ORS 656.262(7)(c). We explained that the issue of whether the claim should be processed under ORS 656.262(7)(c) is a "matter concerning a claim," and under ORS 656.283, any party "may at any time request a hearing on any matter concerning a claim." 52 Van Natta at 111. Therefore, where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *Id.*

Finally, we have subject matter jurisdiction in our Own Motion capacity to review a carrier's Own Motion Notice of Closure. Specifically, where a claimant's aggravation rights have expired on the initial injury claim and the condition worsened requiring surgery, we are authorized to reopen the claimant's claim pursuant to ORS 656.278(1)(a) and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. We also have subject matter jurisdiction in our Own Motion capacity to review the carrier's subsequent closure of that claim. *See SAIF v. Ledin*, 174 Or App 61 (2001); *see also Paul E. Smith*, 52 Van Natta 730 (2000); *Robert A. Olson*, 52 Van Natta 1540 (2000).

Here, the record is undeveloped regarding the question of whether claimant has initiated a "new medical condition" claim or a new condition that has been found compensable after claim closure. In any event, the *Ledin*, *Graham*, and *Prince* rationale is equally applicable. In other words, there is no dispute that claimant's aggravation rights have expired on his initial injury claim. Furthermore, claimant's condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the July 16, 2001 Own Motion Order that authorized the reopening of claimant's claim pursuant to ORS 656.278(1)(a) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review SAIF's subsequent closure of that claim.[3] Therefore, we proceed with that review.

A claim may not be closed unless claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at the date of closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the September 12, 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).

Here, the only medical evidence regarding the medically stationary issue is provided by claimant's attending physician, who opined that claimant was medically stationary as of September 5, 2001. That is the date SAIF declared claimant's condition when it closed the claim.

Claimant makes no argument that he was not medically stationary at the time of closure, nor does he argue that his medically stationary date was incorrect. He also does not contest the temporary disability compensation award. Instead, claimant's argument is procedurally based; *i.e.*, he argues that this particular closure of this Own Motion claim should not be processed under the Board's Own Motion jurisdiction. Because we have rejected that argument and claimant raises no substantive arguments, we affirm SAIF's September 12, 2001 Own Motion Notice of Closure in its entirety. *See Harold G. Magnum*, 52 Van Natta 1824 (2000); *John P. Adkins*, 52 Van Natta 708 (2000).

Accordingly, SAIF's September 12, 2001 Own Motion Notice of Closure is affirmed.

IT IS SO ORDERED.

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[3] We have previously explained that where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *See Prince*, 52 Van Natta at 111. In other words, claimant's relief, if any, regarding his request for claim processing under ORS 656.262(7)(c) and 656.268 lies with the Hearings Division, not the Board in our Own Motion jurisdiction.

In the Matter of the Compensation of
RUSSELL K. LEWIS, Claimant
WCB Case No. 00-07591
ORDER ON REVIEW
S. David Eves, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the SAIF Corporation's denial of his left shoulder and rib injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. On page 2, we replace the second full paragraph with the following:

> Mr. Sanford, the employer, testified that on the way to Pendleton, he discussed with the crew the dangers and differences in cutting pine, rather than fir. (Tr. 8, 32). He explained to the crew that the pine trees have a tendency to spring back or spring from side to side. (Tr. 32). Mr. Sanford testified that no one on the crew drank any alcohol during the trip to Pendleton. (Tr. 53). On the other hand, claimant's brother testified that he and claimant drank beer during the trip to Pendleton, and he said Mr. Sanford was aware of it. (Tr. 79-80). Claimant did not provide any testimony on this issue.

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

> In a statement to an investigator, claimant said that he had five or six beers on June 27, 2000, the day before his injury. (Ex. 25a-6). At hearing, however, claimant testified that he drank "quite a bit" the day before the accident and he characterized his drinking as "[a]n all day thing." (Tr. 9). Claimant said they got off work about noon on June 27, 2000, and he had approximately 12 beers or more before he went to sleep that night. (Tr. 11, 14, 16).
>
> In contrast, Mr. Sanford, testified that he was only aware that claimant had consumed a total of four beers on the night before the accident. (Tr. 34, 43). He took the crew out for dinner on the evening of June 27, 2000, and the crew members had two beers each at dinner. (Tr. 33, 34, 43). After dinner, Mr. Sanford went with the crew to the swimming pool. (Tr. 34). He observed the three crew members drink a six-pack of beer; *i.e.*, each had two beers. (*Id.*)

Claimant, a logger, injured his left shoulder and ribs on June 28, 2000 when he was struck by a tree at the work site. SAIF denied the claim, asserting that the major cause of his injury was the consumption of alcohol or a controlled substance. (Ex. 33).

The ALJ relied on the opinion of Dr. Jacobsen and found that claimant's voluntary intoxication was the major contributing cause of his accident. The ALJ rejected claimant's argument that the employer permitted, encouraged or had actual knowledge of his alcohol consumption. The ALJ found no persuasive evidence that the employer was aware of the large amount of alcohol claimant had consumed while not in the employer's presence. The ALJ also determined that there was no evidence the employer knew, suspected, or should have suspected that claimant was under the influence of alcohol when the crew left for the work site on June 28, 2000.

On review, claimant contends that Dr. Jacobsen cannot render an opinion regarding the major contributing cause of his injury. According to claimant, the trier of fact, not Dr. Jacobsen, must consider all the factors surrounding the logging incident and the consumption of alcohol in determining the major contributing cause of the injury. He argues that the ALJ erred in concluding that the major contributing cause of his injury was due to voluntary intoxication.

As the ALJ pointed out, we have previously determined that the cause and effect of the use of alcohol or controlled substances is a medical question requiring expert medical opinion. *See, e.g., Randy M. Pedersen*, 53 Van Natta 815 (2001); *Erika W. Ortman*, 51 Van Natta 2012 (1999). We reach the same conclusion in this case and we agree with the ALJ that the major contributing cause of claimant's injury was due to voluntary intoxication.

Alternatively, claimant contends that, even if alcohol consumption was the major factor in his accident, ORS 656.005(7)(b)(C) does not preclude compensability because the evidence establishes that the employer permitted, encouraged or had actual knowledge of his consumption of alcohol. For the following reasons, we agree with the ALJ that claimant's alternative argument is not persuasive.

Under ORS 656.005(7)(b)(C), claimant must first establish a *prima facie* case of compensability. If established, then to defeat a finding of compensability under ORS 656.005(7)(b)(C), the carrier must prove, by the preponderance of the evidence, that claimant's "consumption of alcoholic beverages or the unlawful consumption of any controlled substance" was the major contributing cause of the injury. ORS 656.005(7)(b)(C) provides that a compensable injury does not include:

> "Injury the major contributing cause of which is demonstrated to be by a preponderance of the evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, *unless the employer permitted, encouraged or had actual knowledge of such consumption.*"

In construing ORS 656.005(7)(b)(C), our task is to discern legislative intent. *See* ORS 174.020. We begin by examining the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). The context includes other provisions of the same statute and other related statutes. *Id.* at 611. If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. *Id.*

ORS 656.005(7)(b)(C) provides that a compensable injury does not include one caused, in major part, by a claimant's consumption of alcoholic beverages, "unless the employer permitted, encouraged or had actual knowledge of such consumption." The statutory reference to "such consumption" indicates that the employer must permit, encourage or have actual knowledge of a claimant's consumption of alcohol that constitutes the "major contributing cause" of the injury. In other words, the *consumption* of alcohol that the employer "permitted, encouraged or had actual knowledge of" must be the major contributing cause of the injury.

> On the other hand, a contrary [the dissent's] interpretation of ORS 656.005(7)(b)(C) would mean that, if the employer either permitted, encouraged or had actual knowledge of claimant's alcohol consumption, then, regardless of whether consumption of alcohol was the major contributing cause of the injury, the "alcohol defense" would fail and the injury would be compensable. That contrary [the dissent's] reading of ORS 656.005(7)(b)(C) would mean that an employer's permission, encouragement or knowledge of *any* consumption of alcohol by a claimant whatsoever would negate an employer's "alcohol defense." We believe that construction of the statute is unduly harsh and creates a "zero tolerance" policy that precludes the finder of fact from even considering, as in this case, the fact that the employer was *not* aware of the large amount of alcohol claimant consumed on his own, outside of the employer's presence. The contrary [the dissent's] interpretation of the statute would also prevent the fact finder from considering the medical evidence in this case that, based on the alcohol consumption which the employer was aware of, claimant would not have had any alcohol in his blood at the time of the work incident. We do not believe that the legislature intended such an absurd result.

For the following reasons, we agree with the ALJ that there was no persuasive evidence that the employer was aware of the large amount of alcohol claimant consumed while he was not in the employer's presence. Further, the ALJ found no evidence that the employer knew, suspected, or should have suspected, that claimant was under the influence of alcohol when the crew left for work on June 28, 2000.

Mr. Sanford, the employer, testified that he drove a crew consisting of claimant, claimant's brother and another employee to Pendleton for a logging job. (Ex. 32). On the evening of June 27, 2000, Mr. Sanford took the crew out for dinner. (Tr. 33). He said the crew members had two beers each at dinner. (Tr. 34, 43). After dinner, Mr. Sanford went with the crew to the swimming pool. (Tr. 34). He observed the three crew members drink a six-pack of beer; *i.e.*, each had two beers. (*Id.*) Thus, Mr. Sanford was aware that claimant had consumed a total of four beers on the night before the accident. (Tr. 34, 43). He testified that claimant and his brother said they were going to bed about 9:30 p.m. because they had to get up early in the morning. (Tr. 34-35, 43). Mr. Sanford said that, at that time, claimant seemed to be fine. (Tr. 43, 44).

On June 28, 2000, Mr. Sanford and the crew left for the work site about 3:45 a.m. (Tr. 35). Mr. Sanford testified that claimant appeared to be normal at that time. (Tr. 47, 48). Claimant fell asleep in the pickup. (Tr. 35). There was not much conversation in the pickup, which was normal. (Tr. 48).

When they arrived at the job site, they all stopped to put their boots on. (Tr. 49). Mr. Sanford did not observe anything unusual about claimant's actions. (Tr. 49-50). Mr. Sanford dropped claimant and his brother off at a site and he continued to a different location. (Tr. 36). Mr. Sanford testified that he did not know claimant was intoxicated on the morning of June 28, 2000, and he would not have permitted him to work with the knowledge of his intoxication. (Tr. 42). Furthermore, he did not even suspect that claimant was under the influence of intoxicants on that morning. (Tr. 51). Mr. Sanford said that "if I know that anybody is under the influence of anything, they do not work and they do lose their job." (Tr. 47).

In contrast, claimant's actual consumption of alcohol on June 27, 2000 was much greater than Mr. Sanford realized. Claimant testified that they got off work about noon on June 27, 2000, and he had approximately 12 beers or more before he went to sleep that night. (Tr. 11, 14, 16). Claimant explained that he drank "quite a bit" that day and characterized his drinking as "[a]n all day thing." (Tr. 9). Dr. Jacobsen reported that claimant's blood alcohol level was 0.081 gm% at 7:20 a.m., approximately two hours after the accident. (Ex. 32-5). He determined that, based on the blood alcohol level, claimant had 5.1 unmetabolized standard drinks present in his body at the time of the accident. (*Id.*)

Dr. Jacobsen's opinion establishes that, based on Mr. Sanford's understanding of claimant's June 27, 2000 alcohol consumption, claimant would not have had *any* alcohol in his bloodstream on the morning of June 28, 2000. Dr. Jacobsen reported that, based on claimant's metabolism and size, if he had consumed a maximum of six beers starting at 8:00 p.m. the night before the accident, claimant would have had a blood alcohol level (BAL) of 0.00 gm% by no later than 4:30 a.m. on June 28, 2000.[1] (Ex. 32-7). Likewise, Dr. Jacobsen said that, based on the employer's history, the group had dinner at about 6 p.m. and claimant consumed a total of four beers before 10 p.m. (*Id.*) Dr. Jacobsen explained that, in that situation, if claimant had consumed no additional alcohol, his BAL would have been about 0.00 gm% by about midnight on June 27, 2000. (*Id.*)

Under these circumstances, we are not persuaded that the employer permitted or encouraged the *consumption* of the alcohol that was the major contributing cause of claimant's injury. In fact, based on the employer's knowledge of claimant's alcohol consumption on the night before his injury, claimant would have had a BAL of zero percent on the morning of June 28, 2000 when he was injured. (Ex. 32-7). We agree with the ALJ that claimant's injury is not compensable.

ORDER

The ALJ's order dated January 31, 2001 is affirmed.

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[1] Although Dr. Jacobsen referred to the night before the accident as "8/27/00" in part of his report (Ex. 32-7), it is clear from other references in his report that he meant June 27, 2000.

Board Member Phillips Polich dissenting.

The majority affirms the Administrative Law Judge's (ALJ's) order that upholds the SAIF Corporation's denial of claimant's left shoulder and rib injury claim. In so doing, it agrees with the ALJ's determination that, based on Dr. Jacobsen's opinion, alcohol consumption was the major contributing cause of claimant's injury. Moreover, the majority rejects claimant's argument that, even assuming that the above determination was correct, the record establishes that the employer permitted, encouraged or had actual knowledge of his consumption of alcohol and, therefore, that SAIF's "alcohol defense" fails under ORS 656.005(7)(b)(C). Because I would find that the employer permitted, encouraged or had actual knowledge of the alcohol consumption that Dr. Jacobsen concluded was the major factor in claimant's accident, I dissent.

ORS 656.005(7)(b)(C) provides that a compensable injury does not include:

> "Injury the major contributing cause of which is demonstrated to be by a preponderance of the evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, *unless the employer permitted, encouraged or had actual knowledge of such consumption.*" (emphasis added).

Therefore, to defeat a finding of compensability, the employer must prove, by a preponderance of the evidence, that consumption of alcoholic beverages was the major contributing cause of the injury. However, by its terms, the statute provides a mechanism by which the "alcohol defense" can be negated if the employer "permitted, encouraged, or had actual knowledge" of claimant's alcohol consumption.

Focusing on the language "unless the employer permitted, encouraged or had actual knowledge of such consumption," I observe that the statute is phrased in the disjunctive. Thus, meeting any one of the listed requirements is sufficient to negate the alcohol defense. *See Tony D. Houck*, 48 Van Natta 2443 (1996), *aff'd mem Atlas Bolt & Screw v. Houck*, 151 Or App 200 (1997) (construing a different statute whose requirements were stated in the disjunctive). Accordingly, if the employer in this case either permitted, encouraged *or* had actual knowledge of claimant's alcohol consumption, then regardless of whether consumption of alcohol was the major factor in his injury, the "alcohol defense" fails and claimant's injury is compensable.[1]

Claimant testified that he consumed approximately 12 beers the evening of June 27, 2000. (Tr. 11). His injury occurred around 5:30 a.m. on June 28, 2000. The employer testified that he observed claimant drink at least 4 beers. (Tr. 34). The employer further testified that he purchased beer for employees at dinner on the evening of the 27th. (Tr. 43). The employer testified that he bought claimant and other employees two beers each at dinner and observed claimant and other employees consume beer at a hotel swimming pool after dinner. (Trs. 34, 43). In addition, although the employer observed claimant and other employees drinking, he never instructed them to limit or terminate their alcohol consumption.[2]

The majority construes ORS 656.005(7)(b)(C) to mean that the employer must permit encourage, permit or have actual knowledge of the consumption of alcohol that constitutes the major contributing cause of the injury. It cites evidence that the employer was aware of four of the approximately 12 beers that claimant consumed, as well as evidence from Dr. Jacobsen that the alcohol consumption of which the employer was *aware* would not have resulted in any alcohol in claimant's blood at the time of the accident. (Ex. 32-7). Therefore, the majority reasons that the alcohol consumption of which the employer had direct knowledge was not the major contributing cause of claimant's injury. From this, the majority finds that SAIF's "alcohol defense" is not negated by the final clause of ORS 656.005(7)(b)(C).

I believe that the majority too narrowly construes the statutory language to deny this claimant compensation for a serious injury that was obviously work related. I do not disagree with the majority that it appears that the employer did not have direct knowledge of the entire extent of claimant's drinking. The employer did, however, have knowledge of a substantial portion (one-third) of claimant's alcohol consumption. Moreover, the majority's focus on the employer's awareness (*i.e.*, knowledge) of claimant's alcohol consumption gives short shrift to the rest of the statutory language.

As previously noted, not only will employer knowledge negate the alcohol defense, but also employer permission "or" encouragement. Therefore, even assuming that the majority is correct that employer knowledge is limited to only that alcohol consumption of which it is aware, I still believe that the other statutory elements (permission and encouragement of the alcohol consumption that was the major contributing cause of the accident) were satisfied in this case.

The employer admitted to observing claimant drinking four beers at dinner and at a hotel swimming pool the evening before the injury. The employer's further admission that he even purchased alcohol for claimant leads me to conclude that the employer at the very least "encouraged" alcohol consumption during the period of dinner and afterward.[3] Moreover, the employer's purchase of beer for claimant and his observation of alcohol consumption indicate to me that the employer permitted alcohol consumption.

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[1] I note that there is no dispute that claimant's injury otherwise arose out of and in the course of employment.

[2] The employer testified, however, that he would not allow anyone under the influence of drugs or alcohol to work and that they would lose their job. (Tr. 47).

[3] If we accept Dr. Jacobsen's opinion, substantial drinking must have occurred after claimant left the swimming pool area and before the accident. (Ex. 32-7).

Accordingly, based on the above analysis, I would conclude that, even assuming that the employer "knowledge" portion of the statute was not satisfied, the employer "encouraged or permitted" the alcohol consumption that caused claimant's injury. I see nothing in the statute that necessarily limits employer encouragement or permission of alcohol consumption to only that consumption of which the employer was directly aware. Indeed, if, as the majority suggests, all that matters is employer knowledge, then why did the legislature see fit to include the words "permitted" or "encouraged?"

The majority writes that my interpretation of the statute is unduly harsh, creating a "zero" tolerance policy and precluding a finder of fact from considering the fact that the employer was not aware of the allegedly large amount of alcohol that claimant consumed on his own. I am not persuaded by such allegations.

My interpretation of the statute would allow consideration of evidence of the employer's knowledge of the extent of a claimant's drinking. On the other hand, the majority's decision in this case gives little or no consideration to the entire statutory language contained in ORS 656.005(7)(b)(C). As for the majority's "zero tolerance" concerns, interpreting the statute in the manner in which I advocate does not preclude modest alcohol consumption on the job or mean that employer encouragement, permission or knowledge of *any* consumption of alcohol negates an alcohol defense.

Cases arising under ORS 656.005(7)(b)(C) must be evaluated on their own individual facts. In this instance, we are confronted with a situation in which the employer and two crew members (including claimant) were traveling employees engaged in an extremely dangerous occupation (logging). Indeed the majority cites evidence from the record indicating that the employer impressed upon his employees the dangers of their task. (Tr. 8). Yet, knowing full well just how dangerous an occupation logging is and aware that his employees would need to awaken early the next morning to engage in dangerous work activity, the employer purchased alcohol for his crew and observed significant drinking. The employer was aware of claimant's tendency to drink[4], yet he went ahead and permitted and encouraged alcohol consumption under these circumstances. It is, therefore, the majority's decision that creates the "unduly harsh" result in this case by denying claimant compensation for an otherwise compensable injury.

In conclusion, under the circumstances of this case, I would find that the employer permitted or encouraged the alcohol consumption that Dr. Jacobsen opined was the major contributing cause of claimant's accident. Thus, I would conclude that SAIF's alcohol defense is negated under the provisions of ORS 656.005(7)(b)(C). Therefore, I dissent.

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[4] The employer testified that "I know they [the crew] drank beer all the time." (Tr. 47). Granted, the employer further testified that he could not control what his workers did at home and that he would not allow anyone under the influence of alcohol to work. *Id.* However, despite the employer's attempt to show that he controlled his employees at work, the employer could reasonably have assumed that purchasing alcohol for claimant and observing substantial drinking without comment would likely have encouraged additional drinking outside his presence, given his crew's propensity for such conduct.

December 17, 2001 Cite as 53 Van Natta 1619 (2001)

In the Matter of the Compensation of
ANITA DIAZ, Claimant
WCB Case Nos. 00-04188 & 00-01243
ORDER DENYING RECONSIDERATION
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant, *pro se*, requests reconsideration of our November 7, 2001 order that affirmed an Administrative Law Judge's (ALJ's) order that: (1) affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for claimant's lumbar strain condition; and (2) upheld the insurer's denial of claimant's claims for L3-4 and L5-S1 disc bulges, cervical and thoracic sprain/strains, right shoulder post traumatic arthropathy, and mild right temporomandibular joint syndrome. Because we find that our prior order has become final, we lack authority to reconsider our November 7, 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 November 7, 2001 Order on Review was December 7, 2001.

On December 10, 2001, the Board received a copy of a letter which addressed our November 7, 2001 order. We treat such a submission as a request for reconsideration of our decision.

Because our November 7, 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.

In the Matter of the Compensation of
MARTHA NAVARRO, Claimant
WCB Case No. 01-00988
ORDER ON REVIEW
Coughlin, Leuenberger & Moon, Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that affirmed an Order on Reconsideration awarding 34 percent (108.8 degrees) unscheduled permanent disability for a low back condition. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

Before the insurer issued its Notice of Closure, the employer informed the insurer that claimant had "an open spot to return to for [*sic*] work * * * since her date of injury." (Ex. 30). As of her examination with the medical arbiter, claimant had not returned to work. (Ex. 36-3).

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a disc herniation. (Ex. 32). A Notice of Closure, in part, awarded unscheduled permanent disability based only on impairment after noting that claimant had been released to regular work. (Ex. 33-2). The Order on Reconsideration applied non-impairment factors and increased claimant's unscheduled permanent disability from 15 percent to 34 percent. In particular, the Order on Reconsideration based its application of the factors on the DOT category for "Harvest worker, vegetable."

The insurer requested a hearing, arguing that, because claimant was released for regular work, the Notice of Closure correctly awarded unscheduled permanent disability based only on impairment. The ALJ found that the DOT category of "Harvest worker, vegetable," was the "closest compilation of claimant's job duties" and that, based on the medical arbiter's limitations, claimant was not released to her regular work. Thus, the ALJ affirmed the Order on Reconsideration.

On review, the insurer continues to assert that claimant was released to her regular work. Specifically, rather than the DOT category of "Harvest worker, vegetable," the insurer argues that the record shows that claimant worked as a "picker" and that her treating physician released her to this job.

Impairment is the only factor considered in determining unscheduled permanent disability if: the worker returned to regular work; the attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or the attending physician releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury. ORS 656.726(4)(f)(D). "Regular work" means "the job the claimant was doing at the time of injury or employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." OAR 436-035-0005(17)(c).

In applying this statute and rule, we compare claimant's particular job duties at the time of injury with the job duties the worker is performing at the time of evaluation. *E.g., James I. Dorman*, 50 Van Natta 1773, 1774 (1998). In this regard, the DOT category may be relevant if it is consistent with the job held at the time of injury and reflect the "nature, duties, responsibilities, knowledge, skills and abilities" of claimant's regular work. *Id.*

Here, the record shows that claimant picked mushrooms and placed them in a box; she then lifted the boxes and carried them more than 100 feet. (Exs. 4, 9). Claimant was injured while carrying 20 pounds, or two boxes of mushrooms. (Ex. 6-1). A "Work/Educational History" form shows that claimant lifted at least 10 pounds, but is illegible concerning the maximum weight lifted. (Ex. 9-1).[1]

A "Job Analysis" indicated that the job required continuous lifting of one toten pounds, but no lifting over that amount or any requirement to carry objects. (Ex. 15).

Claimant's treating physician, Dr. Weiss, released claimant to "medium work which is 50 lbs occasionally, 25 lbs frequently, avoidance of torquing of lumbar spine (allowance for ad lib position change)," further noting that, if claimant's "regular job meets those limitations, she can be released to that." (Ex. 25-1). After reviewing a job description, Dr. Weiss reported that the job "appears to meet the restrictions for [claimant], except for allowance for ad lib position change with requirement for prolonged standing. If she can be provided with a stool or some ability to sit down on an prn basis, she would be allowed to return to this job as described." (Ex. 26-1).

Dr. Weiss later reported that claimant's "job title as picker, which requires lifting no more than 10 lbs continuously with only occasional bending and twisting" was a "light to medium job description and should be within [claimant's] capacity." (Ex. 29). The employer then informed the insurer that the "picker" job remained available and allowed claimant to "change position as often as needed to maintain comfortable ergonomics." (Ex. 30).

Based on this evidence, we find that claimant was not released to her "regular work." *See* OAR 436-035-0005(17)(c). Dr. Weiss specifically released claimant based on a job description that stated that claimant's work as a picker required no lifting over 10 pounds and no carrying. The record, however, shows that claimant lifted more than 10 pounds and carried objects when she performed her "at injury" job as a picker. Although Dr. Weiss' general release to medium work may be compatible with the regular work of a "picker," Dr. Weiss' specific release was based on a job description that did not accurately describe claimant's "regular work" as a picker. Thus, we conclude that claimant was not released to "regular work." *See* OAR 436-035-0005(17)(c). Accordingly, we agree with the ALJ that unscheduled permanent disability should not only be based on impairment, but on social/vocational factors as well.

The insurer does not dispute, and we agree with, the remaining portion of the ALJ's order concerning the non-impairment factors and the calculation of those factors as resulting in 34 percent unscheduled permanent disability. Thus, we adopt that portion of the ALJ's order.

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[1] SAIF alleges that the figure is 20 pounds, while the ALJ interpreted it as 35 pounds. We decline to resolve this discrepancy because our decision is not dependent on this matter.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, 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 June 14, 2001 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
WALTER SCHWAB, Claimant
WCB Case No. 00-08585
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
Bostwick, et al., Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its *de facto* denial of claimant's occupational disease claim for a pulmonary condition; and (2) assessed a penalty for an allegedly unreasonable denial under ORS 656.262(11)(a). On review, the issues are compensability and penalties.

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

Claimant, a community college ceramics instructor, works around clay dust which he alleged caused his pulmonary conditions. The ALJ set aside the employer's *de facto* denial of claimant's claim for chronic obstructive pulmonary disease and chronic bronchitis based on the opinion of his treating physician, Dr. Riddick.

On review, the employer contends that Dr. Riddick's opinion is unpersuasive. Specifically, the employer contends that Dr. Riddick's opinion does not meet claimant's burden of proof because it did not address all potentially relevant factors, specifically claimant's off-work exposure to clay dust. *See Dietz v. Ramuda,* 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995) (determination of major contributing cause involves evaluation of the different causes of claimant's disease and deciding which is the primary cause).[1] We disagree.

No physician, including Dr. Burton (who performed an insurer-arranged examination (IME)), has implicated claimant's off-work dust exposure as a factor causative of claimant's pulmonary condition. Accordingly, even assuming that Dr. Riddick did not consider claimant's off-work exposure,[2] we decline to find Dr. Riddick's opinion deficient in that regard. *See Yolanda Enriquez,* 50 Van Natta 1507 (1998) (Board declined to find physician's opinion deficient under *Dietz v. Ramuda* where no other medical opinion identified off-work factors as a potential cause of the claimant's condition).

Next, the employer contends that Dr. Riddick did not consider the fact that claimant wore a respirator while working with potentially causative glazing materials at work, and that claimant's exposure was only "theoretic," not actual. However, as the ALJ stated, claimant testified that he did *not* always use a respirator at work, especially when he was not personally mixing a glaze. (Tr. 8, 9, 11). Therefore, we conclude that claimant was actually exposed to clay dust at work.

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[1] The parties agree that this is an occupational disease claim, subject to the "major contributing cause" standard of ORS 656.802(2)(a).

[2] In this regard, Dr. Riddick reviewed Dr. Burton's extensive report which noted claimant's off-work exposure to clay dust and then recited that he had considered the relative contribution of different causes before rendering his final opinion on causation. (Exs. 19, 20, 21, 25-1).

Finally, the employer offers no argument as to why a penalty should not have been assessed, independent of its compensability argument. Consequently, we affirm the ALJ's assessment of a penalty under ORS 656.262(11)(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 regarding the compensability issue is $1,350, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and claimant's attorney's uncontested attorney fee request), the complexity of the issue, and the value of the interest involved. Claimant's counsel is not entitled to an attorney fee for services on review 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 3, 2001 is affirmed. For services on review, claimant's attorney is awarded $1,350, payable by the self-insured employer.

December 17, 2001 Cite as 53 Van Natta 1623 (2001)

In the Matter of the Compensation of
THOMAS R. SLEDD, Claimant
WCB Case No. 96-06662
ORDER ON REMAND
Flaxel & Nylander, Claimant Attorney
David Runner (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Bock.

This matter is before the Board on remand from the Court of Appeals. *SAIF Corporation v. Sledd*, 162 Or App 295 (1999). The court reversed our prior order that adopted and affirmed an Administrative Law Judge's (ALJ's) order that awarded temporary disability benefits from July 7, 1993 to November 28, 1995. In our prior order, we adopted the ALJ's conclusion that the lack of a contemporaneous authorization of time loss from claimant's attending physician (as required by *former* ORS 656.262(4)(f), now subsection (g)), did not preclude his entitlement to "substantive" temporary disability following the closure of his claim. Citing *Fred Meyer, Inc. v. Bundy*, 159 Or App 44 (1999), the court has remanded for reconsideration.

The court, *en banc*, in *Bundy* reversed our decision in *Kenneth P. Bundy*, 48 Van Natta 2501 (1996) that had held that the 14-day statutory limitation on "retroactive" temporary disability authorization from an attending physician (as prescribed in *former* ORS 656262(4)(f), now subsection (g)) was not applicable because the claim had been closed. After reviewing the legislative history in light of the text and context of the applicable statutes, the court concluded that the reference in ORS 656.262(4) to ORS 656.268 was intended to limit the award of retroactive time loss to 14 days, regardless of whether the claim was open or was pending closure. The Supreme Court has reached that same conclusion, reasoning that the statutory scheme makes no distinction between a pending claim and a closed claim respecting retroactive compensation. *Menasha Corporation v. Crawford*, 332 Or 404 (2001).

Here, the record contains no contemporaneous temporary disability authorization from an attending physician for the time period from July 7, 1993 to November 28, 1995. Claimant was not seen by Dr. Davis, the attending physician, from July 7, 1993 until October 30, 1995. (Exs. 17 & 18). Claimant's work status during the disputed period was not addressed by Dr. Davis until February 29, 1996. (Ex. 21).

Because *former* ORS 656.262(4)(f) limited a retroactive award of temporary disability to 14 days, it follows that Dr. Davis' February 29, 1996 letter is insufficient to authorize temporary disability during the disputed period. Therefore, claimant has not established entitlement to temporary disability benefits between July 7, 1993 to November 28, 1995. *See Linda K. Holcomb*, 51 Van Natta 933 (1999).

Accordingly, on reconsideration, the ALJ's "substantive" award of temporary disability from July 7, 1993 to November 28, 1995, as well as the ALJ's "out-of-compensation" attorney fee award from these temporary disability benefits, are reversed. The award of temporary disability in the March 6, 1996 Notice of Closure (as affirmed by the July 9, 1996 Order on Reconsideration) is affirmed.[1] The ALJ's March 12, 1997 order is otherwise affirmed.

IT IS SO ORDERED.

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[1] Because claimant's temporary disability award (as granted by the ALJ's order) has ultimately been reduced as a result of the SAIF Corporation's request for Board review, our previous attorney fee award under ORS 656.382(2) is rescinded.

In the Matter of the Compensation of
ROBERT RICE, Claimant
Own Motion No. 01-0277M
OWN MOTION ORDER ON RECONSIDERATION
Bischoff, Strooband & Ousey, Claimant Attorney
Kemper Ins. Co., Insurance Carrier

Reviewing Panel: Members Haynes and Biehl.

On November 16, 2001, we withdrew our October 24, 2001 Own Motion Order in which we authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant is hospitalized for surgery. Specifically, claimant seeks an assessed attorney fee pursuant to ORS 656.382(1).[1]

In our prior order, we noted that the insurer had not submitted its Own Motion recommendation to the Board within the 90-day period following claim filing pursuant to OAR 438-012-0030(1). Under those circumstances, we found that the insurer's failure to timely process claimant's Own Motion claim was unreasonable. As explained in our prior order, we were unable to assess a penalty under ORS 656.262(11) because there were no amounts "then due" on which to base the penalty.

Where, as here, we find that an insurer has unreasonably resisted the payment of compensation, we may award an attorney fee even in the absence of amounts of compensation "then due." *See Mark A. Vichas*, 52 Van Natta 634, 635 (2000); *Janet F. Berhorst*, 51 Van Natta 464 (1999); *Robert E. Cornett*, 45 Van Natta 1567 (1993). Consistent with these holdings, we conclude that the insurer's conduct constituted an unreasonable resistance to the payment of compensation. Consequently, we award an insurer-paid attorney fee under ORS 656.382(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 regarding this issue is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue, the complexity of the issue, the nature of the proceeding, the value of the interest involved, and the risk that claimant's attorney might go uncompensated.

Accordingly, on reconsideration, as supplemented and modified herein, we adhere to and republish our October 24, 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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[1] The insurer was allowed 14 days in which to respond to claimant's request for reconsideration. To date, we have not received a response. Inasmuch as the allotted time period for responding has expired, we have proceeded with our reconsideration.

In the Matter of the Compensation of
TERRY A. CARETTO, Claimant
WCB Case No. 00-07924
ORDER ON REVIEW
Mustafa T. Kasubhai, P.C., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

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

We adopt and affirm the ALJ's order with the following changes and supplementation.[1] In the last paragraph on page 5 continuing on page 6, we delete the last sentence.

On review, claimant argues that a material cause standard applies to the L4-5 disc injury. He contends there is no evidence to support the ALJ's finding that the L4-5 disc injury combined with any preexisting condition. We disagree.

ORS 656.005(7)(a)(B) provides that if an injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable if the work injury was the major contributing cause of the disability and/or need for treatment of the combined condition. In *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999), the court held that a "combined condition" under ORS 656.005(7)(a)(B) may constitute either an integration of two conditions or the close relationship of those conditions, without integration. In other words, in order for there to be a "combined condition," there must be two conditions that merge or exist harmoniously. *Luckhurst v. Bank of America*, 167 Or App 11 (2000).

Claimant's attending physician, Dr. Keiper, reported that claimant's MRI showed degenerative changes in the entire lumbar spine, greatest at L4-5, and the L5 vertebral body had evidence of a prior compression fracture. (Ex. 11-3). He diagnosed an L4-5 disc herniation with L4-5 stenosis and bilateral L5 radiculopathies. (*Id.*) Dr. Keiper explained that claimant had "significant pre-existing degenerative changes in the lumbar spine that predate this injury." (Ex. 11-4).

Dr. Dietrich, who examined claimant on behalf of SAIF, found that claimant had "marked" degenerative changes at L4-5, a compression fracture at L4-5 and retrolisthesis of L4 on L5 that preexisted the work injury. (Ex. 13-8). He concluded that the preexisting conditions combined with the injury to increase the disability and need for treatment. (*Id.*)

Based on the opinions of Drs. Keiper and Dietrich, we find that claimant had several conditions that "merge[d] or exist[ed] harmoniously," including degenerative changes at L4-5 and a prior compression fracture at L4-5. We agree with the ALJ that claimant had a "combined condition" and, therefore, ORS 656.005(7)(a)(B) applies.

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 and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Although work activities that precipitate a claimant's injury or disease may be the major contributing cause of the condition, that is not always the case. *Id.* The medical expert must take into account all contributing factors in order to determine their relative weight. *SAIF v. Strubel*, 161 Or App 516, 521 (1999).

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). We may give greater weight to the opinion of the treating physician, depending on the record in each case. *Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001).

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[1] The ALJ referred to the examination by Dr. Dietrich as a "CME" (compelled medical examination). For the reasons expressed in *Jamie B. Davis*, 53 Van Natta 1548 (2001), and *Laura J. Decker*, 53 Van Natta 1533 (2001), we refer to such an examination as an insurer-arranged medical examination (IME).

We first address the opinion of Dr. Dietrich, who examined claimant on behalf of SAIF. He reviewed claimant's MRI and said that the "major abnormality is at L4-5 where there is a moderate to marked spinal stenosis." (Ex. 13-6). He said the canal was triangular-shaped. (*Id.*) Dr. Dietrich explained that claimant had several preexisting conditions that resulted in his spinal stenosis,[2] including degenerative disc disease (maximum at L4-5), and degenerative retrolisthesis at L4-5, and the compression fracture at L4-5. (Ex. 13-6, -7, -8). He explained that all of those conditions contributed to the narrowing of the spinal canal at L4-5. (Ex. 13-8). Although Dr. Dietrich examined claimant before the back surgery and believed claimant had a disc rupture based on the MRI scan (Ex. 13-6, -7), he concluded that claimant's need for treatment was the spinal stenosis, which was caused in major part by the preexisting conditions. (Ex. 13-9).

Claimant relies on Dr. Keiper's opinion to establish compensability of his low back injury. For the following reasons, we agree with the ALJ that Dr. Keiper's opinion is not sufficient to sustain claimant's burden of proof.

In his initial October 19, 2000 report, Dr. Keiper diagnosed an L4-5 disc herniation with L4-5 stenosis and bilateral L5 radiculopathies. (Ex. 11-3). He said that claimant had "significant pre-existing degenerative changes in the lumbar spine that predate this injury." (Ex. 11-4). He explained:

> "The acute disc herniation which is evident on the MRI is undoubtedly a work related injury based on the patient's history and physical findings. This would be approximately 51 percent of his present need for care, the other 49 percent being due to his pre-existing degenerative changes in the L5 vertebral body and the L4-5 disc space." (*Id.*)

In a concurrence letter from claimant's attorney, Dr. Keiper agreed that the mechanism of claimant's injury was sufficient to cause a herniation. (Ex. 12-2). He agreed that, although claimant had significant degenerative changes, his lifting incident was the major cause of his condition and need for treatment. (*Id.*)

On March 29, 2001, Dr. Keiper performed a lumbar laminectomy at L4-5. (Ex. 14). His diagnosis was L4-5 lumbar stenosis. (Ex. 14-1). Dr. Keiper explained that he found no signs of herniation on either the right or left side. (Ex. 14-2). Furthermore, he found no fragments and no rent in the annulus. (*Id.*)

Although Dr. Keiper's initial diagnosis was an L4-5 disc herniation with L4-5 stenosis, his post-operative diagnosis was simply L4-5 lumbar stenosis. Dr. Keiper's October 19, 2000 opinion on causation was based on his original diagnosis of an L4-5 herniation. (Ex. 11-3). At that time, he said that the L4-5 herniation, which he said was evident on the MRI, was "approximately 51 percent of his present need for care[.]" (Ex. 11-4). Dr. Keiper opined that the MRI showed a herniation at L4-5, "which is central and to the left resulting in significant lumbar stenosis at L4-5." (Ex. 11-3). At surgery, however, Dr. Keiper reported that there was no herniation and claimant's diagnosis was simply L4-5 lumbar stenosis. He explained that there "was no sign of herniation, simply posterior bulging." (Ex. 14-2).

After performing claimant's surgery, Dr. Keiper signed a concurrence report from claimant's attorney agreeing that he had observed an L4-5 disc protrusion (bulge) posteriorly with the compression of the L5 nerve root. (Ex. 15). He had observed "the presence of osteophytic build-up around the facets which probably contributed to the stenosis." (*Id.*) Dr. Keiper agreed that his opinion on causation remained the same.

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[2] "Spinal stenosis" is defined as:

> "[N]arrowing of the vertebral canal, nerve root canals, or intervertebral foramina of the lumbar spine caused by encroachment of bone upon the space; symptoms are caused by compression of the cauda equina and include pain, paresthesias, and neurogenic claudication. The condition may be either congenital or due to spinal degeneration." *Dorland's Illustrated Medical Dictionary* 1576 (28th ed. 1994); *see SAIF v. Calder*, 157 Or App 224, 227 (1998) (Board may rely on medical dictionaries to define medical terms).

We find that Dr. Keiper's opinion on causation is not persuasive because it is contradictory and lacks adequate explanation. He initially reported that an L4-5 herniation was causing claimant's stenosis, and that the herniation was the major contributing cause of claimant's need for treatment. (Ex. 11). His surgical report, however, said there was no herniation and claimant merely had posterior bulging. (Ex. 14-2). Although Dr. Keiper said that his opinion on causation remained the same, he did not explain how the herniation could be the major cause, in light of his later surgical finding that there was no herniation. In other words, Dr. Keiper's opinion on causation is inconsistent with his own post-operative diagnosis. Dr. Keiper's own surgical report indicates that a bulge is different than a herniation. (Ex. 14). Dr. Keiper's opinion is particularly problematic in view of his own characterization of claimant's stenosis as "severe" (Ex. 14-1), and Dr. Dietrich's opinion that the primary need for claimant's treatment was the preexisting lumbar stenosis. We agree with the ALJ that the medical evidence is insufficient to establish compensability of claimant's low back injury.

ORDER

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

December 20, 2001 Cite as 53 Van Natta 1627 (2001)

In the Matter of the Compensation of
JEFF C. TUNEM, Claimant
WCB Case No. C012871
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Swanson, et al., Claimant Attorney
David L. Bussman, Defense Attorney

Reviewing Panel: Board Members Biehl and Haynes.

On December 3, 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. We approve the proposed disposition.

On page 2, the indicates that the accepted conditions subject to the CDA are "herniated intervertebral discs at L4-5 and L5-S1, along with a psychological depression ordered accepted by ALJ John Mark Mills in WCB Case # 93-10835, *but never formally accepted by the insurer until this Claim disposition Agreement*. No other compensable condition exists with respect to this injury." (Emphasis supplied).

It is well settled that CDAs are not designed for purposes of claim processing. *See, e.g., Kenneth D. Chalk*, 48 Van Natta 1874 (1996); *Kenneth R. Free*, 47 Van Natta 1537 (1995). Here, however, we do not interpret the CDA as accomplishing a claim processing function. Rather, we interpret the CDA as referring to an ALJ's order that found claimant's depression condition compensable. We treat the aforementioned language in the CDA as an acknowledgment of the accepted depression condition.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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
VINITA J. BUTLER, Claimant
WCB Case No. 01-00153
ORDER ON REVIEW
Kryger, et al., Claimant Attorney
Johnson, Nyburg & Andersen, Defense Attorney

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

The insurer requests review of Administrative Law Judge (ALJ) Spangler's order that set aside its denial of claimant's bilateral upper extremity conditions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," with the exception of his finding that claimant washed dishes five to six hours a day. We do not adopt the ALJ's "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial of claimant's multiple bilateral upper extremity conditions (stenosing tenosynovitis in her right ring and left middle fingers, bilateral carpal tunnel syndrome, and bilateral epicondylitis). In so doing, the ALJ found the medical opinions of Drs. Mills and Vela, who opined that claimant's work activities were the major causal factor in claimant's bilateral upper extremity conditions, more persuasive than that of an examining physician, Dr. Nolan. Dr. Nolan opined that claimant's diabetes, obesity and age were the major contributing cause of the disputed conditions. Although at one point Drs. Mills and Vela had concurred with the "findings" in Dr. Nolan's report, the ALJ did not find that this detracted from the persuasiveness of their opinions because he determined that those physicians could agree with examination "findings," while disagreeing with conclusions concerning causation.

On review, the insurer contends that the record does not support the ALJ's conclusion that Drs. Mills' and Vela's concurrences with Dr. Nolan's report were limited. The insurer asserts that those physicians' concurrences were with Dr. Nolan's entire report, including conclusions regarding causation. Because Drs. Mills and Vela never explained the inconsistency between their concurrence with Dr. Nolan's report and their reports supporting compensability, the insurer argues that their opinions are not persuasive and, therefore, cannot satisfy claimant's burden of proof. We agree.

In *Gary A. Tebbetts*, 52 Van Natta 307 (2000), we addressed the issue of the scope of a concurrence report under very similar circumstances. In that case, a physician, Dr. Liu, reviewed the report of an examining physician, Dr. Strum, and concurred with his findings. Dr. Strum had reported that the major contributing cause of the need for surgery was the claimant's multiple-level degenerative disc disease. The claimant contended that Dr. Liu's concurrence with Dr. Strum's report was limited in scope because Dr. Liu was not directed to Dr. Strum's opinion concerning causation, but was expressly directed to Dr. Strum's "findings." The claimant argued that if the insurer had intended to obtain Dr. Liu's opinion concerning Dr. Strum's causation opinion, it should have asked him that particular question.

We noted that the insurer had asked Dr. Liu to review Dr. Strum's June 17, 1999 report "in order to let [it] know whether you concur with Dr. Strum's findings." If Dr. Liu did not concur with the report, he was asked to provide a narrative report detailing "those areas" in which he disagreed. We declined to read Dr. Liu's concurrence letter as narrowly as the claimant urged. We noted that Dr. Strum's report did not include a specific section of his report referring to "Findings" and that his clinical findings were in a section called "Physical Examination." We found no basis in Dr. Liu's concurrence letter to infer that he was only concurring with Dr. Strum's physical examination findings.

Instead, we found it more likely that Dr. Liu was concurring with Dr. Strum's general "findings," which included his discussion regarding causation. We then concluded that Dr. Liu's concurrence with Dr. Strum's opinion did not support compensability and was inconsistent with Dr. Liu's other report. At a minimum, we found that Dr. Liu's final opinion was unclear and was, therefore, unpersuasive. 52 Van Natta at 309.

In this case, the circumstances are strikingly similar to those in *Tebbetts*. Both Dr. Mills and Dr. Vela have opined that claimant's work activities are the major contributing cause of claimant's conditions. However, both doctors concurred with the "findings" in the report of Dr. Nolan, the examining physician. (Exs. 16, 17). Like Dr. Strum's report in *Tebbetts*, Dr. Nolan's report in this case also did not contain a specific section entitled "Findings." Dr. Nolan's clinical findings, like Dr. Strum's, were also contained in a section called "Physical Examination." (Ex. 12-3). Just as in *Tebbetts*, we also find no basis in the Mills and Vela concurrence letters to infer that they were only concurring with Dr. Nolan's physical examination findings. In fact, both Dr. Vela and Dr. Mills were given the opportunity to provide specific details regarding those findings *and* "conclusions" with which they did not concur. Neither physician responded.

Accordingly, in accordance with our reasoning in *Tebbetts*, we conclude that both Dr. Mills and Dr. Vela were concurring with Dr. Nolan's general "findings," which included his discussion regarding causation. We, thus, conclude that Dr. Mills' and Dr. Vela's concurrences with Dr. Nolan's opinion do not support compensability and were inconsistent with their other reports in which they supported compensability. At a minimum, we find the medical opinions of Drs. Mills and Vela are unclear and, therefore, unpersuasive.[1]

Because Dr. Nolan's opinion does not support compensability, and because Drs. Vela's and Mills' opinions are not persuasive, we disagree with the ALJ's decision setting aside the insurer's denial. Therefore, we reverse.

ORDER

The ALJ's order dated May 1, 2001 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] Alternatively, even if we construed the Mills and Vela concurrences as narrowly as the ALJ did, we would still find those medical opinions unpersuasive for lack of an accurate medical history. *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). Both physicians received a history that claimant washed dishes for five to six hours, gripping and handling plates. However, claimant testified to more varied work activity and to working between three and four hours bussing tables and washing dishes. (Trs. 12, 29).

Board Member Phillips Polich dissenting.

The majority reverses the ALJ's decision and finds that claimant's bilateral upper extremity conditions are not compensable. In so doing, it relies on our decision in *Gary A. Tebbetts*, 52 Van Natta 307 (2000). Because I would not find *Tebbetts* controlling, and, further, because I would find the opinion of the examining physician, Dr. Nolan, unpersuasive, I would reach a different conclusion from the majority. For these reasons, I dissent.

In *Tebbetts*, we interpreted a treating physician's concurrence with the "findings" contained in the report of an examining physician as including agreement with that physician's discussion of causation. Notwithstanding that holding, I would not apply that reasoning in this case. Here, we have a claimant who began work for the employer in July 1999 with no prior history of upper extremity problems. As a result of her repetitive work activities washing dishes and busing tables, she developed symptoms in her right hand in October 1999. Although she was eventually forced to seek medical attention, she continued to work. Her condition gradually deteriorated and eventually her symptoms spread to both hands and became severe. Claimant tried to continue working, but her condition worsened with her efforts to return to work.

Having reviewed the record in this case, I do not find the circumstances of this case similar to those in *Tebbetts* and would, therefore, not use that case to deny this claimant compensation for her work related bilateral upper extremity conditions. Moreover, I do not find persuasive the opinion of the examining physician, Dr. Nolan, who does not support compensability.

Dr. Nolan attributes claimant's conditions to diabetes, obesity and advancing age. (Ex. 12-6). However, Dr. Nolan relies on general "epidemiological" studies to support his contention that those factors caused claimant's bilateral upper extremity problems. *Id.* It is well settled that such reliance on statistical analysis, rather than on an analysis applied specifically to claimant, is not persuasive. *See Shannon L. Mathews*, 48 Van Natta 1839, 1840 (1996), *aff'd mem* 148 Or App 635 (1997); *Allen B. White, Sr.*, 46 Van Natta 1779, 1780 (1995).

In addition, Dr. Nolan's opinion is not persuasive since he did not have as complete a history as Drs. Mills and Vela, who support compensability. The extent of Dr. Nolan's history is that claimant was "essentially a kitchen worker, washing dishes, sweeping, mopping, etc." (Ex. 12-2). However, in contrast to that minimal understanding of the nature of claimant's duties, Drs. Vela and Mills correctly understood the rapid nature of claimant's work activities, as well as the duration involved. Their history included an understanding of the specific hand activities that claimant performed, including gripping and pinching. (Exs. 18, 19).

For these reasons, I would affirm the ALJ's determination that claimant satisfied her burden of proof. Despite some superficial similarities between this case and *Tebbetts*, I would also not find that case controlling. Because the majority reaches the opposite conclusion, I dissent.

In the Matter of the Compensation of
PAUL P. PLUIMER, Claimant
Own Motion No. 66-0045M
OWN MOTION ORDER
Malagon, Moore, et al., Claimant Attorney
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The SAIF Corporation submitted claimant's request for medical services that claimant contends are related to his compensable September 13, 1955 back injury claim, which resulted in paraplegia. These medical services consist of a May 25, 2001 surgery for a paraesophageal hernia with Nissan fundoplication. SAIF requests reopening claimant's claim under our Own Motion jurisdiction to provide reimbursement for a medical file review to assist in determining the compensability of requested medical services as they relate to his compensable September 1955 injury.

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

In addition, we have authorized reopening pre-1966 injury claims for carriers to obtain medical reports regarding the compensability of medical services in relation to the compensable injury. *Carl Hight*, 44 Van Natta 224 (1992) (relying on *Brooks v. D&R Timber*, 55 Or App 688 (1982), which held that diagnostic medical services are compensable when the services are reasonable and necessary in order to establish a causal relationship between the compensable condition and the current condition, Board found that a carrier-requested medical report regarding compensability of pre-1966 claim qualified as compensation under ORS 656.005(8) and ORS 656.625, and authorized reopening the Own Motion claim for reimbursement of such a medical report); *Cordy A. Brickey*, 44 Van Natta 220 (1992) (same). In keeping with our holdings in *Hight* and *Brickey*, we find that the requested medical file review is reasonable and necessary and is justified by special circumstances. *Harold L. Avery*, 52 Van Natta 1611 (2000); *Ralph H. Tew*, 52 Van Natta 423 (2000).

Therefore, we authorize SAIF's request for reimbursement for the costs of a medical file review. After it obtains the medical file review, SAIF is directed to supplement the record with a copy of the report as well as its Own Motion recommendation regarding the requested medical services.

This order shall supplement our February 23, 1993 and April 27, 2000 orders that previously reopened claimant's 1955 claim for the payment of ongoing medical care. 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
DENISE L. DUNLAP, Claimant
WCB Case No. 01-00539
ORDER ON REVIEW
Bradley P. Avakian, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

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

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's occupational disease claim for a thoracic spine condition. On review, the issue is compensability.

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

Claimant has been a school bus driver with this employer for approximately 21 years. (Tr. 11; 12). Claimant drives two shifts a day. (Tr. 19). In each shift, she makes between 68 and 70 stops for the purpose of taking on or letting off passengers. (Tr. 18; 38). At each of these stops, claimant is required to put the bus in neutral and apply the brake. (Tr. 15; 18).

On the first day of the 2000 school year, claimant began driving a different type of bus. (Tr. 22). In this bus, the driver's seat is 4 inches further from the bus floor, than the bus claimant had driven in the past. (Tr. 13). As a result, claimant had to bend and twist in order to put the bus in neutral. (Tr. 13; 15-17).

In mid-October 2000, claimant began experiencing pain in her low back. (Ex.3-1; Tr. 22). On October 24, 2000, claimant was seen by Dr. Adams, who took claimant off work through October 31, 2000. (Ex. 2). Claimant's pain level improved. (Ex. 8). On November 2, 2000, claimed filed a claim for her back problem.

The insurer denied the claim. (Ex. 12). Claimant requested a hearing.

The ALJ relied on the opinion of Dr. Karty (treating physician), and concluded that claimant had established the compensability of her thoracic strain. Consequently, the ALJ set aside the denial.

Claimant must prove that her work activities are the major contributing cause of her occupational disease claim. 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 possible alternative causes for her thoracic strain 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. Karty saw claimant on four occasions for her thoracic strain condition. (Exs. 10; 11; 14; 15; 16; 17; 18; 19). Additionally, Dr. Karty has previously treated claimant for an unrelated left elbow epicondylitis condition. (Exs. 11-1; 15-1). Dr. Karty opined that claimant's condition was greater than 50 percent the result of her work exposure. (Ex. 10). Dr. Karty explained that in order to put the bus in neutral at each stop, claimant had to repetitively bend forward and twist her torso, thereby causing the pain and thoracic findings he noted on examination. (Ex. 20).

Dr. Adams, in contrast to Dr. Karty, saw claimant on one occasion, to provide treatment on November 2, 2000.[1] (Ex. 8). Unlike Dr. Karty, Dr. Adams opined that because claimant could not identify a specific bus driving injury, and because she also works around her farm tossing bales of hay, it was impossible to identify the bus driving activities as the major cause of claimant's thoracic strain. (Exs. 8-2; 21-2).

Although Dr. Adams saw claimant for the thoracic strain condition one week before Dr. Karty did, because Dr. Karty had previously treated claimant for an unrelated epicondylitis condition (before the onset of her thoracic sprain condition), we find that Dr. Karty is more familiar with claimant than is Dr. Adams, and as such, is in a more advantageous position to render a causation opinion. *See Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). In light of these circumstances, we find Dr. Karty's opinion more persuasive than Dr. Adams' opinion.[2] Finding no persuasive reason to do otherwise, we defer to Dr. Karty's opinion as the attending physician. *See Weiland v. SAIF*, 64 Or App 810 (1983).

The insurer asserts that Dr. Karty was unaware of claimant's farm work, and thus argues that Dr. Karty did not have the opportunity to consider the possible effects of such work on claimant's back condition. Dr. Karty does not expressly address claimant's off-work farming activities. Nonetheless, based on the following reasoning, we conclude that he was aware of those activities and considered them in rendering his causation opinion.

We previously noted that both Dr. Adams and Dr. Karty are in the same clinic. Additionally, we note that the reference to claimant's farm work (as recorded by Dr. Adams) is written in the clinic's chart notes. (Ex. 8-1). We further note that in Dr. Karty's chart notes, he specifically referenced Dr. Adams' chart note regarding Dr. Adams' authorizations for physical therapy and medication. (Ex. 11-2). Consequently, we conclude that Dr. Karty was aware of the contents of Dr. Adams' chart note, including the reference to farm work. Accordingly, we reject the insurer's argument.

The insurer asserts that Dr. Karty did not have an accurate understanding of the physical requirements of claimant's job. In particular, the insurer argues that Dr. Karty mistakenly believed that claimant not only had to place the bus in neutral, but also had to engage the "parking brake" (as opposed to the normal brake pedal) at each student stop. In his initial chart note, Dr. Karty did record such a history. (Ex.11-2). Nonetheless, in a later chart note, Dr. Karty does not describe the "braking" activity as involving the "parking brake." (Ex. 15-2). Furthermore, in late December 2000, Dr. Karty reported that claimant was able to work without problems if she avoided putting the bus in neutral at each stop. (Ex. 17-2). Consequently, we are not persuaded that Dr. Karty's opinion rests on a mistaken understanding of the physical requirements of claimant's job.

Finally, the insurer contends that because the ergonomic evaluation is not personal to claimant, and not prepared by a "ergonomic" expert, the evaluation should not be given any weight. Because we find that, even without the ergonomic evaluation, Dr. Karty's opinion is more persuasive than Dr. Adams' opinion (based on his familiarity with claimant), we do not address this argument.

In conclusion, we agree with the ALJ that claimant has established the compensability of her thoracic sprain condition.

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[1] Both doctors are in the same clinic.

[2] The insurer contends that Dr. Karty's opinion rests on a mistaken belief that claimant had a similar prior condition. The basis for this assertion is Dr. Karty's closing evaluation (Exhibit 19-2), in which he wrote: "She has had previous problems in reference to the shoulder, upper thoracic spine, extensive occupational/physical therapy and has continued to do the exercises." First, claimant testified that she had not had previous back problems. (Tr. 23). Next, the medical record does not contain any other reference to a prior thoracic problem. Finally, in his earlier chart notes, when describing the unrelated condition for which he treated claimant, Dr. Karty used the terms "left elbow and left epicondylitis" and "arm and elbow;" he did not mention claimant's back. (Exs. 11-1; 15-1). Under these circumstances, we are not persuaded that Dr. Karty mistakenly believed that claimant had a thoracic spine problem that predated the onset of her October 2000 problem. Consequently, we reject the insurer's argument.

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.

ORDER

The ALJ's order dated June 7, 2001 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

Board Member Haynes dissenting.

I disagree with the majority's conclusion that claimant has established the compensability of her thoracic spine condition. In particular, because of alternative causative contributions from claimant's very active life style, the questions surrounding the existence of a similar preexisting condition, and defects in Dr. Karty's opinion, I find that claimant has not met her burden of proof. Therefore, I respectfully dissent.

Unlike the majority, I do not conclude that Dr. Karty's prior treatment of claimant places him in an advantageous position to provide a causation opinion. As a general rule, such an opportunity can place a physician in an advantageous to offer an opinion. *See Kienow's Food Stores v. Lyster*, 70 Or App 416 (1986). Here, however, the record contains very little, if any, information regarding either the time frame and duration of the prior treatment, or the condition treated. Without such information, it is impossible to conclude that Dr. Karty's prior observations of claimant places him in an advantageous position to render a causation opinion regarding the current condition now in dispute. Moreover, even if I were to assume that Dr. Karty's opinion is entitled to some deference, for the reasons explained below, I find his opinion unpersuasive and insufficient to meet claimant's burden of proof.

First, it is not at all clear that Dr. Karty knew of claimant's farm work. If he did, he did not discuss that activity in rendering his opinion on causation. Claimant testified that she lives on an 80 acre farm, and does farm work (consisting of feeding chickens and sheep, including lifting 50 pound bales of hay) "all the time." (Tr. 20-21; 32). Dr. Adams' opinion established that claimant's farm work is a possible cause of claimant's thoracic spine condition. Logically, claimant's farm work appears to be a bigger contributor to her thoracic spine condition than her bus driving activities (having to bend forward a few more inches than normal at each stop). Because Dr. Karty's opinion does not evaluate the relative contributions of the farm work and the bus driving activities in producing the thoracic spine condition, his opinion is insufficient to meet claimant's burden of proof. *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

Additionally, Dr. Karty did not have a full understanding of the physical nature of claimant's bus driving activities. Claimant testified that at each student stop, she was required to place the bus in neutral and place her foot on the brake. (Tr. 15). Nonetheless, according to his chart notes, Dr. Karty was under the mistaken belief that claimant had to engage the parking brake at each passenger stop. (Ex. 11-2). Because Dr. Karty's opinion is based upon incomplete information, it is not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

Finally, there is a substantial question about whether claimant had a similar preexisting medical problem. Claimant testified that she had a previous tendinitis problem with her left arm, but no previous back problems. (Tr. 23-24). Dr. Karty's chart notes, however, refer to claimant's prior medical problem as both a left elbow problem and as a "shoulder, upper thoracic spine" problem. (Ex. 11-1; 19-2). Dr. Karty does not otherwise explain the nature of claimant's preexisting problem, nor does he explain the relative contribution of that problem (if any) to claimant's current thoracic spine condition. Consequently, insofar as claimant's preexisting medical condition is concerned, Dr. Karty's opinion is insufficient to establish the compensability of claimant's "current" thoracic spine condition.

Claimant has the burden to prove the compensability of her thoracic spine condition. ORS 656.266. Here, there are too many unanswered questions regarding the major cause of claimant's thoracic spine condition. Because there is no medical opinion in the record that persuasively established that claimant's bus driving activities (as opposed to her farm work or preexisting condition) is the major cause of her current thoracic spine condition, I conclude that claimant's thoracic spine condition is not compensable. Accordingly, I would reverse the ALJ's order and uphold the insurer's denial. Because the majority reaches a different conclusion, I respectfully dissent.

December 21, 2001 Cite as 53 Van Natta 1634 (2001)

In the Matter of the Compensation of
GARY E. LOMBARDO, Claimant
WCB Case No. 00-08991
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of the order of Administrative Law Judge (ALJ) Howell's order that upheld the self-insured employer's "current condition" denial of multiple level cervical spondylitic disease; right thoracic outlet syndrome; and right medial nerve/carpal tunnel syndrome. 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.

In mid-August 2000, claimant began "pulling green chain" for the employer. (Tr. 5). After two 3-day weekend shifts, claimant experienced problems with his right arm and shoulder. (Tr. 7-8). Claimant sought emergency room medical treatment on August 24, 2000, and filed a claim the next day. (Exs. 2 & 3).

A September 2000 MRI (interpreted by Dr. Hall) revealed "chronic degenerative disc disease, cervical spondylosis and moderate foraminal narrowing from C4-5 through C6-7." (Ex. 6). An October 2000 electrodiagnostic evaluation (interpreted by Dr. Andressen) revealed right carpal tunnel syndrome. (Ex. 8-1).

On November 7, 2000, consulting neurologist Dr. Jensen, diagnosed: (1) cervical spondylosis; (2) musculoligamentous injury causing chronic right shoulder and arm pain; and (3) right carpal tunnel syndrome. (Ex. 10-3). Dr. Jensen opined that the cervical spondylosis was not related to claimant's work. (*Id.*) Dr. Jensen did not offer an opinion regarding the cause of the right carpal tunnel syndrome. (*Id.*)

On November 8, 2000, employer-arranged examiners, Drs. Denekas and Baker diagnosed: (1) right shoulder girdle strain secondary to work-related activities; (2) significant preexisting cervical spondylitic disease; (3) possible mild nerve root irritation secondary to work activities with no true objective findings; and (4) right carpal tunnel syndrome unrelated to work. (Ex. 11-5; 11-6).

On November 21, 2000, the employer accepted a nondisabling "right shoulder girdle muscular strain," and denied: (1) multiple level spondylitic disease; (2) right median nerve/carpal tunnel syndrome, and (3) right thoracic outlet syndrome. (Exs. 12 & 12A). Claimant requested a hearing.

The ALJ, finding no evidence that the employer had accepted a "combined" condition, determined that the employer's partial denial of three specific conditions (multiple level spondylitic disease, right median nerve/carpal tunnel syndrome, and right thoracic outlet syndrome) was procedurally valid. On the merits, the ALJ determined that claimant had failed to establish the compensability of any of the denied conditions. Consequently, the ALJ upheld the employer's denial.

Claimant asserts that his work-related injury (shoulder girdle strain) "combined" with various preexisting conditions to produce his "current" condition. Claimant further asserts that the employer's denial was based on a "combined" condition. Reasoning that the employer did not accept a "combined condition," claimant argues (citing *Croman Corp. v. Serrano*, 163 Or App 136, 140-41 (1999)) that the employer's denial is procedurally invalid.

"The 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." *Blamires v. Clean Pak Systems, Inc.*, 171 Or App 263, 267 (2000). Consequently, in order to determine whether *Croman* is applicable, we must first determine whether the employer accepted a "combined condition." *See Columbia Forest Products v. Woolner*, 177 Or App 639 (2001).

The scope of acceptance is an issue of fact. *See, e.g., SAIF v. Dobbs*, 172 Or App 446, 451, *adhered to as mod on recons* 173 Or App 99 (2001); *Granner v. Fairview Center*, 147 Or App 406 (1997). In order for there to be a "combined condition" there must be two conditions that merge or exist harmoniously. *See Luckhurst v. Bank of America*, 167 Or App 11, 16-17 (2000).

Here, while the medical evidence establishes that claimant has one or more preexisting conditions, the evidence does not support a conclusion that claimant's work injury (shoulder girdle strain) "combined" with those preexisting conditions. First, none of the doctors providing an opinion regarding claimant's current condition (including Dr. Rasmussen, the attending physician) expressly concluding that claimant's current condition is a "combined" condition. Next, Drs. Jensen, Denekas and Baker expressly stated that claimant's preexisting conditions (cervical spondylosis and carpal tunnel syndrome) were unrelated to his work injury. (Exs. 10-3; 11-5; 11-6). Finally, Dr. Rasmussen suggested that all of claimant's symptoms were caused by "the vibration of saws and various [work] duties at the mill." (Ex. 15-1). Such an opinion does not support the existence of a "combined" condition.

Under such circumstances, we conclude that when the employer accepted a "right shoulder girdle muscular strain," it did not accept a "combined" condition. Consequently, we conclude that *Croman* is not applicable, and that the employer's denial was procedurally valid.

On the merits, we adopt the reasoning of the ALJ. Accordingly, the denied conditions are not compensable.

ORDER

The ALJ's order dated June 5, 2001 is affirmed.

December 21, 2001 Cite as 53 Van Natta 1635 (2001)

In the Matter of the Compensation of
MATTHEW M. MERYK, Claimant
WCB Case No. C012924
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Welch, et al., Claimant Attorney
Sheridan, et al., Defense Attorney

Reviewing Panel: Members Bock and Haynes.

On December 6, 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. We approve the proposed disposition.

The proposed CDA explains that an April 6, 2001 Notice of Closure awarded claimant 14 percent unscheduled permanent disability, and an August 24, 2001 Order on Reconsideration awarded claimant 18 percent unscheduled permanent disability and 10 percent scheduled permanent disability. The proposed CDA further provides:

> "That on September 24, 2001, the insurer appealed the August 24, 2001 Order on Reconsideration and, consequently, claimant's award of 18 percent of unscheduled permanent partial disability and 10 percent scheduled permanent partial disability has been stayed pending the appeal, by execution of this settlement agreement the parties agree that the August 24, 2001 Order on Reconsideration is void and vacated and the April 6, 2001 Notice of Closure reinstated."

It is well settled that CDAs are not designed for purposes of claim processing. *See, e.g., Kenneth D. Chalk*, 48 Van Natta 1874 (1996); *Kenneth R. Free*, 47 Van Natta 1537 (1995). Here, however, we do not interpret the CDA as accomplishing a claim processing function. In other words, in approving the CDA, we are not "voiding" or "invalidating" the August 24, 2001 Order on Reconsideration. Rather, we are merely recognizing that any unpaid permanent disability granted by the Order on Reconsideration has been released by the CDA. This conclusion is also consistent with another portion of the CDA, which provides that claimant released his right to permanent disability benefits (including the permanent partial disability award referenced in the Order on Reconsideration). (Page 3, section 13).

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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.

December 21, 2001 Cite as 53 Van Natta 1636 (2001)

In the Matter of the Compensation of
GERALD A. PRITCHETT, Claimant
WCB Case No. 00-09024
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Cavanagh & Zipse, Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the insurer's compensability and responsibility denials of his injury claim for a cervical condition. On review, the issues are compensability
and responsibility.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated August 10. 2001 is affirmed.

Member Phillips Polich dissenting.

I agree with claimant that the opinion from the insurer examiners Drs. Schilperoort and Green in this case is so woefully lacking in factual foundation that I cannot find it persuasive. I would have deferred to claimant's treating surgeon Dr. Mason to set aside the insurer's denials. Therefore, I respectfully dissent.

This is a case where deference to claimant's treating physician is clearly appropriate as a factual matter. *See Dillon v. Whirlpool Corp.*, 172 Or App 484, 489 (2001) (fact finder may give greater weight to the opinion of the treating physician, depending on the record in each case). Dr. Mason has treated claimant a total of 37 times over a span of 15 years. He has performed four of the five cervical laminectomies claimant has undergone, the first in 1986. (Ex. 7). Dr. Mason thus has the advantage of an unusually long time span over which to evaluate the progression of claimant's cervical condition. Dr. Mason is in a vastly superior position to comment on the causation issues in this case. As treating surgeon, his opinion should be accorded great weight. *See Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 701 (1988); *Charles D. Cochran*, 53 Van Natta 1514 (2001).

In contrast to Dr. Mason, Drs. Schilperoort and Green examined claimant only once, at the request of the insurer. (Ex. 190). In addition, I cannot overlook the fact that Dr. Schilperoort did not review a total of 82 medical reports, nor did he review any of the imaging studies. (*See* Ex. 190-1, -2). The insurer's examiners' opinion lacks complete information regarding the history of claimant's condition. As such, I find it unpersuasive. *Miller v. Granite Construction*, 28 Or App 473 (1977).

I acknowledge the deficiencies in Dr. Mason's opinion as noted by the ALJ. Admittedly, his opinion is relatively "sparse." However, it is far from conclusory. Dr. Mason incorporates claimant's preexisting cervical spondylosis into his opinion by stating that the spondylosis has "compromised" claimant's current condition. (Ex. 194). All of this, of course, must be read in the context of Dr. Mason's strong, longitudinal knowledge of claimant's condition that cannot be matched by Drs. Schilperoort and Green.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
ROBERT C. SLOANE, Claimant
WCB Case No. 01-03438
ORDER ON REVIEW
Mustafa T. Kasubhai, P.C., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of claimant's claim for a left knee injury. On review, the issue is course and scope of employment.

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

We do not adopt the second to last sentence on page four of the ALJ's order.

Claimant, a sales associate for a car dealership, brought a bicycle to work, where he intended to show it to a prospective buyer, a coworker. While on the employer's premises during his regular working hours, claimant maneuvered the bicycle through the car lot and operated it in a more open area. While the prospective purchaser and two others were present, claimant demonstrated the bike. One of the gathered coworkers asked him to "pop a wheelie." Claimant obliged, and fell in the attempt, injuring his left knee.

SAIF denied the claim, asserting that claimant's injury did not arise out of and in the course of his employment. Finding an insufficient causal connection between claimant's employment and his injury, the ALJ upheld SAIF's denial.

On review, claimant contends that his injury arose out of his employment. Based on the following reasoning, we disagree.

The "arising out of" element of the work-connection test requires that a causal link exist between the worker's injury and his employment. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 525-26 (1996). The work-connection test may be satisfied if the factors supporting one prong of the statutory test are minimal while the factors supporting the other prong are many. *Id* at 531.

Claimant cites *Wilson v. State Farm Ins. Co.*, 326 Or 413 (1998), as support for his position that the involved activity was work-related. *Wilson*, however, is distinguishable. There the claimant, an office worker, was injured as she skipped or "stutter-stepped" from her supervisor's work area to her own work area. The *Wilson* court concluded that the claimant's activity was work-related as it involved returning to her workplace. The *Wilson* court reasoned that, although the claimant's method of covering the distance between the two points was not anticipated, movement within the office was a work-related risk. According to the court, the unusual "skip-step" manner of locomotion did not render the claimant's resulting injury noncompensable. 326 Or at 418.

By contrast, claimant in this instance was injured when he "popped a wheelie" while demonstrating a bicycle for a group of coworkers which included a prospective buyer. Unlike the claimant's activity in *Wilson*, claimant's activity in this case was unrelated to the accomplishment of any work task. Rather than employing a novel means of accomplishing a work-related task, claimant was not performing a work-related task when his injury occurred.[1] When he began demonstrating the bicycle for the benefit of the prospective buyer and others present, claimant left his job behind and began an activity wholly unrelated to his employment. His injury resulted from an activity, which was neither inherent in nor incidental to any work related risk. No causal link exists between claimant's injury and a risk connected with the nature of his work.

Finally, the claimant asserts that his injury is compensable because it resulted from horseplay to which his employer acquiesced. The evidence does not support this theory.

An injury resulting from a claimant's active participation in horseplay is compensable only if his employer knew or should have known of and acquiesced in the behavior. *See Kammerer v. United Parcel Service*, 136 Or App 200, 204 (1995). Here, claimant's supervisor was unaware that claimant was operating a bicycle at the work site prior to the fall and resulting injury. While the sales manager acknowledged that another employee sometimes rode a bicycle in performance of work-related tasks, and that there were no written or unwritten policies against such use of a bicycle, the supervisor explained that had he seen or been told that a salesman was "popping wheelies" in the parking lot he would have asked the employee to put the bike away. The record does not establish that horseplay was common in this employer's workplace or that the employer knew or should have known of its occurrence. Under these circumstances, the employer cannot be said to have acquiesced in the horseplay exhibited or to have made such activity an aspect of the work environment.

In conclusion, we are persuaded that claimant's injury did not arise out of the course and scope of his employment. Consequently, we affirm the ALJ's decision to uphold SAIF's denial.

ORDER

The ALJ's order dated July 31, 2001 is affirmed.

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[1] Claimant contended that in riding laps around the perimeter of the lot shortly before the fall he was conducting a "spot inventory." Assuming *arguendo* that was the case, his work-related activity concluded on his return to the open area where others were gathered and where he began demonstrating the bicycle for the prospective buyer.

In the Matter of the Compensation of
MICHAEL L. BALTER, Claimant
WCB Case No. 00-09620
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Hitt, et al., Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's current thoracic condition; and (2) awarded a $4,500 attorney fee for services at hearing. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Conclusions of Law and Opinion," beginning on page 5, with the following exceptions and supplementation.[1] We do not adopt the third paragraph on page 5 or the last sentence of the second full paragraph on page 6.

We do not address the "procedural" propriety of the denial, because we agree with the ALJ that claimant's current condition is compensable in any event, based on the medical evidence.

Finally, we acknowledge the employer's argument that the ALJ's attorney fee award should be reduced, considering the "minimal time devoted to the case." The employer notes that the case was decided on the record (without a hearing), and without depositions. The employer also notes that claimant elicited only one medical report.

Claimant responds that the time devoted to the case at the hearing level was not "minimal," explaining that his attorney expended considerable time doing legal research and submitted 12 pages of single-spaced argument to the ALJ based on that research. Claimant also asserts that the case involved issues of above-average legal and medical complexity and the value of the interest involved and benefit secured for claimant were significant. We agree with claimant and the ALJ.

Accordingly, having considered the parties' arguments and the factors under OAR 438-015-0010(4), we agree with the ALJ's application of the rule's factors to the circumstances of this case and conclude that $4,500 is a reasonable attorney fee for claimant's counsel's services at the hearing level. In reaching this conclusion, we also note that claimant's counsel is highly experienced and skilled in workers' compensation matters. And we further note that the time devoted to the case is but one factor that we consider in determining a reasonable attorney fee.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,800, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Finally, claimant is not entitled to an attorney fee for services devoted to the attorney fee issue. *Dotson v. Bohemia, Inc.*, 80 Or App 233 (1986).

ORDER

The ALJ's order dated August 29, 2001 is affirmed. For services on review, claimant is awarded an $1,800 attorney fee, to be paid by the self-insured employer.

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[1] The ALJ referred to Drs. Radecki and Fuller as a compelled medical examiner panel. For the reasons expressed in *Jamie B. Davis*, 53 Van Natta 1548 (2001), and *Laura J. Decker*, 53 Van Natta 1533 (2001), we refer to these doctors as insurer-arranged medical examiners (IMEs).

In the Matter of the Compensation of
BLAINE R. GUEST, Claimant
Own Motion No. 00-0261M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

The SAIF Corporation submitted a request for temporary disability compensation for claimant's 1993 low back condition. Claimant's aggravation rights have expired. SAIF opposed reopening the claim on the grounds that: (1) the proposed surgery was not reasonable and/or necessary; and (2) claimant was not in the work force at the time of his current disability. Furthermore, claimant had appealed a Managed Care Organization's (MCO's) disapproval of claimant's surgery request as medically unnecessary to the Director of the Medical Review Unit (MRU) of the Workers' Compensation Division. (MRU File No. 14637).

On December 20, 2000, we postponed action on this Own Motion matter pending the outcome of that litigation. On February 16, 2001, as reconsidered on April 6, 2001, the MRU found that the proposed surgery was inappropriate medical treatment for claimant's compensable injury. Claimant requested a hearing appealing the MRU's decision. On October 10, 2001, a Proposed and Final Contested Case Hearing Order was issued which affirmed the Director's February 16, 2001 order. That order has not been appealed.

Thereafter, the Board's staff directed a letter to the parties regarding the effect of the Director's order had on this pending Own Motion matter. In response, SAIF contended that claimant is not entitled to Own Motion benefits because the proposed surgery has been found to be inappropriate medical treatment for claimant's compensable condition. Claimant's attorney responded that he no longer represented claimant and all inquiries should be directed to claimant. Claimant has not responded to the Board's inquiry or to SAIF's contention.

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

Here, the dispute regarding the reasonableness and necessity of claimant's proposed surgery has been resolved. ORS 656.327. In light of the MRU's order, we are unable to find that claimant is entitled to temporary disability compensation for an unauthorized and noncompensable surgery. *See Dorothy Vanderzanden*, 48 Van Natta 1573 (1996).

Under these circumstances, we are unable to grant claimant's request for temporary disability. Accordingly, claimant's request for Own Motion relief is denied.[1]

IT IS SO ORDERED.

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[1] It appears from claimant's request that he may not understand his rights under the Workers' Compensation Act. Inasmuch as claimant is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. He may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

DEPT OF CONSUMER & BUSINESS SERVICES
WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE
SALEM OR 97301-3878

In the Matter of the Compensation of
GEORGE D. HILTON, Claimant
Own Motion No. 01-0338M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Liberty Northwest Ins. Corp., Insurance Carrier

Reviewing Panel: Members Biehl and Haynes.

Claimant requests review of the insurer's October 17, 2001 Notice of Closure, which closed his claim with an award of temporary disability compensation from March 20, 2001 through August 2, 2001. The insurer declared claimant medically stationary as of August 2, 2001. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

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

On March 20, 2001, claimant underwent low back surgery. On May 26, 2001, Dr. Weinman, one of claimant's treating physicians, reported that claimant was "getting close to becoming again medically stationary." Dr. Weinman recommended that claimant be referred to a pain management team.

On August 17, 2001, claimant was examined by Dr. Maukonen, a pain specialist. Dr. Maukonen reported that claimant demonstrated a mild decrease in range of motion without pain, no tenderness to palpation over the lumbar spine and no swelling present. He prescribed medication and scheduled claimant for a one month "recheck."

In a September 4, 2001 report, Dr. Helman, another of claimant's treating physicians, agreed that claimant would have no further improvement "of his condition with either treatment or passage of time." He noted that claimant was being "evaluated" by Dr. Maukonen and deferred any "further statement about his long-term prognosis" to Dr. Maukonen.

On September 24, 2001, Dr. Maukonen reported that he had prescribed medication for claimant's leg pain but that there was no follow-up appointment. He recommended that claimant contact him should he have "increased problems."

Dr. Helman reiterated, in an October 16, 2001 report, that he deferred any statement regarding claimant's "long-term prognosis" to Dr. Maukonen and recommended that the insurer contact Dr. Maukonen if "[it was] trying to close the claim on this [claimant] based on lack of further improvement with time or further therapy." He explained that the treatment of lumbar burst fracture with nerve damage "is beyond [his] area of expertise."

On October 26, 2001, Dr. Helman reported that claimant's "dysesthesis" was improving with the medication prescribed by Dr. Maukonen and recommended that claimant continue with the prescribed medication. He noted that claimant was to follow-up "routinely."

Claimant contends that the insurer's October 17, 2001 closure was premature because none of his treating physicians had explicitly declared his condition to be "medically stationary" at claim closure. However, "magic words" are not necessary to establish a medically stationary date. *See Eric R. McKown*, 53 Van Natta 630 (2001).

Although the medical experts do not explicitly state that claimant's condition was medically stationary, their opinions establish that there was no reasonable expectation of material improvement with further treatment or the passage of time. We base our conclusion on the following reasoning.

In September 2001, Dr. Helman opined that claimant would have no further improvement with either treatment or the passage of time. Although he referred claimant to Dr. Maukonen for pain treatment, he did not suggest that this pain management would improve his condition. In fact, in October 2001, Dr. Helman referred further comments regarding claimant's "long-term prognosis" to Dr. Maukonen, stating that treatment of a back condition with nerve compromise was beyond his "area of expertise."

In August 2001, Dr. Maukonen reported that claimant had a mild decrease in range of motion with no pain or tenderness over the lumbar spine. He also noted some tenderness over claimant's left lateral flank with no swelling. Dr. Maukonen prescribed medication to treat claimant's pain complaints. In September 2001, Dr. Maukonen noted that he had prescribed medication for claimant's leg pain and that no further follow-up treatment was scheduled. Dr. Maukonen does not indicate that claimant's condition would materially improve with further treatment or the passage of time.

Drs. Helman and Maukonen's opinions may support a conclusion that claimant continues to require pain management treatment. Nonetheless, the term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation that further or ongoing medical treatment would "materially improve" claimant's compensable condition at claim closure. *Lois Brimblecom*, 48 Van Natta 2312 (1996). Thus, although claimant may require further pain management treatment, the record does not establish that this continuing medical treatment is designed to materially improve his condition.

Under these circumstances, we find that claimant was medically stationary on the date his claim was closed. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's October 17, 2001 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
CINDY L. ZUERCHER, Claimant
Own Motion No. 01-0094M
OWN MOTION ORDER DENYING RECONSIDERATION
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

On March 22, 2001, we authorized the reopening of claimant's 1980 injury claim with the SAIF Corporation for the payment of temporary disability compensation beginning the date claimant is hospitalized for the proposed surgery. Announcing that claimant has decided to postpone her proposed surgery, SAIF requests that our March 22, 2001 order "be withdrawn in its entirety." We treat this request as a request for reconsideration of our prior order. For the following reasons, we deny that request.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if there was good cause for the failure to file within 30 days. The standard for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized by ORCP 71B(1), and *former* ORS 18.610. *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666; *see also Brown v. EBI Companies*, 289 Or 455 (1980). Lack of due diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). However, OAR 438-012-0065(3) also provides that "[n]othwithstanding section (2) of this rule, in extraordinary circumstances that Board may, on its Own Motion, reconsider any prior Board order." *See Larry P. Karr*, 48 Van Natta 2182 (1996); *Jay A. Yowell*, 42 Van Natta 1120 (1990).

In *Charles Kurnick*, 46 Van Natta 2501 (1994), we declined to grant reconsideration where the claimant had not undergone surgery or the required hospitalization following the issuance of a Board's Own Motion order authorizing reopening of the claim. In *Kurnick*, we reasoned that, because surgery or hospitalization is a prerequisite for authorization for reopening, it followed that an Own Motion order

may not authorize the payment of temporary disability benefits until that surgery or hospitalization occurs. ORS 656.278(1)(a). Thus, an Own Motion order that authorizes reopening of a claim for the payment of temporary disability compensation is, essentially, a "contingent" order. If surgery or hospitalization subsequently occurs, then the prerequisite is met and no further Own Motion order is necessary. If, on the other hand, surgery or hospitalization does not occur, then the claim would not be reopened under our Own Motion order as the necessary prerequisite would not have been met.

In *Kurnick*, because the claimant had not undergone surgery, the prerequisite had not yet occurred and the order remained a "contingent" order. Under such circumstances, we held in *Kurnick* that there were no extraordinary circumstances that would justify reconsideration.

Here, as in *Kurnick*, the statutory prerequisite for the payment of temporary disability has not occurred in that claimant has not undergone the proposed surgery. Therefore, the March 22, 2001 Own Motion Order remains a "contingent" order, because the necessary prerequisite for reopening the claim for Own Motion relief has not yet occurred. Inasmuch as the order remains contingent, there are no extraordinary circumstances that would justify reconsideration. *Kurnick*, 46 Van Natta at 2506. *See also Beverly J. Rice*, 53 Van Natta 94 (2001).

Accordingly, SAIF's request for reconsideration of our March 22, 2001 Own Motion Order is denied.[1]

IT IS SO ORDERED.

[1] Based on the foregoing reasoning, SAIF's request that our March 22, 2001 Own Motion Order be "withdrawn in its entirety" is denied.

December 24, 2001 Cite as 53 Van Natta 1643 (2001)

In the Matter of the Compensation of
EARL T. COZART, Claimant
Own Motion No. 01-0357M
OWN MOTION ORDER

Reviewing Panel: Members Biehl and Haynes.

The self-insured employer initially submitted an Own Motion recommendation to "voluntarily reopen" claimant's 1974 claim for the payment of temporary disability compensation. The employer asked the Board to authorize the reopening of claimant's claim. However, the employer's recommendation noted that claimant is retired.

Thereafter, the Board's staff directed a letter to the parties seeking clarification of the employer's request as it was unclear whether the employer had, in fact, voluntarily reopened claimant's 1974 claim and was merely seeking Board authorization or whether it was seeking a Board order reopening the claim. Claimant was also granted an opportunity to submit his written position regarding the employer's recommendation.

In response, the employer clarified that its Own Motion recommendation was "in error." Asserting that claimant was retired and not in the work force at the time of the current disability, the employer requests that we "disregard" its November 16, 2001 Own Motion Recommendation. Claimant has not responded to the Board's inquiry or to the employer's contentions.

Based on the employer's clarification of its previous recommendation, we conclude that it has recommended denial of the reopening request. In other words, we interpret the employer's position to be that claimant is not entitled to temporary disability because he was not in the work force at the time of his current disability.

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

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

The employer contends that claimant was retired at the time of the current disability and therefore not in the work force. Claimant has not responded to the employer's contention. Claimant has the burden of proof on this issue and must provide evidence on that issue (*e.g.*, copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimant's compensable condition for the period in question).

The information submitted to us to date does not demonstrate claimant's presence in the work force at the relevant time.[1] While payment of medical benefits is not in dispute, claimant's request for temporary disability compensation is nevertheless denied. *See id.* We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order.

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

IT IS SO ORDERED.

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[1] In the event that claimant disagrees with our decision that he has withdrawn from the work force, he may request reconsideration. However, because our authority to further consider this matter expires within 30 days of this order, he should submit his information as soon as possible.

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

DEPT OF CONSUMER & BUSINESS SERVICES
WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE
SALEM OR 97301-3878

In the Matter of the Compensation of
JUDIE NELSON, Claimant
WCB Case No. 01-01271
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Hettle & Associates, Defense Attorney

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's injury claim for a herniated C6-7 disc. On review, the issue is compensability.

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

We agree with the ALJ that the opinions of Drs. Franks, LeMay, and Rosenbaum are more persuasive than those of examining physicians, Drs. Yarusso, Williams, and Duff. We reach this conclusion based on the following reasoning.

The contemporaneous medical evidence persuades us that claimant suffered an acute cervical injury at work on November 9, 2000. The examining physicians' causation opinions are based in part on

a belief that claimant did not have an acute injury that day. (*See* Exs. 23, 38, 39-6). We discount the examining physicians' conclusions because they are based on a materially inaccurate history in that respect. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977).

Drs. Franks, LeMay, and Rosenbaum concluded that claimant's work injury was the major contributing cause of her C6-7 herniated disc. These doctors considered the mechanism of the injury and claimant's symptoms and diagnosis, in light of her preexisting cervical degeneration and a materially accurate history. We find these opinions persuasive and conclude that claimant has carried her burden of proof.[1] *See Somers v. SAIF*, 77 Or App 259 (1986).

Claimant's attorney is entitled to an assessed fee for services on review. OR 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,700, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 23, 2000 is affirmed. For services on review, claimant is awarded a $1,700 attorney fee, to be paid by the self-insured employer.

[1] We also agree with the ALJ that there is no evidence suggesting that claimant's fibromyalgia or chiropractic treatments contribute to her cervical disc condition. And we find no persuasive evidence of prior cervical injury. Under these circumstances, we cannot say that claimant's reporting is "impeached."

In the Matter of the Compensation of
STEVEN WONDERLY, Claimant
WCB Case No. 01-00467
ORDER ON REVIEW
Schneider, et al., Claimant Attorney
Jerry Keene, Defense Attorney

Reviewing Panel: Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that awarded claimant 50 percent (24 degrees) scheduled permanent disability for loss of use or function of the left thumb, whereas an Order on Reconsideration awarded 20 percent (30 degrees) scheduled permanent disability for loss of use or function of the left hand. On review, the issue is extent of scheduled permanent disability.

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

Claimant contends that he was entitled to receive a 5 percent chronic condition impairment for his left wrist, that the impairment of the left thumb is converted to the hand, and that he should be awarded 20 percent scheduled permanent disability for the left hand. We disagree.

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 reports of the medical arbiter and attending physician do not establish that claimant was "significantly limited" in the repetitive use of a body part.

Where a medical arbiter is used, impairment is established by the medical arbiter, unless a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14). In this instance, the medical arbiter determined that claimant was only mildly limited in the ability to repetitively use the left wrist and forearm because of the discomfort felt with repetitive motion. A medical opinion identifying mild limitation on repetitive use is insufficient to establish chronic condition impairment. *See Lorraine F. Fortado*, 52 Van Natta 446 (2000).

Claimant relies on the opinion of Dr. Nolan, his attending physician at the time of claim closure. Dr. Nolan opined that, "[i]mpairment of 5% of the left upper extremity seems reasonable for this difficult problem." (Ex. 13). Claimant asks us to infer from these words that the attending physician was of the opinion that he was significantly limited in the repetitive use of a body part. In the absence of explanation or analysis by Dr. Nolan, we are unable to reach such a conclusion. *See Moe v. Ceiling Systems*, 44 Or App 429, 430 (1980) (conclusory and unexplained medical opinion rejected).

In addition, we note that rather than describing claimant's condition as chronic and permanent, the attending physician expressed the hope that claimant's discomfort would improve within six to 12 months. In this context, we are inclined to give greater weight to the opinion expressed by the medical arbiter (who described claimant's repetitive limitation as mild), who examined claimant more than six months after Dr. Nolan's closing exam. *See Kelly J. Zanni*, 50 Van Natta 1188 (1998) (a medical arbiter's report may be more probative where there is a significant time gap between the closing examination and the medical arbiter's examination).

In conclusion, we agree with the ALJ's reasoning and determination that the medical record was insufficient to establish claimant's entitlement to a chronic condition impairment award. We therefore affirm the ALJ's order.

ORDER

The ALJ's order dated July 10, 2001 is affirmed.

December 27, 2001 Cite as 53 Van Natta 1646 (2001)

In the Matter of the Compensation of
BONNIE L. IMEL-HOWER, Claimant
Own Motion No. 99-0189M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Sather, Byerly & Holloway, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

On November 30, 2001, we withdrew our October 31, 2001 Own Motion Order on Reconsideration which adhered to our August 29, 2001 order dismissing claimant's January 26, 2001 request for review of the self-insured employer's August 21, 2000 Notice of Closure as untimely filed. We withdrew our order to consider claimant's request for reconsideration. Specifically, claimant argues that because of her difficulty in obtaining an attorney to represent her in this Own Motion matter, she was unable to timely request Board review of the employer's closure.

In both our August 29 and October 31, 2001 orders, we found that claimant had not established good cause for her failure to file the request for Board review within the required time period. *See* OAR 438-012-0055. After further considering the current record (including claimant's November 27, 2001 letter), we continue to reach our previous conclusion. In other words, we have nothing further to add to the findings and reasoning set forth in our prior orders regarding claimant's failure to timely request Board review of the employer's August 21, 2000 closure.[1] Consequently, we adhere to our previous determination that claimant has not submitted evidence to show good cause why her request for review of the August 21, 2000 Notice of Closure was not made within the allotted appeal period.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 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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[1] We recognize claimant's apparent frustration in relying on her previous attorneys, as well as the difficulties she has encountered in obtaining new legal representation. Nonetheless, for the reasons expressed in our previous decisions, such grounds do not support a conclusion that she had good cause for her failure to file a request for Board review of the employer's Notice of Closure within 60 days of its issuance. If claimant believes her former attorney(s) neglected to file a request in a timely manner, that is matter between claimant and her former counsel(s); it is not a matter for this forum.

In the Matter of the Compensation of
ERIC W. LUNDBERG, Claimant
WCB Case No. 01-03101
ORDER OF DISMISSAL
Employers Defense Counsel, Defense Attorney

Reviewing Panel: Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the insurer's partial denial of his claim for a mental stress condition. The insurer moves to dismiss claimant's request for review, contending (among other grounds) that it did not receive timely notice of claimant's request. We dismiss.

FINDINGS OF FACT

On November 8, 2001, the ALJ issued an Opinion and Order that dismissed claimant's request for hearing for failure to timely request a hearing from the insurer's denial. Copies of the ALJ's order were mailed to claimant, the employer, the insurer, and the insurer's attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for review must be mailed to the other parties within the 30-day appeal period.

On December 11, 2001, the Board received a letter from claimant dated December 7, 2001 and postmarked December 10, 2001. In that letter, claimant requested an "extension of time" for his request for review. Claimant stated that, due to his incarceration, he did not have "access to the same liberties" as others and was not able to copy the request for review or postmark and/or hand deliver it "today," presumably meaning December 7, 2001.

On December 12, 2001, the Board mailed its computer-generated acknowledgment letter to the parties. On December 18, 2001, the insurer filed a motion to dismiss claimant's request for 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).

The 30th day after the ALJ's November 8, 2001 order was December 8, 2001, a Saturday. Accordingly, claimant's appeal period ran until the following Monday, December 10, 2001.[1]

The record fails to establish that the insurer was provided with a copy of, or received actual knowledge of, claimant's request for review within the statutory 30-day period. 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 v. King*, 63 Or App 847, 852 (1983). The failure to timely file and serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992), except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or App 47, 51 (1995); *Argonaut Insurance v. King*, 63 Or App at 853.

Here, based on the insurer's submission, its first notice apparently occurred when it received a copy of the Board's December 12, 2001 letter acknowledging claimant's request for review (which was beyond the statutory 30-day appeal period). Under such circumstances, notice of claimant's appeal was untimely. *Sherry A. Gomes*, 52 Van Natta 2022, 2023 (2000); *Stella T. Ybarra*, 52 Van Natta 1252 (2000).

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[1] We have previously held that, when the last day of the 30-day appeal period falls on a Saturday or legal holiday, including Sunday, the appeal period runs until the end of the next day that is not a Saturday or legal holiday. *E.g., James D. Hill*, 49 Van Natta 308 (1997); *Anita L. Clifton*, 43 Van Natta 1921 (1991). Because the 30th day in this case fell on a Saturday, and the following day (Sunday) was a legal holiday, *see* ORS 187.010(1)(a), claimant's appeal period ran until the end of Monday, December 10, 2001.

Consequently, we conclude that notice of claimant's request was not provided to the other parties within 30 days after the ALJ's November 8, 2001 order. Therefore, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. *See* ORS 656.289(3); 656.295(2).

In his request for review, claimant asked for an "extension of time" within which to request review of the ALJ's order and provide copies of his request for review. However, ORS 656.289(3) unequivocally states that a party who is dissatisfied with an ALJ's order must request Board review within 30 days from the date of the order. Thus, the statutory scheme does not authorize the Board to relax or suspend the statutory 30-day appeal period, regardless of the explanation for an untimely appeal. *See Yolanda V. Reyes*, 50 Van Natta 1790 (1998).

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

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
FOREST C. STALNAKER, Claimant
Own Motion No. 01-0354M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of the SAIF Corporation's October 26, 2001 Notice of Closure, which closed his claim with an award of temporary disability compensation from January 30, 2001 through October 5, 2001.[1] SAIF declared claimant medically stationary as of August 6, 2001.

In his request for review, claimant contends that his closure was "too early" because of his ongoing treatment. We interpret such a contention that claimant was not medically stationary at claim closure.

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

The propriety of the closure turns on whether claimant was medically stationary at the time of the October 26, 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] Claimant's November 5, 1989 claim was accepted as a disabling claim and was first closed on March 31, 1994. Thus, claimant's aggravation rights expired on March 31, 1999. ORS 656.273(4)(a). When claimant's condition worsened requiring surgery in January 2001, claimant's claim was under our Own Motion jurisdiction. ORS 656.278(1)(a). Consistent with our statutory authority, on December 22, 2000, we issued our Own Motion Order authorizing the payment of temporary disability compensation and noted that when claimant was medically stationary, SAIF should close the claim pursuant to OAR 438-012-0055. (WCB Case No. 00-0308M). SAIF issued its October 26, 2001 Notice of Closure for that claim.

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

Here, claimant contends that he is entitled to additional benefits because he continues to require further medical treatment. We interpret claimant's request as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

In an October 15, 2001 827 Form, Dr. Tiley, claimant's attending physician, reported that claimant was medically stationary as of August 6, 2001. He further noted that no further appointment had been scheduled and that the examination of August 6, 2001 was a "closing" examination.

In his request for review of SAIF's closure, claimant states that he has been referred to a neurosurgeon at a Spinal Injection Unit. He contends that due to the "ongoing treatment that is needed," his condition is not medically stationary. Claimant offers no medical documentation to support his contention. Moreover, even if we were to consider claimant's assertion that he requires further medical treatment, this does not support the conclusion that he was not medically stationary when his claim was closed. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation, at claim closure, that further medical treatment would "materially improve" claimant's compensable condition. ORS 656.005(17); *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Thus, based on uncontroverted medical evidence, we find that claimant was medically stationary on the date his claim was closed. We further conclude that he is not entitled to additional temporary disability benefits. Consequently, we hold that the claim closure was proper.[2]

Accordingly, we affirm SAIF's October 26, 2001 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[2] Inasmuch as claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters. He may contact the Workers' Compensation Ombudsman toll-free at 1-800-927-1271 or write to:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter St NE
Salem, OR 97301

In the Matter of the Compensation of
LAWRENCE E. GERADS, Claimant
WCB Case No. 00-09051
ORDER ON REVIEW
Raymond Bradley, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewing Panel: Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that dismissed her hearing request as abandoned under OAR 438-006-0071(1). On review, the issue is the propriety of the ALJ's dismissal order.

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

Pursuant to claimant's hearing request, a hearing was scheduled on February 27, 2001. On January 26, 2001, the case was reported as settled. On July 26, 2001, after more than 60 days had passed and no settlement documents had been received, the ALJ issued an "Order to Show Cause," ordering claimant to show good cause within 15 days of the order why the hearing request should not be dismissed as abandoned or for an unjustified delay.

After the 15-day period had passed without a response to the show-cause order, the ALJ issued an Order of Dismissal on August 21, 2001.

Attached to claimant's request for Board review was an affidavit in which claimant's attorney stated that the case had not been abandoned, that the case had been reported settled in good faith, that there had been confusion about details of the settlement, and that the parties were still attempting to settle the case. Claimant's counsel also stated that, due to the "press of business," it was "impossible" to respond to the show-cause order within the 15 days allowed.

Having reviewed claimant's affidavit, we treat it as a motion for remand. 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, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, we are not persuaded that the "evidence" claimant has submitted for the first time on review was unavailable with due diligence at the time of the ALJ's "show cause" order. Specifically, claimant's attorney does not explain what "press of business" made it "impossible" to timely respond to the ALJ's show-cause order. Moreover, the SAIF Corporation does not agree with claimant's request to reset the case so that settlement negotiations may proceed. Instead, it seeks affirmance of the ALJ's order.

Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Accordingly, it does not merit remand.[1] ORS 656.295(5). Moreover, considering claimant's failure to timely respond to the ALJ's "show cause" order, we further conclude that the ALJ properly dismissed claimant's request for hearing. *See Tsegaye Addisu*, 53 Van Natta 792, 793 (2001) (approving dismissal of hearing request where the claimant failed to timely respond to show-cause order).

ORDER

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

[1] In reaching this conclusion, we distinguish those cases in which we have remanded to an ALJ for consideration of a claimant's response to a "show cause" order. *See Dirk K. Carney*, 53 Van Natta 1525 (2001); *Michael E. Davis*, 53 Van Natta 1059 (2001); *Teresa Marion*, 50 Van Natta 1165 (1998); *Brent Harper*, 50 Van Natta 499 (1998). Unlike here, in each of those cases, the claimant timely responded to the "show cause" order, but the ALJ did not have time to consider or was never notified of the claimant's timely response. In those cases, we found a compelling reason to remand for the ALJ's consideration of the claimant's timely filed response.

In the Matter of the Compensation of
MARIA R. LUNA, Claimant
WCB Case No. 01-01662
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
Johnson, Nyburg & Andersen, 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) Johnson's order that: (1) set aside its "de facto" denial of claimant's injury claim for a right shoulder rotator cuff tear; and (2) assessed a penalty for allegedly unreasonable claim processing. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW

We begin by briefly summarizing the procedural and factual background of the claim. On or about May 7, 2000, claimant, a dietary aide, injured her right shoulder while lifting a coffeepot at work. The initial diagnosis was right acromial clavicular strain and possible mild deltoid muscle strain. (Ex. 1). Claimant then began treating with Dr. Quijano, who diagnosed a cervical sprain/strain and "right shoulder pain, rule out rotator cuff injury." (Ex. 3).

On August 2, 2000, the insurer accepted a disabling "parascapular strain, right shoulder." (Ex. 4).

On August 7, 2000, an MRI scan of claimant's right shoulder was interpreted by a radiologist as showing a "[b]ursal sided partial-thickness tear of the anterior portion of supraspinatus tendon near its insertion on the humeral greater tuberosity." No full thickness tear was seen. (Ex. 5).

On referral from Dr. Quijano, Dr. Puziss, an orthopedic surgeon, evaluated claimant's right shoulder condition on October 6, 2000. (Ex. 7). Dr. Puziss reviewed the August 2000 MRI scan and described the rotator cuff tear as a "[r]ight bursal side partial or nearly full thickness rotator cuff tear." Dr. Puziss termed the tear "significant." Recommending right shoulder arthroscopy and either arthroscopic or open repair, Dr. Puziss opined that claimant's injury was the major contributing cause of the need for treatment.

On November 7, 2000, a panel of physicians consisting of Drs. Green, Bald and Duncan evaluated the right shoulder condition on behalf of the insurer. (Ex. 8). The panel reviewed the MRI scan and agreed with the interpretation of the radiologist. The panel diagnosed a probable right supraspinatus partial thickness tear with associated tendinitis, resolving; a resolved parascapular sprain; and ongoing pain complaints of uncertain etiology. Although the panel concluded that claimant's current symptoms were incompatible with rotator cuff abnormality as the primary source of her complaints, they did opine that the work injury was the major contributing cause of the diagnoses. No preexisting conditions were identified.

On November 17, 2000, claimant's attorney requested acceptance of a right bursal side partial or nearly full thickness rotator cuff tear and possible internal derangement of the right shoulder. (Ex. 9). The insurer did not timely respond to the request, prompting claimant to request a hearing regarding a "de facto" denial.

On March 5, 2001, Dr. Puziss performed right shoulder surgery. The operative report indicated that Dr. Puziss found a "very tiny" bursal side rotator cuff tear that did not require repair. (Ex. 10).

Dr. Bald issued an "addendum" report on April 17, 2001, incorporating a review of Dr. Puziss' operative report. Dr. Bald noted the finding of a "very tiny" rotator cuff tear, opined that it was not of any clinical significance, and advised that the claim acceptance should not be expanded to include a partial or nearly full thickness tear of the rotator cuff. (Ex. 11).

Finally, on May 9, 2001, Dr. Puziss issued a report in response to an inquiry from claimant's counsel. Dr. Puziss concluded that, based on his physical and arthroscopic findings, as well as the MRI scan, claimant's "work activities" were the major contributing cause of her "condition." (Ex. 12).

At hearing, claimant withdrew her claim for internal derangement of the right shoulder. The ALJ, however, set aside the insurer's "de facto" denial of the rotator cuff tear claim. Noting that the record did not establish the presence of a "combined condition" within the meaning of ORS 656.005(7)(a)(B), the ALJ applied a material contributing cause standard. The ALJ reasoned that the coffeepot lifting incident caused a rotator cuff tear, finding the opinion of Dr. Bald unpersuasive because he had changed his opinion without explanation. Determining that the rotator cuff tear claim was supported by "objective findings" and resulted in disability and a need for medical services, the ALJ concluded that the rotator cuff tear was compensable. Moreover, the ALJ determined that the insurer's claim processing was unreasonable in its failure to timely respond to claimant's "omitted" condition claim. The ALJ assessed a 10 percent penalty on amounts "then due" 30 days after the November 17, 2000 letter from claimant's attorney.

On review, the insurer contends that claimant did not establish that her work injury lifting a coffee pot caused the rotator cuff tear or that the rotator cuff tear caused any disability or a need for treatment. For the following reasons, we need not decide whether the right shoulder cuff tear resulted in disability or a need for treatment. That is, we find that the record does not establish claimant's May 2000 work injury was a material contributing cause of the claimed right bursal side partial or nearly full thickness rotator cuff tear. We reason as follows.

Because the medical evidence does not support a conclusion that claimant's work injury "combined" with any preexisting conditions, we use a material contributing cause standard on Board review. *See Albany General Hospital v. Gasperino*, 113 Or App 411 (1992); *Antonio E. Sanchez*, 50 Van Natta 967, 968 (1998); *Ronald L. Ledbetter*, 47 Van Natta 1461 (1995) (major contributing cause standard of ORS 656.005(7)(a)(B) applies only if there is evidence that a compensable injury combined with a preexisting condition). Where the medical evidence is divided, we rely on those opinions that are well reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986).

In this case, we find Dr. Bald's opinion more persuasive than that of Dr. Puziss. As previously noted, Dr. Puziss initially opined on October 6, 2000 that claimant's injury was the major contributing cause of claimant's need for treatment. (Ex. 7). Dr. Puzzis, however, provided no direct explanation for that conclusion. Dr. Puziss did refer in his report to the August 2000 MRI, which he stated demonstrated a right bursal side partial or nearly full thickness tear of the rotator cuff that he described as "significant." Not only is this causation opinion conclusory, but Dr. Puziss' belief that that there was a "significant" partial or nearly full thickness rotator cuff tear was not ultimately borne out by his surgical findings. Those findings revealed only a "very tiny" bursal side tear that did not require repair.

In his report to claimant's attorney, Dr. Puziss opined that "work activities" were the major contributing cause of claimant's "condition." Like his earlier causation opinion, Dr. Puziss' final causation opinion is also not persuasive. Dr. Puziss provides little, if any, explanation of his conclusion. Although Dr. Puziss referred to his physical and arthroscopic findings, as well to the MRI scan, as a basis for his otherwise unexplained conclusion, there is no acknowledgment that the August 2000 MRI scan apparently overstated the degree and nature of the rotator cuff tear or that his initial opinion that claimant had a "significant" tear was in error in light of his operative findings. Finally, Dr. Puziss' opinion is vague in that it refers to "work activities" as the major contributing cause of the "condition."

For all these reasons, we do not consider Dr. Puziss' opinion well reasoned or persuasive. Thus, we do not find that it establishes the compensability of a right bursal side partial or nearly full thickness tear of the rotator cuff.[1] Moreover, we find Dr. Bald's opinion more persuasive.

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[1] Because Dr. Puziss' opinion is not well reasoned, we further conclude that Dr. Puziss' opinion does not establish that the compensable injury is a material contributing cause of the "very tiny" rotator cuff tear found at surgery.

Dr. Bald, as part of the panel of examining physicians, initially agreed that the compensable injury was the major contributing cause of the conditions they diagnosed, which included a probable right supraspinatus partial thickness tear. However, even at that point, the panel questioned whether a rotator cuff abnormality was the primary source of claimant's complaints. (Ex. 8-5). Even assuming that this report supported the compensability of a rotator cuff tear as a result of the coffeepot-lifting incident, Dr. Bald issued a subsequent "addendum" report that incorporated the surgical findings of Dr. Puziss. (Ex. 11).

In that report, Dr. Bald stated that the insurer's acceptance should not be expanded to include a partial or nearly full thickness tear because the "very tiny" rotator cuff tear found at surgery was a "very minimal" finding, was not of any clinical significance, and did not account for any of claimant's symptoms. In contrast to Dr. Puziss' opinion, Dr. Bald's fully incorporates the surgical findings, is well-reasoned and, hence, is a persuasive opinion. Thus, based on Dr. Bald's report, we conclude that claimant's injury did not result in the claimed right bursal side partial or nearly full thickness rotator cuff tear.[2]

Accordingly, we reverse the ALJ decision to set aside the insurer's "de facto" denial of claimant's claim for a right bursal side partial or nearly full thickness rotator cuff tear.[3]

ORDER

The ALJ's order dated June 20, 2001 is reversed. The insurer's "de facto" denial is upheld. The ALJ's penalty and attorney fee awards are also reversed.

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[2] To the extent that Dr. Bald's "addendum report" could be considered a change of opinion, we find that it is explained by his review of Dr. Puziss' operative report. *See Kelso v. City of Salem*, 87 Or App 630 (1987) (physician's opinion found persuasive when accompanied by reasonable explanation for the physician's change of opinion).

[3] As previously noted, the ALJ assessed a penalty for the insurer's allegedly unreasonable claim processing. Given our finding that rotator cuff tear claim is not compensable, it follows that there are no amounts due on which to base a penalty. *See* ORS 656.262(11). Thus, we also reverse the ALJ's penalty assessment.

In the Matter of the Compensation of
LISA R. McDONALD, Claimant
WCB Case Nos. 00-06812 & 00-03562
ORDER ON REVIEW
Malagon, Moore, et al., Claimant Attorney
Employers Defense Counsel, Defense Attorney
Jerry Keene, Defense Attorney

Reviewing Panel: Members Haynes and Phillips Polich.

Liberty Northwest Insurance Corp. (Liberty), on behalf of Kunert Electric Co., requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that found Liberty and Fairmont Insurance Co., c/o TIG Insurance Co. (Fairmont/TIG), on behalf of The Mentone Company, jointly responsible for claimant's claim for multiple injuries. Fairmont/TIG cross-requests review of that portion of the ALJ's order that directed Liberty and Fairmont/TIG to pay claimant's attorney a $3,000 assessed attorney fee. On review, the issues are responsibility and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation pertaining to the attorney fee issue.

Fairmont/TIG cross-requests review of that portion of the ALJ's order that directed Liberty and Fairmont/TIG to pay claimant's attorney a $3,000 assessed attorney fee. Fairmont/TIG interprets the ALJ's order to award a single $3,000 attorney fee for which both insurers are jointly responsible, but it

asserts that the ALJ's order raises the possibility of dual $3,000 payments. Further, Fairmont/TIG contends that the circumstances of this case do not merit the assessment of any fee against Fairmont/TIG. According to Fairmont/TIG, it has never resisted paying benefits to claimant and no efforts by claimant's counsel were necessary to protect claimant's right to compensation from Fairmont/TIG. Alternatively, Fairmont/TIG urges us to retract the attorney fee language from the ALJ's order and leave a fair apportionment to the Department of Business and Consumer Services (the Department).

Liberty responds that, if we affirm the ALJ's order pertaining to responsibility, the order should be modified to require each insurer to pay a $1,500 assessed fee.

ORS 656.307(5) provides, in part:

> "If the claimant appears at any such proceeding [under ORS 656.307] and actively and meaningfully participates through an attorney, the Administrative Law Judge may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the Administrative Law Judge to be the party responsible for paying the claim."

Here, the ALJ found that Fairmont/TIG and Liberty were fully and jointly responsible for claimant's November 1999 injury. The ALJ found further that claimant's attorney was entitled to a $3,000 attorney fee under ORS 656.307(5) and directed Liberty and Fairmont/TIG to pay claimant's attorney a $3,000 attorney fee. We interpret the ALJ's order to award claimant's attorney a $3,000 attorney fee for which both insurers are jointly responsible. Although Fairmont/TIG contends that it has never resisted paying benefits to claimant, both Liberty and Fairmont/TIG denied responsibility of claimant's injury claim, and claimant's attorney "actively and meaningfully" participated in the resolution of the responsibility dispute at hearing. Under ORS 656.307(5), the ALJ, not the Department, has the authority to require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the ALJ "to be the party responsible for paying the claim." Here, we agree with the ALJ that Liberty and Fairmont/TIG are fully and jointly responsible for claimant's injury, and we further agree that both insurers are responsible for the $3,000 attorney fee. In other words, we find that each insurer is responsible for paying a $1,500 attorney fee to claimant's attorney.

Claimant's attorney requests an additional assessed attorney fee for "defending compensation on review." Compensability was not disputed at hearing or on review. Because the Department issued a "307 order" (Ex. 30), the authority for awarding an attorney fee is found in ORS 656.307. Although ORS 656.307(5) provides that an ALJ may award a reasonable attorney fee if claimant appears at a proceeding under ORS 656.307 and actively and meaningfully participates through an attorney, there is no statutory authority under ORS 656.307 to award an assessed attorney fee for claimant's counsel's services on review. *See, e.g., Lynda C. Prociw*, 46 Van Natta 1875 (1994).

ORDER

The ALJ's order dated June 11, 2001 is affirmed.

sought those records. It appears that the agent for Barrett did seek them, and that they were provided, but not until after Barrett had already accepted the claim. There appears to be no reason why the agent for Barrett could not have obtained the records prior to its acceptance of the claim." (Citations to the record omitted.)

After accepting the claim and before issuing the denial, Barrett acquired the following new evidence: It received Van Allen's post-operative report indicating that he still believed claimant's condition resulted from the injury on the job at Barrett and a subsequent report indicating that the condition resulted not from the Barrett injury but from a preexisting condition. It also received Gambee's first review, which indicated that claimant's condition resulted from work at Freightliner, and a second review by Gambee indicating that the condition resulted from his injury at Barrett. It further received the contents of claimant's file from Freightliner, which contained information related to his earlier claim based on work there.

Based on this record, we conclude, as did the Board, that Barrett's denial was not based on later obtained evidence. The new evidence from Gambee ultimately supported Freightliner's position, not Barrett's. The new evidence from the Freightliner file cannot be considered "later obtained" because Barrett knew of its existence and importance at the time it issued the acceptance. *Greenbriar Ag Management*, <**178 Or App 152/153**> 156 Or App at 506-07. Further, that evidence merely confirmed the existence of a preexisting injury, the possibility of which Barrett was aware at the time it accepted the claim, and therefore is not later obtained evidence. *Freightliner Corp.*, 163 Or App at 195.

As to Barrett's contention that new post-operative information from Van Allen played a large part in the "back-up" denial, the Board found otherwise, and substantial evidence supports that finding. Van Allen's only mention of the intraoperative findings is to conclude that they "would be consistent" with his position that the preexisting injury was what necessitated the surgery. He reached the same conclusion based on 1995 x-rays; the Board did not find this to be "reliance" on the intraoperative findings, and, again, substantial evidence supports that finding. And, even if these findings played a small part in the "back-up" denial, this would not be sufficient to justify it. In *Curry Educational Service Dist.*, we affirmed the Board in a finding that a "back-up" denial was procedurally invalid because the physicians' opinions "for the most part relied upon the same information available to employer when it accepted" the claim. 175 Or App at 256.

Barrett, then, issued the back-up denial based on information that was not "later obtained evidence." The denial was therefore invalid.

Affirmed.

In *Freightliner Corp. v. Christensen*, 163 Or App 191, 986 P2d 1263 (1999), the employer accepted a worker's claim stemming from a back injury but subsequently issued a denial based on "new" information indicating that the condition resulted primarily from degenerative disc and joint disease and not from any particular on-the-job trauma. We held that the evidence confirming the non-work-related cause was not "later obtained":

> "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." *Id.* at 195 (emphasis added).

That case, then, further limits what might be considered "later obtained evidence" so as to exclude information confirming facts that the employer had reason to suspect at the time of acceptance.

Most recently, in *Curry Educational Service Dist.*, the employer accepted a claim for a back injury based on two doctors' diagnoses. After acceptance, three more physicians **<178 Or App 150/151>** examined the worker, and all concluded that the first diagnosis was wrong: The employer was not responsible because the worker's injury was caused by a preexisting condition. The employer then issued a "back-up" denial. In concluding that the denial was not authorized by ORS 656.262(6)(a), we held that the "corrected" diagnosis was not "later obtained evidence" under that statute; "[t]he evidence is not 'newly discovered,' only the diagnosis is." 175 Or App at 257. We agreed with the claimant, who argued that the phrase "'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." *Id.* at 256. Thus, "later obtained evidence" does not include new comments on or analyses of preexisting factual data; it includes only new facts in the narrowest sense.

From these cases, we extrapolate the following principle for application here: "Later obtained evidence" does not include evidence that the employer either had, or in the exercise of reasonable diligence should have had, at the time of acceptance, nor does it include the restatement, reevaluation, analysis, or confirmation of such evidence.

The Board found, and substantial evidence supports its findings, that, at the time Barrett accepted claimant's wrist injury,

> "considerable evidence existed to indicate that the condition preceded claimant's injury on the job with Barrett. Claimant had a prior right-wrist injury with Freightliner. Barrett was aware of that. * * * There is no indication, however, that prior to acceptance, the former processing agent for Barrett made an effort to obtain the medical records associated with claimant's Freightliner injury. (Claimant had specifically identified for Barrett's agent the date of the Freightliner injury.)
>
> "The very first day claimant was treated for the Barrett injury, he told the emergency room physician that he had experienced pain in the same area in the past. When claimant saw Dr. Yarusso only a few days later, claimant identified a Freightliner injury of several years earlier and indicated he continued to wear a band on his right wrist and had continued to have bouts of discomfort in the wrist.
>
> **178 Or App 152>** "Most significantly, Dr. Nolan looked at the arthrogram done in May 1997 and interpreted it as showing a chronic, old scapholunate dissociation. It would be difficult to imagine a clearer signal to Barrett's then agent that claimant's problem preexisted his employment with Barrett. Barrett certainly knew of Dr. Nolan's existence, as the processing agent communicated with him in May 1997. The agent had one chart note , but it does not appear that the agent ever asked for the doctor's other notes.
>
> "Dr. Van Allen initially told the Barrett agent that he could not define a specific diagnosis preexisting the Barrett injury. He indicated it was more likely that claimant sustained an acute injury in 1997 rather than a worsening of a preexisting condition, but he warned that there was no way of 'proving' that, as 'medical records were not available following that previous injury.' There is no indication that Dr. Van Allen

On July 27, 1998, claimant was seen by Gambee and Dr. Vessely. Gambee noted that he now had more information than when he made his chart review and acknowledged that he was changing his opinion as a result of this more complete examination. He now opined that claimant's condition was the result of the injury while at Barrett. The next day Freightliner denied responsibility for the claim.

Van Allen then reviewed the records that predated his involvement with the case and concluded that claimant had a preexisting injury, the symptoms of which were only exacerbated by the later Barrett injury--thus contradicting Gambee and putting responsibility back on Freightliner. He also noted that his "intraoperative findings with the mild degenerative changes would be consistent with a more remote injury." In a letter dated September 16, 1998, Barrett rescinded acceptance of the claim, issued the "back-up" denial and claimed that Freightliner bore the responsibility.

Claimant at this point had an injury that both employers agreed was compensable, but for which both denied responsibility. He sought review of both denials. An administrative law judge (ALJ) found that Barrett's back-up denial of the claim was not based on later obtained evidence, **<178 Or App 148/149>** set aside Barrett's back-up denial of responsibility, affirmed Freightliner's denial of responsibility, and assessed a penalty against Barrett. Barrett appealed to the Board, which reversed on the penalty assessment but affirmed the ALJ's conclusion that Barrett bore responsibility for claimant's injury. Barrett seeks judicial review.

The legislative assembly enacted the so-called "back-up" denial provision of ORS 656.262(6)(a) in order to address the problem of "nervous denials," that is, allegedly unwarranted denials issued by employers who feared that, once they had accepted a claim, they would be unable to revoke acceptance even if they later discovered evidence indicating that the claim was not compensable or that they were not responsible for it. *CNA Ins. Co. v. Magnuson*, 119 Or App 282, 285, 850 P2d 396 (1993). ORS 656.262(6)(a) provides, in pertinent part:

> "If the insurer or self-insured employer accepts a claim in good faith * * * 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[.]"

In order to review the Board's order, we must first determine what "later obtained evidence" is and then determine whether Barrett's denial relied on it. Evidence obtained after issuance of the denial is, of course, irrelevant; such evidence could not have affected the denial and is therefore immaterial.

We have examined the phrase "later obtained evidence" in several cases. In *CNA Ins. Co.*, an employer accepted a claim before ORS 656.262 was amended to permit back-up denials. After the amendment, the employer solicited and received a "new" letter from the claimant's physician confirming the physician's earlier theory that the claim was not compensable. *CNA Ins. Co.*, 119 Or App at 284. The Board held that the "new" letter was not "later obtained evidence." We agreed:

> "The legislature intended that evidence warranting a retroactive denial 'come about' after the insurer's original acceptance. We agree * * * that the statute requires new **<178 Or App 149/150>** material, *i.e.*, something other than the evidence that the insurer had at the time of the initial acceptance. The letter that employer offers as new evidence merely repeats the doctor's earlier report[.]" *Id.* at 286.

In *Greenbriar Ag Management*, the employer accepted a worker's claim after the employer had requested the worker's file from a previous employer but before the file arrived. When it did arrive, it contained evidence indicating that the first employer, not the second, was responsible. We held that the material arriving after acceptance was not new to the second employer, despite the fact that employer did not have it until after acceptance, because it "was evidence that insurer *knew of* and, in fact, had requested and was awaiting." *Greenbriar Ag Management*, 156 Or App at 507 (emphasis added). Thus, the term "later obtained evidence" excludes not only information that an employer actually has at the time of acceptance, but also information that the employer knows about but does not yet possess in concrete form.

Cite as 178 Or App 145 (2001) November 14, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Steven P. Stewart, Claimant.

BARRETT BUSINESS SERVICES, INC., Petitioner,
v.
STEVEN P. STEWART and FREIGHTLINER CORP., Respondents.
98-06193 and 98-03468; A111407

Judicial Review from Workers' Compensation Board.
Argued and submitted August 2, 2001.
Scott H. Terrall argued the cause and filed the briefs for petitioner.
Deborah L. Sather argued the cause for respondent Freightliner Corp. With her on the brief was Tracy J. White and Sather, Byerly & Holloway.
Michael A. Bliven waived appearance for respondent Steven P. Stewart.
Before Landau, Presiding Judge, and Brewer and Schuman, Judges.
SCHUMAN, J.
Affirmed.

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178 Or App 147> This workers' compensation case requires us to determine whether Barrett Business Services, Inc. (Barrett), having accepted responsibility for claimant's compensable injury, was entitled subsequently to issue a "back-up" denial based on evidence obtained after claim acceptance, indicating that an earlier employer, Freightliner LLC (Freightliner), was responsible. The Workers' Compensation Board (Board) rejected Barrett's argument, concluding that the denial was not based on "later obtained evidence." We review the Board's understanding of what "later obtained evidence" means for errors of law, ORS 183.482(8)(a); *Curry Educational Service Dist. v. Bengtson*, 175 Or App 252, 27 P3d 526 (2001), and its factual findings for substantial evidence, ORS 183.482(8)(c); *Greenbriar Ag Management v. Lemus*, 156 Or App 499, 965 P2d 493 (1998), *rev den* 328 Or 594 (1999), and affirm.

In November 1994, claimant injured his right wrist while working for Freightliner. Freightliner accepted the condition as a disabling injury. On October 26, 1995, a determination order awarded periods of temporary partial and temporary total disability.

Thereafter, claimant left Freightliner and went to work for Barrett. In March 1997, while on the job at Barrett, he twisted his right wrist lifting a propane tank. He was examined in an emergency room for severe pain. While there, he mentioned that he had experienced wrist pain in the past. He was given a splint and medication.

Several days later, as a result of repeated bouts of discomfort in the wrist, claimant saw Dr. Yarusso. He told the doctor that he had originally injured the wrist while at Freightliner and had continued to wear a band for it. Yarusso diagnosed wrist tendinitis and noted that claimant's symptoms might stem from the injury on his old job. Claimant was referred to Dr. Van Allen, a surgeon. In May 1997, claimant consulted Van Allen and again recounted the history of his earlier wrist injury at Freightliner, reporting that he had experienced intermittent pain since its occurrence. Van Allen suggested surgery and advised Barrett's processing agent **<178 Or App 147/148>** that, in his opinion, claimant suffered from the acute injury he received in March 1997 at Barrett, rather than from an exacerbation of a preexisting condition, but that there was no way to confirm this opinion because medical records were not available for the earlier injury.

On July 14, 1997, Barrett's processing agent accepted a claim for complete scapholunate dissociation with static carpal instability and classified it as nondisabling. Subsequently, the claim was classified as disabling.

On July 30, 1997, Van Allen performed wrist surgery on claimant. His postoperative report indicated that he still believed that claimant's injury was caused by the 1997 incident that occurred while employed by Barrett. However, Dr. Gambee, an orthopedic surgeon, reviewed claimant's charts in February 1998 and concluded that claimant's condition was related to the earlier injury suffered on the job at Freightliner.

degenerative disc condition. That is a question of fact, which we review for substantial evidence. *Granner*, 147 Or App at 411. If the answer is yes, claimant prevails; if the answer is no, employer prevails.

For several reasons, we conclude that the term "low back disability" is not merely a gloss on "low back strain," but an additional accepted condition. The relevant sentence within the CDA reads as follows: "The accepted conditions subject to this claim disposition agreement are low back strain, low back disability and psychological conditions including depression." We interpret a CDA as if it were a contract. *Neighbors*, 167 Or App at 347. That means we begin with the text and context, proceed to extrinsic evidence of the parties' intent if the text and context do not resolve all ambiguities, and, if ambiguity remains after the second step, resort to maxims of construction. *Yogman v. Parrott*, 325 Or 358, 361-64, 937 P2d 1019 (1997).

We begin with the word "disability." Employer argues that this word denotes neither a symptom nor a condition, but "the *classification* of a compensable claim for purposes of determining the amount of compensation." Employer points to the use of the word "disability" in several workers' compensation statutes to bolster that argument. We find that those examples work against employer, not for it. For example, employer cites ORS 656.214(1)(b), which defines "permanent partial disability" as "the loss of either one arm, one hand, * * * or any other injury known in surgery to be permanent partial disability." Employer also cites ORS 656.206(1)(a), where "permanent total disability" is defined to mean "the loss, including preexisting disability, of use or function of any * * * portion of the body[.]" In these statutes, the word "disability" refers to a condition of incapacity, an "injury" that renders the injured person less than completely able--in other words, a condition, injury, disease or symptom. Not surprisingly, this statutory use of the term reflects **<178 Or App 142/143>** its normal usage. *Webster's Third New International Dictionary*, 642 (unabridged ed 1993), contains the following definitions: "the condition of being disabled[;]* * * a physical or mental illness, injury, or condition that incapacitates in any way."[2]

Further, within its sentence, the phrase "low back disability" is one of three coordinate predicate complements of the word "condition." The other two terms ("low back strain," "psychological conditions") are unambiguously symptoms, conditions, or diseases and not "classifications."

In short, we find no ambiguity in the disputed sentence: The CDA accepts three different conditions, not two conditions surrounding a term of legal classification. Even if there were an ambiguity, however, the outcome would not differ. Finding no extrinsic evidence of the parties' intentions, we would reach the third level of contract interpretation, maxims of construction. In particular, we would rely on the maxim that an ambiguous contract is construed against the drafter. *Neighbors*, 167 Or App at 347 ("Even if the CDA provision were to be considered ambiguous, any ambiguity * * * is resolved against insurer as the drafters[.]"). So construed, the CDA in this case includes employer's acceptance of claimant's low back disability.

That conclusion, however, does not resolve the case. Under *Piwowar* and subsequent cases, the 1992 acceptance of low back disability precludes employer from denying claimant's current condition--a degenerated spine--only if the degenerative condition of claimant's spine preexisted the low back disability *and caused it*. If claimant's low back disability in 1992 was unrelated to (not caused by, not a symptom of) the preexisting degenerated spine, then the preexisting degenerated spine was a separate condition from the accepted low back disability, and employer is not now precluded from denying responsibility for it. *Boise Cascade Corp.*, 104 Or App at 735 (acceptance of right wrist strain does not imply acceptance of preexisting disease); *Granner*, **<178 Or App 143/144>** 147 Or App at 409-11 (acceptance of dislocated knee does not imply acceptance of preexisting knock knee condition unless knock knee condition caused dislocation). Because the Board concluded that "low back disability" did not constitute a separate accepted condition, it did not reach the question whether that condition was a result of the preexisting disease. That is a question of fact that the Board should address on remand.

Reversed and remanded.

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[2] Another definition, "the inability to pursue an occupation or perform services for wages because of physical or mental impairment," makes no sense in defining a noun that is modified by the adjectival phrase "low back." One does not speak of a "low back inability to pursue an occupation for wages."

underlying degenerative changes. Dr. Williams reported the panel's opinion that the effects of claimant's 1987 compensable injury had fully and completely resolved. Williams later stated in a deposition that the degenerative changes that were apparent in the 1990 MRI probably preexisted the 1987 compensable claim. Based on the panel's opinion, employer denied responsibility for claimant's current condition.

178 Or App 140> At a hearing on that denial, claimant argued that one of the conditions employer accepted in the 1992 CDA was "low back disability," that "low back disability" was a symptom or result of the underlying degenerative condition, and that, therefore, under the doctrine announced in *Georgia-Pacific v. Piwowar*, 305 Or 494, 753 P2d 948 (1988), employer had accepted the underlying degenerative condition and was precluded from denying a claim based on it. The administrative law judge (ALJ) disagreed with the premise of that argument, namely that the CDA could be interpreted as an acceptance of low back *disability*. Rather, the ALJ concluded that "the CDA recognizes only acceptance of the specific condition of a low back *strain* and the permanent disability awarded to that date for the specific condition of low back strain." (Emphasis added.) According to the ALJ, the term "low back disability" in the CDA was not a separate condition or symptom that employer agreed to accept; rather, it was a reference to the *award* of disability that claimant had received in compensation for his back strain. The Board accepted the ALJ's conclusion without comment. We, however, disagree.

In *Piwowar*, the employer accepted a claim for a "sore back" and subsequently discovered that the sore back was a symptom of an underlying degenerative condition, ankylosing spondylitis. *Piwowar*, 305 Or at 497. The employer maintained that it was not thereafter required to pay compensation for the underlying disease. *Id.* The Supreme Court, however, noted that the employer's position would lead to "instability, uncertainty and delay" and held that acceptance of a particular condition or symptom automatically included "acceptance of the disease causing that condition." *Id.* at 501. Thus, in accepting a "sore back," the employer accepted the ankylosing spondylitis, even though the employer was not in fact responsible for that disease. By contrast, had the employer accepted only a back strain, that acceptance would not have implied acceptance of the disease because the strain and the disease "are two separate infirmities (unless of course one is merely a symptom of the other)." *Id.*

Subsequent cases have confirmed and refined this doctrine. In *Boise Cascade Corp. v. Katzenbach*, 104 Or App **<178 Or App 140/141>** 732, 735, 802 P2d 709 (1990), *rev den* 311 Or 261 (1991), this court held that, when the employer accepted "right wrist strain," it did not automatically accept avascular necrosis because the two infirmities--the strain and the preexisting disease--"are separate conditions," that is, the strain was not caused by, nor was it a symptom of, the disease. In *Granner v. Fairview Center*, 147 Or App 406, 935 P2d 1252 (1997), we held that when the employer's insurer accepted a "right patellar dislocation" (dislocated knee), it did not necessarily and as a matter of law also accept a preexisting condition, "bilateral knock knee deformity," because substantial evidence supported the Board's finding that the preexisting condition was not the "sole cause" of the dislocation--that is, that the dislocation was not merely a "symptom" of the preexisting condition. *Id.* at 409-11. In *Freightliner Corp. v. Christensen*, 163 Or App 191, 986 P2d 1263 (1999), we held that, when the employer accepted a claim for "low back pain," it also accepted "all the conditions that the medical evidence shows underlie the low back pain, including claimant's preexisting degenerative back conditions." *Id.* at 196.

The cases, then, establish that when an employer accepts a symptom such as "back pain" or "sore back," or a condition such as "dislocated knee," it also accepts the underlying preexisting disease or condition that is the cause of the accepted symptom or condition; however, if the accepted condition or symptom and the preexisting condition are separate conditions, that is, if there is no cause-and-effect relationship between them, then the accepted condition does not include the preexisting condition or disease, and an employer may subsequently deny responsibility for it in a later claim.

To apply that rule here, we must resolve the following questions: Did employer, in accepting "low back disability," accept a condition separate from the "low back strain," or does the phrase "low back disability" simply modify or clarify the preceding phrase? That question revolves around the interpretation of the CDA, which is a question of law. *Neighbors v. Blake*, 167 Or App 343, 347, 3 P3d 172 (2000). If the answer is that "low back disability" merely modifies "low back strain," then "low back disability" was not included in the earlier acceptance and employer may deny responsibility **<178 Or App 141/142>** for it now.[1] If, however, employer accepted "low back disability" as a condition or symptom in addition to "low back strain," we must ask whether the disability was caused by the

[1] Claimant does not argue that the strain was caused by the preexisting condition.

Contrary to claimant's contention, that does not mean that undocumented workers will receive no TPD payments once they are able to perform some type of modified work. The modified work that the employer identifies to the physician to shift an undocumented worker to TPD payments must be work that the employer would have offered to the worker at the specified wage rate but for claimant's status as an undocumented worker.[2] Claimant did not dispute that the modified work identified by employer met that standard, so **<178 Or App 87/88>** the Board did not err in its calculation of his TPD benefits. Our disposition of this issue necessarily resolves the question of claimant's entitlement to a penalty.

Affirmed.

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[2] ORS 656.325(5)(c) provides that an undocumented worker can be shifted to TPD payments when the attending physician approves the worker's "employment in a modified job whether or not such a job is available." We understand the language on the availability of the modified job to mean that an employer need not show that the modified job was, in fact, available when the physician approved the worker for it or that the job remained available throughout the time that the worker was eligible to receive temporary disability payments.

Cite as 178 Or App 137 (2001) November 14, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert E. Hill, Claimant.

ROBERT E. HILL, Petitioner,

v.

QWEST, Respondent.

00-00088; A112816

Judicial Review from Workers' Compensation Board.

Argued and submitted August 24, 2001.

Robert F. Webber argued the cause for petitioner. With him on the brief was Black, Chapman, Webber & Stevens.

Marjorie A. Speirs argued the cause for respondent. With her on the brief were Janet M. Schroer and Hoffman, Hart & Wagner, LLP.

Before Landau, Presiding Judge, and Brewer and Schuman, Judges.

SCHUMAN, J.

Reversed and remanded.

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178 Or App 139> Claimant sought workers' compensation benefits for a back condition. Qwest (employer) issued a denial based on medical evidence that the condition was caused by degeneration of the spine unrelated to employment. On administrative review, claimant argued that employer had already accepted an earlier claim that included the degenerative back condition and that employer was therefore precluded from subsequently denying it. Employer responded that its earlier acceptance did not include the underlying degenerative back condition, and the Workers' Compensation Board (Board) agreed. Claimant seeks judicial review. We reverse and remand.

Claimant injured his low back in 1987. The claim was closed later that year with an award of 25 percent unscheduled disability. In 1990, claimant experienced an episode of acute low back pain; an MRI at the time demonstrated degenerative changes. Another episode of acute pain occurred in 1991.

In August 1992, petitioner and employer entered into a claims disposition agreement (CDA) drafted by employer, which stated that "the accepted conditions subject to this claim disposition agreement are low back strain, low back disability and psychological conditions including depression."

In 1997 and 1999, claimant again experienced episodes of low back pain. A panel of doctors examined claimant at that time, reviewed his medical records and concluded that he had experienced exacerbations of lumbosacral pain associated with documented degenerative changes. The panel also concluded that claimant's current symptom, waxing and waning pain, was directly related to the

> "The payment of temporary total disability pursuant to ORS 656.210 shall cease and the worker shall receive that proportion 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."[1]

See also OAR 436-060-0030(2).

ORS 656.325(5) addresses various situations in which a worker who is physically able to assume a modified assignment refuses or otherwise fails to do so. That statute provides, as relevant:

> **178 Or App 86>** "(a) An insurer or self-insured employer shall cease making payments pursuant to ORS 656.210 and shall commence making payment of such amounts as are due pursuant to ORS 656.212 when an injured worker refuses wage earning employment prior to claim determination and the worker's attending physician, after being notified by the employer of the specific duties to be performed by the injured worker, agrees that the injured worker is capable of performing the employment offered.
>
> "(b) If the worker has been terminated for violation of work rules or other disciplinary reasons, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician approves employment in a modified job that would have been offered to the worker if the worker had remained employed, provided that the employer has a written policy of offering modified work to injured workers.
>
> "(c) If the worker is a person present in the United States in violation of federal immigration laws, the insurer or self-insured employer shall cease payments pursuant to ORS 656.210 and commence payments pursuant to ORS 656.212 when the attending physician approves employment in a modified job whether or not such a job is available."

Claimant contends that, because he is forbidden by law from performing it, the wages attributable to modified work for purposes of the proration under ORS 656.212(2) and OAR 436-060-0030(2) are *ipso facto* zero. Therefore, he concludes that the TPD rate should be equal to his TTD entitlement. Employer argues, in polar opposition, that an injured undocumented immigrant worker whose employer proposes modified work with a wage equal to that of the worker's former position should be treated as receiving wages in the same amount for both the preinjury job and the modified job. The effect, respondents urge, is that TPD should be fixed at zero--at least under the facts here.

Both sides argue that the other's reading of the statutory scheme amounts to a total evisceration of it. According to respondents, both ORS 656.212(2) and ORS 656.325(5)(c) contemplate a change from TTD to TPD, while claimant's argument would make the two rates equal in every instance. **<178 Or App 86/87>** According to claimant, on the other hand, respondents' understanding of the statutes would make the possibility of TPD payments to the workers wholly ephemeral: The employer could simply fabricate an "unavailable" modified position having the same wage in fiction as the employer's former position had in fact, and thereby defeat any redeemable right to TPD payments. Claimant asserts that such a result is clearly contrary to the legislature's intent, and notes:

> "The legislature could have simply said that illegal aliens don't get [TPD]. If that is what the legislature had intended, ORS 656.325(5)(c) would have said so; rather than requiring that payments commence pursuant to ORS 656.212. * * * The legislature would not have required that payments commence if it had intended that no payments be made."

The Board, in essence, agreed with employer. We do as well. The legislature intended employers of undocumented workers to be able to get the benefit that is available to employers of workers who are able to perform modified work. That means that undocumented workers who are physically able to perform modified work for an employer are to receive TPD payments that reflect a reduction for the income that the workers would have received but for their undocumented status.

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[1] The statute has been amended since the events in question. Because the amendments are not relevant to our discussion, we quote the present version.

Cite as 178 Or App 82 (2001) November 14, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Alfredo R. Hernandez, Claimant.

ALFREDO R. HERNANDEZ, Petitioner,

v.

SAIF CORPORATION and FIVE STAR TREES, INC., Respondents.

97-10169; A105154

Judicial Review from Workers' Compensation Board.
Argued and submitted April 28, 2000.
Max Rae 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.
ARMSTRONG, J.
Affirmed.

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178 Or App 84> Claimant seeks review of an order of the Workers' Compensation Board (Board) that calculated his benefits for temporary partial disability (TPD) compensation at a rate of zero. We affirm.

On November 16, 1997, claimant compensably injured his foot while working as a Christmas tree harvester for employer. His physician authorized temporary total disability (TTD) through November 17, 1997. Employer proposed a modified job for claimant as a tree tallier/tier, and claimant's physician approved claimant for the modified job. The tree tallier/tier position had the same hours and wages as claimant's previous job, with an average weekly wage of $270. Employer would have offered the job to claimant, except that claimant was unable to prove that he possessed a valid social security number after the validity of the number that he had presented at hire was questioned. For the purposes of this case, claimant waived the opportunity to contest that he was in violation of federal immigration laws, that is, that he was an undocumented worker for the time periods for which he sought compensation.

Insurer paid claimant TPD at the full TTD rate for November 19 and 20, 1997, but has paid no other compensation since claimant was approved for modified work. Claimant has neither reached medically stationary status nor been released for regular work. He has earned no wages since the date of his compensable injury on November 16, 1997.

Claimant filed a request for a hearing, seeking additional temporary disability compensation, as well as penalties for insurer's failure to pay temporary partial disability benefits. The administrative law judge (ALJ) issued an order granting TPD in the amount of $3,060.17 to claimant for the period from November 21, 1997, to March 20, 1998. The ALJ reasoned that ORS 656.325(5)(c) authorizes TPD benefits for undocumented workers regardless of job availability. Thus, the ALJ found claimant's benefits were authorized at his full TTD rate because he had no actual wages. The ALJ held that OAR 436-060-0030(7), under which TPD benefits are calculated "as if the worker had begun the employment," exceeded **<178 Or App 84/85>** the director of the Workers' Compensation Department's rule-making authority, because that rule was inconsistent with ORS 656.325(5)(c) and ORS 656.212(2). The ALJ also held that claimant was not entitled to any penalties because insurer had a legitimate doubt as to how to calculate claimant's TPD benefits.

Both claimant and employer requested that the Board review the ALJ's order. The Board held that, while ORS 656.325(5)(c) provides that claimant is entitled to TPD benefits, claimant's TPD rate was zero, because the wage of employer's modified job was the same as claimant's pre-injury job. *See* OAR 436-060-0030(2). The Board also held that claimant was not entitled to penalties for insurer's failure to pay TPD benefits. Claimant now assigns error to the Board's computation of his TPD rate and to the denial of penalties.

Employees who are compensably injured while working are generally entitled to temporary disability benefits. ORS 656.210. However, after being approved by their physician for modified work, employees have a duty to mitigate their wage loss by accepting modified jobs. *Nelson v. EBI Companies*, 296 Or 246, 674 P2d 596 (1984). When the disability becomes only partial, ORS 656.212(2) becomes applicable and prescribes:

In this case, the Board's failure to explain why employer did not accept a combined condition prevents us from ascertaining whether its decision was based on substantial evidence in the record or whether it was based on an <177 Or App 647/648> incorrect understanding of the applicable legal standard. Because the "Board did not 'provide a sufficient explanation to allow a reviewing court to examine the agency's action,'" *SAIF v. January*, 166 Or App 620, 626, 998 P2d 1286 (2000), we must remand the issue of the scope of employer's acceptance to the Board for reconsideration. *Blamires*, 171 Or App at 267.

Employer next assigns error to the Board's conclusion that employer's preclosure denial was improperly prospective because "there was neither ongoing treatment nor any request for further medical services related to claimant's right shoulder condition." An employer may not deny future benefits or disability on an accepted claim. *Evanite Fiber Corp. v. Striplin*, 99 Or App 353, 357, 781 P2d 1262 (1989). An employer may deny specific unpaid services or a current claimed need for treatment, even if there are no remaining unpaid medical bills. *Boise Cascade Corp. v. Hasslen*, 108 Or App 605, 608, 816 P2d 1181 (1991). Generally speaking, however, there must be a claim for medical treatment or disability for the employer to deny. *Altamirano v. Woodburn Nursery, Inc.*, 133 Or App 16, 19-20, 889 P2d 1305 (1995). "In the absence of a claim, there cannot be a denial that has any effect." *Id.* at 20. Employer does not contend that, at the time of its November 1998 denial, there was a claim for medical treatment or disability for it to deny. However, employer asserts that it nonetheless made a proper preclosure denial of a combined condition under ORS 656.262(7)(b).

The Board will determine on remand whether employer accepted a combined condition. If employer accepted a combined condition, ORS 656.262(7)(b) would apply. Therefore, employer would be *required* to issue a denial--regardless of whether a current request for treatment existed--before it could close the claim. ORS 656.262(7)(b) ("[E]mployer *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." (Emphasis added.)). Accordingly, contrary to the Board's apparent belief, its alternative ground for rejecting employer's denial is not independent from the first. Each hinges on the accuracy of its characterization of the scope of employer's acceptance of claimant's condition.

Claimant relies primarily on *Croman Corp.* for the proposition that the absence of a current claim for medical treatment or disability for the employer to deny renders an employer's denial of a combined condition improperly prospective. That reliance is misplaced. In *Croman Corp.*, the employer accepted a claim for a cervical strain suffered by the claimant at work. The employer later concluded that the claimant's need for ongoing medical treatment was not related to the accepted injury but was, in fact, the result of a preexisting psychological condition. The employer issued a preclosure denial stating that "the conditions [that the claimant] received from [his] fall * * * are completely resolved and [he is] no longer in need of medical treatment." 163 Or App at 138. The Board concluded that the denial amounted to an impermissible denial of future responsibility, and we affirmed:

> "[The] denial by its terms was an attempt to deny future medical treatment on an accepted claim on the ground that ongoing medical treatment was not related to the compensable injury. If [the] employer believed that the accepted conditions were resolved and that [the] claimant was no longer in need of medical treatment for those conditions as it stated in its denial, then it could have closed the claim." *Id.* at 141-42.

In *Croman Corp.*, we determined that the Board's finding that there was no evidence that the employer had ever accepted a combined condition was supported by substantial evidence. Id. at 141. Thus, we held that "the Board did not err in concluding that ORS 656.262(7)(b) did not apply to this case at the time of [the] employer's denial because there had not been an accepted combined condition." *Id.* In short, *Croman Corp.* will control this case only if the Board determines on remand that employer did not accept a combined condition.

Finally, employer assigns error to the Board's award of attorney fees to claimant pursuant to ORS 656.386(1). Because claimant has not yet finally prevailed, the award was erroneous.

Reversed and remanded.

Claimant's argument reduces to the proposition that "magic words" are necessary to signify the acceptance of a combined condition. However, none of the cases on which claimant relies supports that view. In fact, in other workers' **<177 Or App 645/646>** compensation contexts, we have held that evidence need not consist of "magic words" in order to adequately support the Board's findings. *See SAIF v. Strubel*, 161 Or App 516, 521-22, 984 P2d 903 (1999) (holding that an expert's opinion need not be ignored because it fails to include the magic words "major contributing cause"); *Bank of Newport v. Wages*, 142 Or App 145, 150-51, 919 P2d 1189 (1996) (same); *Freightliner Corp. v. Arnold*, 142 Or App 98, 105, 919 P2d 1192 (1996) (same); *Moore v. Douglas County*, 92 Or App 255, 258, 757 P2d 1371 (1988) (same for "reasonable medical probability").

Claimant remonstrates that the context here is different, because a notice of acceptance should be strictly construed against the employer to enhance predictability and clarity in the administration of claims. At oral argument, she contended that

> "[if employers can] make an issue of fact of what the scope of acceptance was, by not requiring a combined condition language in there, it opens up a whole other realm of ambiguity about what in fact is accepted and what in fact is not accepted. * * * [I]t would tend to lead to a great deal more litigation."

We disagree. The scope of an employer's acceptance has *always* been an issue of fact. *See, e.g., Dobbs*, 172 Or App at 451. There is no statute that prescribes a particular manner for acceptance of a combined condition. We have held that an employer accepts a combined condition "pursuant to" ORS 656.005(7)(a)(B).[4] *Birrer v. Principal Financial Group*, 172 Or App 654, 659, 19 P3d 972 (2001); *SAIF v. Belden*, 155 Or App 568, 572-73, 964 P2d 300 (1998), *rev den* 328 Or 330 (1999). However, that statute does not provide a procedure for accepting combined conditions but, rather, explains the substantive effect of the acceptance of such conditions.

177 Or App 647> Nor do more general statutes governing the sufficiency of notices of acceptance support claimant's view. ORS 656.262(6)(a), upon which claimant relies, merely provides that a notice of acceptance shall "specify what conditions are compensable." That requirement does not mandate the use of any particular descriptive label making explicit that two or more conditions have combined. It is true that the acceptance in this case did not expressly inform claimant that the preexisting condition--multidirectional instability--was not being accepted outright and that it was only compensable as part of a combined condition. *See Multifoods Specialty Distribution v. McAtee*, 164 Or App 654, 661, 993 P2d 174 (1999), *rev allowed* 332 Or 305 (2001) (holding that acceptance of a combined condition is not an outright acceptance of a preexisting condition that has combined with a work-related injury or condition). However, the notice *did* apprise claimant of the nature of the compensable conditions covered by the acceptance and, therefore, offended no legal requirement that has been brought to our attention.[5] Accordingly, we conclude that a notice of acceptance that fails to employ the specific words "combined condition" is not--for that reason alone--insufficient as a matter of law to constitute an acceptance of a combined condition for purposes of ORS 656.262(7)(b). *See Freightliner Corp. v. Christensen*, 163 Or App 191, 196, 986 P2d 1263 (1999) (hypothesizing that an acceptance of "back sprain/strain" could properly be viewed as acceptance of a combined condition in light of pre-existing back conditions).[6]

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[4] 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."

[5] ORS 656.262(7)(a) provides that "[an] 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."

[6] Claimant does not argue, and we do not decide, whether "multidirectional instability" describes an accepted symptom, which would render all underlying causes compensable. *See Georgia-Pacific v. Piwowar*, 305 Or 494, 501, 753 P2d 948 (1988) (holding that by accepting the claimant's claim for a symptom, the employer had accepted the claim for all of its underlying causes). *See also Christensen*, 163 Or App at 197 ("Although, as a matter of fact, the preexisting conditions did combine to give rise to claimant's need for treatment, they are compensable in their own right as a matter of law under *Piwowar* and may not be denied.").

Board's determination that employer did not accept a combined condition for substantial evidence. ORS 183.482(8)(c). Employer cites *Blamires v. Clean Pak Systems, Inc.*, 171 Or App 263, 15 P3d 101 **<177 Or App 643/644>** (2000), for the proposition that an acceptance of a combined condition is not required to include the specific words "combined condition." In *Blamires*, the employer issued, in the following order, (1) an acceptance that did not mention a combined condition; (2) a denial under ORS 656.262(7)(b) in reliance on the existence of a combined condition; and (3) an express acceptance of the combined condition. The Board upheld the denial on the basis of the employer's express acceptance of the combined condition. Citing *Croman Corp. v. Serrano*, 163 Or App 136, 986 P2d 1253 (1999), we reversed:

> "The 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. Here, the Board did not make *any* finding about whether the [initial] acceptance was the acceptance of a combined condition. Rather, it did not believe that it was required to do so." *Blamires*, 171 Or App at 267 (emphasis in original).

We remanded the issue to the Board to make a finding on that issue, despite the fact that the words "combined condition" did not appear in the initial acceptance. *Id.*

Employer argues that *Blamires* held, in effect, that no "magic words" are required to establish an acceptance of a combined condition. Claimant responds that *Blamires* is distinguishable, because in that case, the Board made *no determination* regarding whether employer had accepted a combined condition, whereas in this case, the Board expressly decided that employer had *not* accepted a combined condition. Claimant relies on *Bauman v. SAIF*, 295 Or 788, 670 P2d 1027 (1983), and *Tattoo v. Barrett Business Service*, 118 Or App 348, 847 P2d 872 (1993), for the proposition that employer is bound by the express language of its notice of acceptance, which, in this case, merely accepted "multidirectional instability, right shoulder and cervical strain."

In *Bauman*, the employer accepted a claim and paid benefits for three years. However, when the claimant attempted to reopen his claim for aggravation, the employer reversed its position and denied the original claim. The Supreme Court held the employer to its original acceptance:

> **177 Or App 645>** "[The] employer is not at liberty to accept a claim, make payments over an extended period of time, place the compensability in a holding pattern and then, as an afterthought, decide to litigate the issue of compensability. * * *
>
> "Accordingly, we agree with the Court of Appeals that it was not permissible for [the employer] to reconsider and deny the previously accepted claim and that the Board erred in allowing this belated denial." 295 Or at 794.

In *Tattoo*, the claimant sought payment for chiropractic care allegedly necessitated by an injury. The employer issued a denial, which stated that "[m]edical information received to date indicates that current chiropractic care is not reasonable and necessary, and does not result from the * * * injury * * *. Therefore, [we] must respectfully deny current chiropractic care." 118 Or App at 350. At a hearing on claimant's claim, the employer's claims examiner testified that she meant the denial to cover past treatment and treatment into the future and that she did not believe it would be necessary to issue subsequent denials for future treatment. *Id.* at 351. On review, the claimant contended that the examiner's testimony showed that the denial of chiropractic care was impermissibly prospective. We disagreed, stating that "[w]e hold that employers are bound by the express language of their denials and the testimony of the claims examiner here is irrelevant." *Id.* at 351-52.

Both *Bauman* and *Tattoo* stand for the principle that an employer may not accept a condition and later assert a position that contradicts the express language of its acceptance. In this case, however, claimant does not contend that employer is asserting a position that *contradicts* the express terms of its acceptance. Claimant does not deny that her "multidirectional instability" preexisted her work-related cervical strain. Instead, claimant contends that employer failed to accept a combined condition because it did not embellish its acceptance with specific words. Thus *Bauman* and *Tattoo* do not control our decision here.

On January 4, 1999, employer closed the claim. Claimant requested a hearing, challenging the denial. The administrative law judge (ALJ) affirmed the denial:

> "[Employer] accepted a combined condition--multi-directional instability. * * * [T]he damage due to the injury has been repaired surgically--[claimant] now has less laxity than prior to the injury. The major cause of her need for treatment is no longer the injury. Dr. Fowler agrees, noting that the surgery may require future palliative care. Whether claimant's future need for treatment is related in major part to her surgical sequelae is a question for the future. At the time the denial issued, it was technically correct."

Claimant appealed to the Board. In an order dated September 5, 2000, the Board expressly adopted the ALJ's findings of fact, but it reached the opposite conclusion, stating that

> "the employer expressly accepted 'multidirectional instability' of the right shoulder, but it did not accept a 'combined condition.' Because the employer did not accept a combined condition, it may not properly issue a 'preclosure' denial under ORS 656.262(6)(c) or ORS 656.262(7)(b). Accordingly, we reverse that portion of the ALJ's order that upheld the employer's denial."

In a footnote, the Board noted that,

> "at the time the current condition denial was issued, there was neither ongoing treatment nor any request for further medical services related to claimant's right shoulder condition. Accordingly, we also conclude that the employer's November 1998 current condition denial was an improper prospective denial of claimant's right shoulder condition."

The Board also awarded claimant attorney fees of $2,000.

177 Or App 643> On review, employer assigns error first to the Board's determination that employer did not accept a combined condition. Employer contends that the uncontroverted evidence showed that claimant's multidirectional instability was, in fact, a preexisting condition, and that, after surgery, the workplace injury ceased to be the major contributing cause of claimant's need for treatment. Therefore, it argues, it accepted a combined condition, and its preclosure denial was proper under ORS 656.262(7)(b). Claimant responds that: (1) ORS 656.262(6)(b)(A)[3] requires an employer to "specify what conditions are compensable" in its notice of acceptance; (2) employer's notice of acceptance did not state explicitly that it accepted a combined condition; and (3) employer's denial based on a combined condition under ORS 656.262(7)(b) was therefore improper as a matter of law.

The undisputed medical evidence established that claimant suffered from a combined condition. However, after expressly adopting the ALJ's finding of fact that "a pre-existing condition * * * combined with injury to require medical treatment," the Board rejected the ALJ's conclusion that employer had accepted a combined condition. In a single sentence the Board explained that "the employer expressly accepted 'multidirectional instability' of the right shoulder, but it did not accept a 'combined condition.'" The Board cited no particular evidence in support of that determination.

The scope of an acceptance is a question of fact. *See, e.g., SAIF v. Dobbs*, 172 Or App 446, 451, 19 P3d 932, *adhered to as mod on recons* 173 Or App 99 (2001); *Granner v. Fairview Center*, 147 Or App 406, 935 P2d 1252 (1997); *SAIF v. Tull*, 113 Or App 449, 454, 832 P2d 1271 (1992). Accordingly, we review the

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[3] ORS 656.262(6) provides, in part:

"(a) Written notice of acceptance or denial of the claim shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the employer has notice or knowledge of the claim. * * *

"(b) The notice of acceptance shall:

"(A) Specify what conditions are compensable."

Cite as 177 Or App 639 (2001) October 31, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Bonnie J. Woolner, Claimant.

COLUMBIA FOREST PRODUCTS, Petitioner,
v.
BONNIE J. WOOLNER, Respondent.
99-04302, 99-02707, 98-09381; A111862

Judicial Review from Workers' Compensation Board.
Argued and submitted August 24, 2001.
Karen O'Kasey argued the cause for petitioner. With her on the briefs were Jean Ohman Back and Schwabe, Williamson & Wyatt.
Mustafa T. Kasubhai argued the cause and filed the brief for respondent.
Before Landau, Presiding Judge, and Brewer and Schuman, Judges.
BREWER, J.
Reversed and remanded.

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177 **Or App 641>** Employer seeks review of an order of the Workers' Compensation Board overturning employer's current condition denial. The primary question on review is whether an employer may issue a preclosure claim denial under ORS 656.262(7)(b)[1] for a "combined condition" if its earlier acceptance did not expressly identify the claim as one for a combined condition. We reverse and remand.

We state the facts as the Board found them, supplemented with undisputed evidence in the record. Claimant injured her neck and right shoulder at work on May 29, 1996. She had a pre-existing condition, bilateral multi-directional instability, which combined with the work-related injury to require medical treatment. Dr. Fowler subsequently performed surgery on claimant's right shoulder, and employer's insurer accepted a claim for "multi-directional instability, right shoulder and cervical strain."[2] On March 31, 1998, Fowler indicated that claimant's shoulder condition was medically stationary. On November 25, employer issued a preclosure current condition denial that stated:

> "The current medical information indicates that your right shoulder problems preexisted your 5/29/96 injury. The information indicates that your injury of 5/29/96 combined <177 **Or App 641/642>** with the preexisting right shoulder problem and temporarily exacerbated the problem which has now been repaired through surgery and returned to your pre-injury status. Based on the medical information, we are denying the compensability of your current right shoulder condition as the injury of 5/29/96 no longer remains the major contributing cause of that condition and need for treatment."

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[1] ORS 656.262 provides, in part:

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

"(b) Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

[2] Claimant's cervical strain is not at issue in this case.

be within the worker's capabilities." By requiring employers to provide information regarding physical tasks in subsection (a), the structure of the rule indicates that the determination that follows--the physician's evaluation of a worker's capabilities in subsection (b)--is intended to be an examination of *physical* capabilities. *See* ORS 174.010.

Although childcare, labor disputes, or the availability of transportation may affect a worker's employment capabilities generally, those concerns are not within the province of treating physicians or the determination they are asked to make. *See State v. Hval*, 174 Or App 164, 171-72, 25 P3d 958 (2001) (interpretation plausible in the context of statutory scheme favored). As *Wilson* and previous Board opinions confirm, workers' objections to shift changes on those bases are unavailing because they are personal concerns that are unrelated to a claimant's physical capabilities.

By mandating that the employer or insurer in every case provide a description of the "physical tasks to be performed by the injured worker," the legislature has determined that that information is critical for a treating physician to evaluate a worker's physical capabilities, and **<177 Or App 611/612>** ordinarily will be sufficient. The rule, however, does not explicitly limit the determination to that information alone. In asking treating physicians to evaluate a worker's physical capabilities within their field of expertise, OAR 436-060-0030(5) does not say that physicians may consider *only* the "physical tasks to be performed by the injured worker." Subsection (b) asks instead whether, in the doctor's estimation, "the employment" is within the worker's capabilities.

The term "employment" is ordinarily understood to encompass more than the discrete physical tasks for which a worker is responsible. *See Webster's Third New Int'l Dictionary*, 743 (unabridged ed 1993) (defining "employment" as the "activity in which one engages and employs his time and energies"); *PGE v. Bureau of Labor and Industries*, 317 Or 606, 611, 859 P2d 1143 (1993). Employment may entail physical requirements beyond the strength, stamina, or skill needed to accomplish the discrete physical tasks alone. At a minimum, nothing in the rule prohibits a physician from considering the time, place, or other circumstances of employment in determining whether the modified work is within the worker's physical capabilities.[3]

In this case, employer asked Irvine whether claimant was physically able to work the night shift and take her medication later. Irvine indicated that it would be detrimental to her health, but the Board never considered whether Irvine's response meant that he disagreed that the work was within claimant's physical capabilities. Rather, the Board found that it did not need to consider claimant's medical claims or Irvine's medical concerns about night work. It reasoned that, because those concerns were unrelated to her compensable injury, they were irrelevant. As explained above, however, the administrative rules are not that narrow; they do not preclude a physician from considering the time, place, and other circumstances of the modified work in **<177 Or App 612/613>** determining whether it is within a worker's physical capabilities. Because the Board did not consider whether Irvine's medical concerns meant that he did not agree that the modified work was within claimant's physical capabilities, we reverse the Board's order and remand for consideration of that issue.

Reversed and remanded for reconsideration.

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[3] If the only issue that the physician was supposed to consider was whether the worker's compensable injury prevented him or her from performing the modified work, a worker who was diabetic could be expected to accept a position as a food taster, or a worker with vertigo could be offered modified work as a window washer. Nothing in the administrative rules requires a physician to blind him or herself to these obvious limitations on a worker's physical ability to perform modified work in determining whether the job is within the worker's capabilities.

within a "worker's capabilities" is limited to an evaluation of whether the worker can perform the physical tasks required by the modified work. In employer's view, Irvine's opinion that claimant was "OK to fold laundry" demonstrated that the work was within her capabilities.

The Administrative Law Judge (ALJ) reasoned that the modified work employer offered to claimant was "within [her] capabilities" if she could do the tasks that the work itself entailed. On review, the Board affirmed the ALJ's order. Citing *Roseburg Forest Products v. Wilson*, 110 Or App 72, 75, 821 P2d 426 (1991), it noted that "it is well-settled that [an employer] may properly terminate temporary disability when a claimant refuses a modified job for reasons unrelated to the compensable injury." It then reasoned that, "[i]n this case, claimant has declined to accept modified work because of medication requirements for noncompensable medical conditions." It followed, the Board concluded, that employer had no obligation to continue paying claimant temporary disability benefits.

Because the Board's order turns on its reading of *Wilson*, we begin with that decision. The claimant in *Wilson* began receiving TTD benefits after he suffered a compensable injury. *Wilson*, 110 Or App at 74. The employer eventually offered him modified work and the claimant's physician approved the job. *Id.* However, "[w]hen claimant arrived at the designated job site, he encountered a labor dispute and refused to cross the picket line." *Id.* Employer considered the **<177 Or App 609/610>** claimant's failure to report to work to be a refusal of employment and terminated TTD benefits. *Id.* On appeal, we reasoned:

> "In the absence of a legislative direction to the contrary, TTD benefits are not available if the loss results from other than the compensable injury. When a claimant refuses physician approved modified work under former OAR 436-60-030(5), [the] resulting wage loss is not caused by the compensable injury."

Id. at 75. Because the claimant's refusal to cross the picket line did not result from the compensable injury, we held that TTD benefits were not available.[2]

Since *Wilson*, the Board has applied that decision to explain why factors unrelated to a worker's physical capabilities cannot justify a refusal to accept physician-approved modified employment. *See Glenda Jensen*, 50 Van Natta 1074 (1998) (inability to take modified work because of conflicting child care concerns did not prevent employer from terminating TTD); *Robert E. Dixon*, 48 Van Natta 46 (1996) (inconvenience of securing transportation to modified job site did not prevent authorization to terminate disability benefits); *Antonio Garcia*, 46 Van Natta 862 (1994) (same). In all these decisions, the issue has been whether declining a job for reasons that are unrelated to a worker's physical capabilities will disqualify the worker from receiving temporary disability benefits. Neither *Wilson* nor the Board's decisions have considered the issue that claimant raises here--whether an employer can cut off a worker's right to receive temporary disability benefits by offering the worker a job that the worker is physically unable to perform.

Not only did *Wilson* not address that specific question, but its reasoning cuts in claimant's favor. *Wilson's* reasoning is contained in the two sentences quoted above. The first sentence states the general rule that "TTD benefits are **<177 Or App 610/611>** not available if the loss results from other than the compensable injury." *Wilson*, 110 Or App at 75. But that sentence does not identify, with any precision, the degree of proximity that must exist between the "compensable injury" and the "wage loss" before one can be said to "result" from or be caused by the other. The second sentence clarifies that issue. It states that the claimant's "wage loss is not caused by the compensable injury" "when a claimant refuses physician approved modified work." *Id.* Under *Wilson* and the administrative rules, the question whether the wage loss results from the compensable injury turns on whether the physician has approved the modified work pursuant to OAR 436-060-0030(5)(b). We turn to that issue.

The text of OAR 436-060-0030(5) is straightforward. Subsection (a) provides that the employer or insurer must notify the attending physician of the physical tasks to be performed by the injured worker. Subsection (b) provides that the attending physician must then agree that "the employment appears to

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[2] We noted that the legislature had provided that the worker would not lose reemployment rights or any vocational assistance if he or she refused physician-approved modified work because of a labor dispute. *Wilson*, 110 Or App at 75-76. We explained that, because the legislature had omitted any reference to disability benefits, those benefits were unavailable if a worker refused to accept modified work for the same reason. *Id.* at 76.

Cite as 177 Or App 606 (2001) October 31, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Connie Scherer, Claimant.

CONNIE SCHERER, Petitioner,
v.
OREGON VETERANS' HOME and CIGNA, Respondents.
99-06720; A110619

Judicial Review from Workers' Compensation Board.
Argued and submitted April 27, 2001.
J. R. Perkins, III, argued the cause and filed the brief for petitioner.
Tracy White argued the cause for respondents. With her on the brief were Deborah L. Sather and Sather, Byerly & Holloway.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Reversed and remanded for reconsideration.

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177 Or App 608> Employer terminated claimant's temporary total disability (TTD) benefits because she refused modified work. The Workers' Compensation Board upheld employer's decision, and claimant seeks review of the Board's order. We reverse and remand for reconsideration.

Claimant is a certified nursing assistant. She suffered a compensable back injury. After a period of bed rest, her treating doctor, Dr. Irvine, released her to light duty work and noted in the release that claimant was "OK to fold laundry." Employer offered claimant modified work folding laundry during the night shift from 10 p.m. to 6 a.m. Claimant declined the work, citing medical reasons unrelated to her back injury that precluded the change in hours. She told employer that she takes medication in the evening for chronic migraine headaches and insomnia that prevents her from working on the night shift.

Employer wrote to Irvine, asking whether claimant could rearrange her schedule and take the sleep-inducing medication after working the night shift. Irvine marked a box labeled "no" on the note and wrote that the suggested change "would be of detriment" to claimant. Claimant did not accept the modified work. Relying on OAR 436-060-0030(5),[1] employer terminated claimant's TTD benefits.

Claimant requested a hearing and argued, as she does on review, that employer misinterpreted the applicable administrative rule. She did not dispute that, under OAR 436-060-0030(5), a worker who declines physician-approved **<177 Or App 608/609>** modified work is not entitled to the continued payment of TTD benefits. She argued that the employment offered in this case was not physician-approved. Although Irvine had noted that she could perform the physical tasks involved in the modified work, he had objected to the shift change because it would be detrimental to her health. In claimant's view, her inability to work at night was a valid basis on which Irvine could conclude that the modified work was not "within [her] capabilities." *See* OAR 436-060-0030(5)(b). She argued that, because Irvine had not approved the work, her failure to accept the job did not disqualify her from receiving TTD benefits. Employer argued below, as it does on review, that the determination whether employment is

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[1] OAR 436-060-0030(5) provides that an insurer or carrier shall stop paying total disability compensation when an injured worker fails to begin modified work if:

> "(a) The attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker;
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> "(b) The attending physician agrees the employment appears to be within the worker's capabilities; and
>
> "(c) The employer has confirmed the offer of employment in writing to the worker stating the beginning time, date and place; the duration of the job, if known; the wages; an accurate description of the physical requirements of the job and that the attending physician has found the job to be within the worker's capabilities."

> loss, pain, distress, or impairment. INJURY is the most comprehensive, applying to an act or result involving an impairment or destruction of right, health, freedom, soundness, or loss of something of value <sustain a leg *injury* in a fall> <mental or emotional upset is just as truly an *injury* to the body as a bone fracture, a burn, or a bacterial infection--G. W. Gray b. 1886> * * *.'" *K-Mart*, 167 Or App at 50 (quoting *Webster's Third New Int'l Dictionary*, 1164 (unabridged ed 1993)).

In *Evenson*, we concluded that a person suffers an "injury" for purposes of ORS 656.007(1) if the person suffers harm, damage or hurt sufficient either to require medical services or to result in disability or death. *Id.* at 50. Applying that standard here, we find no need to decide whether claimant also suffered an injury to a prosthetic appliance under ORS 656.005(7)(a), because substantial evidence supports the Board's conclusion that claimant suffered an injury to her person. As noted above, claimant received a forceful blow to her chest in the course of her work, experienced immediate pain in her chest, and suffered a notable disfigurement to her body as a result of the blow. The workplace accident resulted in "injury" to claimant under any definition of that term.

SAIF further argues that there are no objective findings, *i.e.*, "verifiable indications of injury," ORS 656.005(19), to support the Board's conclusion. We disagree. In *SAIF v. Lewis*, 170 Or App 201, 212, 12 P3d 498 (2000), *rev allowed* 331 Or 692 (2001), we interpreted the requirement for "objective findings" as follows:

> "The 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. For there to be 'findings,' a process of verification necessarily must take place. The plain import of the language is that the verifiable character of indications of injury or disease are established only if a medical expert engages in a medical examination process that results in their verification. Said another way, to satisfy the statute, the expert must attempt to verify the injury or disease, must succeed in doing so, and must make findings accordingly. Necessarily, then, the indications of **<177 Or App 509/510>** an injury or disease must, at the time of the examination, be *presently* verifiable." (Emphasis in originial.)

SAIF argues that that standard has not been met in this case because Cutler's reports do not indicate that he observed swelling, bruising, or abrasions. However, what SAIF overlooks is that Cutler did observe notable disfigurement that was a result of the workplace accident. That disfigurement was both "observable" and "measurable." ORS 656.005(19). Cutler found that "[t]he left breast and the right breast no longer match." We therefore reject SAIF's argument that the Board erred in concluding that claimant had suffered a compensable injury. ORS 656.005(7)(a).

We note that there are potential issues here disputed by the parties, and encompassed in their arguments, that we do not reach because of the procedural posture of this case, *e.g.*, whether claimant, who has sustained a compensable injury, can receive as a compensable medical service under ORS 656.245 a replacement for the ruptured breast implant,[3] whether a breast implant is a "prosthetic appliance," or whether OAR 436-010-0230 provides an unduly restrictive interpretation of the statutory term "prosthetic appliance." On the narrow issue of whether the Board correctly set aside SAIF's denial of claimant's claim, we agree with the Board that claimant suffered a compensable injury.

Affirmed.

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[3] ORS 656.245(1)(b) requires insurers and self-insured employers to provide medical services for conditions caused by compensable injuries, including "prosthetic appliances * * * and where necessary, physical restorative services."

hearing, after which the ALJ agreed with SAIF that no compensable injury had occurred because claimant's breast implant was not a "prosthetic appliance" for purposes of ORS 656.005(7)(a), given the definition of "prosthetic appliance" found in OAR 436-010-0230(10). Claimant then sought review by the Board, which adopted the ALJ's findings of fact but concluded that it was not necessary to determine whether the breast implant was a "prosthetic appliance" for purposes of the statute because, in any event, there had been an injury to claimant's person. The Board stated:

> "Claimant sought medical treatment both because of the pain she experienced due to the work accident and to determine what could be done about the damage to her chest. Following an examination, Dr. Cutler reported that the left breast implant was 'completely flat' with 'no residual fluid evident in the left breast implant.' Dr. Cutler further found that claimant's chest exhibited 'pronounced asymmetry,' with the left breast and the right breast no longer matching.
>
> "Based on claimant's visit to Dr. Cutler, we find that the work injury required medical services. ORS 656.005(7)(a). In addition, Dr. Cutler's findings during his examination establish an injury by medical evidence supported by objective findings. Specifically, the findings of a 'completely flat' left breast implant, 'no residual fluid evident in the left breast implant,' and the 'pronounced asymmetry' of claimant's breasts, all of which were caused by the work injury, constitute objective findings in support of medical evidence in that these findings are observable, measurable, and verifiable indications of injury. ORS 656.005(19)."

In a concurring opinion, one Board member joined in the reasoning of the majority but also concluded that there existed a separate basis supporting compensability of claimant's claim. The concurring member concluded that the damaged **<177 Or App 507/508>** breast implant was a "prosthetic appliance" for purposes of ORS 656.005(7)(a), and that OAR 436-010-0230(10) impermissibly limited compensable medical expenses involving prosthetic appliances by defining "prosthetic appliance" too narrowly. SAIF sought judicial review of the Board's order.

We begin by noting that SAIF, in its initial denial, and both parties, at times throughout this proceeding, have conflated two separate issues. Whether an injury is compensable is determined by reference to ORS 656.005(7)(a). The compensability of an *injury* is not determined by OAR 436-010-0230, which concerns only the compensability of specific types of medical services. *See generally* ORS 656.245(1)(a) (requiring insurers and self-insured employers to provide certain medical services for compensable injuries). In short, a determination of whether or not a specific medical service that a claimant seeks is compensable under ORS 656.245 or OAR 436-010-0230 is not relevant to whether the claimant suffered a compensable injury in the first place. As noted, this case arose when SAIF denied claimant's claim on the ground that no compensable injury had occurred. Therefore, the only question properly before us is whether, under ORS 656.005(7)(a), a compensable injury occurred.

SAIF asserts that the record does not support the Board's conclusion that claimant suffered a work injury as a result of the accident. We review the Board's determination for substantial evidence. ORS 183.482(8); *Iles v. Fred Meyer, Inc.*, 173 Or App 254, 258, 21 P3d 195 (2001). Substantial evidence supports the Board's conclusion that claimant suffered an injury for purposes of ORS 656.005(7)(a). In *K-Mart v. Evenson*, 167 Or App 46, 50, 1 P3d 477, *rev den* 331 Or 191 (2000), we noted that ORS 656.005(7) does not define "injury." We stated:

> "That word generally means:
>
> "'1 a : an act that damages, harms or hurts * * *;
>
> "'* * * * *
>
> "'2 : hurt, damage, or loss sustained * * * <*injuries* to health> * * * <suffered severe *injuries* in the accident>;
>
> "'**syn** INJURY, HURT, DAMAGE, HARM and MISCHIEF mean in common the act or result of inflicting on a **<177 Or App 508/509>** person or thing something that causes

Cite as 177 Or App 504 (2001) October 31, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Paula T. Smith, Claimant.

SAIF CORPORATION and SELECTEMP CORP., Petitioners,
v.
PAULA T. SMITH, Respondent.
99-00322; A110337

Judicial Review from Workers' Compensation Board.
Argued and submitted July 23, 2001.
Julene Marian Quinn argued the cause and filed the briefs for petitioners.
Christine I. Jensen argued the cause for respondent. On the brief were Evohl F. Malagon and Malagon, Moore & Jensen.
Before Haselton, Presiding Judge, and Linder and Wollheim, Judges.
HASELTON, P. J.
Affirmed.

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177 Or App 506> SAIF Corporation seeks reversal of an order of the Workers' Compensation Board concluding that claimant had suffered a compensable injury when an on-the-job accident caused one of her saline breast implants to collapse. SAIF asserts that the Board erred, as a matter of law, in concluding that a compensable injury occurred, because the accident in question caused neither a compensable injury to claimant nor a compensable injury to a prosthetic appliance. In particular, SAIF argues, first, that the record does not support the Board's finding of an injury to claimant. Second, it argues that the reasoning in a concurring opinion from the Board, indicating that the accident had caused a compensable injury to a prosthetic appliance, is unsound. For the reasons that follow, we affirm the Board's order.

The facts are not disputed. Claimant was employed as a janitor at an airport. As she was entering a restroom in the course of her employment, a customer suddenly came out of a restroom stall and slammed claimant against a wall. Claimant experienced immediate pain on the left side of her chest, and noticed shortly thereafter that her saline breast implant had ruptured. Claimant sought medical treatment from Dr. Cutler, who had performed the breast implant surgery several years earlier. Cutler determined that the left breast implant had ruptured and contained no residual fluid, and noted that as a result, claimant's breasts were asymmetrical. Cutler recommended that the ruptured implant be removed and replaced.

SAIF denied claimant's claim on the ground that she had not suffered a compensable injury under ORS 656.005(7)(a)[1] **<177 Or App 506/507>** and OAR 436-010-0230(10).[2] Claimant sought a

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

"A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, [subject to limitations not at issue here]."

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

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

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

The preservation requirements of ORAP 5.45 for court cases apply with as much force in the administrative arena. *Outdoor Media Dimensions Inc. v. State of Oregon*, 331 Or 634, 643-44 n 5, 20 P3d 180 (2001); *Marvin Wood Products v. Callow*, 171 Or App 175, 184, 14 P3d 686 (2000). Here, the question or issue raised before the Board was whether SAIF's appeal rights should be cut off because of claimant's death, in light of the necessity of applying ORS 656.283(7) in a constitutional manner. The issue raised by petitioner on judicial review is a facial challenge to the constitutionality of the statute. Under petitioner's argument to the Board, no hearing for additional evidence would have occurred, had the Board ruled as she requested. Her argument to us asserts the right to present additional evidence. Thus, the positions that she **<177 Or App 288/289>** took below and to us are qualitatively different. Consequently, we decline to review petitioner's assignment of error under ORAP 5.45.[3]

Affirmed.

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[3] We also agree with the Board's postulation that the subsequent declaration of the unconstitutionality of ORS 656.283(7) would not result in the termination of SAIF's appeal rights.

reconsideration. 331 Or at 374-75. The result of the Supreme Court's *Koskela* decision is that the language in ORS 656.283(7) limiting hearing evidence to evidence presented at reconsideration is void and of no further effect. Without that language, claimant was entitled to present live testimony at hearing and to present evidence beyond what he presented at the reconsideration level."

177 Or App 287> SAIF counters that the issue that petitioner now raises on review was not preserved under ORAP 5.45[1] and that the "no new evidence in reconsideration hearings" rule of ORS 656.287(7) was not applied to petitioner's claim so as to prevent her from offering additional evidence at the hearing before the ALJ.

We turn first to SAIF's argument that the issue that petitioner raises on review is not the same issue that she raised to the ALJ. We find no suggestion in petitioner's argument to the ALJ that this court erred in ruling in *Koskela* that ORS 656.283(7) was constitutional on its face. Rather, petitioner relied on our implicit holding in *Koskela* that the statute could be constitutionally applied.[2] Petitioner's specific argument to the ALJ was that the statute was unconstitutional when applied to claimant's circumstances, because claimant's death had cut off his ability to present additional evidence to the ALJ. It followed, according to petitioner's argument, that ORS 656.283(7), as interpreted by this court, could be constitutionally applied to claimant only if SAIF was precluded from appealing to the hearings division. Significantly, petitioner did not argue that due process entitled her to a hearing; instead, she argued that her due process rights would be violated if any further evidentiary hearings were held.

On review, and in contrast to the above issue, petitioner adopted the claimant's argument in *Koskela* and the dissents' reasoning in this court's decision in *Koskela*. The claimant in *Koskela* made a facial challenge to the constitutionality of ORS 656.283(7), arguing that it could not be applied constitutionally in any case because its limitation on new evidence, when combined with the statutory scheme, **<177 Or App 287/288>** prevented claimants from having a fair adjudicative hearing. In our resolution of *Koskela*, Judges De Muniz and Wollheim dissented:

> "The majority appears to hold that due process is satisfied because, in its view, PTD determinations turn mainly on medical facts and that written submissions generally used at the reconsideration phase are a meaningful way to present such facts. However, workers seeking PTD benefits also have the additional burden of proving a willingness to work and that they have made a reasonable attempt to obtain employment. The burden of proof that a worker must carry on those issues will, for the most part, turn on an evaluation of the worker's credibility. In the context of the workers' compensation system, that kind of evaluation should be made only in an adjudicative hearing. * * * I dissent because denying injured workers an adjudicative hearing in which an ALJ evaluates all of the evidence, including the worker's demeanor and veracity, violates the worker's right to due process." 159 Or at 252 (De Muniz, J., dissenting).

ORAP 5.45(4)(a) provides that,

> "Each assignment of error shall demonstrate that the question or issue presented by the assignment timely and properly was raised and preserved in the lower court."

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[1] ORAP 5.45(4)(a) provides, in part:

> "Each assignment of error shall demonstrate that the question or issue presented by the assignment timely and properly was raised and preserved in the lower court."

[2] The concurring opinion in this court's decision in *Koskela* asserted:

> "ORS 656.283(7) meets general due process standards. That does not mean, in my view, that in a particular case, a claimant could not make a successful 'as applied' challenge if denied the ability to meaningfully controvert an adverse credibility finding after the reconsideration process and if denied the protection of the statute." *Koskela*, 159 Or App at 251-52 (Edmonds, J., concurring).

177 Or App 285> As is evident, petitioner did not ask for a hearing at which to present additional evidence. The only relief that she sought was the legal termination of SAIF's right of appeal at the time of the death of claimant.

SAIF responded to claimant's argument:

> "The complaint that claimant presents with the process is not about a flaw in the process, but in the fact that he has problems producing the evidence that he would like to use to defend his case in the process. Claimant confuses process with persuasive evidence. *Koskela* sets out the process that would be necessary to afford due process to the parties, and that process was in place at the time of the reconsideration proceeding and order."

The ALJ reversed claimant's permanent total disability award. His order said:

> "Even though claimant passed away before the reconsideration process was completed, his representatives and heirs were not precluded from following and engaging in the procedures provided for in the process. Obviously, no affidavit from claimant himself could have been submitted, but affidavits as to relevant facts concerning his capacities and so forth could have been submitted by family, friends, or others with direct knowledge. In terms of other evidence, obviously claimant could not obtain new exams or evaluations where he needed to be present, but he was not precluded from obtaining additional medical or vocational evidence to support his position. In fact, claimant did obtain evidence from Dr. Aversano, exhibit 94, although it was not particularly helpful to claimant's position. Ultimately, as the insurer argues, claimant's death during the reconsideration proceeding did not deprive him of due process rights. He continued to have the same rights that the *Koskela* court found were adequate to satisfy due process concerns. Rather, his death made it more difficult to use that process. That would have been the same situation had claimant been entitled to a full evidentiary hearing in this matter, which was the type of process demanded by the claimant in *Koskela*, the process which the Court of Appeals found was not due."

Petitioner sought Board review of the ALJ's order, and the Board adopted the ALJ's order and opinion in its entirety. Petitioner seeks judicial review from that order.

177 Or App 286> On review, petitioner's entire argument in her initial brief is that:

> "Claimant adopts and incorporates the rationale of the dissenting opinions and claimant's briefs in *Koskela*. Claimant recognizes that this court's decision in *Koskela* requires that her argument be rejected and the decision below affirmed. Claimant has brought this appeal to preserve her rights in the event that the Supreme Court reverses this court's decision in *Koskela*. Claimant has no arguments to present beyond those articulated in the dissenting opinions in *Koskela* and by claimant in that case."

After the briefs in this case were filed, the Supreme Court rendered its decision in *Koskela*, holding that "[t]he post-1995 statutory scheme for assessing whether a worker should receive PTD benefits fails to satisfy procedural due process requirements," because "[a]t no stage of the process is the worker afforded any opportunity to have an oral evidentiary hearing." *Koskela*, 331 Or at 382. The court observed that, under the statute, the worker has the burden of proving total disability and reasoned that, "[b]ecause the worker does not have the opportunity to make a meaningful record on elements of proof that are necessary for the worker to meet the burden of proof and persuasion," the statutory process did not meet due process standards. *Id.*

In a supplemental brief submitted after the supreme court's decision, petitioner argues further:

> "The Supreme Court in *Koskela* declared unconstitutional 'the post-1995 statutory scheme for assessing whether a worker should receive an award of PTD benefits.' 331 Or at 382. The part of ORS 656.283(7) to which the court referred was the part that limits the evidence at a workers' compensation hearing to the written evidence presented at

She then continued:

"The third issue remains: Are the administrative procedures provided by Oregon law to determine a claimant's entitlement to PTD benefits constitutionally adequate? Under the circumstances of this case, the answer is no.

"ORS 656.283(7) unambiguously states that valuation of a worker's disability by the ALJ shall be as of the date of issuance of the Reconsideration Order. *See Joseph Baggett v. The Boeing Company*, 150 Or App 269[, 945 P2d 663] (1997). Because the claimant died on January 2, 1998, the claimant was precluded from doing any of the following to establish his ongoing entitlement to permanent total disability:

"(1) He was unable to submit an affidavit outlining any of the relevant facts regarding a finding of permanent total disability;

"(2) He was unable to undergo an updated physical capacities exam that would demonstrate his current physical capabilities;

"(3) He was unable to get in to see his treating doctor, Dr. Aversano, to review with him his current physical capacities or explain any aspect of the video tapes that are relied on so heavily by the SAIF Corporation;

177 Or App 284> "(4) He was unable to meet with a vocational counselor to get an updated vocational assessment;

"(5) He was unable to seek any of the jobs that are listed in the vocational reports submitted by the SAIF Corporation to see whether or not he could obtain any of the jobs;

"(6) He was unable to meet with his treating psychiatrist for an updated medical report on his condition;

"(7) He was unable to assist his attorney in preparing any aspect of his case including, potentially, cross-examination of the SAIF Corporation's medical, psychological and vocational experts.

"Since the claimant has been precluded from submitting evidence and his extent of disability cannot be rated 'at the time of the Reconsideration Order,' what is the correct solution?

"In order to salvage the constitutionality of the statute in this situation, one solution is to simply hold that where a claimant dies while under a valid Order of permanent total disability, even if that Order is subject to appeal, the Order effectively becomes final at the time of claimant's death. In this manner, all of the procedural difficulties that claimant outlines above would be avoided.

"* * * * *

"An alternative approach would be to find that the statute, under the facts of this case, does not provide sufficient due process protection for claimants. If the ALJ, the Board, and eventually, the Court of Appeals makes such a finding, what would be the practical solution? How could a person who is clearly not available assist in developing the record at any level? * * * The claimant believes that the practical solution should be the same as the alternative offered above, that is, the Determination Order awards a claimant permanent total disability and becomes final on the claimant's death even where the SAIF Corporation is still within its appeal period.

"Since his disability cannot be rated 'at the time of the reconsideration proceeding' in a manner that is consistent with due process, it should be found that the SAIF Corporation's appeals rights died with the claimant."

Cite as 177 Or App 280 (2001) October 17, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Barry P. Veselik, Deceased, Claimant.

JUDY VESELIK, Petitioner,
v.
SAIF CORPORATION and CERAMIC ART TILE, Respondents.
98-06424; A109168

Judicial Review from Workers' Compensation Board.
Argued and submitted June 6, 2001.
James S. Coon argued the cause for petitioner. With him on the briefs were Swanson, Thomas & Coon.
Jerome Patrick Larkin argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges
EDMONDS, P. J.
Affirmed.

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177 Or App 282> Petitioner, the wife of deceased claimant Barry Veselik, seeks judicial review of a determination of the Workers' Compensation Board (Board) that reversed claimant's award for permanent total disability (PTD) benefits. Petitioner argues that ORS 656.283(7) is unconstitutional on its face and that the Supreme Court's decision in *Koskela v. Willamette Industries, Inc.*, 331 Or 362, 15 P3d 548 (2000), compels reversal of the Board's decision. Because the record demonstrates that petitioner does not make the same argument to us on review that she made to the Board, we affirm.

Claimant was a tile-setter who suffered a compensable lower back injury on February 28, 1989. The employer's insurer, SAIF, accepted his claim and began to pay benefits to claimant. Claimant had a number of surgeries on his back but continued to have back pain and limited use of his back. He eventually developed clinical depression, a claim that was also accepted by SAIF. After a hearing in 1994, claimant was declared permanently and totally disabled, and SAIF did not appeal that ruling.

In 1996, SAIF requested reevaluation of the permanent total disability award. ORS 656.206(5) (1995). In October 1997, the Appellate Review Unit affirmed the award. Claimant committed suicide in January 1998, and by operation of ORS 656.204 petitioner acquired claimant's entitlement to his benefits. After claimant's death, but within the 180-day appeal period, SAIF requested reconsideration by the hearings division of the appellate reviewer's decision.

In response to SAIF's request for reconsideration, petitioner argued to the administrative law judge (ALJ) that "this case presents the same issue that the Court of Appeals recently addressed in *Koskela v. Willamette Industries, Inc.*, 159 Or App 229[, 978 P2d 1018] (1999)." She asserted:

> "In the *Koskela* case, the Court of Appeals *en banc*, found that the procedure provided in ORS 656.283(7), which bars evidence that was not submitted at Reconsideration from being considered at the ALJ hearing, did not deprive the claimant of his due process rights in a permanent total disability hearing. The basis for claimant's **<177 Or App 282/283>** attack on the statute in that case was the lack of a trial type hearing at any point in the PTD determination process. The court, in holding that the statute provided due process protections that were constitutionally sufficient, held that the claimant is free to produce affidavits and medical and vocational reports, including any responses to documentation submitted by the opposing party."

In her brief to the ALJ, petitioner included the following excerpt from *Koskela*, 159 Or App at 234:

> "The Fourteenth amendment provides that no state shall 'deprive any person of life, liberty or property without due process of law.' The question of what process constitutionally is due involves three inquiries: (1) Whether the person invoking the due process claim has a constitutionally protected interest in the particular benefit at stake; (2) Whether deprivation of that interest involves government action; and (3) Whether the procedures used or available are constitutionally adequate."

On judicial review, claimant does not argue that the statute permitting the Director to promulgate a case-specific "rule" deprives her of procedural due process, *cf. Koskela v. Willamette Industries, Inc.*, 331 Or 362, 15 P3d 548 (2000) (procedures for determining extent of permanent disability deprive claimant of procedural due process), nor does she argue that the Director's rule fails to address the facts of her particular case, *see Shubert v. Blue Chips*, 330 Or 554, 9 P3d 114 (2000) (temporary rule under ORS 656.726(4)(f)(C) must address claimant's particular situation). Claimant's only argument before this court, and thus the only argument we address, is that the Director exceeded his authority under ORS 656.726(4)(f)(C) because that statute requires him to "accommodate" claimant's disability, and a zero percent rating is not an "accommodation."

The argument does not survive *Shubert*. In that case, the claimant argued that a Director's temporary rule providing that "the impairment value" of his injury "shall be a value of zero" was inconsistent with ORS 656.726(4)(f)(C). The claimant's theory was that the statute allowed the Director to promulgate a case-specific rule for an unscheduled injury only if the injury was, in fact, a disability and that "accommodation" of the disability required recognition of it as such.[2] The Supreme Court disagreed:

> "ORS 656.726(4)(f)(C) requires the Director to adopt a temporary rule when 'it is found that a worker's disability is not addressed by [existing] standards.' * * * If the Director concludes that the condition at issue is not an impairment (or, at least, not one that is entitled to a positive impairment **<177 Or App 221/222>** rating), then the condition is not a disability and no temporary rule is required by ORS 656.726(4)(f)(C). However, the Director nevertheless might wish to explain his or her thinking in that regard. At least in theory, the Director can do so in two ways. First, the Director simply might announce that no temporary rule is required, because he or she has concluded that the condition at issue is not a disability. Alternatively, the Director could adopt a temporary rule that assigns to the condition an impairment value of zero. Either way, the Director would be announcing a legal conclusion that he or she must make to determine his or her obligations under ORS 656.726(4)(f)(C). Either way, the courts then could review the conclusion for legal error. We see nothing in either the wording or the logic of the statute that would preclude the Director from announcing his or her choice through the temporary rule device." *Shubert*, 330 Or at 559-60 (bracketed material in original).

This reasoning, although technically not the "holding" of *Shubert*, is nonetheless dispositive.

Affirmed.

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[2] The claimant's argument in the Supreme Court was based on the reasoning of the dissenting opinion in this court. *See Shubert v. Blue Chips*, 151 Or App 710, 717, 951 P2d 172 (1997) (De Muniz, J., dissenting), *rev'd* 330 Or 554, 9 P3d 114 (2000).

Cite as 177 Or App 218 (2001) October 10, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Judith R. May, Claimant.

JUDITH R. MAY, Petitioner,
v.
MULTNOMAH COUNTY ANIMAL CONTROL, Respondent.
99-06575; A110579

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs June 18, 2001.
R. Adian Martin filed the brief for petitioner.
Thomas Sponsler, County Attorney, and Jacqueline A. Weber, Assistant County Attorney, filed the brief for respondent.
Before Landau, Presiding Judge, and Brewer and Schuman, Judges.
SCHUMAN, J.
Affirmed.

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177 **Or App 220>** Claimant underwent a hysterectomy resulting from an injury she suffered while lifting a heavy dog in the course of her employment as an animal control officer for Multnomah County Animal Control (employer). At the time of the surgery, she was 50 years old and had not reached menopause. Employer accepted her claim, which was ultimately closed by notice awarding no permanent disability. Claimant requested reconsideration and also requested that the Director of the Department of Consumer and Business Services (Director) promulgate a temporary rule pursuant to his authority under ORS 656.726(4). That statute provides, in pertinent part:

> "(4) The director hereby is charged with duties of administration, regulation and enforcement of * * * this chapter. To that end, the director may:
>
> "* * * * *
>
> "(f) Provide standards for the evaluation of disabilities. The following provisions apply to the standards:
>
> "* * * * *
>
> "(C) When, upon reconsideration of a notice of closure pursuant to ORS 656.268, it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph, notwithstanding ORS 656.268, the director shall stay further proceedings on the reconsideration of the claim and shall adopt temporary rules amending the standards to accommodate the worker's impairment."[1]

The Director obliged, promulgating a rule that "assign[ed] an impairment value of zero percent as this worker was no longer within the generally accepted child bearing years." OAR 436-035-0500(3)(h) (2000). Based on that rule, the appellate reviewer found that claimant was "not due an award for unscheduled permanent partial disability." Claimant then requested a hearing and asked the administrative **<177 Or App 220/221>** law judge (ALJ) to remand the case to the Director for promulgation of a second rule, arguing that the first rule was legally insufficient because a rating of zero percent, resulting in no permanent partial disability, is not an "accommodation" as required by the statute. The ALJ rejected the request, and the Workers' Compensation Board affirmed the denial. We affirm as well.

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[1] When this case began, the statute was numbered ORS 656.726(3)(f)(C). In 1999, the legislature renumbered the statute, Or Laws 1999, ch 876, section 9, and amended it in ways that do not affect our analysis. Thus, for purposes of this opinion, we refer to the current version of the statute.

177 Or App 131> Neither *Pitchford* nor *Estate of Greenslitt* provides any reason to depart from our interpretation of the statute based on its text, context, and legislative history. We accordingly hold that Allstate may deduct only the net amount of money that the tortfeasor's insurer and his workers' compensation insurer paid plaintiff. It follows that the trial court should have denied Allstate's motion for summary judgment and granted plaintiff's motion. *See Cochran v. Connell*, 53 Or App 933, 939-40, 632 P2d 1385 (1981).

Reversed and remanded with instructions to enter judgment in plaintiff's favor.

SCHUMAN, J., concurring.

I agree with the majority that the phrase "amount paid" in ORS 742.504(7)(c) could plausibly refer to the net payment that a workers' compensation or disability insurer pays to an insured, that is, the full amount paid minus any amount recouped from the tortfeasor's insurer. I can also join with the majority as it takes the convoluted journey required by *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1994), in order to reach the legislative history, and I agree with the inference the majority draws from that history. In other words, if we were writing on a blank slate, I would not write separately.

But we do not write on a blank slate. The slate contains *Pitchford v. State Farm Mut. Auto. Ins. Co.*, 147 Or App 9, 934 P2d 616, *rev den* 325 Or 621(1997), and *Estate of Linda Greenslitt v. Farmers Ins. Co.*, 156 Or App 75, 964 P2d 1129, *rev allowed* 329 Or 438 (1999), *rev dismissed* 331 Or 692 (2001), and the majority's efforts to distinguish those cases leaves me impressed but unpersuaded. In those cases, this court stated (again under the whip of PGE) in the strongest and clearest terms that the words "paid and payable" in the exact section of the exact statute at issue here were absolutely unambiguous. We did not equivocate or look to legislative intention. The majority correctly points out that in **<177 Or App 131/132>** *Greenslitt* and *Pitchford* we did not decide the precise question at issue here. That is true. But we did decide the exact and complete meaning of the words that must be used to decide the question here. In those cases, this court announced in essence that "paid" referred to gross payments. Now, the majority announces that the same word in the same statute refers to net payments.

To justify this conclusion, the majority asserts that "[l]anguage * * * may be unambiguous in one context but not another." 177 Or App at 130. I respectfully disagree. The meaning of a word varies, of course, depending on its context, that is, the other words that surround it, the function or genre of the work in which it appears, the nature of the linguistic community that produced it, the entire cultural complex in which it is embedded. But the theory that the meaning of words can vary according to the context of the *reader* or the reader's *interpretive* community is contrary to bedrock assumptions about the rule of law, in particular that laws apply equally to different people and across different situations.

I would therefore decide this case as the majority does up to the point at which it takes up *Pitchford* and *Greenslitt*. At that point, I would limit those cases to their own facts and frankly disavow their absolutist definition of "paid."

Allstate relies on the phrase "full amount of workers' compensation benefits paid to plaintiff" to argue that the total (not the net) amount of workers' compensation benefits paid should be deducted from UIM benefits. As the sentence quoted above makes clear, however, the issue that we decided in *Pitchford* was whether the full amount of the benefits paid, as opposed to the statutory lien, should be deducted. We did not decide whether the total or the net benefits paid should be deducted. Put another way, the issue in *Pitchford* was whether the insured could receive a double recovery, not whether the insured was entitled to be made whole up to the policy limits.

Plaintiff also relies on our decision in *Estate of Greenslitt*. The decedent in *Estate of Greenslitt* had purchased UIM coverage from Farmers' Insurance Company. 156 Or App at 77. She later died in a work-related automobile accident. *Id.* The decedent's workers' compensation carrier paid benefits to her heirs but not to her beneficiaries. *Id.* When the beneficiaries later sought to recover UIM benefits from Farmers, Farmers reduced the UIM benefits by the amount of all the payments that the workers' compensation carrier had made. As we framed the issue on appeal, the question was whether the amounts paid to the heirs but not the beneficiaries under the UIM policy were "amount[s] paid" within the meaning of ORS 742.504(7)(c)(B). *Id.* at 79-80.

In answering that question, we explained that the words of the statute were "straightforward and clear" and that they permitted Farmers to reduce the UIM benefits by all the payments that the workers' compensation carrier had made. *Estate of Greenslitt*, 156 Or App at 80. That is, we held that the way that the legislature had expressed its policy **<177 Or App 129/130>** against double recovery required that we consider the total amounts that the insurer had paid. We did not decide the issue presented in this case--*i.e.*, whether, if the workers' compensation carrier had recouped some of the payments it had made, the "amount paid" includes the net or the total payments. Rather, we explained that it was not necessary for us to reach that issue to decide the case, and we specifically reserved it. *Id.* at 78 n 1.[7]

Even though we expressly declined to decide the issue this case presents, Allstate focuses on language from *Estate of Greenslitt* in which we explained that the statute was unambiguous. It appears to argue that if the language was unambiguous in *Estate of Greenslitt*, it is also unambiguous here. Language, however, may be unambiguous in one context but not another. *Cf. Tirumali v. City of Portland*, 169 Or App 241, 246-47, 7 P3d 761 (2000), *rev den* 331 Or 674 (2001) (the term "grade" was ambiguous when applied to filled surfaces). There was no question in *Estate of Greenslitt* that the workers' compensation carrier had paid all the amounts that Farmers sought to deduct from the UIM benefits, and we held that the language unambiguously led to only one resolution of that issue. As explained above, however, the phrase "amount paid" does not unambiguously resolve whether the total or net amount paid may be deducted, and we decline to read *Estate of Greenslitt* as deciding an issue that we expressly reserved.[8]

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[7] We noted in *Estate of Greenslitt*:

> "On appeal, as below, there is also an issue regarding a workers' compensation lien of $13,500 that was paid from the $50,000 tortfeasor settlement, pursuant to ORS 656.593(1). Although plaintiffs do not dispute the propriety of paying the lien from the settlement, they do argue that the recovery from the tortfeasors should be calculated as only $36,500 instead of $50,000. The UIM obligation then would be $63,500, assuming no other offsets or reductions. Plaintiffs agree that the issue is academic and need not be decided if the offset for other workers' compensation benefits is proper, because that offset exceeds the amount of available UIM benefits, no matter how the $13,500 lien is treated. Because we conclude that the offset for workers' compensation benefits was statutorily required, we do not reach plaintiffs' assignment of error regarding the lien calculation." 156 Or App 78 n 1.

[8] Contrary to the suggestion in the concurrence, we do not say "that the meaning of words can vary according to the context of the *reader* or the reader's *interpretative* community." 177 Or App at 132 (Schuman, J., concurring) (emphasis in original). Rather, as in Estate of Greenslitt, a phrase may have only one possible interpretation when applied to one set of facts but not when applied to another. What varies is not the reader but the facts to which the statute must be applied and against which we must interpret the meaning of the words that the legislature used.

Tape Recording, Senate Insurance, Banking and Retirement Committee, SB 31, January 23, 1981, Tape 6, Side A. As initially proposed, the 1981 bill did not make underinsured motorist coverage subject to ORS 742.504. Senator Kulongoski, however, proposed amending the bill to provide that underinsured motorist coverage would be subject to that statute. Tape Recording, Senate Insurance, Banking and Retirement Committee, SB 31, January 25, 1981, Tape 113, Side A. The stated purpose of the amendment was to make the arbitration provisions in ORS 742.504 applicable to underinsured motorist claims. *Id.*[4] The legislature enacted the bill, as amended. *See* Or Laws 1981, sections 2 and 3.

Having examined the text, context, and legislative history of the statute, we conclude that the legislature intended to prevent double recovery by insureds and also to make the insured whole up to the limits of the UIM coverage. Put another way, nothing in the legislative history suggests that, in authorizing an insurer to reduce UIM benefits by the "amount paid" under any workers' compensation laws, the legislature intended to depart from the basic understanding that the insurer would pay the amount of UIM benefits necessary to make the insured whole up to the policy limits. The legislative history of the 1981 amendment leads us to conclude that plaintiff's interpretation of the statute is correct.

Allstate argues, however, that two of our decisions--*Estate of Linda Greenslitt v. Farmers Ins. Co.*, 156 Or App 75, 964 P2d 1129 (1998), *rev dismissed* 331 Or 692 (2001), and **<177 Or App 127/128>** *Pitchford v. State Farm Mutual Auto. Ins. Co.*, 147 Or App 9, 934 P2d 616 (1997)--point in a different direction. We discuss those decisions briefly and begin with *Pitchford*, on which Allstate primarily relies.[5]

The plaintiff in *Pitchford* was injured in a work-related automobile accident. 147 Or App at 11. He recovered $25,000 from the tortfeasor's insurer, $5,000 from the tortfeasor, $25,000 in UIM benefits from his employer's insurer, and approximately $113,000 in workers' compensation benefits from Aetna. *Id.* The plaintiff then sought to recover UIM benefits from his own insurer, State Farm. He argued that, in calculating the amount State Farm owed him under its policy, State Farm could deduct only the $25,000 that he had recovered from the tortfeasor's insurer. *Id.* The trial court held that State Farm could deduct more than that, but limited the applicable deduction for workers' compensation benefits paid to the amount of the workers' compensation carrier's statutory lien. *Id.* at 13.

There is no suggestion in *Pitchford* that the workers' compensation carrier had recovered any portion of the workers' compensation benefits that it had paid the plaintiff. For all that appears from the opinion, the plaintiff in *Pitchford* received and retained all the benefits paid by the carrier, as well as the sums paid by the tortfeasor, the tortfeasor's insurer, and the employer's insurer. *Pitchford* thus was not a case in which we were required to decide whether only the net benefits that the plaintiff had received should be deducted from the UIM benefits that State Farm owed him.

Consistent with that factual posture, we neither considered nor decided that issue in *Pitchford*. *See* 147 Or App at 16. Rather, as noted above, the trial court had ruled that only the workers' compensation carrier's lien--the amount that the carrier may recover from any proceeds the plaintiff received from a third-party tortfeasor's insurer--should be deducted from the UIM benefits. The basis for the trial **<177 Or App 128/129>** court's ruling is not immediately apparent,[6] and we concluded that "the trial court should have held that the *full amount* of workers' compensation benefits paid to plaintiff by Aetna, $113,383.64, not just Aetna's statutory lien amount, is deductible from UIM policy limits." *Id.* (emphasis in original).

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[4] In *Vega*, the *amici* argued that Senator Kulongoski's remarks established that only parts of ORS 742.504 apply to UIM coverage. *See* 323 Or at 302-03 n 9. The court rejected that argument, explaining that the text of "ORS 742.502(4) is clear: It refers to ORS 742.504 in its entirety." *Id.* The court thus held that the legislative history provides no reason for saying that the legislature intended for less than all of ORS 742.504 to apply to UIM coverage. *Id.* It does not follow, however, that the legislative history does not provide guidance in determining how specific subsections of ORS 742.504 apply when those subsections are themselves ambiguous.

[5] Allstate also relies on our decision in *Yokum v. Farmers Ins. Co.*, 117 Or App 546, 844 P2d 937 (1993). Neither the plaintiff nor the insurer, however, relied on ORS 742.504. *See id.* at 549. Rather, the plaintiff based his claim on ORS 742.542, which addresses the relationship between PIP and UIM benefits.

[6] Neither the opinion nor the briefs offered any rationale for limiting the deduction to the lien. Rather, it appears from the briefs that the trial court had, on its own motion, limited the deduction to the amount of the lien.

> "(A) All sums paid on account of such bodily injury by or on behalf of the owner or operator of the uninsured vehicle * * *
>
> "(B) The amount paid and the present value of all amounts payable on account of such bodily injury under any workers' compensation law, disability benefits law or any similar law."

The parties advance different interpretations of the phrase "[t]he amount paid * * * under any workers' compensation law." Allstate argues that the phrase "amount paid" refers to the total amount of workers' compensation benefits paid without regard to whether the workers' compensation insurer has recouped any of those benefits. Allstate's interpretation, while textually permissible, is problematic. It permits a UIM insurer to deduct more than the net amount of payments that its insured has received, giving the insurer a windfall at its insured's expense.

Plaintiff offers a different interpretation. He reasons that the legislature used the phrase "amount paid" to refer to the net amount paid. If, for example, a person bought a computer for $3,000 and received a $1,000 manufacturer's rebate, the amount that the person paid for the computer would, in common usage, be $2,000 or the net amount paid. Plaintiff reasons that the phrase "amount paid" should be given that interpretation, which does not produce the counterintuitive result that Allstate's interpretation does.

Although both interpretations are textually permissible,[2] the context supports plaintiff's interpretation. The Supreme Court has explained that the purpose of ORS 742.504(7)(c) is "to prevent double recovery." *Vega v. Farmers Ins. Co.*, 323 Or 291, 301, 918 P2d 95 (1996) (parenthetically explaining the statute's purpose); *see Hanson v. Versarail* <177 Or App 125/126> *Systems, Inc.*, 175 Or App 92, 97, 28 P3d 626 (2001) (supreme court cases constitute context). As *Vega* makes clear, the statute reflects the legislature's policy choice that an insured should not be paid twice for the same loss, and that the amount of money that other entities have paid on account of a plaintiff's injuries should be deducted from the amount of UIM benefits an insurer owes. Conversely, and consistently with that purpose, an insurer should be allowed to deduct only the net amount of those payments. The purpose of the statute is to prevent double recovery, not to provide an insured with anything less than full recovery up to the UIM policy limits. Plaintiff's interpretation achieves that purpose; Allstate's interpretation defeats it.

Although the text and context are consistent with plaintiff's interpretation, they are not dispositive and we look to the legislative history for guidance. What is now ORS 742.504 was first enacted in 1967. *See* Or Laws 1967, ch 482, section 3.[3] As initially enacted, the statute provided for uninsured motorist coverage. *See id.* The parties have not directed us to anything in the legislative history of the 1967 act that addresses whether the legislature intended that the net or the total amount of workers' compensation benefits paid to an insured could be deducted from uninsured motorist benefits, and we are not aware of any history from that act that bears on the issue.

In 1981, the legislature amended the statutes to require that insurers offer their policyholders underinsured as well as uninsured motorist coverage. *See* Or Laws 1981, ch 586, section 1. Tom Bessonette explained the reason for the change:

> "[I]f you bought $100,000 liability limits and $100,000 uninsured motorist, you would have been better off had the guy who hit you and injured you not had any insurance because * * * if he had $15,000, all you could collect would be $15,000, but if he had no insurance, you could have collected up to $100,000 from your own insurance company. So, this bill provides what we now call underinsurance. You can buy your uninsured motorist up to your policy limits. You can also buy underinsurance so that if you do hit and <177 Or App 126/127> collide with somebody who has a $15,000 policy and you have a $100,000 injury, that you would then collect $15,000 from the wrongdoer and $85,000 from your own insurance company and you would be made whole. That's basically what this law does."

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[2] Each side's interpretation requires that we qualify the phrase "amount paid." Plaintiff would limit the phrase to the net amount paid while Allstate would expand it to the total amount paid.

[3] ORS 742.502 *et seq.* was initially codified as part of ORS chapter 743. We refer to the law as it is presently codified.

Cite as 177 Or App 122 (2001) October 3, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

EDWARD HARLOW, Appellant,
v.
ALLSTATE INSURANCE COMPANY, an Illinois corporation, Respondent.
C98-0340CV; A104859

Appeal from Circuit Court, Washington County.
Louis J. Fasano, Judge *pro tempore.*
Argued and submitted October 14, 1999.
Douglas F. Angell argued the cause for appellant. With him on the brief was Hobson, Hobson & Angell.
R. Daniel Lindahl argued the cause for respondent. With him on the brief were Beth Skillern and Bullivant Houser Bailey.
Before Edmonds, Presiding Judge, and Kistler and Schuman, Judges.*
KISTLER, J.
Reversed and remanded with instructions to enter judgment in plaintiff's favor.
Schuman, J., concurring.

* Schuman, J., *vice* Armstrong, J.

177 Or App 124> Plaintiff brought this action against defendant Allstate Insurance Company, claiming that Allstate owed him underinsured motorist (UIM) benefits. Plaintiff and Allstate filed cross-motions for summary judgment. The trial court denied plaintiff's motion, granted Allstate's motion, and entered judgment in Allstate's favor. On plaintiff's appeal, we reverse and remand with instructions to enter judgment in plaintiff's favor.

Plaintiff was injured in a work-related automobile accident and sustained at least $100,000 in damages. The tortfeasor's insurer paid plaintiff $30,000. Plaintiff's workers' compensation insurer paid him approximately $25,000 in workers' compensation benefits but recouped approximately $13,000 from the $30,000 that he had received from the tortfeasor's insurer. Together, the two insurers paid plaintiff a net amount of approximately $42,000.

Allstate had issued an insurance policy to plaintiff that provided him with $50,000 of UIM coverage. When plaintiff sought to recover under that policy, Allstate took the position that ORS 742.504(7)(c) permitted it to deduct the total amount that the two other insurers had paid (approximately $55,000) from the UIM benefits that it owed plaintiff. Because Allstate's policy provides only $50,000 in UIM benefits, Allstate concluded that it owed plaintiff nothing. Plaintiff took the position that ORS 742.504(7)(c) permitted Allstate to deduct the net amount that the two insurers had paid him (approximately $42,000) but no more than that. Under plaintiff's view, Allstate owed him approximately $8,000 in UIM benefits. As noted above, the parties filed cross-motions for summary judgment, and the trial court granted Allstate's motion.

On appeal, the dispositive issue is whether ORS 742.504(7)(c) authorizes an insurer to deduct the net or the total amount of the proceeds that its insured has received from the UIM benefits it owes.[1] ORS 742.504(7)(c) provides:

> **177 Or App 125>** "Any amount payable under the terms of this coverage because of bodily injury sustained in an accident by a person who is an insured under this coverage shall be reduced by:

[1] The parties agree that the relevant contract provisions are functionally identical to the corresponding statutory provisions and that the proper focus is the statute. *See Vega v. Farmers Ins. Co.*, 323 Or 291, 304, 918 P2d 95 (1996).

The facts show that plaintiff agreed to furnish his services to Butler and that Butler in turn accepted those services. Butler also attempted to pay plaintiff $36 by giving it to his brother. That is sufficient to satisfy the first statutory element of furnishing services for remuneration. *See Buckner v. Kennedy's Riding Acad.*, 18 Or App 516, 521, 526 P2d 450, *rev den* (1974). Further, in a questionnaire sent to him by Liberty Northwest, plaintiff said that he was employed by Butler at the time of his injury and that his rate of pay was $5.50 an hour. That response indicates that plaintiff understood that he would be paid for his labor. *See Montez v. Roloff Farms, Inc.*, 175 Or App 532, 536, 28 P3d 1255 (2001) ("A contract for hire that satisfies the 'engagement' requirement of ORS 656.005(30) may be based on either an express or implied contract."); *see also Hix v. SAIF*, 34 Or App 819, 825, 579 P2d 896, *rev den* 284 Or 1 (1978). The trial court did not err in holding that Butler established that plaintiff agreed to furnish services for remuneration.

We next consider whether plaintiff was subject to the direction and control of Butler. There are four factors **<177 Or App 111/112>** involved in that question: (1) direct evidence of the right to, or exercise of, control; (2) the furnishing of tools and equipment; (3) method of payment; and (4) right to fire. *Stamp v. DCBS*, 169 Or App 354, 357, 9 P3d 729 (2000). In *Stamp*, we said:

> "No single factor is dispositive in all instances. However, a single factor that indicates an employer-employee relationship may constitute proof of an employment relationship whereas contrary evidence, indicating independent contractor status, is, at best, mildly persuasive and may have no effect at all to a determination of worker status." *Id.* at 360.

Here, Butler's employee instructed plaintiff on how to perform the disassembly work and also directed plaintiff to perform specific tasks. This factor indicates that Butler had a right to control plaintiff's work.

The second factor, the furnishing of tools and equipment, is also resolved in favor of an employment relationship, because Butler provided all the disassembly tools to plaintiff, including the 50-pound monkey wrench he was using when he injured himself.

When the method of payment is by the hour, there is a strong indication of a right to control. *Trabosh v. Washington County*, 140 Or App 159, 165, 915 P2d 1011 (1996). Here, there is evidence that plaintiff was to be paid and was paid $5.50 an hour. This factor weighs in favor of an employment relationship.

The final factor, the right to fire, is neutral because there is no evidence about whether Butler could fire plaintiff. Because three of the four factors weigh in favor of finding that Butler had the right to direct and control plaintiff, we hold that the second statutory element is also satisfied. Plaintiff was a worker for Bulter at the time of the accident.

Accordingly, the trial court did not err in concluding that plaintiff was a worker subject to the provisions of the Workers' Compensation Act at the time of his injury, thus immunizing Butler from liability.

Affirmed.

the Rose Festival site where he was paid $36 for his work and given another $36 for plaintiff's work. Plaintiff's brother signed both his name and plaintiff's name on a piece of paper in order to receive the money. Butler was not able to locate this document. Plaintiff's brother kept plaintiff's $36.

A few days after the accident, plaintiff's stepfather, Michael Ratliff, telephoned Butler and spoke with Mary Caspell, Butler's claims manager and assistant administrator. Caspell took notes during this conversation. Those notes indicated that Ratliff told Caspell that his stepson had injured his arm when he fell off a Ferris wheel while working at the Rose Festival. Caspell contacted Joe Yahr, Butler's unit manager and safety director, to verify whether the accident did, in fact, occur. When Yahr confirmed that the accident occurred, Caspell prepared a workers' compensation claim form and forwarded it to Butler's workers' compensation insurance carrier, Liberty Northwest Insurance Corporation. Liberty Northwest had also received a workers' compensation form, labeled "First Medical Report." Liberty Northwest treated both forms as a claim for workers' compensation benefits. Neither form was signed by plaintiff. Liberty Northwest subsequently sent plaintiff a claim history questionnaire. Plaintiff indicated on the form that he was employed by Butler as a laborer at the time of the injury and <177 **Or App 109/110**> that he was paid $5.50 an hour. Plaintiff signed and dated the form twice, indicating that the information he provided was complete and accurate to the best of his knowledge.[1]

Several weeks later, plaintiff received a check from Liberty Northwest but refrained from cashing it until he to spoke with an attorney. He told the attorney he wanted to sue Butler. The attorney advised plaintiff that he could cash the check and also sue Butler. Based on that advice, plaintiff cashed the check.

Meanwhile, Liberty Northwest accepted plaintiff's claim for a right forearm fracture and left heel contusion. Liberty Northwest paid plaintiff's costs associated with the injury and time-loss benefits as part of processing plaintiff's workers' compensation claim.

Plaintiff retained new counsel in April 1998. His new attorney wrote Liberty Northwest, stating that he was concerned whether his client was making a fair and accurate claim under the Workers' Compensation Act (the Act). In response to that letter, Liberty Northwest investigated plaintiff's claim and concluded that plaintiff was a worker for an employer within the meaning of the Act and that the claim was properly accepted and processed. The attorney responded that plaintiff was likely a volunteer and not an employee on the date of his injury. Liberty Northwest continued to process the workers' compensation claim even after this action was filed. Plaintiff never refused or returned any of those benefits but filed this case in September 1998.

As previously mentioned, the trial court bifurcated the trial. Butler's affirmative defenses were tried first to the court, because they were potentially dispositive. One of those affirmative defenses was that plaintiff was a worker under the Act and, therefore, Butler was immune from liability. The trial court agreed. On appeal, plaintiff asserts that the trial court erred in holding that plaintiff was a "worker" as that word is defined in ORS 656.005(30).

177 Or App 111> We review the trial court's findings of fact for any evidence and its legal conclusion as a matter of law. *Illingworth v. Bushong*, 297 Or 675, 694, 688 P2d 379 (1984). We first consider whether plaintiff was a worker. ORS 656.005(30) provides, in part, that a worker is "any person, * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *." *See Martelli v. R.A. Chambers and Associates*, 310 Or 529, 537, 800 P2d 766 (1990).

The trial court concluded that an implied agreement existed between plaintiff and Butler and that both the anticipation of "partying" and the $36 were independently sufficient forms of remuneration to support the conclusion that plaintiff was a "worker." Specifically, the trial court found that Butler did not follow its normal process in hiring plaintiff. However, the trial court found that Butler paid plaintiff $36 in its usual manner--in cash immediately after the conclusion of the labor. Based on those facts, the trial court concluded that an implied agreement existed between plaintiff and Butler. We agree.

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[1] It was actually plaintiff's stepfather who filled out the questionnaire because plaintiff was unable to write with his injured arm. However, plaintiff did sign the questionnaire twice at the end of the form.

Cite as 177 Or App 106 (2001) October 3, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

JESSE W. DEMILLY, Appellant,
v.
BUTLER AMUSEMENTS, INC., a California corporation, Respondent.
9809-06686; A108482

Appeal from Circuit Court, Multnomah County.
John A. Wittmayer, Judge.
Argued and submitted February 15, 2001, Valley Catholic High School, Beaverton.
Gerald C. Doblie argued the cause for appellant. With him on the briefs was Doblie & Associates.
Ruth C. Rocker argued the cause for respondent. With her on the brief was Hoffman, Hart & Wagner, LLP.
Before Haselton, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.
WOLLHEIM, J.
Affirmed.

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177 Or App 108> Plaintiff filed this personal injury action against defendant, Butler Amusements (Butler), for negligence, negligence *per se*, and violation of the Employer Liability Law, ORS 654.305 to ORS 654.335. The trial court granted Butler's motion to bifurcate the trial and first held a bench trial on its affirmative defenses. The trial court agreed with Butler's affirmative defense that plaintiff was a "worker" under the Workers' Compensation Act and that the Act was plaintiff's exclusive remedy. Accordingly, it dismissed plaintiff's complaint and entered judgment for Butler. Plaintiff appeals from that judgment. We affirm.

In June 1997, plaintiff, his brother, and some friends attended the last night of the Portland Rose Festival Fun Center. They rode the Giant Gondola Wheel just before closing. After the ride ended, they were approached by one of Butler's employees, the operator of the gondola. The employee asked them if they wanted to help dismantle the ride that night. The employee told them that the employees had set a record the year before in dismantling the ride and that they wanted to break the record that night. The employee also said that they would all "party" together afterwards. Plaintiff and his brother agreed to do the work.

Butler is a traveling carnival with a full-time, year-round office in Beaverton. Butler employs 12 to 13 full-time administrative employees and employs thousands of seasonal employees. It also hires temporary laborers to assist in dismantling the rides. Butler's typical practice in hiring temporary laborers is to obtain the name, address, and social security number of the temporary laborers on a piece of paper. The laborers are paid minimum wage in cash following the completion of the work.

Plaintiff denies having signed documents or forms. Butler was unable to locate any paper work regarding the laborers who were working for it at the Rose Festival at the time of plaintiff's accident.

Before starting work, Bulter's employee invited plaintiff and his brother to join him underneath the Giant Gondola Wheel. Once there, the employee produced a pipe <177 Or App 108/109> that plaintiff believed contained marijuana. Upon inhaling, plaintiff discovered that the pipe, in fact, contained methamphetamine.

Plaintiff and his brother were instructed generally how to perform the disassembly work and were directed how to perform specific tasks. For example, plaintiff testified that he was instructed on how to take the flags off the ride and put them away and how to take down the ramps, railings, and stairs and where to put them. At one point, plaintiff was working at heights greater than 30 feet, got scared, and asked if he could come down. One of Butler's employees told him that he could come down and that they would find something else for plaintiff to do. While 10 feet above the ground, plaintiff was loosening a bolt with a 50-pound monkey wrench supplied by Butler, when plaintiff fell and injured his arm and heel. Soon thereafter, a Butler employee escorted plaintiff's brother to an office trailer on

On the first issue, ORS 656.802(3)(c) provides that a mental disorder is not compensable unless, among other things, the claimant establishes that "[t]here is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community." In this case, both Malone and Schwerzler diagnosed claimant as suffering from post-traumatic stress disorder, which resulted from the assault at work. Employer argues, however, that, because Malone and Schwerzler had incomplete information, they had no reliable basis to make that diagnosis. In employer's view, on this record, the Board's only option was to find that claimant had failed to prove her case.

Employer's argument sweeps too broadly. Whether a doctor's information is complete or incomplete will vary depending on the particular diagnosis that a doctor is asked to make. In this case, Klecan testified at the hearing that post-traumatic stress disorder "is a very specific unique mental illness with certain criteria for making the diagnosis." The criteria that Klecan identified are the nature of the traumatic event, the nature of the symptoms, and when the symptoms appear. Malone did not disagree that those are the relevant criteria. Rather, he disagreed with Klecan in determining how they applied in this case.

Given Klecan's and Malone's medical opinions, the Board reasonably could find that Malone and Schwerzler had a complete history for the purposes of deciding whether claimant suffered from post-traumatic stress disorder. Both Malone and Schwerzler had all the information that, according to Klecan, is necessary to make that diagnosis. They knew the nature of the precipitating event, the nature of **<177 Or App 120/121>** claimant's symptoms, and their onset.[3] We accordingly disagree with employer that, on this record, the Board was required to find that claimant had failed to prove her case; that is, there is medical evidence in the record from which the Board could find that the information that Schwerzler and Malone lacked was not relevant to diagnosing post-traumatic stress disorder.

The Board, however, did not adopt that rationale. It appears to have assumed that the off-work stressors would ordinarily be relevant to diagnosing post-traumatic stress disorder but reasoned that those stressors were not important in this case because they had essentially resolved by the time of the assault. We agree with employer that the rationale the Board adopted--that the off-work stressors had resolved and would not have any residual effect on claimant--is a complex medical question that requires an expert opinion. *See Benz v. SAIF*, 170 Or App 22, 27-28, 11 P3d 698 (2000). Because the Board's stated reason for saying that Malone's and Schwerzler 's opinions were based on complete information is not supported by any medical opinion, we cannot affirm its order. We accordingly reverse and remand for further consideration.[4]

Reversed and remanded for further consideration.

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[3] We note that Klecan did not testify that the information he learned at the hearing was relevant to determining whether claimant suffered from post-traumatic stress disorder. Rather, he explained that that information could provide an alternative explanation for the symptoms that claimant had reported.

[4] Give our disposition of the first issue, we do not reach the second issue raised by employer--whether a diagnosis of post-traumatic stress disorder is sufficient standing alone to permit the Board to find that the traumatic experience that caused the disorder was also its major contributing cause.

The administrative law judge upheld employer's denial. A divided Board reversed. The majority found Schwerzler and Malone's opinions more persuasive than Klecan's. It explained that Malone's opinion was "thorough and well-reasoned" and was "based on extensive familiarity with claimant's psychological symptoms." It accepted Malone's conclusion that "every line of reasoning Dr. Klecan uses to support fabrication is faulty" and explained that it found Malone's opinion "considerably more persuasive than Dr. Klecan's opinion."

Finally, the majority noted that the dissenting member discounted Malone's opinion because Malone had not considered the impact of potential off-the-job stressors such as claimant's gambling debts, bankruptcy, and marital difficulties. The majority explained:

> "[W]e do not find this to be a fatal flaw in Dr. Malone's opinion because claimant's marital problems had either resolved or improved significantly at the time of the assault and thereafter (claimant's husband was in the store when she was attacked and spent time with claimant in the store after the assault) and claimant's financial difficulties had improved."

Employer petitioned for review raising two related but separate issues. It argued that Malone's and Schwerzler's opinions were legally insufficient because neither doctor had considered the potential effect of off-work stressors on claimant's condition. *See SAIF v. Brown*, 159 Or App 440, 445-46, **<177 Or App 118/119>** 978 P2d 407 (1999) (summarizing employer's arguments). Additionally, employer argued that the Board had erred in not applying a clear and convincing standard to claimant's mental stress claim. *Id.* We did not reach the first issue that employer raised. Rather, we reversed and remanded for reconsideration because it was not clear whether the Board had applied a clear and convincing standard. *Id.* at 446.

On remand, the Board reaffirmed its earlier ruling and found that claimant had established by clear and convincing evidence that the work-related assault was the major contributing cause of her post-traumatic stress disorder. It also noted that employer had argued on judicial review that the Board had "improperly rendered [its] own medical opinion when [the Board] concluded that off-work stressors had improved before the assault occurred." The Board disagreed, reasoning:

> "We did not render a medical opinion. Rather, we drew legitimate inferences from the evidence in the record and concluded that Dr. Malone's opinion should not be discounted on the basis of insufficient consideration of off-the-job stressors. After further consideration of the matter, we continue to find Dr. Malone's opinion persuasive despite his alleged lack of information regarding off-work stressors."[2]

Employer has petitioned for review of the Board's order on remand. It argues that both Malone's and Schwerzler's opinions "were based on incomplete and incorrect information relative to the issue of major contributing cause and thus failed to weigh the relative contribution of different causes of claimant's condition." It follows, employer reasons, that neither opinion provides a legally sufficient basis for the Board's conclusion that the workplace assault was the major contributing cause of claimant's mental disorder. However, neither Malone's nor Schwerzler's opinion expressly addressed the question of major contributing cause. Rather, both were limited to the question whether claimant suffered from a recognized mental disorder--post-traumatic stress disorder--as a result of the workplace assault.

177 Or App 120> In this posture, the issue that employer raises on appeal more properly divides into two separate questions. The initial question is whether Malone's and Schwerzler's opinions are sufficient to support their diagnosis that claimant suffers from post-traumatic stress disorder. If they are, the remaining question is whether their opinions that she suffers from that disorder were sufficient to permit the Board to conclude that the work-related assault was the major contributing cause of her disorder.

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[2] It is unclear whether Malone was unaware of claimant's marital and gambling problems. The Board did not resolve that factual issue but assumed that he was not aware of those issues.

> "I think this question is moot in that I found no need for psychological treatment at all. There is, of course, financial motivation for her to visit a psychologist, but whatever her motivations may be, her history and her mental status examination objectively are not consistent with a diagnosis of mental disorder as claimed by herself."

Both Schwerzler and Malone reviewed Klecan's report. Neither agreed with it. Malone noted that Klecan's "position seems rather extreme and is based on questionable assumptions." He explained that, in his view, claimant had experienced an event that threatened serious injury and that that experience, according to the DSM-III, could cause post-traumatic stress disorder. He also explained why he did not agree with other assumptions on which Klecan based his conclusion. Both Malone and Klecan's opinions were limited to the question whether claimant suffered from post-traumatic stress disorder. Neither opinion addressed whether work was the major contributing cause of her disorder.

Employer denied the post-traumatic stress disorder claim, and claimant requested a hearing. At the hearing, claimant testified that she and her husband had separated in the fall of 1995 but had reconciled in three weeks and that her husband had been with her in December when the assault occurred. The Administrative Law Judge (ALJ) also elicited from claimant that before and during the fall and winter of 1995, she had incurred significant gambling debts **<177 Or App 116/117>** and went through a bankruptcy. Claimant explained on redirect that, in the early part of 1995, she had used her credit card to finance her gambling, that she had incurred a substantial amount of debt, that she had declared bankruptcy in March or April 1995, and that she had given up her credit cards at approximately the same time. Although she continued to gamble, she now did so only with cash in hand and had substantially limited the amount she risked by the date of the hearing. She added that her financial situation was better since she filed for bankruptcy in March or April 1995.

Employer called Klecan to testify. Klecan testified about the criteria for diagnosing post-traumatic stress disorder. He explained that "post-traumatic stress disorder is a very specific unique mental illness with certain criteria for making the diagnosis." "[T]he essential core experience that creates a post-traumatic stress disorder is an experience where a person is held in a position of helpless terror for a period of time and undergoes trauma in that experience." "The core of this diagnosis is that the person is in--is held in this position and psychologically they become overwhelmed. The experience is so extreme, so unusual, that they're not able to cope with it psychologically for awhile." In attempting to come to grips with the experience, the person "goes through a period of having symptoms." Klecan identified the severity of the trauma, the nature of the symptoms, and their timing as the criteria by which one determines whether a person is suffering from post-traumatic stress disorder. Klecan reiterated his position that, in this case, neither the precipitating event nor claimant's reported symptoms were consistent with a diagnosis of post-traumatic stress disorder.

During Klecan's testimony, employer noted that claimant had testified "about some other issues [the gambling and marital problems] that were not raised in either your interview or apparently with Dr. Malone." Employer then asked Klecan whether "those [issues] factor in at all given the time sequence and any of the facts in this case." Klecan replied:

> "To me they would. I think this additional information makes me think that probably there's much that we do not know about her psycho--her life outside of work, about **<177 Or App 117/118>** what was really going on in her marriage, in her personal life. I have myself little doubt that there were issues within the marriage and personal relationships, which were affecting her mental state and in some way involved in her claim in this respect. Although, I don't know what that would be for sure. In the specifics, I just have the sense that there's enough here to warrant that conclusion."

Klecan testified that the off-the-job issues that claimant had experienced before the robbery could provide an explanation for the symptoms she reported after the robbery.[1]

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[1] In his report, Klecan had taken the position that claimant's reported symptoms were embellished, if not fabricated. In his testimony, he appeared to acknowledge that her symptoms might be real but were perhaps caused by other factors.

Cite as 177 Or App 113 (2001) October 3, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lynn M. Brown, Claimant.

SAIF CORPORATION and GARY'S MARKET, Petitioners,
v.
LYNN M. BROWN, Respondent.
96-05732; A107381

Judicial Review from Workers' Compensation Board.
Argued and submitted July 20, 2000.
David L. Runner argued the cause and filed the brief for petitioners.
Greg Noble argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Reversed and remanded for reconsideration.

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177 **Or App 115**> The Workers' Compensation Board found, on remand, that claimant suffers from a compensable mental disorder as a result of a work-related assault. Employer petitions for review of that order. We reverse and remand.

Claimant worked the night shift at a convenience store in Woodburn. On December 14, 1995, sometime after midnight, three young men came into the store. One of them took some beer and tried to leave the store without paying. When claimant tried to stop him, one of the other men hit her in the face. "Claimant's eyeglasses were broken and she sustained a laceration under her left eye." One of the men stayed to help claimant. The other two fled. They were caught shortly after that, and claimant identified them as the persons who had robbed the store and assaulted her. Claimant then went to the hospital where she received stitches for the laceration.

Claimant returned to regular work the week after the assault, and employer accepted the laceration and left cheek contusion as a nondisabling injury. After the assault, claimant's husband stayed with her most nights during her shift until late March 1996. In March 1996, claimant went to her family doctor, Dr. Schwerzler, for a follow-up on her facial injury. He noted that she was having feelings of anxiety, fear, and depression when she had to work alone. Schwerzler referred her to Dr. Malone, a psychologist, and took claimant off work beginning in April.

Malone concluded that claimant "meets [the] criteria for Post Traumatic Stress Disorder (309.89) after the blow to her head on December 14, 1995." He noted that "[t]he trial for one of the youths ended in early March, and [claimant] thought if she sat through the whole trial, she would feel better. Instead she has been even more nervous since then." Malone explained the symptoms that claimant was experiencing:

> "[Claimant] has memories of the incident arising 'out of the blue,' 'like when filling out forms for doctors.' Memories making her 'scared, ashamed, violated, nervous and jumpy.' Nightmares of it were nightly at first and now occur <**177 Or App 115/116**> biweekly. She tries to push memories out of her head. She cries at least every other day, and did during the interview. She has an exaggerated startle response, jumping while watching tv when the wind blows the screen door. She is overly irritable. She was scared to go to work, especially on weekend nights, and thinking of it makes her 'shake inside.' Sleep is erratic."

Dr. Klecan, a psychiatrist, examined claimant at employer's request. In Klecan's opinion, the assault that claimant experienced was not sufficiently severe to cause post-traumatic stress disorder. In his view, there was "[n]o mental disorder." Rather, "[e]mbellishment and/or fabrication of symptoms is present." When asked what was the major contributing cause of claimant's need for treatment, Klecan responded:

> "Claimant's description of these events postures the claim as a conventional bid for interim compensation that accrued during the 'interim' between the submission of a low back claim and the date upon which it was denied. If that is all there were to the matter, the Court would be compelled to reverse."

Additionally, employer noted in a footnote:

> "Employer does not concede error, but acknowledges it has not been able to determine how the Board concluded reinstatement of the denial mooted claimant's procedural entitlement to that portion of the claimed temporary disability benefits ('interim compensation') that might have accrued *before* the employer issued its December 28, 1998 back-up denial." (Emphasis in original.)

Nonetheless, employer argues that its concession does not require an award of interim compensation because, in part, claimant never submitted a valid low-back strain claim under ORS 656.262(7)(a).

The Board never considered claimant's request for interim compensation or penalties for the failure to pay interim compensation. Nor did the Board consider employer's argument that claimant was not entitled to any interim compensation or penalties. The Board needs to consider those arguments.

Order reversed and remanded for reconsideration of interim compensation, penalties, and attorney fees; otherwise affirmed.

Cite as 177 Or App 102 (2001) October 3, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Metin Basmaci, Claimant.

METIN BASMACI, Petitioner,
v.
THE STANLEY WORKS, Respondent.
98-10143; A109614

Judicial Review from Workers' Compensation Board.
Argued and submitted January 16, 2001.
Edward J. Hill argued the cause for petitioner. With him on the brief was Willner Wren Hill & U'ren.
Jerald Keene argued the cause and filed the brief for respondent.
Before Haselton, Presiding Judge, and Deits, Chief Judge, and Wollheim, Judge.
WOLLHEIM, J.
Order reversed and remanded for reconsideration of interim compensation, penalties, and attorney fees; otherwise affirmed.

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177 Or App 104> Claimant seeks judicial review of an order of the Workers' Compensation Board, raising multiple assignments of error. We affirm without discussion all assignments of error except for the assignment of error concerning interim compensation, attorney fees,[1] and penalties.

The facts will be abbreviated because we write on only one assignment of error. Beginning in 1995, claimant sought medical treatment for his feet. In January 1998, the processing agent for employer accepted a nondisabling claim for bilateral plantar fasciitis. Claimant was prescribed custom orthotics. After using the orthotics, claimant developed low-back pain. In June 1998, one of claimant's attending physicians completed a "First Medical Report" form, in which he diagnosed a low-back strain and released claimant for modified work. Employer did not deny the low-back claim until May 1999. From the time that the claim was received by employer until the denial, employer did not pay claimant any interim compensation.

At hearing, claimant sought interim compensation from June 29, 1998, to the date of hearing and a penalty for the employer's unexplained failure to pay interim compensation. The administrative law judge (ALJ) set aside the low-back denial and ordered employer to pay the appropriate amount of interim compensation and a penalty on all compensation due from June 29, 1998, to May 25, 1999, the date of employer's denial of the claimant's low-back strain.

Employer requested Board review. The Board reinstated employer's denial of the low-back strain. The Board also reversed the ALJ's award of interim compensation and penalties. The Board did not discuss whether claimant was entitled to interim compensation:

> "Inasmuch as we have upheld the employer's denial of claimant's low back condition, we also reverse the ALJ's award of temporary disability related to that condition. Similarly, we reverse the ALJ's awards of penalties and **<177 Or App 104/105>** attorney fees because there are no amounts 'then due' and no unreasonable resistance to compensation upon which to base such awards."

Interim compensation is not the same as temporary disability benefits. *Botefur v. City of Creswell*, 84 Or App 627, 630, 735 P2d 20 (1987). In fact, a claimant may be entitled to interim compensation even though there is no entitlement to temporary disability. *Jones v. Emanuel Hospital*, 280 Or 147, 151-52, 570 P2d 70 (1977). Employer candidly conceded that much in its brief:

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[1] If claimant is entitled to any interim compensation, then his attorney would be entitled to an out-of-compensation attorney fee. ORS 656.386(2).

performs in her job require strength. Subsection (4)(a), by explicitly incorporating the DOT descriptions, necessarily incorporates that document's presumptive strength ratings; the DOT makes generic strength ratings for jobs, based on the typical frequency of strength-related tasks such a job entails, and (4)(a) adopts them as well.

Calculating BFC under subsection (4)(c), on the other hand, does *not* require or even permit the Board to consult the DOT; (4)(c) nowhere refers to that document. Rather, the assessment under (4)(c) relies on the categories set out in (4)(e) and defined in *former* OAR 436-35-310(3). Subsection (4)(e) lists the classifications that "shall apply to establish BFCs: sedentary (S), light (L), medium (M) * * *, " etc. Each of these categories is defined in subsection (3). Those definitions incorporate both strength and frequency criteria. Thus, for purposes of (4)(c), a "light" job is one where the worker has the ability to lift 20 pounds "about 1/3 of the time" and lift or carry objects weighing up to 10 pounds "up to 2/3 of the time." *Former* OAR 436-35-310(3)(f), (3)(m), (3)(n). Applying (4)(c), therefore, will require an examination of the frequency and amount of the strength demands of claimant's job at injury.

In sum, properly to calculate claimant's BFC, the Board must have access to facts regarding claimant's work history from which it can determine which subsection of *former* OAR 436-35-310(4)(a) and (4)(c) applies. If (4)(a) is the appropriate subsection, the BFC depends on the DOT code for the claimant's job. If claimant's job duties more closely resemble the combined job duties of two jobs than of any single job, then the appropriate strength rating is the one for the higher of the two jobs. The BFC under (4)(a) can be calculated without any evidence indicating the frequency with which claimant lifts particular weights, because weights and frequencies are categorically incorporated into DOT codes. If (4)(c) is the appropriate subsection, then the BFC is determined according to the scale and definitions in subsections (3) and (4)(e). Those subsections establish their own strength **<177 Or App 22/23>** and frequency criteria. The calculation of BFC under (4)(c) does not involve DOT codes or job categories; each claimant's duties are evaluated on a case-by-case basis.

Claimant originally filed her claim in 1993. The case has been to this court and back to the Board on remand once before. For this reason, and because the Board's legal analysis--the subject of this appeal--seems flawed, I believe that the goals of judicial efficiency in general and the workers' compensation statutes in particular would be better served if we now addressed the issue that brought the case here, instead of waiting for it to reappear.

two or three months at her job when she was injured. That time period is less than the SVP requirement for claimant's job-at-injury. In other words, the record before the Board reveals considerable evidence that the requirements of OAR 436-35-300(3) had not been satisfied. That evidence could satisfy the first requirement of subsection (4)(c). It could be that the parties agreed to the Board's predicate findings, or that there is evidence that supports the Board's reasoning that claimant does not meet the requirements of subsection 4(c), but those facts are not apparent to us from the Board's opinion.

By resorting to subsection (4)(a) without expressing in other than conclusory language why it could not use subsection (4)(c), the Board has failed to adequately explain its rationale in concluding that a calculation under that subsection is more likely to result in a proper calculation of claimant's current BFC. If a reviewing court cannot discern an agency's rationale, it cannot determine whether the agency has erroneously interpreted the law or whether the order is supported by substantial evidence. *Portland Assn. Teachers v. Mult. Sch. Dist. No. 1*, 171 Or App 616, 636-37, 16 P3d 1189 (2000). We are left to "read between the lines" of the Board's order, and "we are not inclined to decide *whether* [the Board] correctly interpreted the law in this regard without first knowing *how* [the Board] interpreted the law." *Id.* at 637. We must therefore remand for an explanation of how the facts found led to the inferences and legal conclusions on which the order is based.

Reversed and remanded for reconsideration.

SCHUMAN, J., concurring.

I agree with the majority that we must remand this case because the record does not provide sufficient information to enable us to decide whether the Workers' Compensation Board erred in applying subsection (a) of *former* OAR 436-35-310(4) instead of subsection (c). I write separately to register my opinion that we should not send this case back to the Board for reconsideration without providing any guidance about how to apply the subsection it ultimately decides is correct.

177 Or App 21> In the process of deciding this case, the Board arguably applied the wrong subsection of *former* OAR 436-35-310(4), arguably misinterpreted that subsection, and indicated that it would arguably have misapplied the other subsection had it chosen to apply that one. We now send the case back to the Board without deciding the issue on which the parties disagree: how should BFC be calculated? Further, claimant argues that the results under subsections (a) and (c) are identical, so that any error in choosing one over the other is harmless. Our remand without addressing that assertion implies that we believe otherwise: why would we remand for a choice if we thought that the choice was irrelevant? To clarify our position on that issue, and to prevent more unnecessary delays, we should offer some guidance. Mine follows.

I begin with (4)(a). Under that subsection, if the claimant's job is precisely described in the DOT, the strength rating assigned by the DOT for that job is used. If, on the other hand, "a combination of DOT codes most accurately describes a worker's duties, the highest strength for the combination of codes shall apply." *Former* OAR 436-35-310(4)(a). This sentence, as employer correctly argues, does not allow a claimant whose job includes only a very few duties from the higher DOT category to bootstrap himself into it. The lawyer (DOT code: "sedentary") who occasionally moves a box of files or carries a heavy suitcase does not, by virtue of those occasional duties, qualify for the same strength rating as a file clerk (DOT code: "light") or baggage clerk (DOT code: "medium"). It strains the plain language beyond its breaking point to say that a combination of coded jobs is the "most accurate" description of a claimant's job merely because no coded job lists every duty of the claimant's job. If, for example, a DOT job description lists 25 duties, and the claimant's job has all of those plus two duties from a higher strength-rated DOT job description, then the single, lower DOT description more accurately describes the claimant's job than the combined description. Under the better reading, "a combination of DOT codes most accurately describes a worker's duties" when a complete list of a worker's duties more closely resembles a combined list of all the duties in two job categories than it does the duties in either category by itself.

177 Or App 22> Contrary to employer's assertion, however, this system does not require a claimant to demonstrate the frequency with which she performs the duties from the higher strength-rated job, or, for that matter, that the specific duties from the higher strength-rated job that she

SAIF seeks review of the Board's calculation and makes two assignments of error: (1) that the Board erred in its application of OAR 436-35-310(4)(a); and (2) that the Board should have instead used OAR 436-35-310(4)(c) in calculating claimant's BFC. Claimant contends that, under either subsection, the correct BFC is "heavy." Our first inquiry is whether the Board's decision to reject (4)(c) as the method for calculation is supported by substantial reason.

OAR 436-35-310(4) required the Board to use the calculation that would result in the "most current" assessment of a worker's capacity. Subsection (4)(c) authorizes the Board to use the "job at the time of injury," under certain circumstances. Thus, subsection (4)(c) appears to be a logical beginning point for a calculation under the rule and the circumstances of this case--claimant's job at the time of injury is likely to be the "most current" assessment. However, subsection(4)(c) can be applied only to workers who (1) do not meet the requirements of OAR 436-35-300(3) regarding formal educational and vocational training, and (2) have not had a "second-level physical capacity evaluation performed prior to the on-the-job injury." The Board does not explain why subsection (4)(c) is inapplicable, other than to conclude that claimant had met the SVP requirements of OAR 436-35-300(3) for her job at the time of her injury. That conclusion is based on the apparent assumptions that the appellate reviewer found claimant to have satisfied the SVP requirements for her nurse's assistant job, that the SVP for that job was the highest possible SVP claimant could obtain, and that the parties did not dispute those findings. However, SAIF disagrees that the appellate reviewer made those predicate findings and points to the appellate reviewer's comments that he had received no work history that would permit a determination of SVP. Moreover, the parties appear to agree that claimant's calculation should be made under subsection (4)(c), which requires a finding that she has *not* satisfied the SVP requirements for her job at the time of her injury under OAR 436-35-300(3).

177 Or App 19> OAR 436-35-300 provided in part:

> "(3) A value for a worker's Specific Vocational Preparation (SVP) time is allowed based on the job(s) the worker has performed during the five (5) years preceding the date of issuance.
>
> "(a) SVP is the amount of lapsed time required by a typical worker to learn the techniques, acquire the information and develop the facility needed for average performance in a specific job-worker situation. The SVP range is from 1 (lowest) to 9 (highest) associated with each DOT code. When a combination of DOT codes most accurately describes a worker's duties, the highest SVP shall apply if the worker has met the specific vocational preparation training time for that specific code.
>
> "(b) The worker's SVP value is the highest SVP of any job that the worker has met in the five years prior to the date of issuance as follows:
>
> "(A) A worker is presumed to have met the SVP training time after completing employment with one or more employers in that job classification for the time period specified in the table in section (4) of this rule.
>
> "(B) A worker has also met the SVP for a job after successfully completing an authorized training program, on-the-job training, vocational training or apprentice training for that job classification. College training organized around a specific vocational objective is considered specific vocational training."

Under OAR 436-35-300(3), the worker's SVP value is based on a five year work history and a prescribed time period of *successful* completion of a particular job. For instance, the DOT provides that, for the job of certified nurse's assistant, the proper SVP value is 4. That SVP value also requires the completion of 3 to 6 months of employment in the job.

In an effort to understand the Board's reasoning and why it decided that claimant's calculation could not be made under subsection (4)(c), we have examined the evidentiary record. There is no evidence of a five year work history in the record before us. Nor is there evidence that claimant successfully performed her job at the time of injury or any other job. Moreover, the appellate reviewer made his calculation under **<177 Or App 19/20>** subsection 4(c), finding that claimant had worked only

On reconsideration, the Board considered the evidence that was the subject of claimant's first request for judicial review. It awarded claimant unscheduled disability of 45 percent. It observed,

> "Adaptability is measured by comparing a worker's Base Functional Capacity (BFC) to the Residual Functional Capacity (RFC) at the time of becoming medically stationary. *Former* OAR 436-35-310(2). Here, there is no dispute that claimant's RFC is "medium/light." The dispute focuses solely on claimant's BFC, with claimant contending that her BFC is "heavy" and SAIF contending that it is "medium." Claimant has the burden of proving the nature and extent of any disability resulting from the compensable injury. ORS 656.266.
>
> "Here, the parties do not dispute the Appellate Reviewer's finding that the highest SVP[2] claimant attained in the last five years was her at-injury job. (Ex 35-5). Thus, we find that claimant has met the SVP requirements pursuant to *former* OAR 436-35-300(3). *Former* OAR 436-35-310(4)(c). Therefore, claimant's BFC is determined under *former* OAR 436-35-310(4)(a), which provides for determination of a worker's BFC using:
>
> **177 Or App 17>** "'The highest strength category assigned in the DOT [Dictionary of Occupational Titles] for the most physically demanding job that the worker has successfully performed in the five (5) years prior to determination. When a combination of DOT codes most accurately describes a worker's duties, the highest strength for the combination of the codes shall apply.'
>
> "The parties do not dispute that the most physically demanding job claimant performed in the five years prior to determination is her at-injury job as a CNA. The dispute arises over whether the duties of claimant's at-injury job more closely fit within the DOT description of a nurse's assistant (DOT 355.674-014) or an orderly (DOT 355.674-018). * * * After reviewing the record, including claimant's testimony, we find that a combination of the two DOT codes for nurse's assistant and orderly most accurately describes claimant's at-injury CNA job." (Footnote omitted.)

The Board appears to have reasoned under OAR 436-35-310[3] as follows: It found that claimant satisfied the SVP requirements for her job at the time of injury. Because of that fact, she met the requirements of OAR 436-35-300(3), and, therefore, her BFC could not be calculated by using subsection (4)(c). The Board then turned to a calculation under subsection (4)(a). Under subsection (4)(a), the Board concluded that it should combine the two DOT job descriptions to most accurately describe claimant's job at injury. As a result, **<177 Or App 17/18>** the Board awarded claimant additional PPD for a total of 45 percent.

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[2] "SVP" is an abbreviation for "specific vocational preparation" or the amount of time required by a typical worker to develop the ability to perform the job. OAR 436-35-300(3)(a).

[3] OAR 436-35-310 provides in part:

"(4) The worker's Base Functional Capacity (BFC) is *the most current of*:

"(a) The highest strength category assigned in the DOT [which, among other things, rates occupations according to the physical demands they impose] for the most physically demanding job that the worker has successfully performed in the five (5) years prior to determination. When a combination of DOT codes most accurately describes a worker's duties, the highest strength for the combination of codes shall apply; or

"* * * * *

"(c) For those workers who do not meet the requirements pursuant to OAR 436-35-300(3), and who have not had a second-level physical capacity evaluation performed prior to the on-the-job injury or disease, their prior strength shall be based on the worker's job at the time of injury.

"* * * * *

"(e) The following classifications shall apply to establish BFCs: sedentary (S), light (L), medium (M), heavy (H), and very heavy (VH) as defined in section (3) of this rule." (Emphasis added).

Cite as 177 Or App 13 (2001) October 3, 2001

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Linda K. Fister, Claimant.

SAIF CORPORATION and SOUTH HILLS HEALTH CARE CENTER, Petitioners,
v.
LINDA K. FISTER, Respondent.
95-05569; A103418

Judicial Review from Workers' Compensation Board.
Argued and submitted October 27, 1999.
David L. Runner argued the cause and filed the brief for petitioners.
Max Rae argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Kistler and Schuman, Judges.*
EDMONDS, P. J.
Reversed and remanded for reconsideration.
Schuman, J., concurring.

* Schuman, J., *vice* Armstrong, J.

177 Or App 15> This case presents a dispute about how to calculate one of the variables used to measure the capacity a worker loses as the result of a compensable injury. We conclude that we are unable on this record to determine whether the Workers' Compensation Board made the proper calculation. We reverse the Board's order and remand for reconsideration.

The amount of compensation that an injured worker receives for a permanent injury depends on the extent of the disability (called "permanent partial disability," or PPD) caused by the injury. ORS 656.214(5). The extent of disability, expressed as a percentage (*e.g.*, "14 percent PPD"), depends in turn on the seriousness of the injury "as modified by factors of age, education and adaptability to perform a given job." ORS 656.726(4)(f)(A). The Department of Consumer and Business Services provides formulas for expressing these modifying factors as numbers. A high number adds to the extent of disability, which, in turn, adds to the injured worker's compensation.

The modifying factor at issue in this case is "adaptability." Adaptability, under the Department's rules, is determined by comparing the worker's ability to perform work before and after the injury or, in the language of the rules, by comparing the worker's "base functional capacity" (BFC) with his or her "residual functional capacity" (RFC). *Former* OAR 436-35-310(2) (1994)[1]. These statutes and rules reflect the proposition that a worker whose injury causes a significant loss of working capacity deserves more compensation than a worker whose injury inflicts minimal harm to working capacity, even if both workers end up identically disabled.

In this case, claimant worked as a certified nursing assistant for employer South Hills Health Care Center. While at work on May 11, 1993, she was injured when she fell. Her employer's insurer, SAIF, accepted her workers' compensation claim and paid for chiropractic treatment. A year after her injury, claimant became medically stationary. **<177 Or App 15/16>** Her claim was subsequently closed by a determination order that concluded that she had not suffered any PPD. She requested reconsideration and, after an evaluation by a medical arbiter, was awarded 14 percent PPD. On review by the hearings division, an administrative law judge (ALJ) increased the award to 31 percent. Claimant then appealed to the Board, arguing that the ALJ erred in classifying her pre-injury capability as "medium" instead of "heavy." The Board rejected her argument but, based on findings not relevant to this case, raised claimant's PPD from 31 percent to 37 percent. Claimant sought review before this court, arguing that the Board had erroneously refused to consider testimony regarding the nature of her job at the time of her injury. We agreed with her argument and remanded to the Board for reconsideration. *Fister v. South Hills Health Care*, 149 Or App 214, 942 P2d 833 (1997), *rev den* 326 Or 389 (1998).

[1] *Former* OAR 436-35-300 (1994) and *former* OAR 436-35-310 (1994) have been renumbered as OAR 436-035-0300 (1996) and OAR 436-035-0310 (1996). All future references to those rules are to the former rules.

Cite as 332 Or 557 (2001) October 4, 2001

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Cindy Mount, Claimant.

CINDY M. MOUNT, Petitioner on Review,
v.
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
and SAIF CORPORATION, Respondents on Review.
(WCB 99-06487, CA A103636; SC S48664)

On petition for review filed July 12, 2001.*
Christopher D. Moore, Eugene, filed the petition for petitioner on review.
No appearance *contra*.
Before Carson, Chief Justice, and Gillette, Durham, Leeson, Riggs, and De Muniz, Justices.**
MEMORANDUM OPINION
The petition for review is allowed. The decision of the Court of Appeals is vacated. The case is remanded to the Court of Appeals for further consideration in light of *Koskela v. Willamette Industries, Inc.*, 331 Or 362, 15 P3d 548 (2000).

* Judicial Review from the Workers' Compensation Board. 161 Or App 664, 986 P2d 28 (1999).

** Balmer, J., did not participate in the consideration or decision of this case.

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Cite as 53 Van Natta ___ (2001)

* Appealed to Courts as of October 31, 2001