VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 48

(Pages 1-714)

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

JANUARY-MARCH 1996

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CITE AS

48 Van Natta ____ (1996)

In the Matter of the Compensation of
RANDY L. NOTT, Claimant
WCB Case No. 94-07180
ORDER ON REVIEW (REMANDING)
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Brazeau's order that dismissed his request for hearing because of his failure to appear at hearing. On review, the issue is the propriety of the dismissal. We remand.

FINDINGS OF FACT

On June 16, 1994, claimant requested a hearing. The case was initially set for hearing on September 15, 1994, but was postponed because claimant discharged his attorney. Claimant obtained new counsel and the case was rescheduled for hearing on April 11, 1995. That hearing was removed from the docket when it was reported as settled. However, claimant's counsel subsequently reported on May 3, 1995 that claimant did not wish to proceed with the settlement and that he was withdrawing as claimant's attorney.

The case was once again rescheduled, this time for September 26, 1995. Claimant did not appear at the hearing, either in person or through counsel. That day, the ALJ issued an order dismissing claimant's hearing request based on claimant's failure to appear at the hearing.

On October 4, 1995, the Board received claimant's letter which explained that he assumed that the September 26, 1995 hearing would be postponed and that he was still attempting to find suitable counsel. Claimant's letter was treated as a request for review of the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if a claimant and his or her attorney fails to attend a scheduled hearing, unless extraordinary circumstances justify postponement or continuance of the hearing. OAR 438-06-071(2). We have previously held on numerous occasions that an ALJ must consider a motion for postponement of a hearing even after an order of dismissal has been issued. See, e.g., Olga G. Semeniuk, 46 Van Natta 152 (1994); Harold Harris, 44 Van Natta 468 (1992); Vincent G. Jacoban, 42 Van Natta 2866, 2867 (1990); Mark R. Luthy, 41 Van Natta 2132 (1989).

Here, in response to the ALJ's September 26, 1995 dismissal order, claimant submitted a letter explaining his assumption that the scheduled hearing would be postponed and recounting his efforts to find counsel. Claimant asks that his case be "rescheduled." Considering these circumstances, we interpret claimant's letter as a motion for postponement of the scheduled hearing. Inasmuch as the ALJ did not have the opportunity to rule on the motion, this matter must be remanded to the ALJ for consideration of the motion. See Olga G. Semeniuk, supra.

In determining that remand is appropriate, we emphasize, as we have in prior cases, that our decision should not be interpreted as a ruling on the substance of any of the representations contained in claimant's submission or a finding on whether postponement of the previously scheduled hearing is warranted. Rather, as we have explained in similar rulings, we take this action because we consider the ALJ to be the appropriate adjudicator to evaluate the grounds upon which the motion is based and to determine whether postponement of claimant's hearing request is justified. Olga G. Semeniuk, supra; Harold Harris, supra.[1]

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[1] The SAIF Corporation may present its objections, if any, to claimant's motion for postponement of the hearing to the ALJ when this case is returned to the Hearings Division.

Accordingly, the ALJ's order dated September 26, 1995 is vacated. This matter is remanded to ALJ Brazeau to determine whether postponement of claimant's hearing request is justified. In making this determination, the ALJ shall have the discretion to proceed in any manner that will achieve substantial justice and that will insure a complete and accurate record of all exhibits, examination and/or testimony. If the ALJ finds that a postponement is justified, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ finds that a postponement is not justified, the ALJ shall proceed with the issuance of a dismissal order.

IT IS SO ORDERED.

January 3, 1996 Cite as 48 Van Natta 2 (1996)

In the Matter of the Compensation of
WCB Case No. 92-10297
CLEON K. SINSEL, Claimant
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

This matter is on remand from the Court of Appeals. Sinsel v. Oregon Board of Forestry, 134 Or App 200 (1995). The court reversed our prior order, Cleon K. Sinsel, 45 Van Natta 2064 (1993), which affirmed the Administrative Law Judge's (ALJ's) order upholding the SAIF Corporation's denial of claimant's chest pain claim. Finding that it could not determine whether our decision would be different under Mathel v. Josephine County, 319 Or 235 (1994), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant worked as a forest firefighter. In June 1992, claimant experienced chest pain while working and sought treatment. The ALJ, finding that claimant's episode of chest pain was due to job stress, applied ORS 656.802 pursuant to SAIF v. Hukari, 113 Or App 475 (1992). The ALJ concluded that claimant failed to carry his burden of proof with clear and convincing evidence and, thus, upheld the denial.

On review, we affirmed. First, citing to Mathel v. Josephine County, 122 Or App 424 (1993), we agreed with the ALJ that claimant did not satisfy ORS 656.802(3). Furthermore, we acknowledged claimant's argument that the claim should be analyzed as one for an accidental injury based on evidence that his chest pain was caused by fatigue from overwork. Even under such a theory, however, we found that claimant did not prevail because he did not provide persuasive medical evidence establishing causation.

The Supreme Court subsequently reversed the Court of Appeals' decision in Mathel. Mathel v. Josephine County, supra. The Court held that a claim for a heart attack, whether caused by physical exertion, job stress, or both, is an accidental injury within the meaning of ORS 656.005(7)(a) rather than a mental disorder under ORS 656.802(3). Here, stating that it "cannot determine whether the Board's decision would have been different had it addressed the issue consistent with the Supreme Court's reasoning" in Mathel, the court in this case reversed and remanded for reconsideration. We proceed with our reconsideration.

On reconsideration, we permitted the parties to submit supplemental briefs. In those briefs, the parties discuss amended ORS 656.802(1)(b), which provides that "'mental disorder' includes any physical disorder caused or worsened by mental stress." Or Laws 1995, ch 332, § 56 (SB 369, § 56). The new law retroactively applies to this case. SB 369, § 66(1); Volk v. America Airlines West, 135 Or App 565 (1995) (retroactively applying amended ORS 656.386(2) pursuant to § 66(1)).

Claimant first asserts that amended ORS 656.802(1)(b) applies only when "mental stress," as opposed to "physical stress," causes or worsens a physical disorder. Claimant further contends that, because the medical evidence shows that he was under "physical stress" rather than "mental stress," his claim does not come under ORS 656.802(1)(b).

We agree with claimant's construction of the medical evidence. Dr. Mutch, who treated claimant's episode of chest pain, stated that claimant's chest pain "was on the basis of stress, and lack of adequate rest" and that he had been "very busy with forest fires and has been stressed out and not getting enough sleep." (Ex. 11). Dr. Mutch subsequently concurred with a "check-the-box" report indicating that claimant's work activities were the major contributing cause of his chest pain. (Ex. 12). Because Dr. Mutch referred to claimant's "stress" in conjunction with a lack of sleep and increased work demands, we find that the most reasonable interpretation of Dr. Mutch's opinion is that claimant's chest pains were caused by physical stress, or fatigue, and not psychological or mental stress. In reaching this conclusion, we note that Dr. Mutch neither mentioned nor diagnosed a psychological component or problem in discussing claimant's chest pain. In the absence of such an opinion from a medical expert, we are not prepared to interpret an oblique reference to "stress" as an indication that claimant's chest pain was attributable to psychological or mental causes.[1]

Based on our review of the record, we must determine which provision is applicable for resolving the claim. DiBrito v. SAIF, 319 Or 244, 248 (1994). Because the claim is for an event (the episode of chest pain) as opposed to an ongoing condition or state of the body or mind, it comes under ORS 656.005(7). See Mathel v. Josephine County, supra, 319 Or at 241-42. Furthermore, according to the treating doctor, fatigue from physical exertion caused claimant's episode of chest pain. Because "mental stress" was not implicated in causing claimant's chest pains, ORS 656.802(1)(b) does not apply.[2]

Inasmuch as the claim comes under ORS 656.005(7)(a), claimant need only prove a material contributing cause between his work and his chest pains. Dr. Mutch's opinion satisfies that standard. Consequently, claimant proved compensability of his chest pains.

Claimant's attorney is entitled to an assessed fee for services before every forum. ORS 656.388(1), 656.386(1). After considering the factors set forth in OAR 438-15-010(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 $7,000, 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 before the Board and the court), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Accordingly, on reconsideration, we reverse the ALJ's order dated November 27, 1992. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. For services before every forum, claimant's attorney is awarded an assessed fee of $7,000, to be paid by SAIF.

IT IS SO ORDERED.

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[1] The dissent asserts that we have "convenient[ly] disregard[ed]" Dr. Mutch's references to "psychological" stress. To the contrary, as discussed above, Dr. Mutch does not relate claimant's stress to a mental or psychological origin. Thus, rather than disregarding Dr. Mutch's opinion, we have interpreted the reference to "stress" within the context of the physical stress addressed in the physician's report.

[2] Thus, we need not consider claimant's argument that ORS 656.802(1)(b) applies only with proof that mental stress is the major contributing cause of the physical disorder. We also do not address claimant's request for remanding the case to the ALJ, since such motion is contingent on requiring him to satisfy ORS 656.802(3).

Board Member Neidig dissenting.

I disagree with the majority's construction of the evidence that Dr. Mutch implicated only physical stress, or fatigue, with regard to claimant's chest pains. Dr. Mutch stated that claimant's chest pain "was on the basis of stress, and lack of adequate rest" and that claimant had worked as a supervisor for inmate firefighting crews and had been "very busy with forest fires and has been stressed out and not getting enough sleep." (Ex. 11). Based on the common usage of "stressed out", the most reasonable interpretation of Dr. Mutch's opinion is that claimant was under psychological or mental stress; this finding is further supported by Dr. Mutch's reference to claimant's supervision of inmate firefighting crews.

The majority's convenient disregard of Dr. Mutch's references to psychological stress allows it to analyze the claim under ORS 656.005(7). Because I read the medical evidence as indicating that both psychological stress and fatigue caused claimant's chest pains, I concede that determining which statute resolves the claim is a difficult question. Inasmuch as the record, however, shows that claimant's chest pain is attributable at least in part to mental stress, the claim comes under ORS 656.802(1)(b).

Claimant did not satisfy the requirements in ORS 656.803(3). Thus, at least a portion (that due to psychological stress) of the claim fails. Furthermore, as discussed in our prior order, the medical evidence does not apportion the degree of causation between mental stress and fatigue. Consequently, even if a part of the claim is compensable under ORS 656.005(7), it would be speculative for us to decide what portion of the claim was due to fatigue. Therefore, the entire claim should fail.

The majority's legal analysis is "cleaner" because it finds only one statute applicable. In my opinion, the analysis is wrong because it is based on a flawed construction of the medical evidence. Thus, I dissent.

January 5, 1996 Cite as 48 Van Natta 4 (1996)

In the Matter of the Compensation of
PAUL R. HUDDLESTON, Claimant
WCB Case Nos. 94-09872, 94-03882, 94-09344, 94-09346, 94-09347, 94-09348 & 94-09342
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys
Thomas Castle (Saif), Defense Attorney

Reviewed by the Board en banc.

Aetna Casualty and Surety Company (Aetna) requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) set aside its denial of claimant's aggravation claim for a L5-S1 herniated disc condition; and (2) upheld denials of claimant's "new injury" claims for the same condition issued by Liberty Northwest Insurance Corporation (Liberty) on behalf of Heintz Construction and the SAIF Corporation (SAIF) on behalf of five employers. Claimant cross-requests review of those portions of the ALJ's order that: (1) declined to assess a penalty against Aetna for an allegedly unreasonable denial; and (2) awarded claimant a $10,000 carrier-paid attorney fee payable by Aetna. On review, the issues are responsibility, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We replace the third, fourth and fifth paragraphs on page 2 with the following:

Claimant sought treatment from Dr. Nelson, osteopathic physician, on March 1, 1991. (Ex. 22). Dr. Nelson reported that claimant had a recurrence of symptoms shortly after the May 7, 1990 injury with Aetna's insured, but claimant "chose 'just to live with it'" and did not seek medical treatment. Dr. Nelson diagnosed "[r]ecurrent low back pain syndrome probably 'structural' in origin." (Id.) On March 29, 1991, claimant was "essentially unchanged" and Dr. Nelson prescribed further physical therapy. (Ex. 25).

Claimant did not seek treatment for his low back condition again until March 1, 1993, when he returned to Dr. Nelson. (Ex. 27). Dr. Nelson diagnosed recurrent low back pain syndrome and questioned whether claimant should continue in heavy construction.

CONCLUSIONS OF LAW AND OPINION

Compensability

On review, the parties do not dispute the compensability of claimant's L5-S1 herniated disc condition.

Responsibility

We briefly summarize claimant's low back symptoms and medical treatment. Claimant injured his low back on May 7, 1990, when he was lifting a manhole lid while working for Aetna's insured. On January 7, 1991, Aetna accepted a nondisabling claim for a center low back strain.[1]

Claimant sought treatment from Dr. Nelson, osteopathic physician, on March 1, 1991. (Ex. 22). In describing claimant's May 7, 1990 injury, Dr. Nelson said that claimant had been lifting a manhole lid and the lid slipped into a six-foot hole, pulling claimant down. Claimant felt a wrenching pain in his back, but ignored it for two weeks. Dr. Nelson reported that claimant had a recurrence of symptoms shortly after the May 7, 1990 injury, but claimant "chose 'just to live with it'" and did not seek medical treatment. According to Dr. Nelson's report, claimant was laid off in December 1990 and had continued low back symptoms. Dr. Nelson described the pain as "constant and aching," although there was no radicular symptomatology into either lower extremity. Dr. Nelson diagnosed "[r]ecurrent low back pain syndrome probably 'structural' in origin." (Id.) Dr. Nelson stated that if the therapeutic program was not effective, further diagnostic studies should be considered to rule out lumbosacral radiculopathy.

On March 29, 1991, claimant was "essentially unchanged" and Dr. Nelson prescribed further physical therapy. (Ex. 25). Dr. Nelson reported that claimant could try to return to work as long as the job did not require significant use of the low back or the operation of heavy equipment.

Claimant experienced back pain on and off between March 1991 and March 1993. (Tr. 48, 49). Claimant did not seek treatment for his low back condition again until March 1, 1993, when he returned to Dr. Nelson. (Tr. 49, 50). Dr. Nelson reported that claimant had low back pain extending into the lower thoracic region, bilaterally. (Ex. 27). Claimant had not worked for the past three months because there had been no work, in addition to having recurrent back pain. (Id.) Claimant's back ache was present in varying degrees almost constantly. Dr. Nelson diagnosed recurrent low back pain syndrome and questioned whether claimant should continue in heavy construction. On March 30, 1993, Dr. Nelson reported that claimant continued to have low back pain and had a hard time getting out of bed in the morning. (Ex. 29).

Claimant returned to Dr. Nelson on July 12, 1993 with increased low back pain. (Ex. 32). Dr. Nelson reported that claimant had been working in heavy construction work and the work had been aggravating his condition. Dr. Nelson diagnosed recurrent low back pain syndrome and noted that claimant's pain was limited to the low back but extended slightly into the left buttock. (Id.) Dr. Nelson examined claimant on September 20, 1993 and diagnosed "[r]ecurrent low back pain syndrome secondary to occupational overuse and structural abnormality of the low back." (Ex. 37).

On November 16, 1993, claimant sought treatment from Dr. Nelson for intense low back pain after he had reached for a stereo speaker at his parents' house. (Ex. 41; Tr. 79). Dr. Nelson reported that claimant felt as though he had been "stabbed with a knife" in the lumbosacral area and pain immediately extended to the left lower extremity, particularly in the buttocks and knee. (Ex. 41). An MRI on December 15, 1993 revealed a herniated disc at L5-S1. (Ex. 47).

The ALJ found that claimant's compensable May 7, 1990 injury remained a material contributing cause of claimant's need to seek treatment and disability. The ALJ found that claimant had not experienced a new compensable injury, and, therefore, Aetna was responsible for claimant's current condition.

Aetna argues that claimant's herniated disc condition is not the same as the accepted central back strain, and, therefore, ORS 656.308(1) does not apply. Aetna contends that it cannot be responsible for the herniated disc condition since it did not exist at the time of the May 7, 1990 injury. Aetna also asserts that the actual cause of claimant's current low back condition was his work exposure beginning in 1993. Claimant contends that S-2 Contractors (SAIF's insured) is responsible for his low back condition.

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[1] We note that the description of the accepted condition in our copy of exhibit 16, Aetna's Notice of Claim Acceptance, is not legible. However, since Aetna asserts that it accepted a nondisabling center low back strain and none of the parties dispute that assertion, we accept Aetna's characterization of the accepted condition in its Notice of Claim Acceptance.

In determining which carrier is responsible for claimant's condition, we must first decide whether ORS 656.308(1) applies to this claim. ORS 656.308(1) provides that when a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. ORS 656.308(1) is triggered when there is an accepted claim for the condition, for which some employer is responsible. SAIF v. Yokum, 132 Or App 18, 23 (1994).

The medical evidence is divided as to whether claimant's current herniated disc condition involves the "same condition" as the claim accepted by Aetna. When there is a dispute between medical experts, we give more weight to medical opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). We tend to give greater weight to the conclusions of a claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983).

We are persuaded by the opinions of Drs. Nelson, Thompson and Melgard that claimant's herniated disc condition arose directly from the May 7, 1990 industrial accident he sustained while working for Aetna's insured. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992) (a condition that arises directly, even if belatedly, from the original injury is subject to a material contributing cause standard); Mark A. Newkirk, 46 Van Natta 1227 (1994) (although the carrier's acceptance was limited to "right forearm strain," the medical evidence established that the claimant's current shoulder condition arose directly from the accepted injury claim).

Claimant's treating physician, Dr. Nelson, reported that claimant's progressive system complex over the years was related to the original injury of May 7, 1990, which was, and is, the major contributing cause of claimant's condition. (Ex. 70).

Dr. Thompson agreed with Dr. Nelson's comment. (Ex. 95). Based on claimant's history, Dr. Thompson concluded that claimant had injured the lumbar disc in the initial May 7, 1990 injury and he believed that the repeated episodes of low back pain were due to internal disruption of the lumbar disc, which had now herniated. (Ex. 52). In a later report, Dr. Thompson agreed that the major contributing cause of claimant's herniated disc was the May 1990 injury, although claimant's ongoing work activities perhaps contributed to his back condition in a minimal fashion. (Ex. 95). Dr. Thompson agreed that claimant's 1990 injury probably led to a tear in the annulus of the disc and the effect of the November 1993 stereo incident was to probably extrude a portion of the already injured disc. (Id.)

Dr. Melgard examined claimant in September 1994 and reported:

> "[Claimant] obviously injured his back in May of 1990 which was the major trauma in his entire history in such a way that he cracked the annulus at L5-S1. He had some temporary treatments and he got better as the annulus had a chance to quiet down. As soon as he did something or aggravated his back then he had more pain. He did not ever recover from this injury.
>
> "Then as time went on the annulus crack has enlarged and allowing [sic] a protrusion of disc to occur and this has been central causing back pain and left sided causing the left leg pain. It is probably getting bigger and the patient is having more sciatica at the present time. * * *
>
> "The other incidents in his history, the sprained ankle, the lifting of a 2 pound stero [sic] speaker, and the bruise of his right femur when he fell off the plow share had nothing to do with his ruptured disc. There is no evidence that there is any other extracurricular nonwork activities that have anything to do with his injury." (Ex. 94).

Drs. Thompson and Nelson concurred with Dr. Melgard's opinion. (Exs. 96, 97).

Aetna argues that the most recent reports of Drs. Thompson, Nelson and Melgard establish that claimant's work activity beginning 1993 caused claimant's disc herniation. (Exs. 102A, 102B, 102D, 102E). We disagree.

We are not persuaded by the most recent "check-the-box" reports of Drs. Thompson, Nelson and Melgard because they were premised on an inaccurate history. In two of the reports, claimant's attorney asked Drs. Thompson and Nelson to make several assumptions about claimant's work at S-2 Contractors, Inc. The physicians were to assume that claimant's work at S-2 Contractors entailed repeated heavy lifting of pipe which weighed about 1000 pounds. (Exs. 102A; 102D). However, claimant testified that he did not actually pick up the pipe; rather, he had to roll it from side to side so he could put the machine on top of it. (Tr. 55).

The physicians were also asked to assume that claimant experienced increasing pain in his back and down into his buttocks throughout his time at S-2 Contractors. (Exs. 102A; 102D). At hearing, claimant testified that he did not have shooting pain down into his buttocks while he was working at S-2 Contractors. (Tr. 122). Claimant testified that he first time he experienced pain into his buttocks and legs was in November 1993. (Tr. 113, 122).

In addition, the physicians were asked to assume that claimant felt that his work at S-2 Contractors was the "heaviest work he ever did in his life." (Exs. 102A; 102D). At hearing, when claimant was asked if S-2 was the heaviest work he had done, claimant responded: "No. It's all basically the same. It's just I did something wrong when I was lifting there." (Tr. 125).

The physicians were asked to assume that claimant first noticed leg pain while he was working at Grimmett Enterprises, Inc. (another employer insured by SAIF) and they were to assume that claimant's work at Grimmett's was not nearly as heavy as the work with S-2 Contractors. (Exs. 102A; 102D). Claimant testified that his work at S-2 Contractors and Grimmett's was "basically pretty close to the same." (Tr. 84).

Since Drs. Thompson and Nelson were asked to make assumptions that were inaccurate, we do not rely on the "check-the-box" reports that concluded that claimant's work activity beginning 1993 was the major cause for the deterioration of claimant's back condition.[2] (Exs. 102A, 102D).

Aetna also relies on Dr. Melgard's December 12, 1994 report to establish that claimant's work activity beginning 1993 caused claimant's disc herniation. On December 9, 1994, Dr. Melgard signed a '"check-the-box" letter from claimant's attorney that concluded that claimant's 1993 work activities were a material contributing cause of the disc herniation. (Ex. 102C). On December 12, 1994, Dr. Melgard reported that he had reviewed information provided by claimant's attorney and he concluded that claimant's "activity in 1993" was a major contributing cause of his need for surgery. (Ex. 102E). Since the record does not disclose what information was provided to Dr. Melgard, and in light of the inaccuracies in the information provided to Drs. Nelson and Thompson, we are not persuaded by Dr. Melgard's subsequent change in opinion.

Aetna contends that Dr. Nelson's opinion is unpersuasive in light of his concurrence with the report from Drs. Zivin and Smith. We disagree.

Claimant was examined by Drs. Zivin and Smith on August 31, 1993, before claimant had been diagnosed with a herniated disc. (Ex. 36). Drs. Zivin and Smith reported that claimant had a lumbar strain on May 7, 1990 and had recurrent lumbar strains since that time. They noted that claimant's symptoms cleared after the May 7, 1990 and they commented that his back "flare-ups" had been at the same location as the May 7, 1990 injury. Drs. Zivin and Smith reported that "it appears that any acute need for 'treatment' would be related to stresses and strains superimposed by new adventures and exposures rather than the May 7, 1990 incident." (Id.) In regard to their impairment findings, Drs. Zivin and Smith raised the question of a neural diagnostic evaluation to clarify a discrepancy. They commented that, although claimant's x-rays were normal, the x-rays did not rule out the possibility of some type of occult lesion, probably in the lower spinal canal or neuromuscular apparatus. (Id.) Dr. Nelson concurred in their report. (Ex. 38).

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[2] On December 8, 1994, Dr. Thompson also signed a "check-the-box" letter from claimant's attorney that stated he had reviewed Dr. Nelson's chart notes and physical therapy reports and had concluded that claimant's work at S-2 Contractors was the major cause of the disc herniation. (Ex. 102B). Since Dr. Thompson signed that "check-the-box" report on the same date that he signed the "check-the-box" report from claimant's attorney that contained several inaccurate assumptions, we do not find either report persuasive.

Since the report from Drs. Zivin and Smith was prepared before claimant was diagnosed with a herniated disc, we are not persuaded by their speculation that "it appears that any acute need for treatment" would be related to new exposures rather than the May 7, 1990 incident. Furthermore, Drs. Zivin and Smith suggested the possibility that claimant had a back problem that had not been detected by the x-rays. We do not discount Dr. Nelson's opinion on the basis of his concurrence with the report from Drs. Zivin and Smith.

Aetna argues that Dr. Nelson's opinion is inconsistent because he reported that the heavy work claimant was performing in July 1993 caused claimant's low back problems. Aetna relies on exhibit 32, which is a July 12, 1993 chart note from Dr. Nelson. Dr. Nelson stated that claimant had increased low back pain and had been working in heavy construction work. Dr. Nelson reported that the activities "have been aggravating and are responsible for this exacerbation." (Ex. 32). Despite that comment, Dr. Nelson prepared a "palliative care request" on the same date that stated that "[p]alliative care is related to accepted injury of 5/7/90." (Ex. 33). In addition, Dr. Nelson diagnosed claimant with recurrent low back pain syndrome, which was the same diagnosis he made in March 1991. Under these circumstances, we are not persuaded by Aetna's assertion that Dr. Nelson believed that the work claimant was performing in July 1993 caused claimant's low back problems.

Although Drs. Brown and Bald did not believe that claimant's May 7, 1990 injury was the major contributing cause of the disc herniation, their report indicates that the original injury was part of the process and was one of the episodes that materially contributed to claimant's condition. Drs. Brown and Bald found that, based on claimant's history, claimant had episodes of low back pain ever since the original injury of May 7, 1990. (Ex. 58). They agreed with Dr. Thompson's interpretation and found that "the episode of November 1993 precipitated the actual herniation, but the process had been going on before that time with multiple episodes of back pain." (Id.)

The final medical opinion is from Dr. Reimer. Dr. Reimer reported that claimant's first radicular symptoms began in November 1993. (Ex. 103). Dr. Reimer commented that, although claimant's activities in November 1993 did not appear to be strenuous, they may have been sufficient to cause a herniated disc. Dr. Reimer concluded that claimant's employment with S2 Contractors was not the major contributing cause of his current need for medical treatment and disability. (Id.) However, Dr. Reimer did not address whether or not claimant's May 7, 1990 injury was causally related to his herniated disc condition.

We conclude that the preponderance of medical evidence establishes that claimant's herniated disc condition arose directly from the May 7, 1990 industrial accident he sustained while working for Aetna's insured. See Albany General Hospital v. Gasperino, supra; Mark A. Newkirk, supra. Since claimant's herniated disc condition arose from the May 7, 1990 injury, Aetna 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."[3] ORS 656.308(1); see SAIF v. Drews, 318 Or 1 (1993); Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314 (1993).

Aetna contends that even if ORS 656.308(1) applies, responsibility for claimant's low back condition shifts forward to subsequent employers because the most persuasive medical opinions show that the major contributing cause of claimant's condition was the work exposure beginning in 1993. Aetna relies on the same medical reports that we have already discussed. We conclude that Aetna has failed to prove that claimant's subsequent work activities were the major contributing cause of claimant's current condition. As such, responsibility remains with Aetna.[4]

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[3] After the ALJ's order, the legislature enacted Senate Bill 369, which amended ORS 656.308(1). Or Laws 1995, ch 332, §37(1) (SB 369, §37(1)). Those amendments do not alter the analysis in this case.

[4] Alternatively, even if ORS 656.308(1) does not apply to this case, we would find Aetna responsible for claimant's herniated disc condition. When ORS 656.308(1) is not applicable, the last injurious exposure rule may be applied to assign responsibility. SAIF v. Yokum, supra. However, when actual causation is proven with respect to a specific employer, it is not necessary to rely on the last injurious exposure rule to assign responsibility. See Runft v. SAIF, 303 Or 493, 501-02 (1987); Rick C. Wertman, 47 Van Natta 340 (1995). Here, since the medical evidence establishes that claimant's May 7, 1990 industrial injury is the major contributing cause of claimant's herniated disc condition, we would find that Aetna is responsible for claimant's condition.

Unreasonable Denial

Claimant argues that the ALJ erred by declining to award a penalty for Aetna's allegedly unreasonable compensability denial. Claimant asserts that Aetna's unreasonable denial prevented him from receiving benefits under ORS 656.307.

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." Amended ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and " legitimate doubt" are to be considered in the light of all the evidence available. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

On February 25, 1994, Aetna issued a denial of compensability and responsibility, stating that claimant's activities since he left employment with Aetna's insured, including non-work-related activities, constituted the major contributing cause of his herniated disc condition. (Ex. 62).

On November 16, 1993, claimant sought treatment for an intense low back pain after he had reached for a stereo speaker at his parents' house. At the time Aetna issued its denial, it had a report from Drs. Brown and Bald, who opined that it was "reasonably medically probable that moving this small object did cause the herniation." (Ex. 58). Drs. Brown and Bald found that "the episode of November 1993 precipitated the actual herniation, but the process had been going on before that time with multiple episodes of back pain." (Id.) In addition, Aetna asserts that discrepancies in the medical history regarding the off-work incident presented a question of claimant's credibility that was still at issue at the hearing.

Under these circumstances, we conclude that Aetna had a legitimate doubt regarding its liability for the claim. Consequently, we do not consider Aetna's denial to have been unreasonable. Accordingly, we decline to award a penalty under ORS 656.262(11)(a).

Attorney Fee - ORS 656.386(1)

At hearing, claimant sought an attorney fee of $38,250. The ALJ awarded claimant $10,000. On review, Aetna argues that the award of attorney fees was excessive. Claimant cross-requests review, contending that a fee of $30,000 to $35,000 is appropriate. Aetna also asserts that, under ORS 656.308(2)(d), the maximum amount claimant can be awarded for participation in the responsibility dispute is $1,000.

Under amended ORS 656.386(1), a claimant is entitled to an attorney fee in cases involving denied claims where a claimant prevails finally in a hearing. Or Laws 1995, ch 332, § 43(1) (SB 369, § 43(1)). Under ORS 656.308(2)(d), a claimant may also be entitled to an attorney fee for prevailing against a responsibility denial. ORS 656.308(2)(d) provides:

> "Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances." Or Laws 1995, ch 332, § 37(2)(d) (SB 369, § 37(2)(d)).

Since ORS 656.308(2)(d) provides that a claimant is entitled to an attorney fee "[n]otwithstanding ORS 656.382(2), 656.386 and 656.388," we conclude that an attorney fee awarded pursuant to ORS 656.308(2)(d) is separate from, and in addition to, an attorney fee awarded for finally prevailing over a compensability denial under ORS 656.386(1) or pursuant to ORS 656.382(2), when a carrier unsuccessfully appeals an ALJ's order which had addressed the compensability of the claim.

Here, at the hearings level, claimant prevailed against Aetna's denial of compensability of his herniated disc condition. Thus, he is entitled to a carrier-paid attorney fee award under ORS 656.386(1).

Claimant's counsel requests a fee of $30,000 to $35,000, arguing that the case was complex and required over two dozen conferences with physicians. Claimant's counsel asserts that the case was complicated by the number of claims and voluminous documents. On the other hand, Aetna asserts that the issue of legal causation was relatively uncomplicated and it contends that the ALJ's $10,000 attorney fee award was unreasonably high.

The record consists of 110 exhibits, 9 of which were generated by claimant's counsel. The hearing transcript consists of 136 pages. Four witnesses testified at the hearing. Although strenuously litigated, the compensability issue is of a medical, legal and factual complexity normally addressed in workers' compensation proceedings. Claimant's counsel skillfully advocated claimant's position in successfully establishing the compensability of the claim. After considering the parties' respective arguments in light of the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the compensability denial is $5,500. Consequently, we modify the ALJ's attorney fee award. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the hearing record and counsel's statement of services), the complexity of the issue, the value of the interests involved, the skill of the attorneys, the nature of the proceedings, and the risk that counsel may go uncompensated.

Attorney Fee - ORS 656.308(2)(d)

In addition, claimant is entitled to a carrier-paid attorney fee award under ORS 656.308(2)(d) because his attorney "actively and meaningfully participated" in the responsibility dispute at hearing and on Board review. Claimant filed a hearing request contesting Aetna's responsibility denial and has successfully prevailed over that denial. Claimant's attorney contended that, although there was abundant evidence that claimant's low back problems were related to the May 7, 1990 injury, claimant believed that S-2 Contractors (SAIF's insured) was responsible for his condition. Although claimant's argument was not successful, his attorney's participation was "active and meaningful"[5] and, by virtue of his successful hearing request, claimant has finally prevailed against Aetna's responsibility denial.

Under ORS 656.308(2)(d), an attorney fee shall not exceed $1,000 absent a showing of extraordinary circumstances. In determining a reasonable attorney fee for claimant's participation in this responsibility dispute, we have considered that claimant's arguments as to the responsible carrier were unsuccessful. See International Paper Co. v. Riggs, 114 Or App 203, 207 (1992) (claimant's pursuit of unsuccessful arguments may be taken into account in determining what fee is reasonable). We acknowledge that claimant's counsel expended a significant amount of effort in securing medical opinions which supported his assertion that claimant's condition constituted a "new injury" for which a later carrier was responsible. Notwithstanding such efforts, we have determined that responsibility for claimant's condition rests with an earlier carrier.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing is $500 and on Board review is $500, for a total award of $1,000, to be paid by Aetna. In reaching this conclusion, we have particularly considered the time devoted to the responsibility issue (as represented by the hearing record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Since claimant's attorney's arguments regarding the responsibility issue were unsuccessful, we find that claimant has not demonstrated extraordinary circumstances to justify an attorney fee of more than $1,000. Furthermore, inasmuch as the total attorney fee awarded regarding the responsibility issue does not exceed $1,000, we need not address Aetna's argument that the legislature intended the award of the fee under ORS 656.308(2)(d) to be cumulative at all levels of litigation.

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[5] In Darrell W. Vinson, 47 Van Natta 356 (1995), we analyzed the phrase "actively and meaningfully participates" in ORS 656.307(5) and concluded that it was the "significance" or "purpose" of counsel's participation that determined the "meaningfulness" of the participation, not the ultimate result of the arbitration proceeding. We noted that the fact that a counsel's position may not ultimately prevail does not render his or her participation meaningless, although that fact may be considered in determining the amount of the fee award. Here, since claimant's wages for his employers varied, it follows that there was a difference of TTD rates under most, if not all, of his claims with the carriers. Since claimant's attorney took a position advocating that a particular carrier was responsible for his claim, we conclude that his attorney's participation was active and meaningful.

Attorney Fee - ORS 656.382(2)

Aetna asserts that it waived any challenge to the issue of compensability in its request for review. Therefore, Aetna contends that any attorney fee is limited under ORS 656.308(2)(d) to $1,000, absent a showing of extraordinary circumstances. We disagree.

On review, claimant's attorney requested that we issue an order designating a paying agent under ORS 656.307, asserting that Aetna had conceded compensability. Through staff counsel, claimant's attorney was advised that, although the Board was not authorized to issue "307" orders, the parties had the option of submitting a proposed stipulation for Board consideration that acknowledged that compensability was uncontested. Since the parties did not submit any such stipulation, the compensability of claimant's condition remained at risk on review by virtue of the Board's de novo review authority of the ALJ's order, which decided both compensability and responsibility. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252-53 (1992), mod 119 Or App 447 (1993). Aetna's appeal to the Board placed claimant's award at risk. Since this proceeding was not limited to solely a responsibility denial, ORS 656.308(2)(d) is not applicable to the potential compensability issue. Consequently, claimant's counsel is entitled to an assessed attorney fee under ORS 656.382(2) for services on Board review regarding the potential compensability issue, payable by Aetna.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $500, payable by Aetna. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that claimant is not entitled to an attorney fee for services on review concerning his unsuccessful cross-requests regarding the penalty and attorney fee issues.

ORDER

The ALJ's order dated April 13, 1995 is affirmed in part and modified in part. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded $5,500 under ORS 656.386(1), to be paid by Aetna. The remainder of the ALJ's order is affirmed. Claimant's attorney is awarded $1,000 under ORS 656.308(2)(d), to be paid by Aetna.

Board Members Haynes and Neidig concurring in part and dissenting in part.

We agree with the majority's decision except for the portion of the order that awards an attorney fee under ORS 656.308(2)(d). For the following reasons, we dissent from that portion of the majority's decision.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628, 632 (1984). In this case, the majority blatantly disregards the statutory language of ORS 656.308(2)(d) in awarding an attorney fee regarding the responsibility dispute.

ORS 656.308(2)(d) provides that claimant is entitled to an attorney fee for "the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial." Or Laws 1995, ch 332, § 37(2)(d) (SB 369, § 37(2)(d)); (emphasis added). In construing a statute, our task is to discern the intent of the legislature. The first level of analysis is to examine both the text and the context of the statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). In so doing, words of common usage are given their plain, natural, and ordinary meaning. Id. at 611.

ORS 656.308(2)(d) does not define the term "prevailing." We therefore look to its common usage. The dictionary defines "prevailing" to mean, as pertinent, "having superior force or influence: efficacious." Webster's Third New International Dictionary 1797 (unabridged 1966). "Efficacious," in turn, means "characterized by qualities giving power to bring about an intended result." Id. at 725. Under those definitions, a claimant "prevail[s] against a responsibility denial" when the claimant's argument has "superior influence" and brings about an intended result. In other words, the claimant must succeed in persuading the administrative law judge or the Board or the court as to the claimant's position on responsibility.

The context of ORS 656.308(2)(d) confirms that meaning.[1] It is clear from the statutory language that there are two prerequisites for an attorney fee under ORS 656.308(2)(d): (1) claimant must prevail against a responsibility denial; and (2) claimant's attorney must appear and provide "active and meaningful participation" in prevailing against the responsibility denial.

In this case, claimant contended in his closing argument at hearing and on review that S-2 Contractors (SAIF's insured) was responsible for his condition. Both the ALJ and the Board rejected claimant's argument and determined that Aetna is responsible for claimant's condition. Consequently, claimant did not prevail against S-2 Contractors' responsibility denial.

Nevertheless, the majority awards a fee under ORS 656.308(2)(d), stating that claimant filed a hearing request contesting Aetna's responsibility denial and had successfully prevailed against Aetna's responsibility denial. Furthermore, the majority found that claimant's attorney's participation was "active and meaningful."

Although Aetna's responsibility denial was set aside, claimant's attorney's participation in "finally prevailing" against that denial was not "active and meaningful." Claimant's attorney's efforts were directed toward establishing that another carrier, not Aetna, was responsible for his condition. Although claimant's attorney noted on review that there was "abundant evidence that the claimant's low back problems, including his herniated disc, is related to his original injury of May 7, 1990," (claimant's brief at 10), that hardly constitutes "meaningful" participation in prevailing against Aetna's responsibility denial. Claimant contended at hearing and on review that the greater weight of the evidence established that his low back condition was related to his work with S-2 Contractors.[2] Claimant's attorney's efforts were not "active and meaningful" in setting aside Aetna's responsibility denial. Therefore, claimant's attorney is not entitled to an attorney fee under ORS 656.308(2)(d).

The majority's reliance on Darrell W. Vinson, 47 Van Natta 356 (1995) is misplaced. In Vinson, the Board analyzed the phrase "actively and meaningfully participates" in ORS 656.307(5),[3] which provides, in part:

> "If the claimant appears at any such [arbitration] proceeding and actively and meaningfully participates through an attorney, the arbitrator may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the arbitrator to be the party responsible for paying the claim."

The majority of the Board concluded that it was the "significance" or "purpose" of counsel's participation that determined the "meaningfulness" of the participation, not the ultimate result of the arbitration proceeding. (Members Neidig and Haynes, dissenting). The Board majority noted that the fact that a counsel's position may not ultimately prevail does not render his or her participation meaningless, although that fact may be considered in determining the amount of the fee award.

Here, unlike ORS 656.307(5), ORS 656.308(2)(d) requires "the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial." (Emphasis added). Thus, unlike the Vinson case, a claimant's position on responsibility must ultimately prevail before the claimant is entitled to an attorney fee under ORS 656.308(2)(d).

The text of ORS 656.308(2)(d) expressly requires a claimant to prevail against a responsibility denial before the claimant is entitled to an attorney fee. In contrast, under ORS 656.307(5), the legislature chose not to require the claimant to "prevail." That choice is up to the legislature. In interpreting a statute, our task is "not to insert what has been omitted, or to omit what has been inserted." ORS 174.010.

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[1] Because the text and context of ORS 656.308(2)(d) are determinative of legislative intent, we need not consider legislative history or other aids of statutory construction. PGE v. Bureau of Labor and Industries, supra, 317 Or at 611.

[2] We note that claimant's written closing argument on responsibility is substantially the same as his responsibility argument on review.

[3] We note that the 1995 amendments to ORS 656.307(5) changed "arbitrator" to "Administrative Law Judge." Or Laws 1995, ch 332, § 36 (SB 369, § 36).

In this case, an award of attorney fees is contrary to the statutory language of ORS 656.308(2)(d). Claimant's position on the responsibility dispute was not successful and claimant is not entitled to a fee for the "appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial."

In deciding the amount of the attorney fee, the majority considered the fact that claimant's arguments as to the responsible carrier were unsuccessful, citing International Paper Co. v. Riggs, 114 Or App 203 (1992). One of the issues in Riggs was whether the claimant was entitled to an attorney fee under ORS 656.382(2). The employer argued that the claimant should not receive a fee because the claimant had argued that another carrier should be held responsible and that argument was not successful. The court rejected the employer's argument, holding that nothing in ORS 656.382(2) suggested that a claimant's right to fees depended on the Board's adoption of the claimant's arguments. Id. at 207. The court noted that the Board may take into account the claimant's pursuit of unsuccessful arguments in determining what fee is reasonable.

Here, unlike ORS 656.382(2), ORS 656.308(2)(d) states expressly that a claimant's entitlement to attorney fees for a responsibility dispute depends on prevailing against a responsibility denial, i.e., claimant's arguments concerning responsibility must be successful. Thus, Riggs is inapposite. Under ORS 656.308(2)(d), claimant's unsuccessful responsibility argument does not merely affect the amount of the attorney fee. Rather, the fact that claimant's responsibility argument was unsuccessful is dispositive. It means that claimant is not entitled to an attorney fee regarding responsibility.

Based on the foregoing reasons, we respectfully dissent from the portion of the order that awards an attorney fee under ORS 656.308(2)(d).

Board Members Gunn and Hall concurring in part and dissenting in part.

We agree with the majority's decision except for its reduction of the ALJ's attorney fee award under ORS 656.386(1). Therefore, we respectfully dissent from that portion of the majority's decision.

At hearing, claimant's counsel sought an extraordinary fee of $38,250. The ALJ considered claimant's counsel's arguments and awarded a fee of $10,000. After reviewing the record, we would defer to the ALJ's attorney fee award and would not reduce it. It has been the Board's general practice to affirm the ALJ's attorney fee awards, unless the factors in OAR 438-15-010(4) were not considered, or unless there is some showing of abuse of discretion by the ALJ. See Lois J. Schoch, 46 Van Natta 1816 (1994) (Board Member Gunn, dissenting).

Here, we agree with claimant's counsel that this is a complicated case that involved numerous medical opinions and required claimant's counsel to file several claims against different carriers. As the majority points out, claimant's counsel has expended significant efforts in preparing this case. We believe that the ALJ, having dealt with the parties, is in the best position to judge the quality and efficacy of claimant's counsel's involvement in the case. We do not advocate second-guessing an ALJ's attorney-fee award absent compelling reasons to do so. See Philip Estes, 47 Van Natta 624 (1995) (Board Member Gunn, dissenting); Patricia L. Row, 46 Van Natta 1794 (1994) (Board Member Hall dissenting). We would defer to the ALJ's determination of an appropriate attorney fee. For these reasons, we must respectfully dissent.

In the Matter of the Compensation of
CHERI A. WILSON, Claimant
WCB Case No. C5-02879
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Lundeen, et al, Defense Attorneys

Reviewed by Board Member Neidig and Gunn.

On October 18, 1995, the Board acknowledged receipt of 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, pro se, releases her rights to all future workers' compensation benefits, except medical services, for the compensable injury.

Prior to our acknowledgment of the CDA, we received a copy of a letter drafted by claimant's former attorney. The letter alleged that the former attorney's office had represented claimant and negotiated with the insurer's claims examiner concerning a CDA. Specifically, claimant's former attorney contended that his office had offered to enter into a CDA for payment to claimant of $25,000 and that the insurer had counter-offered in the amount of $15,000. The letter further stated that claimant then terminated her representation with his office and entered into a CDA on her own behalf. Claimant's former attorney claimed an attorney fee lien of $3,375, based on CDA proceeds of $15,000 (25 percent of the first $12,500 and 10 percent of any amount in excess of $12,500).

Thereafter, we received and acknowledged a CDA signed by claimant, the insurer's counsel, and the insurer's claims examiner. The disposition provided for proceeds of $20,000 to claimant.

After acknowledging the CDA, we wrote to the insurer's attorney, claimant's former attorney and claimant requesting each person's position concerning the attorney fee lien claim. Claimant's response provided a chronology of events leading to her entering into the CDA, including an acknowledgment that her former attorney's office conveyed an offer of $15,000 before she terminated representation. Claimant opposes her former attorney's attempts to collect an attorney fee. According to claimant's former attorney, his services concerning the CDA negotiations resulted in an offer of $15,000 from the insurer. Claimant's former attorney also provided copies of claimant's executed attorney retention agreement and his correspondence to the insurer's claims adjuster.

Our authority with regard to CDAs is limited to approving the disposition unless the proposed agreement is unreasonable as a matter of law, a result of an intentional misrepresentation of material fact, or a party requests the Board to disapprove the disposition. ORS 656.236(1)(a). In approving the CDA, we may also approve an attorney fee. OAR 438-015-0052.

In view of our narrow authority, we consider it inappropriate for us to determine claimant's former attorney's entitlement to an attorney fee lien. Claimant and her former attorney dispute that the latter's services resulted in the $15,000 counteroffer. Thus, resolving the attorney fee dispute necessarily would require making factual findings, including a determination of the extent of former counsel's representation and whether such representation resulted in the insurer's $15,000 counteroffer. Furthermore, because no record was created, we would have to rely on the parties' unsubstantiated allegations provided in their correspondence to the Board.

Consequently, for these reasons, we decline to approve former counsel's attorney fee lien. Other avenues are open to claimant's former attorney to pursue his lien.[1] Such proceedings can more adequately address the attorney fee dispute by developing a record.

The parties' CDA is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1). There is no statutory basis for disapproving the agreement. Id. Accordingly, the parties' claim disposition agreement is approved.

IT IS SO ORDERED.

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[1] For instance, the fee dispute can be arbitrated through the Oregon State Bar. See Rules of the Oregon State Bar on Arbitration of Fee Disputes.

In the Matter of the Compensation of
WILLIAM R. ENGLESTADTER, Claimant
WCB Case No. 94-14109
ORDER ON RECONSIDERATION
Brothers, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The insurer requested reconsideration of our September 8, 1995 Order on Review which concluded that claimant had established that his unscheduled permanent disability for a skin disorder should be increased from 3 percent to 54 percent, and his scheduled permanent disability for a skin disorder of the left forearm should be increased from 3 percent to 38 percent. The insurer argues that, pursuant to ORS 656.268(2), claimant must be medically stationary and the claim closed before permanent impairment may be rated. The insurer further argues that, because we relied on medical reports that issued before claimant was medically stationary, the impairment findings in those reports are not persuasive.

In order to allow us sufficient time to consider the insurer's motion, we abated our prior order on October 4, 1995. Claimant has filed a response to the insurer's motion. We now proceed with our reconsideration.

In concluding that claimant is entitled to a Class 3 impairment due to his skin disorder under OAR 436-35-440(2), the ALJ relied primarily on the opinion of claimant's attending dermatologist, Dr. Zircher. In his deposition, Dr. Zircher explained that claimant's skin damage due to sun exposure was progressive and that, without protection from sun exposure, the number and severity of skin lesions will increase. (Ex. 8A, pp. 21-23). He added that, as a result of long-term sun exposure, claimant's skin is fragile and would restrict him from performing any type of work requiring physical contact with his skin. (Ex. 8A, pp. 12-13, 24-25).

Based on the totality of Dr. Zircher's well-reasoned opinion, we are persuaded that claimant's restrictions from sun exposure and work requiring contact with his skin are permanent. Although Dr. Zircher's deposition was taken on September 17, 1993, approximately three and one half months before the January 4, 1994 medically stationary date, (see Ex. 12), that fact alone does not controvert his opinion that the restrictions are permanent. There is no persuasive evidence that claimant's condition changed during those three and one half months.

In this case, we have found that, at the time of Dr. Zircher's deposition, claimant would not improve to the extent that he would no longer need sun protection or that he could work at a job requiring physical contact with his skin. Consequently, since we have found Dr. Zircher's opinion to be persuasive, we have relied on it in evaluating claimant's permanent impairment.

Finally, we find that the insurer's reliance on Joslin A. McIntosh, 46 Van Natta 2445 (1994), is misplaced. There, the claimant suffered a leg injury and underwent surgery to insert pins into the femur. The claimant was still recovering from the effects of the injury and surgery, and had not become medically stationary, when her disability was evaluated by an examining physician. Unlike this case, there was no evidence in McIntosh that the limitations reported by the physician were permanent. Absent such evidence, the physician's report was not persuasive evidence of permanent disability. Because McIntosh is distinguishable on its facts, we do not find that case controlling here.

Claimant's attorney is entitled to an attorney fee for services on reconsideration. After considering the factors recited in OAR 438-15-010(4), we find that a reasonable attorney fee for such services is $500.00, to be paid by the insurer. In particular, we have considered the time devoted to the issue (as represented by claimant's responses), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 8, 1995 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
RICHARD W. BRANCHCOMB, Claimant
WCB Case No. 95-02997
ORDER ON REVIEW
Parker, Bush & Lane Attys, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel condition. On review, the issue is responsibility.

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

We briefly recap the facts. Claimant worked for Cavi-Tech, Inc. from January 1, 1994 to July 1994, doing hydroblasting to clean rust from the inside of ships. Cavi-Tech, Inc. is covered by the Longshore & Harbor Workers' Compensation Act (LHWCA). After approximately three months, claimant developed pain and numbness in his hands.

In July 1994, claimant began working part-time for R.A.M. Enterprise, Inc. (RAM), SAIF's insured. Claimant's job duties included grinding work, using a belt sander, spreading adhesive and cutting stock. Claimant began working full-time on August 23, 1994.

In September 1994, claimant sought treatment from Dr. Smith, who referred him to Dr. Gambee. On September 22, 1994, Dr. Gambee examined claimant, noting that claimant complained of numbness in the hands. (Exs. 1, 1A). Dr. Gambee diagnosed moderate bilateral carpal tunnel syndrome (CTS).

Claimant filed claims with RAM and with Cavi-Tech, Inc. under the LHWCA. Both claims were denied.[1] The ALJ found that claimant first sought medical treatment for the CTS in mid-September, when he was working for SAIF's insured. The ALJ concluded that claimant's work at SAIF's insured was injurious and assigned responsibility to SAIF's insured.

SAIF concedes that claimant's bilateral CTS is work-related.[2] SAIF contends, however, that the ALJ erred in applying the last injurious exposure rule of causation to impose liability on RAM. SAIF urges that the ALJ's reliance on Silveira v. Larch Enterprises, supra, is misplaced. According to SAIF, the holding in Silveira applies to compensability, but not responsibility.

In Kevin P. Silveira, 47 Van Natta 2354 (1995), the claimant started working for a California employer in April 1983. In October 1990, the employer moved its operations to Oregon and became an Oregon employer. The claimant worked for the employer until February 1991. The claimant sought treatment for low back pain in February 1991 and was diagnosed with degenerative disc disease. On remand from the Court of Appeals, we concluded that the claimant's work activities, including his out-of-state employment, were the major contributing cause of the degenerative disc disease. See Silveira v. Larch Enterprises, supra, 133 Or App at 302-03 (for purposes of establishing that an occupational disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws).

In assigning responsibility, we noted that the Silveira court said that "[t]he consideration of claimant's out-of-state employment for the purpose of determining whether his condition is work related does not necessarily bear on which employer might ultimately be responsible for the claim." 133 Or App at 302. We interpreted that language to mean that the court intended to keep the compensability analysis separate from the responsibility analysis.

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[1] We note that the Oregon Workers' Compensation law provides that if a current state claim is covered by federal workers' compensation law, claimant is a nonsubject worker for purposes of Oregon law. ORS 656.027(4); Mann v. SAIF, 91 Or App 715 (1988).

[2] SAIF contends that claimant must prove that his work activity with RAM was the major contributing cause of a pathological worsening of his preexisting CTS. In light of SAIF's concession of compensability, we need not address this argument.

Although in the usual situation, a carrier can use the last injurious exposure rule defensively to shift responsibility to another carrier, the court in Progress Quarries v. Vaandering, 80 Or App 160 (1986), held that out-of-state employment could not be considered for purposes of determining responsibility. In Silveira, we applied Vaandering and found that we could not consider the claimant's California employment for purposes of determining responsibility. Rather, we analyzed whether the Oregon employment was injurious and provided "potentially causal" conditions. See Silveira v. Larch Enterprises, supra, 133 Or App at 302. Based on the claimant's testimony and the medical reports, we concluded that the claimant's Oregon employment was injurious and provided "potentially causal" conditions for his degenerative disc disease condition. Therefore, we concluded that the Oregon employer was responsible for the claimant's condition.

In the present case, we apply the same analysis as in Kevin P. Silveira, supra, to determine responsibility. In Progress Quarries v. Vaandering, supra, the court said that the basic overall fairness of the last injurious exposure rule "can be achieved only if application of the rule remains under control of the Oregon workers' compensation system." 80 Or App at 166. Although in Vaandering the alternative employment was out-of-state employment, the same principle applies when the alternative employment is not part of the Oregon workers' compensation system. Here, the alternative employment is covered under the LHWCA.

If a worker establishes that disability was caused by disease resulting from causal conditions at two or more places of employment, the last employment providing potentially causal conditions is deemed to have caused the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984). Here, we cannot consider claimant's employment with Cavi-Tech, Inc. for purposes of determining responsibility because it was not covered under the Oregon workers' compensation system. See Progress Quarries v. Vaandering, supra. Therefore, we must determine whether claimant's employment with RAM was injurious and provided "potentially causal" conditions for his bilateral carpal tunnel condition. See Silveira v. Larch Enterprises, supra, 133 Or App at 302 ("for the Oregon employer to be held responsible, the Oregon employment must be injurious and a potential cause of the disease"); Charlene A. Dieringer, 48 Van Natta 20 (1996).

SAIF argues that the medical evidence establishes that claimant's work exposure with its insured was not a "potential cause" of his carpal tunnel condition. We disagree.

The ALJ found that, while claimant was working at RAM, his hand symptoms progressed. Claimant testified that, after working at RAM, his hands started going to sleep again and "it got a little worse." (Tr. 23). Claimant would wake up with his hands numb, (Tr. 25), and on at least one occasion, his left hand never did wake up. (Tr. 26). Claimant testified that "nothing really fell asleep while I worked at Cavi Tech" and he never noticed his hands falling asleep until he worked at RAM. (Tr. 59). Claimant's production manager at RAM testified that claimant told him that his hands were numb and tingly. (Tr. 80). After claimant burned his finger and did not feel it, the manager urged claimant to have his hands checked. (Tr. 81).

Drs. Coate and Gambee concurred with the statement that claimant suffered further injurious exposure to the carpal tunnel while working at RAM. (Exs. 7A, 8A). In a later report, Dr. Coate agreed that claimant's work activities at RAM were not the major contributing cause of claimant's bilateral CTS. (Ex. 18A). However, Dr. Coate did not agree that claimant's work activities at RAM could not have contributed to the CTS condition. Rather, Dr. Coate commented that "[t]hey may have contributed but only a small part < [less than] 50%." (Id.)

Dr. Button did not view claimant's work activities at RAM "to have played any significant factor in the pre-existing carpal tunnel syndromes in respect to progression thereof." (Ex. 14). Dr. Button did not believe those work activities were a major contributing factor to either the progression of symptoms or pathologic worsening of the carpal tunnel syndrome. (Id.) Dr. Button did not view claimant's work activities as either a major or material contributing cause of the CTS.

We are not persuaded by Dr. Button's opinion because he had an inaccurate understanding of claimant's job activities at RAM. Dr. Button's opinion was based, in part, on a videotape of claimant's job activities. However, claimant testified that approximately 45 percent of his job consisted of grinding duties and he said the grinding job was left out of the videotape. (Tr. 34, 36). Claimant's supervisor agreed. (Tr. 75-77). Claimant testified that his hands fell asleep only while grinding. (Tr. 24).

In any event, based on the Silveira case, claimant does not have to prove that his work activities with RAM were the major contributing cause of the carpal tunnel syndrome or even a material contributing cause. Rather, as we discussed earlier, claimant must establish that his employment with RAM was injurious and provided "potentially causal" conditions for his bilateral carpal tunnel condition. See Silveira v. Larch Enterprises, supra, 133 Or App at 302.

Although SAIF argues that claimant's employment with Cavi Tech was the actual cause of his CTS, even if SAIF is correct, that factor is not dispositive. In Beneficiaries of Strametz v. Spectrum Motorwerks, 135 Or App 67, 71, mod 138 Or App 9 (1995), the court said that it was immaterial that the employers in that case were not the actual cause of the claimant's disease. Rather, "[a]ll claimant must show to establish a compensable claim is that condiitons at the Oregon employer were of the type that could have caused the disease." (Id.)

We conclude that the medical opinions establish that claimant's work activities with RAM, SAIF's insured were injurious and provided "potentially causal" conditions for his bilateral carpal tunnel condition. Therefore, SAIF is responsible for claimant's condition. See Kevin P. Silveira, supra; Charlene A. Dieringer, supra.

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 438-15-010(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 (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 26, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the SAIF Corporation.

Board Member Haynes specially concurring.

Under the doctrine of stare decisis, I am obligated to follow the majority's holding in Kevin P. Silveira, 47 Van Natta 2354 (1995). Nevertheless, I direct the parties' attention to the dissenting opinion in Silveira.

In the Matter of the Compensation of
LUIS A. CORDOBA, Claimant
WCB Case No. 94-12321
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of claimant's back injury claim. On review, the issue is subjectivity. We reverse.

FINDINGS OF FACT

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

The employer maintained a permanent office in Oregon for bookkeeping and vehicle maintenance purposes. (See Ex. A-8 through -12; Tr. 36-37). Most of the employer's vehicles are registered in Oregon. (Tr. 50).

From 1993 through 1995, the employer performed tree-planting contracts in Oregon. (See Ex. A; Tr. 45). The employer maintained Oregon workers' compensation insurance coverage during that time. (Ex. A).

CONCLUSIONS OF LAW AND OPINION

Applying the "permanent employment relation test," the ALJ concluded that claimant was a California worker temporarily working in Oregon when he was injured at work in January 1994. Claimant asserts that he was a subject Oregon worker when he was injured. We agree.

Under the "permanent employment relation test," the key inquiry is the extent to which a claimant's work in the state-of-injury is temporary. In applying the test, no one factor controls. Rather, all of the circumstances are relevant, including the intent of the employer, the understanding of the employee, the location of the employer and its facilities, the circumstances surrounding the claimant's work assignment, the state laws and regulations that the employer otherwise is subject to and the residence of the employees. Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or 186, 189-90 (1992).

The factors in this case are mixed. The employer's intent, and claimant's understanding, reveal that both parties anticipated that claimant would plant trees in a number of western states after his initial assignment in Oregon. Those factors weigh in favor of finding that claimant was temporarily in Oregon when he was injured.

The remaining factors weigh against such a finding: Claimant and other employees were Oregon residents at the time of claimant's injury. Further, although the employer's "base" office was in California, it registered most of its vehicles in Oregon and maintained a permanent Oregon office. That the employer's Oregon office was established primarily for bookkeeping and vehicle maintenance purposes does not alter its permanent character.

Next, the employer's maintenance of Oregon workers' compensation insurance coverage both before and after claimant's injury manifests that it was subject to Oregon law generally, and to the Oregon Workers' Compensation Act particularly. Last, and most important, the employer has performed tree planting contracts in Oregon during the past several years. On the basis of that evidence, we find that, at the time of claimant's injury, the employer maintained a permanent presence in Oregon. In turn, based on that finding, we conclude that claimant was not a California worker who was temporarily in Oregon when he was injured; rather, for the reasons stated above, we conclude that he was a subject Oregon worker at the time of his injury.

In reaching these conclusions, we recognize that, had claimant not been injured, he likely would have worked outside Oregon eventually. Given, however, the employer's performance of tree planting contracts in Oregon for years, both before and after claimant's injury, claimant had a reasonable expectation of returning to work for the employer in Oregon. Hobson v. Oregon Dressing, Inc., 87 Or App 397 (1987). That factor supports our analysis.

In sum, claimant was an subject Oregon worker at the time of his January 1994 injury. Consequently, we reverse the ALJ's decision setting aside SAIF's denial.[1]

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,192, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs and his attorney's statements of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated February 10, 1995 is reversed. The SAIF Corporation's denial is set aside and the claim is remanded to SAIF for processing according to law. Claimant's attorney is awarded $3,192 for services at hearing and on Board review, to be paid by SAIF.

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[1] The parties dispute whether, under ORS 656.126 and James Crawley, 47 Van Natta 364 (1995), the employer had a temporary or permanent Oregon workplace when claimant was injured. Because we have concluded, under the "permanent employment relation test," that the employer maintained a permanent presence in Oregon when claimant was injured, we need not address that dispute.

In the Matter of the Compensation of
CHARLENE A. DIERINGER, Claimant
WCB Case No. 94-13529
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order that upheld the insurer's denial of claimant's occupational disease claim for a bilateral upper extremity condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. Claimant, a CPA, worked for Vanport Express (Vanport) in Vancouver, Washington from February 1990 until August 1993. Claimant's job duties included data entry and preparation of sales and financial reports. In January 1993, claimant began experiencing aching and cramping in the palms of her hands, pain in her wrists and weakness in her arms.

On August 4, 1993, claimant sought treatment from Dr. Irvine, who referred claimant to Dr. Brown for electrodiagnostic studies. On August 18, 1993, Dr. Brown diagnosed bilateral ulnar entrapment neuropathy across the cubital tunnels.

On August 20, 1993, claimant was laid off by Vanport. She was unemployed for approximately one month. Her symptoms greatly improved to the point that she had only minor discomfort in her hands and wrists.

On September 21, 1993, claimant began working at The New Portland Meadows (Portland Meadows) as a controller. Her job duties were similar, although she worked more hours and spent more time on the computer. Within weeks, claimant's symptoms began to return. On May 31, 1994, Dr. Irvine recommended claimant undergo surgery for her condition.

Claimant filed a claim with Portland Meadows on July 7, 1994 and she also filed a claim with Vanport. Both claims were denied. Claimant's claim with Vanport has also been appealed.

The ALJ found that claimant's bilateral ulnar entrapment neuropathy compressive disorder was caused by her employment at Vanport and preexisted her employment at Portland Meadows. The ALJ applied amended ORS 656.802(2)(b) and ORS 656.005(7)(a)(B), reasoning that claimant had to prove that employment conditions at Portland Meadows were the major contributing cause of the combined condition and pathological worsening of her bilateral ulnar entrapment neuropathy. The ALJ concluded that, since claimant's condition was not worsened by her employment at Portland Meadows, her claim was not compensable.

Compensability

Claimant argues that she relied on the last injurious exposure rule and the ALJ erred by applying a "worsening" standard. The insurer contends that, since the "triggering event" for assignment of responsibility occurred during the Washington employment, claimant must prove actual causation by the Oregon employment with Portland Meadows.

In Silveira v. Larch Enterprises, 133 Or App 297 (1995), the Court of Appeals considered and rejected an argument similar to the insurer's. In that case, the claimant initially worked for an out-of-state employer and subsequently an Oregon employer. After the claimant's Oregon employment ended, he sought treatment for low back pain and was diagnosed with degenerative disc disease. The claimant filed a claim with the Oregon employer. The carrier argued that, because only one potentially responsible employer remained in the case, the last injurious exposure rule was inapplicable and the claimant had to show actual causation by the Oregon employer.

The Silveira court disagreed, reasoning that for purposes of establishing that an occupational disease is work related, a claimant may rely on all employments, even those that are not subject to Oregon's workers' compensation laws. The court cited Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994), which had held that in determining whether a disease is work related, the rule of proof aspect of last injurious exposure rule allows consideration of all employments, even those that could not ultimately be held responsible for the claim. The court also relied on Progress Quarries v. Vaandering, 80 Or App 160 (1986), for the proposition that a claimant is not required to file a claim with other potentially causative out-of-state employers in order to receive compensation in Oregon.

On remand from the Court of Appeals, in Kevin P. Silveira, 47 Van Natta 2354 (1995), we found that there was no evidence in the record that the claimant's degenerative disc disease was a preexisting condition and, therefore, in order to establish the compensability of his degenerative disc disease, the claimant had to prove that employment conditions were the major contributing cause of the disease. Amended ORS 656.802(2)(a); Or Laws 1995, ch 332, § 56(2)(a) (SB 369, § 56 (2)(a)). We concluded that the medical evidence established that the claimant's work activities, including his out-of-state employment, were the major contributing cause of the degenerative disc disease.

In the present case, the ALJ found that claimant's condition was caused by her employment at Vanport and preexisted her employment at Portland Meadows. According to the ALJ, claimant had to prove that employment conditions at Portland Meadows were the major contributing cause of the combined condition and pathological worsening of her bilateral ulnar entrapment neuropathy. We disagree.

Since claimant is relying on both her employments to prove compensability, there is no "preexisting condition." Under ORS 656.005(24), a "preexisting condition" is defined as any injury, disease, or 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 Laws 1995, ch 332, § 1(24) (SB 369, § 1(24)) (emphasis added).

This is the initial claim for claimant's bilateral upper extremity condition. Here, claimant has filed an occupational disease claim for bilateral upper extremity condition. Based on Silveira v. Larch Enterprises, supra, claimant may rely on both her employments, even her employment with Vanport which was not subject to Oregon's workers' compensation laws, for purposes of establishing that her bilateral upper extremity condition is work related. There is no evidence that claimant's condition preceded her employment with Vanport. Claimant's claim is not based on the worsening or combining of a preexisting disease or condition. Therefore, there is no upper extremity condition that preexisted the initial onset of this claim. Consequently, neither amended ORS 656.802(2)(a) nor ORS 656.005(7)(a)(B) apply to this case.

Thus, in order to establish the compensability of her bilateral upper extremity condition, claimant must prove that her employment conditions at Vanport and Portland Meadows were the major contributing cause of her condition. Amended ORS 656.802(2)(a); Or Laws 1995, ch 332, § 56(2)(a) (SB 369, § 56 (2)(a)).

In January 1993, claimant began experiencing aching and cramping in the palms of her hands, pain in her wrists and weakness in her arms. She sought treatment from Dr. Irvine on August 4, 1993. Dr. Irvine reported that claimant had a 6 to 12 month history of left forearm pain and cramping and bilateral wrist pain. (Ex. 1-1). Dr. Irvine diagnosed nerve compression syndrome of the left upper extremity with possible carpal tunnel syndrome.

Dr. Irvine reported on September 1, 1993 that claimant had recently been laid off and he anticipated that it might help her to get away from the computer terminal. (Ex. 1-2). Dr. Irvine suspected that claimant's computer work was causing her problems.

On October 13, 1993, Dr. Irvine reported that claimant had been off work and her symptoms had totally disappeared. (Ex. 1-2). He commented that claimant had gone back to work and, after 2 1/2 weeks, the symptoms started to occur on both arms. Dr. Irvine recommended conservative management and mentioned the possibility of surgery.

On May 31, 1994, claimant returned to Dr. Irvine. He reported that, when she began working seven months ago, she had a recurrence of her left elbow, forearm and hand pain, numbness and sense of weakness. (Ex. 1-3). Dr. Irvine's examination showed irritability about the cubital tunnel and some decrease in ulnar intrinsic motor function. Dr. Irvine discussed the risks of surgery.

Dr. Irvine reported on July 19, 1994 that claimant's work-related activities were the major contributing cause of her need treatment. (Ex. 1-8). Dr. Irvine explained:

> "[Claimant] works as an accountant for Portland Meadows and uses keyboards and key punch devices on a repeated basis and says that when she had the onset of symptoms, she was doing a great deal of work on the keyboards. She then took 4-6 weeks off and symptoms improved substantially. She then went back to this type of work and again her symptoms recurred." (Ex. 1-8).

On August 5, 1994, Dr. Nye examined claimant on behalf of the insurer. Dr. Nye reported that the major contributing cause for the development of her bilateral ulnar nerve compressive disorders was her "job type." (Ex. 7). On August 22, 1994, Dr. Brown performed nerve conduction studies and reported that the findings were essentially static or unchanged since August 1993. (Ex. 9). Based on Dr. Brown's studies, Dr. Nye concluded that there was no worsening of claimant's condition. (Ex. 10). Dr. Nye explained:

> "Therefore, we have a condition that began in the summer of 1993 when working at Vanport Express. There was an interval of time off with improvement in her condition. The patient's symptoms have returned, but there is no objective evidence of a worsening of her condition that was diagnosed at her prior job. Therefore there is no evidence of a worsening of her condition since her job change to Portland Meadows." (Ex. 10).

Dr. Irvine concurred with Dr. Nye's reports. (Ex. 12).

Both Drs. Irvine and Nye agreed that claimant's work activities were the major contributing cause of her bilateral upper extremity condition. Both physicians commented that claimant's condition had improved while she was not working. There are no medical opinions attributing claimant's condition to any off-work activities. Based on the medical reports, we conclude that claimant's work activities, including her employment with Vanport, was the major contributing cause of her bilateral upper extremity condition. See amended ORS 656.802(2)(a); Silveira v. Larch Enterprises, supra. Consequently, we conclude that claimant's bilateral upper extremity condition is compensable.

Responsibility

If a worker establishes that disability was caused by disease resulting from causal conditions at two or more places of employment, the last employment providing potentially causal conditions is deemed to have caused the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984). Here, we cannot consider claimant's employment with Vanport for purposes of determining responsibility because it was not covered under the Oregon workers' compensation law. See Progress Quarries v. Vaandering, supra; Kevin P. Silveira, supra. Therefore, we must determine whether claimant's employment with Portland Meadows was injurious and provided "potentially causal" conditions for her bilateral upper extremity condition. See Silveira v. Larch Enterprises, supra, 133 Or App at 302 ("for the Oregon employer to be held responsible, the Oregon employment must be injurious and a potential cause of the disease"); Richard W. Branchcomb, 48 Van Natta 16 (1996).

Claimant testified that, while working at Vanport, her symptoms bothered her from "moderate" to "quite a bit," and she rated her pain level at that time as "seven to seven and a half." (Tr. 12). Claimant worked 32 hours per week at Vanport.

While she was off work, claimant testified that, after two weeks, her wrists were not bothering her very much. (Tr. 13). When she started work at Portland Meadows, she had only a "little bit" of symptoms. (Id.)

Claimant began working at Portland Meadows on September 21, 1993. Claimant worked 60 to 70 hours per week, doing the same type of work as at Vanport. (Tr. 14). By January 1994, her symptoms were "bad." (Tr. 15). In April 1994, she was doing a major amount of data entry and she rated her pain level at "ten." (Id.) Claimant testified that she could not write very well because her

hands shake. (Tr. 20). Her fingers ached most of the time and her arms were more tired. (Tr. 21). Claimant testified that, before the August 1994 nerve conduction studies, she had been on vacation for two weeks and had been auditing for a couple of weeks, during which her data entry duties were curtailed. (Tr. 22). She rated her symptom level in August 1994 at "six or seven." (Id.)

Drs. Irvine, Nye and Brown agreed that, based on the comparison of the August 1993 and August 1994 nerve conduction studies, there was no evidence of a worsening of claimant's condition during her employment at Portland Meadows. (Exs. 10, 12, 15). However, the critical issue is whether claimant's employment with Portland Meadows was injurious and provided "potentially causal" conditions for her bilateral upper extremity condition. See Silveira v. Larch Enterprises, supra.

Although there are no medical opinions that specifically address that issue, the reports from Drs. Irvine and Nye establish that claimant's employment with Portland Meadows was injurious and provided "potentially causal" conditions for her condition. Dr. Irvine reported on October 13, 1993 that claimant had been off work and her symptoms had totally disappeared. (Ex. 1-2). He commented that claimant's symptoms started to occur on both arms after she had been back to work at Portland Meadows for 2 1/2 weeks. Dr. Irvine's May 31, 1994 examination indicated that claimant had some decrease in ulnar intrinsic function. (Ex. 1-3). Since conservative management had been unsuccessful, Dr. Irvine recommended surgery.

Dr. Nye also reported that claimant's condition had improved while she was off work but her symptoms returned after she began working at Portland Meadows. (Ex. 10).

We are persuaded that, based on the reports from Drs. Irvine and Nye, claimant's work activities at Portland Meadows were injurious and provided "potentially causal" conditions for her bilateral upper extremity condition. Therefore, Portland Meadows is responsible for claimant's condition.[1] See Kevin P. Silveira, supra; Richard W. Branchcomb, supra.

Although the insurer argues that there is no proof that claimant's employment with Portland Meadows actually caused her condition, even if the insurer is correct, that factor is not dispositive. In Beneficiaries of Strametz v. Spectrum Motorwerks, 135 Or App 67, 71, mod 138 Or App 9 (1995), the court said that it was immaterial that the employers in that case were not the actual cause of the claimant's disease. Rather, "[a]ll claimant must show to establish a compensable claim is that conditions at the Oregon employer were of the type that could have caused the disease." (Id.) See also Richard W. Branchcomb, supra.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated August 28, 1995 is reversed. The insurer's denial is set aside and claimant's claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant's attorney is awarded $3,500, payable by the insurer.

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[1] In light of our disposition, we do not address claimant's alternative argument that the case should be reopened to allow her to meet the requirements of Senate Bill 369.

Board Member Haynes specially concurring.

Under the doctrine of stare decisis, I am obligated to follow the majority's holding in Kevin P. Silveira, 47 Van Natta 2354 (1995). Nevertheless, I direct the parties' attention to the dissenting opinion in Silveira.

In the Matter of the Compensation of
LINDA V. GREENSLITT, Deceased, Claimant
WCB Case No. 95-00696
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members en banc.[1]

The insurer requests review of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its denial of death benefits for Taylor Marie Richardson (Taylor); (2) set the rate of death benefits for Taylor and Reannan Michelle Greenslitt (Reannan) at $400 per month; (3) awarded interim compensation to Taylor for death benefits during the period prior to the insurer's denial; and (4) awarded an assessed attorney fee for prevailing against the insurer's denial of Taylor's death benefits. On review, the issues are entitlement to death benefits, rate of death benefits, interim compensation and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with one change. We change the first paragraph to reflect that Richard Greenslitt suffered a fatal injury in October 1994, rather than 1995.

CONCLUSIONS OF LAW AND OPINION

Benefits for Taylor

The decedent and her husband, Richard, had two children, Robin Cantu and Brett Greenslitt. Robin has a daughter, Reannan Michelle Greenslitt (Reannan). The decedent and Richard became Reannan's legal guardians in 1988. Reannan has a daughter, Taylor Marie Richardson (Taylor), born November 22, 1993. The decedent suffered a compensable fatal injury on August 30, 1994. Richard died in October 1994.

The insurer contends that Taylor has not established that she is entitled to death benefits. Under ORS 656.005(5), a "child" includes a "child toward whom the worker stands in loco parentis." A person is said to stand in loco parentis when the obligations of parenthood have been voluntarily assumed and discharged. Javier Mendoza, 42 Van Natta 373, 374 (1990), aff'd Mell v. W.C. Ranch, Inc., 108 Or App 105, rev den 312 Or 234 (1991). We agree with the ALJ's reasoning and conclusion that the decedent stood in loco parentis to Taylor.[2] Therefore, Taylor is considered a "child" under ORS 656.005(5) and is entitled to death benefits pursuant to ORS 656.204.

Retroactive Application of Amended ORS 656.204

Generally, the changes made to the Workers' Compensation law made by Senate Bill 369 apply to cases in which the Board has not issued a final order or for which the time to appeal the Board's order has not expired on the effective date of the Act. Volk v. America West Airlines, 135 Or App 565, 569 (1995). However, one exception to the retroactive effect of Senate Bill 369 applies here. Subsection (2) of section 66 of Senate Bill 369 provides, in part, that the amendments to ORS 656.204 by section 13 apply only to injuries occurring on or after the effective date of this Act. Or Laws 1995, ch 332, § 66(2) (SB 369, § 66(2)). Since decedent's death occurred before the effective date of Senate Bill 369, we apply the former version of the statute.[3]

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[1] Board Chair Hall has recused himself from participation in this case. See OAR 438-11-023.

[2] In the second and third paragraphs on page 4 of the ALJ's Opinion and Order, we change the ALJ's references from "Katie" to "Taylor."

[3] Because Senate Bill 369 contains an emergency clause, its effective date is June 7, 1995, the date the Governor signed the bill into law. Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). We note that ORS 656.204(2)(c) now provides: "If a surviving spouse receiving monthly payments dies, leaving a child under 18 years of age who is entitled to compensation on account of the death of the worker, a monthly benefit equal to 4.35 times 25 percent of the average weekly wage shall be paid to each such child until the child becomes 18 years of age." Or Laws 1995, ch 332, § 13 (SB 369, § 13).

Rate of Benefits

The ALJ found that the provisions of ORS 656.204(2)(e) and ORS 656.204(7) were in conflict. The ALJ reasoned that ORS 656.204(7) was unnecessary, inconsistent and could not be given effect in any logical way. The ALJ concluded that the death benefits for Reannan and Taylor should be calculated at $400 per month pursuant to ORS 656.204(2)(e).

The insurer argues that the death benefits for Reannan and Taylor should be calculated at $150 per month. The insurer relies on ORS 656.204(7), which provides, in part:

> "If a surviving spouse receiving monthly payments dies, leaving a child under the age of 18 years who is entitled to compensation on account of the death of the worker, a monthly payment of $150 shall be made to each child until the child becomes 18 years of age."

According to the insurer, since the decedent's surviving spouse, Richard, was "receiving monthly payments" in connection with the decedent's death at the time of his own death, ORS 656.204(7) applies to determine the amount of benefits. The insurer contends that the $400 per month provision in ORS 656.204(2)(e) is intended to apply to a surviving spouse who has remarried and dies with children under the age of 18.

The beneficiaries contend that ORS 656.204(2)(e) controls and that the legislature intended the higher rate of compensation to apply in this situation. ORS 656.204(2)(e) provides:

> "If the surviving spouse dies before all the children of the deceased worker become 18 years of age, then each child under 18 years of age shall be paid $400 per month until the child becomes 18 years of age."

The beneficiaries assert that when the 1991 legislature added section to (2)(e) to ORS 656.204, it neglected to delete the conflicting provision in ORS 656.204(7).

In construing a statute, our task is to discern the intent of the legislature. The first level of analysis is to examine both the text and the context of the statute, including other provisions of the same statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 610-11 (1993). If the legislature's intent is clear, no further inquiry is necessary. If the intent of the legislature is not clear from the text and the context of the statute, we then consider the legislative history of the statute. Id. at 611-12.

Both ORS 656.204(2)(e) and ORS 656.204(7) refer to a situation in which a surviving spouse dies before all the children of the deceased worker have become 18 years old. Both statutes provide that the children are to continue to receive monthly payments. The primary difference is that ORS 656.204(2)(e) provides for a higher amount of monthly payments. In addition, ORS 656.204(7) refers to a surviving spouse who has been "receiving monthly payments."

The insurer points out that ORS 656.204(2)(e) does not refer to a surviving spouse "receiving monthly payments." The insurer asserts that a surviving spouse would not be "receiving monthly payments" if he or she had remarried. See ORS 656.204(2)(c) ("[u]pon remarriage, a surviving spouse shall be paid 24 times the monthly benefit in a lump sum as final payment of the claim"). Therefore, the insurer urges that the proper construction of ORS 656.204(2)(e) is that it applies only when a surviving spouse has remarried and is no longer receiving benefits. According to the insurer, since Richard had not remarried and was "receiving monthly payments" at the time of his death, ORS 656.204(7) applies.

In essence, the insurer asks us to construe ORS 656.204(2)(e) to include a reference to remarriage that is not expressly in the statute. The effect of the insurer's argument would be to add the phrase "after remarriage" to ORS 656.204(2)(e) so that it would read: "If the surviving spouse dies after remarriage, but before all the children of the deceased worker become 18 years of age, then each child under 18 years of age shall be paid $400 per month until the child becomes 18 years of age."

In interpreting a statute, we are "not to insert what has been omitted, or to omit what has been inserted." ORS 174.010. There is nothing in the text of ORS 656.204(2)(e) to suggest that it applies only when a surviving spouse has remarried and is no longer receiving benefits. Furthermore, the context of

section 2 of 656.204 does not indicate that the entire section applies only when a surviving spouse has remarried. Therefore, we disagree with the insurer that the proper construction of ORS 656.204(2)(e) is that it applies only when a surviving spouse has remarried and is no longer receiving benefits.

We acknowledge that ORS 656.204(7) could apply to this case because Richard was "receiving monthly payments" at the time of the decedent's death. However, ORS 656.204(2)(e) could also apply to the facts in this case. We conclude that the pertinent text and context of ORS 656.204 are not clear as to when we apply section 2(e) or when we apply section 7 to determine the proper amount of benefits. Because the text of either statute could reasonably apply to this case, we turn to the legislative history of the statute for assistance. See PGE v. Bureau of Labor and Industries, supra, 317 Or at 611-12.

In 1991, the legislature amended ORS 656.204 by adding section 2(e) and by increasing the amount of benefits for children of a deceased worker who have been orphaned. Or Laws 1991, ch 473, § 1. At a March 27, 1991 public hearing, Representative Mannix, sponsor of House Bill 2724, explained its purpose:

> "The genesis of [House Bill] 2724 is the fact that we are moving more and more towards a single parent family structure. The current statutory scheme does not recognize that in terms of the amount of benefits available when a parent who is a worker dies. This $150 figure has been in place for years and it is obvious that no child can be supported for that kind of money. I suggest we change the benefit from $150 to $400 a month." Minutes, House Committee on Labor, March 27, 1991, p. 7.

At the same public hearing, Chris Davie, on behalf of the SAIF Corporation, pointed out that a clarification was necessary to determine whether the benefit increased to $400 if the other surviving spouse died. Minutes, House Committee on Labor, March 27, 1991, p. 7. He explained:

> "One other point I would like to make about this bill. If the bill were to pass, if the spouse is alive at the time of the death, the child's benefit is $150 per month. If the child is an orphan at the time of the death of the parent with no other spouse, with no spouse surviving, then the benefit would be $400 per month. That creates a situation that you have to address if the surviving spouse dies, does that benefit then jump to $400 or does it stay at $150? I think that would need to be clarified. It's not a problem right now because the benefits for both are the same at $150 per month." Tape recording, House Committee on Labor, March 27, 1991, Tape 75, Side B.

At a work session held on April 10, 1991, Representative Mannix said that amendments were prepared to clarify the language of House Bill 2724. Representative Mannix explained:

> "We were trying to also clarify that if someone is in the situation where they're -- first of all, the bill says if you are orphaned, you would have a higher level of benefits. What happens if the parent dies, leaves a surviving spouse, but then a week later or a month later or a year later, the surviving spouse dies, leaving the child orphaned? This says that if the surviving spouse dies before the child reaches 18, then the benefits for that child are increased to $400 a month.
>
> "And that addresses what was brought out during the prior hearing as a gap, that we were dealing with people who were orphaned immediately but if someone is orphaned later on, we weren't providing them with the benefits. And those benefits are supposed to provide support in light of the lack of a parent to provide support. It won't happen very often, but in the rare occasion when it would happen, that's what this modification is about. That was a problem that came up during a hearing as something we weren't addressing." Tape recording, House Committee on Labor, April 10, 1991, Tape 96, Side A.

The House Committee on Labor moved House Bill 2724, as amended, to the floor with a "do pass" recommendation. Minutes, House Committee on Labor, April 10, 1991, p.13.

There is nothing in the legislative history to support the insurer's argument that ORS 656.204(2)(e) applies only when a surviving spouse has remarried and is no longer receiving benefits. Rather, the legislative history indicates that the higher benefit of $400 per month applies when a surviving spouse dies before all the children of the deceased worker have become 18 years old. However, we find no guidance as to why the legislature did not repeal or amend ORS 656.204(7) to remove the inconsistency.[4]

We are to attempt to construe ORS 656.204, if possible, to give effect to all its provisions. ORS 174.010; PGE v. Bureau of Labor and Industries, supra, 317 Or at 611. Nevertheless, if two laws are totally irreconcilable, the legislature's later enactment usually prevails. Harris v. Craig, 299 Or 12, 15 n 1 (1985); Pioneer Trust Bank v. Mental Health Division, 87 Or App 132, 136 (1987).

Here, we agree with the ALJ that ORS 656.204(2)(e) and ORS 656.204(7) are totally irreconcilable. The more recent provision is ORS 656.204(2)(e). The 1991 legislative history regarding ORS 656.204(2)(e) indicates that the legislature intended that the higher benefit of $400 per month should apply when a surviving spouse dies before all the children of the deceased worker have become 18 years old. Therefore, we conclude that the death benefits for Reannan and Taylor should be calculated at $400 per month pursuant to ORS 656.204(2)(e).

Interim Compensation

The ALJ concluded that Taylor was entitled to interim compensation for death benefits during the period prior to the insurer's denial. The ALJ relied on ORS 656.262(2) and ORS 656.262(6) to reach that conclusion.

The insurer contends that there is no case law mandating payment of interim compensation for a beneficiary claiming entitlement to death benefits. The insurer argues that interim compensation is based on temporary total disability benefits and there can be no claim for interim compensation here since the decedent died at the time of the accident and would not be entitled to temporary disability benefits.

Before the enactment of Senate Bill 369, a claimant was entitled to receive interim compensation for disability from the date the claim was filed until the claim was accepted or denied. See ORS 656.262(2); Bono v. SAIF, 298 Or 405 (1984), Jones v. Emanuel Hospital, 280 Or 147 (1977). Amended ORS 656.262(4)(a) provides that the "first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation." Or Laws 1995, ch 332, § 28(4)(a).

As we mentioned earlier, the changes made Senate Bill 369 generally apply to cases in which the Board has not issued a final order or for which the time to appeal the Board's order has not expired on the effective date of the Act. Volk v. America West Airlines, supra. Since there is no specific exception to the retroactive application of amended ORS 656.262(4)(a), we must apply the new law.

Amended ORS 656.262(4)(a) requires a carrier to pay temporary disability compensation "if the attending physician authorizes the payment of temporary disability compensation." Here, there is no evidence that an attending physician has authorized the payment of temporary disability compensation. Therefore, we conclude that Taylor is not entitled to interim compensation.

Attorney Fees

The ALJ concluded that the beneficiaries' counsel was entitled to an assessed fee of $3,000 for prevailing against the denial of death benefits for Taylor. The insurer contends that Taylor is not entitled to attorney fees.

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[4] Although it is not clear from the legislative history what the precise amendments to House Bill 2724 were, it is clear from the legislative history that the intent was to raise the monthly payments to $400.

Under amended ORS 656.386(1), a claimant's attorney is entitled to an attorney fee in cases involving denied claims where a claimant prevails finally in a hearing. A "denied claim" is defined, in part, as a claim for compensation which a carrier "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." Or Laws 1995, ch 332, § 43 (SB 369, § 43).

The insurer denied benefits to Taylor on the basis that there was insufficient information that she qualified as a beneficiary of the decedent. (Ex. 17A). We find that the insurer refused to pay on the express ground that the decedent's death did not give rise to an entitlement to compensation on behalf of Taylor. Therefore, Taylor's claim for benefits constitutes a "denied claim" under amended ORS 656.386(1). Since Taylor's attorney "prevailed finally" concerning that issue at the hearing, Taylor was entitled to a reasonable attorney fee pursuant to amended ORS 656.386(1).

The beneficiaries' attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the death benefits for Taylor is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review regarding the interim compensation and attorney fee issues. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated June 9, 1995, as corrected June 16, 1995, is affirmed in part and reversed in part. The portion of the ALJ's order that awarded interim compensation to Taylor Marie Richardson is reversed. The remainder of the order is affirmed. For services on review, the beneficiaries' attorney is awarded $1,000, payable by the insurer.

January 8, 1996 Cite as 48 Van Natta 28 (1996)

In the Matter of the Compensation of
ELLEN E. HEATON, Claimant
WCB Case No. 93-07224
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Williams, Zografos, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Balasubramani's order which set aside its partial denial of claimant's bilateral carpal tunnel condition claim. In her brief, claimant disagrees with that portion of the ALJ's order which found that the insurer had not previously accepted her condition. On review, the issue is compensability.

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

On review, the insurer contends that the ALJ should have relied upon the opinion of Dr. Radecki. However, after reviewing the medical opinions in this case, we agree with the ALJ that Dr. Long has provided the most persuasive opinion with respect to the issue of causation. Specifically, Dr. Long has provide an extensive opinion, consisting of numerous medical reports and a deposition. Dr. Long acknowledged and considered claimant's non-work factors, yet he continued to conclude that claimant's work was the major contributing cause of her condition. Drs. Thompson and Nash concurred with Dr. Long's opinion.

On the other hand, as explained by the ALJ, Drs. Radecki and Nathan provided opinions that were not persuasive, as the opinions were based on surveys of individuals other than this claimant. See Mark Ostermiller, 46 Van Natta 1556 (1994). Under the circumstances, we agree with the ALJ that Dr. Long has provided the most persuasive expert opinion in this case.

Finally, the insurer contends that amended ORS 656.005(24) requires consideration of preexisting conditions which predispose a worker to disability or need for treatment. In response, claimant challenges the validity of this amended statute, in light of the Constitution and the Americans with Disabilities Act. However, we need not resolve these constitutional challenges because even if claimant's personal factors or predispositions are considered as a preexisting condition, based on the persuasive medical evidence, claimant has nevertheless established that work is the major contributing cause of her carpal tunnel condition.

Claimant is entitled to an attorney fee for services on review concerning the issue of compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $3,000, 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 and claimant's counsel's statement of services), the complexity of the issue, and the value of the interest involved. We further note that claimant is not entitled to an attorney fee for her counsel's services devoted to the unsuccessful argument that the insurer had previously accepted the bilateral carpal tunnel condition and was precluded from issuing its denial.

ORDER

The ALJ's order dated May 25, 1995 is affirmed. For services on review, claimant is awarded an assessed attorney fee of $3,000, to be paid by the insurer.

January 8, 1996 Cite as 48 Van Natta 29 (1996)

In the Matter of the Compensation of
JULIE A. JOHNSON, Claimant
WCB Case No. 94-14909
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Lipton's order which: (1) limited claimant's out-of-compensation fee to 25 percent of increased temporary disability compensation created by the ALJ's order; and (2) declined to assess an attorney fee under former ORS 656.382(1) for the insurer's allegedly unreasonable resistance to the payment of compensation. On review, the issue is attorney fees.

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

Relying on our decision in Joseph M. Lewis, 47 Van Natta 381 (1995), the ALJ authorized an out-of-compensation attorney fee, payable out of the increased temporary disability compensation created by his order, if any. Claimant contends that the attorney fee should be based on permanent disability, as well as on temporary disability. We disagree.

In Lewis, we acknowledged that a claimant is entitled to an "out-of-compensation" fee for his counsel's services in obtaining claim reclassification. In addition, we held that the proper source of that out-of-compensation fee was the claimant's temporary (but not permanent) disability compensation. Reasoning that our "out-of-compensation" fee awards have uniformly been limited to the compensation created by the order awarding the fees, we concluded that since the compensation created by our order reclassifying the claim was temporary disability benefits, the "out-of-compensation" attorney fee was limited to a percentage of the claimant's temporary disability benefits. We affirmed our conclusion on reconsideration. Joseph M. Lewis, 47 Van Natta 616 (1995).

Here, claimant requested a hearing on the Director's denial of reclassification. Subsequent to the hearing request, the insurer voluntarily reclassified the claim as disabling. The only benefits which flow directly from the reclassification are temporary disability benefits, if any. See amended ORS 656.210; 656.212; OAR 436-30-045(7)(a). Although reclassification made it possible for claimant to

receive a permanent disability award, permanent disability benefits did not flow directly from reclassification. Instead, permanent disability benefits, if any, will be awarded only after claim closure. See amended ORS 656.268.

Furthermore, we have previously held that neither the Hearings Division nor the Workers' Compensation Board has authority to award an out-of-compensation attorney fee for an attorney's services in securing claim closure by the Director. Rogelio Munoz-Martinez, 47 Van Natta 1412, 1413 (1995). We reasoned that because the compensation was neither awarded nor approved by the Hearings Division or the Board, and since neither party requested reconsideration of the Determination Order, neither we nor the ALJ had authority to approve an out-of-compensation attorney fee. Here, too, claimant asks that we approve an attorney fee out of compensation that neither the Hearings Division nor the Board has awarded or approved. We are without authority to do so.

We also agree with the ALJ's refusal to assess a penalty under former ORS 656.382(1) for the insurer's allegedly unreasonable resistance to the payment of compensation by initially classifying the claim as nondisabling. SAIF v. Condon, 119 Or App 194 (1993).

ORDER

The ALJ's order dated March 17, 1995 is affirmed.

January 8, 1996 Cite as 48 Van Natta 30 (1996)

In the Matter of the Compensation of
ALLEN T. KNIGHT, Claimant
WCB Case Nos. 94-14842, 94-14120, 94-10461, 94-09999, 94-10460 & 94-10134
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Ronald K. Pomeroy (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation, on behalf of KenDon Enterprises (SAIF/KenDon), requests review of that portion of Administrative Law Judge (ALJ)[1] Black's order that: (1) set aside its responsibility denial of claimant's low back injury claim; and (2) upheld Wausau Insurance Company's (Wausau's) responsibility denial, on behalf of the same employer, of the same condition. Claimant cross-requests review of the ALJ's failure to award a carrier-paid fee for participating in the arbitration proceedings. On review, the issues are responsibility and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On August 30, 1994, DCBS/WCD issued an order pursuant to ORS 656.307 designating SAIF/KenDon as the paying agent under its 1993 (not 1992) claim. (Ex. 37).

CONCLUSIONS OF LAW AND OPINION

Standard of Review

This case arose under former ORS 656.307. Under former ORS 656.307(2), our review was limited to questions of law. Under amended ORS 656.307(2), proceedings "shall be conducted in the same manner as any other hearing and any further appeal shall be conducted pursuant to ORS 656.295 and 656.298." SB 369, § 36; Dan J. Anderson, 47 Van Natta 1929 (1995). Under ORS 656.295, our review is de novo. See e.g., Destael v. Nicolai Co., 80 Or App 596, 600-601 (1986). Accordingly, under amended ORS 656.307, our review is de novo.

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[1] Under former ORS 656.307, the factfinder in the responsibility proceeding was called an arbitrator. Under amended ORS 656.307, the factfinder is called an Administrative Law Judge. Or Laws 1995, ch 332, § 36 (SB 369, § 36).

The next question is whether amended ORS 656.307 applies in this case. We conclude that it does. Except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565, 572-73 (1995). Amended ORS 656.307 is not among the exceptions to the general rule. See SB 369, § 66 (enumerating exceptions to the general retroactivity provision). Consequently, because it is not excepted from the general retroactivity provisions, the amended statute applies here. Accordingly, we review this case de novo under amended ORS 656.307. See Dan J. Anderson, supra.

Responsibility

Claimant has been employed at KenDon Enterprises as a truck mechanic and fabricator since approximately 1991. KenDon was insured by SAIF at the time of claimant's 1993 accepted low back strain injury. KenDon was insured by Wausau at the time of the May 5, 1994 incident. SAIF contends that the ALJ erred in finding it responsible, under the 1993 KenDon claim, for claimant's 1994 low back strain. We disagree.

In 1986, claimant experienced a low back strain at Harry and David, SAIF's insured. At that time he was diagnosed with bilateral spondylolysis and Grade I spondylolisthesis at L5-S1. SAIF accepted a low back strain. The claim was closed with no permanent disability.

In March 1992, claimant experienced a low back sprain after lifting a tire at KenDon, SAIF's insured. SAIF accepted the claim, which was closed with no permanent disability.

On June 18, 1993, claimant experienced a low back strain after lifting a glass rack at KenDon, SAIF's insured. SAIF accepted the claim, which was closed with no permanent disability.

On May 5, 1994, claimant sought treatment for acute back pain after lifting glass racks he was welding at KenDon, now Wausau's insured. He filed a claim for low back strain with Wausau. Wausau denied the claim, naming SAIF, on behalf of Harry and David and KenDon, as the potentially responsible carrier. SAIF denied responsibility for the 1994 claim, naming itself as the potentially responsible carrier in relation to the 1993, 1992 and 1986 claims. Thereafter, a "307" order issued, naming SAIF/KenDon as the paying agent and referring the matter to the Hearings Division for arbitration.

The ALJ, applying ORS 656.005(7)(a)(B), concluded that claimant had not experienced a "new injury" to his low back sufficient to shift responsibility to Wausau, pursuant to ORS 656.308(1).[2] We adopt and affirm the ALJ's opinion with the following supplementation.

Claimant has spondylolysis and spondylolisthesis at L5-S1 that preexisted his 1986 low back strain injury. The low back strain combined with the preexisting condition in 1986. That preexisting condition has been a part of each subsequent back strain, including the one in 1994. (Exs. 6, 43 and 44-5). Consequently, we find that claimant's 1994 claim involved the same condition as his prior claims, including the 1993 accepted low back strain. See Smurfit Newsprint v. DeRosset, 118 Or App 368, on remand Armand DeRosset, 45 Van Natta 1058 (1993).

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[2] SB 369 amended ORS 656.308. SB 369, § 37. Amended ORS 656.308 now provides that the standards for determining the compensability of a combined condition under ORS 656.005(7) shall also be used to determine the occurrence of a new compensable injury or disease under that section. Amended 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."

Because the standard of proof remains the same under the former and amended statutes, the amendment has no effect on the analysis or outcome of this case.

Attorney Fees

The ALJ did not award claimant's attorney a carrier-paid fee for his services at hearing. Claimant contends that he is entitled to a carrier-paid attorney fee pursuant to ORS 656.386(1) and/or 656.307(5).

ORS 656.386(1) Attorney Fee

Citing SAIF v. Allen, 320 Or 192 (1994), claimant contends that he is entitled to a carrier-paid attorney fee against SAIF for its failure to pay medical bills pursuant to the "307" order. Based on a lack of sufficient evidence in this record, we conclude claimant has not established entitlement to a fee.

There is insufficient evidence to prove that SAIF failed to pay medical bills within 90 days from the date of its receipt of such bills. At most, claimant testified that: (1) he paid for two or three office visits with Dr. Kelty; (2) he submitted those medical bills to KenDon's secretary; and (3) he had not received reimbursement for those bills. (Tr. 13-14). However, there is no evidence of when he submitted those bills to KenDon's secretary. Even assuming for the sake of argument that a failure to accept or deny medical bills within 90 days of SAIF/KenDon's receipt of those bills constitutes a "denied claim" under ORS 656.386(1), the record does not establish when KenDon received those bills. Under such circumstances, we decline to award a fee under ORS 656.386(1).

ORS 656.307 Attorney Fee

Claimant asserts that he is entitled to a carrier-paid fee under ORS 656.307(5) for actively and meaningfully participating in the responsibility proceeding. SAIF contends that, if claimant prevails against SAIF's responsibility denial, he is entitled to a fee no greater than $1,000 under amended ORS 656.308(2)(d). We agree that claimant is entitled to a carrier-paid fee under ORS 656.307(5),[3] but we do not agree that the fee is subject to the limitation of ORS 656.308(2)(d).

We recently addressed this question in Dan J. Anderson, supra. In Anderson, we concluded that, where a case arose under former ORS 656.307, amended ORS 656.307(5) applies, and 656.308(2)(d) does not. Because amended ORS 656.307(5) contains no limit on the amount an ALJ may award a claimant for his or her attorney's services in a "307" proceeding, a reasonable attorney fee, which may exceed $1,000, may be awarded claimant's attorney for actively and meaningfully participating in the "307" proceeding. Moreover, because our review of the matter is de novo under amended ORS 656.307, we may find facts from which to determine whether claimant's counsel is entitled to an assessed fee under amended ORS 656.307(5). Cf. Darrell W. Vinson, 47 Van Natta 356 (1995).

Here, claimant's attorney was instrumental in making a claim against Wausau and moving to exclude other carriers, which were on the risk prior to the 1993 accepted claim with SAIF/KenDon, as parties to claimant's case in order to expedite the hearing. Moreover, claimant personally appeared at the arbitration proceeding, and his counsel actively participated in the proceeding, offering exhibits into the record and eliciting testimony from claimant. Claimant asserted through counsel that Wausau should be found responsible for his condition. It is undisputed that claimant would receive a higher rate of temporary total disability benefits under the Wausau claim than he would receive under the 1993 SAIF/KenDon claim.

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[3] Amended ORS 656.307(5) provides:

"The claimant shall be joined in any proceeding under this section as a necessary party, but may elect to be treated as a nominal party. If the claimant appears at such proceeding 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."

The amended statute, which merely specifies that Referees are now called Administrative Law Judges, is essentially the same as the former version of the statute. See former ORS 656.307(5). Amended ORS 656.307(5) is not among the exceptions to the general retroactivity provisions of SB 369. See SB 369, § 66.

Because claimant had a material, substantial interest in the responsibility dispute and actively advocated a position on that issue, we conclude that claimant actively and meaningfully participated in the "307" hearing. See Darrell W. Vinson, supra. Accordingly, claimant's attorney is entitled to a reasonable attorney fee pursuant to amended ORS 656.307(5), to be paid by SAIF/KenDon in relation to the 1993 claim.

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at the "307" proceeding is $2,500, payable by SAIF/KenDon. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, and the value of the interest involved.

Claimant submitted a respondent's brief on review in which he advocates SAIF/KenDon as the responsible party. However, compensability was not litigated at hearing and claimant's TTD rate would be higher under the Wausau claim than under the SAIF claim. Because claimant's compensation was not at risk of disallowance or reduction,[4] claimant's attorney is not entitled to an attorney fee for services on Board review. See ORS 656.382(2); Long v. Continental Can Co., 112 Or App 329 (1992); John H. Kirkpatrick, 47 Van Natta 2105 (1995); Rito N. Nunez, 45 Van Natta 25, 26 (1993). Moreover, claimant is not entitled to an attorney fee for services on review of an ALJ's order arising from a "307" proceeding. See ORS 656.307(5); Linda C. Prociw, 46 Van Natta 1875 (1994). Finally, claimant's attorney is not entitled to a fee for services related to securing the attorney fee award. See Ernest C. Richter, 44 Van Natta 101, on recon 44 Van Natta 118 (1992).

ORDER

The ALJ's order dated March 31, 1995 is affirmed in part and reversed in part. That portion of the order that awarded no attorney fee is reversed. Claimant's attorney is awarded $2,500 for services at the "307" proceeding, to be paid by SAIF/KenDon. The remainder of the ALJ's order is affirmed.

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[4] We note that, even when a ".307" order has issued, compensability can be at risk at hearing. See Ronnie E. Taylor, 45 Van Natta 905, on recon 45 Van Natta 1007 (1993), aff'd Taylor v. Masonry Builders, Inc., 127 Or App 230, rev den 319 Or 281 (1994) (the issuance of a ".307" order does not preclude a carrier from subsequently denying compensability). Here, it appears that compensability was conceded and that, on this record, compensation was not at risk.

In the Matter of the Compensation of
GREGORY W. WHITE, Claimant
WCB Case No. 94-04381
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Brian Pocock, Defense Attorney

Reviewed by Board Members Hall and Christian.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) denied a motion for discovery; (2) set aside that portion of its denial that denied a neck and upper back injury; and (3) assessed a penalty for an allegedly unreasonable denial. Claimant cross-requests review of the ALJ's order, seeking an order finding the specific diagnosis of thoracic outlet syndrome compensable. On review, the issues are evidence, compensability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the ALJ's "Findings of Ultimate Fact." We make the following additional findings.

On July 12, 1994, the self-insured employer's attorney filed a "Motion to Produce" with the Hearings Division. The employer requested records which included claimant's tax returns from 1992 and 1993, as well as all records of claimant's river guide business, including records of the specific dates when the river guiding activities took place.

Prior to the February 22, 1995 hearing, the employer served claimant with a subpoena for the records regarding his river guiding business. In an August 11, 1994 order, the Presiding ALJ granted the employer's motion and ordered claimant to produce income tax returns for 1992 and 1993 and records of dates on which claimant acted as a river guide from September 2, 1992 to the date the order issued. In a September 23, 1994 "Discovery Order on Reconsideration," the Presiding ALJ reconsidered the August 11, 1994 discovery order and denied the motion for discovery.

At hearing, the employer once again raised the motion for discovery of the dates claimant conducted river guiding activities after September 2, 1992. The ALJ denied the motion on the grounds that the material requested was not relevant to the compensability issue. (Tr. 39).

Claimant testified that he went river guiding twice in September 1992. However, claimant did not remember the specific dates he performed the river guiding activities.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the self-insured employer's denial to the extent that it denied a neck and upper back injury. In addition, the ALJ assessed a penalty against the employer for an allegedly unreasonable denial. Finally, the ALJ denied the employer's motion for discovery of records concerning claimant's river guiding business.

We briefly recount the relevant facts. On September 2, 1992, claimant (a fireman) fell through a roof while fighting a fire for the employer. Claimant fell partly through the roof and then caught himself with his arms out. The incident was witnessed and was documented in the employer's minor injury log. Claimant first sought medical treatment on December 28, 1993 from Dr. Balter, a chiropractor, 15 months after the September 1992 injury. Claimant reported upper back and left arm pain. Claimant was treated by Dr. Goodwin, who referred claimant to Dr. Herring, a neurologist, in April 1994. Claimant was also examined by Dr. Woolpert, an orthopedic surgeon, on behalf of the employer. The employer denied the claim in March 1994.

Claimant has a side business as a fishing guide. He has been a licensed guide for twenty-seven years. (Tr. 24). Claimant's river guiding business involved rowing a boat which involved use of the upper extremities. Claimant performed approximately two dozen river guiding trips between September 1992, when he fell through the roof at work, and December 28, 1993, the date he first sought medical treatment. Claimant made two river guiding trips in September 1992, but could not remember the specific dates of those trips.

Compensability

Three physicians give opinions concerning the causation of claimant's neck, upper back and left arm condition.

Dr. Woolpert, an orthopedic surgeon, examined claimant on behalf of the employer. He diagnosed degenerative disc disease of the lumbar spine and left arm weakness and pain, etiology undetermined. Dr. Woolpert noted that, at the time of his examination, claimant was not having symptoms in the neck and that his symptoms seemed to be confined to the left arm. Dr. Woolpert explained that claimant's degenerative disc disease could explain claimant's left arm symptoms. He further explained that claimant's biceps weakness and symptoms correspond with a C5 nerve root impingement. However, Dr. Woolpert indicated that the MRI and CT/myelogram did not show enough findings to cause claimant's symptoms. Dr. Woolpert found it difficult to relate claimant's 1993 problems to the September 1992 injury. He noted that the problem that brought claimant in for treatment was the left arm. Based on claimant's history, Dr. Woolpert believed that claimant's left arm symptoms were fairly acute in onset and that they had not been ongoing since September 1992.

In conclusion, Dr. Woolpert opined that the September 1992 injury caused a cervical dorsal strain which had resolved and that claimant had a second problem, most likely independent of the 1992 injury, the cause of which was undetermined. Dr. Woolpert concluded that the 1992 injury was not the major cause of claimant's current problem.

Dr. Herring, a neurologist, saw claimant on referral from Dr. Goodwin, claimant's attending physician.[1] Dr. Herring believed that claimant's symptoms were caused by a posturally mediated, non-surgical left thoracic outlet syndrome. Dr. Herring concluded that, after falling through the roof in September 1992, claimant sustained some cervical and shoulder strain injuries which resulted in altered body mechanics and posture. Dr. Herring believed that, over time, claimant developed a postural left thoracic outlet syndrome. Dr. Herring found no evidence of cervical radiculopathy. Dr. Herring opined that the mechanism of injury was such that the injury was more likely than not responsible for claimant's left arm symptoms. Dr. Herring believed that the September 2, 1992 incident was the major cause of claimant's left arm weakness and pain complaints for which he sought treatment in December 1993.

Dr. Woolpert responded to Dr. Herring's opinion. Dr. Woolpert indicated that the diagnosis of thoracic outlet syndrome was a very difficult diagnosis to make. Dr. Woolpert stated that he had not found thoracic outlet syndrome in his examination of claimant. Dr. Woolpert explained that the only truly diagnostic studies are those which are done with vascular diminution studies or those studies which have neurological deficits typical of a thoracic outlet syndrome. Dr. Woolpert indicated that claimant's neurological studies did not support thoracic outlet syndrome. He felt that the diagnosis of thoracic outlet syndrome was tentative. Dr. Woolpert indicated that there are cases where postural slumping causes thoracic outlet type symptoms. Dr. Woolpert indicated that the position while doing rowing activity could be consistent with such symptoms. At his deposition, Dr. Woolpert believed that claimant's rowing activities were as reasonable an explanation for claimant's left arm symptoms as the September 1992 fall.

Dr. Herring agreed with Dr. Woolpert that the thoracic outlet syndrome diagnosis was difficult to make. Dr. Herring explained that there was no single test or battery of tests that make or disprove the diagnosis of thoracic outlet syndrome. Dr. Herring indicated that the diagnosis was based on clinical presentation and was made by a physician, rather than a test. Dr. Herring believed that Dr. Woolpert's comment that claimant's rowing activity may have put him in such a posture to cause thoracic outlet symptoms did not take into account claimant's history, progression of symptoms and responses to conservative therapies.

Dr. Barth, neurologist, performed a records review for the employer. Since the onset of weakness of the left biceps muscle was gradual in onset, occurring one year after the industrial injury, and was accompanied by documented x-ray evidence of an abnormality at the C5-6 level, Dr. Barth concluded that the degenerative change of the cervical spine was the primary cause of claimant's physical symptoms and physical findings of decreased cervical ranges of motion and biceps weakness and pain, rather than the September 1992 injury. Dr. Barth explained that thoracic outlet syndrome involves the lower trunk of the brachial plexus, namely the C8 and T1 levels, which affect intrinsic hand muscles and sensory disturbance on the ulnar aspect of the arm and hand. According to Dr. Barth, thoracic outlet syndrome does not affect the biceps muscle or the sensory distribution at the C6 level. Dr. Barth explained that he did not concur in the diagnosis of thoracic outlet syndrome since the primary distribution of weakness and pain is not seen in that condition. Finally, Dr. Barth opined that claimant's rowing activities as a river guide were of the kind that would be capable of aggravating degenerative cervical disc disease.

When there is a dispute between medical experts, we rely on those medical opinions which are both well reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). In addition, we normally defer to the treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983).

Here, Dr. Herring has treated claimant for his upper back, cervical and left arm complaints. We find no persuasive reasons not to defer to his opinion. Moreover, Dr. Herring is a neurologist with additional expertise in treating and diagnosing claimant's condition. See Abbott v. SAIF, 45 Or App 657 (1980). Although Dr. Barth is also a neurologist, Dr. Barth only performed a records review and did not examine claimant. Finally, we find Dr. Woolpert's opinion that claimant's rowing activity could have caused claimant's condition to be speculative. Because we find Dr. Herring's opinion to be based on

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[1] Dr. Goodwin opined that claimant did not have radiculopathy or a brachial plexus neuropathy. However, Dr. Goodwin deferred to Dr. Herring with regard to the diagnosis of thoracic outlet syndrome.

complete information and to be well reasoned, we defer to his opinion regarding compensability. Accordingly, we conclude that claimant has established compensability of his upper back, cervical and left arm condition.

Claimant seeks an order concluding that the specific condition of thoracic outlet syndrome is compensable. Based on the opinion of Dr. Herring, we conclude that claimant's upper back, neck and left arm condition, diagnosed as thoracic outlet syndrome, is compensable.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

Penalty

The ALJ concluded that the employer's denial was unreasonable because he believed that the employer "ignored" the opinion of its examiner, Dr. Woolpert, that claimant had suffered a cervical dorsal strain as a result of the September 1992 injury. On this basis, the ALJ assessed a penalty against the employer. We disagree with the ALJ's reasoning.

At the time the employer denied claimant's claim, it had Dr. Woolpert's report. Dr. Woolpert's report does not support a conclusion that claimant suffered a compensable injury in September 1992, i.e., an injury that required medical treatment or caused disability or death. See ORS 656.005(7)(a). Although Dr. Woolpert diagnosed a cervical dorsal strain in relation to the September 1992 event, he also indicated that the strain had resolved (without medical treatment). Dr. Woolpert further indicated that the condition claimant sought treatment for in December 1993 was not causally related to the September 1992 incident. Thus, Dr. Woolpert's report does not indicate that claimant had a condition caused by the September 1992 incident which resulted in disability or required medical treatment.

The mere fact that Dr. Woolpert diagnosed a strain (which had not required medical treatment or resulted in disability), does not render the employer's denial unreasonable. In fact, the report gave the employer reason to believe that claimant's condition and medical treatment in 1993 was not compensable. Under such circumstances, we find that the employer had a legitimate doubt concerning its liability. Because the denial was not unreasonable, we reverse the ALJ's award of penalties.

Evidence

The employer challenges the ALJ's evidentiary ruling that records of claimant's river guiding activities were not relevant to the compensability issue. We review the ALJ's evidentiary ruling for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

The employer argues that the dates of claimant's river guiding trips are directly relevant to the compensability issue because they are evidence concerning the severity of claimant's injury from the September 1992 incident. Claimant responds by arguing that claimant's tax returns are irrelevant to the compensability issue.

Although the specific dates that claimant performed river guiding activities are arguably relevant to the compensability issue, there is already evidence in the record that claimant made two river guiding trips in September 1992 and that claimant made two dozen such trips between the date of the September 2, 1992 injury and December 28, 1993, the date of first medical treatment. Moreover, the medical experts in this case, Drs. Woolpert, Barth and Herring, were aware that claimant worked as a river guide after the September 1992 incident and that this activity required extensive rowing. In fact, Drs. Woolpert and Barth implicated claimant's river guiding activities as a potential cause of claimant's left arm symptoms.

Thus, because the medical experts were aware of claimant's rowing activities and because the record contains evidence concerning the rowing claimant performed after the September 1992 incident,

we do not find that the ALJ's failure to admit evidence concerning the specific dates of those trips to rise to the level of an abuse of discretion. In other words, in light of the medical evidence, we are not persuaded that the specific dates in September 1992 that claimant performed the rowing activity would alter our decision regarding compensability.

ORDER

The ALJ's order dated April 27, 1995 is affirmed in part and reversed in part. That portion of the ALJ's order which assessed a penalty for an unreasonable denial is reversed. The remainder of the ALJ's order is affirmed. For services on Board review regarding the compensability issue, claimant's attorney is awarded $1,000, payable by the self-insured employer.

January 9, 1996 Cite as 48 Van Natta 37 (1996)

In the Matter of the Compensation of
EDWARD F. EBERT, Claimant
WCB Case No. 94-15103
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Jeffrey R. Gerner (Saif), Defense Attorney

Claimant requests reconsideration of our November 8, 1995 Order on Review that affirmed an Order on Reconsideration's award of 21 percent (67.2 degrees) unscheduled permanent disability. Specifically, claimant contends that our order appears to be contrary to our decision in Deborah A. Johnston, 47 Van Natta 1949 (1995). On November 28, 1995, we abated our order to allow the SAIF Corporation an opportunity to respond. Having received that response, we proceed with our reconsideration.

At issue in Johnston, as in this case, was the extent of the claimant's unscheduled permanent disability. One factor specifically in dispute was the claimant's Specific Vocational Preparation (SVP), which is based on the jobs the worker has performed during the five years preceding the time of determination. OAR 436-35-300(3) (WCD Admin. Order No. 93-056). SVP is the amount of "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." OAR 436-35-300(3)(a). The SVP ranges from one to nine, and is associated with each Dictionary of Occupational Titles (DOT) code. Id.

In Johnston, the claimant's SVP was determined by a "pre-injury" job as a stock clerk. A stock clerk (DOT 22.367-042) has an SVP value of 4, which equates to a 3 to 6 month training time. See OAR 436-35-300(4). Citing OAR 436-35-300(3)(b)(A),[1] we stated in Johnston that the "claimant can meet the requirements of OAR 436-35-300(3) (i.e., the higher SVP value) only if she completed employment for a particular job for the maximum period specified in the SVP table in OAR 436-35-300(4)." 47 Van Natta at 1950 (emphasis added). We found, however, that the claimant had met the SVP requirements with respect to the stock clerk position, because we concluded that she had performed the job duties for a total of more than 6 months.

Here, claimant worked as finish carpenter for 3 3/4 years prior to the time of determination. The DOT for finish carpenter (860.381-022) lists an SVP of 7, which requires a training time of "2+ years - 4 years." See OAR 436-35-300(4). Citing the DOT's explanation of the various levels of SVP, we noted in our previous order that an SVP of 7 provides a range of time within which a worker could become proficient at the particular job. See Dictionary of Occupational Titles, Vol. II, at 1009 (4th ed. 1991).

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[1] OAR 436-35-300(3)(b)(A) provides: "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 maximum period specified in the table in section 4 of this rule."

Thus, in our prior order, we reasoned that OAR 436-35-300(3)(b)(A) set out a rebuttable presumption that, because claimant had worked less than 4 years, but more than 2 years, he could rebut the inference that he had the skills needed for average performance in the specific job. Because there was no evidence that claimant was not proficient or was unable to perform the work, we concluded claimant was properly assigned an SVP value of 7.

We continue to adhere to our prior conclusion. In Johnston, the reference to the claimant meeting the requirements of OAR 436-35-300(3) was merely "dicta," with no precedential value, because the claimant had exceeded the SVP time period, whereas, in this case, claimant's work experience falls within the "training proficiency" period.

Accordingly, on reconsideration, as supplemented herein, we republish our November 8, 1995 order in its entirety. The parties' appeal rights shall begin to run from the date of this order.

IT IS SO ORDERED.

January 9, 1996 Cite as 48 Van Natta 38 (1996)

In the Matter of the Compensation of
THOMAS J. LUCAS, GARY C. NEIBERT, JUNIOR E. PEAL, and JAMES C. LOMINICKY, Claimants
WCB Case Nos. 94-00523 (LUCAS), 93-15389 (NIEBERT), 93-15388 (PEAL) & 93-15137 (LOMNICKY)
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

Claimants request review of Administrative Law Judge (ALJ) Daughtry's order that: (1) upheld the SAIF Corporation's denials of claimants' claims for toxic exposure; and (2) declined to award penalties and attorney fees for allegedly unreasonable denials. On review, the issues are compensability and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimants are millwrights who, in August and September 1993, all worked on a centrifuge containing a yellow powder. The yellow powder stained their clothing and exposed skin; eventually, a chemical known as n-methyl-p-nitroaniline (aniline) was identified as being present in the yellow powder. All claimants assert that their symptoms were caused by their exposure to aniline.

The ALJ analyzed the claims as those for occupational disease and concluded that there was insufficient proof that the aniline exposure was the major contributing cause of claimants' conditions. Claimants first argue that, because they were exposed to aniline "during a discrete period of time in August and September 1993," their claims constitute accidental injuries. Furthermore, claimants contend that, whether analyzed as accidental injuries or occupational diseases, they proved compensability.

We agree with the ALJ that the claims qualify as occupational diseases.[1] Compensable injuries refer to events while occupational diseases refer to ongoing conditions or states of the body or mind. Mathel v. Josephine County, 319 Or 235, 241-42 (1994). In this regard, an occupational disease is gradual rather than sudden in onset. Id. at 240 (quoting James v. SAIF, 290 Or 343, 348 (1981)). See also Donald Drake Co. v. Lundmark, 63 Or App 261, 266 (1983), rev den 296 Or 350 (1984) (the claimant's back trouble coincided precisely with jolting of the faulty loader; the fact that the claimant's back pain grew worse over his six-week employment did not make it "gradual in onset").

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[1] Inasmuch as we conclude these claims should be analyzed as occupational diseases, we need not address SAIF's argument that claimants are precluded from asserting compensability under an accidental injury theory.

The onset of claimants' symptoms did not correspond to a specific "event." Rather, each claimant's symptoms arose at various times during and after their work on the centrifuge and, in most cases, were described as waxing and waning. Thus, we conclude that the claims more properly relate to ongoing conditions rather than an event and that they qualify as occupational diseases. As such, claimants must show that employment conditions were the major contributing cause of their conditions. ORS 656.802(2)(a).

In asserting that they satisfied this standard, claimants rely on the opinion of their treating occupational medicine specialist, Dr. Smith. According to Dr. Smith, the exposure to aniline was "subacute," and resulted in claimants' initial symptoms. (Exs. 27, 43-39).[2] Dr. Smith relied on the findings by Dr. Binder, neuropsychologist, who examined Lomnicky and Peal; his finding that there was a strong temporal relationship between exposure and the onset of symptoms; the absence in claimants' histories of somatic focus; and his personal observations of claimants. (Ex. 43-24, 43-25). Based on these reasons, Dr. Smith concluded that the major contributing cause of claimants' initial conditions was the exposure to aniline at work.

Claimants also rely on a report by Drs. Keifer and Schumacher, occupational medicine specialists, who examined all claimants on Dr. Smith's referral. In this report, the physicians state that all were "significantly exposed" and that such exposure caused Lomnicky's and Peal's neurological deficits. (Ex. 45). In a subsequent deposition, Dr. Keifer stated that chemical exposure caused claimants' symptoms and the most compelling reason for this conclusion was the coincident onset of symptoms in a group of people with no history of a somatic or functional overlay pattern. (Ex. 46-6, 46-18).

We first note that both Dr. Smith and Dr. Keifer limited their opinions to claimants' initial symptoms; both conceded that the persistence of symptoms was only possibly related to chemical exposure and that psychosocial factors could be causing their problems. (Exs. 43-26, 43-37, 43-38, 46-33). Thus, we find that the medical evidence, at best, shows only that chemical exposure was the major contributing cause of claimants' initial need for treatment. We further find that the evidence is insufficient to prove claimants' preliminary symptoms.

First, in his deposition, Dr. Keifer expressed an understanding that claimants were exposed to multiple toxins and that aniline, by itself, was not sufficient to cause claimants' symptoms. (Ex. 46-22, 46-32). We find such evidence contrary to the proof showing that aniline was the only chemical capable of causing toxic reactions to which claimants were exposed. Thus, because Dr. Keifer did not have an accurate understanding of the exposure, we find his opinion to be unpersuasive. See Somers v. SAIF, 77 Or App 259 (1986).

We further find that Dr. Binder, who Dr. Smith relied on, provides little or no support. When Dr. Binder initially examined Lomnicky, he found that Lomnicky exhibited abnormal neuropsychological findings that were consistent with chronic toxic encephalopathy. (Ex. 24-6). Dr. Binder also found that, in the absence of other causes, it was reasonable to attribute the condition to aniline exposure. (Id. at 7). In the case of Peal, Dr. Binder found that the neuropsychological evaluation did not support the existence of somatoform behavior and diagnosed an organic mental disorder. (Ex. 34-7, 34-8 (Peal)). Dr. Binder also attributed this condition to exposure to aniline. (Id. at 8).

Dr. Binder again examined both claimants in January 1995. He found Lomnicky's neuropsychological performance generally unchanged and showing a mild impairment. (Ex. 47-4, 47-5). Significantly, Dr. Binder found that the results were not diagnostic of neurotoxic exposure, instead characterizing the deficits as "nonspecific." (Id. at 5). Dr. Binder found that Peal showed a slight improvement, although he continued to exhibit abnormalities. (Ex. 50-4 (Peal)). Dr. Binder neither rejected nor attributed the condition to aniline exposure. (Id.). Although Dr. Binder did not expressly retreat from his initial opinions concerning Lomnicky and Peal, we find that his subsequent reports, at a minimum, cast doubt on his earlier opinions that both claimants had mental disorders from toxic exposure.

Examining physician Dr. Burton, medical director of the Oregon Poison Center at the Oregon Health Sciences University who saw all four claimants, explained that aniline caused neurotoxic effects

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[2] The record contains four separate exhibit groups (one for each claimant). For ease of reference, all citations are to the exhibits for James C. Lomnicky, unless otherwise indicated.

only when exposure was sufficiently great to cause a condition called methememoglobinemia, which results when hemoglobin cannot carry oxygen to the body. (Exs. 21-8, 31-3). This condition is preceded by cyanosis, characterized by bluish-brown coloring around the lips and skin. (Ex. 21-8). Other symptoms, including euphoria, headache, breathlessness and confusion, do not occur until profound methememoglobinemia, when oxidization of hemoglobin is at fifty percent. (Id.)

According to Dr. Burton, because none of the claimants had methememoglobinemia, any exposure to aniline did not produce their symptoms. (Id.) Instead, Dr. Burton found that the symptoms were of a psychological nature and resulted from claimants' belief they were exposed to a neurotoxin. (Exs. 31-8, 38-3, 46-19 (Peal), 20-6 (Neibert), 12-8 (Lucas)). In Lomnicky's case, Dr. Burton found some of his symptoms were due to Benign Paroxysmal Positional Vertigo (BPPV) and that the cause of the condition was not associated with chemical exposure. (Ex. 21-8). Dr. Epley, an otologist who treated Lomnicky's BPPV, Dr. Daniel, occupational medicine specialist who examined Lomnicky on Dr. Smith's referral, and Dr. McMenomey, examining otolaryngologist, agreed that chemical exposure did not cause BPPV. (Exs.. 20-1, 26-2, 29-2, 33-2).

Dr. Parvaresh, examining psychiatrist, saw Lomnicky and Peal. Dr. Parvaresh reported that, in the absence of an organic cause, anxiety was the cause of Lomnicky's cognitive dysfunction, and that Peal had a preexisting psychological disorder. (Exs. 36-7, 36-8, 34A-6 (Peal)). Finally, examining neuropsychologist Dr. Friedman agreed with Dr. Burton that Peal's symptoms were in reaction to a belief of toxic exposure and diagnosed psychological factors affecting physical condition. (Exs. 42-8, 48-25, 48-28 (Peal)).

After reviewing the medical evidence, we find it insufficient to prove that exposure to aniline caused claimants' symptoms. Dr. Burton specializes in evaluating toxic exposure and offered persuasive reasoning explaining why any aniline exposure was not great enough to be neurotoxic. Dr. Smith, on the other hand, had no prior experience with persons exposed to aniline and could provide no support, such as studies or other expert opinion, for his "subacute exposure" theory. For the most part, Dr. Smith appears to have based his opinion on his belief that the onset of claimants' symptoms coincided with exposure to aniline. Factually, we find evidence of any temporal relationship to be tenuous. Although the onset of symptoms varied for each person, it was not immediate with work on the centrifuge; according to Dr. Burton, neurotoxic exposure to aniline would produce immediate symptoms. Furthermore, in at least one case, symptoms were not reported until after work on the centrifuge had stopped and there had been notification of chemical exposure. Thus, for these reasons, we find the evidence, at best, is in equipoise and not sufficient to carry claimants' burden of proof. ORS 656.802(2)(a).

Finally, claimants assert that they proved compensable psychological conditions. In making this argument, it is unclear whether claimants rely on ORS 656.005(7)(a)(A) or 656.802(3). We find no basis for finding any psychological claim compensable as a consequential condition under ORS 656.005(7)(a)(A) in view of our previous finding that there is no compensable injury.

In order to prevail under ORS 656.802(3), there must be satisfaction of numerous elements, including a diagnosis of a mental or emotional disorder and proof that the employment conditions were the major contributing cause of the disorder. In the absence of any diagnosed mental or emotional disorder for Neibert and Lucas, their claims for psychological conditions fail.

In asserting that they proved causation, claimants contend that inaccurate information from the employer and inadequate medical care from SAIF caused their psychological conditions. We disagree. Even assuming that Lomnicky and Peal have diagnosed mental disorders as a result of their perception of having been exposed, according to Dr. Burton, such a belief was due to the employer's actions (specifically, the safety officer), claimants' underlying personalities, and their exchange of information with each other. (Ex. 46-19, 46-20) (Peal)). Dr. Parvaresh also found that Peal had a preexisting psychological disorder. (Ex. 34A-6) (Peal)). Thus, based on evidence that Lomnicky's and Peal's underlying psychological makeups were factors in causing their psychological conditions, we find insufficient proof that employment conditions were the major contributing cause of any mental disorders. Thus, we also agree with the ALJ that claimants did not prove compensable psychological conditions.

In the absence of any compensable claims, there is no basis for awarding a penalty and related attorney fee. ORS 656.262(11)(a).

ORDER

The ALJ's order dated March 30, 1995 is affirmed.

Board Member Gunn dissenting.

I disagree with the majority's decision that claimants did not prove compensability. This case is pretty simple. Claimants are hard-working employees, none of whom have any history of somatic or functional symptoms. They were exposed to a toxic chemical; it is undisputed that aniline was found in the yellow powder that covered their hands and clothes at work. There also is no question that aniline causes toxic reactions. Claimants then developed symptoms after their exposure to aniline.

These facts alone prove to me that claimants are sick because they were exposed at work to a toxic chemical. Furthermore, there is plenty of medical evidence supporting this conclusion. Dr. Smith extensively treated claimants and had accurate information about the exposure. He strongly believes that aniline was the major contributing cause of claimants' need for treatment. His opinion is shared by Drs. Keifer and Schumacher, who also examined claimants. Dr. Binder also agreed aniline harmed Lomnicky and Peal.

The majority's reasoning for discounting these opinions is not persuasive. If aniline did not make claimants sick, then what did? The majority's suggestion that claimants' symptoms are all "in their heads" simply is not convincing in the absence of any prior history of somatic reactions. Plenty of physicians in this case concluded that claimants were toxically exposed and, as a result, developed symptoms. We should be able to come to the same conclusion. Specifically, I would hold that claimants proved compensable injury claims and that any psychological symptoms are compensable as consequential conditions.

January 10, 1996 Cite as 48 Van Natta 41 (1996)

In the Matter of the Compensation of
GAIL A. ALBRO, Claimant
WCB Case No. 93-14886
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) T. Lavere Johnson's order that set aside its denial of claimant's injury claim for a neck, right shoulder and right arm condition. In her respondent's brief, claimant requests the assessment of a penalty for the employer's allegedly unreasonable denial. On review, the issues are compensability and penalties.

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

The ALJ concluded that claimant has carried her burden of proving the compensability of her injury claim for a neck, right shoulder and right arm condition. The ALJ reasoned that claimant was a credible witness and has proven legal and medical causation in relating her condition to an injury which allegedly occurred at work on July 18, 1993. On review, the employer challenges the ALJ's credibility finding and contends that legal and medical causation has not been proven. We disagree.

We begin with a brief summary of the undisputed facts. Claimant has worked as a registered nurse for the employer since 1984. On July 18, 1993, she was assisting Dr. Law, an emergency room doctor, and Ms. Szalewski, an emergency medical technician (EMT), with suturing of a patient's scalp laceration. The patient was intoxicated, agitated and combative. Claimant had to physically restrain the patient from getting up from the gurney. After the laceration was repaired, claimant administered a tetanus shot to the patient, and the patient was discharged.

From July 19 through July 27, 1993, claimant continued to perform her regular nursing duties. She went on vacation, driving to and from Montana, from August 1 through August 7, 1993.

On August 8, 1993, claimant returned to work and told Dr. Faber that, on July 18, 1993, she was struck in the jaw and chest by a drunken patient at work and that she subsequently developed pain in the neck, right shoulder and right arm which worsened over time. X-rays taken on August 9, 1993 showed cervical disc space narrowing. Claimant was released from work and filed a claim for her condition. The employer first received notice of the injury claim on August 9, 1993.

Claimant was referred to neurosurgeon, Dr. Gallo. An MRI scan revealed a small-to-moderate sized, central disc herniation at C5-6. Claimant initially treated conservatively for her symptoms, which had progressed to include right arm weakness and numbness and tingling in the right hand. When conservative treatment failed to yield improvement, Dr. Gallo performed a cervical discectomy and fusion of C5-6 on September 13, 1993. Claimant's condition improved following surgery, though she continued to have minimal pain and weakness in her right upper extremity.

Following an employer-arranged medical examination by orthopedic surgeon Dr. Woolpert, the employer issued a denial letter on December 15, 1993, which denied that claimant's condition arose out of and in the course and scope of her employment. Claimant requested a hearing, and the ALJ set aside the denial.

The central issue in this case is claimant's credibility. The ALJ found claimant to be a credible witness based on her demeanor. We generally defer to the ALJ's demeanor-based credibility finding. See International Paper Co. v. McElroy, 101 Or App 61 (1990). However, we are in as good a position as the ALJ to evaluate the credibility of a witness based on an objective review of the substance of testimony and other inconsistencies in the record. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Timothy D. McCune, 47 Van Natta 438 (1995). Such inconsistencies can be a sufficient basis to disagree with the ALJ's credibility finding if they raise such doubt that we are unable to conclude that material testimony is credible. David A. Peper, 46 Van Natta 1656 (1994); Angelo L. Radich, 45 Van Natta 45 (1993).

The employer raises a number of inconsistencies in the record which allegedly impeach claimant's credibility. Based on our review of those inconsistencies, we agree with the ALJ's conclusion that claimant's credibility has not been impeached.

The employer argues that claimant's testimony of the alleged incident on July 18, 1993 was contradicted by the testimonies of Dr. Law and EMT Szalewski who were present in the emergency room at the time. We disagree. Claimant testified that the patient first struck her in the jaw while she was restraining him in a prone position and later struck her in the chest while she was administering a tetanus shot. (I Tr. 19-21).[1] Dr. Law testified that he recalled claimant being struck once in the chest by the patient. (I Tr. 98-99). He added, however, that he was focused on treating the patient and that the contact between the patient and claimant "didn't make a really strong impression." (I Tr. 97-98). Therefore, although Dr. Law did not see the patient strike claimant in the jaw, given the fact that he was focused on treating the scalp laceration, we are not persuaded that his testimony contradicted claimant's testimony.

EMT Szalewski also recalled seeing the patient strike claimant in the chest. (II Tr. 21). Although she testified that claimant was struck in the chest while the patient was in the prone position (II Tr. 21), whereas claimant testified she was struck in the jaw at that time, Szalewski cautioned that her memory was not positive. (II Tr. 24). Szalewski did not specifically recall seeing the patient strike claimant as she administered the tetanus shot, but Szalewski recalled looking away at one point during the shot when, out of the corner of her eye, she saw claimant react in a backward movement and the patient's arm coming back to his side. (II Tr. 23-24). This latter testimony, in our view, tends to corroborate claimant's testimony of being struck the second time.

The employer also contends that claimant's testimony that she had a bruise on her jaw following the incident was not supported by either Dr. Law or EMT Szalewski. Although Dr. Law did not recall any bruise or marks on claimant, he indicated that he did not examine claimant for marks and that he

[1] The designation "I Tr." will be used to refer to the transcript of the first day of hearing, on March 3, 1994; "II Tr." will refer to the transcript of the second day of hearing on March 4, 1995.

would have relied on claimant to bring any symptoms to his attention. (I Tr. 99-100). Szalewski was not asked about any observable bruise or marks on claimant. Co-workers Powell-Newton and Kasow testified they did not notice any bruise, (I Tr. 150, II Tr. 4), but we are not persuaded that either co-worker was looking for marks of any kind.[2] Accordingly, the fact that they did not notice a bruise does not contradict claimant's testimony that such a bruise existed.

The employer notes that claimant denied any bruising in an earlier recorded statement she gave to the employer's claims processing agent. However, our reading of the statement shows that claimant reported bruising on her chest, though she did not recall any in the jaw area. (Ex. 32-28). Although there is some inconsistency between claimant's statement and her testimony, given claimant's consistency in reporting that bruising occurred, we find the inconsistency (as to the location of the bruise) to be minor and insufficient to undercut her credibility.

Next, the employer argues that claimant's report to Dr. Gallo of the immediate onset of symptoms following the July 18 incident is inconsistent with her testimony that symptoms began on the following day. (Compare Ex. 7-1 and I Tr. 23-25). Dr. Gallo's August 13, 1993 report does, in fact, reflect claimant's history of an "immediate" onset of symptoms. (Ex. 7-1). In her deposition, however, Dr. Gallo expressly relied on claimant's history of having the onset of right upper extremity pain "within 24 hours" of the blow to her neck. (Ex. 32-8). Hence, it apparently was of minor significance to Dr. Gallo whether the onset of symptoms was "immediate" or "within 24 hours." Therefore, we are not persuaded that the inconsistency was of sufficient importance to undercut claimant's credibility.

The employer also contends that claimant's behavior after July 18, 1993 is not consistent with her allegation of an injury on that date. The employer notes that claimant delayed reporting her alleged injury to the employer for three weeks, despite the hospital policy of immediately reporting traumatic incidents. Like the ALJ, we are persuaded by claimant's reasonable explanation for the delay. She explained that she expected her condition to improve with the passage of time and during her vacation, and that she sought treatment and filed the claim only after her condition appeared to worsen, rather than improve. (Ex. 32, pp. 29-32).

The employer introduced testimony from Ms. Wagner, a co-worker, who recalled that claimant practiced guitar once a week for two to three hours at a time, between July 18, 1993 and August 1, 1993. (I Tr. 180-81). Ms. Wagner also recalled that, upon claimant's return from vacation on August 7, 1993, claimant performed on guitar at a farewell party for one of the doctors. (I Tr. 179-80). Ms. Wagner recalled no complaints from claimant and did not see any pain behavior during the practices and performance. (I Tr. 181-82). The employer asserts that Wagner's testimony contradicts claimant's testimony that she was in pain during her performance at the farewell party. (I Tr. 37). We disagree. Claimant testified that her pain worsened over time, especially upon her return from vacation. She did not testify that she was incapacitated prior to going on vacation. Moreover, the mere fact that claimant neither complained of pain nor exhibited pain behavior during the "post-vacation" performance does not necessarily contradict her testimony that she was in pain. We recognize that some individuals are stoic in demeanor and would not necessarily make their pain obvious to their co-workers, particularly during a party at work. By claimant's own admission, she is one of those types of individuals. (I Tr. 30).

The employer notes that claimant personally drove her daughter and herself to and from Montana during her vacation in August 1993, despite her testimony that she was in pain at that time. Claimant testified that, in retrospect, it was not wise for her to do the driving because it made her symptoms worse. (I Tr. 34). However, at the time, she did not expect the driving to make her symptoms worse. (I Tr. 86). She explained that she did not have her daughter drive because her daughter had to hold the cat during the drive. (I Tr. 34-35). The employer points out that claimant could have stopped and obtained a cat carrier, instead of driving, if she had been in pain. However, claimant testified that there was no room in the car for another box, and in any event, she did not anticipate the driving would make her symptoms worse. (I Tr. 86).

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[2] In other respects, Powell-Newton and Kasow gave testimonies which tended to support claimant's injury claim. Both recalled claimant complaining about a combative patient she tended to on July 18, 1993. Kasow saw claimant on July 18, 1993, soon after she treated the patient. Claimant told Kasow that a patient "took a swing" and that "there was some kind of incident." (II Tr. 4). Powell-Newton saw claimant the next day (July 19, 1993) and recalled claimant saying that she was struck a couple of times by a drunk patient. (I Tr. 148). Powell-Newton also recalled that claimant complained of pain in the neck, shoulder and arm on July 19, 1993 and thereafter. (I Tr. 149).

Next, the employer points to claimant's failure to note on the patient's medical record that he had actually hit her during his treatment. On the patient's July 18, 1993 chart note, claimant wrote that the patient was abusive and "swings at staff." (Ex. 30). We do not find that notation to be inconsistent with claimant's testimony that the patient had actually struck her. Claimant explained that she did not feel comfortable documenting in the patient's medical record that she was struck by the patient. (I Tr. 68). We find her explanation to be reasonable.

Finally, the employer argues that claimant's medical history was inconsistent. Although Dr. Gallo's initial report reflects a history of immediate onset of symptoms following the July 18, 1993 incident, (Ex. 7-1), in her deposition, Dr. Gallo relied on history that the onset of symptoms was within 24 hours of the incident. (Ex. 22A, pp. 7-8). As we stated above, we find this inconsistency to be of minor significance.

There is a discrepancy between claimant's testimony and the medical records concerning neck problems she experienced following a September 1986 motor vehicle accident. Claimant recalled that her primary problem was pain in the mid-back region, though she had neck spasms as well, and that she treated with a chiropractor for a month or two. (I Tr. 43-44). However, the medical record shows that she treated for mid-back and neck symptoms through April 1988. (Ex. 28-4). It is apparent from claimant's testimony that she did not have a clear recollection of the 1986 accident and its aftermath. (See I Tr. 52-54). Claimant's lack of clear recollection is reasonable, given the passage of time since the accident. In any event, claimant clearly testified that she had no neck symptoms, chronic or otherwise, just prior to the 1993 work incident.

For the foregoing reasons, we find that claimant's credibility was not impeached by the employer. Accordingly, we conclude that claimant's testimony and Dr. Gallo's medical opinion, (Exs. 7, 22A-8), establish legal and medical causation supporting her claim, under either the material or major contributing cause standard. In this regard, we find that, contrary to the employer's contention, Dr. Gallo was aware of claimant's 1986 accident and the involvement of her neck in treatment following the accident. (Ex. 22A-11, Depo Ex. 2). Hence, we agree with the ALJ's conclusion that Dr. Gallo had a complete history and well-reasoned opinion. See Somers v. SAIF, 77 Or App 259, 263 (1983).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 10, 1994 is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $1,000, payable by the self-insured employer.

January 10, 1996 Cite as 48 Van Natta 44 (1996)

In the Matter of the Compensation of
KAREN K. DEATON, Claimant
WCB Case Nos. 94-04671, 91-18480 & 94-04050
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Frohnmayer, et al, Attorneys
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that declined to award her an attorney fee under ORS 656.382(2). On review, the issue is attorney fees.

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

A hearing was convened in this matter in January 1993 and January 1994, at which time the parties presented evidence. The hearing was eventually continued until December 14, 1994, at which time the parties stipulated to the dismissal of the NCE's hearing requests in this case.[1] Additionally, they stipulated that the noncomplying employer (NCE) would accept responsibility for claimant's accepted disabling right knee strain. Pursuant to the stipulation, the ALJ dismissed the NCE's hearing requests and affirmed a Department NCE order and SAIF's acceptance of claimant's injury claim on behalf of the NCE. Citing Donna I. Spencer, 47 Van Natta 117 (1995), the ALJ declined to award claimant an attorney fee pursuant to ORS 656.382(2).[2] Claimant asserts that Spencer is distinguishable, because there, the ALJ made no decision on the merits and no hearing was held. We disagree.

ORS 656.382(2) authorizes an attorney fee award if a carrier requests a hearing and an ALJ subsequently "finds that compensation to a claimant should not be disallowed or reduced." The ALJ must find, or decide, on the merits that the claimant's award of compensation should not be disallowed or reduced. Strazi v. SAIF, 109 Or App 105, 108 (1991); see SAIF v. Curry, 297 Or 504, 510 (1984) (ORS 656.382(2) authorizes attorney fee award when court actually allows employer's petition for review and decides that awarded compensation should not be disallowed or reduced).

Claimant asserts that, by virtue of the parties' stipulations, there was a decision on the merits and, therefore, that the ALJ erred by not awarding an attorney fee under ORS 656.382(2). As support for that assertion, claimant refers us to International Paper Co. v. Pearson, 106 Or App 121 (1991), and Eileen A. Edge, 45 Van Natta 2051 (1993), for the proposition that issues resolved by stipulation are considered to be actually litigated and determined by a valid final judgment.

Pearson and Edge are inapposite; they are issue preclusion cases. That a stipulation may preclude further litigation on a particular issue does not address whether the issue was decided "on the merits" for purposes of ORS 656.382(2).

Here, the stipulation does not address the merits of this case; it merely reflects the parties' agreement that the NCE would withdraw its hearing requests. That agreement effectively prevented the ALJ from finding "on the merits" that claimant's award of compensation should not be disallowed or reduced. See Wilfred E. Oddson, 47 Van Natta 1050 (1995) (employer's withdrawal of medically stationary issue at the beginning of the hearing forestalled ALJ from making a finding on the merits that the claimant's award of compensation was not disallowed or reduced and was without authority to award attorney fees under ORS 656.382(2)); see also SAIF v. Curry, supra, 297 Or at 510 (ORS 656.382(2) authorizes attorney fee award when court actually allows an employer's petition for review). The parties' stipulation that the NCE would accept responsibility for claimant's accepted disabling right knee strain does not alter this conclusion, because that stipulation merely states affirmatively the effect of the NCE's withdrawal of its hearing requests. For these additional reasons, we agree with the ALJ's decision not to award claimant an attorney fee under ORS 656.382(2).

Claimant asserts that she is entitled to an attorney fee under ORS 656.382(2), because the NCE withdrew its hearing requests after the hearing was convened. We need not address that issue, because we have already concluded that no basis exists for an attorney fee award under that statute. See Wise v. Gary-Adams-Trucking, 106 Or App 654, 656 (1991) (court did not address whether ORS 656.382(2) authorizes attorney fee award in NCE case because, lacking decision on merits, there was no predicate for a fee award).

In sum, for the reasons stated in the ALJ's order, as supplemented here, we agree that claimant is not entitled to an attorney fee under ORS 656.382(2).

ORDER

The ALJ's order dated March 10, 1995 is affirmed.

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[1] The parties also stipulated to the dismissal of WCB #94-04671, which pertains to two other potential employers.

[2] The Legislature recently amended ORS 656.382(2) to refer to Administrative Law Judges instead of referees. Or Laws 1995, ch 332, § 42b.

In the Matter of the Compensation of
ROBERT E. DIXON, Claimant
WCB Case No. 95-00247
ORDER ON REVIEW
Myrick, Seagraves, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board en banc.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order which found that claimant was entitled to temporary disability benefits. On review, the issue is procedural entitlement to temporary total disability benefits. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the "Findings of Ultimate Fact," and briefly summarize the pertinent facts as follows:

Claimant, a truck driver, suffered a compensable traumatic closed head injury when his truck was struck by a train. After several months, claimant was released for light duty "handyman" work with supervision, although he was still experiencing bouts of vertigo. On the work release form approving the modified job, claimant's attending physician, Dr. Maukonen, indicated that claimant "needed transportation to and from work" and that he was "not released to drive." (Ex. 21-3). In a follow-up letter, Dr. Maukonen reported: "The patient's current restrictions are those of no driving, and no working with moving machinery or at heights." (Ex. 24).

The employer offered claimant the attending physician-approved light duty "handyman" position at its main office in Glendale, Oregon, some 35 miles from claimant's home in the Grants Pass area. The employer subsequently indicated that co-workers could provide partial transportation to the job site, if claimant could arrange his own transportation to designated pick-up location. Claimant did not accept the job offer and did not report to the work site. The insurer then terminated payment of claimant's temporary disability benefits.

CONCLUSIONS OF LAW AND OPINION

The ALJ framed the issue as whether or not the position offered to claimant complied with the terms of his release to modified work. Reasoning that the restriction on driving was a work-related restriction, the ALJ found that the employer's failure to completely accommodate claimant's inability to drive rendered the job offer outside of claimant's work restrictions. The ALJ further found that because the employer's offer of modified employment was insufficient, the insurer could not terminate claimant's temporary disability benefits under former ORS 656.268(3)[1]. We disagree.

If the attending physician documents that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment, the carrier may terminate the worker's temporary total disability benefits. ORS 656.268(3)(c). The parameters necessary for compliance with the statute are set out in OAR 436-60-030. This rule provides, in part, that a carrier may cease paying temporary total disability benefits when it has confirmed the offer of employment in writing, including an accurate description of the job requirement, and the attending physician has found the job to be within the worker's capabilities.

In this case, the attending physician documented on several occasions that claimant was released for light duty work with supervision. Dr. Maukonen specifically noted that he had reviewed the handyman job description provided by the employer and that claimant was capable of performing the job described. (Ex. 21-2). The handyman position was offered in writing to claimant (Exs. 25A, 25AA) and was declined. (Ex. 25B). Under these circumstances, we conclude that the insurer properly terminated temporary total disability benefits in compliance with the statute and rules.

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[1] Subsequent to the ALJ's order, ORS 656.268(3) was amended by Senate Bill 369, Or Laws 1995, ch 332 § 30 (SB 369, § 30). To the extent applicable, the amendments to this section are not pertinent to the outcome in this case. We find that the result in this case would be the same under either version of the statute.

Unlike the ALJ, we do not construe Dr. Maukonen's notation that claimant "needs transportation to and from work" as a condition of his work release. Claimant was restricted from driving or operating moving machinery. The employer's offer of modified employment did not require that he perform these tasks,[2] and therefore came within claimant's restricted capabilities.

We have consistently held that a carrier may properly terminate temporary total disability benefits under ORS 656.268(3) even when the worker refuses the employer's offer of physician approved modified work on the basis of an inability to arrange transportation to the work location. See Antonio Garcia, 46 Van Natta 862 (1994) (carrier's termination of temporary disability benefits proper where the claimant did not return to the modified job because he had no practical means of transportation); Diana M. Cooper, 45 Van Natta 1211 (1993) (same). Indeed, we held in Rhonda P. Stockwell, 46 Van Natta 446 (1994) that the employer properly terminated temporary total disability benefits even though the modified job offer was geographically inconvenient to the claimant and the claimant was under a physician's restriction against driving or riding for more than 30 minutes. We see no meaningful distinction between Stockwell and the circumstances in this case.

Here, as in Stockwell, it was inconvenient for claimant to secure transportation to the job site to perform the proposed modified job.[3] Nevertheless, the indisputable fact remains that claimant was offered a job, approved by his physician as within his capabilities and he declined to begin the employment. Although claimant's misgivings about the job's location and proposed duties are understandable, such concerns do not eliminate the insurer's authorization to unilaterally terminate claimant's temporary disability benefits under ORS 656.268(3)(c). Despite the physician's notation that claimant needs transportation to and from the job site, we cannot conclude that the employer is responsible for providing this transportation just because claimant was injured on the job. The need for transportation is not a job-related restriction because it does not pertain to matters directly affecting claimant's performance of the modified job while on the work site. Because this limitation is not job-related, it is irrelevant to our examination of whether the employer has satisfied the statutory prerequisites for termination of benefits.

In conclusion, because we find that the insurer properly terminated claimant's temporary disability benefits in compliance with ORS 656.268(3) and the applicable rules, we reverse the ALJ's order.

ORDER

The ALJ's order dated April 4, 1995 is reversed.

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[2] The job description listed the specific task requirements as light cleaning duties, phone answering and some paperwork. (Ex. 21-3).

[3] The employer's shop in Glendale is approximately 35 miles from claimant's home south of Grants Pass. (Tr. at 15). However, in re-issuing the job offer to claimant on September 9, 1994, the employer made arrangements with two of its employees to provide claimant transportation to and from the Glendale shop from a meeting place in North Grants Pass or Merlin, approximately 10 miles from claimant's home. (Ex. 25C, Tr. at 16). Therefore, unlike Stockwell (where the claimant moved to Medford after her injury and was offered modified employment in Portland), the modified employment offer in this case was not truly geographically inconvenient. Indeed, since the employer's second offer provided transportation to Glendale from a local meeting place, claimant was not necessarily being required to travel on his own any farther than he had been required to travel to work prior to his injury (i.e., to the Grants Pass truck dispatch site).

Board Member Gunn and Board Chair Hall dissenting.

Because we agree with the ALJ that the employer's failure to completely accommodate claimant's inability to drive rendered the job offer outside of claimant's work restrictions, we dissent.

Under the specific circumstances of this case, we would find that the employer's offer of modified employment did not strictly comply with the release terms approved by Dr. Maukonen. Claimant had been working as a semi-truck driver. His on-the-job injury left him unable to drive or operate moving machinery, but capable of light duty work with supervision. Agreeing that claimant

could perform the light duty job described by the employer, and knowing that the employer's offer of work as shop handyman was at a geographically inconvenient location (different from that of claimant's regular employment at injury), Dr. Maukonen specifically indicated that claimant was restricted from driving and needed transportation to and from the job site as a term of the release for modified work.

The law requires strict compliance with the provisions of ORS 656.268(3) and the applicable administrative rules as a prerequisite to terminating a worker's temporary total disability benefits. E.g., Fairlawn Care Center v. Douglas, 108 Or App 698 (1991); Marie E. Kendall, 46 Van Natta 2520 (1994) on recon, 47 Van Natta 335 (1995). Because we construe claimant's inability to drive and need for transportation as a component of Dr. Maukonen's work release and the employer's offer did not accommodate this particular restriction, we would conclude in this case that the insurer could not properly terminate claimant's temporary total disability benefits.

We would further find that this case is distinguishable from Rhonda P. Stockwell, 46 Van Natta 446 (1994). There, the Board held that the employer properly terminated temporary total disability benefits where the claimant, who moved with her husband to Medford after her injury, would not accept a modified job in the Portland area. Although the claimant's physician restricted claimant from riding or driving more than 30 minutes, claimant's failure to accept the modified job was based on the fact it was geographically inconvenient as she had chosen to move to Medford. Moreover, in Stockwell, the parties stipulated that the employer's job offer complied in all respects with the applicable administrative rule, which is not the case here.

In short, because we would find that the insurer failed to strictly comply with ORS 656.268(3) and the applicable rules, we would affirm the ALJ's order.

January 10, 1996 Cite as 48 Van Natta 48 (1996)

In the Matter of the Compensation of
DARREL H. FISH, Claimant
Own Motion No. 95-0437M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

On September 22, 1995, the Hearings Division of the Workers' Compensation Board received claimant's September 19, 1995 letter (copy enclosed to the SAIF Corporation). On September 26, 1995, claimant's letter was forwarded to the Own Motion Section, where claimant's request was treated as a new request for reopening under ORS 656.278.

On September 6, 1995, we issued our Own Motion Order, in which we declined to reopen claimant's 1986 industrial injury claim for the payment of temporary disability compensation because he failed to establish that his compensable condition required surgery or hospitalization now or in the near future. In addition, we noted that SAIF opposed reopening of the claim on the grounds that: (1) claimant's current condition is not causally related to the accepted condition; (2) SAIF is not responsible for claimant's current condition; (3) surgery or hospitalization is not reasonable and necessary for the compensable injury; and (4) claimant was not in the work force at the time of current disability.

Pursuant to OAR 438-012-0065(2), claimant had 30 days from the date of our September 6, 1995 order to request that the Board reconsider its decision. In extraordinary circumstances we may, on our own motion, reconsider a prior order notwithstanding the 30-day filing deadlines prescribed in that rule. Here, we initially treated claimant's September 19, 1995 letter as a new request for own motion reopening under ORS 656.278. However, after further consideration, we conclude that claimant's September 19, 1995 letter actually constitutes a request for reconsideration of our September 6, 1995 Own Motion Order. Under the particular circumstances of this case, we conclude that an exception to the 30-day deadline is appropriate. We withdraw our prior order and proceed with our reconsideration.

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

Here, neither SAIF nor the Board has received any medical information or a request from a physician for treatment of any kind. SAIF contends that claimant's current medical status is "unknown." Therefore, the record fails to demonstrate that claimant requires surgery or hospitalization for treatment now or in the near future. As a result, we continue to find that claimant's compensable condition has not worsened requiring surgery or hospitalization, and therefore, no temporary disability compensation is due.

Because of the foregoing conclusion, any further argument or request for authorization of temporary disability compensation, is unnecessary.[1]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 6, 1995 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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[1] In his September 19, 1995 letter, claimant contends that, "[s]ince Measure 17 passed, it is now the law that all inmates must work, and . . . inmates are paid for doing this work." (See item number (5) in claimant's September 19, 1995 letter). Thus, claimant contends that he is entitled to temporary disability compensation because he was in the work force when his current condition worsened. Further, claimant contends that his current condition is related to his compensable 1986 back strain injury. (See item number (6) in claimant's September 19, 1995 letter). Under ORS 656.245, claimant is entitled to medical services for the compensable condition for life. However, SAIF contends that claimant's current condition is not related to his compensable injury, and thus, will not pay for medical services unrelated to the accepted condition. With respect to claimant's request for own motion relief, he has failed the test prescribed by ORS 656.278 (surgery or hospitalization is required to qualify for own motion relief), and thus, his other arguments do not have any effect on the Board with respect to the authorization of temporary disability compensation under that statute.

In the Matter of the Compensation of
BILL D. GONYER, Claimant
WCB Case No. 95-01432
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Gunn and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Neal's order that set aside its denial of claimant's low back strain injury claim. The insurer also asserts that the ALJ erred in allowing claimant to testify by telephone. On review, the issues are evidence and compensability.

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

The insurer contends that the ALJ erred in allowing claimant to testify by telephone because there was no showing of extraordinary circumstances as required by OAR 438-07-022. We disagree.

Under OAR 438-07-022, lay witnesses must testify by personal appearance unless unable to attend the hearing due to extraordinary circumstances beyond the offering party's control and either: (1) all parties and the ALJ agree; or (2) the ALJ finds that the witness's testimony should be taken by other than personal appearance. Under the rule, a determination must first be made as to whether a witness is unable to attend the hearing due to extraordinary circumstances beyond the control of the party offering the testimony. See Mike Rice, 42 Van Natta 2442 (1990).

Here, claimant's counsel provided an unrebutted affidavit which establishes that claimant was unable to attend the hearing for medical reasons.[1] Specifically, the affidavit indicates that Dr. Hogan, who was treating claimant in Maine, opined that claimant could not physically attend the hearing as he was "disabled and can barely stand."[2] This unrebutted assertion is supported by claimant's telephone testimony. (Tr. 20-22). Under these particular circumstances, claimant has established extraordinary circumstances for his inability to personally attend the hearing. Consequently, the ALJ did not err in allowing claimant to testify by telephone.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated May 8, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

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[1] The insurer argues that the affidavit is not sufficient as it is based on hearsay. However, the ALJ is not bound by technical or formal rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7). Moreover, the declarant, claimant's counsel, was present at the hearing, and conceivably could have been called as a witness had the insurer so requested.

[2] The insurer also asserts that "substantial justice" was not achieved because the ALJ did not allow it to cross-examine Dr. Hogan. However, the insurer did not seek permission to cross-examine Dr. Hogan. Inasmuch as the insurer did not request cross-examination of Dr. Hogan, we are not inclined to address this issue on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

In the Matter of the Compensation of
GREGORY H. HOHIMER, Claimant
WCB Case Nos. 93-02554, 91-07552 & 90-20037
ORDER ON REVIEW
Svoboda & Associates, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys
H. Thomas Anderson (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order which: (1) upheld the SAIF Corporation's denials of an occupational disease claim for post-traumatic stress disorder (PTSD); (2) upheld Liberty Northwest Insurance Corporation's denial of the same condition; and (3) upheld the EBI Companies' denial for the same condition. On review, the issues are res judicata, compensability, and if the condition is compensable, responsibility.

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

First, we briefly summarize the relevant facts. Claimant, who was employed as an emergency medical technician and firefighter, sustained an acute low back injury while moving a patient on January 15, 1986. SAIF accepted the claim as an acute lumbar strain. The claim was closed in January 1987.

In February 1987, claimant experienced an exacerbation of his low back symptoms. In March 1987, claimant sought treatment from a psychologist, Dr. Stipek, who diagnosed severe depression with psychotic features and suicidal ideation. Claimant was taken off work. In September 1987, SAIF accepted an aggravation of the January 1986 injury.

On June 19, 1990, claimant was declared medically stationary with respect to his mental condition, with no impairment as a result of that condition. A Determination Order issued July 16, 1990 regarding the aggravation of the January 1986 injury which awarded claimant permanent disability for his low back condition. In rating the extent of his permanent disability, the Evaluation Section considered claimant's psychological condition.

In 1991, claimant again sought treatment for stress symptoms, and his physician sought reopening of the claim for a recurrent psychological condition. In February 1991, SAIF issued a disclaimer and claim denial for a separate occupational disease involving stress, separate from the accepted low back injury of January 1986. Subsequently, SAIF amended its denial indicating its position that claimant's psychological condition had been processed as a component of the January 1986 low back injury claim. In October 1992, SAIF denied a compensable relationship between claimant's current psychological condition and the accepted 1986 claim.

Claimant last treated with Dr. Stipek in July 1992, when he was working as a truck driver. No recurrence of PTSD symptoms was noted at that time.

Claimant requested a hearing to litigate the compensability of his PTSD condition as a separate occupational disease. SAIF had been processing the psychological condition as part of the 1986 low back injury claim.

A party may not relitigate any issue resolved by a stipulation, since a party is bound to the terms of the agreement. E.g., Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993). Furthermore, when the agreement purports to resolve all issues which were raised or could been have raised, the settlement bars a subsequent claim for a condition that could have been raised before the date of the agreement. Good Samaritan Hospital v. Stoddard, 126 Or App 69, 73 (1994). In Stoddard, the court relied on the Board's findings that the disputed condition was related to the work injury, and that it had been diagnosed, and medical treatment had been requested prior to the settlement to conclude that the condition was an issue that could have been raised before the date of the agreement.

Here, claimant entered into a stipulation in December 1987 concerning his accepted 1986 claim with SAIF whereby he agreed to "resolve all issues raised or raisable" at that time. (Ex. 72). By the terms of the agreement, one medical billing was to remain denied, while "medical billings relating to claimant's compensable psychological condition . . . shall be paid by SAIF Corporation." (Id.) (emphasis added).

At the time of the agreement, claimant was undergoing treatment by psychologist Dr. Stipek, Ph.D., for his psychological condition. Dr. Stipek testified that in December 1987, claimant was suffering from PTSD. (Tr. 14 on 3rd day). In fact, Dr. Stipek testified that claimant suffered from the symptoms of PTSD when he first began treating him in March 1987. (Tr. 19-20 on 3rd day). Therefore, we conclude that at the time of the December 1987 stipulation regarding his accepted 1986 claim with SAIF, claimant's PTSD condition as a separate occupational disease with SAIF's insured was an issue that could have been raised and negotiated. Accordingly, since the stipulation resolved all issues that were "raised or raisable" at that time, we find that the compensability of claimant's PTSD condition was resolved by the December 1987 stipulation and cannot now be relitigated.[1]

Therefore, we affirm the ALJ's order upholding the denials of claimant's separate occupational disease claim for PTSD. We also affirm the ALJ's finding that claimant's psychological condition had been accepted and processed by SAIF along with his 1986 back injury claim.

ORDER

The ALJ's order dated July 26, 1994, as reconsidered on November 16, 1994, is affirmed.

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[1] Our conclusion pertains only to claimant's psychological condition as it existed at the time of the December 1987 stipulation. Inasmuch as claimant did not assert an occupational disease claim based on an allegedly changed psychological condition subsequent to the 1987 stipulation, such a claim has not been considered. See e.g., Popoff v. J.J. Newberrys, 117 Or App 242 (1992); Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989); Amber D. Applebee, 45 Van Natta 2270, 2272 (1993).

Board Chair Hall concurring in part and dissenting in part.

I concur with the majority's order to the extent that it holds that claimant cannot relitigate the compensability of a separate occupational disease claim for post-traumatic stress disorder (PTSD). However, because I would also hold that SAIF is precluded from denying the compensability of claimant's psychological condition, I respectfully dissent in part.

Just as claimant is precluded from relitigating the compensability of his psychological condition, so too is SAIF precluded from denying the condition. A carrier is precluded from denying a claim which, by prior stipulation, is compensable. Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993); Betty J. Lincoln, 45 Van Natta 2018 (1993). Here, SAIF stipulated in December 1987 that claimant's psychological condition was compensable. SAIF is subsequently precluded from denying that the same condition was compensable. Ledbetter v. SAIF, 132 Or App 508 (1995) (SAIF accepted underlying osteomyelitis condition by its stipulated acceptance of "right thigh condition"). Accordingly, I would set aside SAIF's denials to the extent they deny the psychological condition SAIF accepted in the December 1987 stipulation. Simply stated, the principles of Seney and Stoddard, to which the majority cites, apply equally to all parties.

In the Matter of the Compensation of
RICHARD H. KELLISON, Claimant
WCB Case Nos. 93-08887 & 93-08886
ORDER ON REVIEW
Michael M. Bruce, Claimant Attorney
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. The employer cross-requests review of that portion of the order that set aside its denial of claimant's occupational disease claim for an L4-5 herniated disc 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," except for the "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

CTS

The ALJ concluded that claimant failed to prove his CTS claim, based on a finding that the opinion of Dr. Nathan, examining physician, was more persuasive than those of Drs. Hartmann, treating neurologist, and Klump, treating neurosurgeon. We disagree.

Claimant bears the burden of establishing that his work activities for the employer were the major contributing cause of his CTS condition. If such a condition preexisted his work exposure, claimant must prove that his work activities were the major contributing cause of a worsening of the preexisting condition. See ORS 656.802(2).[1]

In evaluating medical evidence concerning causation, we give the most weight to those opinions which are both well-reasoned and based on accurate and complete information. Somers v. SAIF, 77 Or App 259 (1986).

All physicians agree that CTS is a constellation of symptoms. However, only Dr. Nathan also believes that CTS symptoms only occur in the context of an abnormal nerve condition. Based on Dr. Nathan's reasoning, the employer argues that claimant has not established that his work activities caused a worsening of his abnormal nerve condition. We are not so persuaded.

First, because Dr. Nathan's opinion is general, rather than specific to claimant, it is not particularly persuasive. See Sherman v. Western Employers Insurance, 87 Or App 602 (1987). Second, in the absence of evidence that claimant had a preexisting forearm condition (or an abnormal nerve, as posited by Dr. Nathan), we decline to infer that claimant had such a condition. See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Jason E. Donovan, 45 Van Natta 792 (1993). Finally, considering the treating doctors' accurate history regarding claimant's nine years of forearm and hand intensive work activities and Dr. Klump's advantageous position as treating surgeon, we find the opinions of Drs. Hartmann and Klump the most persuasive. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988); Weiland v. SAIF, Or App 810 (1983). Accordingly, based on the latter opinions, we find that claimant's work activities for the employer were the major contributing cause of his CTS condition. Consequently, claimant has carried his burden under ORS 656.802.

L4-5 Herniated Disc

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

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[1] On June 7, 1995, Senate Bill 369 amended ORS 656.802. The result would be the same under either version of the statute.

Claimant's attorney is entitled to an assessed fee for services on review devoted to the success defense of the low back claim. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding this matter is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Claimant's attorney is also entitled to an assessed fee for services at hearing and on review regarding the CTS claim. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review concerning the CTS claim is $3,000 payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 13, 1995 is reversed in part and affirmed in part. That portion of the order that upheld the self-insured employer's denial of claimant's claim for a bilateral CTS condition is reversed. The denial is set aside and the claim is remanded to the employer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review regarding the CTS condition, claimant is awarded a $3,000 attorney fee, payable by the employer. For services on review regarding the low back condition, claimant is awarded a $1,000 attorney fee, payable by the employer.

In the Matter of the Compensation of
HERBERT J. LOGSDON, Claimant
WCB Case No. 94-15154
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order which upheld the insurer's denial of claimant's tooth injury claim. On review, the issue is compensability.

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

On July 3, 1994, claimant was washing dishes for his employer. He asked and was given permission from his supervisor to eat a piece of pizza. While eating the pizza, claimant broke a crown and post on his tooth. The crown had been cemented in June 1993, and recemented in September 1993, and March 1994. (Ex. 1). Originally, Dr. Freeman recommended treating claimant's tooth using a "bridge" instead of a crown, but the cost was prohibitive for claimant. (Ex. 1-6).

Applying ORS 656.005(7)(a)(B), the ALJ found that claimant's work activity was not the major contributing cause of his broken tooth crown. On review, claimant contends that the medical opinion of Dr. Freeman establishes that his work incident was the major contributing cause of his tooth injury condition.

Because claimant's crown on his tooth was a preexisting condition, which combined with a work related accident to cause his current condition, he must establish that the work accident is the major contributing cause of his current, resultant condition and need for medical treatment. ORS 656.005(7)(a)(B).[1]

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[1] After the ALJ's order, the legislature enacted Senate Bill 369 which amended ORS 656.005(7)(a)(B). Or Laws 1995, ch 332, § 1 (SB 369, § 1) . We need not decide whether amended ORS 656.005(7)(a)(B) applies retroactively to this case, because the outcome would be the same under either the former or amended versions of ORS 656.005(7)(a)(B).

"Major cause" means an activity or combination of activities, which contributes more to causation than all other causative agents combined. See David K. Boyer, 43 Van Natta 561 (1991), aff'd mem 111 Or App 666 (1992); Dethlefs v. Hyster Co., 295 Or 298, 310 (1983).

Dr. Freeman, treating dentist, initially stated that he could not "say one way or the other" that claimant's work incident was the major cause of his tooth injury. (Ex. 9). Subsequently, Dr. Freeman changed his opinion stating that, it "seems likely" that the force that broke the tooth and post occurred while claimant was eating pizza at work. (Ex. 13).

Magic words are not necessarily required to establish the compensability of a claim. See McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). However, considering the number of problems claimant has had with his tooth prior to the work incident, the fact that Dr. Freeman initially recommended a "bridge" instead of a crown and his failure to state that claimant's work accident was the major contributing cause of claimant's condition, we do not find the treating dentist's opinion sufficient to prove the compensability of claimant's claim. Consequently, we conclude that the medical evidence fails to support a finding that the major contributing cause of claimant's tooth injury was his work activities. Accordingly, we affirm the ALJ's order.

ORDER

The ALJ's order dated March 28, 1995 is affirmed.

Board Member Gunn dissenting.

The crux of this case depends on the majority's finding that claimant's "crown" on his tooth was a preexisting condition. As such, the majority imposed upon claimant the "major contributing cause standard" of ORS 656.005(7)(a)(B). Because I find that the expanding definition of a "preexisting condition" will exceed limits of constitutionality and common sense, I must respectfully dissent.

As Representatives Uherbelau and Brown expressed in their opposition to Senate Bill 369 (during the legislative session) because the definition of "preexisting condition" pulls in, as a preexisting condition, those things that we are predisposed to (i.e. cavities, poor eyesight, suntans, allergies). As such, every single worker in Oregon is now predisposed to something. Therefore, the "amended/new" definition of a preexisting condition will exclude coverage for many legitimately injured workers.

First, I find such an "expansion" of a preexisting condition absurd and unconstitutional. By finding that claimant's crown on his tooth is a preexisting condition, the majority has effectively taken steps towards discouraging workers from practicing preventive dental hygiene. Claimant would have been in a better position if he had not sought out dental care for his tooth because then he would not have been deemed to have a preexisting condition and therefore, required to prove major causation. As such, the expanding definition of preexisting condition promulgates the absurd result that workers are better off not obtaining preventative dental/medical care or risk the prospective burden of proving any future work injury under the major cause standard.

Additionally, I assert that SB 369's expanding definition of preexisting condition will eventually be found unconstitutional because its application can be based on classifying "preexisting conditions" solely on the basis of gender. For instance, an example of the unconstitutional application of the amended definition of a "preexisting condition" is found in Darlene J. Reed, 47 Van Natta 1716 (1995). Initially, I cite Hewitt v. SAIF, 294 Or 33 (1982), to acknowledge the constitutional analysis which must be applied to the classification of what is and what is not, a preexisting condition under ORS 656.005(24).

In Hewitt v. SAIF, supra, the Court held that classifications made on the basis of gender are inherently "suspect" and therefore, unconstitutional unless the classification reflects specific biological differences between men and women. Id. at 46. Further, the Court held that this "suspicion" is not overcome when other personal characteristics or social roles are assigned to men or women because of their gender and for no other reason.

In Reed, the claimant sustained a herniation into her vagina which was caused by her work. However, the Board found that the claimant was predisposed to the "herniation" because of a "weakening" of her vaginal muscles, which was attributed to the claimant from having given birth to her children. As such, we determined that claimant's "weakened" vaginal muscles constituted a "preexisting" condition under amended ORS 656.005(24) and therefore, claimant was required to prove her claim under the major contributing cause standard. See amended ORS 656.005(7)(a)(B).

In applying the Hewitt constitutional analysis to Reed, I contend that classifying the claimant's "weakened vaginal muscles" as a "preexisting" condition is a classification based on gender which is inherently suspect and therefore, unconstitutional. Further, this "suspicion" is not overcome, as a "specific biological difference between men and women" because the responsibility for the propagation of the human species is a social role exclusively assigned to women. As such, the basis for classifying the claimant's "vaginal condition" as a preexisting condition was attributable to a social role (because a woman is the only gender capable of bearing children) imposed upon her because of her gender. Therefore, Reed is a valid example where the classification of what is a "preexisting condition" pursuant to amended ORS 656.005(24) is unconstitutional. See Hewitt, supra.

In sum, my concerns in Reed, as well as in the present case stem from the constitutionality of classifying certain preexisting or predisposing conditions that arise based solely on personal or social characteristics assigned to men or women because of their gender, age and/or disabilities. Consequently, I respectfully dissent from the majority's holding.

January 10, 1996 Cite as 48 Van Natta 56 (1996)

In the Matter of the Compensation of
HERBERT J. LOGSDON, Claimant
WCB Case No. 95-00231
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Gunn, Christian and Neidig.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order which upheld the insurer's denial of claimant's nose injury claim. On review, the issue is course and scope of employment. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but not his "Ultimate Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant was employed as a pizza delivery driver. As part of his delivery duties, claimant was expected to observe the speed limit, be polite, courteous and avoid accidents. (Tr. 9). During the evening of October 21, 1994, claimant was delivering pizza when another automobile, driven by Mr. Wyland, "cut-off" and almost collided with claimant's automobile. Claimant flashed his "high beam" lights at Mr. Wyland's vehicle. The two automobiles proceeded to stop at an intersection because of a red light. While stopped at the red light, Mr. Wyland shouted an obscenity and extended his middle finger to claimant. (Tr. 14). Claimant responded by also extending his middle finger at Mr. Wyland.

Mr. Wyland exited his vehicle and walked back to claimant's automobile. Claimant rolled down his driver's side window. Mr. Wyland challenged claimant to get out of his car and "have it out." (Tr. 15). Claimant asked Mr. Wyland for an apology for "almost running" into him. When the light turned green, another car behind claimant's automobile honked its horn. As claimant looked towards the honking car, Mr. Wyland struck him in the face.

The ALJ found that claimant's injuries were not compensable because they did not arise out of his employment. In so doing, the ALJ determined that claimant's obscene gesture was not a risk relevant to delivering pizza, thereby carrying him into a zone of personal risk and active participation in the assault.

On review, claimant contends that his injuries occurred "in the course of" and "arose out of" his employment. Additionally, claimant asserts that his claim is not precluded under ORS 656.005(7)(b)(A), because he was not an active participant in the assault. We agree.

A compensable claim is one "in the course of" and "arising out of" employment. ORS 656.005(7)(a). "In the course of employment" concerns the time, place and circumstances of the injury. "Arose out of employment" concerns the causal connection between the injury and the employment. Norpac Foods, Inc., v. Gilmore, 318 Or 363 (1993).[1]

Here, although claimant disregarded the employer's rules of being courteous and polite, it did not involve a prohibited, overstepping of the boundaries defining his "ultimate job" of delivery driver. In other words, claimant's violation of his employer's rules related to the method of accomplishing his ultimate work duties as a delivery driver. See David Bottom, 46 Van Natta 1485 (1994), aff'd mem Liberty Northwest Insurance Corporation v. Bottom, 133 Or App 449 (1995) (breach of the employer's drug/alcohol policy related to the employer's desire that its employees work unencumbered by drugs or alcohol, which merely defined the method of performing the ultimate work to be done and, as such, did not remove the claimant from the course and scope of employment).

Consistent with the Bottom rationale, despite claimant's violation of his employer's rules (which related to the method of accomplishing his work as a delivery driver) he, nevertheless, was performing his ultimate work as a delivery driver when he was injured. See David Bottom, supra; Patterson v. SAIF, 64 Or App 652 (1983). Thus, claimant remained within the course of his employment at the time he was injured. As such, claimant was injured "in the course of" his employment. Norpac Foods, Inc., v. Gilmore, supra.

The "arising out of" prong tests the causal connection between the injury and a risk connected with his employment. See Phil A. Livesley Co. v. Russ, 296 Or 25, 29 (1983). Here, claimant was a delivery driver. Claimant's work put him in a position which required him to confront the various hazards associated with driving an automobile, including being "cut-off" in traffic and engaging in personal exchanges (non-verbal, verbal and physical). In regard to the "hazards" of driving, and the potential for physical confrontations, claimant's employer placed him in a position of having to confront other drivers.

Based on these facts, we find that claimant's injuries "arose out of" his employment because his injuries were connected to a risk associated with his employment. Phil A. Livesley Co. v. Russ, supra. Consequently, we find that claimant's injuries occurred "in the course of" and "arose out of" his employment and are thus compensable.

Next, we must decide whether claimant's actions towards Mr. Wyland placed him in the position of an "active participant" in the confrontation that resulted in his injuries. Based on the following reasoning, we do not consider claimant to have been an "active participant."

ORS 656.005(7)(b)(A) provides that an "[i]njury to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties" is not compensable. A claimant may be an "active participant" if he assumes an active or aggressive role in a fight, and if he has an opportunity to withdraw from the encounter and not participate in the fight, but fails to withdraw. See Irvington Transfer v. Jasenosky, 116 Or App 635, 640 (1992). Because claimant was not an active participant, we find that compensability of his claim is not barred under ORS 656.005(7)(b)(A).

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[1] The Court of Appeals determined in First Interstate Bank of Oregon v. Clark, 133 Or App 712, 717 (1995), that the proper framework for our analysis under ORS 656.005(7)(a) was set forth in Norpac Foods, Inc., v. Gilmore, 318 Or 363 (1993). In Norpac Foods, the Court stated that the proper analysis to determine whether an injury was sufficiently work-connected to justify compensability consisted of a two prong test. The first prong considers whether the injury occurred "in the course of employment" and the second prong evaluates whether the "injury arose out of the employment." Norpac Foods v. Gilmore, supra. The Court determined that neither prong was dispositive, and the Board must consider the "totality of the circumstances" to determine if the claimant has shown a sufficient work connection. Id. at 366,369.

Here, after being "cut-off" by Mr. Wyland, claimant "flashed his headlights" at Mr. Wyland's automobile. While stopped by the traffic signal, Mr. Wyland shouted an obscenity and extended his middle finger to claimant. Claimant returned the sign. Mr. Wyland exited his vehicle and walked back to claimant's automobile. Mr. Wyland invited claimant to fight. Claimant did not accept the invitation, but rather sought an apology. Thereafter, while looking backwards, claimant was punched by Mr. Wyland in the nose through claimant's open car window.

Although the extension of claimant's finger at Mr. Wyland suggests participation in the "traffic dispute," it does not constitute an invitation to a physical confrontation. Mr. Wyland escalated the situation by getting out of his car, approaching claimant's vehicle and taunting him. At this point, claimant did not participate in furthering the dispute by asking Mr. Wyland for an apology. Because claimant did not exhibit any provocative actions which would have suggested that he was being physically aggressive, (such as unbuckling his seat belt, exiting his car, or affirmatively responding to Mr. Wyland's challenge to fight), we find that claimant was not an "active participant" in an assault or combat. See Ronald A. Smith, 47 Van Natta 807 (1995) (the claimant found to be active participant because he prepared to actively participate in the conflict between himself and his assailant); Irvington Transfer v. Jasenosky, supra, 116 Or App at 640 (the claimant was not an active participant even though the claimant shouted at his assailant asking him why he wanted to fight); Ismeal M. Barajas, 43 Van Natta 1774 (1991) (the claimant was found an active participant because he waited for and intended to fight his assailant). Finally, claimant was seated in his car, between Mr. Wyland's car in front of him and the "honking car." Under such circumstances, we find that claimant did not have sufficient opportunity to withdraw from his confrontation with Mr. Wyland. Irvington Transfer v. Jasenosky, supra.

Accordingly, ORS 656.005(7)(b)(A) does not exclude claimant's injuries from compensability. Consequently, the ALJ's order is reversed and the insurer's denial is set aside.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, 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 issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated December 30, 1994 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with the law. For services at hearing and Board review, claimant's counsel is awarded $3,000, to be paid by the insurer.

Board Member Neidig dissenting.

The majority has concluded that claimant was not an active participant in the confrontation which resulted in his injuries. Because I agree with the ALJ that claimant's actions amounted to a deviation from his "customary duties," I dissent.

The ALJ determined that claimant's conduct towards the other driver (Mr. Wyland) was not relevant to carrying out his work duties of delivering pizzas. As such, the ALJ found that claimant was an active participant in the confrontation with Mr. Wyland. Therefore, the ALJ concluded that claimant's injuries did not arise out of his employment. I agree with the ALJ based on the following reasoning.

I find this case to be distinguishable from cases involving violations of work rules governing a worker's method of accomplishing his or her ultimate work. In David Bottom, 46 Van Natta 1485 (1994), the claimant was injured when a box fell on him while he was unloading freight. At the time, the claimant was intoxicated, although his injury was not related to his intoxication. The employer had a policy specifically prohibiting the use of drugs and alcohol at work. Reasoning that the employer's policy related to its desire that its employees work unencumbered by drugs or alcohol, and not to the claimant's ultimate freight unloading responsibilities, we concluded that the claimant's violation of the drug and alcohol policy was a violation of a rule concerning the method of execution of his ultimate work duties. Id. at 1487. Therefore, we concluded that claimant's injury occurred within the course and scope of his employment.

In Patterson v. SAIF, 64 Or App 652 (1983), the claimant was a security guard for the employer, Oregon Health Sciences University. The employer had a rule prohibiting the transport of unwanted persons beyond the edge of the employer's premises. Although the claimant knew of this rule, he transported an unruly patient to a destination beyond the edge of the employer's premises, at which point he was injured. The court concluded that the claimant's disregard of the employer's work rule did not involve a prohibited overstepping of the boundaries defining his ultimate job responsibilities, i.e., the transportation of unwanted persons off the premises. Id. at 656. Instead, the court concluded that the employer's rule concerned the sphere of execution of the claimant's employment responsibilities. Id. at 656. Reasoning that the claimant's misconduct was a violation of the designated method of execution of his ultimate work, the court concluded that claimant's injury was sufficiently work-related to be compensable. Id.

In both Bottom and Patterson, the claimants' misconduct involved violation of rules concerning how they were to perform their ultimate work responsibilities. In Bottom, the claimant violated a work rule designed to ensure that he performed his ultimate work duties in a sober state; in Patterson, the claimant's misconduct involved a rule that merely limited the sphere within which he was to perform his ultimate work duties.

Here, claimant's actions did not involve a mere deviation from the "method" of his ultimate work. Claimant's job was a delivery driver. As such, the major task in accomplishing his work duties involved driving an automobile. The employer had a policy that its delivery drivers conduct themselves on the road with politeness and courtesy. (Tr. 9). As the ALJ found, examples of "deviant methods" of executing claimant's work (driving an automobile) would include "driving too fast or carelessly."

In contrast to Bottom and Patterson, claimant's conduct involved more that a mere violation of the "method" of performing his job (i.e. driving too fast or carelessly). Claimant breached a specific policy of the employer's. He flashed his headlights and returned an obscene gesture, both of which breached the employer's policy of conducting himself politely and courteously while delivering its pizzas. Therefore, claimant became an active participant in the confrontation because he escalated a situation which would have dissipated but for claimant breaching the employer's policy. Consequently, this is not a case of claimant merely deviating from the "method of executing" his work. See David Bottom, supra; Patterson v. SAIF, supra. As such, I conclude that claimant's injuries occurred outside the course and scope of his employment.

January 10, 1996 Cite as 48 Van Natta 59 (1996)

In the Matter of the Compensation of
KEVIN P. SILVEIRA, Claimant
WCB Case No. 91-05623
ORDER OF ABATEMENT
Coughlin, et al, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

On December 11, 1995, we issued an Order on Remand that: (1) affirmed an Administrative Law Judge's (ALJ's) order which set aside the SAIF Corporation's denial of claimant's occupational disease claim for a low back condition; (2) affirmed the ALJ's $2,200 insurer-paid attorney fee award; and (3) awarded a $3,500 insurer-paid attorney fee for claimant's counsel's services before the court and before the Board on review and remand. Submitting an affidavit and time records from his counsel, claimant asks that our $3,500 attorney fee award be increased to $9,112.

In order to further consider claimant's motion, we withdraw our December 11, 1995 order. SAIF is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEAN L. WATKINS, Claimant
WCB Case No. 94-11710
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Bottini, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Gunn.

The self-insured employer requests, and claimant cross-requests, review of Administrative Law Judge (ALJ) Schultz's order that: (1) awarded temporary disability; and (2) dismissed claimant's hearing request insofar as it pertained to a medical services dispute regarding prescription medications. The employer also seeks remand to the ALJ for consideration of "post-hearing" information regarding claimant's knee injury claim with a subsequent employer. On review, the issues are remand, temporary disability, jurisdiction and compensability of medical services. We deny the motion for remand and, on the merits, reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for his first finding of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Remand

The employer requests that this matter be remanded to the ALJ for consideration of new evidence, which it received after the hearing, regarding claimant's right knee injury claim with a subsequent employer. The employer asserts that the new evidence bears on claimant's alleged lack of credibility and manipulation of the workers' compensation system.

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed or heard by the ALJ. In order to satisfy this standard, the additional evidence must be 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). For the following reasons, we are not persuaded the additional evidence in this case is reasonably likely to affect the outcome of the case.

The additional evidence in this case concerns a claim which claimant filed for an injury he allegedly suffered while working for a subsequent employer in April 1995. That claim is not at issue in this case, nor is it material to the temporary disability and medical services issues in dispute here. Furthermore, we find no persuasive evidence that claimant has demonstrated a lack of credibility regarding the 1995 claim. The employer apparently assumes that the 1995 claim is not legitimate; however, there is no evidence to support that assumption.

Finally, even if the additional evidence demonstrated claimant's lack of credibility, the evidence would not affect the outcome of this case because the issues in this case turn on legal and medical questions, not on claimant's credibility or lack thereof. On the temporary disability issue, it is undisputed that claimant returned to work while his claim remained in open status, and that he was subsequently disabled from work due to compensable jaw surgery. The dispositive question is of a legal nature, i.e., whether claimant's return to work qualified him for temporary disability benefits, notwithstanding an earlier, final determination that he had withdrawn from the work force. The medical services jurisdiction issue is likewise a legal question which turns on statutory construction. Finally, the issue of compensability of claimant's prescription medications turns on expert medical evidence, rather than claimant's credibility.

For these reasons, we are not persuaded that the additional evidence regarding claimant's 1995 injury claim is material to the issues in this case. Inasmuch as the additional evidence is not reasonably likely to affect the outcome of this case, we deny the employer's motion for remand.

Temporary Disability

We adopt the ALJ's conclusions and opinion on this issue with the following supplementation.

The issue is whether claimant is entitled to temporary disability benefits beginning May 6, 1995, the date he was released from work for his recent compensable jaw surgery. Like the ALJ, we conclude that claimant is so entitled.

We begin with a brief summary of the relevant facts. Claimant's claim was reopened for an aggravation as of March 1992, but the employer declined to pay temporary disability benefits. The parties litigated the issue of claimant's entitlement to temporary disability benefits. By Opinion and Order dated December 15, 1992, a prior ALJ held that claimant was not entitled to temporary disability benefits because he had voluntarily withdrawn from the work force. (Ex. 12). That order was affirmed by the Board and the Court of Appeals, and it became final by operation of law. Claimant's claim has remained in open status through the date of hearing in this matter.

It is undisputed that claimant returned to work in March 1995 and was subsequently disabled from working due to compensable jaw surgery in May 1995. The employer asserts, however, that claimant does not qualify for temporary disability benefits because he has not proven a worsening of his compensable condition and, alternatively, that his claim for temporary disability benefits is precluded by the prior adjudication. We disagree.

A claimant is not required to prove a worsening of the compensable condition in order to receive temporary disability benefits prior to claim closure. Rodgers v. Weyerhaeuser Co., 88 Or App 458 (1987); Robert L. Compton, 46 Van Natta 2431 (1994). Therefore, because claimant was released from work in May 1995, while his claim remained in open status, he was not required to prove a worsened condition.

Furthermore, claimant's claim for temporary disability benefits is not precluded by the prior adjudication. The "issue preclusion" doctrine of res judicata bars future litigation between the same parties concerning an issue that was actually litigated and determined by a final and valid judgment and the determination was essential to the judgment. Drews v. EBI Companies, 310 Or 134, 139-40 (1990); Jerry L. Conover, 46 Van Natta 456 (1994). Here, the parties actually litigated the issue of whether claimant was in the work force at the time of his aggravation in March 1992. The prior ALJ's determination that claimant was not in the work force at that time became final and therefore bars claimant from relitigating the same issue. It does not, however, bar claimant from proving that his employment status changed following the prior ALJ's order. Indeed, such a change of employment status could not have been litigated prior to closure of the hearing record before the prior ALJ. Hence, issue preclusion does not bar claimant from proving that he had reentered the work force subsequent to the prior ALJ's December 1992 order. See also Wausau Ins. Companies v. Morris, 103 Or App 270, 273 (1990) (A finding that a claimant withdrew from the work force at one time does not irrevocably commit the claimant to retirement for purposes of receiving temporary disability benefits.)

Finally, we reject the employer's argument that, because claimant was found not to be in the work force at the time of his 1992 aggravation, he is prevented from proving he had subsequently reentered the work force while his claim remained in open status. The employer relies on the following language in Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989): "To receive temporary total disability upon aggravation of a work-related injury, the claimant must be in the work force at the time of the aggravation." However, that language must be viewed in its proper context. In Dawkins, the issue was whether the claimant was entitled to temporary disability benefits from the time of his aggravation claim. Hence, the Court focused on claimant's employment status at the time of the aggravation. That approach is typical of aggravation cases, where the claimant is seeking to establish entitlement to temporary disability benefits beginning the date of the aggravation.

The issue in this case is whether claimant is entitled to temporary disability benefits while his claim is in open status. Under these facts, we turn to the general rule of law set forth in Weyerhaeuser Co. v. Kepford, 100 Or App 410, 414, rev den 310 Or 71 (1990): "[T]he critical time for determining whether a claimant has withdrawn from the work force is at the time of his disability." (Emphasis supplied.) In this atypical case, where the worker changes employment status while the claim is in open status, we look to the date of disability as the critical date for determining claimant's eligibility for temporary disability benefits.

Here, given the undisputed facts that claimant returned to work in March 1995 and was released from work beginning May 6, 1995, (Ex. 23), we find that the date of claimant's disability was May 6, 1995. On that date, inasmuch as claimant had been engaged in regular gainful employment, we conclude that claimant was in the work force and therefore qualified for temporary disability benefits. See Dawkins v. Pacific Motor Trucking, supra. Accordingly, we affirm this portion of the ALJ's order.

Medical Services

On cross-appeal, claimant contends that the ALJ erred in dismissing, for lack of jurisdiction, his hearing request concerning prescription medications which the employer denied by letter dated March 15, 1995. We agree and reverse this portion of the ALJ's order.

On June 7, 1995, Senate Bill 369 amended the Workers' Compensation Law. Or Laws 1995, ch 332 (SB 369). Many of the amendments were intended to apply retroactively to cases already in litigation. In the absence of a specific exception, the amendments made by SB 369 apply to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act (June 7, 1995). SB 369, § 66; Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 569 (1995). Here, no specific exception applies, and the ALJ's order has not become final. Therefore, the amendments in SB 369 apply retroactively to this case.

Amended ORS 656.327(1) provides that if an injured worker, a carrier, or the Director believes that an injured worker's medical services, not subject to ORS 656.260, are excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." SB 369, § 41. ORS 656.245(6) provides that, "if a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker, insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327." SB 369, § 25.

In Walter L. Keeney, 47 Van Natta 1387 (1995), we retroactively applied the amendments to ORS 656.327, as well as the new provision, ORS 656.245(6), to claims currently pending before the Board. Based on the text and context of amended ORS 656.327(1), as read in conjunction with SB 369's retroactively provisions, we concluded that the Director has exclusive jurisdiction over ORS 656.327(1) medical services disputes, including those presently pending before the Board.

In Lynda J. Zeller, 47 Van Natta 1581 (1995), on recon 47 Van Natta 2337 (1995), relying on ORS 656.245(6), we held that the Board retained jurisdiction to determine whether a claimant's current condition was related to her compensable injury. However, once that determination was resolved, we further concluded that, under ORS 656.327(1) and Keeney, the Board is without authority to address the propriety of a proposed surgery for that disputed condition. Thus, in Zeller, having found that the claimant's current condition was compensable, we then dismissed the claimant's hearing request insofar as it sought resolution of a dispute regarding whether the proposed medical treatment was reasonable and necessary. See also Janet Anderson, 47 Van Natta 1692 (1995).

In Richard L. Wheeler, 47 Van Natta 2011 (1995), we found that the parties' dispute concerned whether medical treatment for claimant's current condition was causally related to his compensable injury. Reasoning that the dispute necessarily involved the compensability of the condition for which the medical treatment was provided, we concluded that the employer's formal denial pertained to the "compensability of the underlying claim." Thus, we held that we retained jurisdiction over the dispute.

This case is similar to Wheeler. In its March 15, 1995 denial letter, the employer wrote, in pertinent part:

> "A review of your file indicates that the only compensable conditions related to the original injury are your TMJ and psychological condition. You have been receiving medications for conditions that, in our opinion, are not the result of the original injury. Therefore, we are issuing this denial for the following medications: Scopolamine Patches, Clonidine TTS-Transdermal, Baclofen, Nicotine Patches, Promethazine, Soma, and Lorazepam. We will continue to pay for those medications we feel are necessary for the maintenance of the accepted conditions." (Ex. 21A, emphasis supplied).

Based on our reading of the denial letter, the employer is disputing whether the conditions for which the aforementioned medications were prescribed are related to the compensable injury. Therefore, we conclude that the employer's formal denial in this case pertained to the "compensability of the underlying claim." See id. Accordingly, we have jurisdiction over this dispute.

In order to establish the compensability of the conditions for which the disputed medications were prescribed, claimant must prove that the compensable injury was a material contributing cause of those conditions and the resultant need for treatment. See ORS 656.245(1); Beck v. James River Corp., 124 Or App 484, 487 (1993), rev den 318 Or 478 (1994); Roseburg Forest Products v. Ferguson, 117 Or App 601, 604, rev den 316 Or 528 (1993).

Claimant moves for remand of this matter to the ALJ for consideration of this compensability issue. As we previously stated, however, our remand authority is limited to those cases which have been improperly, incompletely or otherwise insufficiently developed or heard by the ALJ. See ORS 656.295(5). This case does not meet that criteria. Claimant has submitted a questionnaire, which was completed by his attending physician, Dr. Toffler. In that questionnaire, Dr. Toffler rendered his expert opinions concerning the relationship of the medications, the conditions for which they were prescribed, and the compensable injury. (Ex. 24). Therefore, we find that this record has been sufficiently developed on the compensability issue. Accordingly, claimant's motion for remand is denied.

On the merits, we rely on the uncontroverted opinions of Dr. Toffler. (Ex. 24). In his questionnaire, he related all of the disputed medications to conditions caused or exacerbated by the compensable injury. Regarding the nicotine patches, for example, Dr. Toffler opined that the stress and pain related to the compensable injury made claimant's smoking cessation efforts more difficult. (Ex. 24-3). Dr. Toffler's opinions, though somewhat conclusory, are unrefuted. Therefore, we find that claimant has carried his burden of proving that his need for the prescription medications in dispute are materially related to the compensable injury. Accordingly, we set aside the employer's denial.

Although we are setting aside the "compensability" portion of the employer's denial, our decision has no bearing on the issue of whether the disputed medications are appropriate treatment for the compensable injury and related conditions. The appropriateness issue is properly within the Director's exclusive jurisdiction pursuant to amended ORS 656.327(1).[1]

Claimant's attorney is entitled to an assessed fee for services at hearing and on review in prevailing over the employer's medical services denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the employer's denial is $2,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review regarding the temporary disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 19, 1995 is reversed in part and affirmed in part. That portion of the order that dismissed claimant's hearing request regarding the self-insured employer's "compensability" denial of prescription medications is reversed. The hearing request is reinstated insofar as it pertained to the compensability portion of the employer's denial. The employer's March 15, 1995 partial denial of compensability is set aside and the claim is remanded to the employer for processing according to law.

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[1] We note that the employer's disapproval of the disputed medications was submitted for the Director's review on July 18, 1995. Our decision in this case has no preclusive effect on the Director's review or ultimate decision regarding the appropriateness of the medications.

The remainder of the order is affirmed. For services at hearing and on review regarding the employer's partial denial, claimant's attorney is awarded an assessed fee of $2,000, to be paid by the employer. For services on review regarding the temporary disability issue, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the employer.

Board Member Gunn concurring in part and dissenting in part.

I agree with the majority's denial of the employer's motion for remand. I also agree that claimant is entitled to temporary disability benefits. However, I disagree with the majority's conclusion that its "compensability" determination has no preclusive effect on the "medication" dispute.

The employer's denial in this case clearly included specific medications for treatment of the specific conditions we have found compensable. Since the compensability portion of the employer's denial is inextricably entwined with the medication dispute, the resolution of the compensability dispute necessarily determines the medication issue. Because the parties have actually litigated these issues, this determination precludes their re-litigation before another forum. See Drews v. EBI Companies, 310 Or 134 (1990); SAIF v. Roles, 111 Or App 597, 601, rev den 314 Or 391 (1992) (subject matter jurisdiction depends on whether the tribunal had the authority to make an inquiry into the dispute); Carr v. Allied Plating Co., 81 Or App 306, 309 (1986).

To reach any other conclusion would not only be inconsistent with the stated objectives of the Workers' Compensation Law under ORS 656.012(2)(b) to provide a fair and just administrative system that reduces litigation, but also creates the potential of inconsistent rulings concerning the same issue from separate adjudicative forums. Finally, considering that there may well be several years between these disparate decisions from these duplicative forums, another objective enumerated in ORS 656.012(2)(c) (to restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable) would not be achieved.

In conclusion, the majority's decision necessarily resolves the "medication" dispute which is integral to the parties' dispute as framed by the employer's denial. As such, further litigation of this issue is precluded. Such a conclusion is not only consistent with issue / claim preclusion principles, but it advances the legislative goals recited in ORS 656.012. Consequently, I dissent from the majority's conclusion that our order in this case has no preclusive effect.

January 11, 1996 Cite as 48 Van Natta 64 (1996)

In the Matter of the Compensation of
DANA ROSENLUND, Claimant
WCB Case No. 95-05534
ORDER ON REVIEW (REMANDING)
Terry & Wren, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order which declined to award claimant temporary disability beginning November 15, 1993. On review, the issue is temporary disability. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable respiratory condition (reactive airways disease) resulting from a claim filed in September 1994. On May 15, 1995, while the claim was open, claimant filed a Motion for an Order to Show Cause why temporary disability was not being paid.

A June 21, 1995 hearing was held in response to claimant's motion. Claimant alleged entitlement to temporary disability commencing November 15, 1993, the date the employer had terminated claimant's employment because of excessive absences from work. (Ex. 35). In a June 26, 1995 order, the ALJ denied claimant's request for temporary disability, reasoning that claimant had not established that she had a medically verified inability to work due to her compensable condition.

On review, claimant contends that she was entitled to payment of temporary disability on November 15, 1993, relying on retroactive authorizations of temporary disability provided by Drs. Hirsch and Keppel. (Exs. 59, 66). Attaching a copy of a July 7, 1995 Notice of Closure to its brief on review, the employer responds that claimant must address the issue of temporary disability through a direct appeal of the Notice of Closure, inasmuch as claimant is seeking an award of temporary disability greater than that awarded by the Notice of Closure. See George E. Freyer, 47 Van Natta 1301 (1995). The Notice of Closure was not admitted at hearing.

In Freyer, we held that, consistent with Galvin C. Yoakum, 44 Van Natta 2403, 2404, on recon 44 Van Natta 2492 (1992), and Michael J. Drake, 45 Van Natta 1117 (1993), when a claimant is seeking benefits in an amount greater than that granted by a Notice of Closure, the appropriate method for resolution of that dispute is by means of appealing that administrative closure. We reasoned, as we had in Yoakum and Drake, that such a procedure would assure that decisions involving a claimant's entitlement to temporary disability (and the carrier's responsibility for such benefits) were uniformly and consistently decided. However, we need not decide the applicability of Freyer to this case.

The Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." Rodney J. Thurman, 44 Van Natta 1572 (1992). This has been held to include agency orders and stipulations by the parties. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Jenetta L. Gans, 41 Van Natta 1791 (1989); Susan K. Teeters, 40 Van Natta 1115 (1988). However, we have refused to take administrative notice of an insurer-prepared document such as a form 1502. Rodney J. Thurman, supra. Thus, based on our decision in Thurman, we decline to take administrative notice of an employer-prepared Notice of Closure.[1]

Although we decline to take administrative notice of the employer's closure notice, we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). To warrant remand, there must be good cause or a compelling basis or a compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Based on the above criteria, we find that a compelling basis exists to remand to the ALJ for admission of the Notice of Closure. First, not only does the Notice of Closure concern disability in that it can award temporary or permanent disability, but it can also affect claimant's "pre-closure" entitlement to temporary disability in this proceeding. See Michael J. Drake, supra. Second, the July 7, 1995 Notice of Closure was not obtainable at the time of hearing because it did not issue until after both the June 21, 1995 hearing and the ALJ's June 26, 1995 order. Finally, admission of the Notice of Closure is likely to affect the outcome of the case, since an important factor in determining whether the ALJ or the Board will address claimant's entitlement to temporary disability is whether or not a claim has been closed and whether claimant is seeking an award in excess of that awarded by the closure notice/order.

Accordingly, we vacate the ALJ's order and remand for admission of the employer's Notice of Closure. The ALJ shall conduct further proceedings in any manner that will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.[2]

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[1] Under certain circumstances, it may be appropriate to take administrative notice of a document other than an agency order or stipulation of the parties. See Susan K. Teeters, supra (appropriate to take administrative notice of a request for hearing if present in any file of the Board). However, there is no indication that the July 7, 1995 Notice of Closure is present in any agency file.

[2] In light of our decision to remand, we do not address claimant's or the employer's other contentions on review.

ORDER

The ALJ's order dated June 26, 1995 is vacated. This case is remanded to ALJ Podnar for further proceedings consistent with this order.

January 11, 1996 Cite as 48 Van Natta 66 (1996)

In the Matter of the Compensation of
SUE A. SPRINGER, Claimant
WCB Case No. 93-14317
ORDER ON REMAND
Daniel M. Spencer, Claimant Attorney
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. In our prior order, Sue A. Springer, 47 Van Natta 752 (1995), we affirmed the Administrative Law Judge's (ALJ) order that directed the insurer to reimburse claimant for home health care services, including child care services, at the full rate requested by claimant. Pursuant to its December 11, 1995 order, the court has remanded this matter for reconsideration in light of Or Laws 1995, ch 332 (SB 369).

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sought reimbursement from the insurer for 24-hour child care and housekeeping services rendered during the acute phase of her recovery from compensable shoulder surgery. Claimant's attending physician had prescribed the services for a period of 6-8 weeks following surgery, in order to aid claimant's healing process. When the insurer did not reimburse the full amount of the health care services, claimant requested a hearing.

The ALJ found that the health care services, including child care, were compensable medical services under ORS 656.245 and ordered the insurer to reimburse claimant in the full amount requested (at a rate of $3 per hour). The ALJ also assessed a penalty against the insurer for unreasonable claim processing. In our prior order, we affirmed the ALJ's order. Sue A. Springer, supra. The insurer petitioned for judicial review. The court has now remanded for reconsideration "pursuant to Senate Bill 369." We proceed with our reconsideration in accordance with the court's mandate.

Subsequent to the date of the ALJ's order, and while this case was pending before the court, the legislature amended ORS 656.327(1) and added ORS 656.245(6). Both ORS 656.327(1) and 656.245(6) require review of medical services disputes by the Director, unless a claim for medical services is denied on the basis that the underlying claim is not compensable. SB 369, §§ 41, 25. In Walter L. Keeney, 47 Van Natta 1387, 1389, recon den 47 Van Natta 1525 (1995), we concluded that these statutes apply retroactively to pending cases and that the Director now has exclusive jurisdiction over such medical services disputes. See also Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565 (1995).

Here, the dispute pertains to whether claimant's health care services, including child care, were reimbursable under ORS 656.245, and, if so, at what rate. There is no dispute regarding the compensability of claimant's underlying accepted claim (for a left shoulder condition). Accordingly, because there is no dispute regarding the compensability of the underlying left shoulder claim, jurisdiction over this dispute lies with the Director, not the Hearings Division. See ORS 656.245(6); John L. Willhite, 47 Van Natta 2334 (1995). In addition, the Hearings Division and the Board also lack authority to award penalties or attorney fees for matters arising under the review jurisdiction of the Director. SB 369 § 42d(5).

Consequently, on reconsideration of our prior order, we vacate the ALJ's September 24, 1994 order. Claimant's request for hearing is dismissed for lack of jurisdiction.

IT IS SO ORDERED.

In the Matter of the Compensation of
BETTY S. TEE, Claimant
WCB Case No. 88-11538
SECOND ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Claimant requests reconsideration of our December 22, 1995 Corrected Order on Reconsideration which reversed an Administrative Law Judge (ALJ's) award of permanent total disability benefits. In our prior order, we applied amended ORS 656.206(1)(a) retroactively and found that a telemarketing job available to claimant was a "gainful occupation," as defined by the statute. Additionally, we concluded that retroactive application of Senate Bill 369 was not unconstitutional, as the legislature had a legitimate purpose in reducing workers' compensation premiums. Consequently, we concluded that claimant was not entitled to permanent total disability benefits.[1]

On reconsideration, claimant requests that this matter be remanded to the ALJ. Specifically, claimant contends that remand "would allow the development of a record on whether claimant's private interest outweighs the public interest in reducing premiums." For the following reasons, we decline to remand this matter to the ALJ.

We may remand to the ALJ for the taking of additional evidence if we determine that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or some other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

First, because claimant has not previously requested remand, we are not inclined to consider such a request for the first time on reconsideration. See Kenneth D. Nichols, 45 Van Natta 1729 (1993). Alternatively, although claimant contends that remand would permit evidence regarding claimant's private interest versus the public interest in reducing premiums, we conclude that claimant has not shown a compelling basis for remand. We base this conclusion on the following reasoning.

Claimant asserts that "[r]emand would allow the development of a record on whether claimant's private interest outweighs the public interest in reducing premiums (and any other alleged public interest employer may try to introduce)." Claimant has not, however, apprised us of, nor have we discovered, any legal support for the application of an "interests balancing test" in a case such as this, which involves a substantive due process challenge to social or economic legislation. In any event, claimant has not identified what evidence she plans to submit on remand. Under the circumstances, we find no compelling basis for remand. See e.g. Betty R. Young, 44 Van Natta 47, 49 (1992)(Board declined to remand when moving party failed to identify evidence it proposed to submit on remand).

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented herein, we republish our December 22, 1995 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] Board Chair Hall has recused himself from participating in this case. See OAR 438-011-0023.

Board Member Gunn dissenting.

I continue to disagree with the majority's position in this case, for the reasons set forth in my dissent in the prior order. Furthermore, because the law has been substantially changed by the legislature, I would grant claimant's remand request. At the very least, claimant in this case should be permitted to put on evidence regarding the constitutional test if the majority persists in applying that test in reaching its conclusion.

In the Matter of the Compensation of
EDWARD J. WITSBERGER, Claimant
WCB Case No. 93-10464
ORDER ON REVIEW
Lawrence Baron, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Neidig, Christian and Gunn.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order which set aside a Determination Order that found claimant no longer permanently and totally disabled (PTD). In his brief, claimant requests review of that portion of the ALJ's order which declined to assess a penalty for allegedly unreasonable conduct in seeking to terminate claimant's permanent total disability award. On review, the issues are permanent total disability, and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the insurer had failed to establish that claimant was no longer PTD. Thus, the ALJ reversed the May 6, 1993 and May 27, 1993 Determination Orders which found claimant no longer PTD. We disagree.

When an injured worker has received an award for permanent total disability, the award may be revoked or diminished only upon a showing by a preponderance of the evidence by the employer or insurer that the worker is capable of performing work at a gainful and suitable occupation. Harris v. SAIF, 290 Or 683, 696-97 (1982). The employer or insurer may do so by proving "that a claimant is presently capable of performing some work and that * * * capacity may be indicated either by proof of improvement in the claimant's medical condition or by circumstantial evidence of his employability." Kytola v. Boise Cascade Corp., 78 Or App 108, 111, rev den 301 Or 765 (1986) (emphasis in original); Ralph L. Reed, 47 Van Natta 483 (1995). Here, we conclude that the insurer has proved that claimant is capable of performing work, as demonstrated by circumstantial evidence of his employability.

The employer proposed to employ claimant in the position of expediter for the purchasing department. (Ex. 58). Claimant would work at home, following up with vendors that supplied materials to the employer. The employer would supply claimant with an orthopedic chair, computer and modem, fax machine, furniture and other office equipment. Id. Although there was no specific person performing the job functions of "expediter" prior to the employer offering the job to claimant, the job duties of expediter were performed by the purchasing agents. (Tr. 15). Nevertheless, when the employer's business began to improve, the employer found it necessary to hire a separate employee to fill the expediter position because the purchasing agents were too busy to perform those duties. (Tr. 17, 18).

On May 6, 1991, Dr. Gripekoven, treating physician, approved the position of expediter. (Ex. 58). On May 20, 1992, the employer offered claimant a job as Purchasing Expediter, a position which would average 20 hours per week at a salary of $12 per hour. (Ex. 62). The job offer indicated that there would be a trial work period to determine whether the job would work out for claimant and the employer. Claimant did not begin working for the employer at that time.

In July 1992, claimant underwent a physical capacity evaluation (PCE) to define his current physical abilities and determine whether he could perform the physical demands as a "Home Bound Worker" in the position of purchasing expediter for the employer. (Ex. 64). The examiners concluded that claimant was capable of work in the sedentary physical demand category. (Ex. 64-2). The examiners also stated that claimant perceived himself as severely disabled and therefore, the results of claimant's testing might be an underestimation of his physical abilities. Id. Furthermore, the examiners stated that the work of expediter was well within claimant's mental capabilities. (Ex. 64-6). Dr. Gripekoven concurred with the conclusions of the evaluation. (Ex. 65).

In January 1992, a vocational evaluator compared claimant's residual functional capacity in July 1992 with his capacity at the time of his 1989 evaluation. (Ex. 71). The evaluator noted that claimant demonstrated work endurance in excess of four hours a day on a limited basis, and that claimant had been released to work on a four hour per day basis. (Ex. 71-3). The evaluator concluded that claimant had greater vocational capabilities than he did in 1989 due, in part, to "home bound" employment opportunities. Id.

On October 8, 1992, the employer again offered claimant the job of expediter. (Ex. 66). Dr. Gripekoven again approved the position, and released claimant to perform the work for four hours per day. (Ex. 66-6). Claimant did not accept or decline the position within the specified 10 days, therefore the employer withdrew the offer on October 23, 1992. (Ex. 68). In light of the above mentioned evidence, we conclude that the employer has met its burden of proving that claimant is currently able to engage in suitable and gainful employment. Harris v. SAIF, supra.

Additionally, we conclude that the evidence in this record shows that claimant is not willing to seek regular gainful employment. See SAIF v. Stephen, 308 Or 41 (1989). Moreover, for the following reasons, we conclude that claimant's psychological condition has improved, and that it is not futile for claimant to seek work. SAIF v. Stephen, supra; Kytola v. Boise Cascade Corp., supra.

Claimant was determined to be PTD by a January 1990 Opinion and Order that was affirmed in December 1990. In large part, the determination of PTD was based on psychological conditions, including "depression" and "pain syndrome," which evaluators agreed must be addressed before a return-to-work effort could be made. (Ex. 47-4).

In March 1991, claimant was examined by Dr. Turco, psychiatrist. (Ex. 56). Dr. Turco concluded that there was no psychological reason why claimant could not work. (Ex. 56-6). Turco also reviewed the employer's home-based work proposal, and stated that claimant was not a good candidate for the program because he was not interested. Rather, Dr. Turco noted that claimant wanted to be considered PTD and would defeat any attempt to assist him otherwise. Id.

In April 1993, Dr. Stanulis, who had examined claimant approximately three years earlier, re-evaluated claimant. (Ex. 77). At that time, he noted that claimant had no significant change in his clinical status, but that he remained disabled by chronic pain syndrome. There is no evidence, however, that Dr. Stanulis reviewed current medical reports but, rather, he based his diagnosis of chronic pain syndrome on claimant's subjective reporting. Id.

In July 1994, Dr. Stanulis reviewed claimant's records. (Ex. 98). At that time, he concluded that claimant suffered from a pain disorder and several psychological factors affecting claimant's pain disorder. Again, however, Dr. Stanulis based his conclusions on the numerous references in the record to claimant's subjective "feelings" that he is disabled, and that any interventions or attempts to return to work would only worsen his condition. (Ex. 98-2, 3). Furthermore, Dr. Stanulis' conclusion concerning psychological factors is directly contrary to his April 1990 opinion that claimant did not suffer from formal depression, and there is no apparent explanation for his change of opinion.

In August 1994, Dr. Turco reviewed Dr. Stanulis' July 1994 report. (Ex. 104). Dr. Turco noted that prior examinations of claimant revealed no objective findings of a psychiatric disorder. Dr. Turco disagreed with Dr. Stanulis' DSM-IV diagnosis of pain syndrome in the absence of objective medical findings. (Ex. 104-2). Additionally, Dr. Turco also questioned the validity of claimant's claim in light of considerable discrepancies with regard to claimant's physical presentation.

In September 1994, Dr. Binder, psychologist, reviewed Dr. Stanulis' reports. (Ex. 106). Dr. Binder noted that, because the criteria for Dr. Stanulis' pain disorder diagnosis were so broad, claimant appeared to fit into the diagnosis. However, Dr. Binder also reiterated Dr. Stanulis' observations that claimant believes he is completely disabled, and is unwilling to pursue treatment. Dr. Binder therefore concluded that it is claimant's perception about his situation which disables him, rather than his actual medical condition. Id.

After our de novo review of the record, we are persuaded by the opinions of Drs. Turco and Binder that claimant has no specific psychological diagnosis. Accordingly, based on the lack of a

psychological diagnosis, and Dr. Gripekoven's medical release to work for at least four hours per day, we conclude that claimant's condition has improved since his determination of PTD. Furthermore, in light of the evidence discussed above, we conclude that a preponderance of the evidence shows that claimant is not willing to seek regular gainful employment.[1] See SAIF v. Stephen, supra; Kytola v. Boise Cascade Corp., supra. Accordingly, we reverse that portion of the ALJ's order that found that claimant remains permanently and totally disabled. The Determination Orders are reinstated and affirmed.

Penalties

We adopt the portion of the ALJ's order that declined to assess a penalty for unreasonable conduct in seeking to terminate claimant's permanent total disability award.

ORDER

The ALJ's order dated February 2, 1995 is reversed in part and affirmed in part. That portion of the order that reversed the May 6, 1993 Determination Order, as amended May 27, 1993, that found claimant no longer permanently and totally disabled, is reversed. The ALJ's attorney fee award is also reversed. The Determination Orders are reinstated and affirmed. The remainder of the order is affirmed.

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[1] We note that claimant made one unsuccessful attempt to work at a telephone sales job in December 1993, several months after the director found him no longer PTD. (Ex. 92).

Board Member Gunn dissenting.

An award for permanent total disability may be revoked or diminished only upon a showing by a preponderance of the evidence by the employer or insurer that the worker is capable of performing work at a gainful and suitable occupation. Harris v. SAIF, supra. Furthermore, the determination of permanent total disability status turns upon whether claimant is currently employable or able to sell his services on a regular basis in a hypothetically normal labor market, undistorted by such factors as sympathy of the employer or friends.

Here, there has been absolutely no showing that claimant is able to work on a regular basis in a hypothetically normal labor market. Rather, the employer has offered to provide claimant, in claimant's small home, all the necessary equipment to perform a "telecommuting" job. Further, it is questionable whether that job existed at the employer's business before he offered the job to claimant. Moreover, assuming claimant is capable of performing the job duties of an "expediter" (a fact that has not been determined), I do not consider this a job that exists in a theoretically normal labor market, or a job for which claimant has the training or experience to perform. See OAR 436-30-055(1)(b).

Moreover, after reviewing the medical evidence, including reports from claimant's treating psychologist, I am persuaded that the medical evidence is, at best, in equipoise concerning any improvement in claimant's physical and psychological conditions. Therefore, the insurer has failed to meet its burden of proving that claimant does not remain permanently and totally disabled. See Kytola v. Boise Cascade Corp. supra. Accordingly, I respectfully dissent.

In the Matter of the Compensation of
ANSELMO PEREZ, Claimant
WCB Case Nos. 94-12353 & 94-10743
ORDER ON REVIEW
H. Galaviz-Stoller, Claimant Attorney
James Booth (Saif), Defense Attorney
John E. Snarskis, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Holtan's order that upheld Industrial Indemnity's denial of his claim for a low back injury. On review, the issue is compensability.

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

Analyzing the claim under former ORS 656.005(7)(a)(B), the ALJ determined that the major cause of claimant's disability and need for treatment in July 1994 was his preexisting low back condition (including a history of low back strains, pain and a hemiated disc at L5-S1) rather than any event occurring at work.

On review, claimant contends that a lifting incident occurring at work on July 5, 1994 was the major contributing cause of his need for treatment during July 1994. Conceding that his preexisting disc condition was not caused or worsened by the work incident, claimant asks that we treat the back strain and muscle spasm diagnosed by the emergency room physician on July 5, 1994 as anew compensable injury separate from his preexisting condition. However, on this record, claimant's low back symptoms as of July 5, 1994 cannot be separated from his preexisting condition. The ALJ therefore correctly applied ORS 656.005(7)(a)(B).[1]

Like the ALJ, we conclude that claimant has not sustained his burden of proof. Only two experts, Dr. Fuller (who examined claimant at Industrial Indemnity's request) and Dr. Gabr (who claimant saw on referral from his treating doctor, Dr. Mata) provided opinions concerning the cause of claimant's condition and need for treatment. Dr. Fuller concluded that claimant's current pain was simply a waxing and waning of his preexisting condition, which dated back to a 1989 injury. Dr. Fuller stated unequivocally that claimant's preexisting condition was the major contributing factor in his need for treatment.[2] We note that Dr. Fuller had the benefit of examining claimant on two occasions, once in 1992 and again after the alleged injury of July 5, 1994.

Although Dr. Gabr's opinions were less definite than Dr. Fuller's, Dr. Gabr did acknowledge that any strain caused by claimant's work activity would have combined with his preexisting disc pathology to cause the need for treatment. (Ex. 24-14). Ultimately, Dr. Gabr testified that claimant's preexisting disc pathology likely contributed more to claimant's need for treatment than his work activity. (Ex. 24-14; 24-24).

Given this medical evidence, we conclude that claimant has failed to establish that an on-the-job injury was the major contributing cause of his need for treatment on his low back during July 1994. Consequently, we affirm the ALJ's order.

ORDER

The ALJ's order dated June 12, 1995 is affirmed.

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[1] This section was amended by Or Laws 1995, ch 332 § 1 (SB 369, § 1). Although we apply the amended version in our analysis (see SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995)), we note that the result in this case would be the same under the former law as well.

[2] Claimant's treating physician, Dr. Mata, concurred with Dr. Fuller's report.

In the Matter of the Compensation of
CATHY O. RAVINS, Claimant
WCB Case No. 94-06076
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Balasubramani's order that upheld the insurer's denial of claimant's left shoulder condition. On review, the issue is compensability.

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

The insurer argues that the claim is not compensable under ORS 656.005(7)(b)(B) because the dragon boat races were recreational activities primarily for claimant's personal pleasure. We agree.

Participating in the boat races was not part of claimant's job duties. She was not paid to participate. The boat races did not occur on the employer's premises and occurred at a time when claimant was not actually working for the employer. The employer did not require participation, but rather it was voluntary. The only benefit to the employer was improved employee health and morale. Accordingly, the claim is not compensable under ORS 656.005(7)(b)(B) because claimant was participating in the dragon boat races primarily for her personal pleasure. See Michael W. Hardenbrook, 44 Van Natta 529 (1992), aff'd mem 117 Or App 543 (1992).

Moreover, even if the claim was not excluded under ORS 656.005(7)(b)(B), the ALJ found that claimant's participation in the boat races was not work related under the Mellis' factors.

Subsequent to the ALJ's order, the Court of Appeals determined in First Interstate Bank of Oregon v. Clark, 133 Or App 712, 717 (1995), that the proper framework for our analysis under ORS 656.005(7)(a) was set forth in Norpac Foods, Inc., v. Gilmore, 318 Or 363 (1993). In Norpac Foods, the Court stated that the proper analysis to determine whether an injury was sufficiently work-connected to justify compensability consisted of a two prong test. The first prong considers whether the injury occurred "in the course of employment" and the second prong evaluates whether the "injury arose out of the employment." Norpac Foods v. Gilmore, supra. The Court determined that neither prong was dispositive, and the Board must consider the "totality of the circumstances" to determine if the claimant has shown a sufficient work connection. Id. at 366,369.

Here, notwithstanding the ALJ's reliance on the Mellis' factors, we agree with the ALJ's conclusion that claimant's participation in the boat races was not work related. For the reasons we found the activity a noncompensable recreational activity, we likewise find it unrelated to work under the Norpac Foods' analysis.[1] Consequently, we find that the risk of injury from participating in the dragon boat races was personal to claimant. See Henderson v. S.D. Deacon Corp., 127 Or App 333 (1994)(injury does not arise out of employment where the conditions of the employment does not put the claimant in a position to be injured).

ORDER

The ALJ's order dated April 5, 1995 is affirmed.

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[1] Considering the totality of the circumstances, the employer's willingness to adjust claimant's work schedule to accommodate the "dragon boat" practice sessions, is insufficient to establish a work connection.

Board Member Hall specially concurring.

While I agree with the majority that claimant has failed to establish that her work activities caused her left shoulder condition, I write separately to address the course and scope issue. Based on this record, I would find there is insufficient evidence to reach a conclusion, under the Norpac Food's analysis, of whether or not claimant's participation in the dragon boat races was a work-related activity. Thus, given the lack of evidence, claimant has failed to meet her burden of proof on this issue.

January 16, 1996 Cite as 48 Van Natta 73 (1996

In the Matter of the Compensation of
DEANNA L. KLOCK, Claimant
WCB Case No. 94-08902
ORDER ON RECONSIDERATION
Whitehead & Klosterman, Claimant Attorneys
Scheminske & Lyons, Defense Attorneys

The insurer requested reconsideration of our November 15, 1995 Order on Review that found that claimant is entitled to have her temporary partial disability (TPD) benefits reinstated after December 15, 1993. The insurer contends, first, that it raised the issue of claimant's entitlement to temporary disability benefits after January 1994, when claimant allegedly left work for reasons unrelated to her injury; and, second, that claimant returned to regular work.

On December 14, 1995, we withdrew our order to consider the insurer's request and give claimant the opportunity to respond. Having received claimant's response, we proceed with our reconsideration.

At hearing, the issue was framed as the unilateral termination of temporary disability compensation after December 15, 1993 on an open claim. (Tr. 2). The insurer indicated that there were no cross-issues. (Id.) At this point, discussion ensued between the parties and the ALJ regarding the insurer's willingness to go forward on the unilateral termination issue as of the date of December 15, 1993, rather than January 4, 1994. (Tr. 5 through 9). After the insurer verified with its claims examiner the date it terminated temporary disability payments, the insurer agreed it no longer objected to the revised issue; i.e., the December 15, 1993 date of termination. (Tr. 10). Thus, the sole issue raised at hearing was unilateral termination of claimant's temporary disability payments as of December 15, 1993. Consequently, we continue to decline the insurer's request to address an issue not raised at hearing.

Finally, our order adequately explains our conclusion that claimant was not released to regular work. Thus, we find it unnecessary to provide further discussion regarding this issue.

Accordingly, as supplemented herein, we adhere to and republish our November 15, 1995 Order on Review in its entirety. The parties' rights of appeal shall begin to run as of the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM K. BOWLER, Claimant
WCB Case No. 95-04253
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Bailey & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Schultz's order that: (1) found the Hearings Division had jurisdiction over claimant's request for temporary disability, notwithstanding claimant's receipt of benefits under a federal law; and (2) awarded additional temporary disability. On review, the issues are jurisdiction, preemption, and temporary disability. We affirm.

FINDINGS OF FACT

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

On August 5, 1994, claimant compensably injured his right knee and underwent surgery for this injury on September 7, 1994. The employer accepted the claim and paid temporary total disability from September 7, 1994 through September 18, 1994. As of September 19, 1994, claimant was released to and returned to modified (sedentary) work for the employer. The employer paid claimant his at-injury wage for this modified work. Claimant performed this modified work until September 28, 1994, when the employer closed the plant. Claimant performed no services for the employer after the plant closure.

Notification of plant closure was given to the employees on September 26, 1994. Pursuant to the federal Worker Adjustment and Retraining Notification Act (WARN Act), claimant continued receiving full wages from the employer for 60 days following the notification of the plant closure, i.e., he was paid full wages through November 26, 1994.

Claimant did not receive unemployment compensation during this time because he had previously exhausted those benefits. On or about October 17, 1994, claimant was hired in a light duty job in computer sales. This job pays $1,000 gross per month, which is less than the at-injury job paid. After claimant stopped working on September 28, 1994, the employer did not resume temporary total disability benefits or temporary partial disability benefits. On April 14, 1995, an Order to Show Cause for Failure to Pay Compensation was issued pursuant to claimant's motion under OAR 438-06-075. As of the date of hearing on this "show cause" order, claimant's condition was not yet medically stationary.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction/Preemption

The ALJ found that the Hearings Division had jurisdiction to decide the Workers' Compensation matter. The ALJ also found that the federal law did not preempt application of Oregon Workers' Compensation Law. On review, the employer renews its jurisdiction/preemption arguments. We agree with the ALJ that both arguments fail.

Regarding jurisdiction, ORS 656.283(1)[1] provides, in relevant part, that "any party or the Director . . . may at any time request a hearing on any question concerning a claim." ORS 656.704(3) defines the phrase "concerning a claim," and sets forth the respective authority of the Director and the Board (and its Hearings Division) to conduct hearings, investigations and other proceedings under Chapter 656. That statute provides, in relevant part:

> "[M]atters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any proceeding for resolving a dispute regarding medical treatment or fees for which a procedure is otherwise provided in this chapter."

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[1] Subsequent to the ALJ's order, Senate Bill 369 (SB 369) was enacted. SB 369, 68th Leg., Reg. Sess. (June 5, 1995). The bill amends ORS 656.283(1) and ORS 656.704(3). Sections 34 and 50. However, we need not resolve the applicability of these amendments because, under either version of the statutes, the result would be the same.

The present claim relates to claimant's entitlement to temporary disability benefits following the plant closure. Therefore, the exclusions in ORS 656.283(1) and ORS 656.704(3) which might take a claim out of the Board's (and its Hearings Division's) jurisdiction do not apply to this claim. In addition, the dispute over claimant's entitlement to temporary disability is a "matter concerning a claim," since claimant's right to receive compensation is directly in issue. Because no statutory exclusions apply, this dispute is within the jurisdiction of the Hearings Division and the Board.

The employer argues that federal district courts have exclusive jurisdiction to determine whether payments under the WARN Act are "wages." We disagree with this argument. The WARN Act actually provides that a person seeking to enforce liability under its provisions "may sue . . . in any district court of the United States . . . ." 29 USC § 2104(a)(5). However, while we certainly agree that we have no jurisdiction to enforce provisions of the WARN Act, that is not the issue before us. Instead, the issue before us is a workers' compensation claim regarding temporary disability benefits. That issue is within our jurisdiction. ORS 656.283(1); 656.704(3); see also Division of Employment Security v. Labor & Industrial Relations Commission, 884 S.W.2d 399, 402 (Mo.App. W.D. 1994) (citing Labor & Industrial Relations Commission v. Division of Employment Security, 856 S.W.2d 376, 380 (Mo.App. E.D. 1993), wherein the court noted that the Missouri Employment Security statute, not the WARN Act, governed the deductibility of employee pay from unemployment benefits; therefore, its task was to determine whether WARN payments amount to wages within the meaning of that state statute).

The employer also argues that we may not decide claimant's entitlement to temporary disability during the period he received payments pursuant to the WARN Act because such a decision is preempted by federal law. We disagree.

Congress has the power to preempt state law pursuant to the Supremacy Clause of Article VI of the U.S. Constitution. In Louisiana Public Service Commission v. F.C.C., 106 S. Ct 1890, 1898 (1986), the Supreme Court explained federal preemption as follows:

> "Pre-emption occurs when Congress, in enacting a federal statute, expresses a clear intent to pre-empt state law, when there is outright or actual conflict between federal and state law, where compliance with both federal and state law is in effect physically impossible, where there is implicit in federal law a barrier to state regulation, where Congress has legislated comprehensively, thus occupying an entire field of regulation and leaving no room for the States to supplement federal law, or where the state stands as an obstacle to the accomplishment and execution of the full objectives of Congress." (Citations omitted).

Any interaction between the WARN Act and the Oregon Workers' Compensation Law regarding temporary disability benefits does not meet any of the requirements for federal preemption. The WARN Act expresses no intent to preempt state worker's compensation laws. See 29 USC §2101 - 2109. In addition, there is no conflict between the two laws since each deals with totally unrelated subjects. In this regard, the WARN Act deals with the federal requirement that certain employers give 60 days notice before closing a plant and the consequences of failing to give adequate notice, whereas the Oregon Workers' Compensation Law deals with benefits to injured workers, including temporary disability. Furthermore, it is not impossible to comply with both laws, nor does the Oregon law present an obstacle to the congressional objectives.[2] See also Capitol Castings, Inc. v. Arizona Department of

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[2] The purpose of the WARN Act is to provide protection to workers and their families by providing advance notice of plant closures and mass layoffs in order to provide "some transition time to adjust to the prospective loss of employment, to seek and obtain alternative jobs and, if necessary, to enter skill training or retraining that will allow these workers to successfully compete in the job market." Worker Adjustment and Retraining Notification, 20 C.F.R. § 639.1.

The employer argues that if we require payment of temporary disability in addition to the payment required under the WARN Act, it would encourage employers to require injured workers to show up for work at closed plants. This, the employer argues, would thwart congressional objectives by reducing the amount of time injured workers could look for other work. However, nothing in the WARN Act requires an employer to give a worker time off to look for a new job. The WARN Act requires notification of a plant closure or mass layoff and provides for penalties if the required notice is not given. It is this notification that allows workers time to seek new jobs. Payment of temporary disability benefits under Oregon law has no affect on the WARN Act's notification requirement.

Economic Security, 828 P. 2d 781, 785-86 (Ariz.App. 1992) (court held that because the WARN Act did not purport to govern the classification of state unemployment compensation payments, it would not assume Congress intended its use of the term "backpay" to control a recipient's eligibility for state unemployment compensation; therefore, the court found no reason in the WARN Act for changing the classification required by state law for payments made by an employer to its employees in anticipation of violating the WARN Act notice provision).

Temporary Disability Benefits

Relying, in part, on Arturo G. Vasquez, 44 Van Natta 2443 (1992), and Kati A. Hanks, 44 Van Natta 881 (1992), aff'd Safeway Stores, Inc. v. Hanks, 122 Or App 582 (1993), the ALJ concluded that claimant was entitled to reinstatement of temporary total disability (TTD) benefits on September 29, 1994 because the modified job he had been performing was withdrawn at that time as a result of the employer's plant closure. In addition, the ALJ concluded that, when claimant began receiving income from new employment on October 17, 1994, he was no longer entitled to TTD benefits but was entitled to temporary partial disability (TPD) benefits instead. We adopt the ALJ's reasoning and conclusions regarding the temporary disability issue and write only to address the employer's arguments on review.

The employer argues that neither Vasquez, supra, nor Hanks, supra, apply to the facts of this case. In Vasquez, we held that ORS 656.268(3), 656.325(5)[3], and the rules applying those statutes require that TTD must be reinstated when an offer of modified employment is withdrawn. The employer argues that it did not withdraw its offer of modified employment when it closed the plant on September 29, 1994. It argues that the modified job offer was not withdrawn until November 26, 1994, when the WARN Act notice period expired. We disagree. Obviously, when the plant closed the modified job claimant was performing was no longer available. In addition, there is no evidence that claimant was offered any other modified job by the employer after the plant closed. In this regard, it is undisputed that claimant performed no services for the employer after plant closure. Therefore, we find Vasquez applicable to this case.

We also find Hanks applicable. In Hanks, we found that the employer's lock out effectively withdrew modified employment from the claimant and entitled her to TTD benefits during the lock out. There, claimant was unable to return to her regular work with another employer because of the physical limitations due to her work injury and could not voluntarily continue the modified job because of the lock out. Here, the employer argues that its plant closure is not similar to a lock out because it continued paying claimant as if he were working in order to meet the requirements of the WARN Act. We disagree. The plant closure had the same effect as a lock out in that claimant could not voluntarily continue to perform the modified work due to the closure, nor could he perform his regular work for another employer due to the limitations from his work injury.

Regarding the payments it made to avoid violating the WARN Act, the employer argues that those payments were wages, not penalties. Therefore, the employer argues, claimant is not entitled to temporary disability benefits during the period he received WARN Act payments because he received his full wages during that period. We disagree.

The crucial point is whether the WARN Act payments constitute wages under Oregon Workers' Compensation Law. In order to make that determination, we must interpret what constitutes "wages" under the Oregon Workers' Compensation Law. This line of analysis follows that performed by other jurisdictions in interpreting the appropriate state laws to determine the affect of WARN Act payments on other entitlement programs. See Division of Employment Security v. Labor & Industrial Relations Commission, supra (court interpreted Missouri unemployment compensation law in determining that WARN payments were "wages" under Missouri law and were fully deductible from unemployment benefits); Capitol Castings, Inc. v. Arizona Department of Economic Security, supra (court interpreted Arizona unemployment compensation law in determining that WARN payments were not "wages" under Arizona law and were not deductible from unemployment benefits); Georgia-Pacific Corporation v. Unemployment Compensation Board of Review, 630 A.2d 948 (Pa.Cmwlth. 1993) (court interpreted Pennsylvania unemployment compensation law in determining that WARN payments were not "wages" under Pennsylvania law and were not deductible from unemployment benefits); see also In re Cargo,

[3] SB 369 amended ORS 656.268(3) and ORS 656.325(5). Sections 30 and 40. However, we need not resolve the applicability of these amendments because, under either version of the statutes, the result would be the same.

Inc., 138 B.R. 923 (Bkrtcy.N.D.Iowa 1992) (court interpreted federal Bankruptcy Code in determining that WARN payments were "wages" under the Bankruptcy Code and were entitled to priority as claims for wages).

We have determined that claimant is entitled to reinstatement of TTD benefits upon the withdrawal of the modified job offer at plant closure. TTD compensation is computed as a percentage of a worker's "wages." ORS 656.210(1). "Wages" is defined in ORS 656.005(27), renumbered ORS 656.005(29), as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident. . . ." Thus, the definition of "wages" is tied to the concept of rendering services in exchange for money. Here, it is undisputed that claimant rendered no services for the employer in exchange for the WARN Act payments. Claimant provided no services for the employer after the plant closure.

The employer argues that, if claimant is found entitled to TTD benefits in addition to the WARN Act payments, he would receive a windfall that his uninjured co-workers would not be entitled to. We disagree. There is nothing in the WARN Act that would prohibit a worker from obtaining full-time employment with another employer at the same time he or she was receiving payments under the WARN Act. Furthermore, the WARN Act does not provide for deductions from WARN Act payments for wages paid by other employers. 29 USC § 2104(a)(2). On the other hand, due to his work injury, claimant was restricted to modified work during the time he was receiving WARN Act payments. In other words, due to the work injury, claimant was unable to seek his regular work. Claimant's uninjured co-workers were not at that disadvantage. (Although claimant was able to obtain modified work in another field, that job pays less than claimant's at-injury wage.) We do not consider claimant's entitlement to TTD benefits under the circumstances of this case to constitute a "windfall."

In summary, given the definition of "wages" as involving services rendered for money, and the fact that claimant rendered no services after the plant closure, we find that the payments made by the employer in compliance with the WARN Act are not "wages" within Oregon's Workers' Compensation Law. Therefore, the WARN Act payments have no effect on claimant's entitlement to temporary disability benefits. Accordingly, claimant is entitled to TTD benefits from September 29, 1994, until October 17, 1994, at which time he began light duty work with another employer. Claimant is entitled to TPD from October 17, 1994 until such payments may be discontinued pursuant to law.

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 438-15-010(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 employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated May 25, 1995 is affirmed. For services on review, claimant is awarded an assessed attorney fee of $1,300, payable by the self-insured employer.

January 17, 1996 Cite as 48 Van Natta 77 (1996)

In the Matter of the Compensation of
STEVEN L. CLINE, Claimant
WCB Case No. 93-00701
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Cline, 135 Or App 155 (1995). The court reversed our prior order, Steven L. Cline, 46 Van Natta 132, on recon 46 Van Natta 512 (1994), which assessed a penalty under ORS 656.268(4)(g) when an Order on Reconsideration increased claimant's scheduled permanent disability award from 23 percent (11.04 degrees) for the thumb to 42 percent (20.16 degrees) for the thumb and 6 percent (9 degrees) for the hand. Holding that the extent of disability is determined by the extent of disability to the whole worker, translated into degrees, and that a worker is at least 20 percent disabled when he or she has suffered 64 degrees of disability, the court has remanded for reconsideration.

The relevant facts are as follows. A Notice of Closure awarded claimant 23 percent (11.04 degrees) scheduled permanent disability for the loss of use or function of his right thumb. Claimant requested reconsideration.

On reconsideration, the Department increased the scheduled permanent disability award to 42 percent (20.16 degrees) for the thumb and 6 percent (9 degrees) for the right hand. The Department did not award a penalty under former ORs 656.268(4)(g).[1]

Claimant requested a hearing, contending, inter alia, that he was entitled to the assessment of a penalty under former ORS 656.268(4)(g). The Administrative Law Judge (ALJ) (formerly Referee), finding that claimant was at least 20 percent disabled and that the disability award was increased at least 25 percent on reconsideration, assessed a penalty under former ORS 656.268(4)(g). SAIF requested review of that portion of the ALJ's order.

On review, we adopted and affirmed the ALJ's order. Steven L. Cline, supra. SAIF requested reconsideration of our order. On reconsideration, we adhered to our prior order. Id.

The court has reversed our decision. SAIF v. Cline, supra. SAIF contended that a penalty was not appropriate because the percentage of claimant's disability, when converted to that of the whole worker, was less than 20 percent disabled. The court identified the issue as the validity and applicability of former OAR 436-30-050(13), which provided that a total sum of 64 degrees of scheduled or unscheduled disability shall constitute at least 20 percent disabled.

The court reasoned that, because the text of former ORS 656.268(4)(g) refers to the disability of "the worker," not a particular body part, percentage of disability of a particular body part must be converted to a percentage of the whole worker before the statute may apply. SAIF v. Cline, supra, 135 Or App at 159. The court instructed that, in order to determine the extent of disability to the whole worker, the disability must be translated into degrees, the statutory measuring unit. Id. Because 320 degrees comprises the whole worker, he or she must have suffered at least 64 degrees of permanent disability (20 percent of 320 degrees) in order to be at least 20 percent disabled for purposes of former ORS 656.268(4)(g). See id. at 160. Because former OAR 436-30-050(13) was consistent with that reasoning, the court concluded that the rule was valid. Id.

Consequently, the court has remanded for reconsideration. Pursuant to the court's mandate, we proceed with our reconsideration.

Here, claimant received a scheduled permanent disability award on reconsideration of 42 percent (20.16 degrees) for the thumb and 6 percent (9 degrees) for the hand. Because claimant has received less than 64 degrees of disability, he is not entitled to a penalty under former ORS 656.268(4)(g). SAIF v. Cline, supra; former OAR 436-30-050(13).

Accordingly, on reconsideration of our January 26, 1994 order, as reconsidered on March 25, 1994, we reverse that portion of the ALJ's May 13, 1993 order which assessed a penalty under former ORS 656.268(4)(g).

IT IS SO ORDERED.

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[1] Former ORS 656.268(4)(g) provided:

"If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

We note that ORS 656.268(4)(g) has been amended by the 1995 Legislature. Or Laws 1995, ch 332, §30(4)(g) (SB 369, §30). Those amendments apply only to claims that become medically stationary on or after June 7, 1995, the effective date of the Act. SB 369, §§ 66(4), 69. Claimant became medically stationary on April 2, 1992. (Ex. 15A-4). Therefore, the amendments do not apply, and we analyze this matter under former ORS 656.268(4)(g).

In the Matter of the Compensation of
BARBARA COOPER-TOWNSEND, Claimant
WCB Case No. 94-07087
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Claimant requests reconsideration of our December 21, 1995 order which: (1) declined to award unscheduled permanent disability for a bilateral shoulder condition; and (2) decreased her scheduled permanent disability award for loss of use or function of the left arm from 5 percent, as award by the ALJ, to 4 percent and decreased her scheduled permanent disability award for loss of use or function the right arm from 8 percent, as awarded by the ALJ, to 5 percent. Specifically, claimant contends we erred in not awarding an assessed attorney under ORS 656.382(2) for defending against the self-insured employer's cross-request for review which asserted that claimant's permanent disability should be reduced to zero. We disagree.

ORS 656.382(2) allows for an assessed fee where a carrier initiates an appeal and claimant's compensation is not reduced or disallowed. Here, the employer requested review and the compensation awarded by the ALJ was reduced by our order. Consequently, claimant is not entitled to an assessed fee pursuant to ORS 656.382(2). See Marie E. Brewer, 45 Van Natta 815 (1993).

Accordingly, our December 21, 1995 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our December 21, 1995 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
HARLEY J. GORDINEER, Claimant
WCB Case Nos. 94-04853, 94-00533 & 93-14467
ORDER ON RECONSIDERATION
David C. Force, Claimant Attorney
Schwabe, et al, Defense Attorneys
Alan Ludwig (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

On November 8, 1995 we withdrew our November 6, 1995 Order on Review on our own motion, to consider the effect, if any, amended ORS 656.308(2)(d) has on claimant's attorney fee award to be paid by Liberty Northwest Insurance Corporation for services at hearing for prevailing over Liberty's denial of claimant's "new injury" claim for a low back condition. Having received and considered the parties' supplemental briefing, we proceed with our reconsideration.[1]

We need not determine whether, under these circumstances, Liberty denied responsibility only, because even if it did, we find extraordinary circumstances justified the $8,000 fee under ORS 656.308(2)(d). Moreover, if Liberty denied compensability and responsibility, the fee would be the same under ORS 656.386 and ORS 656.308(2)(d).

Amended ORS 656.308(2)(d)[2] provides:

> "Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the insured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances." SB 369, § 37. (Emphasis added).

Accordingly, notwithstanding ORS 656.386(1) (that entitles claimant to an attorney fee for prevailing over a compensability denial), and ORS 656.382(2) (that provides for an attorney fee for successfully defending against a carrier's request for hearing/review), amended ORS 656.308(2)(d) limits claimant to a maximum $1,000 attorney fee for "finally prevailing against a responsibility denial," absent a showing of extraordinary circumstances. See Julie M. Baldie, 47 Van Natta 2249 (1995).

Assuming, without deciding, that ORS 656.308 applies, we must determine whether claimant's counsel appeared and participated (in an active and meaningful manner) in finally prevailing against a responsibility denial. If he did, an attorney fee will be awarded, not to exceed $1,000 absent a showing of extraordinary circumstances.

Claimant's counsel appeared at hearing and actively and meaningfully participated in finally prevailing against Liberty's responsibility denial.[3] Claimant requested a hearing contesting Liberty's

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[1] Following our abatement order, we received a hand-written letter from claimant. (Inasmuch as it is unclear whether copies of this letter were provided to the insurers' and claimant's counsel, copies have been furnished with the counsels' copies of this order.) Specifically, claimant sought an opinion from the Board's staff counsel regarding whether our November 8, 1995 abatement order pertained to all issues decided in our November 6, 1995 Order on Review. This submission bears some similarity to claimant's counsel's supplemental brief which urged us to revise our abatement order to limit the "withdrawn" portion of our Order on Review to claimant's attorney fee award.

First, in light of his legal representation, claimant's inquiries regarding the effect of our prior orders on his rights to benefits are referred to his attorney. Secondly, in response to claimant's counsel's request, by virtue of this reconsideration order, our prior "withdrawn" order, as supplemented herein, has been republished. Consequently, claimant's counsel's request for revision of our abatement order has become moot.

[2] Amended ORS 656.308(2)(d) applies retroactively to cases pending on Board review, including this one. See Dan J. Anderson, 47 Van Natta 1929 (1995).

[3] See Paul R. Huddleston, 48 Van Natta 4 (1996) (Claimant's attorney entitled to a carrier-paid fee under ORS 656.308(2)(d) for "[a]ctive and meaningful participation" in "finally prevailing against a responsibility denial" when attorney advocated that a particular carrier (with a different TTD rate) was responsible for the claim, even though another carrier was ultimately determined to be responsible.

denial. In his opening statement and written closing argument, claimant's attorney contended that responsibility should shift to Liberty. Moreover, claimant's counsel elicited testimony from claimant and cross-examined another witness. Finally, resolution of the responsibility determination is "meaningful" in that if the "un-joined" carrier was found responsible, claimant would not receive compensation, if Cigna was found responsible, claimant's aggravation rights under that claim have expired; and, finally, his temporary disability rates are different for the SAIF, Cigna, and Liberty claims. On these facts, we find that claimant has established entitlement to an attorney fee for services at hearing under ORS 656.308(2)(d). We further find that claimant has shown extraordinary circumstances justifying an assessed fee greater than $1,000. We base this conclusion on the following reasoning.

The medical and legal issues in this voluminous record (consisting of approximately 120 exhibits) are complex, involving three potentially responsible employers and application of numerous statutes. The transcript is over a hundred pages long. The hearing lasted 4 1/2 hours and involved three witnesses. The value of claimant's interest is substantial, with the risk of a complete loss of benefits (had the "empty chair" defense succeeded) and potential loss of future permanent disability benefits and vocational assistance.[4] Claimant's counsel has skillfully and successfully advocated claimant's position in this procedurally and substantively complex case.

Based on the aforementioned factors, we conclude that this case constitutes extraordinary circumstances justifying an attorney fee beyond the $1,000 cap of ORS 656.308(2)(d). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for these extraordinary circumstances is $8,000, payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issues, the value of the interest, the skill of the attorneys, the nature of the proceeding, and the risk that counsel might go uncompensated.

In addition, we address the following issues raised by the parties' arguments on reconsideration.

SAIF contends that claimant's testimony regarding his wages is insufficient to determine that his temporary disability compensation was underpaid. We disagree. Instead, we find, as did the ALJ, that claimant's unrebutted testimony establishes that his temporary disability should be determined based on a wage rate of $12.28 per hour.

SAIF also argues that the attorney fee of 25 percent of the additional temporary disability compensation awarded by the ALJ's order (not to exceed $1,050) should be "out of" claimant's compensation" instead of "in addition to" that compensation. We agree. See ORS 656.386(2); OAR 438-15-0045. The ALJ's order is modified accordingly.

Cigna argues that it should not be liable for the $1,000 attorney fee awarded by our initial order for services on review. However, as we stated in our initial order, Cigna's cross-request for review regarding its denial placed claimant's entitlement to compensation at risk. Thus, Cigna must pay claimant's attorney fee for services on review concerning the denial issue under ORS 656.382(2).

Finally, claimant is entitled to an attorney fee for services on reconsideration, to the extent that those services pertain to defending his temporary disability award. See ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on reconsideration concerning the temporary disability issue is $100, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's briefs on reconsideration), the complexity of the issue, and the value of the interest involved.

Accordingly, on reconsideration, as supplemented, amended, and modified herein, we adhere to and republish our November 6, 1995 order in its entirety. The parties' rights of appeal shall begin to run as of the date of this order.

IT IS SO ORDERED.

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[4] Because the 1979 claim with Cigna was in "own motion" status, a shifting of responsibility to Cigna's 1979 claim would have resulted in no future awards of either vocational assistance or permanent disability for his low back condition. See ORS 656.278; Independent Paper Stock v. Wincer, 100 Or App 625 (1990).

In the Matter of the Compensation of
PAULA A. GRANNER, Claimant
WCB Case No. 95-01626
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Daughtry's order that set aside its denial of claimant's current right knee condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant has a congenital bilateral knock knee deformity (genu valgum). As a result, she has suffered recurrent right knee patellar dislocations. Prior to 1990, three of the dislocations required a physician to relocate the patella.

In October 1990, claimant suffered a right knee patellar dislocation while working for SAIF's insured. In November 1990, SAIF issued a Notice of Acceptance, for a right patella dislocation. Claimant's claim was closed by a December 26, 1990 Notice of Closure which awarded temporary disability benefits only.

Following the injury, claimant continued to experience right knee pain and swelling. She did not sustain further dislocation or injury to her right knee. In June 1994, claimant began treating with Dr. Gallagher, M.D., who diagnosed chronic right patella dislocation and subluxation; right knee patellofemoral arthritis; probable right knee medial joint arthritis; and generalized ligamentous laxity. Dr. Gallagher prescribed a right knee patellar stabilizing brace. Thereafter, Dr. Gallagher recommended that claimant undergo right knee patellar realignment surgery.

SAIF denied claimant's right knee condition on the basis that her injury was not the major contributing cause of her recurrent subluxations. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the major contributing cause of claimant's current right knee condition was her preexisting patellar misalignment and hypermobility. Furthermore, concluding that SAIF had accepted claimant's preexisting condition, the ALJ set SAIF's denial aside. We disagree.

Whether an acceptance occurs is a question of fact to be decided based on all the evidence. SAIF v. Tull, 113 Or App 449, 454 (1992).

Here, claimant made a claim for a right knee injury occurring in October 1990. (Ex. 1). Her injury was diagnosed as a right knee patella dislocation. (Exs. 2, 3, 4). On November 5, 1990, SAIF issued a Notice of Acceptance which specified that it was accepting "right patella dislocation." (Ex. 10). There is no contrary evidence. Although Dr. Gallagher believes that from a medical standpoint SAIF's acceptance should have included claimant's preexisting right knee condition, that belief does not establish that SAIF did in fact accept the preexisting condition. (Ex. 29). Rather, the record establishes that SAIF only accepted a right patellar dislocation. Consequently, we conclude that SAIF's acceptance did not include claimant's preexisting right knee malalignment and hypermobility.

Inasmuch as we have found that SAIF did not accept claimant's preexisting right knee condition, and since that preexisting condition has combined with claimant's accepted dislocation condition, in order to establish that her current right knee condition is compensable, claimant must prove that the October 1990 compensable injury is the major contributing cause of her current right knee condition and need for treatment. ORS 656.005(7)(a)(B).[1]

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[1] Subsequent to the hearing in this matter, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among those amended provisions was ORS 656.005(7)(a)(B). Or Laws 1995, ch 332, § 1. Both the former and amended versions of the statute require application of the "major contributing cause" test of compensability. Because the evidence fails to meet that test, we conclude that claimant's claim fails under either version.

Dr. Fuller, who examined claimant at the request of SAIF, reported that claimant's preexisting condition had combined with her compensable injury and opined that the preexisting condition was the major cause of her current right knee condition. (Ex. 24). Both Dr. McKillop, who performed a records review at the request of SAIF, and Dr. Gallagher, claimant's treating physician, agree with Dr. Fuller. (Exs. 25, 28).[2] Although Dr. Gallagher later indicated that the compensable injury was the major contributing cause of claimant's current right knee condition, his change in opinion is based on the erroneous presumption that SAIF's acceptance included claimant's preexisting right knee patellar malalignment and hypermobility. (Ex. 29). Consequently, we are not persuaded by Dr. Gallagher's later opinion.

Inasmuch as there is no persuasive medical evidence which establishes that claimant's compensable injury is the major contributing cause of her current right knee condition, claimant has failed to prove that her current right knee condition is compensable.[3] Accordingly, SAIF's denial must be upheld.

ORDER

The ALJ's order dated May 30, 1995 is reversed. SAIF's denial is reinstated and upheld. The ALJ's award of an assessed attorney fee is also reversed.

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[2] Contrary to claimant's assertions, none of the medical opinions describe claimant's preexisting malalignment and hypermobility as a "predisposition" rather than a preexisting condition. (Exs. 24-6, 25-3, 28). Therefore, we do not accept claimant's contention that her preexisting malalignment and hypermobility cannot be considered in assessing the relative contribution of those factors to claimant's current right knee condition. In any event, predispositions are now included within the definition of "preexisting conditions." ORS 656.005(24).

[3] Claimant also contends that the Americans with Disabilities Act (ADA), 42 USCA § 12101 et seq., requires that the compensability of her right knee condition be evaluated without consideration of her preexisting malalignment and hypermobility. Former ORS 656.005(7)(a)(B) allowed such a consideration, and claimant did not raise this issue at hearing. Inasmuch as claimant raises the ADA issue for the first time on review, we will not address that issue. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991) (Board has discretion to not address issue raised for the first time on review).

Board Member Gunn dissenting.

The majority concludes that SAIF's acceptance did not include claimant's patella malalignment and hypermobility. Because I agree with the ALJ that those conditions were encompassed within SAIF's acceptance, I dissent.

Claimant sustained a compensable right knee patella dislocation in 1990. Although she had suffered previous dislocations, the 1990 compensable dislocation was the most traumatic. Since that time, she has not had any further dislocations, however she did have ongoing right knee pain and swelling. As a result of these ongoing symptoms, Dr. Gallagher is now recommending that claimant undergo right knee patellar realignment surgery.

Dr. Gallagher opined that the major cause of claimant's 1990 injury was her preexisting malalignment and hypermobility and, therefore, SAIF's acceptance of that injury would necessarily include those conditions. (Ex. 29). In addition, Dr. Gallagher noted that since claimant had continued to experience right knee symptoms since 1990 and had not sustained further dislocations, the 1990 compensable injury remains the major contributing cause of her current right knee condition. (Ex. 29). Like the ALJ, I understand Dr. Gallagher's opinion to mean that claimant could not have had the 1990 patellar dislocation in the absence of her preexisting patellar malalignment and hypermobility. I liken this to occupational disease cases in which the symptoms are the disease. That is, claimant's right knee dislocations are a symptom of her patellar malalignment and hypermobility and cannot be separated. Consequently, by accepting the dislocation, SAIF has accepted the preexisting condition as well. See e.g. Georgia Pacific v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991). Moreover, given claimant's ongoing symptoms, without further incident, there is a clear causal relationship between the 1990 compensable injury and her current condition. Under these circumstances, I would conclude that claimant's current right knee condition and need for surgery is compensable.

For these reasons, I respectfully dissent.

In the Matter of the Compensation of
ROBERT E. MULLANEY, Claimant
WCB Case No. 94-14196
ORDER ON REVIEW
Brothers, et al, Claimant Attorneys
David Fowler (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its denial of claimant's back condition claim; and (2) assessed an attorney fee and penalty for an alleged discovery violation. In his brief, claimant moves to remand the case for admission of additional evidence. On review, the issues are whether SAIF is precluded from denying the condition, remand, compensability, and penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In April 1991, SAIF accepted a lumbosacral strain. After claim closure, SAIF reopened the claim. In July 1993, SAIF issued a Notice of Closure awarding scheduled and unscheduled permanent disability; the accompanying worksheet indicated a loss of "strength of right quadriceps - L4 nerve root."

In October 1994, SAIF denied a request to reopen the claim. The ALJ set aside the denial, finding that claimant's condition for which he sought treatment was the same as that for which SAIF awarded permanent disability pursuant to the July 1993 Notice of Closure. The ALJ concluded that, therefore, "[u]nder the law of the case, the condition is compensable."

Preclusion to Deny Condition/Remand

SAIF first challenges the ALJ's conclusion that it is precluded from denying compensability of claimant's condition. According to SAIF, amended ORS 656.262(10) overruled Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), and, therefore, any payment of permanent disability pursuant to the Notice of Closure does not preclude it from contesting compensability. We agree.

Amended ORS 656.262(10) provides, in part:

> "Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." Or Laws 1995, ch 332, § 28 (SB 369, § 28).

We recently considered the effect of this provision in Craig L. Hiatt, 47 Van Natta 2287 (1995). We first found that, pursuant to SB 369, § 66, the statute applied retroactively. We further concluded that, according to the clear language of the statute, a carrier was not precluded from denying a condition for which it had paid a permanent disability award, unless the carrier had formally accepted the condition.

Here, SAIF did not formally accept any condition other than a lumbosacral strain. The record shows that spinal stenosis is the subject of the current claim. Thus, consistent with Hiatt, we conclude that, whether or not SAIF paid permanent disability pursuant to the July 1993 Notice of Closure for spinal stenosis, it is not precluded from now denying the compensability of that condition.

In his brief, claimant asserts that, even if SAIF is not precluded from denying compensability by virtue of ORS 656.262(10), SAIF accepted spinal stenosis as a factual matter. In support of this argument, claimant attached to his brief a December 1991 Form 1502 and SAIF's letter informing claimant that it was reopening his claim. The Form 1502 indicates that, on December 5, 1991, SAIF accepted an aggravation claim and paid temporary total disability. The letter, dated December 5, 1991, states that SAIF "reviewed all information regarding the worsening of your condition and have reopened your claim." Claimant asserts that we should remand the case to the ALJ for admission and consideration of this additional evidence.

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of the hearing; and (3) is reasonably likely to affect the outcome. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

We find no compelling reason to remand. First, the two documents sought to be submitted by claimant were obtainable at the time of hearing. Although claimant concedes this point, he asserts that the relevance of the evidence "was not apparent until SB 369 passed" and "[b]ecause of SB 369's retroactive application, claimant's theory of the case has to change somewhat." We understand claimant to argue that he no longer is relying on Messmer, as he did at hearing and, on review, instead asserts that SAIF, as a factual matter, accepted the stenosis condition. Thus, because he now seeks to assert a different theory, he should be allowed to submit additional evidence in support of the current theory.

Claimant bases his current theory that SAIF's scope of acceptance included the stenosis upon law that was well-established prior to the enactment of SB 369. See SAIF v. Tull, 113 Or App 449 (1992) (holding that whether an acceptance occurs is an issue of fact). Although, as discussed above, SB 369 changed the holding in Messmer, claimant does not argue that the new law affected Tull. Therefore, we disagree with claimant that the documents he seeks to admit were not relevant until the passage of SB 369. On the contrary, because claimant could have relied on the holding in Tull at hearing, the documents were as relevant at that time as subsequent to the passage of SB 369.

We further find that the documents are not likely to affect the outcome of the case. The documents do not refer to stenosis and so provide no inference that SAIF accepted stenosis when it reopened the claim in 1991. Consequently, for these reasons, we find no compelling reason to remand the case for admission of additional evidence and deny claimant's motion. Having also concluded that SAIF is not precluded from denying compensability of the stenosis, we proceed to address the merits.

Compensability

The medical evidence shows that claimant's spinal stenosis preexisted his 1991 injury. (Exs. 45, 48, 50B). Only claimant's treating orthopedic surgeon, Dr. Johnson, additionally relates claimant's symptoms to the 1991 injury. (Ex. 50B). We interpret Dr. Johnson as indicating that claimant's preexisting condition combined with the 1991 injury. Thus, claimant must prove that his compensable condition is the major contributing cause of the combined condition. ORS 656.005(7)(a)(B).

According to Dr. Johnson, claimant "is receiving treatment for a condition directly relatable to his injury in 1991." (Ex. 50B-2). More specifically, however, Dr. Johnson also stated that the spinal stenosis "was symptomatically worsened by his accident" and the "degenerative process is probably exacerbated by the 1991 injury." (Id. at 1-2).

We find such statements insufficient to show that the 1991 injury is the major contributing cause of the combined condition. At best, the evidence indicates that the injury contributed to a worsening of symptoms from the preexisting condition; it is also evident, however, that the degenerative condition is the major contributing cause of the need for treatment of the combined condition.

The remaining evidence rejects any causal connection with the 1991 injury. (Exs. 45-6, 48, 50A). Consequently, we conclude that claimant failed to carry his burden of proving his spinal stenosis compensable.

The ALJ assessed a penalty and related attorney fee pursuant to former ORS 656.262(10) for SAIF's delay in disclosing a particular document to claimant for the hearing. Because claimant failed to prove compensability, there are no "amounts then due," as required by ORS 656.262(11)(a) and no compensation to have resisted under ORS 656.382 (1). Thus, we also reverse the ALJ's assessment of a penalty and related attorney fee.

ORDER

The ALJ's order dated August 7, 1995 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee and penalty awards also are reversed.

In the Matter of the Compensation of
ROBERT T. RIES, Claimant
WCB Case No. 95-03137
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's occupational disease claim for L3-4, L4-5 and L5-S1 disc conditions.[1] On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on the reports of treating physician, Dr. Franks, the ALJ concluded that claimant had established the compensability of his current low back condition. We agree.

To establish a compensable occupational disease, a claimant must prove that his or her employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). If an occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the claimant must prove that his or her employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b).

Here, there is some evidence that claimant has preexisting degenerative disc disease. The conditions for which he presently seeks compensation are, however, L4-5 disc herniation, an L3-4 disc bulge and an L5-S1 disc protrusion. There is no persuasive evidence that claimant seeks compensation for degenerative disc disease generally. Consequently, we find that claimant's occupational disease claim is not based on the worsening of a preexisting disease or condition. Hence, he need not establish a pathological worsening of any condition. Rather, he need only establish that his work activities were the major contributing cause of his lumbar disc herniation and bulges.[2] Claimant has met that burden.

Claimant developed low back pain while working as a truck driver for the employer. Claimant job duties included moving heavy objects and required repetitive lifting and bending. Claimant filed a claim on February 22, 1995. (Ex. 1). Claimant began treating with Dr. Franks, who diagnosed L4-5 and L5-S1 disc disorders and recommended surgery. (Ex. 2). A post-myelogram CT scan revealed an L3-4 bulge, an L4-5 extrusion and an L5-S1 protrusion. (Ex. 1b).

Drs. Wilson and Tesar examined claimant on SAIF's behalf. They concluded that the major contributing cause of claimant's current low back condition was his degenerative disc disease. (Ex. 5-7). In a supplemental report, Dr. Wilson concluded that it was highly unlikely that claimant's February 1995 work injury caused three levels of lumbar disc pathology. (Ex. 7A-4).

In contrast, Dr. Franks concluded that the single most important cause of claimant's lumbar disc pathology was his work activities. (Ex. 8-2). In reaching that conclusion, Franks noted that claimant was

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[1] SAIF actually denied a lumbar strain. (Ex. 3). At hearing, claimant clarified that the claim was for the above-mentioned lumbar conditions. (Tr. 4-5). SAIF did not object to the clarification. (Tr. 4).

[2] Dr. Franks concludes that claimant's work activities led to the degenerative changes, which in turn, led to claimant's current lumbar problems. (Ex. 8-2; see Ex. 10). Because claimant does not make a claim for his degenerative condition generally, we do not address whether Franks' opinion would suffice to establish the compensability of that condition.

only 33 years old, that he lacked any significant off-work factors[3] and that he did not have a long history of back abnormalities. (Id. at 1-3). Finally, Franks noted claimant's lack of L5-S1 disc space narrowing, the site of most degenerative disc disease. (Id. at 3). In a supplemental report, Dr. Franks agreed that claimant's L4-5 disc herniation was caused, in major part, by his work activities. (Ex. 9-2).

On this record, we find that Dr. Franks' reports are the most persuasive. Franks had the benefit of treating claimant for a period of months, whereas Drs. Wilson and Tesar saw claimant only once. Moreover, Dr. Franks' consideration of claimant's relative youth, lack of significant off-work factors or history of back problems, and the absence of any L5-S1 disc space narrowing lends credence to his conclusions.

In contrast, Drs. Tesar and Wilson did not persuasively evaluate those factors. Rather, they focused almost solely on the role that claimant's allegedly preexisting degenerative disc condition played in his current lumbar condition. Because they did not address the factors that Dr. Franks raised, we discount their report.

Further, Dr. Wilson's supplemental report is also unpersuasive, His conclusion regarding the onset of claimant's lumbar condition is based on a faulty premise: Wilson supposes that claimant sustained a work injury in February 1995. That is incorrect. Rather, claimant's theory is that he has sustained an occupational disease as a result of his repetitive, stressful work activities. Because Wilson's supplemental report rests on an unsupported premise, we discount it.

In sum, we agree with the ALJ that claimant has established the compensability of his lumbar disc conditions under an occupational disease theory. Accordingly, we affirm the ALJ's decision setting aside SAIF's denial of those conditions.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 July 14, 1995 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the SAIF Corporation.

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[3] Dr. Franks noted, and rejected as insignificant, claimant's off-work Nautilus activities. (Ex. 8-2, -3). Neither Dr. Tesar nor Dr. Wilson refutes that conclusion.

In the Matter of the Compensation of
VERONICA M. STRACKBEIN, Claimant
WCB Case No. 92-08264
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Holtan's order that set aside its "de facto" denial of reimbursement for acupuncture treatment. On review, the issues are jurisdiction and medical services. We vacate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's "de facto" denial of claimant's acupuncture treatment for her accepted cervical condition. SAIF argued on review that claimant's acupuncture treatments were not reimbursable because there was no written treatment plan as required by OAR 436-10-040(3)(a) and because there was no "written authorization" from the attending physician for acupuncture treatment as required under ORS 656.245(3)(b)(A). In response, claimant contended that, under Michele R. Sunseri, 43 Van Natta 663 (1991), compliance with the written treatment plan required by OAR 436-10-040(3)(a) is only one factor to consider in determining whether medical treatment is reasonable and necessary. Claimant further argued that SAIF did not raise its argument concerning ORS 656.245(3)(b)(A) at hearing and should not be allowed to raise the issue for the first time on Board review. Because we conclude that we lack jurisdiction over this matter, we do not address the merits of these contentions.

Subsequent to the ALJ's order, the legislature enacted SB 369 which amended ORS 656.327(1) and ORS 656.245(6). Or Laws 1995, ch 332, § 25, 41 (SB 369, § 25, 41). The court has held that SB 369 applies retroactively to cases in which an order or decision has not become final, subject to the other exceptions listed in § 66. Volk v. America West Airlines, 135 Or App 565 (1995).[1] Amended ORS 656.327(1) and 656.245(6) are not among the exceptions listed in § 66. See SB 369, § 66. In addition, in Walter L. Keeney, 47 Van Natta 1387 (1995), we concluded that the amendments to ORS 656.327 and ORS 656.245(6) applied to all pending cases. Reviewing the plain language of § 66 of SB 369, we concluded that the legislature clearly intended amended ORS 656.327(1) and 656.245(6) to apply to claims pending before the Board. We further concluded that the legislature intended that ORS 656.327(1) medical services disputes be resolved exclusively by the Director, not the Board or Hearings Division. Accordingly, based on the holdings of Volk and Keeney, we conclude that the amendments contained in SB 369 apply to this case.

Amended ORS 656.327(1) provides that, if an injured worker, a carrier or the Director believes that an injured worker's medical services, not subject to ORS 656.260 are excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." SB 369, § 41 (emphasis added). The Director now has exclusive jurisdiction over all ORS 656.327(1) medical services disputes, including those currently pending before the Board. Walter L. Keeney, supra.

Consequently, to the extent that this is a "327" medical services dispute, exclusive jurisdiction over this case now rests with the Director. Id. Under such circumstances, neither the Board nor its Hearings Division have jurisdiction over this dispute.

Assuming ORS 656.245 governs this dispute, we likewise conclude that we lack jurisdiction. Amended ORS 656.245(6) provides:

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[1] Claimant has cited to § 66(5)(a) as additional authority for his position that SB 369 does not apply to this case. The Volk court held that the legislature's intent in § 66(5)(a) was to make the new law applicable to matters for which the time to appeal a decision had not expired or, if appealed, had not been finally resolved. The ALJ's order was timely appealed and this matter has not been finally resolved on appeal. Thus, under Volk , SB 369 applies retroactively to this case.

> "If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker, the insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550." SB 369, § 25 (emphasis added).

The plain, mandatory text of amended ORS 656.245(6) reveals the legislature's intent that, unless a formal denial of a worker's underlying claim is disputed, ORS 656.245 medical services disputes "shall" be resolved exclusively by the Director, not the Board or the Hearings Division. See Walter L. Keeney, supra, 47 Van Natta at 1389. Accordingly, to the extent that this dispute arises under ORS 656.245, we conclude that we lack jurisdiction inasmuch as claimant's underlying claim for her accepted inner ear concussion syndrome, adjustment reaction with anxiety and depression and lumbar and cervical strain/sprain conditions has not been formally denied. See Thomas L. Abel, 47 Van Natta 1571 (1995) (Board lacks jurisdiction over medical services disputes arising under ORS 656.245 where compensability of the worker's underlying claim is not contested).

Because SAIF did not raise the issue of attorney fees under ORS 656.386(1), on review, claimant asserts that there is no basis for us to reverse or vacate the ALJ's attorney fee award. We disagree. By virtue of our de novo review authority, we may consider any issue addressed by the ALJ's order. See, e.g., Destael v. Nicolai Co., 80 Or App 596, 600 (1986). In addition, § 42d(5)[2] of SB 369 provides that neither an ALJ nor the Board may award penalties or attorney fees for matters arising under the Director's jurisdiction. Consequently, because we lack authority to grant claimant the relief she seeks (i.e., ordering the insurer to pay medical bills for her acupuncture treatment), we likewise have no authority to award attorney fees in this case. Accordingly, we vacate the ALJ's attorney fee award.

Finally, claimant raises several objections to the retroactive application of SB 369 to this case. First, relying on the reasoning contained in Ida M. Walker, 43 Van Natta 1402 (1991), claimant contends that, to apply SB 369 would produce an absurd result which would be inconsistent with the purposes and policies of the workers' compensation law. Specifically, claimant argues that retroactive application of SB 369 would result in delay and expense associated with relitigating medical services issues that have already been decided by the Hearings Division. Claimant contends that this result is contrary to the objective set forth in ORS 656.012(2) to reduce litigation and restore the injured worker physically and economically in an expeditious manner.

We have previously addressed this issue in Walter L. Keeney, supra. There, we noted that a literal reading of the amended statutes was that medical services disputes would be decided by the Director rather than the Hearings Division and the Board. We did not consider this change of forum for medical services cases to be an absurd or unintended result. We reasoned that the clear language of amended ORS 656.327(1) and ORS 656.245(6) indicated that this result was exactly the result intended by the legislature. Concluding that the legislature intended that medical services disputes be heard by the Director, rather than the Board or its Hearings Division, we found no basis for departing from a literal reading of §66. Based on our reasoning in Keeney, we reject claimant's argument that application of the amended statutes would produce an absurd result.

Claimant also challenges the retroactive application of SB 369 to this case on constitutional grounds. We are not inclined to address claimant's constitutional arguments because we have previously held that if the Board lacks jurisdiction over a claim, it likewise lacks authority to address claimant's constitutional arguments. See Kathleen M. Butler, 47 Van Natta 2202 (1995); Mary S. Leon, 45 Van Natta 1023, 1024 (1993). Nevertheless, we have considered claimant's constitutional arguments, and, for the following reasons, we have rejected those arguments.

Claimant contends that retroactive application of SB 369 violates the Due Process Clause of the Fourteenth Amendment of the United States Constitution. Citing no authority (but see Liberty Northwest Insurance Corporation v. Yon, 137 Or App 413 (1993)), claimant asserts that the legislative

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[2] Because section 42d(5) is not among the exceptions to the general retroactivity provision of SB 369, see SB 369, § 66, and because it does not alter a procedural time limitation, we apply it retroactively to this case. See Volk v. America West Airlines, supra; Cigna Insurance Co. v. McMasters, supra; Walter L. Keeney, supra.

purpose behind SB 369 is to reduce premiums. Claimant also asserts that the application of SB 369 will not further this legislative interest because, instead of reducing premiums, it will increase them by causing cases to be relitigated in a different forum.

We have previously rejected the constitutional argument raised by claimant. In Betty S. Tee, 47 Van Natta 2396 (1995)[3], we found that the public interest behind Senate Bill 369 was to reduce workers' compensation premiums. Applying the rational basis test, we concluded that workers' compensation premium reduction was a legitimate legislative purpose. We further concluded in Tee, that the legislative implementation of stricter requirements for the receipt of benefits, and the retroactive application of those requirements to pending cases, were rational means for reducing workers' compensation premiums. On that basis, we concluded that retroactive application of Senate Bill 369 did not violate the claimant's substantive due process rights. Id. For the reasons express in Tee, we likewise conclude that the application of Senate Bill 369 to this case does not violate claimant's substantive due process rights. Accordingly, we reject claimant's constitutional argument.

Finally, claimant contends that because we lack jurisdiction to address the parties' medical services dispute, we also lack jurisdiction to review the ALJ's order. We disagree. Under ORS 656.289 and 656.295, we have authority to review the ALJ's order and determine whether jurisdiction exists. Accordingly, we reject claimant's argument that we lack authority to vacate the ALJ's order.

ORDER

The ALJ's order dated February 17, 1995 is vacated. Claimant's request for hearing is dismissed for lack of jurisdiction.

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[3] Although a signatory to this order, Member Gunn directs the parties to his dissent in Tee.

In the Matter of the Compensation of
ROBBIE W. WORTHEN, Deceased, Claimant
WCB Case No. TP-93011
THIRD PARTY DISTRIBUTION ORDER ON REMAND
G. Jefferson Campbell, Claimant Attorney
Schwabe, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Worthen v. Lumbermen's Underwriting Alliance, Inc., 137 Or App 434 (1995). The court has reversed our prior order, Robbie W. Worthen, DCD, 46 Van Natta 226, rev den 46 Van Natta 987 (1994), which held that Lumbermen's was entitled to a share of proceeds from the deceased worker's third party recoveries. Citing its companion decision, 137 Or App 368 (1995) (which had affirmed a probate court's order that held that Lumbermen's lien had been effectively extinguished because the litigation costs and attorney fees exceeded the total recoveries from the third party actions), the court has remanded for reconsideration.

In light of the court's determination, we conclude that Lumbermen's is not entitled to a share of proceeds from the deceased worker's third party recoveries. Consequently, in accordance with the court's decision, the aforementioned proceeds shall be distributed in the manner prescribed by the probate court.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA L. ADAMS, Claimant
WCB Case No. 94-03311
ORDER ON REVIEW
Nancy F. A. Chapman, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that: (1) increased claimant's scheduled permanent disability award from 9.31 percent (17.88 degrees) for a binaural hearing loss, as awarded by an Order on Reconsideration, to 11.28 percent (21.66 degrees); (2) awarded a fee of $1,000 for claimant's attorney's services regarding the employer's pre-hearing rescission of its "de facto" denial of the inner ear concussion condition; (3) assessed a penalty for the employer's allegedly unreasonable failure to timely process the inner ear concussion claim; (4) directed the employer to process the inner ear concussion condition to closure; and (5) set aside the employer's denial of claimant's aggravation claim for the bilateral hearing loss condition. Claimant makes no cross-request for review; however, with her respondent's brief, she submits additional evidence. We treat this submission as a request for remand. On review, the issues are remand, extent of scheduled permanent disability, aggravation, claims processing, penalties, and attorney fees. We deny the motion for remand, modify in part, reverse in part, and affirm in part.

FINDINGS OF FACT

Claimant's date of birth is June 14, 1949. On February 11, 1992, claimant suffered multiple injuries when involved in a motor vehicle accident while working as a cosmetic marketing coordinator for the employer. On March 17, 1993, the employer, through its claims processing agent, accepted a disabling cervical/thoracic strain and bilateral hearing loss. (Ex. 56).

By March 18, 1992, claimant's inner ear concussion condition was identified by Dr. Grimm, consulting neurologist. (Ex. 17). On November 6, 1992, Dr. Epley, claimant's treating otolaryngologist, opined that the major contributing cause of the inner ear concussion condition was the compensable February 11, 1992 motor vehicle accident. (Ex. 40).

The claim was closed by a December 6, 1993 Determination Order that awarded 11.28 percent scheduled permanent partial disability for loss of binaural hearing from both ears and 19 percent unscheduled permanent disability. (Ex. 75). She was found medically stationary on September 30, 1993. At that time, only the cervical/thoracic strains and hearing loss were accepted.

Claimant requested reconsideration of the December 6, 1993 Determination Order. Neither party disputed the impairment findings or requested appointment of a medical arbiter. An Order on Reconsideration issued on April 6, 1994, and reduced the hearing loss award to 9.31 percent loss of binaural hearing from both ears and otherwise affirmed the Determination Order. (Ex. 96). This reduction in the hearing loss award was based on a preexisting hearing loss measured by a May 31, 1990 audiogram. (Ex. 96-4).

On March 17, 1994, claimant requested a hearing regarding the Order on Reconsideration. In addition, claimant raised, among other issues, the issue of the "de facto" denial of the inner ear concussion condition.

On May 31, 1994, the employer accepted a disabling inner ear concussion condition as part of the February 11, 1992 injury claim. (Ex. 99). Prior to May 31, 1994, the employer had not accepted or denied the inner ear concussion condition.

On June 15, 1994, the employer issued an aggravation denial, denying that claimant had sustained a worsening since claim closure. (Ex. 100).

Dr. Epley is claimant's attending physician and has treated claimant since June 18, 1992. Dr. Epley opined that claimant's compensable bilateral hearing loss worsened as of March 1994, due to the compensable injury. (Exs. 99A, 102). The increased hearing loss is established by objective findings contained in audiograms. Since March 1994, claimant has been less able to function due to this increased hearing loss. (Ex. 102-48). This increased hearing loss is more than a waxing and waning of symptoms. (Exs. 99A-4, 102-15-17).

Dr. Hertler, otolaryngologist, examined claimant on the employer's behalf on November 9, 1992, and July 6, 1994.

CONCLUSIONS OF LAW AND OPINION

Remand

With her respondent's brief, claimant submits copies of July 6, 1994 and August 22, 1994 correspondence between her attorney and the employer's attorney. Claimant requests that the Board consider this correspondence as evidence that the agreement as to the amount of attorney fees to be awarded to claimant's attorney for her services in obtaining rescission of the "de facto" denial broke down between the initial hearing and the reconvened hearing. We treat this submission as a motion to remand for the taking of further evidence. Judy A. Britton, 37 Van Natta 1262 (1985).

We may remand a case to the ALJ for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, the evidence claimant asks us to consider is correspondence between her attorney and the employer's attorney that took place before the reconvened September 9, 1994 hearing. This correspondence was clearly obtainable with due diligence at the time of the reconvened hearing. Accordingly, we deny the motion for remand.

Extent of Scheduled Permanent Disability

Claimant sustained compensable injuries in a February 11, 1992 motor vehicle accident. Her claim was closed by Determination Order on December 6, 1993. At that time, claimant's accepted conditions included cervical/thoracic strain and bilateral hearing loss. (Ex. 56). The Determination Order awarded 28 percent scheduled permanent disability for loss of binaural hearing in both ears and 19 percent unscheduled permanent disability. (Ex. 75). In making the scheduled award, no deduction was made for any preexisting hearing loss.

Claimant requested reconsideration. However, neither party disputed the impairment findings or requested appointment of a medical arbiter. The April 6, 1994 Order on Reconsideration reduced the scheduled permanent disability award to 9.31 percent loss of binaural hearing in both ears. (Ex. 96). In making this award, the appellate reviewer found that the medical records established a preexisting hearing loss in claimant's left ear of 15.75 percent, as determined by a May 31, 1990 audiogram, and reduced the scheduled award accordingly. (Ex. 96-4). The remainder of the Determination Order was affirmed.

Claimant requested a hearing. The only issue at hearing and on review regarding the Order on Reconsideration is the scheduled permanent disability award for claimant's bilateral hearing loss. Specifically, the issue is whether claimant's award for bilateral hearing loss should be reduced by any preexisting hearing loss. The parties obtained considerable "post-reconsideration order" medical evidence, including medical reports and deposition testimony from Dr. Epley, claimant's treating otolaryngologist, as well as a report from Dr. Hertler, who examined claimant on behalf of the employer.

Relying on Dr. Epley's "post-reconsideration" deposition and reports, the ALJ determined that the evidence did not establish that claimant had a preexisting hearing loss that could be offset. Therefore, the ALJ reinstated the Determination Order award of 11.28 percent loss of binaural hearing in both ears. On review, the employer contends that the preexisting hearing loss documented by the May 31, 1990 audiogram should be offset against the hearing loss measured at the time of Dr. Epley's closing evaluation. We agree.

At the outset, we note that there have been significant changes in the law regarding the medical evidence which can be considered at hearing regarding extent of disability. At the time of hearing, the parties could present "post-reconsideration" medical evidence inasmuch as a medical arbiter had not been appointed pursuant to former ORS 656.268(7). See Scheller v. Holly House, 125 Or App 454 (1993). The parties availed themselves of the opportunity to do so pursuant to former ORS 656.283(7). Furthermore, on review, the parties rely on this "post-reconsideration" evidence in support of their respective positions regarding the extent issue.

However, effective June 7, 1995, the legislature enacted Senate Bill 369, amending ORS 656.283(7). Or Laws 1995, ch 332, § 34 (SB 369, § 34). Amended ORS 656.283(7) provides, in pertinent part, that "[e]vidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing." In the absence of a specific exception, this amended statute would appear to be retroactively applicable. See Volk v. American West Airlines, 135 Or App 565 (1995). However, we need not resolve that question because, whether we limit our consideration to the "reconsideration record" or consider the entire record, we reach the same conclusion: that the Order on Reconsideration correctly reduced claimant's impairment by her preexisting hearing loss. Duane B. Onstott, 47 Van Natta 1429 (1995). In other words, claimant failed to establish by a preponderance of the evidence that the disability "standards" were incorrectly applied in the Order on Reconsideration. We base this conclusion on the following reasoning.

We apply the disability standards in effect on the date of the Determination Order or Notice of Closure and any relevant temporary rules adopted pursuant to ORS 656.726(3)(f)(C). OAR 436-35-003(2). Claimant's claim was closed by Determination Order dated December 6, 1993. Accordingly, those standards contained in WCD Admin. Orders 6-1992 and 17-1992 apply to claimant's claim.

OAR 436-35-250(2) provides that "[c]ompensation may be given only for loss of normal hearing which results from an on-the-job injury or exposure." In addition, the rule states that offset will be made against hearing loss in the claim for presbycusis and for "[h]earing loss which existed before this injury or exposure, if adequately documented by a baseline audiogram obtained within 180 days of assignment to a high noise environment." OAR 436-35-250(2)(a) and (b). Claimant does not dispute that hearing loss due to presbycusis may be offset; however, she argues that she has no "adequately documented" preexisting hearing loss that can be offset. We disagree.

On November 11, 1989, claimant underwent surgical repair to her left eardrum to correct problems created by a noncompensable ear infection. (Exs. 1, 3). By May 31, 1990, claimant was "having no problems [with] her ear." (Ex. 1-5). An audiogram given on that date showed a 15.75 percent loss of hearing in the left ear, as calculated pursuant to OAR 436-35-250(4). (Ex. 4).

Claimant relies on Orval R. Ogbin, 46 Van Natta 499, on recon 46 Van Natta 931 (1994), in support of her argument that the May 31, 1990 audiogram does not adequately document a preexisting hearing loss. In Ogbin, an earlier version of OAR 436-35-250(2)(a) applied that allowed offset of preexisting hearing loss, if such loss was documented by a pre-employment audiogram. The record contained no pre-employment audiogram, and the claimant testified that his pre-employment physical did not include an audiogram. The carrier attempted to rely on a business record that contained an entry regarding the claimant's decibel levels from an audiogram which was allegedly conducted several years earlier, shortly before the claimant's employment. We found that the business record did not serve to adequately document a preexisting hearing loss by a pre-employment audiogram as required by former OAR 436-35-250(2).

We find Ogbin distinguishable on the facts. Here, the record contains an audiogram establishing a hearing loss in the left ear prior to the compensable February 11, 1992 injury. In addition, claimant concedes that she has never been assigned to a "high noise environment." Therefore, the requirement that the baseline audiogram be "obtained within 180 days of assignment to a high noise environment" does not apply to claimant's claim. Under these circumstances, we find that the May 31, 1990 audiogram adequately documents a preexisting hearing loss of 15.75 percent that is to be offset against hearing loss in the claim pursuant to OAR 436-35-250(2)(a).

The audiogram performed at the time of Dr. Epley's closing examination showed monaural hearing loss in the left ear of 25.50 percent and the right ear of 9.25 percent, after offsetting the value

for presbycusis pursuant to OAR 436-35-250(2)(b) and (4). (Ex. 61). After reducing the left ear hearing loss by the preexisting 15.75 percent loss and converting the monaural values to a binaural value, claimant has a binaural hearing loss of 9.31 percent. OAR 436-35-250(2)(a) and (5). Accordingly, we reinstate the reconsideration order award of 9.31 percent loss of binaural hearing in both ears.[1]

Aggravation

The ALJ found that claimant had established a compensable aggravation of her compensable bilateral hearing loss condition. We agree.

In order to establish a compensable aggravation of a scheduled condition, claimant must prove, by medical evidence supported by objective findings, a worsened condition resulting from the compensable condition. ORS 656.273(1) and (3)[2]; Perry v. SAIF, 307 Or 654 (1989). To prove a worsening of a scheduled body part, claimant must show that she is more disabled, i.e., has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. Fred Meyer, Inc. v. Farrow, 122 Or App 164 (1993); International Paper Co. v. Turner, 304 Or 354 (1987), on rem 91 Or App 91 (1988). Because claimant received a previous permanent disability award for her condition, she must also establish that any worsening is more than waxing and waning of symptoms contemplated by the previous permanent disability award. ORS 656.273(8).[3]

The "baseline" for determining whether a compensable condition has worsened is the claimant's "medically stationary" condition at or before the last award or arrangement of compensation. Lindon E. Lewis, 46 Van Natta 237, 239, aff'd mem Morgan Manufacturing v. Lewis, 131 Or App 267 (1994). In other words, evidence regarding a claimant's "medically stationary" condition up to and including the "last award or arrangement of compensation" that precedes the alleged worsening establishes the "baseline" for purposes of analyzing an aggravation under ORS 656.273(1). Id. at 240.

Here, claimant's condition allegedly worsened after the December 6, 1993 Determination Order, but before the April 6, 1994 Order on Reconsideration. Consequently, the last award or arrangement of compensation that preceded the alleged worsening was the December 6, 1993 Determination Order. Thus, in order to establish a compensable aggravation claim, claimant must prove that her compensable bilateral hearing loss condition worsened since the December 6, 1993 Determination Order. Lindon E. Lewis, supra.

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[1] We would reach the same result were we to consider the "post-reconsideration" medical evidence. We base this conclusion on the following reasoning. In his "post-reconsideration" reports and deposition, Dr. Epley has not challenged the May 1990 "pre-injury" audiogram which documented preexisting hearing loss. Instead, he has discussed the likelihood that claimant's current hearing loss was attributable to minimal preexisting hereditary sensorineural factors, ear infections, conductive loss, or the compensable injury-related sensorineural factors. The fact that Dr. Epley concluded that any conductive loss component had resolved prior to the compensable injury or that he relates a worsening of claimant's hearing loss to the compensable injury does not dispel the notion that claimant experienced preexisting hearing loss. Since the "pre-injury" audiogram quantifies that preexisting hearing loss, we consider it appropriate to offset that loss against claimant's present hearing loss findings.

[2] We note that Senate Bill 369 amends ORS 656.273. (SB 369, § 31). In this regard, amended ORS 656.273(1) provides, in part: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by evidence of actual worsening of the compensable condition supported by objective findings." Or Laws 1995, ch 332, § 31 (SB 369, § 31; emphasis added to indicate new language). In Carmen C. Neill, 47 Van Natta 2371 (1995), we held that an "actual worsening" under amended ORS 656.273(1) may be established either by showing a pathological worsening of the compensable condition or by showing a symptomatic worsening of the compensable condition that is in excess of the waxing and waning contemplated by a prior award of permanent disability. Similarly, under former ORS 656.273(1), a pathological worsening was sufficient to establish an aggravation. E.g., Caroline F. Wood, 46 Van Natta 2278 (1994). Here, as explained in the body of our order, we find Dr. Epley's opinion persuasive. Dr. Epley opined that the acute "episodes" caused by the work injury caused deterioration of claimant's balance and hearing apparatus. (Exs. 99A-4, 102-15-17). Such deterioration establishes a pathological worsening of the compensable hearing loss condition. Thus, the result in this case is the same under either version of the statute.

[3] Senate Bill 369 amends ORS 656.214 by adding section (7), which provides that "[a]ll permanent disability contemplates future waxing and waning of symptoms of the condition. The results of waxing and waning of symptoms may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability, or inpatient hospitalization." (SB 369, § 17). We need not resolve the applicability of this amendment because, under either version of the statute, the result would be the same.

In conducting our de novo review of the aggravation issue, we consider all of the evidence admitted at hearing, including the "post-reconsideration" evidence. The record contains medical evidence regarding the aggravation issue from Dr. Epley and Dr. Hertler, examining otolaryngologist.

On July 6, 1994, Dr. Hertler examined claimant on behalf of the employer. (Ex. 101). Dr. Hertler had previously examined claimant on November 9, 1992. (Ex. 43). He opined that claimant's ear pain and drainage in March 1994, with associated decreased hearing in the left ear, was the result of an infection, not the compensable injury. (Ex. 101-3). In addition, he opined that, although claimant had sustained increased bilateral hearing loss since he last examined her in November 1992, this increased loss was the result of her inherited sensorineural hearing loss, not the compensable injury. Id.

Dr. Epley disagreed with Dr. Hertler's opinions. (Exs. 101A, 102-55-58). Specifically, he found that Dr. Hertler was mistaken in finding that claimant had an ear infection in March 1994 and in relating her decreased hearing in the left ear to that infection. Dr. Epley noted that his records showed that claimant's ear infection occurred in May 1994, and that the audiograms show that her increased hearing loss was present before that infection. (Exs. 101A-1). In addition, Dr. Epley explained that the type of hereditary sensorineural hearing loss claimant has is not progressive, noting that her hearing loss had been minimal and had remained stable until the time of the compensable injury. (Exs. 99A-5, 101A, 102-58). Dr. Epley opined that the increased hearing loss was caused by the compensable motor vehicle accident. Id.

In addition, Dr. Epley opined that the work injury has caused damage to claimant's inner ears, resulting in intermittent episodes of further deterioration of both the vestibular and cochlear systems. (Exs. 99A-4). Dr. Epley opined that these episodes were due to the compensable motor vehicle accident and, in March 1994, claimant had a severe episode that resulted in further bilateral sensorineural hearing loss. (Exs. 99A-4). He opined that, since the March 1994 episode, claimant has been less able to function as a result of the increased bilateral hearing loss. (Ex. 102-48).

We find Dr. Epley's opinion well-reasoned and based on accurate information. In addition, as claimant's treating otolaryngologist, Dr. Epley is in the best position to know when claimant had an ear infection and the effect of any such infection. Furthermore, Dr. Epley explains his opinion that claimant's bilateral hearing loss worsened in March 1994 due to the compensable injury and why this worsening was not due to any infection or hereditary hearing loss condition. (Exs. 99A, 101A, 102). In contrast, Dr. Hertler's opinion is conclusory. Therefore, we find Dr. Epley's opinion more persuasive.

The employer argues that claimant failed to establish that her increased loss in hearing in 1994 was permanent, relying on portions of Dr. Epley's deposition in support of its argument. The employer offers no legal citations in support of its argument, and we can find none. To the contrary, a worker can prove an aggravation of a scheduled condition by establishing that he or she has sustained an increased loss of use or function of that body part, either temporarily or permanently, since the last arrangement of compensation. Fred Meyer, Inc. v. Farrow, supra; International Paper Co. v. Turner, 304 Or 354 (1987), supra. In addition, although ORS 656.273(8) provides that the worker must establish that the worsening is more than waxing and waning of symptoms contemplated by the previous award, it does not eliminate a temporary worsening that satisfies that standard.[4]

The employer also argues that claimant has not established that the increased hearing loss was caused by the compensable injury. In support of this argument, the employer points to Dr. Epley's statement that claimant may have had a conductive hearing loss between March and May 1994, and his statement that the automobile accident did not cause any conductive loss. (Ex. 102-71). We disagree with the employer's argument. Dr. Epley also stated that the surgery claimant underwent on December 18, 1993 to correct the compensable inner ear concussion caused a conductive component that was not present prior to that surgery. (Ex. 99A-3). We find that Dr. Epley's opinion as a whole establishes that the March 1994 worsening was caused by the compensable injury. (Exs. 99A, 101A, 102).

Furthermore, we find that this worsening was more than any waxing and waning of symptoms contemplated by the previous award. In this regard, Dr. Epley opined that the acute "episodes" caused by the work injury cause deterioration of the balance and hearing apparatus. (Exs. 99A-4, 102-15-17). Such deterioration establishes more than a waxing and waning of symptoms. Accordingly, we conclude that claimant has established a compensable aggravation claim.

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[4] ORS 656.273(8) was not amended by SB 369.

Attorney Fee Award on Pre-Hearing Rescission of "De Facto" Denial

The ALJ awarded claimant's attorney an assessed fee of $1,000 for her services in obtaining the employer's pre-hearing rescission of its "de facto" denial of the inner ear concussion condition. (Ex. 99). The employer does not contend that claimant's attorney is not entitled to an assessed fee for these services. However, it contends that the parties agreement to an assessed fee of $500 should be enforced. Thus, the only issue on review is the amount of the assessed attorney fee.

The hearing initially convened on June 7, 1994. At that time, the parties agreed that the employer would pay a fee of $500 for claimant's attorney's services regarding the "de facto" denial claim. (#1 Tr. 4). The hearing was continued for the taking of Dr. Epley's deposition and reconvened on September 9, 1994. At the reconvened hearing, the issues included "attorney fees" on the accepted inner ear concussion condition, without any specific amount being mentioned. (#2 Tr. 13-15).

On review, the employer argues that the parties should be bound by their agreement at the initial hearing. Claimant argues that that agreement broke down between the two hearing sessions. However, contrary to claimant's argument, the record contains no evidence that the parties' rescinded their agreement regarding the amount of the assessed attorney fee. Furthermore, we decline to look behind the parties' agreement, given the fact that the parties unambiguously agreed to a $500 fee for claimant's attorney's services relating to the pre-hearing rescission of the "de facto" denial. (#1 Tr. 4). Hubert A. Mustion, 43 Van Natta 1247 (1991).

The legislature amended ORS 656.386(1) in regard to the award of attorney fees on pre-hearing denial rescissions and defined a "denied claim" in that regard. (SB 369, §43(1)). However, because the parties agreed to an assessed attorney fee award, we interpret their positions as an acknowledgment that claimant prevailed over a denied claim for claimant's inner ear condition. Guillermo Rivera, 47 Van Natta 996, on recon 47 Van Natta 1723 (1995). Consequently, we need not determine whether these amendments apply to this case. See Evans v. Rookland, Inc., 85 Or App 213 (1987) (court ordered the enforcement of the parties' agreement to an assessed attorney fee, whether or not the claimant would have been entitled to the fee under the pertinent law).

Penalty

The ALJ awarded a penalty under ORS 656.262(10), renumbered ORS 656.262(11), for the employer's unreasonable failure to timely process the inner ear concussion claim. We adopt the ALJ's reasoning and conclusions regarding the employer's unreasonable failure to timely process the inner ear concussion claim and write to address the penalty issue.

The employer argues that, because it paid all compensation related to the inner ear concussion condition, there are no amounts "then due" to support a penalty under ORS 656.262(11). Claimant responds that, if there was no compensation due at the time of acceptance of the inner ear condition, she is still entitled to an attorney fee regarding the employer's unreasonable resistance to payment of compensation. We agree with claimant.

The employer acted unreasonably in failing to timely accept or deny the inner ear concussion condition. However, there is no evidence of any amounts due upon which to base a penalty. ORS 656.262(11). Under these circumstances, claimant is entitled to an employer-paid attorney fee for unreasonable resistance to the payment of compensation. ORS 656.382(1).

After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for the employer's unreasonable claims processing is $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved.

Claims Processing

Relying on Food Services of America v. Ewen, 130 Or App 297 (1994), the ALJ ordered the employer to process to claim closure the inner ear concussion condition, which the employer accepted after claimant's claim was initially closed. We adopt the ALJ's reasoning and conclusions regarding this issue.

Attorney Fee on Review

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the aggravation and claim processing issues is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief and her counsel's statement of services), the complexity of the issues, and the value of the interest involved. In addition, we have considered the fact that claimant did not prevail on the employer's appeal of the extent issue. Finally, inasmuch as penalties and attorney fees are not compensation for purposes of ORS 656.382(2), claimant is not entitled to an assessed attorney fee for services on review regarding the penalty and attorney fee issues. Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated September 29, 1994, as supplemented by the order denying reconsideration dated October 27, 1994, is modified in part, reversed in part, and affirmed in part. In lieu of the ALJ's award, the Order on Reconsideration award of 9.31 percent (17.88 degrees) scheduled permanent disability for binaural hearing loss is reinstated and affirmed. The ALJ's "out-of-compensation" attorney fee award is reversed. In lieu of the ALJ's assessed attorney fee award of $1,000 for the "de facto" denial rescission, claimant's counsel is awarded an assessed fee of $500, to be paid by the self-insured employer. In lieu of the ALJ's penalty award, claimant's counsel is awarded an assessed fee of $500 for the self-insured employer's unreasonable resistance to payment of compensation, to be paid by the employer. The remainder of the order is affirmed. For services on Board review regarding the aggravation and claim processing issues, claimant's attorney is awarded $1,000, to be paid by the employer.

January 18, 1996 Cite as 48 Van Natta 97 (1996)

In the Matter of the Compensation of
PAUL BILECKI, Claimant
WCB Case No. 95-02358
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order that upheld the insurer's denial of claimant's aggravation claim for a low back injury. On review, the issue is aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly summarize the relevant facts. Claimant compensably injured his neck and low back in October 1991. A March 12, 1993 Opinion and Order awarded 9 percent unscheduled permanent disability. On October 3, 1994, claimant sought treatment for low back and foot pain. Dr. Kirschner, his attending physician, took him off work, prescribed physical therapy, and ordered an MRI, which was normal. Claimant's muscular spasms and range of motion improved with physical therapy. Claimant filed an aggravation claim, which was denied.

The ALJ concluded that claimant had failed to establish an aggravation claim, reasoning that, although claimant has persistent back complaints, his accepted condition has not "actually worsened." Claimant makes two arguments: First, that his condition has "actually worsened" because he has shown a symptomatic worsening; and, second, that, because no waxing and waning was contemplated by the 9 percent permanent disability award, claimant's symptomatic worsening cannot be a waxing and waning of symptoms contemplated by the previous permanent disability award.

The insurer contends that, pursuant to amended ORS 656.214(7), waxing and waning is contemplated by all permanent disability awards and that claimant must establish that his "actual worsening" is greater than the expected waxing and waning of his symptoms.

In Carmen C. Neill, 47 Van Natta 2371 (1995), we held that an "actual worsening" under amended ORS 656.273(1) is established by: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the condition greater than that anticipated by the prior award of permanent disability.

Here, claimant was treated by Dr. Kirschner for increased symptoms related to his compensable injury. She ordered an MRI, which was normal, and claimant's muscular spasms and range of motion improved with physical therapy.

In November 1994, Drs. Geist and White examined claimant for the insurer. Although they found reduced range of motion in the neck and low back when compared with range of motion findings at the time of claim closure, they opined that their findings were invalid due to claimant's hyperventilation while they were performing the measurements. They further opined that claimant's condition was a waxing and waning as contemplated by the prior permanent disability award and found no objective evidence that claimant's condition had worsened.

Dr. Kirschner indicated she did not concur in their report. However, she failed to specify any reason for her disagreement.

Subsequently, claimant was examined by Drs. Marble and Gardner, who also concluded that claimant's condition had not worsened since the 1992 claim closure and that his complaints were well within the waxing and waning of symptoms contemplated by a 9 percent permanent disability award. Dr. Kirschner concurred in their opinion.

Thus, no doctor has indicated that claimant's condition had actually worsened. Rather, the medical opinions attribute claimant's symptoms only to minor waxing and waning of his low back strain.

Claimant contends that, in effect, because no waxing and waning was contemplated by the last arrangement of conpensation, any waxing and waning of symptoms constitutes an "actual worsening" of the condition. We disagree.

Amended ORS 656.214(7) applies retroactively. Carmen C. Neill, supra. The statute provides that "all permanent disability contemplates future waxing and waning of symptoms of the condition. The results of waxing and waning may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability, or inpatient hospitalization." (Emphasis added). Here, claimant received a 9 percent permanent disability award. Thus, future waxing and waning of his symptoms were contemplated. ORS 656.214(7). In order to establish an aggravation claim, claimant must prove that his waxing and waning is greater than that anticipated by the prior award.

The uncontroverted medical opinions indicate that claimant's symptoms are within the range of waxing and waning of his low back strain as contemplated by his prior award. Therefore, claimant has failed to prove that his symptomatic worsening constitutes an "actual worsening of the condition." Accordingly, claimant's aggravation claim fails.[1]

ORDER

The ALJ's order dated June 14, 1995 is affirmed.

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[1] Alternatively, claimant agrees that amended ORS 656.214(7) creates a presumption of waxing and waning resulting from any award of disability. However, he maintains that he has carried his burden by establishing that, due to his increased symptoms, he is no longer capable of performing the regular work to which he was released at the time of claim closure. Although the results of waxing and waning of symptoms may include loss of earning capacity, claimant must nevertheless establish that such symptoms are greater than those anticipated by the prior award. For the reasons expressed above, the medical opinions do not support such a conclusion.

In the Matter of the Compensation of
CATHERINE GROSS, Claimant
WCB Case No. 95-00202
ORDER ON REVIEW
Bradley P. Avakian, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Neal's order which set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability.

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

Relying on the opinion of Dr. Jewell, the employer argues that findings on claimant's nerve conduction tests, in particular, "mildly slowed conduction velocity," are insufficient objective findings [in support of medical evidence] to establish compensability. We disagree.

Dr. Jewell noted discrepancies between the findings by Drs. Ash and Kaesche, claimant's treating doctor. In particular, Dr. Kaesche found atrophy in the thenar muscles in both hands and weakness. These findings were not found by Drs. Ash and Jewell. In addition, the positive Tinel's sign found by Dr. Ash was not found by Drs. Kaesche and Jewell. Dr. Jewell otherwise found a paucity of objective findings that would support a diagnosis of CTS. Dr. Jewell, therefore, opined that the abnormalities on the nerve conduction studies were without clinical correlation.

We have held that "objective findings" is a legal term, not a medical term, and that a physician's opinion that examination findings do not constitute objective findings is irrelevant if those findings otherwise satisfy ORS 656.005(19).[1] Scott Petty, 46 Van Natta 1051 (1994); Craig H. Ayer, 43 Van Natta 2619 (1991).

We conclude that the nerve conduction test findings constitute objective findings. They are technologic/measurable evidence apart from physical examination findings. Consequently, Dr. Jewell's opinion that the test findings do not constitute objective findings is irrelevant. Scott Petty, supra.

Whether or not these objective findings are sufficient to prove that claimant's bilateral CTS was established by medical evidence supported by objective findings is a medical question requiring expert medical opinion. See Uris v. Compensation Department, 247 Or 420 (1967).

Based on claimant's complaints and on nerve conduction studies performed by Dr. Ash, both Drs. Kaesche and Ash diagnosed bilateral carpal tunnel syndrome. The nerve conduction studies showed a mildly slowed conduction velocity on the right and were normal on the left. Dr. Kaesche opined that it was not unusual that the diagnosis of CTS is based totally upon the claimant's complaints, with or without supporting objective findings, including nerve conduction tests. He explained that the condition may not have progressed to where the nerve conduction tests would be abnormal, but claimant has classic CTS symptoms in both upper extremities. Dr. Kaesche concluded that claimant's nerve conduction test findings supported claimant's complaints. We find Dr. Kaesche's opinion persuasive because it is well-reasoned and because it considers the nerve conduction test results.

Accordingly, we conclude that claimant has established she has bilateral CTS based on medical evidence supported by objective findings.

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 438-15-010(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 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] Subsequent to the ALJ's order, the Legislature amended the definition of "objective findings" in ORS 656.005(19). Or Law 1995, ch 332 §1 (SB 369, §1). We need not address the retroactive applicability of this amendment because, under either version of the statute, our analysis remains the same.

ORDER

The ALJ's order dated June 6, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,200 to be paid by the self-insured employer.

January 18, 1996 Cite as 48 Van Natta 100 (1996)

In the Matter of the Compensation of
JANICE E. INGERSOLL, Claimant
WCB Case No. 92-03277
ORDER ON REVIEW
Victor Calzaretta, Claimant Attorney
Jeffrey R. Gerner (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order which: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a mental disorder; and (2) declined to award penalties or attorney fees for SAIF's allegedly unreasonable claim processing. On review, the issues are compensability, penalties and attorney fees.

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

Claimant filed an occupational disease claim under ORS 656.802 for a mental disorder, which she alleged was a result of the employer's act of suspending her for four days without pay. The parties stipulated that: (1) claimant suffered from a generally recognized mental or emotional disorder; and (2) the employer's investigation into allegations that claimant had sexually harassed a male employee and resulting discipline were the major contributing cause of claimant's mental disorder. The sole issue before the ALJ was whether the employer's investigation and resulting discipline were reasonable. See ORS 656.802(3)(b). Concluding that the employer's disciplinary action was reasonable, the ALJ upheld SAIF's denial of claimant's mental disorder claim.

On review, claimant alleges that the ALJ erred in upholding SAIF's denial, asserting that the employer's investigation was superficial and that the discipline imposed on claimant was unreasonable. We disagree.

Whether or not employer disciplinary actions are reasonable must be decided on a case-by-case basis, taking into account the particular facts of the case. David B. Koepping, 46 Van Natta 751 (1994). We may consider a variety of evidentiary matters bearing on the reasonableness of an employer's conduct, such as evidence that an employer's treatment of a claimant was inconsistent with governing employment law, that it was not consistent with its treatment of other employees, and that it was not consistent with its own policies. Daniel A. Jackson, 43 Van Natta 2361, 2365 (1991).

In this regard, we note that the employer had a strong written policy prohibiting sexual harassment and that the discipline imposed on claimant was consistent with other employer disciplinary actions. (Ex. 3-2, Trs. 379-83). In addition, an investigation by the Bureau of Labor and Industries determined that there was no substantial evidence of an unlawful employment practice based on sex. (Ex. 17-4). Included in this investigation was a finding that claimant's conduct did constitute sexual harassment. (Id.)

Moreover, we find that the employer conducted a "fair and objective investigation" before administering discipline and obtained substantial evidence before imposing sanctions. See Daniel L. Jackson, supra, 43 Van Natta at 2367. The employer, through its human resources manager, Ms. Dorsey, conducted a prompt investigation beginning January 6, 1992 after being notified of allegations against claimant. Ms. Dorsey interviewed the employee (Channel) who alleged four instances of inappropriate conduct: that claimant pinched his buttocks, touched his genital region at a restaurant while he and claimant were having lunch with a number of individuals, that claimant became angry when he did not appear for dinner at claimant's residence, and that claimant publicly berated the quality of his work because he was unwilling to accede to her sexual advances.

Ms. Dorsey then conducted an interview with claimant for approximately one hour and 15 minutes. Although claimant's and Ms. Dorsey's version of what transpired differ, Ms. Dorsey's notes of the conversation indicate that claimant admitted to feeling very angry with Channel about his work, that claimant did pinch Channel as well as another employee on the buttocks, that she "did something" to Channel's napkin in the restaurant and that she did invite claimant to dinner at her house on a couple of occasions. (Ex. 4-87). Claimant denied that her actions amounted to sexual harassment in a subsequent letter to Ms. Dorsey, but that, if there was sexual harassment, it was "mutual." (Ex. 8-100). Claimant alleged that Channel had made as many or more sexual innuendoes and advances as she had. (Ex. 8-100).

Believing that claimant had essentially admitted to the instances of inappropriate conduct alleged by Channel, Ms. Dorsey ceased further investigation and met with claimant's supervisor (Ms. Bingham) and Mr. Cole, the employer's president. (Tr. 360). In a memo to Ms. Dorsey, Ms. Bingham recounted the content of a discussion she had with claimant in which claimant allegedly conceded that she had admitted her actions to Ms. Dorsey. (Ex. 4-56). However, claimant had insisted that her intent was not sexual harassment and that the matter was being "misperceived." (Id.)

Based on the information obtained in Ms. Dorsey's three-day investigation, it was decided on January 9, 1992 that claimant would be suspended for four days without pay and given a written warning. (Tr. 360). Claimant was given an additional opportunity to meet with Ms. Dorsey and Ms. Bingham on January 14, 1992, to provide any additional information concerning the matter. (Tr. 363). Ms. Dorsey testified that it was not absolutely decided that claimant would be disciplined, and that had extenuating or additional information been presented by claimant, then it was possible that no discipline would have been imposed. (Id.) The scheduled meeting never occurred, however, because Ms. Dorsey refused to conduct it in the presence of an acquaintance who claimant had brought with her to attend the conference. (Tr. 366, Ex. 4-82). Claimant was then presented with the warning letter and suspended without pay for four days. (Tr. 367).

Claimant asserted at hearing that she never admitted that Channel's allegations were true and that there were no independent witnesses to verify them. Thus, she contends that the employer's investigation was unreasonable because it was based on inaccurate and unverified information. However, based on this record, we cannot conclude that the employer's investigation was unreasonable.

The employer promptly interviewed both Channel and claimant upon learning of possible sexual harassment in violation of its written policy prohibiting such conduct. Ms. Dorsey's notes of her conversation with claimant support her belief that claimant had admitted to at least a substantial portion of channel's allegations. (Ex. 4-87). Ms. Binghams' memorandum also lends credence to Ms. Dorsey's belief as well.[1] Considering the evidence available to the employer prior to imposing its discipline of claimant, we are unable to conclude that the employer's investigation was unfair or biased or that the employer did not obtain substantial evidence before imposing its discipline. Daniel L. Jackson, supra. Accordingly, we agree with the ALJ's determination that the employer's disciplinary action this case was reasonable. We, therefore, agree that SAIF's denial was proper.

ORDER

The ALJ's order dated February 16, 1995 is affirmed.

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[1] We note that there is a "post-discipline" affidavit from a person (Fortson) who sat next to Channel in the restaurant which tends to verify Channel's version of what happened in the restaurant. (Ex. 8-123).

In the Matter of the Compensation of
MICHAEL R. LANGFORD, Claimant
WCB Case No. 94-15576
ORDER ON REVIEW
Emerson G. Fisher, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Hall.

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

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

It is undisputed that claimant's repetitive work activities were superimposed on preexisting right shoulder degeneration and that a combination of the work activities and the preexisting condition caused claimant's recent need for treatment for his right shoulder. (Exs. 2-2, 7-5, 8). Under these circumstances, claimant must establish that the work activities caused a worsening of his preexisting condition; a worsening of symptoms alone is not sufficient. See ORS 656.802(2).[1]

The evidence otherwise supporting claimant's position (that his work exposure was the major contributing cause of his right shoulder problems) is provided by Dr. Switlyk, treating physician. Although Dr. Switlyk acknowledged claimant's preexisting condition and a work-related worsening of symptoms, he did not indicate that claimant's work caused a worsening of the preexisting condition. Accordingly, we agree with the ALJ that claimant has not carried his burden of proof.

ORDER

The ALJ's order dated May 1, 1995 is affirmed.

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[1] On June 7, 1995, Senate Bill 369 amended ORS 656.802. The result would be the same under either version of the statute.

Board Chair Hall dissenting.

In assessing the medical opinions in this case, the majority focuses on claimant's "preexisting" condition. Whether claimant had a "preexisting" condition is, however, the issue precedent which determines the very parameters of the analysis. What claimant must prove in order to establish compensability depends on whether a "preexisting" condition existed. See former and amended ORS 656.005(7)(a)(B).

First, the proponent of the element must provide persuasive evidence to establish the fact. See Harris v. SAIF, 292 Or 683, 690 (1992) ("The general rule is that the burden of proof is upon the proponent of a fact or position, the party who would be unsuccessful if no evidence were introduced on either side."). In this case, the element in question is the existence, if any, of a "preexisting" condition. Absent persuasive evidence establishing a preexisting condition, claimant need not carry any additional burden associated with a preexisting condition. See Delbert D. Shuck, Sr., 47 Van Natta 248 (1995) (Where there was no evidence that a shoulder condition preexisted the claimant's 31 year work exposure to heavy work for the employer, the claimant was not required to carry an additional burden associated with a preexisting condition); see also Susan A,. Michl, 47 Van Natta 20, on recon, 47 Van Natta 167 (1995). Second, in this occupational disease claim (with an "onset" based on claimant's work exposure with this subject employer), "preexisting" is defined in relation to claimant's employment with the subject employer. Id.; see also amended ORS 656.005(24).

In the present case, claimant has worked for the subject employer for approximately thirty years. (Tr. 5). There is no persuasive evidence that claimant suffered from any degenerative arthritis, tendonitis, or impingement syndrome before beginning work for this employer. Therefore, contrary to the majority's opinion, claimant need not prove that work activities caused a worsening of his "preexisting condition."

The majority's legal error is compounded when applied to the medical evidence. Specifically, to the extent that Dr. Farris evaluated medical causation based on the role of other conditions predating the onset of claimant's claimed tendonitis/impingement syndrome, his opinion is unpersuasive because it not based on an accurate history. (Ex. 7). Claimant had no "preexisting" conditions, based on the evidence in this record.

Moreover, Drs. Wilson and Duff's conclusion -- that claimant's tendonitis would have occurred even if claimant had not been working (ex. 4-4) -- is unsupported by explanation and therefore unpersuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

In contrast, Dr. Switlyk, treating physician, acknowledged the role of "some natural degeneration with time" in the "multifactorial" cause of claimant's impingement syndrome, there is no evidence that "natural degeneration" preexisted claimant's employment beginning thirty years ago. Dr. Switlyk explained the role which claimant's work activities played and concluded that claimant's work was the major contributing cause of claimant's syndrome. I find the opinion of Dr. Switlyk to be the most persuasive. As I believe the majority errs in requiring claimant to prove the worsening of a "preexisting" condition and in relying on unpersuasive evidence, I respectfully dissent.

January 18, 1996 Cite as 48 Van Natta 103 (1996)

In the Matter of the Compensation of
MARTIN L. MOYNAHAN, Claimant
Own Motion No. 95-0472M
SECOND OWN MOTION ORDER ON RECONSIDERATION
AIG, Insurance Carrier

Claimant requests reconsideration of our September 29, 1995 Own Motion Order, as reconsidered on November 16, 1995, in which we: (1) concluded that the Board, under its own motion authority, has jurisdiction to consider claimant's 1988 injury claim; and (2) declined to reopen claimant's 1988 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery or hospitalization.

On December 15, 1995, we abated our prior orders, and allowed the insurer 14 days in which to file a response to the motion. No further responses have been received. We proceed with our reconsideration.

The Board's own motion authority extends to claims for worsened conditions which arise after the expiration of aggravation rights. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988). Aggravation rights expire five years after the first claim closure unless the injury was in a nondisabling status for one or more years after the date of injury, in which case the aggravation rights expire five years after the date of injury. ORS 656.273(4)(a) and (b).

We continue to conclude that the insurer was not notified that claimant's condition had worsened prior to the expiration of his aggravation rights. See Krajacic v. Blazing Orchards, 84 Or App 127 (1987). Thus, even if, as claimant contends, his condition was "misdiagnosed " in September 1994, the insurer received a report from Dr. Brooks, claimant's then-treating physician, that claimant "appears not to require formal physical therapy or consideration of operative treatment." Therefore, we find that claimant did not perfect a claim for aggravation under ORS 656.273, and this case is properly processed under our own motion authority.

Turning to the merits, claimant would be otherwise entitled to temporary disability compensation under his own motion claim if he can establish that he was in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

In our prior order, we found that claimant did not support his contention that he was willing to work, but that it was futile for him to seek work because of the compensable injury. With his request for reconsideration, claimant submitted a November 28, 1995 letter from Dr. Rodi, claimant's current treating physician, in which Dr. Rodi opined that "[s]ince 1989 [claimant] was not working but willing to work, and was not seeking work because the work related injury has made such efforts futile."

Standing alone, Dr. Rodi's opinion would appear to support claimant's contention. However, Dr. Rodi did not become claimant's physician until September of 1995, nor had he examined claimant on any prior occasion. Contrary to Dr. Rodi's opinion, the record establishes that claimant was released to, and did return to suitable, modified work in 1989. Claimant voluntarily quit that job and retired in 1990.

As noted in our prior order, the record does not indicate that claimant's compensable condition worsened requiring surgery until Dr. Chamberlain opined, on June 7, 1995, that further knee revision would be indicated. Thus, we find that the record would support that, at best, it was futile for claimant to seek work since June of 1995.

In his December 6, 1995 letter, claimant contended that "I had hoped, and still do hope, to work at something related to my experience and training. Perhaps a welding supply, parts supply, hobby shop, etc." However, there is no evidence in the record to establish that claimant has sought work in these areas in the last five years, even though he was qualified.

Here, we do not find that any wages were earned or contemplated by claimant since his 1990 retirement. Therefore, in light of claimant's five-year hiatus from the work force, and considering that he has been released to light or sedentary work but has not sought work for which he is qualified in this category, we do not find Dr. Rodi's opinion that claimant has been "unable to work since 1989" persuasive.

We do find that the record establishes that claimant: (1) returned to suitable, modified work in 1989; (2) voluntarily left his employment and retired in 1990; (3) was not disabled from work until June of 1995; and (4) although qualified and released, did not seek work of the light to sedentary type since 1990. Therefore, we do not find that claimant was in the work force at the time of disability.

Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our September 29, 1995 order, as reconsidered on November 16, 1995, in its entirety. 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
JERRY SIMMONS, Claimant
Own Motion No. 92-0581M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Heiling, Dodge & Associates, Claimant Attorneys
R. Thomas Gooding (Saif), Defense Attorney

The SAIF Corporation has requested reconsideration of our December 28, 1995 Own Motion Order Reviewing Carrier Closure which: (1) set aside SAIF's November 13, 1995 Notice of Closure in this claim; and (2) declined to assess a penalty for SAIF's allegedly unreasonable failure to pay compensation.

By a January 11, 1995 letter received by the Board on January 12, 1996, SAIF requests that the Board set aside that portion of our order which vacates its November 13, 1995 Notice of Closure "ab initio" and orders the commencement of temporary disability compensation beginning November 6, 1995.

By letter dated January 16, 1996, claimant requests: (1) affirmation of our December 28, 1995 order; (2) assessment of a penalty in the amount of 25 percent for SAIF's alleged refusal to pay retroactive compensation pursuant to our December 28, 1995 order; and (3) an attorney fee for defending against SAIF's motion for reconsideration.

SAIF contends that claimant refused surgery, and therefore was appropriately declared medically stationary on November 6, 1995. Based on a chart note submitted by Dr. Uhle, claimant's treating surgeon, SAIF declared claimant medically stationary on November 6, 1995, and closed the claim on November 13, 1995. Claimant subsequently underwent the surgery on December 14, 1995. On December 26, 1995, Dr. Uhle opined that the surgery revealed a reoccurring hernia and foreign body. In addition, Dr. Uhle opined that claimant was not capable of returning to work and was in need of curative treatment when examined previously in October and November 1995.

Apparently, SAIF argues that claimant's refusal to undergo surgery by November 6, 1995 precludes his right to subsequently undergo surgery on December 14, 1995. Therefore, SAIF asserts, claimant was precluded from being found not medically stationary even if medical evidence supported the position that, in hindsight, the original determination was incorrect.

In our prior order, we found that, in determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987). We continue to find Dr. Uhle's opinion persuasive, as he was the attending physician at the time of closure, and his revised opinion that claimant was not medically stationary at claim closure was based on medical findings discovered during the December 14, 1995 surgery. Weiland v. SAIF, 64 Or App 810 (1983); Scheuning v. J.R. Simplot & Co., supra. Therefore, we affirm our holding that SAIF's November 13, 1995 closure was premature.

Claimant requests that we assess a penalty for SAIF's alleged delay in paying compensation for more than 14 days after the date of our December 28, 1995 order. We note that OAR 436-60-150(4)(h) states that timely payment of temporary disability benefits means that payment has been made no later than 14 days after the date any litigation authorizing retroactive temporary disability becomes final. Our December 28, 1995 order (had it not been appealed by SAIF) would become final on January 29, 1996. Inasmuch as the temporary disability granted by our December 28, 1995 order has not become due under the applicable rule, SAIF's failure to pay the award is not unreasonable.

Finally, claimant requests that his attorney be granted an additional assessed fee for his services in this matter. In our prior order, we allowed claimant's attorney an out-of-compensation fee in the amount of 25 percent of the increased temporary disability compensation awarded by that order, not to exceed $1,050. That fee is payable by SAIF directly to claimant's attorney under OAR 438-015-0010(4) and 438-015-0080.

Entitlement to attorney fees in workers' compensation cases is governed by statute. Unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). Here, claimant does not cite, nor have we found, any statutory authority which would allow the Board to award an additional attorney fee where a carrier requests reconsideration of a Board's Own Motion Order. Since our own motion order results from claimant's request for review of an own motion notice of claim closure, it follows that claimant's attorney fee is payable from the increased compensation resulting from our order setting aside that Notice of Closure (subject to the limitations prescribed in the applicable Board rules) .

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our December 28, 1995 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.

In the Matter of the Compensation of
RICKEY C. AMBURGY, Claimant
WCB Case No. 94-09505
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall and Christian.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Thye's order that set aside its denial of claimant's herniated disc condition. Claimant cross-requests review of those portions of the order that upheld the employer's denial of his low back strain and degenerative disc disease conditions. Claimant also argues that the attorney fee award was inadequate. On review, the issues are compensability and attorney fees.

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

At hearing, claimant contended that he sustained either a compensable low back injury or an occupational disease. The ALJ analyzed the claim as an occupational disease. The ALJ concluded that claimant's work activities were the major contributing cause of his herniated disc, but not of his degenerative disc disease. The ALJ also concluded that claimant had not sustained a compensable low back strain.

Herniated Disc

On review, the employer argues that claimant failed to establish the compensability of his herniated disc condition as either an injury or an occupational disease.

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's herniated disc condition was an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. Mathel v. Josephine County, 319 Or 235, 240 (1994); James v. SAIF, 290 Or 343 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982). The phrase "sudden in onset" refers to an injury occurring during a short, discrete period, rather than over a long period of time. Donald Drake Co. v. Lundmark, 63 Or App 261 (1983), rev den 296 Or 350 (1984); Valtinson v. SAIF, supra.

We find that claimant's herniated disc condition arose during the time the employer had installed new machinery that necessitated a change in claimant's work habits and required heavy lifting. The record as a whole supports the occurrence of an injury on approximately February 15, 1994. The injury was unexpected, as claimant's back had been asymptomatic for several years, except for occasional back symptoms that did not require medical attention. Moreover, claimant's back injury was "sudden in onset" in that it occurred over a discrete, identifiable period of time. The fact that claimant's pain grew progressively worse over a short period of time does not make it "gradual in onset." Donald Drake Co. v. Lundmark, supra (the claimant's back trouble coincided precisely with jolting of the faulty loader; the fact that the claimant's back pain grew worse over his six-week employment did not make it "gradual in onset"). Therefore, we analyze the claim as an accidental injury, rather than an occupational disease.

The medical evidence establishes that claimant had degenerative disc disease prior to the February 15, 1994 work incident. The medical evidence also establishes that claimant's work incident combined with the preexisting degenerative disc disease to cause his disability and need for treatment. (Exs. 11, 12-15, 13-26 to 13-28). Therefore, claimant must prove that the work incident was the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition. Amended ORS 656.005(7)(a)(B).

We agree with the ALJ's reasoning and conclusion that, based on Dr. Gehling's opinion, claimant's herniated disc condition is compensable. Dr. Gehling reported that, on a more probable than not basis, claimant injured his back while working and that resulted in his L-5 radiculopathy. (Ex. 10). Dr. Gehling concluded that claimant's injury was the reason for his medical treatment and need for surgery. (Id.) Although Dr. Gehling admitted that the question of causation was a "very close call," his ultimate opinion, based on a medical probability, was that claimant's work incident was the major contributing cause of his herniated disc condition. (Exs. 13-31, 13-51, 13-56).

Degenerative Disc Disease

Claimant also contends that his degenerative disc disease is compensable. After reviewing the record, we agree with the ALJ's reasoning and conclusion that the medical evidence fails to establish that claimant's work activities were the major contributing cause of his degenerative disc disease. See amended ORS 656.802.

Strain

Claimant argues that he suffered a compensable strain. Claimant relies on Dr. Turnbull's deposition testimony. According to claimant, since Dr. Turnbull admitted that he could not treat degenerative disc disease chiropractically, but continued to treat claimant, he must have been treating claimant's strain. We disagree.

Dr. Turnbull is the only physician who mentioned that claimant had a strain. (Ex. 12-24). However, there is no evidence in the record that claimant received medical treatment for a strain alone. Dr. Turnbull testified that he was treating claimant's "strain and the other aspects of things that were going on in his lower back." (Id.) Dr. Turnbull testified that the combination of the degenerative disc disease and the strain caused claimant's need for treatment. (Exs. 12-41 & 12-42). We agree with the ALJ that claimant did not suffer a compensable low back strain.

Attorney Fee Award

Claimant contends that the attorney fee award at hearing was inadequate. After reviewing the record and considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we conclude that the ALJ's award concerning the herniated disc condition is reasonable. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the herniated disc condition is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that claimant is not entitled to an attorney fee for services on review concerning the degenerative disc disease condition, the strain condition or the attorney fee issues.

ORDER

The ALJ's order dated April 6, 1995 is affirmed. For services on review concerning the herniated disc condition, claimant's attorney is awarded $1,200, payable by the self-insured employer.

In the Matter of the Compensation of
RAYMOND J. DOMINIAK, Claimant
WCB Case No. 94-14253
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order which dismissed claimant's hearing request for lack of jurisdiction. On review, the issues are jurisdiction and, if jurisdiction, penalties.

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

As a preliminary matter, we note that the self-insured employer submitted with its brief a copy of a Board order that was issued after the ALJ's order issued. Raymond J. Dominiak, 47 Van Natta 1091 (1995). We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," including agency orders and docketed appeals. See, e.g., Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). Inasmuch as our prior decision meets the aforementioned standard, we take administrative notice of it. Sandra R. Farrow, 45 Van Natta 1506 (1993).

On review, claimant argues that the Board and its Hearings Division has jurisdiction to interpret and enforce the November 16, 1993 Stipulated Order approved by a prior ALJ. Claimant also argues that he is entitled to a penalty, pursuant to former ORS 656.262(10), renumbered ORS 656.262(11), for the employer's allegedly unreasonable failure to pay procedural temporary disability benefits from August 10, 1993, the stipulated medically stationary date, through November 9, 1993, the date claimant signed the stipulation.

We agree that the Board and its Hearings Division generally has authority to enforce Stipulated Orders. However, that authority is subject to exceptions.[1] Under the circumstances of this case, we do not have jurisdiction over the ORS 656.262(11) penalty issue, the sole issue before us. ORS 656.262(11)(a) provides, in part, that "[n]otwithstanding any other provision of this chapter, the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection." (Emphasis added). Thus, although we generally have authority to enforce stipulation orders, where the only issue is a penalty under ORS 656.262(11), the director has exclusive jurisdiction over that issue.[2] Corona v. Pacific Resource Recycling, 125 Or App 47 (1993); Ronald A. Stock, 43 Van Natta 1889 (1991).

In addition, we find the current case distinguishable from Harry E. Forrester, 43 Van Natta 1480 (1991). In Forrester, the claimant sought relief in the form of the unpaid benefits awarded by a prior Board order and penalties for the carrier's unreasonable failure to pay those benefits. We found that we had jurisdiction over this penalty issue combined with an enforcement action regarding a Board order that had not been satisfied by the carrier. However, here, although claimant characterizes the current case as an enforcement action, he is not seeking benefits under the Stipulation. Instead, he is solely seeking a penalty under ORS 656.262(11). Thus, the only issue is a penalty under ORS 656.262(11) and the Director has exclusive jurisdiction over that issue. Corona v. Pacific Resource Recycling, supra; Ronald A. Stock, supra.

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[1] One such exception not applicable here is where the stipulation terms are such as to invoke the Director's jurisdiction. Under those conditions, the claimant cannot invoke the jurisdiction of the Hearings Division before seeking administrative review by the Director. See B.D. Schlepp, 44 Van Natta 1637 (1992); Patrick E. Riley, 44 Van Natta 281 (1992), aff'd mem Pendleton Woolen Mills v. Riley, 115 Or App 758 (1992); Kevin A. Haines, 43 Van Natta 1041 (1991).

[2] In Raymond J. Dominiak, supra, the issues were jurisdiction and, if jurisdiction, claimant's entitlement to temporary disability and penalties. There, we affirmed a prior ALJ's decision that the Hearings Division did not have jurisdiction. We note that Member Hall specially concurred, stating that he would find that the Board would have jurisdiction over the matter, if claimant were "merely seeking enforcement of the settlement stipulation." 47 Van Natta at 1092. However, in that prior case, there were multiple issues. Although claimant characterizes the present action as a request for enforcement of the Stipulated Order, the distinguishing factor is that, here, the sole issue is an ORS 656.262(11) penalty and, by the terms of that statute, we do not have jurisdiction.

Finally, claimant contends that he is entitled to "a penalty paid through ORS 656.382(1), in accordance with ORS 656.262(11)." However, in Stock, supra, we rejected a similar attempt to vest jurisdiction in the Hearings Division by invoking ORS 656.382(1), stating that:

> "we reject the view that a party may vest jurisdiction in the Hearings Division over a penalty issue simply by also alleging entitlement to a fee under ORS 656.382(1). To take that approach would permit a party to avoid the Director's jurisdiction by making groundless allegations. Instead, we believe that, if the sole issue remaining at the time set for hearing is penalties and attorney fees for the same conduct, then the request must be dismissed for lack of jurisdiction." 43 Van Natta at 1891.

Here, the sole issue is penalties and attorney fees for the same conduct. Therefore, the ALJ correctly dismissed the hearing request for lack of jurisdiction.

ORDER

The ALJ's order dated April 20, 1995 is affirmed.

Board Chair Hall specially concurring.

I write separately to reiterate the position I expressed in my special concurrence in Robert Geddes, 47 Van Natta 2388 (1995). In that special concurrence, I expressed my agreement with Member Gunn's dissenting opinion that this Board retains jurisdiction to address hearing requests seeking an attorney fee under ORS 656.382(1) for a carrier's refusal to pay compensation granted by an ALJ, Board, or court order. As explained in Member Gunn's dissent, since such requests are not requesting an "additional amount" as described by "this subsection [ORS 656.262(11)]," the Director does not have exclusive jurisdiction over such matters. However, in Geddes, because I agreed with the majority's finding that the claimant's counsel did not request a hearing seeking an attorney fee award under ORS 656.382(1), with the claimant's request solely limited to penalties under ORS 656.262(11), I concurred with the majority's reasoning that exclusive authority over the issue rests with the Director. Based on the following, I find that, here, too, the issue at hearing was limited to penalties under ORS 656.262(11). Therefore, I agree that exclusive authority over this penalty issue rests with the Director.

In his request for hearing, claimant listed several issues in addition to the penalty issue, including attorney fees. At hearing, claimant withdrew all issues except the penalty issue.[1] (Tr. 1-2). In addition, at hearing, claimant argued only entitlement to a penalty for the employer's allegedly unreasonable failure to pay procedural temporary disability benefits. (Tr. 6-7, 9, 14, 16). On review, claimant stated the issues as "penalty and jurisdiction" and continued to argue that he is entitled to a penalty for the employer's allegedly unreasonable claims processing. (Claimant/Appellant's Brief, page 1, 2).

On the other hand, at the end of his brief, claimant cites ORS 656.382(1), noting that that statute "relates to a different situation [than does ORS 656.262(11)], in which the insurer refuses to obey an [o]rder of the Board or its Hearings Division." (Claimant/Appellant's Brief, page 3-4). Claimant further states that the "mere fact that the only possible relief is a penalty paid through ORS 656.382(1), in accordance with [former] ORS 656.262(10), does not deprive the Board of jurisdiction to enforce its own orders." (Claimant/Appellant's Brief, page 4). Finally, claimant requests relief of "a 25% penalty for the insurer's unreasonable failure to pay procedural time loss." Id.

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[1] Following the close of the hearing, claimant attempted to reinstate the issue of extent of permanent disability for the sole purpose of securing jurisdiction in the Hearings Division, although acknowledging that he was not entitled to any additional permanent disability award. Claimant did not attempt to reinstate the attorney fee issue. The ALJ denied claimant's post-hearing motion to reinstate the extent issue, noting that, under the circumstances of this case, allowing claimant to reinstate the extent issue at that time for the sole purpose of obtaining jurisdiction "would result in an unwarranted circumvention of the [D]irector's exclusive jurisdiction under [former] ORS 656.262(10)(a)." (Opinion and Order, page 2).

On this record, I find that the only issue at hearing and on review was penalties under ORS 656.262(11). At hearing, claimant withdrew all other issues, and explicitly stated that the only remaining issue was claimant's entitlement to a penalty. In addition, on review, although citing ORS 656.382(1) in his argument, claimant expressly seeks a 25 percent penalty for the employer's allegedly unreasonable failure to pay procedural time loss. Since ORS 656.382(1) pertains to carrier-paid fees and ORS 656.262(11) refers to "an additional amount up to 25 percent of the amounts then due," it is apparent that claimant is only seeking a penalty assessment under ORS 656.262(11). Robert Geddes, supra at n.2. Inasmuch as the issue at hearing and on review was solely limited to penalties under ORS 656.262(11),[2] I concur with the lead opinion that exclusive authority over the issue rests with the Director.

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[2] In reaching this conclusion, I am aware that the court has held that an issue raised in pleadings is properly before the Board, even if that issue was not subsequently "raised" at hearing. Liberty Northwest Ins. Corp. v. Alonso, 105 Or App 458 (1991). In Alonso, the insurer raised the issue of offset in its pleadings. However, the issue was not subsequently "raised" at hearing; therefore, the Board did not rule on the insurer's request to recover an overpayment. The court reversed, finding that raising the offset issue in the pleadings was sufficient to bring the issue before the Board.

I find Alonso distinguishable. In Alonso, the insurer raised the offset issue in its pleadings, did not withdraw that issue at hearing, and reasserted the issue on Board review. Here, although claimant raised the issue of attorney fees in his pleadings, at hearing he withdrew all issues except the penalty issue. (Tr. 1-2). In addition, as evidenced by his request for relief on review, claimant continued to seek only an ORS 656.262(11) penalty on review. Therefore, I find that the issue at hearing and on review was solely limited to penalties under ORS 656.262(11).

In the Matter of the Compensation of
MARIA R. FUENTES, Claimant
WCB Case No. 94-10967
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
Yturri, Rose, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that declined to award claimant additional temporary total disability (TTD). The insurer moves for reconsideration of our administrative decision to reject its untimely filed respondent's brief. On review, the issues are timeliness of briefing and temporary disability. We deny the insurer's motion and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the "NOTICE FACTS."[1]

CONCLUSIONS OF LAW AND OPINION

Timeliness of Respondent's Brief

The insurer's respondent's brief was rejected as untimely filed. The insurer now moves for reconsideration of that rejection on the ground that the brief was late due to a calendaring error. A calendaring error does not justify an untimely filed brief. Lester E. Saunders, 46 Van Natta 1153, 1154 (1994). Therefore, we deny the insurer's motion.

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[1] The "NOTICE FACTS" consist of a brief description of claimant's behavior during hearing. Those "facts" are not germane to the issues in this case. Moreover, the ALJ does not appear to rely on them for any purpose. Accordingly, we decline to adopt them.

Temporary Disability

The ALJ concluded that, in view of the parties' stipulation, claimant was barred from seeking TTD up to the date the stipulation was approved. The ALJ also concluded that claimant was not entitled to TTD after the stipulation was approved. Claimant asserts that the ALJ erred in concluding that the stipulation barred her from seeking to establish her entitlement to TTD. We agree; nevertheless, we conclude that claimant is not entitled to the TTD that she seeks.

Claimant ceased working in December 1990 due to her medical problems. The insurer initially accepted right CTS and paid TTD from August 23, 1991 through December 16, 1991. (Exs. 104, 105).

In July 1992, claimant, through her attorney, contended that she suffered from neck, right shoulder and right arm pain, C5 radiculopathy, C4-5 and C5-6 disk bulges and left CTS. (Exs. 75, 76). Thereafter, she filed a hearing request, alleging a "de facto" denial of those conditions. (See Ex. 99-2).

On September 17, 1993, a prior ALJ approved a stipulation agreement in which the insurer agreed to rescind its denial of claimant's left CTS and right elbow lateral epicondylitis and "to provide benefits and process claims for those conditions in accordance with the law." (Id. at 3). The parties further stipulated to the dismissal of the hearing request * * * "with prejudice as to all issues raised or raisable as to the date of the parties' stipulation."[2] Claimant subsequently filed the hearing request in this case, asserting an entitlement to TTD related to the CTS and epicondylitis from November 2, 1989 through October 7, 1993.[3]

If a stipulation contains language settling "all issues that were raised or raisable" at the time of settlement, the parties are barred from litigating a matter that was at issue, or of which they had notice, at the time of settlement. Safeway Stores, Inc. v. Seney, 124 Or App 450, 454 (1993); see Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994). That rule is usually applied to bar a claimant from litigating matters that could have been negotiated before approval of a settlement agreement. See, e.g., Seney, supra; Stoddard, supra; Daniel R. Loynes, 47 Van Natta 1075 (1995). It also applies to carriers. Therefore, if an agreement settles all issues "raised or raisable," both the carrier and the claimant are barred from litigating any matter that was at issue, or of which they had notice, at the time of settlement.

Here, claimant's benefits for her left CTS and right elbow lateral epicondylitis were at issue at the time of the September 17 settlement agreement. Because the agreement settled all issues "raised or raisable," and because the insurer agreed "to provide benefits and process claims for those conditions in accordance with the law," the agreement bars the insurer from litigating its obligation to provide benefits for those conditions. A separate inquiry is whether, "in accordance with the law," claimant is entitled to any particular benefits. For the following reasons, we conclude that claimant is not entitled to any additional TTD.

Claimant relies primarily on five documents to prove her entitlement to additional TTD: January and July 1991 and November 1994 reports by Dr. Ball, a treating physician, and July 1992 and November 1994 reports by Dr. Smith, another treating physician.

In January 1991, Dr. Ball stated that "[t]he exact etiology of claimant's presenting complaints was uncertain, but it was believed most likely related to a lateral epicondylitis, as well as a probable underlying C-5 radiculopathy." (Ex. 33). In July 1991, Dr. Ball determined that claimant's symptomology "seems to be related to bilateral carpal tunnel syndrome and, perhaps, a continued element of previous suspected epicondylitis of the right elbow." (Ex. 48-2). Later in the same report, Ball stated that claimant's "ongoing symptoms" were most likely related to CTS and epicondylitis. (Id. at 3).

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[2] Because the parties' agreement does not constitute a "settlement stipulation" unless approved in writing by an ALJ, OAR 438-09-001(3), we conclude that the date of the stipulation is September 17, 1993, the day the prior ALJ approved the agreement.

[3] Claimant's hearing request actually seeks TTD from December 24, 1990 through October 7, 1993. At hearing, claimant amended this request to request TTD from November 2, 1989 through October 7, 1993. (Tr. 5).

In July 1992, Dr. Smith determined that claimant has unable to work from September 3, 1991 through October 17, 1991, because of right CTS surgery. (Ex. 77).

In November 1994, Dr. Ball concluded that, "to give [claimant] the benefit of the doubt, [Dr. Ball] would have to place [claimant's] inability to work due to her carpal tunnel syndrome and epicondylitis as far back as 1989." (Ex. 131-2). Dr. Smith concurred with that conclusion. (Ex. 132).

To establish her entitlement to additional TTD benefits, claimant must prove that her inability to perform her regular work from November 1989 to October 1993 was due to her compensable conditions. ORS 656.210; e.g., Hugh D. Brown, 43 Van Natta 2188, 2189 (1993). She has not met that burden.

Dr. Ball's initial report states that the etiology of claimant's complaints was uncertain, but that they were most likely related to her compensable lateral epicondylitis and noncompensable C-5 radiculopathy. Ball's July 1991 report states that claimant's symptoms "seem" to be or "perhaps" or "most likely" are related to her compensable conditions. Those reports address the cause of claimant's symptoms in 1991; neither of them, however, addresses whether claimant was unable to perform her regular work at any time due to her compensable conditions. Moreover, the reports are couched in equivocal language. Consequently, we find Dr. Ball's 1991 reports insufficient to establish claimant's entitlement to additional TTD benefits.[4]

That conclusion finds support in Drs. Ball's and Smith's 1994 reports. In those reports, Ball and Smith purported to give claimant "the benefit of the doubt" in concluding that her inability to work "as far back as 1989" was due to her compensable conditions. We find those reports unpersuasive. At most, Ball and Smith were speculating about the cause of claimant's inability to work. Because that constitutes Ball's and Smith's final word in this case, it supports our conclusion that their reports fail to establish that claimant is entitled to any additional TTD benefits.

Last, we reject claimant's reliance on Dr. Smith's July 1992 report. That report concerns claimant's entitlement to TTD for a period for which she has already been paid TTD benefits. (Exs. 104, 105). Consequently, Dr. Smith's report does not help claimant.

For these reasons, we affirm the ALJ's decision not to award claimant any additional TTD benefits.

ORDER

The ALJ's order dated January 20, 1995 is affirmed.

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[4] A treating physician's retroactive authorization of the payment of temporary disability compensation is limited to 14 days prior to issuance of an authorization. Amended ORS 656.262(4)(f); Or Laws 1995, ch 332, § 28. Consequently, to the extent that Dr. Ball's 1994 "benefit of the doubt" report constitutes an authorization for the payment of temporary disability, it is effective no more than 14 days prior to its issuance. Delores L. Holmes, 47 Van Natta 2359 (1995).

In the Matter of the Compensation of
KAREN HUDSON, Claimant
WCB Case No. 94-13996
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that set aside its denial of claimant's injury claim for stress-related physical symptoms. Claimant cross-requests review of that portion of the ALJ's order that awarded a $4,000 assessed attorney fee. In addition, claimant has filed a motion for remand. On review, the issues are compensability, attorney fees and remand. We deny the motion for remand and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on Dibrito v. SAIF, 319 Or 244 (1994), the ALJ analyzed claimant's claim under the injury statute and concluded that claimant had established compensability of her stress-related physical symptoms.

As the parties acknowledge, subsequent to the ALJ's order, the legislature amended ORS 656.802(1). Or Laws 1995, ch 332 § 56 (SB 369, § 56). ORS 656.802(1)(b) now provides: "As used in this chapter, 'mental disorder' includes any physical disorder caused or worsened by mental stress." In addition, amended ORS 656.802(1)(a)(B) provides that an occupational disease includes "[a]ny mental disorder, whether sudden or gradual in onset, which requires medical services or results in physical or mental disability or death."

Except as otherwise provided, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565, 572-73 (1995). Because amended ORS 656.802 is not among the exceptions to retroactive application of SB 369, and because this matter has not been finally resolved on appeal, the amended statute applies to this claim. SB 369, § 66.

In light of the amendments to ORS 656.802(1), claimant has moved for remand. Claimant contends that, at the time the case was tried, physical symptoms caused by mental stress were analyzed under a material contributing cause standard under the injury statute, ORS 656.005(7). Claimant notes that, under amended ORS 656.802(1), she would be required to prove a claim for a mental disorder in order to establish that her stress-caused physical symptoms are compensable. Claimant acknowledges that, in reliance on the law as set out in Dibrito, she withdrew her mental condition claim for an "adjustment disorder" at hearing and elected to pursue only her claim for her physical condition. Nevertheless, claimant argues that the case should be remanded for further development of the issues and evidence in light of the statutory changes. The employer opposes claimant's motion for remand and argues that the record has been fully developed with regard to claimant's physical and mental conditions. Based on the following reasoning, we deny the motion for remand.

We may remand a case to the ALJ 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. Kienows 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).

Regardless of her reasons for doing so, claimant concedes that she withdrew her mental disorder theory and elected instead to pursue an injury theory for her claim for physical conditions under the

holdings of Mathel v. Josephine County, 319 Or 235 (1994), and Dibrito v. SAIF, supra. As a result of the 1995 legislative amendments, physical conditions caused by mental stress must now be analyzed under the "mental disorder" statute. Claimant concedes that, unless her motion for remand is granted, her claim will fail if analyzed under the "mental disorder" statute.

As claimant acknowledges, she voluntarily chose to withdraw her claim based on a mental disorder theory. Thus, it cannot be said that evidence pertaining to the mental disorder claim was unobtainable with due diligence at the time of hearing. In light of such circumstances, we conclude that remand is not appropriate. Accordingly, we deny the motion for remand.

Based on the text and context of ORS 656.802(1)(b), we conclude that claimant's stress-caused physical conditions must now be analyzed under the occupational disease statute. See PGE v. Bureau of Labor and Industries, 317 Or 606 (1993) (In determining legislative intent, we first examine the statute's text and context of the statute). The statute provides that the term "mental disorder" includes any physical condition caused or worsened by mental stress. Amended ORS 656.802(3) sets out the requirements to establish compensability of a "mental disorder."[1] When amended ORS 656.802(1)(b) is read in conjunction with amended ORS 656.802(3), it is evident that physical conditions that are caused or worsened by mental stress are considered "mental disorders" and are therefore subject to the requirements set out in amended ORS 656.802(3) for establishing compensable mental disorders. Because we find the statute unambiguous, we do not resort to legislative history.

Consequently, in order to establish compensability of her stress-caused physical symptoms, claimant must meet the requirements of amended ORS 656.802(3) and must prove that employment conditions were the major contributing cause of her mental disorder. See amended ORS 656.802(1)(b); 656.802(2)(a). The medical opinions which support a causal relationship between claimant's physical symptoms and her work activities do not diagnose a mental disorder which is generally recognized in the medical or psychological community. See amended ORS 656.802(3)(c). Accordingly, we agree with claimant that her claim for a mental disorder fails under the occupational disease statute governing mental disorders.

ORDER

The ALJ's order dated May 1, 1995 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's award of a $4,000 assessed attorney fee is also reversed.

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[1] Amended ORS 656.802(3) provides:

"Notwithstanding any other provision of this chapter, a mental disorder is not compensable under this chapter unless the worker establishes all of the following:

"(a) The employment conditions producing the mental disorder exist in a real and objective sense.

"(b) The employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles.

"(c) There is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

"(d) There is clear and convincing evidence that the mental disorder arose out of and in the course of employment."

In the Matter of the Compensation of
CODY L. LAMBERT, Claimant
WCB Case Nos. 95-00916, 95-03025 & 95-03026
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys
John E. Snarskis, Defense Attorney

Reviewed by Board Members Haynes and Christian.

The self-insured employer, Roseburg Forest Products, requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of claimant's claim for symptomatic spondylolisthesis; and (2) found it responsible for claimant's condition and need for surgery. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

In December 1979, claimant sustained a low back injury while working for the employer. The employer's then insurer accepted the claim. Claimant was treated by Dr. Streitz for what was diagnosed as a lumbosacral strain superimposed on spondylolysis/spondylolisthesis at L5-S1. The claim was closed in 1980 and, by stipulation, claimant was awarded 20 percent unscheduled permanent disability.

Claimant's back symptoms resolved completely until December 1986, when he fell at work and reinjured his back. Dr. Streitz again diagnosed a lumbosacral strain, and x-rays documented the spondylolysis/spondylolisthesis at L5-S1. Claimant's symptoms subsided shortly thereafter. In November 1989, claimant once again strained his back at work and was treated by Dr. Streitz. As before, his symptoms resolved and he experienced no pain or limitations.

On October 24, 1992, claimant sustained a compensable right knee injury. Dr. Streitz performed a partial medial meniscectomy on December 3, 1992 and claimant returned to work in January. On February 4, 1993, claimant reported to Dr. Streitz that his knee became sore when he traveled up and down the stairs at work, although his physical examination showed normal gait, no effusion and full range of motion. Claimant reported to his physical therapist in February 1993 and again in May 1993 that his back pain had increased since his right knee injury and subsequent surgery. He related this back pain to his limping resulting from favoring his injured knee.

On May 7, 1993, claimant began treating with Dr. Mohler for continuing knee pain. Dr. Mohler noted that claimant walked without a limp, and found claimant's pain unsettling in the absence of distinct physical findings. In light of claimant's continued knee discomfort, Dr. Mohler performed an arthroscopy early August 1993. The surgery showed the remainder of the meniscus was intact. Dr. Mohler declared claimant medically stationary as of August 30, 1993, with full range of motion.

Claimant was examined by a medical arbiter on December 11, 1993 in connection with the processing of his 1992 knee injury. Claimant complained to the arbiter of continued knee difficulty, particularly with stairs, but did not complain of low back symptoms. Similarly, at the 1994 hearing regarding the extent of permanent disability in his right leg, claimant described many problems with his knee but did not mention any low back symptoms.

On September 9, 1994, claimant sought treatment from Dr. Golden for back pain and lower extremity radiation. In this initial exam, Dr. Golden noted that claimant walked with a limp, both with and without a knee brace. Dr. Golden reported that claimant has had progressive changes in his back, secondary to spondylolisthesis.

CONCLUSIONS OF LAW AND OPINION

Relying on the assessment of Dr. Golden, the ALJ found that claimant's "altered gait" resulting from his 1992 knee injury was the major contributing cause of his spondylolisthesis becoming

symptomatic to the point of requiring surgery.[1] The ALJ further determined that the employer (which was self-insured by 1992) was responsible for this treatment, rather than the insurer on the risk at the time of claimant's initial back injury in 1979.

On review, the employer argues that claimant's condition and need for surgery are not compensable because a preponderance of the evidence establishes that claimant's preexisting degenerative back condition, and not the compensable 1992 knee injury, is the major contributing cause of his current condition and need for treatment. We agree.

Three physicians provided opinions on the cause of claimant's current condition and need for treatment. Dr. Golden, who began treating claimant in September 1994 opined that claimant's altered gait was the major contributing cause because he had been asymptomatic for several years prior to his knee injury. Specifically, Dr. Golden reported that claimant's underlying spondylolisthesis "had been stabilized at the time of his injury" and "[b]ecause of the stress imposed on his back due to the injury, he again became symptomatic." (Ex. 70).

Dr. Streitz, who had been claimant's treating physician for many years until he and claimant had a falling out in April 1993, opined that claimant's back symptoms were likely the result of a natural progression of his preexisting spondylolysis and spondylolisthesis, and not directly related to his work or other injuries. (Ex. 60).

Dr. Streitz' opinion is supported by Dr. Donahoo, who examined claimant at the employer's request. Dr. Donahoo specifically rejected an altered gait as the major cause of claimant's back problems, reporting that there is no medical literature of consequence studying the relationship between gait patterns and aggravation of spondylolysis and spondylolisthesis. (Ex. 61-10). Moreover, after reviewing the recent x-rays, which confirmed that there had been no interim slippage at L5-S1 subsequent to claimant's knee injury, Dr. Donahoo reiterated his opinion that the major contributing cause of claimant's current symptoms was his preexisting degenerative disc disease.

We ordinarily defer to the opinion of the attending physician unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). We accord such deference because the attending physicians generally have had a better opportunity to observe and evaluate a claimant's condition over an extended period of time. Id. Here, however, the record indicates that Dr. Golden did not begin treating claimant until nearly two years after his October 1992 injury. Given Dr. Golden's inability to evaluate claimant's condition and, more specifically, the nature and extent of his altered gait during the two years between his knee injury and the exacerbation of his back pain, we decline to give his opinion the greater weight ordinarily given to attending physicians' opinions. See, e.g., Douglas B. Robbins, 47 Van Natta 806 (1995) (when treatment follows long after key event, Board will not give treating physician's opinion the usual deference).

After evaluating the opposing medical opinions, we are most persuaded by those of Drs. Streitz and Donahoo. Both physicians opined that claimant's longstanding preexisting asymptomatic degenerative condition was the major cause of his current condition and need for treatment. Although Dr. Streitz' causation opinion is somewhat brief (and does not comment on the altered gait factor),[2] we find the opinion of Dr. Donahoo particularly thorough and well-reasoned. Dr. Donahoo's report specifically addresses the relative contribution of the many different potential causes for claimant's condition, i.e., his preexisting degenerative condition, prior back injuries, continued work activities and

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[1] The ALJ analyzed the compensability of claimant's current condition under former ORS 656.005(7)(a)(B). Given claimant's position that the sequela of his compensable knee injury (an altered gait) has combined with his preexisting spondylolysis and spondylolisthesis to cause disability and need for treatment, we agree that application of this section (which has since been amended by Or Laws 1995, ch 332 § 1 (SB 369, § 1)) is appropriate. We note, however, that had we instead analyzed claimant's condition as a "consequential condition" under ORS 656.005(7)(a)(A) the legal standard and the result would be the same.

[2] This may be because there is no medical finding of a gait disturbance until claimant saw Dr. Golden in September 1994. Both Dr. Streitz and Dr. Mohler reported in February and May 1993, respectively, that claimant had a normal gait. (See Exs. 38, 42).

post-knee injury gait disturbance and concludes that the preexisting spondylolysis and spondylolisthesis is the most significant factor. (Ex. 61).

Dr. Golden, on the other hand, employs a "but for" analysis rather than weighing the relative contribution of the different causes for claimant's current symptoms. Dr. Golden reasons that because claimant's back was asymptomatic before his knee injury, "it is logical to assume that the knee injury is the major contributing cause of his exacerbation" of back and lower extremity pain. (Ex. 70). We have previously found that such a "but for" analysis is unpersuasive and essentially the same as the "precipitating cause" analysis rejected by the court in Dietz v. Ramuda, 130 Or App 397 (1994). See Alec E. Snyder, 47 Van Natta 838 (1995).

In sum, given the medical evidence in the record, we are not persuaded that claimant's compensable knee injury and its sequelae are the major contributing cause of his current low back symptoms and need for treatment. Instead, we conclude that a preponderance of the evidence establishes that claimant's noncompensable longstanding preexisting degenerative disc disease is the major cause of his disability. Accordingly, we reverse the ALJ's order.

ORDER

The ALJ's order dated May 10, 1995 is reversed in part and affirmed in part. Roseburg Forest Product's denials of January 12, 1995 and February 23, 1995 are reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

January 19, 1996 Cite as 48 Van Natta 117 (1996)

In the Matter of the Compensation of
PATRICIA L. McVAY, Claimant
WCB Case No. 94-15088
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
H. Thomas Anderson (Saif), Defense Attorney

Claimant requests abatement and reconsideration of our December 22, 1995 Order on Review that increased claimant's scheduled permanent disability for the loss of use or function of the right arm from 12 percent (23.04 degrees) to 19 percent (36.48 degrees) and the loss of use or function of the left arm from 14 percent (26.88 degrees) to 21 percent (40.32 degrees). The order also awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by our order, not to exceed $3,800.

In requesting abatement and reconsideration, claimant asserts that, because the SAIF Corporation requested the hearing from an Order on Reconsideration and because those awards have not been disallowed or reduced, she is entitled to an attorney fee pursuant to ORS 656.382(2) for services at hearing and on review.

In order to consider this matter, we withdraw our December 22, 1995 order. SAIF is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Therefore, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEANNA L. ROSS, Claimant
WCB Case No. 94-03955
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order which: (1) found that no claim was made as of August 30, 1994 for an L4-5 nerve root irritation condition; (2) upheld the insurer's partial denial of claimant's preexisting degenerative low back condition; and (3) affirmed an Order on Reconsideration that awarded no unscheduled permanent disability. On review, the issues are compensability and extent of permanent disability. We affirm, as modified.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On January 6, 1993, claimant sustained a compensable injury. The insurer accepted "lumbosacral muscle strain." In July 1993, Dr. McGirr, consulting physician, identified inflammation of the nerve root at L4-5 that was causing left leg radiculitis. (Ex. 24). He attributed the inflammation and left leg problems to claimant's January 1993 work injury. (Ex. 44-19). Dr. McGirr also reported preexisting degenerative conditions of claimant's spine, which he did not attribute to the work injury.

Claimant's claim was closed in September 1993. On March 8, 1994, the insurer issued a partial denial of "underlying degenerative condition and chronic sclerotic changes and any impairness [sic] related thereto." On January 11, 1995, claimant requested clarification of the denial, asking that the insurer acknowledge responsibility for inflammation of the L4-5 nerve root. (Ex. 45). The denial was not clarified at that time.

At hearing, claimant contended that lumbar nerve root irritation was part of her claim and should be formally accepted. Therefore, claimant stated that she was specifically contesting the insurer's partial denial to the extent it purported to deny radicular problems. (Tr. 2). Claimant was not asserting compensability of the preexisting conditions.

Based on dialogue between the parties prior to hearing (Tr. 4-6), the ALJ framed an issue as whether a "claim" had been made for a nerve root irritation condition. The ALJ concluded that a claim had not been made, but stated that, even if a claim had been made, "the condition described by [the physician] was encompassed within those conditions previously <u>denied</u> by the insurer." (Opinion at 3)(emphasis added).

Claimant contends that, in the above-cited quote, the ALJ misstated the insurer's position with regard to the status of the nerve root irritation. We agree.

At hearing, the parties clarified the issues that were before the ALJ. The insurer stated that its March 8, 1994 denial denied only claimant's preexisting degenerative changes. (Tr. 7). Furthermore, the insurer specifically indicated that the radicular symptoms had been accepted as compensable symptoms of the low back injury, and that the insurer was not contesting the compensability of the lumbar root irritation which caused the radicular symptoms. (Tr. 8). Accordingly, we conclude that the ALJ's order should read, "the condition described by [the physician] was encompassed within those conditions previously <u>accepted</u> by the insurer.

Claimant next asserts that the ALJ also misstated the scope of the matters being litigated, to the extent that the ALJ concluded that the major cause of claimant's disability and need for treatment in 1993 was her preexisting degenerative condition. We agree.

The insurer issued a specific partial denial of claimant's "underlying degenerative condition and chronic sclerotic changes and any impairness [sic] related thereto." The denial was not a denial of claimant's current condition, although the ALJ's order appears to address it as such, when it concludes that "the major cause of [claimant's] disability and treatment in 1993 was her preexisting degenerative condition."

Accordingly, as requested by claimant, we modify the ALJ's order to recite the parties' mutual understanding that the lumbar root irritation is a compensable component of claimant's accepted injury claim, and that the insurer's denial did not pertain to claimant's current condition. Instead, as clarified by the insurer's counsel at hearing, the insurer's denial pertained to "preexisting degenerative changes that were identified by MRI scan and x-ray." (Tr. 7).

Furthermore, because the insurer's amended acceptance occurred only after the scope of the insurer's partial denial was clarified at hearing, we conclude that claimant is entitled to an assessed attorney fee under ORS 656.386(1) for her counsel's efforts in securing acceptance of the L4-5 nerve root irritation condition. See Wesley R. Craddock, 46 Van Natta 713 (1994); see also Ronald R. Willard, 45 Van Natta 937 (1993)(attorney fee appropriate for obtaining clarification of insurer's overbroad denial).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the L4-5 nerve root irritation condition is $1,000, 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 appellant's brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 15, 1995 is affirmed, as modified above. For services at the hearings level and on Board review regarding the nerve root irritation condition, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by the insurer.

January 19, 1996 Cite as 48 Van Natta 119 (1996)

In the Matter of the Compensation of
PAUL D. RUTTER, Claimant
WCB Case No. 94-05163
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's aggravation claim for a C5-6 pseudoarthrosis condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), rev den 320 Or 587 (1995), the ALJ determined that claimant's compensable 1989 injury was a material contributing cause of his increased cervical symptoms. The ALJ also concluded that claimant's "cervical condition" had worsened since the last arrangement of compensation, that he had established a diminished earning capacity as a result of the worsened condition and that his worsening exceeded a mere waxing and waning of symptoms.

SAIF argues that this case must be analyzed as a "combined condition" under amended ORS 656.005(7)(a)(B) and it contends that claimant must prove that his compensable 1989 injury was the major contributing cause of his current disability or need for treatment.

Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.273(1) to provide, in part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." Or Laws 1995, ch 332, § 31 (SB 369, § 31; emphasis added).

Except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565, 572-73 (1995). Because amended ORS 656.273(1) is not among the exceptions to this general rule, see SB 369, § 66 (listing exceptions to general retroactivity provision), the amended version of the statute applies here. See Gloria T. Olson, 47 Van Natta 2348 (1995); Helen M. Callander, 47 Van Natta 1626 (1995).

Claimant contends that, if the law is applied in the way SAIF contends it should, the law is unconstitutional. Claimant asserts that Article I, sections 20 and 21, of the Oregon Constitution prohibit ex post facto legislation. Claimant does not, however, elaborate or explain this contention. Because this constitutional argument is not adequately developed for our review, we decline to address the issue. See Thurman M. Mitchell, 47 Van Natta 1971, 1973 (1995). In any event, we note that the Oregon Constitution's prohibition against ex post facto laws applies only to criminal statutes. Kilpatrick v. Snow Mountain Pine Co., 105 Or App 240, rev den 311 Or 426 (1991); Thurman M. Mitchell, supra.

Claimant also argues that, since SAIF did not appeal or request reconsideration of his 1990 permanent partial disability award, SAIF is precluded from arguing that there was no permanent cervical injury. Contrary to claimant's assertion, SAIF does not dispute that claimant suffered a permanent cervical injury. Rather, the issue here is whether claimant has had an actual worsening of the 1989 compensable condition.

In Gloria T. Olson, supra, we held that amended ORS 656.273(1) requires proof of two elements in order to establish a worsened condition: (1) "actual worsening;" and (2) a compensable condition. Both elements must be satisfied in order to establish "a worsened condition resulting from the original injury." In Olson, there was no dispute that the claimant's shoulder condition had "worsened." Compare Helen M. Callander, supra (the record was insufficiently developed for us to determine whether the claimant's condition had "actually worsened"). Rather, the dispute in Olson concerned the applicability of material versus major contributing cause standards.

In Olson, we analyzed amended ORS 656.273(1) and determined that the unambiguous language of the statute modified the court's holding in Jocelyn v. Wampler Werth Farms, supra, by specifically defining the elements of proof which establish a "worsened condition resulting from the original injury." We noted that in Jocelyn, the court reasoned that, since former ORS 656.273(1) did not refer to the term "compensable injury" or otherwise reference ORS 656.005(7)(a)(B), the latter statute did not apply to aggravation claims. Jocelyn, supra, 132 Or App at 171. Under the 1995 amendments, however, the legislature inserted the term "compensable condition" in the aggravation statute.

We concluded that, since the compensability of a condition is established under ORS 656.005(7)(a), amended ORS 656.273 requires that a condition which is not already compensable must be established as compensable in order to prove "a worsened condition resulting from the original injury." In Olson, the claimant's accepted right shoulder condition was diagnosed as a strain, or tendinitis. The worsened condition was a right rotator cuff tear. The rotator cuff tear was not an accepted condition; rather, it developed some three years after the original 1988 injury. We concluded that, in order to establish a worsened condition resulting from the original injury, the claimant had to first establish that the rotator cuff tear was a compensable condition. We analyzed amended ORS 656.005(7)(a)(B), amended ORS 656.005(24) and amended ORS 656.273 and held that amended ORS 656.005(7)(a)(B) was applicable in aggravation claims. Since the claimant's compensable injury combined with her preexisting degenerative condition, we concluded that the claimant had to establish that her compensable injury was the major contributing cause of her worsened condition.

We apply the same analysis in this case. SAIF accepted an acute cervical strain and acute "lumbar sacral" strain as a result of claimant's 1989 injury. (Ex. 16). Claimant's current condition has been diagnosed as pseudoarthrosis at C5-6. (Exs. 39, 40, 41). Since claimant's pseudoarthrosis is not an accepted condition, in order to establish a worsened condition resulting from the original injury, he must first establish that the pseudoarthrosis is a compensable condition.

We briefly recap claimant's medical history. In 1981, claimant injured his low back in a work-related injury with a different employer in Louisiana. In March 1983, claimant injured his neck and head in a non-work-related motor vehicle accident. In April 1984, claimant underwent low back surgery, a lumbar laminectomy at L4-5. By October 1984, claimant's neck symptoms had worsened. In March 1985, Dr. Adatto performed an anterior cervical fusion and C4-5 and C6-7.

After claimant's cervical surgery, he continued to experience neck and headache symptoms. A cervical MRI performed on July 31, 1987 revealed a solid fusion at C4-5. The radiologist concluded, however, that there were surgical changes at C5-6, but "the general appearance suggests failed arthrodesis at probable pseudoarthrosis." (Ex. A).

On March 23, 1989, claimant injured his neck and low back while working for SAIF's insured. SAIF accepted a claim for acute cervical strain and acute "lumbar sacral" strain. A January 2, 1990 Determination Order awarded claimant 11 percent permanent partial disability. (Ex. 26).

Claimant continued to experience thoracic symptoms in January 1992 and April and May 1993. In September 1993, claimant experienced an acute cervical spasm after crawling under his house. Claimant was examined by Dr. Edmonds, who referred claimant to Dr. Olson. Based on the results of a bone scan, Dr. Olson diagnosed C5-6 pseudoarthrosis and recommended a repeat fusion.

SAIF contends that claimant's pseudoarthrosis constitutes a preexisting condition pursuant to amended ORS 656.005(24). A cervical MRI performed on July 31, 1987 indicated that claimant had probable pseudoarthrosis at C5-6. (Ex. A). In addition, Dr. Adatto's September 11, 1987 chart note indicated that the MRI showed potential pseudoarthrosis at C5-6. Dr. Adatto commented:

> "This [the potential pseudoarthrosis] may or may not be part of the problem. He is learning to live with the pain. We discussed again, the fact that if it doesn't get any worse or better, he would probably do better to leave it alone. If the pain increases, it would probably be best to repeat the discogram. If that is the symptomatic disc, he may need a refusion." (Ex. A).

Dr. Adatto also noted that claimant was moving to Salem, Oregon. Dr. Adatto wrote to a physician in Portland, asking for an orthopedist or neurosurgeon for claimant in Salem. Dr. Adatto noted that "[o]ne of the levels of ACF at C5-6, may not be totally fused but he is trying to learn to live with it." (Ex. A).

Dr. Fuller opined that claimant had a pseudoarthrosis at C5-6 diagnosed in July 1987 and he concluded that claimant's pseudoarthrosis preexisted his 1989 compensable work injury. (Ex. 53A). Based on these reports, we are persuaded that claimant's pseudoarthrosis constitutes a "preexisting condition" pursuant to amended ORS 656.005(24).

Dr. Fuller also indicated that claimant's 1989 work incident combined with the preexisting pseudoarthrosis to cause or prolong his disability or need for treatment. (Exs. 53A, 54). Although Dr. Olson did not express a specific opinion as to whether claimant's 1989 cervical strain combined with the preexisting pseudoarthrosis, his October 17, 1994 response to claimant's questionnaire indicates that both the work injury and pseudoarthrosis contributed to claimant's current condition. (Ex. 55). We conclude that claimant's 1989 work incident combined with the preexisting pseudoarthrosis to cause or prolong his disability or need for treatment. Therefore, claimant must establish that his compensable injury was the major contributing cause of his worsened condition. See amended ORS 656.005(7)(a)(B); Gloria T. Olson, supra.

There are only two medical opinions on causation that considered claimant's Louisiana medical records and the extent of his preexisting pseudoarthrosis, those from Drs. Fuller and Olson. Although claimant relies on the opinion of Dr. Edmonds, we agree with the ALJ that Dr. Edmonds' opinion on causation is not persuasive because there is no evidence that he was aware that claimant had been diagnosed with C5-6 pseudoarthrosis in 1987.

Dr. Fuller examined claimant on behalf of SAIF and later reviewed claimant's medical records from Louisiana. Dr. Fuller believed that the major contributing cause of claimant current neck symptoms was the "failure of the anterior cervical fusion at C5-6 causing a pseudoarthrosis" which was diagnosed in 1987. (Exs. 53A; 54-26). Dr. Fuller states that it was likely that the 1989 injury may have provided a minor material cause of claimant's neck symptoms, but the injury "certainly didn't cause the pseudoarthrosis which was firmly established prior to the 1989 incidence." (Ex. 53A). In addition, Dr. Fuller reported that there were no new objective findings that indicated that his compensable injury had worsened. (Id.) In a deposition, Dr. Fuller reiterated those conclusions. (Ex. 54A).

Claimant relies on the opinion of Dr. Olson. In a questionnaire from claimant's attorney, Dr. Olson was asked whether he agreed that it was "more likely than not, even if there was a pseudoarthrosis before March 23, 1989, that the injury which occurred on that date aggravated the condition." (Ex. 55). Dr. Olson checked the "unknown" box. (Id.) Claimant contends that any ambiguity in Dr. Olson's response is eliminated by his detailed answer. Dr. Olson included a handwritten note to question # 1 that said:

> "Prob. some degree of instability prior Mar. 89 aggravates & worsened to significant instab thereafter * * * Dx pseudoarthrosis * * * instab after Mar 89."[1] (Id.)

Dr. Olson was also asked: "If the 1989 injury did cause or aggravate the pseudoarthrosis, is the result of that injury still the major contributing cause for the need for treatment?" Dr. Olson replied: "See # 1 [the question noted above]." Claimant asked Dr. Olson to assume, for the sake of argument, that the 1989 industrial injury neither caused nor aggravated the pseudoarthrosis condition. Claimant asked whether it was "more likely than not that some treatment is required for a condition or some conditions that resulted from the industrial injury and that the pseudoarthrosis in turn needs to be treated to permit substantial improvement?" Dr. Olson replied: "See # 1."

We find that Dr. Olson's opinion is, at best, ambiguous. Based on Dr. Fuller's report, we are persuaded that claimant's preexisting pseudoarthrosis condition is the major contributing cause of his current condition. Accordingly, we conclude that claimant has failed to establish that he has a "compensable condiiton" under ORS 656.273. Therefore, his aggravation claim fails.

ORDER

The ALJ's order dated April 13, 1995 is affirmed in part and reversed in part. That portion of the order that set aside SAIF's denial of claimant's aggravation claim is reversed. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

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[1] Omissions in Dr. Olson's handwritten reply indicate medical abbreviations that are not defined in the record.

In the Matter of the Compensation of
TERRY L. SMOTHERS, Claimant
WCB Case No. 94-11585
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the insurer's denial of his occupational disease claim for a lower respiratory condition. With his brief, claimant has submitted additional evidence and requests that the Board consider this evidence on review. We treat such a request as a motion to remand. On review, the issues are compensability and remand. We deny the motion for remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following corrections:

The fifth sentence of the sixth paragraph on page two is corrected to reflect that on December 23, 1993, claimant was found lying on the lunchroom floor from illness. The third paragraph on page three is corrected to reflect that claimant saw Dr. Miracle for bronchitis on six occasions during June and July 1994.

The pertinent facts may be summarized as follows:

Claimant worked as a mechanic for the employer, a trucking company, from November 1992 to mid-June 1994. His job required that he work in a mechanic's "pit" inside the shop. Just outside the shop, on the side adjacent to the mechanic's pit, is the "wash rack" area where the employer's trucks are washed. The trucks are washed with a chemical mixture (consisting of sulfuric acid and small amounts of hydrochloric and hydrofluoric acid), which is diluted in a pumping device, sprayed onto the vehicles and rinsed with water. With the shop's doors open, acid mist and fumes from the truck washing process would drift into the shop and the mechanic's pit area, and it was common for claimant's eyes to itch, burn and water on the job. Claimant also experienced headaches.

Claimant developed an upper respiratory infection associated with a productive cough in January 1993, which developed into pneumonia. He was admitted to the hospital for five days and was off work for four weeks. Claimant was also off work in February 1993 with a productive cough and possibly another episode of pneumonia.

Claimant was diagnosed with bronchitis in November 1993. On December 23, 1993, claimant became ill at work and was told to go home. He was diagnosed with bacterial bronchitis that day, and remained bed-ridden throughout the holiday season. By January 1994, his bronchitis was resolving but his doctor was concerned with the slow rate of recovery.

Claimant returned to work during January 1994. He phoned in sick a number of times between March and mid-June 1994, when he ultimately left work because of illness. On June 24, 1994, claimant filed a claim for a lung disorder as a result of his alleged chemical exposure at work.

CONCLUSIONS OF LAW AND OPINION

Remand

With his brief, claimant has submitted additional evidence marked as "Appendix B" and requests that the Board consider this document, which is an excerpt on "Sulfuric Acid" from a treatise titled "Courtroom Toxicology" by M. Houts, et al (1995), on review. Because we lack the authority to consider evidence not presented at hearing, we treat claimant's request as a motion to remand. Judy A. Britton, 37 Van Natta 1262 (1985).

We may remand to the ALJ should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656. 295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Keinow's Food Stores v. Lyster, 79 Or App 416 (1986). Here, although it is not clear whether this particular treatise was available as of the date of hearing (since it was published in 1995), we do not consider the present record, without this particular document, to be improperly, incompletely, or insufficiently developed. Moreover, we do not find that admission of this evidence would likely affect the outcome of the case. For these reasons, claimant's motion to remand is denied.

Compensability

Because of its progressive onset, claimant's lung disorder must be analyzed as an occupational disease. See Valtinson v. SAIF, 56 Or App 184 (1982). To prove compensability of an occupational disease, claimant must show that his work exposure was the major contributing cause of his lower respiratory condition. See ORS 656.802(2).

Relying on the opinion of Dr. Burton, the ALJ found that claimant's employment conditions were not the major contributing cause of his lower respiratory condition. On review, claimant contends that we should give greater weight to the opinions of claimant's treating physicians, Drs. Miracle and Uri, who opined that claimant's symptoms were caused by his occupational exposure to sulfuric acid mist.[1]

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[1] OR-OSHA testing of the air in the breathing zone of the mechanic's pit during August and October 1994 indicated that when transport trucks were being washed, the mechanic's exposure to the sulfuric acid mist was .95 mg/m3, or 95% of the permissible exposure limit of 1.0 mg/m3. According to OR-OSHA, it is probable, given the test results and accounting for error in the sampling procedure, that a full work shift of spray washing can cause the mechanic to be exposed to sulfuric acid mist just over the permissible exposure level. (Ex. AA34).

Absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). When the medical evidence is divided, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

In this case, we agree with that ALJ that there are persuasive reasons not to defer to the opinion of claimant's treating physicians. As noted above, claimant treated with Dr. Miracle on six occasions during June and July 1994. Dr. Miracle's impression as to the cause of claimant's condition is limited to one sentence. On a June 30, 1994 chart note Dr. Miracle reported: "Bronchitis, probably secondary to his exposure to various chemicals that he comes in contact with at work." (Ex. 1-3). We are not persuaded by Dr. Miracle's opinion because it lacks explanation and appears to be based entirely on claimant's report that he is exposed to "a lot of chemicals at work" and the mistaken belief that the chemicals were sodium hydroxide and anhydrous ammonium. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (medical opinions based on incomplete or inaccurate information are not afforded persuasive force). Further, Dr. Miracle is not an expert in pulmonary medicine or toxicology.

Dr. Uri, who is a specialist in pulmonary medicine, first saw claimant in August 1994 on referral from Dr. Miracle. In his initial report, Dr. Uri diagnosed "reactive airways disease, possibly caused by occupational exposure." He also noted that "a cause-and-effect relationship is very difficult to prove in these situations." (Ex. 9). On a November 1, 1994 follow-up examination, Dr. Uri reported that claimant had "severe asthma precipitated by occupational exposure." (Ex. 9A-3). Later, in a supplemental report prepared in response to Dr. Burton's report and deposition, Dr. Uri agreed that claimant was suffering from "acute bronchitis and probably not an upper respiratory infection." He concluded that "based on the methacholine challenge test and the patient's history, I believe that Mr. Smothers has reactive airways disease caused by his occupational exposure. . . [T]he lack of asthma-type symptoms prior to his occupational exposure argues strongly in favor of the exposure as being the principal precipitating cause." (Ex. 20-2).

In ultimately opining that claimant's asthma condition was "precipitated" by his occupational exposure, Dr. Uri relied on results of methacholine tests performed pursuant to an admittedly abbreviated protocol.[2] (Ex. 20-2). Dr. Uri also conceded that he is not an expert about the potential medical harm that can be caused by the various chemicals used around claimant's work area. While these two factors alone tend to undermine the persuasiveness of Dr. Uri's opinion, we also find that Dr. Uri's report is lacking in medical analysis. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical report). Moreover, from a legal standpoint, Dr. Uri's opinion is insufficient because the mere fact that claimant's work exposure may have "precipitated" claimant's symptoms does not mean that the work exposure was the major contributing cause of his current lower respiratory symptoms. See Alec E. Snyder, 47 Van Natta 838 (1995) ("but for" analysis of causation not persuasive).

Dr. Burton, on the other hand, has provided a thorough, complete and well-reasoned opinion concerning claimant's condition. Dr. Burton, who is board certified in occupational medicine and toxicology, obtained an accurate history from claimant, including his various complaints and symptoms while working for the employer. Dr. Burton found, based on the results of methacholine tests performed at OHSU pursuant to a rigid protocol, that claimant did not have asthma, but recurrent bronchitis and a possible disease of the esophagus. Dr. Burton concluded that while claimant was exposed to sufficient concentrations of sulfuric acid mist to produce certain immediate and transient upper airway symptoms such as watery eyes and nose and throat irritation, his work exposure was not the cause of his lower respiratory symptoms. Dr. Burton further noted that claimant's clinical course, specifically his continuing symptoms and worsening after he left his employment, was not consistent with exposure to acid mist, which resolves rapidly without sequelae. (Ex. 13).

In his deposition, Dr. Burton offered further explanation for his causation opinion. He explained that because sulfuric acid is water soluble, the first place exposure results in irritation is in the nose, eyes and throat. The effects from acid fumes are so overpowering that a significant exposure would result in such tremendous upper respiratory symptoms that claimant would be unable to continue working and would need to escape to fresh air. (Ex. 15-21). Dr. Burton testified that acid mist does not

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[2] Dr. Burton testified that pulmonary function test results obtained by Dr. Uri at Portland Adventist Medical Center were probably a false positive because of the protocol administered (no baseline was established prior to proceeding with the methacholine challenge) and the dose of methacholine. (Ex. 15-31). Dr. Uri acknowledged that the protocols used at Portland Adventist and OHSU are different and the protocol used at Portland Adventist was "abbreviated." (Ex. 20-2).

get into the lungs and cause pulmonary damage unless there has been a massive exposure, in which case the upper respiratory and eye symptoms would also be significantly more severe. Finally, Dr. Burton reported that the kind of exposure that claimant experienced (according to claimant's history of symptoms and the OSHA testing) "has never been described as producing long-term pulmonary injury, [and] certainly not occupational asthma." (Ex. 15-30 - 15-35).

Accordingly, on this record, we agree with the ALJ's conclusion that claimant has not established the compensability of his lower respiratory condition by a preponderance of the evidence.

ORDER

The ALJ's order dated April 19, 1995 is affirmed.

Board Member Gunn dissenting.

Relying on the opinion of Dr. Burton over the assessments of claimant's treating physicians, the majority concludes that claimant has not established the compensability of his respiratory condition by a preponderance of the evidence. Because I see no persuasive reason not to defer to the opinions of Drs. Uri and Miracle, I respectfully dissent.

It is undisputed that claimant was exposed to significant, if not impermissible, amounts of acid mist at work. It is also undisputed that during the time of this exposure, claimant experienced upper respiratory problems leading to pneumonia in early 1993, that he developed bronchitis in late 1993, and that his recovery from this bout of bronchitis in the early months of 1994 was exceptionally slow.

Dr. Miracle, who treated claimant just before, during and after he left his employment as a result of recurring bronchitis in June 1994, opined that his condition was secondary to his work exposure. Dr. Uri, a pulmonary specialist who treated claimant on referral from Dr. Miracle, also determined that claimant's condition was caused by his exposure to chemicals at work.

Unlike the majority, I would conclude that Dr. Uri's report is the most persuasive. Because he is an expert in pulmonary and critical care medicine, Dr. Uri is qualified to render an opinion concerning the cause of claimant's condition. Further, as claimant's treating specialist, Dr. Uri had first hand knowledge of the nature and extent of claimant's symptoms as well as an accurate history concerning the chemicals to which claimant was exposed. I find his report thorough, well-reasoned and see no persuasive reason not to give it greater weight. See Weiland v. SAIF, 64 Or App 810, 814 (1983) (absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time). Accordingly, I dissent.

January 19, 1996 Cite as 48 Van Natta 125 (1996)

In the Matter of the Compensation of
EUGENIA S. TORRES, Claimant
WCB Case No. 94-08906
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
David J. Lillig (Saif), Defense Attorney

Reviewed by Board en banc.

Claimant requests review of Administrative Law Judge (ALJ) Galton's order that dismissed claimant's request for hearing from an Order on Reconsideration. On review, the issue is the propriety of the dismissal order. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. However, we do not adopt the ALJ's ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

The SAIF Corporation issued a September 29, 1993 Notice of Closure which awarded temporary total disability (TTD) for March 11, 1993, and from April 14, 1993 through June 21, 1993. (Ex. 52)

(emphasis added). The Notice contained a statement notifying claimant of her "180 day" rights to seek reconsideration. Thereafter, SAIF issued a January 17, 1994 Notice of Closure which "corrected" the September 29, 1993 Notice of Closure and awarded TTD for March 11, 1993, and from April 14, 1993 through July 22, 1993. (Ex. 53)(emphasis added). SAIF added a typewritten statement on the Notice of Closure which stated: "Please note that your appeal rights run from the date of closure dated 9/29/93."

Within 180 days of the corrected notice (but more than 180 days from the initial notice), claimant requested reconsideration of the January 17, 1994 corrected Notice of Closure. An Order on Reconsideration issued on July 15, 1994. (Ex. 62A). The Order on Reconsideration awarded TTD for March 11, 1993, and from June 18, 1993 through July 22, 1993. When claimant requested a hearing, SAIF moved for dismissal.

Relying on Gerald H. Coulsey, 46 Van Natta 873 (1994), the ALJ dismissed claimant's hearing request. On review, claimant challenges the ALJ's dismissal order and seeks an award of unscheduled permanent disability. Based on the following reasoning, we reinstate claimant's hearing request, but conclude that claimant is not entitled to an unscheduled permanent disability award.

In Coulsey, the carrier issued a Notice of Closure followed by a corrected Notice of Closure. The claimant requested reconsideration and the Department issued an Order Denying Reconsideration. The claimant requested a hearing. We affirmed the ALJ's order, which dismissed the claimant's hearing request as untimely on the grounds that the claimant's appeal rights ran from the first, rather than the corrected, Notice of Closure. In Coulsey, we also found an alternative reason for dismissing the claimant's hearing request. We concluded that the claimant's hearing request was untimely even if based on the mailing date of the corrected Notice of Closure.

Here, concerning the issue of whether claimant's hearing request should be dismissed, the holding in Coulsey is distinguishable. In Coulsey, the Director had issued an "Order Denying Reconsideration" from which claimant had appealed. Reasoning that claimant's request was untimely filed from the initial or corrected Notice of Closure, we found that the claimant's hearing request in Coulsey should be dismissed.

Here, by contrast, the Department issued an "Order on Reconsideration" in response to claimant's timely request for reconsideration of the corrected Notice of Closure. Under such circumstances, we conclude that the Hearings Division has jurisdiction to consider claimant's hearing request from the Order on Reconsideration. However, inasmuch as more than 180 days has expired since the issuance of the initial Notice of Closure which awarded no permanent disability, neither the ALJ nor this Board is authorized to grant claimant's request for a permanent disability award.[1] (We further note that, since the Director was without authority to alter the initial Notice of Closure's award of temporary disability, the reconsideration order modifying the temporary disability awarded by the initial Notice of Closure, would appear to be invalid. Nevertheless, since neither party seeks modification of the temporary disability award granted by the Order on Reconsideration, we shall not disturb the award).

Our conclusion that the ALJ had jurisdiction to address claimant's request for hearing is supported by the court's holding in McGinnis v. Tigard School District #23J, 87 Or App 363 (1987). In McGinnis, the Department issued a Determination Order which awarded the claimant temporary and permanent disability. The insurer subsequently filed a second determination request and included a medical report which was not available at the time of the first request. In response, the Department issued a second Determination Order which stated that the new medical information did not require a modification of the first Determination Order. The claimant filed a request for hearing which was untimely as to the first Determination Order, but was timely as to the second Determination Order. Claimant's hearing request raised issues decided by the first Determination Order, but did not raise the issue decided by the second Determination Order.

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[1] We note that the legislature has subsequently enacted SB 369 which changes the time periods for requesting reconsideration of Determination Orders and Notices of Closure from 180 to 60 days. Amended ORS 656.268(4)(e) and (5)(b). In addition, under amended ORS 656.268(6)(f), a party now has 30 days from the date of the reconsideration order to request a hearing. Or Laws 1995, ch 332, § 30 (SB 369, § 30). Nevertheless, the amendments to ORS 656.268(4) and (6) apply only to claims that become medically stationary on or after the effective date of the Act. SB 369, § 66(4). Here, because the claimant became medically stationary before the effective date of the Act, amended ORS 656.268(4), (5) and (6) do not apply to her claim.

The court held that the claimant's request for hearing was untimely as to the issues raised by the first Determination Order. The court held, however, that the request was timely as to the issue raised by the second Determination Order, i.e., whether the additional medical information submitted by the insurer requireda change in the award. On this basis, the court affirmed the Board's decision that it could not decide the questions of extent and time loss addressed in the first Determination Order.

We hold here, as the court did in McGinnis, that claimant may challenge issues decided by the second closure order, but may not challenge those issues decided by the first closure order since that order was not timely appealed and is final. Thus, consistent with the court's holding in McGinnis, we may address issues raised by the "corrected" Notice of Closure since claimant filed a timely request for hearing insofar as the reconsideration pertained to that closure notice.

Subsequent to the events arising during the processing of this claim, the Department promulgated OAR 436-30-020(10), which provides:

> "Requests for reconsideration of a Notice of Closure corrected pursuant to Section (9) of this rule must be received within 180 days of the mailing date of the corrected Notice of Closure. Requests for reconsideration of a corrected Notice of Closure may only address those areas changed by the corrected Notice."

This rule did not become effective until January 1, 1995. Although OAR 436-30-020(10) was not in effect at the time claimant filed her hearing request, we find the rule instructive. Consistent with the rule and with the holding in McGinnis, we hold that where a claimant does not appeal an original Notice of Closure but timely appeals a corrected Notice of Closure which substantively changes the original Notice of Closure, the claimant continues to have 180 days from the original Notice of Closure to challenge the award, as well as 180 days from issuance of the corrected notice to challenge the portion of the corrected notice which changes the original closure notice.[2]

Here, claimant seeks a permanent disability award. However, the only change made by the corrected Notice of Closure was to claimant's award of TTD. Claimant does not challenge the TTD award made by the corrected Notice of Closure and we do not alter that award. Accordingly, because the original closure order awarding no permanent disability has become final, we are without authority to alter that order.

Accordingly, for the reasons expressed above, we reinstate claimant's hearing request. However, because claimant did not timely appeal the original Notice of Closure, we are without authority to award permanent disability as claimant requests.

ORDER

The ALJ's order dated October 21, 1994 is modified. Claimant's hearing request is reinstated. Claimant's request for permanent disability benefits is denied.

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[2] We believe that the rule contained in OAR 436-30-020(10) serves the interests of substantial justice to both parties. In this regard, a claimant who fails to timely appeal a Notice of Closure will only be allowed to challenge those areas of a corrected Notice of Closure which change the original Notice of Closure. In addition, the rule guards against the possibility that a carrier might make a significant change to a claimant's permanent or temporary disability award at the end of the 180-day appeal period. Under the "Coulsey" rationale, a carrier could conceivably make a significant change to a claimant's permanent or temporary disability award on the 179th day after issuance of the original closure order. Under such a scenario, the claimant might not be able to appeal the change. For these reasons, we believe that the rule set out in OAR 436-30-020(10) best serves the interests of substantial justice to both parties.

Board Chair Hall dissenting.

Former ORS 656.268(6)(b) provided for a period of 180 days to request a hearing from a Determination Order. The issue here is whether claimant satisfied that requirement, thereby investing the Hearing Division and the Board with jurisdiction of this matter.

In Gerald H. Coulsey, 46 Van Natta 873 (1994), the carrier issued a Notice of Closure, then a corrected Notice of Closure. Following the claimant's request for reconsideration, the Department issued an Order Denying Reconsideration. The claimant then requested a hearing. We affirmed the ALJ's order dismissing the claimant's request for hearing as untimely on the ground that the claimant's appeal rights ran from the first, rather than the corrected, Notice of Closure.

McGinnis v. Tigard School District #23J, 87 Or App 363, rev den 305 Or 405 (1987), concerned a Determination Order which awarded the claimant temporary and permanent disability. The insurer subsequently filed a second determination request and included a medical report which was not available at the time of the first request. In response, the Department issued a second Determination Order which stated that the new medical information did not require a modification of the first Determination Order. The claimant filed a request for hearing which was untimely as to the first Determination Order, but timely as to the second Determination Order.

The Board dismissed the hearings request as untimely. In affirming, the court stated:

> "Although the second determination order does not use the word 'reconsideration,' it does, in fact, reconsider the first order and conclude that no change is necessary. It does not independently address the questions of extent and time loss and makes no independent determination of benefits and no adjustment to the previous award. We conclude that the second determination order was a reconsideration of the first, pursuant to ORS 656.268(4), and that it extended by nine days, to July 28, 1985, the time for seeking a hearing on the issues decided by the first determination order. [Footnote omitted.] Claimant's August 9, 1985, request for hearing was therefore untimely as to those issues. The request would have been timely, however, as to the one issue decided by the second determination order: whether the additional medical information submitted by SAIF requires a change in the award. There is no indication that claimant sought to place that issue before the [ALJ]." 87 Or App at 366-67.

From Coulsey, I can conclude that, if a second closure order merely constitutes a reissuance of the first closure order, the 180 days runs from the first closure order. Similarly, McGinnis provides that when no modification of the first closure order is made, the statute of limitations runs from that order.

However, if the second order modifies the first and is in fact a corrected, changed order, then the 180 days begins with the entire corrected order. That is, the appeal period is not divided up between the closure orders depending on the issues each addresses. Rather, the entire appeal period runs from the second order because, unlike Coulsey (no correction required and thus reconsideration denied) and McGinnis (no correction made), if the second closure order qualifies as a corrected order, the second order in fact is a new and different order than the original. Reaching any other conclusion promotes the bad policy of providing different appeal periods for the same claim.

Here, the second Notice of Closure was a corrected, independently reviewed, and modified order. It was not simply a denial of reconsideration (as in Coulsey) or a reconsideration of a non-corrected order (as in McGinnis). Thus, the second Notice of Closure should provide the appeal period.

A second problem with the majority's analysis is that, because both orders are silent with regard to permanent disability, it is just as likely as not that SAIF reconsidered whether to award permanent disability when it issued the second Notice of Closure. In McGinnis, because the insurer requested from the Department a second Determination Order and provided the reason for doing so, there was evidence regarding the issue which the insurer sought to be reconsidered. In contrast, here there no is documentation explaining why SAIF decided to provide the second Notice of Closure. Thus, there is a complete absence of proof for concluding (as the majority does) that SAIF did not again consider entitlement to permanent disability and decide to continue to not award permanent disability with the second Notice of Closure.

In essence, I find the record to be in equipoise whether SAIF reconsidered the permanent disability issue. Especially in this case, where SAIF itself is issuing the closure orders, the burden should be on SAIF to show that its reason for issuing the second Notice of Closure was limited to modifying temporary disability. Because such evidence is absent, claimant should be allowed to challenge the lack of permanent disability provided by the second Notice of Closure since her request for hearing was timely with regard to this order.

Therefore, for these reasons, I dissent.

In the Matter of the Compensation of
ANDREW D. LLOYD, Claimant
WCB Case No. 94-12686
ORDER ON REVIEW
Lauren Paulson, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order which: (1) declined to award an attorney fee under former ORS 656.386(l) for claimant's counsel's services in obtaining vocational assistance; and (2) declined to assess an attorney fee under former ORS 656.382(l) for the insurer's allegedly unreasonable resistance to the payment of compensation regarding vocational assistance. On review, the issue is attorney fees. We vacate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant sought an assessed attorney fee under former ORS 656.386(l) for his counsel's services in obtaining vocational assistance. In addition, claimant sought an assessed attorney fee under former ORS 656.382(l) due to the insurer's allegedly unreasonable resistance to the payment of vocational assistance benefits.

Subsequent to the ALJ's order in this case, the legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was the addition of § 42d to ORS 656.382 to 656.388, which provides that in disputes under the Director's jurisdiction, the Director shall award appropriate attorney fees. Or Laws 1995, ch 332 § 42d (SB 369, § 42d). Subsection (5) of § 42d provides, in pertinent part:

> "Notwithstanding any other provision in ORS 656.382 or 656.386, an Administrative Law Judge or the Workers' Compensation Board may not award penalties or attorney fees for matters arising under the review jurisdiction of the director."

SB 369, § 42d (5). Finding no relevant exceptions to these amendments, we conclude that § 42d applies retroactively to this case. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995); Walter L. Keeney, 47 Van Natta 1387 (1995) (retroactive application of SB 369 to deprive Board of jurisdiction over medical treatment disputes is not absurd or unjust).

Disputes concerning vocational assistance are under the exclusive jurisdiction of the Director. Amended ORS 656.283(2); Ross M. Enyart , 47 Van Natta 1540 (1995) (Director has exclusive jurisdiction over vocational assistance disputes). Attorney fees and penalties arising out of vocational assistance disputes are also under the Director's exclusive jurisdiction. SB 369, § 42d.

The sole issue at hearing was attorney fees arising out of a vocational assistance dispute. We conclude that we lack jurisdiction over this matter. SB 369, § 42d(5). Accordingly, we vacate the ALJ's order.

ORDER

The ALJ's order dated February 7, 1995 is vacated. Claimant's hearing request is dismissed.

Board Member Hall concurring.

As discussed in my dissenting opinion in Walter L. Keeney, 47 Van Natta 1387, 1392 (1995), I believe we should first consider supplemental briefs and arguments from the parties before issuing this order. Like Keeney, this case was litigated, appealed and briefed before the Board under pre-SB 369

law. The issues surrounding jurisdiction and the consequences of dismissal are of such significance that the parties, the forum, and the public would be better served if we considered points and authorities from the parties before rendering our decision. Allowing the parties to first discuss the impact of the new law not only promotes fairness in processing this case but could only result in a better decision from this forum.

January 11, 1996 Cite as 48 Van Natta 130 (1996)

In the Matter of the Compensation of
LEWIS W. STANDIFORD, Claimant
Own Motion No. 95-0583M
SECOND INTERIM OWN MOTION ORDER CONSENTING TO
DESIGNATION OF PAYING AGENT (ORS 656.307)
Emmons, et al, Claimant Attorneys
SAIF Legal Department, Defense Attorney

On December 11, 1995, we issued an Interim Own Motion Order Consenting to Designation of Paying Agent. Submitting to the Board a copy of the Department of Consumer and Business Service's (DCBS') December 19, 1995 order which declined to direct the SAIF Corporation to pay temporary disability compensation under claimant's 1988 claim, claimant asks that we issue an order reopening the claim. We treat claimant's submission as a motion for reconsideration of our December 11, 1995 order.

We begin with a summary of the procedural history of this claim. On December 7, 1995, the Benefits Section of the Workers' Compensation Division notified the Board that it was prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer had provided its written acknowledgment that the only issue was responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1988 injury claim with the SAIF Corporation expired on December 1, 1993. Thus, that claim is subject to ORS 656.278.

Under OAR 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent <u>if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the</u> party <u>responsible for payment of compensation</u>. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. ORS 656.278; <u>Patricia D. Lee</u>, 47 Van Natta 1632 (1995). (Although the claimant failed to demonstrate that her compensable condition required surgery or hospitalization on a particular date, as specifically required by ORS 656.278, the Board authorized the payment of temporary disability compensation beginning the date the claimant would enter the hospital for the proposed surgery related to the compensable condition).

By Interim Own Motion Order Consenting to Designation of Paying Agent (ORS 656.307) issued on December 11, 1995, the Board notified the parties that the record established that there has been a worsening of claimant's compensable injury requiring surgery. We based our conclusion on a September 19, 1995 letter, in which Dr. Buza, claimant's treating physician, opined that claimant has a "need for surgical intervention." Inasmuch as claimant would be entitled to own motion relief if the own motion insurer was found responsible for claimant's current condition, the Board <u>consented</u> to the order designating a paying agent for temporary disability compensation under claimant's 1988 own motion claim, beginning the date claimant is hospitalized for the proposed surgery. ORS 656.278(1)(a). In addition, we issued our order postponing action on the own motion request pending outcome of litigation regarding the responsibility for claimant's current condition pending before the Hearings Division. (WCB Case No. 12558). As we noted in our December 11, 1995 order, our decision is <u>not</u> a final order authorizing a reopening of the claim under ORS 656.278 and the Board's rules.

DCBS has issued its Order Designating a Paying Agent for medical services only (under ORS 656.245) on December 19, 1995. Apparently, DCBS reasoned that, because claimant has not provided documentation that he has undergone surgery, no temporary disability compensation is yet due. In this

respect, DCBS is correct. Claimant, however, requests "the Workers' Compensation Board to so advise the Department of Consumer and Business Services that temporary disability payments are due and owing as verified by the attending physician," and "to determine the claimant's entitlement to time loss benefits under that [1988] claim."

We emphasize that, contrary to the statement in DCBS' December 19, 1995 order that "[t]he Workers' Compensation Board has declined to provide consent for an Order pursuant to ORS 656.307 for temporary disability benefits," our December 11, 1995 order specifically stated that we found that claimant's compensable condition had worsened requiring surgery, and that he would be eligible, under his own motion claim, for temporary disability compensation beginning the date he is hospitalized for the proposed surgery. DCBS has subsequently declined to authorize the payment of temporary disability compensation under the 1988 own motion claim because it has not received medical verification that claimant has undergone the proposed surgery. However, pursuant to ORS 656.278, we find that claimant remains eligible for own motion relief beginning the date he enters the hospital for the proposed surgery. Patricia D. Lee, supra.

Therefore, we issue our Second Interim Own Motion Order to clarify our responsibility to the parties under ORS 656.307. We have found that claimant's compensable condition has worsened requiring surgery, so that he is eligible for temporary disability compensation under his 1988 claim, beginning the date of hospitalization for that surgery. As exemplified by our decision in Patricia D. Lee, claim reopening under ORS 656.278 contingent on a claimant's undergoing surgery on a future date, is a common practice. Further, we continue to consent to an order designating a paying agent for the payment of temporary disability compensation under claimant's 1988 claim if the Benefits Section determines that claimant is entitled to temporary disability compensation by virtue of undergoing the proposed surgery. Finally, inasmuch as it is currently unclear which insurer will ultimately be held responsible for claimant's current condition and treatment, the Board is prevented from issuing its final order reopening the claim pending resolution of the responsibility issue.

As we have postponed action on the final own motion decision pending outcome of the hearing in WCB Case No. 95-12558, we request that the parties advise the Board of their positions regarding own motion relief upon resolution of the responsibility issue. Upon finality of the decision in the pending litigation, and receipt of the parties' positions regarding own motion relief, we will issue our final order either denying reopening (if the own motion insurer is found not to be responsible for claimant's current condition) or authorizing the payment of temporary disability compensation under claimant's 1988 injury claim (if the own motion insurer is ultimately determined to be responsible for claimant's current condition).

IT IS SO ORDERED.

January 17, 1996 Cite as 48 Van Natta 131 (1996)

In the Matter of the Compensation of
MIKE R. CAMPBELL, Claimant
WCB Case No. 94-15295
ORDER ON REVIEW
Brad L. Larson, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) held that claimant's October 1993 right back, thoracic, shoulder and elbow injury claim remains in open status; (2) set aside as premature the insurer's aggravation denial pertaining to that claim; and (3) set aside the insurer's denial of claimant's C5-6 disc herniation. Claimant cross-requests review of those portions of the ALJ's order that declined to assess penalties for the insurer's claim processing and for its issuance of an aggravation denial. On review, the issues are claim status, aggravation, compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claim Status

he ALJ concluded that, based on the insurer's September 14, 1994 rescission of a June 2, 1994 Notice of Closure, the insurer's December 9, 1994 Notice of Closure reinstating the June 2 closure notice was without legal effect. Therefore, the ALJ held, claimant's October 1993 injury claim remains in open status. We agree, but offer the following analysis.

The insurer initially closed claimant's October 1993 injury claim with a June 2, 1994 Notice of Closure. (Ex. 31). Thereafter, the insurer concluded that the closure notice had issued in error and, by way of a September 14, 1994 closure notice, rescinded the June 2 notice. (Ex. 38). On December 9, 1994, the insurer issued a third closure notice, rescinding the September 14 notice and reinstating the original June 2 notice.

Claimant sought reconsideration of the September 14 and December 9 closure notices. An Order on Reconsideration affirmed the former Notice of Closure; another Order on Reconsideration rescinded the latter closure notice. (Exs. 43C, 45). No one appealed either order. (Tr. 11).

In view of the unappealed Orders on Reconsideration, we find that both the June 2 and December 9 closure notices have been rescinded. There presently being no other viable notice closing claimant's October 1993 injury claim, we agree with the ALJ that the claim is in open status.

Aggravation

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

Compensability

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

Penalties

We adopt and affirm the ALJ's analysis regarding this issue, with the following supplementation.

Claimant asserts that he is entitled to a penalty under former ORS 656.262(10)(a) (since renumbered ORS 656.262(11)(a)) related to the insurer's issuance of a premature aggravation denial. We disagree.

Former ORS 656.262(10)(a) authorizes a penalty when a carrier unreasonably delays acceptance or denial of a claim. Here, there has been no delay with respect to any claim; indeed, the insurer issued an aggravation denial in the absence of an aggravation claim. Under the circumstances, there exists no basis for assessing a penalty under former ORS 656.262(10)(a). Cf. Safeway Stores, Inc. v. Johnson, 134 Or App 432, 436-37 (1995) (claimant who prevailed over carrier's "partial denial" of permanent disability award not entitled to attorney fee under ORS 656.386(1), which authorizes a fee related to a "claim for compensation," because award was not written request for compensation).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. We have not considered counsel's services related to the penalty issues. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986).

ORDER

The ALJ's order dated May 30, 1995 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the insurer.

In the Matter of the Compensation of
ROBERT F. SHELTON, Claimant
WCB Case No. 94-14790
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that partially set aside the employer's denials of claimant's current low back condition and need for treatment. On review, the issues are procedural propriety of a denial and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt and affirm the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Procedural Propriety of Denial

We adopt and affirm that portion of the ALJ's order that determined that the employer's October 17, 1994 denial was procedurally improper because it denied "further medical treatment." We also adopt and affirm that portion of the ALJ's order that awarded an attorney fee for claimant's counsel's services in rectifying that denial.

Inasmuch as we have not disallowed or reduced the compensation awarded to claimant by this portion of the ALJ's order, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the issue of the procedural propriety of a denial is $100, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Compensability

The ALJ determined that claimant had established a material causal relationship between his compensable January 1993 injury and his need for medical treatment in August 1994. In doing so, the ALJ relied on Olson v. Safeway Stores, Inc., 132 Or App 424 (1995), and former ORS 656.245 to hold that claimant's burden was to establish a material relationship between his compensable injury and his subsequent need for treatment. We disagree.

First, we briefly summarize the relevant facts. Claimant sustained a left-sided low back injury in January 1993, which was accepted as a low back strain. (Exs. 6-12, 13). Claimant also had a chronic right hip, right leg and low back condition that preexisted his compensable injury. (See Exs. 6 at 1-12). The January 1993 injury claim was closed by Determination Order in March 1994, awarding 18 percent unscheduled permanent disability. (Ex. 21). In August 1994, claimant sought treatment for low back pain which he related to his compensable injury. (Ex. 6-21).

Subsequent to the ALJ's order in this matter, the legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was ORS 656.245(1)(a), which now provides that for consequential and combined conditions described in ORS 656.005(7), "the insurer or self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury." Amended ORS 656.245(1)(a), Or Laws 1995, ch 332, § 25(1)(a) (SB 369, § 25).

As relevant here, amended ORS 656.005(7)(a)(B) provides that where a compensable injury combines with a preexisting condition, claimant must establish that the compensable injury is the "major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition." SB 369, § 1. Since no relevant exception exists, we shall retroactively apply the statutory amendments enacted by Senate Bill 369. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995).

Amended ORS 656.245(6) provides that "[i]f a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed," the dispute shall be resolved by the Director. SB 369, § 25(6). We have held that a dispute concerning whether medical treatment for a claimant's current condition is causally related to a compensable injury necessarily involves the question of the compensability of the condition on which the medical treatment is based. Richard L. Wheeler, 47 Van Natta 2011 (1995). Therefore, we found that the employer's formal denial pertained to the "compensability of the underlying claim," and concluded that we retained jurisdiction over the parties' dispute. Id. citing Janet Anderson, 47 Van Natta 1692 (1995) and Lynda J. Zeller, 47 Van Natta 1581 (1995), on recon 47 Van Natta 1926 (1995).

Here, the employer denied the compensability of claimant's current condition. (Ex. 26A). Relying on Richard L. Wheeler, supra, we find that the parties' dispute concerns the "compensability of the underlying claim." See amended ORS 656.245(6). Accordingly, we conclude that we have jurisdiction over this dispute.

At the outset, we find that claimant's need for treatment arose from a combined condition, based on the following reasoning. Claimant had a chronic low back and right hip and leg condition that preexisted his compensable left-sided low back strain of January 1993. In August 1994, after closure of his compensable January 1993 injury claim, claimant sought treatment for central low back pain. (Exs. 6-21, 27-24).

Treating physician Dr. Moline opined that in August 1994 claimant's condition had a contributing element from the January 1993 injury, as well as from the prior chronic condition. (Ex. 27-17). He explained that it was difficult with claimant to sort out what was due to his chronic problem and what was due to his January 1993 injury. (Ex. 27-10). He opined that claimant would probably still have low back pain currently had he not had the January 1993 injury. (Ex. 27-22). Dr. Moline further opined that he believed claimant's current low back condition was due to the cumulative effect of his prior injuries. (Exs. 6-22, 27-25).

Under such circumstances,[1] we find that claimant's current need for treatment is due to a combined condition resulting from the combination of claimant's compensable January 1993 injury with his preexisting low back condition. Amended ORS 656.005(7)(a)(B). Accordingly, under amended ORS 656.245(1)(a), the employer is obligated to provide only those medical services "directed to medical conditions caused in major part by the injury."[2]

We again rely on Dr. Moline's opinion. Dr. Moline opined repeatedly that claimant's January 1993 remained a material contributing cause of his current low back condition. (See Exs. 6-22, 25 and 27 at 13-14). However, Dr. Moline did not opine that claimant's current condition and need for treatment was caused in major part by his January 1993 injury. Amended ORS 656.245(1)(a). Accordingly, we conclude that claimant's current condition and need for treatment are not compensable.

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[1] The only contrary opinion is from Dr. Dickerman who performed an examination at the employer's request in October 1994. (Ex. 23). Dr. Dickerman opined that claimant's January 1993 injury, resulting in a lumbar strain, had resolved and did not contribute to his current condition. (Ex. 23 at 8-9). Since Dr. Moline has treated claimant over several years, for both his 1993 injury and his chronic low back and right-sided problems, we find Dr. Moline's opinion more persuasive. (See Exs. 6, 27 at 26-27).

[2] In determining that claimant had only to prove a material causal relationship between his compensable injury and his current need for treatment, the ALJ relied in part on the court's decision in Olson, supra. We distinguish Olson insofar as that case involved an aggravation claim under former ORS 656.273. Since no aggravation claim is involved in this case, we do not consider Olson to be directly applicable. In addition, we distinguish that portion of the Olson decision that held, relying on Beck v. James River Corp., 124 Or App 484, rev den 318 Or 478 (1994), that the standard for the continued need for medical treatment under former ORS 656.245 is material contributing cause. We have previously explained that Beck is limited to those situations where a worker seeks medical services for an already accepted condition. Shirreline J. Bray-Lodwig, 47 Van Natta 1358, 1359 (1995); Joseph R. Klinsky, 47 Van Natta 872, 873 (1995). In this case, we have found that claimant sought treatment for a combined condition, rather than for the same condition that was accepted as a result of the January 1993 injury. Accordingly, we conclude that Beck does not apply in this situation.

ORDER

The ALJ's order dated May 30, 1995 is affirmed in part and reversed in part. That portion of the ALJ's order that set aside the employer's March 28, 1994 denial and awarded an attorney fee for overcoming that denial is reversed. The employer's March 28, 1994 denial is reinstated and upheld. The remainder of the ALJ's order is affirmed. Claimant's attorney is awarded $100 for services on Board review, payable by the self-insured employer.

January 18, 1996 Cite as 48 Van Natta 135 (1996)

In the Matter of the Compensation of
JAN W. JAHNKE, Claimant
WCB Case No. 94-13343
ORDER OF REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Gunn, Haynes and Christian.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that found claimant permanently and totally disabled due to her right ankle injury and resultant depression. On review, the issue is permanent total disability.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the 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 5, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the employer.

Board Member Haynes specially concurring.

The issue before the Board on review is the extent of disability arising out of claimant's accepted right ankle injury and consequential psychological condition. On this record, I agree that a preponderance of the evidence establishes that claimant's psychological condition precludes her from returning to gainful employment and that she is currently totally disabled as a result of her depression. I write separately, however, to note that there is what I consider persuasive evidence in the record indicating that claimant's current psychological condition is no longer directly related to her 1985 compensable ankle injury.

In his September 2, 1994 report finding that claimant suffered from Class 2 or 3 chronic depression and anxiety, the medical arbiter reported: "I suspect that initially [claimant's condition] was related somewhat to her injury of record, however over time the effects of her own personality have become more prominent and help in understanding why this injury has had such a devastating effect on her life." Similarly, examining psychiatrist, Dr. Pavaresh, reported in January 1994 that "it is highly medically improbable that the sprained ankle plays a major contributing role in her current dysthymia." Even Dr. Weinstein's notes of claimant's treatment sessions from 1988 through February 1995 tend to support this contention. The treating doctor's notes contain significantly more reports of claimant's anxiety over her marital and family relationships, life events and other physical ailments than reports of continuing ankle pain.

Accordingly, had the compensability of claimant's current condition been in issue, I would have found that claimant had not sustained her burden.

In the Matter of the Compensation of
JERRY L. BARKER, Claimant
WCB Case No. 95-07496
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order which dismissed his request for hearing regarding a vocational assistance dispute for lack of jurisdiction. On review, the issue is jurisdiction.

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

Citing amended ORS 656.283(2), the ALJ dismissed claimant's hearing request regarding vocational assistance for lack of jurisdiction. Claimant contends that we should remand for completion of the record, alleging that it is inadequate to determine whether "SAIF waived the issue of constitutionality." We interpret claimant's contention to be that SAIF "waived" its right to contest the ALJ's jurisdiction over the subject matter of this dispute. For the following reasons, we deny claimant's motion.

Subject matter jurisdiction may be addressed by the Board at any time in the course of litigation, whether or not raised by the parties. See Schlecht v. SAIF, 60 Or App 449, 451 (1982); Ace Tree Company, 46 Van Natta 880 (1994), on recon 46 Van Natta 1067 (1994), aff'd mem 133 Or App 770 (1995). Therefore, even assuming that SAIF somehow "waived" the issue of subject matter jurisdiction, it is within our authority to address the issue. Accordingly, we find no good cause or compelling basis for a remand. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Claimant also contends that jurisdiction over this vocational assistance matter should remain with the Board because amended ORS 656.283 deprives him of a "due process" right to a "meaningful hearing". Based on the following reasoning, we disagree.

We have previously addressed the question of jurisdiction over vocational assistance disputes in Ross M. Enyart, 47 Van Natta 1540 (1995). In that case, the claimant requested a hearing regarding a Director's order which found that the claimant was not entitled to vocational assistance. The ALJ found that the claimant was entitled to such assistance, and the carrier sought Board review. We held, relying on Volk v. America West Airlines, 135 Or App 565 (1995), that absent a specific exception, the amendments made by Senate Bill 369 are retroactively applicable to cases pending before the Board. We found no such exception pertaining to review of vocational assistance disputes. Accordingly, we concluded that amended ORS 656.283(2), which provides for Director review of vocational assistance disputes, was applicable. Consequently, based on amended ORS 656.283(2), we held that the exclusive jurisdiction over vocational assistance disputes rests with the Director. Therefore, we vacated the ALJ's order and dismissed claimant's hearing request for lack of jurisdiction.

Based on our reasoning in Enyart, we continue to hold that the Director has exclusive jurisdiction over vocational assistance issues. See also Donald D. Paul, 47 Van Natta 1946 (1995); Richard B. Enders, 47 Van Natta 1651 (1995). Moreover, we are not persuaded by claimant's constitutional objections to amended ORS 656.283(2).[1]

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[1] Claimant asserts that the Board is not "competent" to address a constitutional issue because its members are only political appointees of the legislative and executive branches. Claimant states that he is proceeding merely to exhaust his administrative remedies. We disagree with claimant's assertion that we cannot review the constitutional issue he raises. We have the authority to decide constitutional questions. Cooper v. Eugene School District No 4J, 303 Or 358, 364-5 (1986). While we generally do not address constitutional issues in instances where a party is merely exhausting his or her administrative remedies, see Sandra L. Deel, 43 Van Natta 2482 (1991), we will consider claimant's constitutional objection to amended ORS 656.283(2) since claimant has provided at least some argument to consider.

In Liberty Northwest Insurance Corporation v. Yon, 137 Or App 413 (1995), the court rejected the claimant's contention that the amendments to ORS 656.245, ORS 656.327, and ORS 656.704 denied him "due process" under the Fourteenth Amendment of the United States Constitution. The court reasoned that the amendments had eliminated the claimant's choice to have his medical services dispute resolved by the Board, but that they did not deny him the right to have his claim for medical services reviewed through a contested case hearing and review of that order in the Court of Appeals.

Similarly, in this case, claimant has now been deprived of his right of Board review of the Director's order regarding vocational services. However, amended ORS 656.283(2)(c) and (d) also provide for review through a contested case hearing and review of that order by the Court of Appeals. Therefore, pursuant to Yon, claimant in this case has not been deprived of his right to have his vocational assistance dispute reviewed. Claimant's constitutional challenge fails under Yon.

ORDER

The ALJ's order dated July 24, 1995 is affirmed.

January 19, 1996 Cite as 48 Van Natta 137 (1996)

In the Matter of the Compensation of
DARYL R. GABRIEL II, Claimant
WCB Case No. 95-00256
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The self-insured employer seeks review of Administrative Law Judge (ALJ) Mills' order that set aside its denial of claimant's request for an out-of-state detoxification and pain management treatment program. On review, the issues are jurisdiction and, alternatively, medical services. We vacate.

FINDINGS OF FACT

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

Claimant compensably injured his back on April 5, 1988. Since that time, he has undergone several back surgeries and has received psychological counseling for anxiety, depression and anger. During the course of his treatment, claimant has become addicted to prescription pain medications.

In late 1994, claimant's counselor and treating psychologist determined that claimant needed to be admitted into a detoxification and pain management treatment program. They recommended that claimant enter the program at St. Joseph's Hospital in Phoenix, Arizona, since that program includes a detoxification program, drug treatment and a pain clinic. Dr. Miller, claimant's medical doctor, concurred in this recommendation.

The employer agrees that the treatment claimant seeks for his compensable condition is reasonable and necessary in general, but takes the position that it is unnecessary for claimant to travel out-of-state to obtain this treatment. The employer contends claimant could receive the same services through similar programs in Oregon.

CONCLUSIONS OF LAW AND OPINION

On review, the employer argues that, based on the SB 369 amendments to ORS 656.327(1)(a), jurisdiction over this dispute lies with the Director, and not the Hearings Division or the Board. We agree.

Subsequent to the ALJ's order, the legislature amended ORS 656.327(1)(a) to provide that if an injured worker, a carrier, or the director believes that the medical service the injured worker has received, is receiving or is proposed to receive is excessive, inappropriate, ineffectual or in violation of the rules regarding the performance of medical services, the injured worker or carrier "shall request review of the treatment by the director and so notify the parties." Or Laws 1995, ch 332 § 41(1) (SB 369 § 41(1) (emphasis added). The legislature also added amended ORS 656.245(6), which provides that if a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim, and the claim is disputed, the injured worker or carrier "shall request administrative review by the director pursuant to this section [.]" Or Laws 1995, ch 332, § 25(6) (SB 369, § 25(6)).

These provisions apply retroactively to all cases currently pending before the Board. Newell v. SAIF, 136 Or App 280 (1995) (Board lacks jurisdiction to review appropriateness of proposed treatment under amended ORS 656.327(1)); Walter L. Keeney, 47 Van Natta 1387 (1995); Ronald E. Norton, 47 Van Natta 1580 (1995).

Here, the dispute does not involve a denial of the compensability of claimant's condition. Rather, the dispute pertains to the appropriateness of the proposed out-of-state medical treatment. Because this dispute falls under amended ORS 656.327(1)(a), jurisdiction over this matter rests exclusively with the Director. We must therefore vacate the ALJ's decision concerning the medical services dispute.

Claimant argues that the employer has waived the jurisdictional challenge to the ALJ's order by failing to raise the issue at hearing. We disagree. Subject matter jurisdiction, which in this case is proscribed by amended ORS 656.327(1), amended ORS 656.245, and amended ORS 656.704(3),[1] is not issue that may be waived by the parties. See Newell v. SAIF, supra.

Claimant also contends that the retroactive application of amended ORS 656.327 in this case is unconstitutional in that it denies him due process of law under the Fourteenth Amendment to the United States Constitution. Specifically, claimant argues that he is being deprived of a federally protected property interest (his right to continuing medical benefits) because the matter has already been litigated and resolved in his favor before the ALJ.

We have previously held that we are not inclined to address constitutional arguments in opposition to the retroactive application of SB 369. See, e.g., Mary S. Leon, 45 Van Natta 1023, 1024 (1993) (if Board lacks jurisdiction over claim, it also lacks authority to address claimant's constitutional arguments); but see Amalgamate Transit v. Lane Co. Mass Transit, 295 Or 117, 119 (1983) (having determined that matter was moot, court did not address constitutional issue).

Despite our disinclination to address claimant's arguments, we nevertheless consider and reject claimant's due process challenge. See Kathleen M. Butler, 47 Van Natta 2202 (1995). First, the retroactive application of amended ORS 656.327 does not affect any "substantive entitlement" or vested right to benefits because no order regarding claimant's benefits has yet to become final. See Kathleen M. Butler, supra, (citing State Ex rel. v. Kiessenbeck, 167 Or 25, 30 (1941) (the first and essential quality of a judgment or decree that gives rise to a vested right is that it be a final determination of the rights of the parties); see also Roberts et al v. State Tax Com., 229 Or 609, 614 (1962) ("vested right" is an immediate right to present enjoyment, or a present fixed right to future enjoyment)).

Second, the legislative amendments have also not "deprived" claimant of any benefit; they have simply clarified that the Director is the proper entity before which these matters are now to be litigated. The Director has the same authority as the Board had to award benefits in medical service disputes. See Liberty Northwest Ins. Corp. v. Yon, 137 Or App 413 (1995) (amendments to ORS 656.245, 656.327 and 656.704 eliminated the claimant's choice to have medical services dispute resolved by Board, but did not deny the claimant due process because Director retains jurisdiction to review claim); see generally amended ORS 656.327; see also SB 369, § 42d(1), (5) (authorizing Director to award attorney fees in disputes arising under amended ORS 656.327, and prohibiting the Board or the Hearings Division from awarding attorney fees or penalties for matters arising under the Director's jurisdiction). We therefore find no due process violation by the retroactive application of amended ORS 656.327 in this case.

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[1] This provision expressly excludes "disputes arising under ORS 656.245, 656.248, 656.260, 656.327 and any other provisions relating to the provision of medical services to workers" from the definition of "matters concerning a claim."

In sum, because we are without jurisdiction to address the merits of this medical services dispute (i.e., whether claimant's proposed out-of-state treatment is reasonable and necessary) under the new law, we vacate the ALJ's order and dismiss claimant's hearing request.

ORDER

The ALJ's order dated May 31, 1995 is vacated. Claimant's hearing request is dismissed.

January 19, 1996 Cite as 48 Van Natta 139 (1996)

In the Matter of the Compensation of
MARY S. SMITH, Claimant
WCB Case Nos. 94-05728 & 94-03442
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Karl Goodwin (Saif), Defense Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

CNA Insurance Companies (CNA), on behalf of Kelly Services, Inc., requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside the right wrist portion of its denial of compensability and responsibility for claimant's claim for bilateral carpal tunnel syndrome (CTS) on the basis of claim preclusion; and (2) upheld the SAIF Corporation's denial of compensability and responsibility for the same condition. In her brief, claimant contends that her bilateral CTS condition is compensable. On review, the issues are claim preclusion, compensability, and, if compensability is found, responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claim Preclusion

Relying on Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 120 Or 507 (1995), the ALJ concluded that CNA was barred by claim preclusion from denying that claimant's right carpal tunnel syndrome is not part of its accepted 1991 injury claim. In Messmer, a determination order awarded permanent partial disability based in part on the effects of a surgery that had treated an unaccepted degenerative disc condition. The determination order was not appealed. The court held that claim preclusion barred the carrier from denying that a noncompensable condition that served as a basis for a final permanent disability award was part of the claimant's compensable claim.

Here, CNA contends that Messmer has been overturned by the legislature's amendment of ORS 656.262(10). There is support for that contention. Craig L. Hiatt, 47 Van Natta 2287 (1995) (Board Chair Hall and Member Gunn dissenting). However, we need not address CNA's contention because we are not persuaded that claimant's right CTS served as a basis for a final permanent disability award.

In December 1991, CNA accepted a neck strain. (Ex. 7A). In November 1991, claimant was diagnosed with bilateral CTS, right greater than left. (Exs. 5, 6 and 8). An August 1992 Determination Order awarded claimant scheduled permanent partial disability for her right arm. This award was based on reduced range of motion in the wrist and elbow, as was a November 1992 Order on Reconsideration that reduced the award. (Exs. 25 and 33). An August 17, 1993 Opinion and Order further reduced the right arm award, finding an impairment value only for a chronic condition limiting repetitive use of the right upper extremity, based on the arbiter's findings. (Ex. 37-3 and -6). This order was not appealed. Thus, it is this final order, and not the determination order or order on reconsideration, that establishes the basis for the final permanent disability award.

As found by the prior ALJ, the arbiter's findings regarding pain and tenderness about the neck, right shoulder and right hand, together with sensory losses in the fingers and range of motion losses in the elbow, shoulder and neck were not deemed by the arbiter to be reliable. The arbiter reported that claimant had sustained a right shoulder and arm pain condition related to the work exposure and felt that claimant had sustained a chronic condition limiting repetitive use of her right shoulder and right upper extremity. (Exs. 31-3 and -4; 37-3). We conclude that, although the prior ALJ rated claimant's right arm pain condition, he did not rate claimant's right carpal tunnel condition in the August 17, 1993 Opinion and Order. Accordingly, CNA was not barred by claim preclusion from denying claimant's current claim for her right CTS condition.

Compensability

We briefly summarize the relevant facts. Claimant had been diagnosed with diabetes prior to her work at CNA's insured. (See, e.g., Exs. 4-2, 8-1). She is morbidly obese at five feet tall and weighing 220 pounds. (Ex. 4-2). Claimant worked for CNA's insured at a recycling plant. In October 1991, claimant experienced an on-the-job injury to her neck and right arm. Claimant's complaints included numbness in her right hand. Her left hand was asymptomatic. Nerve conduction tests revealed bilateral CTS, right greater than left. Dr. Kim attributed claimant's CTS symptoms to her work and recommended bilateral carpal tunnel releases. (Ex. 5). Claimant objected to surgery and changed doctors. (Exs. 7 and 8).

In February 1993, claimant began working for SAIF's insured as a shrimp picker, which required picking shells from unshelled shrimp with both hands as they passed along a conveyor belt; a fish weigher and packer; and a crab packer, which required bagging frozen crab and tying the bags. (Tr. 13-15). In February 1994, claimant sought treatment for pain and numbness in both hands. Dr. Bert diagnosed bilateral CTS, for which he recommended surgery. (Ex. 32-1 and -2). Claimant filed claims for her bilateral CTS condition with SAIF and CNA. Both insurers denied compensability and responsibility.

The ALJ found the right CTS compensable as a result of claim preclusion, but concluded that claimant had failed to prove the compensability of her left CTS. On review, claimant contends that her bilateral CTS condition is compensable.

We agree with the ALJ's finding that claimant had bilateral CTS prior to her 1991 injury at CNA's insured[1]. (See Exs. 43-8, 44-6, 50-3, 51-6, and 52-2). To prove compensability of her bilateral CTS condition, claimant must show that her work exposure is the major contributing cause of the pathological worsening of her condition. See ORS 656.802(2).[2] We also agree with the ALJ's finding that claimant's bilateral CTS pathologically worsened between November 1991 and April 1994. (Exs. 5, 6, 45 and 53-8). Thus, the next inquiry is whether claimant's pathologically worsened bilateral CTS condition was caused in major part by claimant's work exposures. In evaluating the "major contributing cause," we consider the relative contribution of the different causes of claimant's condition. McGarrah v. SAIF, 296 Or 145 (1983); Dethlefs v. Hyster Co., 295 Or 298 (1983). We conclude that claimant's worsened condition was not caused in major part by her work.

In addition to Dr. Bert, orthopedist, claimant was examined by Dr. Brooks, neurologist, for SAIF, and Drs. Barth, neurologist and Arbeene, orthopedist, for CNA, regarding the cause of her CTS. Barth and Arbeene's opinion that the worsening of claimant's CTS could not have resulted from her work exposure at SAIF's insured is not persuasive, as they erroneously believed that claimant worked at that job for only three weeks in November 1993. Weiland v. SAIF, 64 Or App 810 (1983); Miller v. Granite Construction Co., 28 Or App 473 (1977).

Dr. Brooks found that claimant's condition worsened over time. However, he was unable to state that her work was the major cause of her worsened condition Rather, he opined that claimant's preexisting CTS is the major contributing cause of her worsened condition, noting that claimant's weight and diabetes may also be contributing factors. (Ex. 44).

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[1] We do not interpret Dr. Kim's opinion to contradict this finding. Dr. Kim, who first diagnosed claimant's bilateral CTS condition and attributed the symptoms to work, did not indicate that work caused the condition. (Exs. 4 and 5).

[2] Subsequent to the ALJ's order, ORS 656.802 was amended by the 1995 Legislature. Or Laws 1995, ch 332, § 56. However, application of the amended statute would not change our analysis or result in this case.

The sole opinion in support of claimant's work as being the major contributing cause of her worsened condition is from Dr. Bert, which he provided during the earlier part of his deposition. (Ex. 53-8). However, we do not find this opinion persuasive, as Dr. Bert later contradicted that statement without explanation when he stated that the major contributing cause of claimant's hand symptoms both prior to February 1993 and in January 1994 was her preexisting CTS. (Exs. 54-9 and 54-10). Moreover, he also concurred with the opinion of Drs. Brooks and Barth, which is also in contradiction to his opinion in the earlier deposition. (Ex. 50-5). See Somers v. SAIF, 77 Or App 259 (1986); Moe v. Ceiling Systems, 44 Or App 429 (1980). Consequently, claimant has failed to carry her burden of proving that the pathological worsening of her bilateral CTS was due to her work activities.

Because claimant has failed to establish the compensability of her claim, we need not address responsibility.

ORDER

The ALJ's order dated May 9, 1995 is reversed in part and affirmed in part. That portion of the order setting aside CNA's denial of claimant's right carpal tunnel syndrome is reversed. CNA's denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

January 22, 1996 Cite as 48 Van Natta 141 (1996)

In the Matter of the Compensation of
GAYLYNN GRANT, Claimant
WCB Case No. 93-03010
ORDER ON REMAND
Welch, Bruun, et al, Claimant Attorneys
James W. Moller (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Grant, 135 Or App 293 (1995). The court has reversed our prior order, Gaylynn Grant, 46 Van Natta 468 (1994), which set aside the SAIF Corporation's denial of claimant's left ulnar nerve lesion. Concluding that we incorrectly evaluated a physician's opinion, the court has remanded for reconsideration.

We begin with a brief summary of the relevant facts. In February 1991, claimant, a mental health therapist, was attacked by a patient and suffered compensable injuries to her ribs, chest, left shoulder and neck. After returning to work, claimant was again injured while subduing another combative patient. In September 1991, claimant changed her attending physician to Dr. Takacs. Claimant complained of neck, upper back, left rib and left arm pain. Dr. Takacs diagnosed cervical, thoracic and rib strain and developing chronic pain syndrome. Dr. Takacs ordered a nerve conduction study, which indicated a normal left ulnar nerve. SAIF closed the claim.

Claimant subsequently entered a vocational program to train as a medical assistant. In September 1992, claimant returned to Dr. Takacs complaining of a gradual onset of left hand numbness and pain while performing typing and computer work in the training program. Dr. Takacs diagnosed a left ulnar nerve lesion of the left elbow. Dr. Takacs opined that claimant's ulnar nerve problem was a result of her training program, not a result of her previous workers' compensation injury. SAIF denied claimant's left elbow ulnar nerve lesion claim. Dr. Takacs referred claimant to Dr. Baum for surgical consultation. Dr. Baum diagnosed ulnar nerve compression at the left elbow and requested surgery. The ALJ relied on Dr. Takacs' opinion that claimant's left elbow condition was not related to her compensable injury. Consequently, the ALJ upheld SAIF's denial.

We found that claimant's original injury had included left elbow symptoms. Because Dr. Takacs did not mention claimant's 1991 left elbow symptoms in relation to the 1993 "vocational program" injury, we concluded that Dr. Takacs did not have claimant's complete medical history. Consequently, we concluded that Dr. Baum's opinion was more persuasive than that of Dr. Takacs. The court found that the reasoning supporting our conclusion that Dr. Takacs did not have a complete medical history was incorrect. In light of our incorrect evaluation of Dr. Takacs' opinion, the court determined that our order was not supported by substantial reason and remanded for a reevaluation of the evidence.

On reconsideration, we adopt and affirm the ALJ's opinion on the merits with the following supplementation.

If a condition arises directly, even if belatedly, from a work incident; then the material contributing cause standard applies to establish compensability. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). If a condition is not directly related to the work incident, but is a consequence of the injury that had necessitated vocational rehabilitation, then the condition would be compensable if the injury is the major contributing cause of the consequential condition. Id. However, if the condition is due to the vocational program, it is not compensable. Kephart v. Green River Lumber, 118 Or App 76 (1993).

Due to the passage of time and the number of potential causes for claimant's ulnar nerve lesion condition, the causation issue is a complex medical question that requires expert medical evidence for its resolution. Uris v. Compensation Department, 247 Or 420, 424 (1967); Barnett v. SAIF, 112 Or App 283 (1993).

After our review of the record, we conclude that the opinion of Dr. Takacs, claimant's treating doctor, is more persuasive than that of Dr. Baum for the following reasons. First, inasmuch as Dr. Takacs examined claimant regarding her elbow complaints in 1991 and again in 1993, after her current condition had arisen, we find that Dr. Takacs was in a particularly advantageous position to evaluate claimant's current ulnar lesion condition. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986). Second, Dr. Takacs, as claimant's treating physician since 1991, was in a better position than Dr. Baum, who saw claimant one time, to provide an opinion on causation. Weiland v. SAIF, 64 Or App 810 (1983). Moreover, Dr. Takacs' opinion is supported by the nerve conduction studies made after claimant complained of left arm pain in 1991, after her work injuries. Those 1991 studies reported normal ulnar findings. (Ex 4c).

Finally, Dr. Baum states that a "late result of [claimant's work] injury is numbness and tingling in the ring and little finger of the left upper extremity." Nevertheless, Dr. Baum also acknowledges that claimant's typing and data entry may have produced this paresthesia. Dr. Baum's report is, at best, ambiguous.

Accordingly, on reconsideration of our March 23, 1994 order, the ALJ's order dated June 30, 1993 is affirmed.

IT IS SO ORDERED.

January 22, 1996 Cite as 48 Van Natta 142 (1996)

In the Matter of the Compensation of
JOSE A. VALLADERES, Claimant
WCB Case No. 93-14014
ORDER ON REVIEW
Dye & Malagon Associates, Claimant Attorneys
James B. Thwing (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) declined to award temporary total disability benefits for the period beginning August 30, 1993; and (2) declined to assess a penalty for the SAIF Corporation's allegedly unreasonable failure to pay those benefits. On review, the issues are temporary total disability and penalties. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ declined to award claimant temporary total disability compensation for periods commencing August 30, 1993. The ALJ opined that Dr. Witczak's February 16, 1994 opinion that claimant was on "off-work status" as of August 30, 1993 (Ex. 16) "constituted a prima facie basis for procedural entitlement to interim time loss benefits." (O&O p.2). However, finding that claimant was not working after August 30, 1993 for reasons unrelated to his compensable injury, the ALJ concluded that claimant was not entitled to temporary total disability benefits.[1] We reach the same result, based on the following reasoning.

Considering the employer's flexibility regarding claimant's work duties, (see Tr. 7), we agree with the ALJ's finding that the employer had work within claimant's physical restrictions available to claimant on August 4, 1993 (when claimant was laid off for reasons unrelated to his injury) and thereafter (specifically, on August 30, 1993, the date Dr. Witczak mistakenly believes that no such work was available). See Exs. 23-23-24; 23-35; 23-38-39; Tr. 7). Thus, because Dr. Witczak's history in this regard was inaccurate, we conclude that the purported time loss authorization is unpersuasive. See Michael R. Lambertson, 46 Van Natta 2489 (1994) (Where doctor's opinion that claimant was previously disabled was not persuasive, claimant failed to prove entitlement to temporary disability).[2]

Finally, because claimant has not established entitlement to the benefits claimed, SAIF's failure to pay those benefits was not unreasonable.

ORDER

The ALJ's order dated January 25, 1995 is affirmed.

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[1] The ALJ relied on RSG Forest Products v. Jensen, 127 Or App 247 (1994).

[2] Since the ALJ's order, the legislature amended ORS 656.262, regarding temporary disability. Assuming, without deciding, that the amended statute applies to this case, we would reach the same result.

January 23, 1996 Cite as 48 Van Natta 143 (1996)

In the Matter of the Compensation of
LUIS R. CAMPBELL, Claimant
WCB Case No. 95-00252
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the insurer's partial denial of claimant's bilateral electrophysiological negative carpal tunnel syndrome (CTS) condition. On review, the issue is compensability.

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

In this case, none of claimant's medical services or disability are CTS-related. Under these circumstances, a denial of CTS would generally be considered to be premature. See Dorothy M. Jackson-Duncan, 42 Van Natta 1122 (1990). Nevertheless, a carrier is free to partially deny any condition which it reasonably believes could be a claim. See Weyerhaeuser Co. v. Warrilow, 96 Or App 43 (1989). Here, because claimant's treating doctor did diagnose CTS at one point, we find that the insurer's "precautionary" partial denial of CTS was procedurally proper. See Calvin E. Bigelow, 45 Van Natta 1577 (1993). Moreover, because we agree with the ALJ's conclusion that claimant does not have CTS (for which disability or medical services are claimed), we also agree that the denial is properly upheld.

ORDER

The ALJ's order dated April 26, 1995 is affirmed.

In the Matter of the Compensation of
JAMES R. COUNTS, Claimant
WCB Case No. 94-11842
ORDER ON REVIEW
Ormsbee & Corrigall, Claimant Attorneys
Paul L. Roess, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order that upheld the self-insured employer's denial of a diagnostic medical services claim for a chest wall injury. On review, the issues are jurisdiction and compensability.

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

The self-insured employer contends that the only issue on review is whether the diagnostic services were necessary and appropriate. On this basis, the employer contends that the Board and Hearings Division lack jurisdiction over the dispute. We do not agree that the dispute pertains to the reasonableness and necessity of the medical treatment.

The issue tried at hearing and argued on review is whether the diagnostic services were necessary to determine the relationship of claimant's chest pain to the compensable chest wall injury, or were performed because of claimant's risk factors for a non-work-related cardiac condition. In other words, the dispute pertains to whether the diagnostic medical services are causally related to the compensable injury.

We have previously held that under amended ORS 656.245(6), we retain jurisdiction to determine whether a claimant's condition is causally related to his compensable injury. Richard L. Wheeler, 47 Van Natta 2011 (1995). Accordingly, because this dispute involves the compensability of the condition on which the medical treatment is based, we conclude that the employer's formal denial pertained to the "compensability of the underlying claim." See amended ORS 656.245(6); Richard L. Wheeler, supra. Consequently, we retain jurisdiction to consider the parties' dispute.

Turning to the merits, based on the reasoning expressed in the ALJ's order, we are unable to conclude that the disputed diagnostic services were causally related to claimant's compensable injury. Consequently, we uphold the employer's denial.

ORDER

The ALJ's order dated June 21, 1995 is affirmed.

In the Matter of the Compensation of
CHARLENE A. DIERINGER, Claimant
WCB Case No. 94-13529
CORRECTED ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys

On January 8, 1996, we reversed an Administrative Law Judge's (ALJ's) order which had upheld the insurer's denial of claimant's occupational disease claim for a bilateral upper extremity condition. It has come to our attention that our order contains a clerical error. Specifically, in the last sentence of the first paragraph on Page 4 of our order, we state that "Consequently, neither amended ORS 656.802(2)(a) nor ORS 656.005(7)(a)(B) apply to this case." Inasmuch as our citation to ORS 656.802(2)(a) was in error, we replace the aforementioned sentence with the following sentence: "Consequently, neither amended ORS 656.802(2)(b) nor ORS 656.005(7)(a)(B) apply to this case."

Subject to this correction, we adhere to our January 8, 1996 order in its entirety. The parties' rights of appeal shall continue to run from the date of our January 8, 1996 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JENNIFER KAMMERER, Claimant
WCB Case No. 93-05996
ORDER ON REMAND
Patrick K. Mackin, Claimant Attorney
Bostwick, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Kammerer v. United Parcel Service, 136 Or App 200 (1995). The court has reversed our prior order which had affirmed an Administrative Law Judge's order that upheld the insurer's denial of claimant's right eye injury claim. Reasoning that claimant was not a participant in horseplay at her employment, the court concluded that we had erroneously determined that claimant's injury did not arise from her employment because the co-worker who hit claimant with a plastic tag was engaging in horseplay and had deviated from his employment. Holding that claimant was not precluded from receiving compensation on the ground that her injury arose from horseplay, the court has remanded for reconsideration.

In light of the court's decision, it follows that claimant's injury arose from her employment. Inasmuch as this "work connection" argument was the sole basis on appeal for the insurer's objection to the claim, we conclude that claimant's injury is compensable. Consequently, the insurer's denial is set aside and the claim is remanded to the insurer for processing according to law.

IT IS SO ORDERED.

In the Matter of the Compensation of
RALPH L. KELLER, Claimant
WCB Case No. 95-05552
ORDER ON REVIEW
Dye & Malagon Associates, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that declined to increase claimant's temporary total disability rate. On review, the issue is the rate of temporary disability. We reverse.

FINDINGS OF FACT

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

Claimant, a concrete finisher, was regularly employed by Art Bowers. On January 4, 1995, Bowers gave claimant permission to work for Dave Moon (Moon). Moon had a full crew of employees, but needed extra help to complete a job. Claimant had previously worked for Moon for two days in March, 1994, two days in the second quarter of 1994, two days in the third quarter of 1994, and one day on December 16, 1994. No employment relationship between claimant and Moon was maintained between these employments. (Ex. 10, Tr. 14). At the time claimant took the job in January 1995, the parties anticipated that he would work for 2 or 3 days, 8 hours a day, although the hours could vary, depending on work load and weather. Claimant was compensably injured on January 4, 1995, and left work on January 5, 1995, after working a total of 17 hours. The employer completed a Form 801 for claimant on which it noted that claimant's wage was $13.00 an hour for an 8:00 a.m. to 4:00 p.m. shift, for three or fewer days per week. SAIF calculated claimant's rate of temporary disability by averaging the wages claimant earned during the prior 52 weeks of employment at Moon.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that SAIF's calculations were proper. Claimant contends that his temporary disability rate should be calculated on the intent at the time of hire because he was employed less than four weeks by the employer. SAIF asserts that it properly calculated claimant's temporary disability rate, reasoning that, because claimant had been employed part-time, on call, for two years, the gaps between employments did not constitute "extended gaps" which would serve to break the continuity of the employment relationship.

OAR 436-60-025(5)(a) (WCD Admin. Order 94-055) provides:

> "(5) The rate of compensation for workers *** employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this rule. * * * *"
>
> "(a) For workers employed on call, paid hourly, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exists and where there has been no change in the amount or method of the wage earning agreement, insurers shall use the actual weeks of employment with the employer at injury up to the previous 52 weeks. Where there has been a change in the amount or method of the wage earning agreement during the previous 52-week period, insurers shall use only the actual weeks under the wage earning agreement at time of injury. For workers employed less than four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker."

Claimant's earnings were irregular and his hours of work varied with the work load and weather. Thus, the rule is applicable. Determining what is an "extended gap" includes consideration of the length of the break in work and whether the gap has caused a change in the work relationship

between employer and employee. Steven B. Caldwell, 44 Van Natta 2566, 2567 (1992); see Craig E. Hobbs, 39 Van Natta 690 (1987). Such a determination is made on a case-by-case basis, considering such factors as whether the work was steady or seasonal. Dena L. Barnett, 43 Van Natta 1776 (1991); Sally M. Turpin, 37 Van Natta 924, 926 (1985). An "extended gap" does not generally exist where the claimant's varying work schedule is within the reasonable expectations of the claimant and the employer. See Steven B. Caldwell, supra.

Here, the record shows that claimant was an occasional worker for Moon. Claimant was available for work only at his regular employer's convenience. Moreover, the employment relationship with Moon ceased at the end of each period of work. There is no evidence that claimant's breaks in employment were due to expected seasonal factors or that he was merely "laid off" for an extended period, with the expectation that he would return to work at some time in the future.

In light of the above, we conclude that claimant was employed for "less than four weeks" at the time of his injury. Although he had previously been employed by Moon, his status as a regular employee of Art Bowers required that, at the end of his employment stint with Moon, he effectively terminated his employment with Moon and renewed it only if Moon again needed temporary help and Bowers permitted the employment. Thus, at the time of his injury in 1991, claimant had been on his "new" job fewer than four weeks.

Because claimant had been employed fewer than four weeks at the time of his injury, OAR 436-60-025(5)(a) requires that the insurer use the intent of the employer and the worker at the time of hire in calculating the rate of compensation. The 801 form filled out by the employer and the testimony at hearing establish the parties' intent at the time of hire. Qualified Contractors v. Smith, 126 Or App 131 (1994). Here, the 801 form completed by the owner of the company stated that claimant worked less than three days a week, eight hours per day, at $13.00 per hour . (Ex.1). Both claimant and the employer testified that, depending on the work load and weather, claimant would maintain that schedule. (Tr. 9, 15). Thus, the parties' intent at the time of hire was for claimant to work an eight hour day for three days or less per week at the rate of $13.00 per hour. Claimant worked two eight hour days and one hour of overtime prior to the day of injury. (Ex. 10-2) Because there is no evidence that claimant regularly worked overtime, we conclude that the weekly rate should be calculated based on two eight hour days at $13.00 per hour, or a total of $208 per week.

Claimant's counsel is entitled to an attorney fee of 25 percent, not to exceed $3,800, of any increased compensation that results from the recomputation of his temporary total disability benefits. See ORS 656.386(2); OAR 438-15-055(1).

ORDER

The ALJ's order dated June 28, 1995 is reversed. The SAIF Corporation is directed to calculate claimant's temporary disability compensation consistent with this order. Claimant's attorney is entitled to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

In the Matter of the Compensation of
GARY L. DOTY, Claimant
WCB Case Nos. 94-11868 & 94-07844
ORDER ON REVIEW
Patrick Mackin, Claimant Attorney
Roberts, et al, Defense Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Cigna Insurance Companies, on behalf of Stanley Works, (Cigna/Stanley) requests review of that portion of Administrative Law Judge (ALJ) Thye's order that set aside its denial of claimant's thoracic outlet syndrome condition. Claimant cross-requests review on those portions of the order that declined to assess an attorney fee against Cigna Companies, on behalf of Consolidated Metco, (Cigna/ConMetco), and Cigna/Stanley for their alleged compensability denials of claimant's neck and shoulder condition. Claimant also contends that he is entitled to a penalty and attorney fee for an allegedly unreasonable denial. On review, the issues are compensability, attorney fees and penalties.

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

We briefly recap the facts. Claimant injured his neck and right shoulder on September 8, 1987, while working for Stanley (Cigna's insured). Claimant was diagnosed with a chronic shoulder girdle muscle strain. (Ex. 10). The claim was closed with no award of permanent disability. (Ex. 25).

Claimant continued to have neck and right shoulder pain. The claim was reopened in April 1990 and claimant was diagnosed with a chronic cervical/dorsal right shoulder strain. (Ex. 40). The aggravation claim was closed on August 22, 1990, with an award of 17 percent unscheduled permanent partial disability. (Ex. 47).

Claimant began working for Consolidated Metco (ConMetco), Cigna's insured on February 14, 1994. In April 1994, claimant filed a claim with Cigna/ConMetco because he felt his back, neck and shoulder pain had worsened. (Ex. 56; Tr. 40). Claimant also filed a claim with Cigna/Stanley Works. (Ex. 72). In July 1994, Dr. Berkeley diagnosed thoracic outlet syndrome. (Ex. 74).

The ALJ found that claimant had thoracic outlet syndrome and concluded that claimant's 1987 injury at Stanley and its "chronic sequelae" were the major contributing cause of the thoracic outlet syndrome.

Cigna/Stanley argues that the ALJ erroneously found that Dr. Berkeley was claimant's attending physician and his opinion was entitled to deference. See Weiland v. SAIF, 64 Or App 810 (1983). We disagree.

Claimant testified that Dr. Berkeley was now his treating doctor. (Tr. 49). Claimant plans to have Dr. Berkeley perform the surgery for the thoracic outlet syndrome if it proves to be necessary. (Tr. 47). Under these circumstances, we agree with the ALJ that Dr. Berkeley was claimant's attending physician and his opinion is entitled to deference.

Cigna/Stanley argues that there is insufficient evidence to establish that claimant has thoracic outlet syndrome. After reviewing the record, we agree with the ALJ that claimant has thoracic outlet syndrome.

Alternatively, Cigna/Stanley contends that, if claimant has thoracic outlet syndrome, the condition is not related to his September 8, 1987 industrial injury. Cigna/Stanley argues that § 3(1) of Senate Bill 369 applies to this case. According to Cigna/Stanley, Dr. Berkeley's opinion is legally insufficient under § 3(1) to establish compensability.

After the ALJ's order, the legislature enacted Senate Bill 369. The Act applies retroactively to cases in which an order or decision has not become final, subject to exceptions listed in section 66. See Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565 (1995). Since no exceptions apply, we retroactively apply the amendments to this case.

Claimant contends that it violates his federal and state constitutional rights, including his due process rights, for Cigna/Stanley to belatedly assert a new standard. Claimant does not, however, explain or develop this argument, nor does he specify the constitutional rights that would be violated. Because this constitutional argument is not adequately developed for our review, we decline to address the issue. See Thurman M. Mitchell, 47 Van Natta 1971, 1973 (1995); compare Kathleen M. Butler, 47 Van Natta 2202 (1995) (addressing constitutional arguments concerning proposed medical treatment).

Section 3 of Senate Bill 369 provides, in part:

> "In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:
>
> "(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition." Or Laws 1995, ch 332, § 3 (SB 369, § 3); (emphasis added).

In order to determine the applicability of § 3(1), we must decide what condition is being claimed and whether it is preexisting. See Colin J. McIntosh, 47 Van Natta 1965 (1995).

Claimant's current condition has been diagnosed as thoracic outlet syndrome. We agree with Cigna/Stanley that Dr. Berkeley described claimant's thoracic outlet syndrome as a "congenital anomaly." (Ex. 84). As such, it constitutes a "preexisting condition" under ORS 656.005(24).[1] Nevertheless, there is no medical evidence that indicates claimant's disability was solely caused by his preexisting condition or that his medical treatment is solely directed to the preexisting condition.

Dr. Berkeley is the only physician who diagnosed thoracic outlet syndrome. We find that Dr. Berkeley's opinion establishes that claimant's work injury combined with the preexisting condition to cause the disability and need for treatment. On January 3, 1995, Dr. Berkeley reported:

> "[Claimant's] 1987 work injury is the major contributing cause for his thoracic outlet syndrome to become symptomatic. The thoracic outlet syndrome is due to some congenital anomaly in the anatomical structure of the thoracic outlet, but such conditions can remain totally undiagnosed and quiescent until an injury provokes some inflammatory process and/or decompensation until then, compensating mechanisms, thus causing a manifest syndrome." (Ex. 84; emphasis added).

In a deposition, Dr. Berkeley explained that claimant's 1987 injury caused the thoracic outlet syndrome to become symptomatic. (Exs. 89-9; 89-10). Dr. Berkeley testified that, after the injury, the thoracic outlet syndrome came "to a stage of decompensation, and as a result of this he developed neck and right upper limb symptoms and signs." (Ex. 89-10).

In light of Dr. Berkeley's opinion, we are not persuaded that claimant's disability is solely related to, or his need for medical services is solely directed to, his preexisting congenital condition. Consequently, we conclude that section 3 of Senate Bill 369 does not apply to this case. See Colin J. McIntosh, supra.

Dr. Berkeley's opinions indicate that claimant's 1987 work injury combined with his preexisting thoracic outlet syndrome. Under those circumstances, claimant must prove that the 1987 work injury was the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition. Amended ORS 656.005(7)(a)(B).

After reviewing the record, we agree with the ALJ's reasoning and conclusion that, based on Dr. Berkeley's opinion, claimant's 1987 injury was the major contributing cause of the thoracic outlet syndrome. (Exs. 79, 84, 85 & 89). Dr. Berkeley reported:

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[1] ORS 656.005(24) defines a "preexisting condition" as "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273." (Emphasis added).

> "Within reasonable medical probability, it is my opinion that the major cause of the right thoracic outlet syndrome was [claimant's] industrial injury in September 1987. This resulted in a chronic pattern of symptoms in the neck, arm and shoulder which have been persistent since that time. [Claimant's] subsequent work activities, including his work at Consolidated Metco most recently, would only contribute to his thoracic outlet syndrome on a symptomatic basis. When viewed objectively, one would have to conclude that the 1987 injury with its resulting chronic condition is the major cause of [claimant's] current thoracic outlet syndrome. His subsequent work activity, even if repetitive and heavy in nature, would only produce symptomatic aggravation." (Ex. 79).

We are persuaded that claimant's 1987 work injury was the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition. Amended ORS 656.005(7)(a)(B). Similarly, even if the claim is analyzed as a consequential condition under ORS 656.005(7)(a)(A), claimant's condition is compensable because the 1987 work injury is the major contributing cause of the thoracic outlet syndrome.[2]

Attorney Fees

Claimant cross-requests review on those portions of the ALJ's order that declined to assess an attorney fee against Cigna/ConMetco and Cigna/Stanley for their alleged compensability denials of claimant's neck and shoulder condition. The ALJ found that neither Cigna/ConMetco nor Cigna/Stanley issued a compensability denial for claimant's neck and shoulder condition.

According to claimant, Cigna/Stanley did not concede compensability until the hearing. We disagree.

On September 30, 1994, Cigna/Stanley notified claimant:

> "As you are aware, we have previously accepted your claim for a right shoulder girdle strain and have provided benefits for that condition. We continue to accept that condition and will pay for medical services related to that condition." (Ex. 78; emphasis added).[3]

We agree with the ALJ that Cigna/Stanley never denied the accepted condition and there was no compensability denial of the neck and back condition by Cigna/Stanley upon which to base an assessed fee. Therefore, claimant's attorney is not entitled to an attorney fee under either former or amended ORS 656.386(1).[4]

Claimant also contends that Cigna/ConMetco's position on compensability of the neck and shoulder condition was not clarified until the hearing. To the contrary, Cigna/Stanley accepted claimant's neck and shoulder condition well in advance of the hearing. We agree with the ALJ that there was no compensability denial of claimant's neck and back condition by Cigna/ConMetco that would justify the assessment of a fee under former or amended ORS 656.386(1).

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[2] The ALJ found that claimant's 1987 injury and its "chronic sequelae" were the major contributing cause of claimant's need for medical treatment. At hearing, claimant and Cigna/Stanley litigated the claim as to Stanley as a consequential condition. (Tr. 19, 20). See ORS 656.005(7)(a)(A). However, in light of the 1995 amendments, it is unclear whether the parties are litigating this matter on review as a consequential or combined condition claim. Since claimant has satisfied the major contributing cause standard under either theory, we need not decide whether this matter should be analyzed as a consequential or combined condition.

[3] Cigna/Stanley also said that it was denying claimant's right carpal tunnel condition and/or thoracic outlet syndrome because neither condition was related to his 1987 industrial injury. (Ex. 78).

[4] Claimant also contends that he is entitled to an attorney fee under ORS 656.307(5). Since this case did not arise under ORS 656.307, ORS 656.307(5) does not apply. Compare Dan J. Anderson, 47 Van Natta 1929, 1932 (1995) (since the case arose under former ORS 656.307, amended ORS 656.307(5) applied and ORS 656.308(2)(d) did not).

Unreasonable Denial

Claimant argues that he is entitled to a penalty and attorney fee for allegedly unreasonable denials. Claimant asserts that the medical information related his thoracic outlet syndrome and/or neck condition to the original accident.

Cigna/Stanley contends that we should not consider this issue because claimant did not raise the issue at hearing and it was not addressed by the ALJ. Although claimant marked "penalties and attorney fees" in his requests for hearing, it does not appear that he pursued the penalty issues at hearing. Under these circumstances, we are not inclined to consider the penalty issues on review. In any event, we disagree with claimant's argument.

Claimant is entitled to a penalty if the carrier "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." Amended ORS 656.262(11)(a). The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and " legitimate doubt" are to be considered in the light of all the evidence available. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

In light of our conclusion that Cigna/Stanley did not deny compensability of claimant's neck condition, claimant is not entitled to penalties for an unreasonable denial of that condition. Furthermore, we conclude that Cigna/Stanley had a legitimate doubt as to its liability for claimant's thoracic outlet condition. Cigna/Stanley denied compensability of claimant's thoracic outlet syndrome on September 30, 1994. (Ex. 78). At the time Cigna/Stanley issued its denial, it had a May 1989 report from Dr. Ebert that said claimant's neurological exam was negative for thoracic outlet symptoms. (Ex. 27). In addition, Cigna/Stanley had a May 24, 1994 report from Dr. Ebert which said that the possibility of thoracic outlet seemed very unlikely. (Ex. 60). In light of Dr. Ebert's reports, we conclude that Cigna/Stanley had a legitimate doubt as to its liability. Consequently, its denial of claimant's thoracic condition was not unreasonable.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the thoracic outlet condition is $1,500, payable by Cigna/Stanley. 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 affidavit in support of attorney fees), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services on review concerning the attorney fee and penalty issues. See Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated March 21, 1995 is affirmed. For services on review concerning the thoracic outlet condition, claimant's attorney is awarded $1,500, payable by Cigna/Stanley.

In the Matter of the Compensation of
DAVID L. GOODING, Claimant
WCB Case No. 94-13183
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) directed the employer to recalculate the rate of claimant's temporary partial disability (TPD) consistent with the decision in Stone v. Whittier Wood Products, 124 Or App 117 (1993), rev den 318 Or 459 (1994); and (2) assessed a penalty for the employer's allegedly unreasonable claims processing. On review, the issues are temporary disability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Preliminary Matter

As a preliminary matter, we address the employer's request that we clarify the ALJ's order language to reflect the parties' stipulations at hearing. The parties made several stipulations at hearing regarding various penalties and increasing the wage upon which TPD was calculated from $6.25 per hour to $7.00 per hour, claimant's at-injury wage. (Tr. 1). The parties also stipulated that claimant first became eligible for TPD subsequent to October 1, 1994. The ALJ recorded these stipulations in his Opinion and Order. (Opinion and Order, page 2-3).

Although the employer requests that we clarify the order portion of the ALJ's opinion to clearly reflect these stipulations, it does not contend that the ALJ inaccurately recorded these stipulations, nor does it direct us to any inaccuracies or "confusing" language within the order language. After reviewing the order language, we are persuaded that it accurately recites the parties' stipulations. Accordingly, we see no reason to "clarify" the order language regarding those stipulations.

Rate of Temporary Disability

Claimant's at-injury job paid $7.00 per hour and consisted of an eight hour day, 40 hour work week. As of the date of hearing, claimant had been returned to modified work and was working five hours per day. The employer stipulated to payment of TPD based on claimant's at-injury wage of $7.00 per hour. The issue at hearing was whether the at-injury wage was the correct rate of TPD.

Relying on the court's decision in Stone, supra, and the Director's rule which implemented that decision, the ALJ concluded that the employer had miscalculated the rate of claimant's temporary disability by failing to take into account his highest wage earned during the five years preceding his injury. The employer contends that the Stone decision was legislatively overruled by Senate Bill 369, effective June 7, 1995. We agree.

Subsequent to the ALJ's order, the legislature enacted SB 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was ORS 656.212, which now provides, in pertinent part, that temporary partial disability shall be calculated based on the loss of wages in relation to the wage used to calculate temporary total disability. Or Laws 1995, ch 332, § 16 (SB 369, § 16). Finding no relevant exceptions to the retroactive application of this amendment, we conclude that § 16 applies retroactively to this case. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995); Walter L. Keeney, 47 Van Natta 1387 (1995) (retroactive application of SB 369 to deprive Board of jurisdiction over medical treatment disputes is not absurd or unjust). Furthermore, application of this amendment retroactively to determine claimant's rate of temporary disability will not produce an absurd or unjust result inconsistent with the purposes and policies of the workers' compensation law. Harley J. Gordineer, 47 Van Natta 2138 (1995); Alda S. Carbajal, 47 Van Natta 1596, 1598 n 2 (1995); Ida M. Walker, 43 Van Natta 1402 (1991).

Accordingly, we reverse that portion of the ALJ's order which directed the employer to recalculate claimant's temporary disability compensation based on an hourly rate of $8.00 (taking into consideration claimant's highest wage in the five years preceding his injury). Instead, we direct the insurer to calculate claimant's temporary partial disability consistent with amended ORS 656.212. Lonnie L. Dysinger, 47 Van Natta 2282 (1995).

Penalties

The ALJ assessed a penalty of 25 percent of the difference between the calculation of TPD based on $8.00 per hour, claimant's highest wage within five years preceding the date of injury, and that based on $7.00 per hour, claimant's at-injury wage. The ALJ assessed this penalty against the employer for its unreasonable failure to calculate TPD as required by the Director's rule in effect at the time claimant became eligible for TPD. We disagree.

We have concluded that amended ORS 656.212 applies retroactively to claimant's claim. Furthermore, amended ORS 656.212 provides that TPD shall be calculated based on the loss of wages in relation to the wage used to calculate temporary total disability, i.e., based on the at-injury wage. Moreover, the employer calculated claimant's TPD rate based on his at-injury wage, the calculation claimant is entitled to pursuant to amended ORS 656.212. Therefore, it follows that the employer's failure to calculate claimant's TPD rate on any other basis was not unreasonable.[1] See Robin R. Oliver, 45 Van Natta 318 (1993) (finding that the 1990 amendments to ORS 656.313 were retroactively applicable to the claimant's claim, the Board applied amended ORS 656.313 in determining the insurer's liability for a penalty and found that no penalty was due, reasoning that the insurer's failure to pay benefits pending appeal was not unreasonable because amended ORS 656.313 allowed such a stay of compensation); Raymond J. Seebach, 43 Van Natta 2687 (1991) (applying the 1990 amendments to ORS 656.313 retroactively to the claimant's claim, the Board determined that, since the insurer was entitled to stay payment of compensation pending appeal, the insurer's failure to pay those stayed benefits was not unreasonable; therefore, no penalty was due); Bryan L. Dunn, 43 Van Natta 1673 (1991) (applying the 1990 amendments to ORS 656.262(6) retroactively to the claimant's claim, the Board declined to assess a penalty for untimely denial of a claim where the insurer had 90 days under the amended law to accept or deny a claim and the insurer timely denied the claim within 90 days).

Accordingly, because we do not find the employer's conduct unreasonable, we reverse the ALJ's assessment of a penalty for unreasonable conduct based on the calculation of claimant's TPD rate. Harley J. Gordineer, supra.

Inasmuch as the compensation awarded by the ALJ (outside of that stipulated to by the parties) has been reduced, claimant is not entitled to an assessed attorney fee for services on review. ORS 656.382(2).

ORDER

The ALJ's order dated January 27, 1995, as reconsidered on February 10, 1995 is reversed in part and affirmed in part. That portion of the ALJ's order which directed the self-insured employer to recalculate claimant's temporary disability compensation based on an hourly rate of $8.00 is reversed. Instead, the insurer shall calculate claimant's temporary disability compensation based on amended ORS 656.212. That portion of the ALJ's order assessing a penalty for the employer's allegedly unreasonable calculation of temporary partial disability benefits is reversed. The remainder of the ALJ's order is affirmed.

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[1] In light of our conclusion that the employer's conduct was not unreasonable, it is unnecessary to determine whether there were amounts "then due" upon which to assess a penalty under ORS 656.262(11)(a). Furthermore, since the Zaragoza rationale discussed in the dissenting opinion is premised on a finding of unreasonable conduct (a finding that we have not made), the Zaragoza holding is not controlling.

Board Chair Hall concurring in part and dissenting in part.

I agree with the majority that there is no reason to "clarify" the ALJ's order language regarding the parties stipulations. I also agree that amended ORS 656.212 applies retroactively to this case and that retroactive application of amended ORS 656.212 to determine the substantive issue of claimant's rate of temporary disability will not produce an absurd or unjust result. However, I disagree with the majority's holding that claimant is not entitled to a penalty for the employer's unreasonable claims processing conduct under the facts of this case. Because I would assess a penalty for this unreasonable conduct, I must respectfully dissent.

The ALJ assessed a penalty of 25 percent of the difference between the calculation of TPD based on $8.00 per hour and that based on $7.00 per hour. The ALJ assessed this penalty against the employer for its unreasonable failure to calculate TPD as required by the Director's rule in effect at the time claimant became eligible for TPD. The employer argues that, because the state of law regarding calculation of TPD "has been in great flux and subject to varying interpretations," the ALJ erred in assessing the penalty. I disagree.

The parties stipulated that claimant was entitled to TPD benefits subsequent to October 1, 1994. Although the legislature has since changed the law regarding the calculation of TPD benefits, at the time claimant became entitled to TPD the law held that TPD benefits were to be calculated considering the proportionate loss of earning power at any kind of work, not just the loss in actual wages from the time of injury. Stone v. Whittier Wood Products, supra.

In addition, the Director adopted temporary rules applying the Stone decision effective March 1, 1994, and permanent rules effective August 28, 1994. (WCD Admin. Order No. 94-050; DCBS Admin. Order No. 94-055). Therefore, at the time claimant became eligible for TPD in October 1994, the established law held that the at-injury wage was not the controlling factor in calculating the TPD rate and that TPD benefits were to be calculated considering the proportionate loss of earning power at any kind of work.

The employer had a duty to process the claim. ORS 656.262; Donald R. Lewis, 46 Van Natta 2408, 2409 (1994) (the carrier has a continuing duty to process the claimant's claim). There is no evidence that the employer made any attempt to comply with the law and rules in effect at the time claimant became eligible for TPD. I agree with the ALJ that the employer's failure to do so was unreasonable.

However, subsequent to the employer's unreasonable failure to calculate TPD under the law and rules in effect at the time claimant became eligible for TPD, the legislature amended ORS 656.212 to provide that TPD is to be calculated in the same manner as TTD, i.e., based on the at-injury wage, which is the wage at which the employer agreed to calculate claimant's TPD.[1] Given this subsequent change in the law, the question becomes whether the Board may assess a penalty for the employer's unreasonable claims processing prior to the enactment of amended ORS 656.212. For the following reasons, I conclude that such a penalty is justified and that the Board may assess it.

Penalties may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10), renumbered ORS 656.262(11). 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, 110 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available to the carrier at the time of its conduct. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988); Price v. SAIF, 73 Or App 123, 126 n. 3 (1985). There is no indication that the legislature intended to change that standard. In fact, the legislature simply renumbered ORS 656.262(10) as ORS 656.262(11); it made no changes in the language of ORS 656.262(10). Therefore, I conclude that the legislature made no change in the application of the "reasonableness" standard in renumbered ORS 656.262(11).

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[1] The employer initially calculated claimant's TPD at a wage lower than his at-injury wage. However, the employer later agreed to calculate claimant's TPD using the at-injury wage and stipulated, in part, to a penalty for its failure to calculate the TPD rate using the at-injury wage. That stipulated penalty is not at issue on review.

While the statute for determining TPD has since been amended, the reasonableness of the carriers conduct is judged according to the evidence and law in effect at the time of the conduct. To hold otherwise would allow a carrier to flaunt established law with impunity. In other words, the employer would be allowed to profit from deliberately disobeying established law at the time of its conduct.

Here, the established law at the time of the employer's conduct directed it to calculate TPD in accordance to the Stone decision and the rules applying that decision. Amended ORS 656.212 was not yet in existence. Accordingly, I find that the employer was unreasonable in failing to calculate claimant's TPD rate according to the established law at the time of the employer's conduct.

In order to assess a penalty, there must be amounts of compensation "then due" upon which to base the penalty. See ORS 656.262(11)(a); Eastmoreland Hospital v. Reeves, 94 Or App 698 (1989). In light of the retroactive applicability of the provisions in amended ORS 656.212 that provide for the calculation of TPD at the at-injury wage, the wage used by the employer to calculate claimant's TPD, an argument could be advanced that there are no "amounts then due" upon which to base a penalty. I disagree with that argument for the following reasons.

I find Pascual Zaragoza, 45 Van Natta 1221 (1993), aff'd mem Zaragoza v. Liberty Northwest Insurance Corp., 126 Or App 544 (1994), analogous to the present case. In Zaragoza, the insurer unreasonably failed to pay procedural temporary disability from the date the claimant was medically stationary until the date of claim closure. Because the claim had not been prematurely closed, the issue was substantive entitlement to temporary disability, not procedural entitlement. Relying on Lebanon Plywood v. Seiber, 113 Or App 651 (1992), the Board held that we could not award the claimant temporary disability benefits beyond the medically stationary date, because to do so would create an "administrative" overpayment which otherwise would not exist. 45 Van Natta 1222.

However, also relying on Seiber, we found that imposition of penalties was the appropriate sanction where the carrier unreasonably delayed or refused to pay temporary disability benefits. In addition, we found that the "amounts then due" upon which to base the penalty consisted of the temporary disability benefits that the insurer should have paid if it had complied with its obligations. We concluded that "[t]o reach any other result would permit the insurer to profit by its refusal to comply with clear statutory and administrative obligations." 45 Van Natta 1223.

I would reach the same conclusion in the present case. Here, as in Zaragoza, we may not award the TPD benefits the employer should have paid if it had complied with its statutory and administrative obligations. This "unpaid" TPD consists of the difference between the calculation of TPD benefits at $8.00 per hour and that calculated at $7.00 per hour. However, as in Zaragoza, we may assess a penalty based on the compensation "then due" at the time of the employer's unreasonable conduct. To do otherwise would permit the employer to profit from its unreasonable failure to comply with its then-existing statutory and administrative obligations.

Here, the ALJ assessed a penalty of 25 percent of the difference between the calculation of TPD benefits at $8.00 per hour and that calculated at $7.00 per hour, retroactive to the date TPD was first due. I would affirm that penalty and only clarify that the penalty period is to extend from the date TPD was first due until the date of the hearing.

In the Matter of the Compensation of
GREGORY J. KNICKERBOCKER, Claimant
WCB Case Nos. 94-15278 & 94-14487
ORDER ON REVIEW
Darrell E. Bewley, Claimant Attorney
David R. Fowler (Saif), Defense Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) upheld the SAIF Corporation's denial of claimant's low back injury claim; (2) upheld Houston General Insurance Group's (Houston's) denial of the same claim; and (3) declined to assess a penalty for Houston's allegedly unreasonable failure to pay chiropractic bills. On review, claimant asserts that Houston is estopped from denying its liability for those bills. On review, the issues are compensability, responsibility, estoppel and penalties.

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

Claimant asserts that, regardless of the compensability issue, Houston should be estopped from denying its liability for Dr. Kelley's chiropractic treatment because Houston authorized that treatment. We disagree.

The doctrine of equitable estoppel only protects those who materially change their position in reliance on another's acts or representations. Meier & Frank Co. v. Smith-Sanders, 115 Or App 159, 163 (1992) (quoting Stovall v. Salley Salmon Seafood, 306 Or 25, 34 (1988)), recon 118 Or App 261, rev den 316 Or 142 (1993). Claimant asserts that he materially changed his position in reliance on Houston's authorization of chiropractic services. We disagree.

Claimant began treating with Dr. Kelley, on September 15, 1994. (Ex. 6). Dr. Kelley's office staff called Houston sometime after September 19, 1994, and obtained authorization for the chiropractic treatment. Thus, claimant began treating with Kelley before Houston authorized the treatment. In view of that fact, and because there is no evidence regarding whether claimant would have ceased treatment after September 19 had Houston not authorized it, we are unable to conclude that claimant changed his position in reliance on Houston's authorization. Consequently, we reject claimant's estoppel argument.

ORDER

The ALJ's order dated May 23, 1995 is affirmed.

Board Member Hall dissenting.

The majority concludes that claimant has failed to establish a compensable low back injury claim. Because I believe that the majority has misconstrued the medical evidence and applied the wrong legal standard, I respectfully dissent.

In reaching its conclusion, the majority evidently applies the major contributing cause standard of either ORS 656.005(7)(a)(A) or (B), based on, among other things, the following evidence: (1) the report of Dr. Stanford, examining physician, who, in view of claimant's delay in reporting low back symptoms and claimant's intervening work as a fire fighter, "simply [could] not find a connection between [claimant's] low back pain and his injury of June 18, 1994." (Ex. 11-4); (2) Drs. Stanford's and Fox's "check-the-box" concurrence reports, which indicate that claimant's low back complaints were not related to his work as a fire fighter. (Exs. 22, 23); (3) Dr. Fox's report stating that, based on claimant first complaining of back pain three months after his work injury, claimant's low back condition was not related to the June 18, 1994 work injury (Ex. 24); and (4) Dr. Farris' medical examination report stating, without meaningful explanation, that claimant's preexisting leg length discrepancy was the major contributing cause of his low back pain. (Ex. 21-6).

Such evidence is not persuasive. Drs. Stanford and Fox ignore evidence establishing that claimant's back pain began shortly after the June 1994 accident, even if he did not seek treatment until some time later. Moreover, their "check-the-box" opinions lack a persuasive analytical foundation and concern claimant's work as a fire fighter, not his June 1994 work injury. Marta I. Gomez, 46 Van Natta 1654 (1994). Last, Dr. Farris' report is too conclusory. For all these reasons, I would give those reports minimal or no weight.

Instead, I would rely on the report of Dr. Kelley, treating chiropractor. Dr. Kelley concluded that, in view of claimant's onset of low back pain shortly after the June accident, "[w]ith an extremely high degree of medical probability, the accident of June 18, 1994, when [claimant] was struck by the van, was a material contributing cause of [his low back condition]." (Ex. 20). Kelley's report establishes that claimant's low back injury was the direct result of his June 1994 work injury. Consequently, I would apply the material contributing cause standard. ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992). Because Dr. Kelley's report suffices under that standard, I would hold that claimant's claim is compensable.

In reaching this conclusion, I note that both the ALJ and the Board, by adoption, specifically find that claimant developed low back pain within a week of the June 18 injury. (Opinion and Order at 2). That finding, coupled with Dr. Kelley's compelling report and the lack of persuasive evidence regarding any preexisting or consequential condition, support the direct causation analysis I offer above.

Finally, I make one comment regarding the chiropractic bill issue. It is unclear to me why claimant cannot claim a breach of contract for the payments Houston General Insurance Group authorized, but failed to pay. Because no one has raised a breach of contract theory, however, I am unable to reach that issue.

In sum, I would hold that, under a direct causation theory, claimant has established the compensability of his low back injury claim. The majority concludes otherwise and, therefore, I dissent

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January 24, 1996 Cite as 48 Van Natta 157 (1996)

In the Matter of the Compensation of
HARRY T. McCREA, JR., Claimant
WCB Case Nos. 93-05231 & 93-02507
ORDER ON REVIEW
James L. Edmunson, Claimant Attorney
Dennis L. Ulsted (Saif), Defense Attorney
John M. Pitcher, Defense Attorney

Reviewed by Board Members Neidig and Christian.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order which: (1) upheld Weyerhaeuser's denial of compensability and responsibility for claimant's current low back condition; and (2) upheld the SAIF Corporation's occupational disease denial of compensability and responsibility for the same condition. In his brief, claimant contends that his preexisting condition previously was made a part of his accepted claim, and that Weyerhaeuser may not now deny the condition. On review, the issues are compensability and responsibility.

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

Claimant sustained a compensable low back injury in 1982 while working for Weyerhaeuser. The accepted back strain was superimposed on Grade I spondylolysis (L5-S1 level) and spondylosisthesis (L4-5 level). The claim was first closed in October 1984, with no award of permanent disability. In 1987, a prior ALJ ordered that the claim be reopened for an aggravation. The claim was last closed in April 1988, with no award of permanent disability. In 1989, another prior ALJ granted claimant a 10 percent unscheduled permanent disability award.

Claimant worked for Weyerhaeuser until August 1991. At that time, claimant began working for SAIF's insured. In August 1992, claimant returned to a doctor for treatment of increased low back pain and stiffness. Weyerhaeuser denied compensability of an aggravation of claimant's current low back condition. SAIF denied compensability of an occupational disease for the same low back condition.

The ALJ concluded that the major contributing cause of claimant's current low back condition was his preexisting low back conditions and, therefore, the current condition was not compensable. Claimant now contends that his preexisting conditions had previously been accepted by way of prior ALJs' orders (see Exs. 4, 9) and, therefore, the current ALJ applied the incorrect legal test for compensability with regard to the Weyerhaeuser's current condition denial. We do not agree.

Claimant first argues that a prior ALJ's order, making reference to "aggravation" of claimant's preexisting conditions, is sufficient to find that the prior ALJ included claimant's preexisting conditions as an accepted part of claimant's 1987 aggravation claim. (See Ex. 4). We disagree.

We have previously held that, under specific circumstances, a preexisting condition may become part of an accepted condition by way of a prior order which has become final. See Patricia V. Standard-Franklin, 46 Van Natta 1574 (1994). We find Standard-Franklin distinguishable from the present case.

In Standard-Franklin, a prior ALJ concluded that the claimant had sustained an injury to her low back in January 1989, that "materially worsened her degenerative low back condition." 46 Van Natta at 1575. The ALJ therefore assigned responsibility for the injury, including the worsened preexisting condition, to the insurer on the risk at the time of the 1989 injury. We affirmed the prior ALJ's order, and it was not appealed. Subsequently, in a later litigation, we concluded that the prior order had established, as a matter of law, that the claimant's preexisting degenerative condition was compensable. Id. at 1576.

Here, the issue at the prior hearing was compensability of an aggravation claim for claimant's 1982 accepted low back strain. Acceptance of a preexisting condition was not at issue, and the prior ALJ did not address the compensability of claimant's preexisting condition. Although the prior ALJ made reference to a physician's opinion stating that claimant's preexisting condition was "aggravated by the April 1982 compensable injury," we do not find that such a reference is sufficient to support a conclusion that the prior ALJ's order included claimant's preexisting condition as an accepted part of claimant's 1987 aggravation.

Claimant further argues that his preexisting condition became part of his accepted condition when another prior ALJ awarded permanent disability based, in part, on a symptomatic worsening of claimant's preexisting condition. (See Ex. 9). We disagree.

A carrier's acceptance of a claim includes only those injuries or conditions specifically accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Whether acceptance of a claim has occurred is a question of fact. SAIF v. Tull, 113 Or App 449 (1993). Here, the accepted condition resulting from claimant's 1982 low back injury was a nondisabling back strain. (See Ex. 1). There is no evidence, and claimant does not contend, that his preexisting condition has specifically been accepted.

Furthermore, subsequent to the ALJ's order in this case, the 1995 Legislature amended ORS 656.262(10)[1], which applies retroactively to this case. Or Laws 1995, ch 332, §§ 28, 66; Volk v. America West Airlines, 135 Or App 545 (1995).

In applying amended ORS 656.262(10), we have held that the amended statute permits the employer to contest the compensability of the condition rated by the closure order where the condition has not been formally accepted. Craig L. Hiatt, 47 Van Natta 2287 (1995). In other words, in this case, merely because the prior ALJ's permanent disability award was arguably based, in part, on a symptomatic worsening of claimant's preexisting condition, the preexisting condition did not, thereby, become part of the accepted claim. See ORS 656.262(10). Accordingly, we agree with the ALJ that claimant has failed to meet his burden of proving that his current low back condition is compensable.

ORDER

The ALJ's order dated July 29, 1994 is affirmed.

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[1] Amended ORS 656.262(10) provides:

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

In the Matter of the Compensation of
VALERIA E. MOON, Claimant
WCB Case No. 95-04860
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

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

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

The ALJ found that claimant was injured while working in the course and scope of her employment. In so doing, the ALJ relied on Robert J. Hunt, 42 Van Natta 1047 (1990), to find that the employer and its client (a telemarketing business), were jointly responsible for claimant's injury.

On review, the insurer contends that claimant's injury occurred outside the scope of her employment for its insured. Therefore, according to the insurer, claimant's claim is not compensable nor the responsibility of its insured. ORS 656.005(7)(a).

In Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), the Supreme Court re-examined ORS 656.005(7)(a)'s work-connection standard and clarified the proper analytical framework. The Court reiterated that, to establish the compensability of an injury, the claimant must show that the injury: (1) occurred "in the course of employment," which concerns the time, place and circumstances of the injury; and (2) "arose out of employment," which concerns the causal connection between the injury and the employment. Id. at 366. As the Court explained, neither element is dispositive; rather, one must consider "all the circumstances" to determine if the claimant has satisfied the work-connection test. Id. at 366, 369.

Claimant worked for the insured, a temporary worker placement company (placement company). The placement company contracted with a telemarketing business to have claimant work as a telesurveyor. (Tr. 30). The contract stated that the placement company would be notified should claimant's duties change while at the telemarketing business. (Ex. 11).

On February 13, 1995, claimant reported to work at the telemarketing business. She was then told by her supervisor to drive over and pick up a co-worker who needed a ride to work. Upon returning from picking up her co-worker, claimant injured her low back when she slipped in the telemarketing business' parking lot.

After considering all the circumstances, we find that claimant's injury occurred within the course and scope of her employment for the insured. Claimant was directed by the placement company to report to the telemarketing business. The placement company informed claimant that she would be working as a telesurveyor. (Tr. 11, 34). Claimant was instructed to follow the instructions of the telemarketing business.[1] She was ordered to go and pick up a co-worker, and she sustained an injury to her back in so doing. Accordingly, based on the totality of the circumstances, we find that claimant

[1] We acknowledge the testimony of the insured representative, Mr. Urness. Initially, Mr. Urness testified that claimant should notify the placement company if she was told to do a task outside of her job description. (Tr. 36). However, Mr. Urness then stated that if claimant was told to do a task outside of her job description, she had the "luxury" to call the placement company "if she's not comfortable with the task that's assigned." (Tr. 41). As such, it is unclear from these two statements if claimant was absolutely required to call the placement company or whether claimant was to call only if she were uncomfortable with performing a particular task. Therefore, we decline to decide whether claimant's "notice" (or in this case failure to notify) may have taken claimant out of the course and scope of her employment.

was acting within the course and scope of her employment for the insured.[2] See First Interstate Bank of Oregon v. Clark, 133 Or App 712 (1995).

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

ORDER

The ALJ's order dated August 9, 1995 is affirmed. For services on review, claimant's attorney is awarded $500 payable by the insurer.

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[2] Because we conclude that claimant was injured in the scope of her employment for the insured, we need not address, nor do we adopt, the ALJ's finding that claimant was a joint employee. Robert J. Hunt, supra. We so decide because the ALJ's finding only affects the rights between the insured and its client (who was not a party to this dispute) since as joint employers they may be jointly and severally liable. See Mission Insurance Co. v. Miller, 73 Or App 159, 163 (1985).

In the Matter of the Compensation of
BRADLEY S. PARKER, Claimant
WCB Case No. 94-07649
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Administrative Law Judge Thye's order which: (1) directed it to pay temporary total disability benefits (TTD) between June 7, 1994 and July 28, 1994; and (2) assessed a 25 percent penalty for the insurer's allegedly unreasonable claims processing. On review, the issues are temporary disability and penalties.

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

We begin with the relevant procedural history. In August 1992, claimant sustained a compensable injury when his left elbow was struck by a falling rock. Claimant was taken off work beginning approximately in November 1992. He treated conservatively with Dr. Swanson, who subsequently determined that claimant could not return to regular work without surgery.

Surgery was not performed, and claimant stopped treating for his injury. On August 18, 1993, the insurer stopped TTD payments. On August 23, 1993, the insurer issued a "back-up" denial of claimant's claim.

Claimant requested a hearing. On June 7, 1994, a prior ALJ's order set aside the "back-up" denial. The insurer appealed the prior ALJ's order, but did not begin paying TTD. On April 6, 1995, we affirmed the prior ALJ's order. Our order was not appealed.

On December 23, 1994, as modified January 11, 1995, the ALJ found that claimant was entitled to TTD benefits for the period June 7, 1994 to July 28, 1994 (the parties had stipulated that claimant was medically stationary on July 28, 1994). The ALJ also assessed a penalty for the insurer's failure to pay TTD benefits following the prior ALJ's June 7, 1994 order.

While the insurer's appeal of the prior ALJ's June 7, 1994 order was pending, claimant had returned to regular work on August 2, 1994. Claimant's claim was closed by Determination Order (DO) on August 31, 1994. The DO found claimant medically stationary on July 28, 1994. The insurer requested reconsideration, and a January 4, 1995 Order on Reconsideration found claimant medically stationary as of August 11, 1993. Claimant requested a hearing and, on July 10, 1995, as reconsidered

August 18, 1995, and September 7, 1995, a subsequent ALJ issued an order in WCB Case No. 95-03560[1], which, inter alia, affirmed the August 11, 1993 medically stationary date. That order was not appealed.

Pending the outcome of WCB Case No. 95-03560, Board review in the instant case was suspended at the parties' request. Because an Opinion and Order has been issued in WCB Case No. 95-03560, we now proceed with our review.

Here, the insurer argues that it properly terminated claimant's TTD benefits when claimant returned to modified work in September and October 1993, and that claimant did not reestablish entitlement to benefits after that time. We disagree.

OAR 436-60-030(11) states in pertinent part:

> "Temporary partial disability compensation * * * shall continue until: * * * (b) The job no longer exists or the job offer is withdrawn by the employer. This includes, but is not limited to, termination of temporary employment, layoff or plant closure. A worker shall be included in this subsection who has been released to and doing modified work at the same wage as at the time of injury from the onset of the claim. The worker is entitled to temporary total disability compensation as of the date the job no longer is available."

Here, the parties stipulated that claimant was not medically stationary until July 28, 1994. In September and October 1993, claimant was neither released to regular work, nor did he return to regular work. Rather, pursuant to claimant's unrebutted testimony, he performed light, easy jobs, for two different employers, in September and October 1993. (Tr. 14, 47-48). Those jobs were temporary, each lasting only a few days. Claimant then did not return to regular work following those jobs until August 2, 1994. Accordingly, we conclude that claimant was entitled to TTD benefits after his modified work ended in October 1993, until July 28, 1994, the date the parties stipulated as claimant's medically stationary date.[2]

The insurer further argues that the issue in this appeal is now moot because of the order issued by the subsequent ALJ in WCB Case No. 95-03560. Specifically, the insurer contends that, because the ALJ has subsequently found that claimant was medically stationary on August 11, 1993, the insurer is not required to pay TTD benefits from June 7, 1994 (the date of the appealed prior ALJ's order) to July 28, 1994 (the "stipulated" medically stationary date). We disagree.

On June 7, 1994, a prior ALJ issued an order setting aside the insurer's "back-up" denial of claimant's claim. The insurer requested review of the ALJ's order. While review was pending, the insurer neither closed the claim nor paid temporary disability. Yet, ORS 656.313(1)(a)(A) obligates a carrier to continue paying temporary disability compensation during a carrier appeal from the date of the order appealed until claim closure or until the appealed order is reversed, whichever occurs first. See Anodizing, Inc. v. Heath, 129 Or App 356 (1994); Mary J. McKenzie, 47 Van Natta 1082 (1995).

Therefore, contrary to the insurer's contention, the ALJ's order in WCB No. 95-03560, which found claimant medically stationary on August 11, 1993, did not eliminate the employer's statutory obligation to continue paying "post-litigation order" temporary disability benefits during its appeal of the ALJ's June 7, 1994 order. Anodizing, Inc. v. Heath, supra; Darlene L. Bartz, 47 Van Natta 984 (1995); Mary J. McKenzie, supra. Accordingly, we affirm the ALJ's decision "enforcing" the prior ALJ's award of TTD benefits from June 7, 1994 to the "stipulated" medically stationary date, July 28, 1994.

With regard to the penalty assessed by the ALJ, the insurer argues that it had a legitimate doubt regarding claimant's eligibility for TTD, and that claimant failed to respond to the insurer's inquiries concerning claimant's status, thereby providing no basis for a penalty. We disagree.

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[1] We take official notice of the facts and conclusions contained in the Opinion and Order in WCB Case No. 95-03560, issued while the present case was pending review.

[2] Claimant would appear to be lawfully entitled to TTD benefits through August 2, 1994, the date he returned to regular work. See ORS 656.268(3)(a). Nevertheless, because the parties have agreed that claimant's disputed TTD shall not extend beyond July 28, 1994, we will not modify the ALJ's TTD award.

A penalty may be assessed when an employer "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11)(a). The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the employer at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988); Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

Here, pursuant to statute, administrative rules, and case precedent, the insurer was obligated to pay TTD benefits pending its appeal of the ALJ's order. See ORS 656.313(1)(a)(A); OAR 436-60-150(4)(e), (h); Roseburg Forest Products v. McDonald, 116 Or App 448 (1992); John R. Heath, 45 Van Natta 840 (1993), aff'd Anodizing, Inc. v. Heath, supra. Furthermore, the medical records and claimant's work records support the fact that TTD was due as of the prior appealed order. See (Ex. A-5, 2, 4A). Accordingly, we affirm the ALJ's assessment of a penalty equal to 25 percent of the unpaid TTD benefits.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the TTD issue is $900, 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. We further note that claimant is not entitled to an attorney fee for his counsel's services devoted to the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated December 14, 1994 is affirmed. For services on Board review, claimant's attorney is awarded an assessed attorney fee of $900, payable by the insurer.

January 24, 1996 Cite as 48 Van Natta 162 (1996)

In the Matter of the Compensation of
JOHN G. RANDOLPH, Claimant
WCB Case No. 94-15232
ORDER ON REVIEW
Pozzi, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Neidig and Christian.[1]

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the SAIF Corporation's denial of claimant's cervicothoracic injury claim. On review, the issue is whether claimant's motor vehicle accident arose within the course and scope of his employment. We reverse.

FINDINGS OF FACT

Claimant has worked for the employer as a juvenile probation officer for 20 years. He is "on call" 24 hours per day seven days per week, in addition to his regular weekday work schedule. He spends a major portion of his time in the field. Although claimant has an office at the employer's place of business, he does not go there every day.

Claimant is assigned an employer-owned car which he drives to and from his office or field assignment. He parks the car at home, as he has for 20 years.

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[1] Member Gunn has recused himself from participation in the review of this case. See OAR 438-11-023.

In 1987 and 1992, claimant advised the employer that he would transport his two children to daycare in the morning on his way to work. Claimant was orally authorized to transport his children in this manner and the employer did not object to this practice prior to claimant's injury. Other employees similarly transported their children in the employer's cars.

On September 21, 1994, claimant left his home in the car, with his children, at about 8:20 AM. He intended to drop them off at school on his way to a 9 A.M. work appointment. On the way to the children's school, another vehicle hit claimant's car and claimant suffered a cervicothoracic strain injury.

Dropping the children off at school necessitated approximately a 10 block deviation from the route claimant would have taken to his appointment if he did not take the children to school on his way to work.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the only connection between claimant's injury and his employment was the fact that claimant was on his way to work in an employer-owned vehicle at the time of the injury. Reasoning that such a connection is insufficient to establish a compensable claim, the ALJ upheld SAIF's denial.[2]

Claimant argues that he is a "traveling employee" acting within the course and scope of his employment when he was injured. We agree.

As a general rule, injuries sustained while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210 (1987). However, where travel is a necessary incident of the employment, risks incidental to travel are covered by workers' compensation law even though the employee may not be working at the time of injury. Proctor v. SAIF, 123 Or App 326, 329 (1993); see SAIF v. Reel, supra, 303 Or at 216 ("[W]hen the travel is essentially part of the employment, the risk remains an incident to the employment even though the employee may not actually be working at the time of the injury.").

In this case, claimant spends a major portion of his work time "in the field;" i.e., at locations other than his office. He is "on call" 24 hours per day seven days per week, in addition to his regular weekday work schedule. The employer provided claimant with the car, which claimant drove to and from work and parked at home. Thus, because travel was a necessary incident of claimant's employment, we conclude that claimant was a "traveling employee" at the time of his injury. See Savin Corp. v. McBride, 134 Or App 321 (1995); PP&L v. Jacobson, supra (Where claimant's job necessitated travel on a daily basis, claimant was a "traveling employee").

"[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.'" Savin Corp. v. McBride, supra, 134 Or App at 324. Because we have found that claimant has the status of a traveling employee, the question becomes whether his ten block detour to drop his children off at school constituted "a distinct departure on a personal errand" which was a personal mission so unrelated to his work that his injury during that detour was outside the course and scope of his employment.

SAIF contends that claimant's activity at the time of his injury was a purely personal mission and therefore the injury is not compensable. SAIF's argument in this regard is very similar to the employer's argument in Savin Corp. v. McBride, supra. The Savin court responded, "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." 134 Or App at 325 (citing Proctor v. SAIF, supra; Slaughter v. SAIF, 60 Or App 610 (1982)) (emphasis added).[3]

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[2] In reaching this conclusion, the ALJ applied the seven part test enunciated in Mellis v. McEwen, Hanna,Gisvold, 74 Or App 571, rev den 300 Or 249 (1985). That test is not determinative where the injured worker is a "traveling employee." See SAIF v. Reel, 303 Or 210 (1987); Proctor v. SAIF, 123 Or App 326, 329 (1993); PP&L v. Jacobson, 121 Or App 260 (1993).

[3] SAIF argues that claimant was not a traveling employee at the time of his injury, because the employer-provided car was not being used for a business purpose at the time of the injury. If claimant was not a traveling employee, the argument might be persuasive. However, because claimant is a traveling employee, (i.e., travel is a necessary incident to his employment generally), he may be covered even though he was not actually working at the time of the injury. See SAIF v. Reel, supra.

In Savin, the traveling employee was injured while returning from a three to five block detour for the purpose of conducting personal bank business after her normal working hours and before traveling home. Reasoning that the claimant's detour was reasonably related to her traveling status, the court concluded that the claimant's injury was compensable.

Here, as in Savin, claimant's detour was brief in time and short in distance. In other words, it was "minimal in terms of both time and space. Such a departure is so transitory and slight as to be disregarded as insubstantial." 134 Or App at 326 (citation and footnote omitted). Considering claimant's travel status, the insubstantial nature of his detour, and the employer's course of conduct in approving such travel (for claimant and other employees), we conclude that claimant's injury is compensable. See ORS 656.005(7)(a).

Finally, we note SAIF's request that we take administrative notice of documents[4] submitted for the first time on review and claimant's objection to that request. We need not decide whether the disputed evidence would be properly subject to notice because, even if these submitted documents were considered, they would not affect the result in this case.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review in prevailing over SAIF's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 7, 1995 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 is awarded a $3,500 attorney fee, payable by SAIF.

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[4] These documents are represented as copies of a map of the area where claimant lives and works (and was injured) and a page from a telephone book listing the address of claimant's September 21, 1994 morning appointment.

In the Matter of the Compensation of
STACY L. SORENSEN, Claimant
WCB Case No. 95-02198
ORDER ON REVIEW
Hunnicutt, et al, Claimant Attorneys
John Snarskis, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that dismissed as untimely claimant's hearing request concerning the insurer's December 6, 1994 denial of claimant's claim for a bilateral carpal tunnel syndrome condition. On review, the issue is timeliness of the hearing request.

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

Claimant received the December 6, 1994 denial on December 8, 1994. Her request for hearing, dated February 17, 1995, was received by the Board's Hearings Division on February 21, 1995. There is no dispute that claimant's hearing request was not timely filed. Therefore, the issue is whether claimant established good cause for her untimely hearing request. ORS 656.319(1).[1] Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234 (1985).

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[1] Subsequent to the date of hearing, the legislature amended ORS 656.319(1). Or Laws 1995, ch 332, § 39 (SB 369, § 39). The result is the same under either version.

On review, claimant argues that she has established good cause because she underwent a left carpal tunnel release surgery on February 6, 1995, the final date to timely request hearing. We disagree.

We have held that medical incapacity may establish good cause for failure to timely file a hearing request where the worker is sufficiently incapacitated during the relevant period following a denial to prevent him or her from seeking a timely hearing request. See Patricia J. Mayo, 44 Van Natta 2260 (1992); Jerry M. McClung, 42 Van Natta 400 (1990). In both Mayo and McClung, the claimants were essentially physically and/or mentally incapacitated due to medications and multiple surgeries and hospitalizations from the time before they received denials of their claims until after the expiration of the 60 day period in which to timely request a hearing.

However, the facts of this case do not rise to the level of medical incapacity that would satisfy the good cause standard. Claimant does not allege that she was medically incapacitated from requesting a hearing before February 6, 1995, the date of her left carpal tunnel release surgery. Prior to surgery, claimant had almost two months to request a hearing from the denial. In addition, the evidence shows that claimant was not medically or mentally incapacitated during this two month period. On the contrary, during this period, claimant actively sought financial help from other governmental agencies. Claimant presents no evidence as to why she could not have requested a hearing during this period. Claimant's lack of diligence does not establish good cause. Cogswell, supra.

ORDER

The ALJ's order dated June 9, 1995 is affirmed.

January 24, 1996 Cite as 48 Van Natta 165 (1996)

In the Matter of the Compensation of
KATHLEEN A. WILFONG, Claimant
WCB Case No. 94-03815
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that set aside a Determination Order that had classified claimant's bilateral wrist claim as nondisabling. Claimant cross-requests review, moving that we remand this matter for the admission of additional evidence regarding the classification issue. Claimant also cross-requests review of the ALJ's attorney fee award. On review, the issues are claim classification, remand and attorney fees. We deny the remand motion and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Classification

Relying on Sharman R. Crowell, 46 Van Natta 1728 (1994), the ALJ found that claimant's claim should be classified as disabling, because her physician had released her to modified work following the onset of her wrist symptoms. SAIF asserts that the legislature overruled Crowell when it enacted Senate Bill 369, Or Laws 1995, ch 332, on June 7, 1995. Therefore, it asserts, under amended ORS 656.005(7)(c), claimant's claim is not disabling because no temporary benefits were due and payable. We agree.

Amended ORS 656.005(7)(c) now defines a "disabling compensable injury" as an "injury which entitles the worker to compensation for disability or death." An injury is "not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury." Amended ORS 656.005(7)(c).

That language legislatively overruled Sharman R. Crowell when it amended ORS 656.005(7)(c). Karren S. Maldonado, 47 Van Natta 1535 (1995). Therefore, "it is not enough that a claimant be limited to modified work; there must also be an entitlement to temporary benefits or a reasonable expectation of permanent disability." Maldonado, supra, 47 Van Natta at 1536.

Here, claimant was released to, and performed, modified work. She was not, however, entitled to temporary disability. The record establishes that, after claimant was released to modified work, she left work for "worker's compensation" purposes half of each day on May 21, May 28, and June 4, 1993. (Exs. 22, 23).[1] Because claimant did not miss more than three days of work as a result of her claim, she is not entitled to any time loss benefits. Amended ORS 656.210(3); amended 656.212(1); Melton I. Jackson, Jr., 42 Van Natta 264, 266 (claimant who missed three non-consecutive days of work due to compensable injury not entitled to compensation). Therefore, no temporary benefits were due and payable, and her claim is not disabling unless there is proof of a reasonable expectation of permanent disability. Amended ORS 656.005(7)(c); Clifford E. Clark, 47 Van Natta 2310 (1995). There is not. On January 27, 1994, claimant's treating physician declared her medically stationary and concluded that she had no permanent impairment. (Ex. 19). That controverts any assertion that there was a reasonable expectation of permanent disability resulting from claimant's compensable wrist condition. See Karren S. Maldonado, supra, 47 Van Natta at 1536.

For these reasons, we conclude that, under amended ORS 656.005(7)(c), claimant's claim is not disabling. Consequently, we reverse the ALJ's decision classifying the claim as disabling.

Claimant asserts that amended ORS 656.005(7)(c) violates her "equal protection" rights under Article I, Section 20, of the Oregon Constitution.[2] We disagree.

Article I, section 20, provides that "[n]o law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens." The first inquiry is whether there exists a "class" that is cognizable under Article I, section 20. In evaluating that issue, "we must first determine whether the class "'is created by the challenged law itself' or 'by virtue of characteristics * * * apart from the law in question.'" Sealey v. Hicks, 309 Or 387, 397 (1990) (quoting State v. Clark, 291 Or 231, 240 (1981)). "Those characteristics said to exist apart from the law itself include 'antecedent personal or social characteristics or societal status * * *.'" Ag West Supply v. Hall, 126 Or App 475, 478 (1994) (quoting Hale v. Port of Portland, 308 Or 508, 525 (1989)). Only classes based on those characteristics are considered classes for purposes of Article I, section 20; groups created by virtue of a challenged statute are not considered to be classes for the purposes of Article I, section 20. Hicks, supra, 309 Or at 397.

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[1] Claimant also left work for 2.5 hours for "therapy" on May 18, 1993. (Exs. 22, 23-2). Assuming that the therapy was related to her compensable wrist condition, because claimant left work for less than four hours, she is not entitled to temporary disability benefits for that time. ORS 656.210(4). During the relevant time, claimant also left work early and took sick leave on several occasions. (Exs. 22, 23). We do not consider any of that time in determining claimant's entitlement to temporary disability benefits.

Also, we note that, on May 11, 1993, claimant's treating physician released her to four hours of work per day for two weeks. (Ex. 7). Claimant did not comply with that restriction. Instead, she worked more than four hours per day for the ensuing two weeks, except for May 21, when she took off four hours for workers' compensation purposes. (Ex. 22). On the other days, claimant worked between 5.5 and 8 hours, taking the balance off as sick leave, to attend therapy (see above), or for an unexplained reason. (Id.) Claimant asserts that, because the employer failed to establish that her sick leave was not "workers' compensation" leave, she has established her entitlement to temporary disability compensation. We disagree. There is insufficient evidence regarding why claimant took sick or unexplained leave during this time (claimant did not appear or testify at hearing). Consequently, we do not consider that leave in analyzing the temporary disability issue.

[2] Claimant also asserts that amended ORS 656.005(7)(c) violates her equal protection rights under the Fourteenth Amendment of the federal constitution. In view of claimant's failure to refer us to any federal authority, and her concession that, "[i]n most cases, a law which is sufficient to meet the requirement of Article [I], section 20 will also meet the requirement of the Fourteenth Amendment * * *," Claimant's Brief at 3, we do not consider her federal constitutional arguments.

Here, claimant asserts that amended ORS 656.005(7)(c) impermissibly classifies injured workers based on "the common understanding of the word 'disabled.'" Claimant's Brief at 4. We disagree. The classification that claimant challenges is created wholly by statute. Amended ORS 656.005(7)(c) potentially divides injured workers into at least three groups: Persons to whom "no temporary benefits are due and payable;" those to whom benefits are due and payable; and those with respect to whom there is a reasonable expectation of permanent disability. Those "classes" do not exist apart from the Workers' Compensation Act: Whether temporary benefits are or are not due and payable, and whether there is a reasonable expectation of permanent disability depends solely on the terms of the Act, not on antecedent personal or social characteristics or societal status. Ag West Supply v. Hall, supra 126 Or App at 478. Therefore, the classification claimant challenges does not involve a "class" for Article I, section 20, purposes. Accordingly, we reject her "equal protection" arguments.

Remand

Claimant moves for remand of this case to the ALJ for further evidence taking in light of the amendments to ORS 656.005(7)(c). We deny the motion.

We may remand a case to an ALJ for further evidence taking if we find the case improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand, the moving party must establish, among other things, that the evidence is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Here, claimant has neither identified any evidence that he would submit on remand nor established that any such evidence would be reasonably likely to affect the outcome of the case. Under the circumstances, we find no basis for granting claimant's remand motion; therefore, we deny it.

Attorney Fees

Claimant cross-requests review of the ALJ's attorney fee award. Because we have concluded that claimant's claim is non-disabling and, hence, that she is entitled to no additional compensation, we reverse the ALJ's attorney fee award. Consequently, we do not address claimant's attorney fee arguments.

ORDER

The ALJ's order dated May 4, 1995 is reversed. The Determination Order ordering that claimant's claim remain classified as nondisabling is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

Board Member Hall concurring.

I write separately to express my belief that, in certain cases, remand may be appropriate in claim classification disputes that fall under amended ORS 656.995(7)(B)(c). When the record was developed under the former law, and yet contains some evidence of a colorable claim for reclassification under the amended law (that is there is a reasonable expectation that permanent disability will result from the injury), I believe that remand may be appropriate for further development of the record. Clifford E. Clark, 47 Van Natta 2310 (1995) (Member Hall, specially concurring). Here, there is no such evidence in the record. In fact, claimant's treating doctor has already concluded that claimant has not suffered any permanent disability as a result of her injury. It is unlikely, therefore, that remand would affect the outcome of this issue. Therefore, remand is not appropriate.

As the lead opinion states, there are two ways to establish a disabling claim under amended ORS 656.005(7)(B)(c). One way is to show a reasonable expectation that permanent disability will result from the injury. The other way is to establish that temporary total or partial disability benefits are due and payable. See amended ORS 656.005(7)(B)(c).

I am concerned about cases in which a claimant has performed modified work and, hence, is potentially eligible for temporary partial disability benefits. I agree that evidence that a claimant is performing modified work is not enough, by itself, to establish a disabling claim. When, however, a claimant establishes an entitlement to temporary partial disability compensation as a result of the performance of modified work, the claim should be classified as disabling. In those cases, although the modified work would not, by itself, result in a disabling classification, the entitlement to temporary partial disability would. Clifford E. Clark, supra, (Member Hall, specially concurring). Here, the record establishes that, although claimant was released to modified work, she is not entitled to temporary partial disability compensation for the reasons stated in the lead opinion.

January 25, 1996 Cite as 48 Van Natta 168 (1996)

In the Matter of the Compensation of
GEANA K. CANNON, Claimant
WCB Case No. 94-08747
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

On June 22, 1995, we withdrew our May 26, 1995 order that: (1) affirmed that portion of an Administrative Law Judge's (ALJ's) order which set aside a "de facto" denial of claimant's cervical condition; (2) reversed that portion of the ALJ's order that set aside a "de facto" denial of claimant's bilateral upper extremity overuse syndrome; and (3) modified the ALJ's attorney fee award. We took this action to consider the insurer's motion for reconsideration. While this case has remained pending reconsideration, the parties have submitted a proposed "Settlement Stipulation and Order," which is designed to resolve all issues raised or raisable between them, in lieu of all prior orders.

Pursuant to the stipulation, the parties agree that both our order and the ALJ's order will be "set aside." The parties further stipulate that claimant's hearing request "be dismissed with prejudice as to all issues raised or raisable."

We have approved the parties' stipulation, thereby resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLIFFORD L. CAREY, Claimant
WCB Case No. 94-13671
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Fred Meyer, Inc. (Fred Meyer), a self-insured employer, requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its October 7, 1994 denial of claimant's occupational disease claim for a low back condition; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) denial of the same condition. On review, Fred Meyer asserts, alternatively, that claimant's low back claim is an aggravation of a prior low back claim, or that Liberty is the responsible carrier. Fred Meyer also asserts that the ALJ meant to uphold its October 7, 1994 denial and to set aside its May 12, 1995 denial, and asks us to modify the order accordingly. On review, the issues are aggravation, compensability and responsibility. We affirm in part and modify in part.

FINDINGS OF FACT

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

Fred Meyer was incorporated in Oregon until December 1981; thereafter, it became a Delaware Corporation. (Ex. 75).

Claimant's current low back claim arose on July 21, 1994, following a lifting incident at work.

CONCLUSIONS OF LAW AND OPINION

Aggravation

Fred Meyer first asserts that claimant's current low back condition is a compensable aggravation of claimant's 1981 low back injury claim. We disagree.

Claimant has worked for Fred Meyer for over thirty years performing heavy warehouse work. Fred Meyer was incorporated in Oregon until 1981; thereafter, it became a Delaware corporation. (Ex. 75).[1]

In April 1981, claimant filed a claim with Fred Meyer for a pulled low back muscle. (Exs. 1, 3). Dr. Dresher, claimant's long-time treating surgeon, diagnosed an L4-5 disc herniation. (E.g., Ex. 5-1). Dr. Duff, examining physician, diagnosed impending or actual disc rupture. (Ex. 7-2). Fred Meyer closed the claim in 1981, awarding claimant unscheduled permanent disability. (Ex. 9). After Dresher performed an L4-5 laminectomy in 1982, claimant was awarded additional permanent disability. (Ex. 16).

Claimant thereafter sustained additional work-related low back injuries. His present claim arose in July 1994, after a lifting incident at work. Dr. Dresher subsequently diagnosed claimant with pervasive lumbar degenerative disc disease. That condition is the subject of this dispute.

A compensable aggravation requires proof of a worsened condition resulting from a compensable condition. ORS 656.273(1).[2] The record does not specifically identify claimant's compensable 1981 condition. On this record, we find that the only conditions Fred Meyer could have accepted were a pulled low back muscle and L4-5 disc herniation or rupture. Claimant presently seeks compensation for multilevel lumbar degenerative disc disease. Because that condition is something other than claimant's accepted 1981 condition, and because there is insufficient evidence that claimant's current condition is the result of his accepted 1981 condition, we reject Fred Meyer's aggravation argument.

Compensability

Fred Meyer asserts that claimant has failed to establish the compensability of his lumbar degenerative disc condition under an occupational disease theory. We disagree.

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[1] In this order, Fred Meyer refers to the Delaware corporation, unless the context requires otherwise.

[2] The legislature amended ORS 656.273 in June 1995. Or Laws, ch 332, § 31 (SB 369, § 31). Those amendments are not material to this case.

To establish a compensable occupational disease claim for his lumbar degenerative disc condition, claimant must prove by a preponderance of the evidence that his work activities were the major contributing cause of the onset or pathological worsening of that condition. Amended ORS 656.802(2). He has met that burden.

In August 1994, Dr. Dresher diagnosed "a new sprain[3] of [claimant's] back which is afflicted with degenerative disc disease" related to claimant's July 1994 lifting incident (Ex. 56; see Ex. 63).[4] On October 7, 1994, Integra Claims Service (Integra), Fred Meyer's current claims processor, denied the compensability of and responsibility for claimant's lumbar strain and degenerative disc disease, and disclaimed to a prior claims processor. (Ex. 66).

In November 1994, Dr. Dresher concluded that claimant's July 1994 work incident was not the cause of his "ongoing current problem;" rather, Dresher felt that claimant's long work history and prior work injuries cumulatively caused his present low back condition. (Ex. 72). Thereafter, Dresher concluded that claimant's 30-plus year work history with Fred Meyer had caused an acceleration of his underlying degenerative condition and was a "very significant cause of his ongoing back difficulty." (Exs. 77, 81). Dresher further concluded that claimant's low back condition had worsened since 1981 and that his employment was the major cause of that worsening. (Ex. 77; see Ex. 81-2).

Drs. McKillop and Reimer examined claimant on Fred Meyer's behalf. They concluded that claimant's warehouse work involves some lumbar microtrauma that could advance his degenerative spinal condition. (Ex. 83-7). They found no off-work factors that might have contributed to claimant's degenerative condition. (Id. at 9). Dr. Dresher concurred with that report. (Ex. 88). Drs. McKillop and Reimer later supplemented their report, concluding that claimant's work activities from 1981 forward were the major contributing cause of his current low back problem and need for treatment or of a pathological worsening of his degenerative disc condition. (Ex. 87-2).

Meanwhile, Fred Meyer disclaimed responsibility for claimant's low back occupational disease claim to Liberty, which had been on the risk from February 1984 to January 1987. (Ex. 75). Fred Meyer eventually also issued a denial of the claim. (Ex. 89).

Fred Meyer appears to assert that, because claimant's degenerative condition preexisted 1981, the year it became a Delaware corporation, claimant must establish a pathological worsening of the degenerative condition to prove a compensable occupational disease. On this record, we find insufficient evidence that claimant's widespread lumbar degenerative condition existed before 1981. In any event, even if we accept Fred Meyer's characterization of claimant's condition, claimant prevails.

The reports of both Dr. Dresher and Drs. McKillop and Reimer establish a pathological worsening of claimant's degenerative condition since 1981. Dr. Dresher specifically concluded that claimant's degenerative condition had worsened since 1981, that his work history had caused an acceleration of the underlying condition, and that his employment was the major cause of the worsening. That is sufficient to establish a pathological worsening of claimant's degenerative condition that was caused, in major part, claimant's post-1981 work activities.

Drs. McKillop and Reimer's final report supports that proposition: It specifically states that claimant's work activities from 1981 forward were the major contributing cause of his current low back problems and need for treatment or of a pathological worsening of his degenerative disc condition. Moreover, McKillop and Reimer (and Dresher, by way of concurrence) identified no off-work factors that could have contributed to claimant's degenerative condition. As a whole, we find those reports more than sufficient to meet claimant's burden of proof. Consequently, claimant has established a compensable occupational disease claim for his lumbar degenerative disc condition.

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[3] Although Dr. Dresher initially diagnosed a lumbar strain (Exs. 56, 63), he eventually focused solely on claimant's degenerative condition (Ex. 72), eventually reading a "working diagnosis" of lumber degenerative disc disease. (Ex. 77; see Exs. 81, 83-6, 88). On this record, we find that claimant's low back strain, if he had one, is a manifestation of his degenerative condition. Therefore, we do not analyze the strain separately.

[4] The legislature amended ORS 656.802 in June 1995. SB 369, § 56. We need not consider those amendments because, in this case, the analysis under the former and present law is the same.

Responsibility

The remaining issue concerns who is responsible for claimant's lumbar degenerative disc condition. Fred Meyer asserts that Liberty is responsible. We disagree.

During the 30-odd years of claimant's employment, Fred Meyer was either self-insured or, between 1984 and 1987, insured by Liberty. No one has accepted claimant's lumbar degenerative disc disease.[5] Therefore, we analyze this case under the last injurious exposure rule. SAIF v. Yokum, 132 Or App 18, 23-24 (1994). That rule provides that where, as here, a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Here, claimant first sought treatment in 1981 for low back symptoms that were related to an L4-5 disc herniation. Claimant intermittently treated for low back pain thereafter. He was not, however, specifically diagnosed with multilevel lumbar degenerative disc disease until 1987, when Fred Meyer was on the risk. In March 1987, Dr. Dresher diagnosed "degenerative disc disease with increasing x-ray changes." (Ex. 24). A May 1987 MRI revealed degenerative abnormalities from L3 to S1. (See Exs. 5-9, 27). Before 1987, the medical evidence had focused on claimant's L4-5 dysfunction. (E.g., Exs. 2, 5-1, -2, 12). On this record, we find that claimant first sought treatment in 1987 for symptoms of the specific degenerative condition for which he now seeks compensation.[6]

Consequently, we initially assign responsibility for claimant's lumbar degenerative disc disease to Fred Meyer. Boise Cascade Corp. v. Starbuck, supra, 296 Or at 244. Fred Meyer can shift responsibility to Liberty, the prior carrier, by showing that claimant's work exposure while Liberty was on the risk was the sole cause of claimant's current low back condition, or that it was impossible for conditions while Fred Meyer was on the risk to have caused that condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985).

Fred Meyer has not met its burden. The medical evidence establishes that claimant's work activities from 1981 to present, which includes Liberty's and Fred Meyer's exposures, caused his current low back condition. That undercuts any assertion that Liberty's exposure was the sole cause of that condition or that it was impossible for conditions during Fred Meyer's exposure to have caused it. Accordingly, Fred Meyer remains responsible for claimant's lumbar degenerative disc disease.

For these reasons, we affirm the ALJ's decision setting aside Fred Meyer's October 7, 1994 denial. We also set aside Fred Meyer's March 13, 1994 disclaimer and its May 12, 1995 denial. In doing so, we acknowledge Fred Meyer's request that we uphold its October 7, 1994 denial as it pertains to claimant's lumbar strain. Because we have found the strain (or sprain) to be a manifestation of claimant's degenerative disease, see note 3 supra, and because we have concluded that Fred Meyer is responsible for that condition, we deny Fred Meyer's request.

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[5] Fred Meyer asserts that Liberty's 1985 claim is the last accepted claim in this record. There is insufficient evidence regarding what, if anything, Liberty may have accepted. Liberty's file regarding that claim was destroyed, and we have the benefit only of an internal computer record that states that claimant made a claim in 1985 for "strained low back," but does not state whether the claim was accepted or denied. (Ex. 84).

[6] Fred Meyer asserts that claimant first sought treatment for his current low back condition in 1981. We disagree. Drs. Dresher and Duff diagnosed lumbar disc pain and probable L4-5 disc herniation (which was later surgically treated). (See Exs. 5-1, 7-2, 8). There is insufficient evidence that, in 1981, claimant even had, much less sought treatment for, the multilevel degenerative condition he has today. Moreover, even if claimant's "onset of disability" was in 1981, for the reasons stated in the our compensability analysis, responsibility would shift to Fred Meyer, because the record establishes that claimant's later employment with Fred Meyer actually contributed to a worsening of his degenerative condition. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992).

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 438-15-010(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 Fred Meyer. 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 8, 1995 is affirmed in part and modified in part. Fred Meyer's March 13, 1994 disclaimer and May 12, 1995 denial are set aside. The claim is remanded to Fred Meyer for processing according to law. Claimant's attorney is awarded $1,000 for services on review, payable by Fred Meyer. The remainder of the ALJ's order is affirmed.

January 25, 1996 Cite as 48 Van Natta 172 (1996)

In the Matter of the Compensation of
SHARON M. CAROTHERS, Claimant
WCB Case No. C6-00136
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Jolles, et al, Claimant Attorneys

Reviewed by Board Members Neidig and Gunn.

On January 12, 1996, 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.

Parties may dispose of all matters concerning a claim, except for medical services, with a CDA "subject to such terms and conditions as the Workers' Compensation Board may prescribe." ORS 656.236(1). The worker, insurer or self-insured employer may request disapproval of the disposition within 30 days of its submission to the Board. ORS 656.236(1)(a)(C). Notwithstanding this provision, however, the CDA may provide for waiver of the 30 day period if the worker was represented by an attorney at the time the worker signed the disposition. ORS 656.236(1)(b).

Effective January 1, 1996, the Board promulgated OAR 438-009-0022(3)(k) (WCB Admin. Order 2-1995). This rule now requires that the first page of the CDA contain a "statement indicating whether or not the parties are waiving the '30-day' approval period of ORS 656.236(1)(a)(C) as permitted by ORS 656.236(1)(b)." The Board also promulgated OAR 438-009-0022(2) (WCB Admin. Order 2-1995), requiring the insurer or self-insured employer to "provide the claimant with information explaining claims dispositions in a separate enclosure accompanying the proposed" CDA and providing that the "Board shall prescribe by a bulletin the specific form and format for the enclosure."[1]

Here, the CDA provides that the parties agree to waive the 30-day period. Thus, the CDA complies with the statutes for waiving the "cooling off" period. The CDA, however, does not comply with OAR 438-009-0022(3)(k) because there is no statement on the summary page indicating that the parties are waiving the "30-day" approval period. The CDA also does not comply with OAR 438-009-0022(2) because the enclosure accompanying the CDA is in the form prescribed by the Department rather than the Board.

Because the CDA contains at least one signature from a party dated before the Board's rules became effective, however, OAR 438-009-0022(2) and (3)(k) do not apply. Therefore, because the CDA otherwise is in accordance with the terms and conditions of the Board, we approve the parties' CDA. An attorney fee of $1,000, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

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[1] As with all Board rules pertaining to CDAs, these rules apply to any CDA filed with the Board on or after January 1, 1996 where all signatures contained in the CDA are dated on and after January 1, 1996. WCB Admin. Order 2-1995.

In the Matter of the Compensation of
RONALD J. LAMB, Claimant
WCB Case Nos. 94-10554 & 94-02799
ORDER DENYING MOTION TO DISMISS
Bischoff & Strooband, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Claimant has requested review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld denials of claimant's injury claim issued by Barrett Business Services. Contending that a party to this proceeding (the SAIF Corporation) did not receive timely notice of claimant's appeal, Barrett has moved for an order dismissing the request for review. The motion is denied.

FINDINGS OF FACT

Claimant requested a hearing regarding denials of his injury claim issued by Barrett. Prior to claimant's hearing request, the Department had issued an investigation report which concluded that claimant was directly employed by Barrett. The Department further determined that Space Solutions, Inc. was a subject and noncomplying employer.

In light of the Department's findings, claimant moved for joinder of the Department as a party to the pending hearing. Although the motion was initially granted, it was subsequently modified to list the Department as an interested party for informational purposes, but not to formally join the Department as a party to the proceeding. As a potential statutory assigned claims agent for Space Solutions (in the event that Space Solutions was later determined to be claimant's subject employer and should the Department issue a noncomplying employer order referring the claim to SAIF for processing under ORS 656.054), SAIF was also listed as a party on formal announcements regarding the pending hearing.

Prior to closure of the record, SAIF announced that it would no longer be participating in the case. In light of amended ORS 656.054, SAIF noted that it was no longer the only carrier who could serve as a statutory assigned claims agent. Since it had not been assigned the claim (no noncomplying employer order had issued), SAIF reasoned that it could not accommodate the Department's request to further participate in the case.

The ALJ's Opinion and Order issued on October 3, 1995 and was amended on October 6, 1995. Concluding that claimant's injury did not arise out of the course and scope of his employment, the ALJ upheld Barrett's denials. Copies of the orders were mailed to claimant, Space Solutions, Barrett, its claims administrator, the Department, and SAIF, as well as the aforementioned individuals / entities' legal representatives (if any).

On November 1, 1995, the Board received claimant's October 31, 1995 request for review of the ALJ's order. The request included a Certificate of Mailing, certifying that a copy of the request had been mailed on October 31, 1995 to the following individuals / entities: Barrett (including its claims administrator and counsel); the Department; and Space Solutions.

A computer-generated acknowledgment of claimant's October 31, 1995 request for review was mailed by the Board on November 3, 1995. The acknowledgment was mailed to Barrett, its attorney and claims administrator, and to Space Solutions.

On January 4, 1996, Barrett filed its motion to dismiss. Noting that claimant's request for review "was not copied to a party, SAIF Corporation," Barrett argued that claimant's appeal was jurisdictionally defective.

CONCLUSIONS OF LAW

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to 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). Yet, in the absence of prejudice to a party, timely service of a request for review on an employer's insurer or the attorney for the party is sufficient compliance with ORS 656.295(2) to vest jurisdiction with the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975).

Here, Barrett seeks dismissal of claimant's request for review based on a theory that claimant neglected to provide timely notice of his appeal to SAIF (who Barrett contends is a "party" to this proceeding). In light of amended ORS 656.054 and particularly in the absence of a Department order finding Space Solutions to be a noncomplying employer, it is questionable whether we would agree with Barrett's characterization of SAIF's status as a "party" in this case. Nevertheless, we need not resolve that question because, even if we considered SAIF to be a party, it is undisputed that Space Solutions received timely notice of claimant's appeal.

Inasmuch as SAIF would be serving as Space Solutions' statutory assigned claims agent (under Barrett's argument) and since the record does not support a conclusion that SAIF has been prejudiced by its failure to receive actual notice of claimant's appeal, we conclude that claimant's timely notice to Space Solutions (as well as to the Department, the entity who would be authorized to refer the claim to SAIF as an assigned claims agent under amended ORS 656.054) constitutes adequate compliance with ORS 656.295(2). See Argonaut Insurance v. King, supra; Juan A. Hernandez, 47 Van Natta 2421 (1995); Robert K. Warren, 47 Van Natta 84 (1995). Consequently, we retain appellate jurisdiction to consider claimant's appeal.

Accordingly, Barrett's motion to dismiss is denied. In light of these circumstances, the following revised briefing schedule shall be implemented. Barrett's respondent's brief must be filed within 21 days from the date of this order. (If either the Department or SAIF wish to file a respondent's brief, such a submission must likewise be filed within 21 days from the date of this order.) Claimant's reply brief must be filed within 14 days from the date of mailing of Barrett's brief. Thereafter, the case will be docketed for Board review.

IT IS SO ORDERED.

January 25, 1996 Cite as 48 Van Natta 174 (1996)

In the Matter of the Compensation of
MIKE D. MICHELI, Claimant
WCB Case No. 95-03047
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
SAFECO Legal, Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Thye's order that increased claimant's scheduled permanent disability for loss of use or function of the left foot/leg from 5 percent of the foot (6.75 degrees), as awarded by an Order on Reconsideration, to 7 percent of the leg (10.5 degrees). On review, the issue is extent of scheduled permanent disability.

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

The Order on Reconsideration issued on March 9, 1995, rather than on March 9, 1994.

Claimant contends that the ALJ erred in relying on a medical arbiter's report of an examination that was performed before, but not prepared until after the Order on Reconsideration issued. We disagree. See Daniel L. Bourgo, 46 Van Natta 2505 (1994) (interpreting former ORS 656.268(6)(a) and former ORS 656.268(7) to permit admission of an initial medical arbiter report that was requested, but not completed, before expiration of the statutory time limit for the Department's reconsideration).

ORDER

The ALJ's order dated June 26, 1995 is affirmed.

In the Matter of the Compensation of
SAMUEL PRADO, Claimant
WCB Case No. 95-05423
ORDER ON REVIEW (REMANDING)
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Neal's order that dismissed as premature claimant's hearing request from the insurer's "de facto" denial of a disc bulge with lumbosacral "radiopathy." On review, the issue is dismissal. We vacate and remand.

FINDINGS OF FACT

On May 5, 1995, the Hearings Division received claimant's May 4, 1995 hearing request raising, among other issues, the issue of a "'[d]e facto' denial of disc bulge with lumbosacral radiopathy." On June 19, 1995, the Hearings Division received the insurer's June 16, 1995 response to claimant's hearing request. In that response, the insurer stated that it denied the relief claimant seeks. Specifically, the insurer stated that "[t]he claim has been properly processed to date and the employer knows of no further relief to which claimant is entitled."

The matter was set for hearing August 4, 1995. On June 22, 1995, the Hearings Division received the insurer's June 21, 1995 Motion for Dismissal. On June 27, 1995, the Hearings Division received claimant's response to the insurer's motion. By Dismissal Order dated July 13, 1995, the ALJ granted the insurer's motion to dismiss, finding that claimant's hearing request was premature. No hearing was convened.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that amended ORS 656.262(6)(d) applied retroactively to claimant's claim. Furthermore, the ALJ concluded that claimant's hearing request for a "de facto" denial did not comply with the requirements of amended ORS 656.262(6)(d). Therefore, the ALJ dismissed claimant's hearing request as premature. On review, claimant renews his argument that he complied with the requirements of amended ORS 656.262(6)(d) through his written hearing request. We agree with claimant.

After claimant filed his hearing request and before the ALJ issued her order, the legislature enacted Senate Bill 369 which, inter alia, amended ORS 656.262(6)(d). Or Laws 1995, ch 332, § 28(6)(d) (SB 369, § 28(6)(d)). Amended ORS 656.262(6)(d) prohibits a worker from alleging a "de facto" denial at any hearing or other proceeding on the claim if the worker did not provide a written objection to the carrier's notice of acceptance.

As a preliminary matter, we determine that amended ORS 656.262(6)(d) applies retroactively to claimant's claim. In this regard, the legislature explicitly stated its intent that the Act "is intended to be fully retroactive unless a specific exception is stated[.]" SB 369, § 66(1). None of the exceptions listed in section 66 of SB 369 apply to the current matter. Therefore, we conclude that amended ORS 656.262(6)(d) applies retroactively to claimant's claim. See Guillermo Rivera, 47 Van Natta 1723 (1995) (applying amended ORS 656.262(6)(d) retroactively to the claimant's claim).

Subsequent to the ALJ's order, in Guillermo Rivera, supra, we addressed the issue of whether a written request for hearing can serve as a written communication objecting to a carrier's notice of acceptance. There, two days before hearing, the claimant filed an additional written request for hearing alleging a "de facto" of a cervical strain. Shortly before hearing, the self-insured employer accepted the cervical strain. We found that the claimant's additional request for hearing constituted "communication in writing" to the employer of claimant's objections to the notice of acceptance pursuant to amended ORS 656.262(6)(d). The employer had 30 days to respond to the claimant's written communication concerning the notice of acceptance. Since the employer accepted the cervical strain before the hearing and effectively revised the notice of acceptance to include that injury, we concluded that the provisions of amended ORS 656.262(6)(d) were satisfied. 47 Van Natta at 1724.

In reaching that conclusion, we noted that, had the employer not accepted the cervical strain on the date of hearing (two days after the claimant's "written communication"), the employer could have challenged the claimant's cervical "de facto" denial allegation as premature. In making this notation, we reasoned that, pursuant to amended ORS 656.262(6)(d), a claimant's failure to first provide written communication to the carrier to allow it 30 days within which to respond precludes the claimant from alleging a "de facto denial" at any hearing or other proceeding. Id. at 1724 n1.

Here, claimant's written May 5, 1995 hearing request alleging a "de facto" denial of a disc bulge with lumbosacral "radiopathy" constitutes "communication in writing" to the insurer of claimant's objections to the notice of acceptance under amended ORS 656.262(6)(d). The May 5, 1995 hearing request was a written communication that effectively challenged the scope of the notice of acceptance with regard to the disc bulge with lumbosacral "radiopathy." The insurer had 30 days to respond to claimant's written communication concerning the notice of acceptance. The insurer did not respond within 30 days. However, on June 16, 1995, the insurer responded that the claim had been properly processed and it knew of "no further relief to which claimant is entitled." On the basis of the lapse of more than 30 days and the insurer's ultimate response that, in its opinion, no further relief was due, we conclude that the provisions of amended ORS 656.262(6)(d) were satisfied. Therefore, claimant's hearing request was not premature and the ALJ had jurisdiction over claimant's claim.

We may remand a case to the ALJ should we find that the record has been "improperly, incompletely or otherwise insufficiently developed. " ORS 656.295(5). Here, no hearing was convened and no record was developed because the ALJ determined that claimant's hearing request was premature. Under the circumstances of this case, we find the record insufficiently developed.

Accordingly, we vacate the ALJ's Dismissal Order dated July 13, 1995. Inasmuch as the ALJ dismissed this matter without a hearing, we remand to ALJ Neal for the convening of a hearing.

ORDER

The ALJ's order dated July 13, 1995 is vacated. This matter is remanded to ALJ Neal for further proceedings consistent with this order.

Board Chair Hall specially concurring.

I agree with the lead opinion that the provisions of amended ORS 656.262(6)(d) were satisfied by claimant's written hearing request. Therefore, claimant's hearing request regarding the insurer's "de facto" denial was not premature and the ALJ had jurisdiction over claimant's claim. However, I write to address an alternative basis for finding that the ALJ had jurisdiction over claimant's claim.

In response to claimant's hearing request regarding the "'[d]e facto' denial of disc bulge with lumbosacral radiopathy," the insurer stated in its pleadings, under the heading "denies" that "[t]he claim has been properly processed to date and the employer knows of no further relief to which claimant is entitled." I would find this response to be an express denial of the "disc bulge with lumbosacral radiopathy." Because the insurer expressly denied the relief claimant sought, there was no "de facto" denial. Instead, there was an express denial. Therefore, in the alternative, I would find that the provisions in amended ORS 656.262(6)(d) restricting "de facto" denial claims do not apply to the present case. On this alternative basis, claimant's hearing request was not premature and the ALJ had jurisdiction over claimant's claim.

In the Matter of the Compensation of
RONALD R. ZIMBELMAN, Deceased, Claimant
WCB Case Nos. 93-02973 & 93-02972
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Roseburg Forest Products v. Zimbelman, 136 Or App 75 (1995). In our prior order, we affirmed the Administrative Law Judge's (ALJ) order that set aside the self-insured employer's denial of the deceased worker's myocardial infarction. Ronald R. Zimbelman, 46 Van Natta 1893, on recon 46 Van Natta 2194 (1994). The court has reversed our prior order and remanded for a determination of whether the decedent's emotional condition was caused in major part by his compensable carpal tunnel syndrome and cervical conditions.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. However, we do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that decedent's compensable carpal tunnel syndrome and cervical conditions were the major contributing cause of his myocardial infarction. On Board review, we affirmed the ALJ's order. Ronald R. Zimbelman, supra. We concluded that the decedent's "myocardial infarction was caused, in major part, by his emotional upset over his inability to work, his pain, and his reaction to the employer's processing of his [carpal tunnel syndrome and cervical condition] claim." On the basis of this reasoning, we concluded that decedent's myocardial infarction was compensable as a consequential condition under ORS 656.005(7)(a)(A).

The court reversed our order. Roseburg Forest Products v. Zimbelman, supra. The court reasoned that since a compensable consequential condition is itself a compensable injury, if the decedent's emotional condition was a compensable injury in its own right, then a condition (heart attack) that is caused in major part by the compensable emotional condition may also be compensable as a consequential condition. Noting that we had never found that the original compensable injury was the major contributing cause of the heart attack (but rather had found that the emotional condition was the major cause), the court remanded for a determination of whether the decedent's emotional condition was caused in major part by his carpal tunnel syndrome and cervical condition.

In accordance with the court's instructions, we proceed to determine whether the decedent's emotional condition was caused in major part by the compensable carpal tunnel syndrome and the cervical condition. In conducting this reconsideration, we acknowledge the court's footnote, in which it discussed our finding that the decedent's emotional state was also attributable to his reaction to the processing of his claim. The court explained that a claimant's reaction to the amount of compensation and to claims processing is not caused by the compensable injury; it is caused instead by the process by which the claimant is compensated for the injury. The court concluded that because those causes are collateral to the injury, they cannot be considered as "caused by" the compensable injury.

Turning to the medical evidence, five physicians give opinions concerning causation. Dr. Wysham, cardiologist, treated decedent for his myocardial infarction. Dr. Wysham did not find any indication that decedent's carpal tunnel syndrome and cervical conditions played any part in causing decedent's myocardial infarction. (Ex. 50).

Dr. Grossman, an internal medicine specialist, received a history from decedent's widow that, prior to his death, decedent was extremely angry after receiving his mail and finding that his compensation check was less than he believed he was due. Dr. Grossman had a history that decedent had been waiting nervously for the mail, which arrived at about 11:30 a.m. The decedent had remained angry and upset after receiving the check and, within one hour, developed chest pain, dizziness, sweating and vomiting.

Based on this history, Dr. Grossman opined that emotional upset can in some instances trigger a heart attack in patients with preexisting coronary atherosclerosis. Dr. Grossman noted that this kind of emotional experience can elevate blood pressure, and if a susceptible plaque exists, it can rupture and be followed by coronary thrombosis and myocardial infarction.

Addressing claimant's case specifically, Dr. Grossman indicated that the temporal relationship strongly supported a conclusion that decedent's heart attack was triggered by his emotional upset. Dr. Grossman further concluded that since decedent's emotional upset was job related, work must be considered the major factor in his myocardial infarction occurring when it did. (Ex. 51). Dr. Grossman noted that decedent's recent surgery for his cervical condition and his history of smoking were also risk factors for myocardial infarction.

Dr. Toren, a cardiologist, did not directly address the cause of the decedent's emotional condition, but opined that there was no direct evidence in the cardiology literature of an association between a patient's emotional state and myocardial infarction. Dr. Toren further opined that the decedent died from the type of myocardial infarction characterized by plaque rupture and thrombus formation. Dr. Toren opined that this type of myocardial infarction is not likely associated with emotional distress. Dr. Toren believed that it is likely that decedent would have suffered the myocardial infarction even had he been under no stress.

Dr. Teal, a plastic surgeon, indicated that, during his treatment of the decedent for his upper extremity problems, the decedent showed signs of severe stress. Dr. Teal indicated that the stress was manifested by tenseness, perspiration and mild agitation which decedent exhibited after his return to modified work. Dr. Teal indicated that decedent reported a feeling of being harassed because of his inability to work his regular job and anger at the apparent suspicion of his superiors that he might not truly be disabled. Dr. Teal indicated that, while claimant's physical problems and the medical and surgical treatment were obviously stressful, it appeared that the physiological reactions that decedent exhibited were more related to the concerns about his treatment on the job. Based on this observation, Dr. Teal opined that the signs of stress that he observed in decedent were related to problems in dealing with his claim and his modified duty status at work. (Ex. 55A).

Dr. DeMots, a cardiologist, testified at hearing on behalf of the employer. He opined that emotional upset or psychological stress was not associated with myocardial infarctions.

In order to establish compensability of the emotional condition as a compensable consequence of the carpal tunnel and cervical condition claims, it must be established that the compensable carpal tunnel and cervical conditions are the major contributing cause of the emotional condition. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Based on the preponderance of the medical evidence, we are not persuaded that the decedent's emotional condition is a compensable consequence of his carpal tunnel syndrome and cervical condition. Dr. Grossman attributed the decedent's emotional distress to the events surrounding the arrival of the decedent's compensation check and the decedent's belief that the check was less than was due to him. These events pertain to the processing of the decedent's claim. The Zimbelman court has previously reasoned that the stress arising from these events cannot be considered to be caused by the injury. Consequently, these events cannot be attributed to the compensable carpal tunnel and cervical claims.

We likewise are not persuaded by Dr. Teal's opinion which relates claimant's stress partly to "problems in dealing with his claim." Where a physician attributes the major contributing cause of a condition both to the compensable injury and to claims processing without differentiating between the two possible causes, the claimant has failed to establish that the compensable injury is the major contributing cause of the disputed condition. See Douglas R. Barr, 46 Van Natta 963 (1994) (on recon). Under ORS 656.266, the burden of proving that an injury or disease is compensable is upon the worker. In light of the aforementioned unpersuasive medical opinions, we conclude that claimant's beneficiary has not proven that the carpal tunnel and cervical conditions were the major contributing cause of the decedent's emotional condition.

Consequently, we conclude that decedent's myocardial infarction is not compensable. Accordingly, on reconsideration of our order dated September 22, 1994, as reconsidered October 13, 1994, the ALJ's January 3, 1994 order is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

IT IS SO ORDERED.

Member Haynes specially concurring.

Although I concur with the conclusion that claimant's myocardial infarction condition was not compensable because his emotional condition was not compensably related to his accepted conditions, I write separately to provide another reason for this "noncompensability" conclusion. That additional reasoning is as follows.

Even if the decedent's emotional condition was considered to be a compensable consequence of his accepted carpal tunnel and cervical conditions, I would conclude that the decedent's myocardial infarction was not caused in major part by his emotional distress.[1] In reaching this conclusion, I would rely on the opinions of the three cardiologists, Drs. Wysham, Toren and DeMots. These physicians have all opined that there is no causal relationship between the decedent's emotional distress and the myocardial infarction which resulted in his death. As specialists in the field of cardiology, I would find the opinions of Drs. Wysham, Toren and DeMots are entitled to greater weight concerning the cause of the decedent's myocardial infarction than is the contrary medical opinion of Dr. Grossman (internist). See Abbott v. SAIF, 45 Or App 657, 661 (1980) (where medical opinions are divided, we generally rely on physicians who are specialists in the field in question).

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[1] I recognize that our prior order found that there was a causal relationship between the decedent's emotional distress and his myocardial infarction. However, because the court has reversed our prior order, that order is a nullity and I am free to reach a different conclusion on remand. See Kevin P. Silveira, 47 Van Natta 2354, 2357 n. 3 (1995); see also, Dung T. Nguyen, 44 Van Natta 477 (1992) (order on remand reached different conclusion than the order on review); Nancy C. Evenhus, 42 Van Natta 2625 (1990) (since the court had remanded for the Board to review the remaining issues raised by the denial, no finding within an order had yet become final).

January 26, 1996 Cite as 48 Van Natta 179 (1996)

In the Matter of the Compensation of
KATHY D. ELKINS, Claimant
WCB Case No. 94-03145
CORRECTED ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

On January 25, 1996, the Board issued an Order on Review affirming an Administrative Law Judge's (ALJ's) order which: (1) found that the self-insured employer was not responsible for certain medical bills for claimant's current right hip condition; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claims processing. It has come to our attention that the order contains some clerical errors. Specifically, the last phrase of the first paragraph of the order erroneously states that "We reverse." In addition, a "Findings of Fact" section and the phrase "Conclusions of Law and Opinion" have been inadvertently included on Page 1 of the decision. To correct these errors, the Board's January 25, 1996 is withdrawn and replaced by the following order. The parties' rights of appeal shall begin to run from the date of this order.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order which: (1) found that the self-insured employer was not responsible for certain medical bills for claimant's current right hip condition; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claims processing. On review, the issues are compensability, penalties and attorney fees.

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

Claimant sustained a compensable right hip injury in April 1992. The employer accepted a claim for right hip strain, lumbar strain and trochanteric bursitis. Claimant's claim was closed in January 1993. From August 1993 to October 1993, claimant received medical treatment for pain in her right buttock, hip, thigh and knee.

In September 1993, the employer issued a Notice of Intent to Disclaim Responsibility for claimant's ongoing right hip complaints. Claimant requested a hearing, and the parties entered into a Disputed Claim Settlement (DCS). The employer contended, in the DCS, that claimant's current right hip condition was not compensably related to her accepted injury. Further, the DCS stated that the employer's denial, "as supplemented by the contentions of the employer stated herein, "shall remain in full force and effect..." should the ALJ approve the agreement. (Ex. 46-3) (emphasis added) The DCS further provided that the parties desired "to settle all issues, raised or raisable, at this time by entering into the "settlement" (Id.) (emphasis added). On December 30, 1993, the DCS received ALJ approval.[1]

On June 30, 1994, claimant received physical therapy for pain in the right buttock, hip, thigh and knee. The employer denied payment for claimant's medical services during August 1993 to October 1993 and for treatment on June 30, 1994. Claimant requested a hearing regarding the employer's failure to pay for the above mentioned medical billings.

The ALJ found that the parties agreed in the DCS that claimant's then current right hip condition was not compensably related to her accepted injury of April 1992. Further, the ALJ determined that claimant's medical services claim was for that "unchanged" right hip condition. (In reaching this conclusion, the ALJ noted that claimant had not asserted that her hip condition had changed since the DCS). As such, the ALJ concluded that the parties dispute was precluded by the DCS.

On review, claimant does not challenge the employer's contention that the ALJ did not have jurisdiction to review this dispute. Nevertheless, because the dispute involves the question of whether the medical service claims for a disputed condition are causally related to claimant's compensable injury, we retain jurisdiction over this matter. See Richard L. Wheeler, 47 Van Natta 2011 (1995).

Generally, the changes made to the Workers' Compensation law made by SB 369 apply to cases in which the Board has not issued a final order or for which the time to appeal the Board's order has not expired on the effective date of the Act. Volk v. America West Airlines, 135 Or App 565, 569 (1995).

In Walter L. Keeney, 47 Van Natta 1387 (1995), we concluded that the amendments to ORS 656.327, as well as the new provision, ORS 656.245(6), apply to claims currently pending before the Board. We held that the language of ORS 656.327(1) and ORS 656.245(6) clearly revealed the legislature's intent that medical services disputes be resolved exclusively by the Director, not the Board or Hearings Division. Accordingly, based on the text and context of amended ORS 656.327(1), as read in conjunction with SB 369's retroactivity provisions, we concluded that the Director has exclusive jurisdiction over ORS 656.327(1) medical services disputes, including those presently pending before the Board.

In Lynda J. Zeller, 47 Van Natta 1581 (1995), relying on ORS 656.245(6), we held that the Board retained jurisdiction to determine whether a claimant's current condition was related to her compensable injury. However, once that determination was resolved, we further concluded that, under ORS 656.327(1) and Keeney, the Board is without authority to address the propriety of a proposed surgery for that disputed condition. Thus, in Zeller, having found that the claimant's current condition was compensable, we then dismissed the claimant's hearing request insofar as it sought resolution of a dispute regarding whether the proposed medical treatment was reasonable and necessary. See also Janet Anderson, 47 Van Natta 1692 (1995).

Here, as in Zeller and Anderson, and unlike Keeney, the parties' dispute concerns whether medical treatment for claimant's current condition is causally related to her compensable injury. Inasmuch as such a dispute necessarily involves the compensability of the condition on which the medical treatment is based, we find that the employer's formal denial pertained to the "compensability

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[1] The dissent charges that the DCS was confined to resolution of the parties' dispute regarding an aggravation claim. The emphasized portions of the settlement confirms that the parties wished to resolve all "raised or raisable" issues which expressly extended to the employer's contention that claimant's then current right hip condition was not compensably related to her accepted injury. In light of such circumstances, the parties' expressed intentions in the DCS do not support the dissent's interpretation of the agreement.

of the underlying claim."[2] See Richard Wheeler, supra. Consequently, we retain jurisdiction to consider the parties' dispute. See ORS 656.245(6); Janet Anderson, supra; Lynda J. Zeller, supra.

We turn to the merits of the parties' dispute. After conducting our review of this record, we adopt and affirm the ALJ's order in regard to the compensability to claimant's current condition. Therefore, because claimant's medical services claim for her current hip condition is not causally related to her compensable injury, the employer is not responsible for payment of medical bills to treat claimant's non-compensable condition.

ORDER

The ALJ's order dated April 27, 1995 is affirmed.

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[2] Although not determinative, we note that our rationale that jurisdiction over causation disputes regarding medical treatment rests with the Board is consistent with the Director's administrative rules. OAR 436-10-046(3)(a) provides that, when compensability of treatment is at issue before another adjudicative body, any party may request Director review within 30 days after the order deciding compensability becomes final.

Board Chair Hall dissenting.

The majority, in adopting and affirming the decision of the ALJ, has misconstrued the very nature and purpose of the Disputed Claim Settlement and, in so doing, had prevented the payment of claimant's "post-DCS" medical bills relating to her compensable injury. For the following reasons, I respectfully dissent.

Claimant sustained a compensable right hip injury in April 1992. The employer accepted a claim for right hip strain, lumbar strain and trochanteric bursitis. Claimant's claim was closed in January 1993. From August 1993 to October 1993, claimant received medical treatment for pain in her right buttock, hip, thigh and knee.

In September 1993, the employer issued a Notice of Intent to Disclaim Responsibility for claimant's ongoing right hip complaints.[1] Claimant requested hearing, and the parties entered into a Disputed Claim Settlement (DCS) which set forth the "issue" as "compensability of the aggravation of claimant's right hip condition." (Ex. 43). The DCS included language of a denial, issued by the employer, in response to "claimant's claim for aggravation." (Ex. 4b-2,3). The denial reads in pertinent part:

> "Claimant is now seeking reopening of her right hip condition claim. [The employer] hereby issues a denial of the current right hip aggravation claim on the basis that the accepted injuries of April 13, 1992 have not compensably worsened." (Emphasis added) (Ex. 4b-2).

The DCS then set forth the contentions of the parties as follows:

> "Claimant contends that her right hip condition has worsened and the [employer] is responsible. She relies upon her anticipated lay testimony in support of her position."
>
> "The employer contends that claimant's right hip condition has not compensably aggravated, that her current right hip condition is not compensably related to the accepted April 13, 1992 injury and that a later employer is responsible for her current right hip condition. The employer relies upon expected lay testimony in support of its position."

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[1] This statement is accepted as fact based upon its inclusion in the Disputed Claim Settlement agreed to by the parties, though the Notice of Intent to Disclaim Responsibility itself is not in the record. (Ex. 4b-2).

Further, the DCS contained the basis of the bona fide dispute upon which the DCS was premised:

> "The parties agree that a bona fide dispute exists between them as to the compensability of claimant's current right hip aggravation claim.... Claimant shall have no further entitlement to compensation, or any other legal right, relating to the denied aggravation claim. However, the parties acknowledge that claimant retains all rights that may later arise under ORS 656.245, 656.273, 656.278, and 656.340 insofar as these rights may be related to the original accepted right hip sprain, trochanteric bursitis, and lumbar strain condition. " (Emphasis added) (Ex. 46).
>
> "The parties further agree that, since claimant's accepted condition has not compensably worsened, there is no responsibility issue at this time and the employer's Notice of Intent to Disclaim Responsibility date September 17, 1993 is null and void and is withdrawn in its entirety, without monetary consideration." Id. (Emphasis added)

On its face, in unambiguous terms, the DCS resolved a disputed aggravation claim, nothing more and nothing less. In fact, the employer's disclaimer of further responsibility for claimant's claim was withdrawn.

On December 30, 1993, the DCS received ALJ approval. On June 30, 1994, claimant received physical therapy for pain in the right buttock, hip, thigh and knee. The employer, thereafter, denied payment for claimant's medical services during August 1993 to October 1993 and for treatment on June 30, 1994. Claimant requested a hearing regarding the employer's failure to pay for the above mentioned medical billings.

The ALJ found that claimant's medical services claim for treatment prior to the DCS were resolved by that settlement. In so doing, the ALJ determined that the parties agreed that claimant's then current condition was not compensable. As such, the ALJ found that claimant's "post-DCS" medical services were also precluded by the DCS because claimant's need for medical services in August 1993 to October 1993 and in June 1994 were for the "same condition."[2] The majority has adopted and affirmed the ALJ's findings and analysis.

ORS 656.289(4) authorizes settlement of a claim when there is a bona fide dispute as to compensability. Roberts v. Willamette Industries, 82 Or App 188 (1986); Pruitt Watson, 45 Van Natta 1633 (1993). In other words, a bona fide dispute as to compensability is a prerequisite to a valid DCS. See Pruitt Watson, supra.

In the present case, the DCS was entered into by the parties because of claimant's claim for medical services, from September 1993 through October 1993, which the employer characterized as an aggravation claim. The DCS settled the parties' dispute over claimant's then current aggravation claim. By the very terms of the DCS, no other dispute existed. Consequently, as a matter of law, any attempt to settle any issue other than the disputed aggravation claim would be invalid. Thus, interpreting the DCS to cover more than the then existing (disputed) aggravation claim is error.

Given the existence of the medical bills for treatment in August 1993 through October 1993, and given that such treatment gave rise to the disputed aggravation claim, then it is factually and legally correct to find that such medical services and billings were subject to (and indeed the subject of) the DCS. See Good Samaritan Hospital v. Stoddard, 126 Or App 69, 73 (1994).

In order for the DCS to preclude claimant's June 1994 medical services bill, and/or claimant's condition in June 1994, the DCS would need to be interpreted as having settled a dispute over the future-ongoing compensability and responsibility of claimant's accepted condition. Given the specific language of the DCS, limiting the bona fide dispute to claimant's aggravation claim and preserving claimants' rights under the original claim, such an interpretation is error. Consequently, the compensability of claimant's June 1994 medical services claim must be analyzed separately.

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[2] We note that the only evidence that claimant's need for medical services was for the "same condition," is to compare the August 1993 to October 1993 chart notes with the comments of claimant's physical therapist in June 1994. (Exs. A-14; B).

Medical services "for conditions resulting from the injury" are compensable if the need for treatment bears a material relationship to the compensable condition. ORS 656.245(1); Beck v. James River Corp., 124 Or App 484, 487 (1993), rev den 318 Or 478 (1994). If the prescribed medical services constitute an integral part of the total medical treatment for the condition due to the compensable injury, the medical services are compensable. Williams v. Gates McDonald & Co., 300 Or 278 (1985); Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987).

Here, Dr. Browning (in the June 1994 chart note) diagnosed chronic right gluteal/hip pain. (Ex. A-13). Dr. Browning noted the etiology of the onset of claimant's chronic condition as her April 1992 industrial accident. Id. Absent contrary evidence, I find that claimant's April 1992 compensable injury is at least materially related to her need for medical services in June 1994. Such services are, therefor, compensable.

January 26, 1996 Cite as 48 Van Natta 183 (1996)

In the Matter of the Compensation of
MICHAEL E. PELCIN, Claimant
WCB Case No. 95-02351
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order which: (1) set aside its "de facto" denial of claimant's occupational disease claim for a right shoulder condition; and (2) assessed a penalty for the insurer's allegedly unreasonable claim processing. The insurer contends that claimant's occupational disease claim is barred by prior litigation. On review, the issues are claim preclusion and, if the claim is not barred, compensability and penalties/attorney fees. We reverse.

FINDINGS OF FACT

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

On July 19, 1995, following ALJ Lipton's order in the present case, the Board affirmed that portion of ALJ Neal's order that determined that claimant's claim for right acromioclavicular (A/C) degenerative joint disease was made less than 90 days prior to hearing and that, therefore, at the time of hearing, the claim had not been "de facto" denied. Michael E. Pelcin, 47 Van Natta 1380 (1995). ALJ Neal concluded, and the Board affirmed, that it was premature to litigate the compensability of the right A/C degenerative joint disease claim. Claimant appealed our order to the court on August 16, 1995.

On August 18, 1995, the Board affirmed that portion of ALJ Menashe's order that found that claimant failed to establish that his right shoulder degenerative joint disease was compensably related to his May 18, 1993 industrial injury. Michael E. Pelcin, 47 Van Natta 1521 (1995). Our order was not appealed and has become final.

CONCLUSIONS OF LAW AND OPINION

ALJ Lipton concluded that claimant's occupational disease claim for right shoulder degenerative joint disease was not precluded by the litigation before ALJ Menashe because the claim was not yet "de facto" denied at the time of the earlier hearing. ALJ Lipton reasoned that claimant's occupational disease claim was first made by Dr. Brenneke's October 3, 1994 report and that, therefore, it was premature to litigate an occupational disease claim at the December 19, 1994 hearing before ALJ Menashe. We disagree and conclude that claimant's occupational disease claim for right shoulder degenerative joint disease is precluded by prior litigation.

Under the res judicata doctrine of claim preclusion, if a claim is litigated to a final judgment, the judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Restatement (Second) of Judgments, §§ 17-19, 24; see also Carr v. Allied Plating Co., 81 Or App 306, 309 (1986); Million v. SAIF, 45 Or App 1097, 1102, rev den 289 Or 337 (1980). Claim preclusion bars future litigation not only of every claim included in the pleadings, but also every claim that could have been alleged under the same aggregate of operative facts. Million, supra; Derek J. Schwa-

ger, 44 Van Natta 1505 (1992), on recon 45 Van Natta 428, aff'd mem 124 Or App 681 (1993), rev den 319 Or 36 (1994). Claim preclusion does not require actual litigation of an issue; however, it does require the opportunity to litigate, whether or not used. Drews v. EBI Companies, 310 Or 134, 140 (1990).

Here, the parties litigated the compensability of claimant's right shoulder degenerative joint disease in the proceeding before ALJ Menashe in December 1994. (See Ex. 48). Although the claim was tried under an injury theory (that is, claimant contended that the degenerative disease was compensably related to his May 1993 work injury), claimant could have alleged an occupational disease theory of compensability as well under the same aggregate of operative facts. At hearing before ALJ Lipton, claimant alleged that his work activities at the employer were the major contributing cause of his right shoulder degenerative joint disease, while at the hearing before ALJ Menashe, claimant alleged that a particular work activity (resulting in a compensable injury) caused the degenerative disease. The same condition, right shoulder degenerative joint disease, was litigated in both proceedings. The medical evidence in support of an occupational disease theory, Dr. Brenneke's October 3, 1993 report, was in evidence at the December 1993 hearing. (Ex. 42). Claimant relied on this same evidence to support his occupational disease theory in the hearing before ALJ Lipton.

Under these circumstances, we find that an occupational disease claim could have been alleged under the same aggregate of operative facts in the litigation before ALJ Menashe. We also find that claimant had the opportunity to litigate his occupational disease claim before ALJ Menashe. The judgment in the litigation before ALJ Menashe has now become final, since our order on review was not appealed. Accordingly, we conclude that claimant's occupational disease claim for the same condition that was litigated before ALJ Menashe, right shoulder degenerative joint disease, is precluded by the prior litigation. Million, supra; Derek J. Schwager, supra.

ALJ Lipton found that claimant did not have an opportunity to litigate his occupational disease claim because less than 90 days had passed since claimant first made the occupational disease claim. In so holding, ALJ Lipton found that the occupational disease claim was first made by Dr. Brenneke's October 3, 1994 report. (Ex. 42). We disagree.

In a prior hearing before ALJ Neal in September 1994, the ALJ determined that claimant's claim for right shoulder degenerative joint disease was premature, because the claim first had been made less than 90 days before the hearing. In so holding, ALJ Neal found that Dr. Brenneke's July 6, 1994 report was the first indication of a claim for the right shoulder degenerative joint disease. (Ex. 40-3). We affirmed this portion of ALJ Neal's order on review. Accordingly, we conclude that the claim for compensability of claimant's right shoulder degenerative joint disease was made in July 1994. That claim could have been tried on alternate theories of compensability, including an occupational disease theory.

OAR 438-06-031 allows for the raising of issues throughout the course of a hearing, provided that the evidence supports the issue not previously raised. The ALJ may also continue the hearing upon motion of the other party if that party is surprised and prejudiced by the additional issue. Id. Whether a party is allowed to raise an issue for the first time during the course of a hearing is a matter within the ALJ's discretion. Susan D. Troxell, 42 Van Natta 1300 (1990).

Here, there is no indication that claimant raised an occupational disease theory at the hearing before ALJ Menashe. (See Ex. 48). If the insurer had been surprised or prejudiced by claimant's raising an occupational disease theory in the hearing before ALJ Menashe, the insurer's remedy would have been to request a continuance. Darlene H. Mertes, 46 Van Natta 2353 (1994). However, by failing to raise the occupational disease theory at the prior hearing, claimant is barred by claim preclusion from later litigating the compensability of the occupational disease theory under the same aggregate of operative facts. Million, supra; Darlene H. Mertes, supra at 2354.

Accordingly, we conclude that claimant's occupational disease claim for right shoulder degenerative joint disease is barred by prior litigation. Because we uphold the insurer's "de facto" denial of claimant's occupational disease claim, claimant is not entitled to a penalty for allegedly unreasonable resistance to the payment of compensation. ORS 656.262(11)(a).

ORDER

The ALJ's order dated June 5, 1995 is reversed. The insurer's "de facto" denial of claimant's occupational disease claim for right shoulder degenerative joint disease is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
SHERRY A. YOUNG, Claimant
WCB Case No. 91-12999
ORDER ON REMAND
Callahan & Stevens, Claimant Attorneys
Rick Dawson (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Young v. SAIF, 137 Or App 193 (1995). The court reversed our prior order, Sherry A. Young, 45 Van Natta 1809, on recon 45 Van Natta 2331 (1993), which found that: (1) the Hearings Division had jurisdiction over a proposed surgery dispute; (2) the dispute had been rendered moot by subsequent events involving a second surgery request; and, alternatively (3) claimant would not be entitled to an assessed attorney fee even if the merits of the case had been reached. Noting that the remaining issue pertains to claimant's entitlement to an attorney fee award, the court has remanded for reconsideration pursuant to Or Laws 1995, ch 332 (SB 369).

FINDINGS OF FACT

We republish the "Findings of Fact" from our previous order.

CONCLUSIONS OF LAW AND OPINION

We first set forth the procedural history of this case. An Administrative Law Judge[1] (ALJ) set aside a Director's order which found that claimant's proposed surgery was not appropriate. The ALJ's order also awarded claimant an assessed attorney fee. SAIF requested Board review.

While SAIF's appeal was pending, the Director issued a second order. Based on additional medical evidence, the Director found that claimant's surgery was appropriate. The Director's second order was not appealed and the surgery was performed.

On review of the ALJ's order, we held that our jurisdiction over the first proposed surgery dispute was limited to a "substantial evidence" review of the first Director's order under ORS 656.327. Consequently, we reversed the ALJ's order and affirmed the first Director's order which had found that the proposed surgery was inappropriate.

Claimant subsequently requested reconsideration on the ground that the Director's order was not supported by substantial evidence. By that time, the court had issued its opinion in Jefferson v. Sam's Cafe, 123 Or App 464 (1993), which found that the Director review process under ORS 656.327 did not apply to requests for future medical treatment and, therefore, the Board had jurisdiction to resolve such disputes.

On reconsideration, we found that the ALJ had jurisdiction to resolve the dispute and neither the ALJ's nor the Board's review was limited to "substantial evidence." However, we further found that, because claimant's need for surgery had been resolved, the issue submitted for determination had become moot. Finally, we concluded that, in light of the Court of Appeal's decision in SAIF v. Allen, 124 Or App 183 (1993), even if claimant prevailed on the merits of the case, there would be no basis for an assessed attorney fee award as the "compensability" of the proposed surgery was not at issue. Accordingly, we vacated the ALJ's order and the Director's first order.

Claimant again requested reconsideration, contending that her counsel was entitled to an assessed attorney fee. Claimant's second request for reconsideration was denied.

Claimant requested judicial review. The Court of Appeals has reversed our order and has remanded this matter for reconsideration in light of Senate Bill 369. We proceed with our reconsideration.

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[1] Formerly referred to as "Referee."

Subsequent to the ALJ's order, the legislature amended ORS 656.327(1) and added ORS 656.245(6), each of which requires review of medical services disputes by the Director, unless a claim for medical services is denied on the basis that the underlying claim is not compensable. SB 369, §§ 41, 25. In Walter L. Keeney, 47 Van Natta 1387, 1389, recon den 47 Van Natta 1525 (1995), we concluded that these statutes apply retroactively to pending cases and that the Director now has exclusive jurisdiction over such medical services disputes. See also Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565 (1995).

Here, the court held that the only "live" issue in this case is claimant's entitlement to an assessed attorney fee. Claimant's request for an attorney fee is based on her contention that services have been rendered by her counsel in conjunction with the dispute over her proposed surgery. Specifically, the parties' dispute pertained to whether proposed surgery for her compensable low back condition was reasonable or necessary. There has been no dispute regarding the compensability of her underlying claim (low back condition). Accordingly, review of the "mooted" medical services dispute lies with the Director, not the Hearings Division. See ORS 656.245(6); Richard L. Wheeler, 47 Van Natta 2011 (1995). Likewise, because the remaining attorney fee issue was contingent on the resolution of the medical services issue, we are without authority to consider the accompanying attorney fee issue. See SB 369, § 42b(5); David L. Black, 47 Van Natta 2165, 2166 (1995).

Consequently on reconsideration of our prior orders, we vacate the ALJ's November 14, 1991 order. Claimant's request for hearing is dismissed for lack of jurisdiction.

IT IS SO ORDERED.

January 23, 1996 Cite as 48 Van Natta 186 (1996)

In the Matter of the Compensation of
DEWEY W. KENNEDY, Claimant
WCB Case No. 93-14332
ORDER ON REMAND
Welch, Bruun, et al, Claimant Attorneys
James Thwing (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. By order dated December 18, 1995, the court remanded our prior order, Dewey Kennedy, 47 Van Natta 394 (1995), for reconsideration under amended ORS 656.704(3). In that prior order, we affirmed the Administrative Law Judge's (ALJ's) order that found that: (1) the Hearings Division had jurisdiction over a proposed medical treatment dispute arising from a Managed Care Organization (MCO); and (2) the proposed treatment was appropriate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back in 1968 and subsequently underwent five low back surgeries, with the last surgery being performed on November 1, 1991. Claimant's hip and leg pain returned after the surgery. In April 1993, Dr. Rosenbaum recommended surgical implantation of a spinal infusion pump to dispense pain relieving medication. Dr. Misko, attending physician, and several consulting physicians concurred with the surgical recommendation.

Claimant was enrolled in CareMark Comp, a MCO with which the SAIF Corporation had contracted. In July 1994, CareMark Comp disapproved claimant's proposed surgery request. This decision was appealed to the next level of review within the CareMark Comp system. At the time of hearing, CareMark Comp had not yet issued its final decision; however, it eventually issued a final decision disapproving the proposed surgery. This decision was appealed to the Director, who issued a September 19, 1994 order finding the proposed treatment appropriate.

In the meantime, claimant requested a hearing regarding, among other issues, SAIF's alleged "de facto" denial of his claim for low back surgery. The ALJ, inter alia, found that: (1) the Hearings Division had jurisdiction over the proposed surgery issue; and (2) the proposed surgery was reasonable and necessary. SAIF requested review of these findings.

On review, we adopted and affirmed the ALJ's order with supplementation. Dewey Kennedy, supra. In doing so, we relied on Job G. Lopez, 47 Van Natta 193 (1995), in which we rejected the carrier's contentions that, under former ORS 656.260, the MCO statute, and former ORS 656.704(3), the Director had exclusive jurisdiction over an MCO proposed medical services dispute. Rather, we concluded that, in the MCO context, determining where jurisdiction lies depends on the nature of the medical services issue in dispute. Id. at 200. Citing Martin v. City of Albany, 320 Or 175 (1994), and Jefferson v. Sam's Cafe, 123 Or App 464 (1993), rev den 320 Or 453 (1994), we held that, because dispute in Lopez involved a proposed surgery, the Hearings Division had exclusive jurisdiction to review the matter. 47 Van Natta at 201-202.

The Court of Appeals remanded our order for reconsideration in light of amended ORS 656.704(3). We proceed with our reconsideration.

Subsequent to our prior order, the legislature amended the Workers' Compensation Law. Or Laws 1995, ch 332 (SB 369). ORS 656.260(6) and ORS 656.704(3) are among the amended statutes. SB 369, § 27, 50. Amended ORS 656.260(6) provides, in part, that "[a]ny issue concerning the provision of medical services to injured workers subject to a managed care contract * * * shall be subject solely to review by the director or the director's designated representatives, or as otherwise provided in this section." SB 369, § 27(6). Amended ORS 656.704(3) provides that "matters concerning a claim," over which the Board has jurisdiction, "do not include any disputes arising under ORS 656.245, 656.248, 656.260, 656.327, any other provisions directly relating to the provision of medical services to workers or any disputes arising under ORS 656.340 except as those provisions may otherwise provide." SB 369, § 50(3) (emphasis added).

In Ronald R. Streit, Sr., 47 Van Natta 1577 (1995), we found that amended ORS 656.260(6) applied retroactively. We concluded that, under amended ORS 656.260(6), the Director has exclusive jurisdiction over all MCO medical services disputes, including those currently pending before the Board.[1] We also found that amended ORS 656.704(3) supported this conclusion. In addition, we held that amended ORS 656.260(6) overruled our decision in Job G. Lopez, supra.

Here, the matter at issue pertains to a MCO dispute. Accordingly, review of this dispute lies with the Director, not the Hearings Division. Amended ORS 656.260(6); 656.704(3); Ronald R. Streit, Sr., supra. Consequently, we vacate the ALJ's March 29, 1994 order, and dismiss claimant's request for hearing for lack of jurisdiction.

IT IS SO ORDERED.

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[1] Here, we find that the present MCO medical services dispute is currently pending before the Board. In the absence of a specific exception in section 66 of SB 369, the changes to the Workers' Compensation Law made by SB 369 apply to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act (June 7, 1995). Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 573 (1995). Here, our prior order was appealed and the case has been remanded to us from the court. Because our appealed order has not become final, SB 369 is applicable. Furthermore, as decided in Streit, supra, there are no exceptions in section 66 of SB 369 to retroactive application of amended ORS 656.260(6). Therefore, the matter remains pending before the Board and amended ORS 656.260(6) applies retroactively to this matter.

In the Matter of the Compensation of
WILLIAM T. FORSHEY, Claimant
WCB Case No. 95-02968
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Crumme's order which awarded an assessed attorney fee of $2,000. On review, the issue is attorney fees.

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

On review, SAIF contends that the ALJ's attorney fee award should be reduced for claimant's failure to cooperate in the investigation of the claim and for his counsel's failure to properly provide discovery. SAIF asserts that it would never have issued its denial had claimant or his attorney provided the name of his attending physician, and that claimant's counsel should not be allowed to benefit from a failure to cooperate and assist in the investigation of the claim. We disagree with SAIF's request for a reduced attorney fee.

As claimant notes, SAIF defended its denial at hearing both on the merits and on timeliness grounds. Moreover, SAIF did not accept the claim when presented with evidence establishing that there had been medical treatment. Under such circumstances, we are not persuaded that SAIF would have accepted the claim merely upon provision of the name of claimant's attending physician. Accordingly, we conclude that the ALJ's attorney fee should not be reduced.

Finally, we note that claimant's counsel is not entitled to an attorney fee for services on review concerning the attorney fee issue. Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

The ALJ's order dated July 7, 1995 is affirmed.

In the Matter of the Compensation of
WILLIAM L. KARNATH, Claimant
WCB Case Nos. 94-10309 & 94-03828
ORDER ON REVIEW
Ginsburg, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Jim Thwing (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that: (1) upheld Liberty Northwest Insurance Corporation's denial of claimant's aggravation claim for a neck condition; (2) upheld the SAIF Corporation's denial of claimant's "new occupational disease" claim for the same condition; and (3) declined to award a penalty and attorney fee for SAIF's allegedly unreasonable claims processing. On review, the issues are compensability, responsibility and penalties.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated March 20, 1994 is affirmed.

Board Member Gunn dissenting.

Claimant is an ironworker who was employed on the Blazer Arena Project when he began experiencing upper extremity and neck pain. In December 1993, claimant noticed that his right chest muscle had atrophied and he eventually underwent surgical nerve root compression.

I disagree with the majority that claimant did not prove the compensability of his cervical nerve root irritation condition. Claimant's work required extensive use of his hands, arms, and shoulders. Both of claimant's treating physicians, Dr. Smith and Dr. Mason (who performed the surgery), provided their opinions that such activity was the major contributing cause of claimant's condition.

There are no persuasive reasons for not deferring to these opinions. Weiland v. SAIF, 64 Or App 810 (1983). The physicians exhibited their familiarity with claimant's medical and work conditions, and provided well-reasoned opinions for attributing claimant's need for treatment to his employment. Certainly, the opinion relied upon by the ALJ, from Dr. White, is not sufficiently persuasive to overcome those of the treating physicians.

Inasmuch as I disagree with the majority's evaluation of the medical evidence, which I believe carries claimant's burden of proof, I dissent.

In the Matter of the Compensation of
DARLENE E. PARKS, Claimant
WCB Case No. 91-14715
ORDER DENYING RECONSIDERATION
Hollander, et al, Claimant Attorneys
Cummins, Goodman, et el, Defense Attorneys

Claimant requests reconsideration of our December 27, 1995 Order on Review which, among other decisions: (1) affirmed that portion of an Administrative Law Judge's (ALJ's) order which declined to grant claimant permanent total disability; and (2) increased claimant's unscheduled permanent disability award from 15 percent (48 degrees) to 17 percent (54.4 degrees). Specifically, claimant seeks en banc review of the permanent total disability issue. Inasmuch as we find that our prior order has become final, we lack authority to reconsider our order.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). 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 December 27, 1995 order was January 26, 1996. Claimant mailed her request for reconsideration to the Board on January 26, 1996. However, the Board did not receive claimant's motion until January 29, 1996. Thus, before we could respond to claimant's motion, the 30-day period of ORS 656.295(8) had expired. Inasmuch as our December 27, 1995 order has neither been stayed, withdrawn, modified, nor 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, supra; Fischer v. SAIF, supra; Donald J. Bidney, 47 Van Natta 1097 (1995). Consequently, claimant's motion for reconsideration is denied.

As we have noted on prior occasions, the Board attempts to respond to motions for reconsideration as expeditiously as possible. Connie A. Martin, 42 Van Natta 495, recon den 42 Van Natta 853 (1990). Notwithstanding these stated intentions, the ultimate responsibility for preserving a party's rights of appeal must rest with the party. Id.

Here, as previously noted, claimant's motion for reconsideration was not mailed to the Board until the 30th day following our December 27, 1995 order. Under such circumstances, the statutory 30-day period had already expired by the time claimant's reconsideration motion was received by the Board. Consequently, even with our stated intentions for an expeditious response to such motions, our authority to conduct reconsideration of our decision had expired prior to our receipt of the motion.

Accordingly, claimant's motion for reconsideration is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWARD L. PEARSON, Claimant
WCB Case No. 95-03486
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's right ankle fracture claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on the reports of treating physician, Dr. Benz, the ALJ concluded that claimant had established the compensability of his right ankle fracture. We agree.

Claimant fractured both of his ankles in May 1993 during a nonwork-related accident. Dr. Benz performed surgery on both ankles, twice on the right. Claimant recovered and was asymptomatic after November 1993.

In November 1994, claimant fell on his right ankle at work. He sought treatment from Dr. Benz, who diagnosed a new fracture, and sought authorization to surgically correct the fracture. (Exs. 11, 12). Subsequently, in a letter to SAIF, Benz confirmed that claimant had a new fracture and that the major contributing cause of claimant's condition and need for treatment was the November 1994 work injury. (Ex. 13).[1]

Dr. Arkless thereafter reviewed claimant's imaging studies and some of his medical records. He concluded that claimant had a nonunion, but did not identify the cause of that condition. (Ex. 16).

Last, Dr. Woll examined claimant on SAIF's behalf. Without the benefit of claimant's imaging studies, Woll determined that, "[a]t this point, the major cause for [claimant's] medical condition and need for surgery appears to be his original injury on May 8, 1993." (Ex. 22-4).

SAIF denied claimant's right ankle refracture. (Ex. 18). Claimant requested a hearing. After a hearing, the ALJ concluded that claimant's right ankle condition was compensable. SAIF requested Board review.

As a preliminary matter, we note the parties' dispute about claimant's correct diagnosis. We do not address that issue because, as explained below, we find that claimant has shown that his right current ankle symptoms are attributable to his work. See Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992) (a claimant need not prove a specific diagnosis if he proves that his symptoms are attributable to his work).

We turn to the causation issue. The parties do not dispute that, in view of claimant's preexisting right ankle condition, this case is governed by the major contributing cause standard of ORS 656.005(7)(a)(B).[2] On this record, we find Dr. Benz' reports sufficient to meet that burden. He concludes that the major contributing cause of claimant's current condition and need for treatment was the November 1994 work injury.

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[1] Dr. Benz also stated, "It is very possible that the injury that [claimant] describes could indeed have resulted in a fracture of this nature regardless of his preexisting problem." (Ex. 13). SAIF argues that, because that assertion is couched in terms of "possibility," it is insufficient to meet claimant's burden. We disagree. Dr. Benz' statement concerns the possibility of claimant sustaining an injury notwithstanding his preexisting ankle problems. Because claimant has had prior ankle problems, that statement is of little import and we afford it minimal weight.

[2] The legislature recently amended that statute. Or Laws 1995, ch 332, § 1. Those amendments are not germane here.

The other physicians' reports are not persuasive. Dr. Arkless never addressed that cause of claimant's current right ankle condition. Further, although Dr. Woll did address that issue, attributing that condition to claimant's 1993 non-work injury, we discount that opinion, because Woll rendered it without the benefit of claimant's imaging studies.

In sum, then, we conclude that claimant has established the compensability of his current right ankle condition. Accordingly, we affirm the ALJ's decision setting aside SAIF's denial of that condition.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-15-010(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 SAIF Corporation. 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 14, 1995 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the SAIF Corporation.

January 30, 1996 Cite as 48 Van Natta 192 (1996)

In the Matter of the Compensation of
GLENN C. SMITH, Claimant
WCB Case No. 95-03853
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Stan Kapustka (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that found that his claim was not prematurely closed. On review, the issue is premature closure.

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

The dispositive issue is whether there was a reasonable expectation of material improvement in claimant's compensable condition at the time of claim closure (August 29, 1994). See ORS 656.005(17). See Ricky R. Deeds, 47 Van Natta 1110 (1995).

Here, on August 29, 1994 (the corrected date of claim closure), Dr. Metzger acknowledged that surgical removal of residual of claimant's skin graft "may eventually" be removed and local excision of the remainder of another graft "might be done." (Ex. 16). In our view, the speculative nature of Dr. Metzger's possible plans for claimant do not indicate a reasonable expectation of material improvement in claimant's condition as of claim closure. Accordingly, we agree with the ALJ that claimant has not established that his claim was prematurely closed.

ORDER

The ALJ's order dated July 20, 1995 is affirmed.

In the Matter of the Compensation of
APRIL C. BECK, Claimant
WCB Case No. 95-00021
ORDER ON REVIEW (REMANDING)
Robert G. Dolton, Claimant Attorney
Julene M. Quinn (Saif), Defense Attorney

Reviewed by Board Members Christian and Hall.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Claimant filed the aggravation claim at issue here on September 20, 1994 which SAIF denied on September 26, 1994. Finding that claimant sustained a worsening of her compensable condition, the ALJ set aside SAIF's denial.

Subsequent to the ALJ's order, we issued our decision in Carmen C. Neill, 47 Van Natta 2371 (1995). In Neill, we held that an "actual worsening," as required to prove an aggravation claim under amended ORS 656.273(1), may be established by showing either a pathological worsening of the compensable condition or by showing a symptomatic worsening of the compensable condition that is in excess of the waxing and waning contemplated by a prior award of permanent disability. Since the record established that claimant suffered a symptomatic worsening of her compensable condition, but had not received a prior award of permanent disability, we concluded that the record was incompletely developed with regard to whether the claimant had suffered an "actual worsening." Neill, supra. Consequently, we remanded the matter for submission of further evidence on that issue.

Here, as in Neill, claimant's claim was classified as nondisabling and therefore, she has not received a prior award of permanent disability. Moreover, other than evidence that claimant's back symptoms became worse in 1993, the record is devoid of either documentary or testimonial evidence regarding whether claimant sustained an "actual worsening" of her compensable condition. In light of the fact that claimant has not received a prior award of permanent disability and given the parties' lack of opportunity to generate medical evidence regarding whether claimant sustained an "actual worsening" of her condition, we consider the record to be incompletely and insufficiently developed to determined wither claimant sustained a compensable aggravation. Moreover, because amended ORS 656.273(1) went into effect after this record was developed/closed and prior to this matter becoming final, we find that there is a compelling reason to remand this matter for the submission of additional evidence regarding whether claimant sustained an "actual worsening" with respect to her 1991 back claim.

Accordingly, this matter is remanded to ALJ Bethlahmy for further proceedings in which each party will be permitted to present evidence regarding the compensability of claimant's a 1993 aggravation claim. Those proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final appealable order.

ORDER

The ALJ's order dated April 24, 1995 is vacated. This case is remanded to ALJ Bethlahmy for further proceedings consistent with this order.

In the Matter of the Compensation of
KENNETH C. FELTON, Claimant
Own Motion No. 96-0005M
OWN MOTION ORDER
Swanson, Thomas & Coon, Claimant Attorneys
EBI Companies, Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable knee with multiple surgeries, lateral joint compartment and meniscus injury. Claimant's aggravation rights expired on December 31, 1979. The insurer opposes authorization of temporary disability compensation, contending that: (1) no surgery was requested; and (2) claimant has withdrawn from the work force.

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

Although the insurer contends that claimant has only undergone a diagnostic outpatient procedure, we find that the surgery qualifies for "inpatient or outpatient surgery." Claimant underwent outpatient "arthroscopy and debridement of the lateral compartment" on December 19, 1995. In his September 27, 1995 request for authorization to perform the surgery, and in his operative report, Dr. Cook, claimant's treating physician, prescribed treatment in conjunction with the evaluative procedure. The December 19, 1995 operative report describes the procedure as "arthroscopy, debridement of lateral compartment." In the report, Dr. Cook stated that:

> "Following complete diagnostic arthroscopy, the femoral condyle was debrided with the motorized shaver. The joint was irrigated. The stab wound was closed."

Thus, we conclude that claimant's compensable condition had worsened requiring outpatient surgical treatment.

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

The insurer contends that claimant was not in the work force at the time of the current worsening or the time of surgery. Claimant has the burden of proof on this issue and must provide persuasive evidence that he remained in the work force at the time of disability.

On January 9, 1996, claimant requested an extension of time within which to submit information regarding the work force issue. On January 16, 1996, the Board granted claimant's request. In a January 25, 1996 letter, claimant advised the Board that he "will not be submitting any additional evidence in this matter." On the record, we conclude that claimant has not carried his burden of proving that he remained in the work force at the time of disability.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
DAVID L. GRENBEMER, Claimant
Own Motion No. 94-0544M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Saif Legal Department, Defense Attorney

Claimant, pro se, requests review of the SAIF Corporation's October 18, 1995 Notice of Closure, which closed his claim with an award of temporary disability compensation from August 18, 1994 through November 10, 1994. SAIF declared claimant medically stationary as of August 22, 1995. Claimant requests "a review of my file" and "that my claim remain open [un]til we have resolved these matters." In addition, claimant contends that: (1) he is entitled to additional temporary disability compensation from November 11, 1994 through April 30, 1995 because he was released only to "light duty"; (2) SAIF is not entitled to reimbursement of an alleged overpayment; (3) he is entitled to relief or medical benefits for lifetime physical therapy; and (4) he is entitled to "monetary compensation due to the loss of my knee joint."

Premature 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 18, 1995 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.

In an October 3, 1995 letter, Dr. Chamberlain, claimant's treating orthopedic physician, opined that claimant was medically stationary as of August 22, 1995. In his November 16, 1995 letter, claimant asserts (regarding Dr. Chamberlain's October 3, 1995 opinion) that "I agree that the letter is very straight forward as to when I became medically stationary." In his December 18, 1995 letter, claimant contends that, although he continues to have pain and swelling and is limited in his activities, "I may be medically stationary, whatever that means." Here, we find that, although claimant complains of continued pain and feels that his condition "limits me the rest of my life," Dr. Chamberlain's medical opinion that he was medically stationary on August 22, 1995 is unrebutted.

Apparently, claimant also contends that, because SAIF allegedly paid for a six-month membership to an athletic club for physical therapy, his ongoing physical therapy defeats a physician's opinion that he was medically stationary on August 22, 1995. There are no medical opinions in the record which establish that a physician recommended or that claimant requires ongoing care for an indefinite period of time. Notwithstanding the lack of evidence to support a recommendation for continued physical therapy, the provision of ongoing care would not necessarily establish that claimant was not medically stationary on August 22, 1995. Maarefi v. SAIF, 69 Or App 527, 531 (1984). In this respect, there is no evidence to indicate that claimant's compensable condition would improve with continued treatment or the passage of time. ORS 656.005(17). Contrary to the above requirement, claimant asserts that the ongoing physical therapy will only "keep up" (maintain) the development of his left leg muscles. (See claimant's letters dated November 16, 1995 and December 18, 1995).

For the reasons cited above, we conclude that claimant has not carried his burden of proving he was not medically stationary on October 18, 1995, when SAIF closed his claim.

Temporary Disability Benefits

Claimant contends that he is entitled to additional temporary disability compensation from November 11, 1994 through April 30, 1995. In this regard, claimant contends that he returned to "limited part[-]time duty on October 24, 1994," that he was not released to "full time duty," and that "I continued with time loss through April 1995."

A claimant is substantively entitled to temporary total disability benefits from the date of surgery or hospitalization until his condition is medically stationary. A claimant's substantive entitlement to temporary disability benefits is determined on claim closure, and is proven by the establishment from

evidence in the record, that he was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

There is no evidence in the record to persuade us that a physician restricted claimant only to light or part-time duty, or that any modifications in his work were due to the compensable injury. Inasmuch as the evidence in the record establishes that claimant returned to work on October 24, 1994 (even if it were in a modified capacity, as claimant contends), we are not persuaded that he was disabled due to his compensable injury after that date. See Debra Dale, 47 Van Natta 2344 (1995). Furthermore, there is no evidence in the record to support claimant's contention that he "continued with time loss through April 1995" due to the compensable injury.

Claimant submitted attendance reports issued by his employer from August 1994 through April 1995. Purportedly, these reports were meant to support claimant's position that he used "sick leave" and "vacation time" after October 24, 1994 for his compensable injury, and thus, he was entitled to temporary disability benefits after that date. However, this information does not persuade us that claimant lost any wages due to the compensable injury or that he was entitled to temporary disability compensation after October 1994. Consequently, claimant has not established entitlement to temporary total disability benefits after October 24, 1994.

Offset

Claimant requests that the Board order SAIF to have an offset, or overpayment, "removed from [the] file and corrected to zero owed." Claimant contends that SAIF paid him $934.80 for the period from October 28, 1994 through November 11, 1994, and that he was entitled to that payment. Claimant returned to work on October 24, 1994. There is no evidence in the record to persuade us that claimant provided SAIF with proof of any loss of wages due to the compensable injury after he returned to work. In his November 1, 1995 letter, claimant asserts that he "listed time loss through 11/21/94" in an application for additional payment. Claimant also notes that "you would think I would have heard from [SAIF], if there was some reason [for] discontinuing my benefits." Nevertheless, there is no evidence that SAIF received that request, or that the information sent to SAIF by claimant was any more perspicuous than that which claimant forwarded to the Board. In other words, we do not have any evidence that SAIF made an overpayment. Therefore, we do not find either that SAIF made an overpayment, or that claimant was entitled to the compensation during that time period.

Medical Benefits

Claimant contends that he is entitled to a lifetime membership in "Superior Court," an exercise/physical therapy facility in his area. Under ORS 656.245, claimant is entitled to lifetime medical benefits related to his compensable injury. However, under ORS 656.278, the Board does not have jurisdiction over disputes involving medical services. Entitlement to medical services is determined by the Hearings Division (if the causal relationship between the membership and the compensable injury is in dispute) or, otherwise, by the Director. Thus, we are unable to grant claimant's request for lifetime physical therapy.

Permanent Disability

Claimant also contends that he is entitled to an additional award of disability "due to loss of my knee joint." We disagree. Because claimant's aggravation rights have expired, his claim is in own motion status. That means that, although he is entitled to lifetime medical benefits related to his compensable injury, his only entitlement to future disability compensation is restricted to time loss benefits under limited circumstances. ORS 656.278(1)(a). Effective January 1, 1988, the Board no longer has own motion authority to award permanent disability benefits. Independent Paper Stock v. Wincer, 100 Or App 625 (1990). Accordingly, we are not authorized to grant claimant's request. See Charles H. Jones, 47 Van Natta 1546 (1995).

Accordingly, we affirm SAIF's October 18, 1995 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
JESUS FLETES, Deceased, Claimant
WCB Case No. 92-02935
And, In the Matter of the Compensation of
GABRIEL L. ALVAREZ, Claimant
WCB Case No. 92-01344
And, In the Matter of the Complying Status of
EDWIN HAYES, Noncomplying Employer
WCB Case No. 92-02586
ORDER ON REMAND
Bischoff & Strooband, Attorneys
Bruce D. Smith, Attorney
Cowling, Heysell, et al, Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Hayes v. SAIF Corporation, 132 Or App 455 (1995). The court reversed our prior Order of Dismissal,[1] which found that we lacked appellate jurisdiction to review the Administrative Law Judge's (then Referee's) order affirming the Department's order which found Edwin Hayes to be a noncomplying employer. The court determined that the Board retained jurisdiction to review the ALJ's order under ORS 656.740(4)(c), and remanded the matter to the Board for de novo review.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and summarize the pertinent facts as follows:

Edwin Hayes retired from mill work in December 1990. Since approximately 1979, he has run a small cattle operation on farm land that he either owned or leased. In September 1991, he had 20 head of cattle.

During the period of September 5 through 7, 1991, Hayes hired a group of men, including Gabriel Alvarez Lopez and Jesus Fletes, to haul hay for the cattle. No express or implied contract for a certain wage or rate per load was discussed, although Hayes intended to pay the men $5.00 each per truckload of hay hauled. Using Hayes' flatbed truck and trailer, the crew hauled no fewer than nine loads of hay over the three day period.

On Saturday, 7, 1991, the work crew was riding on top of the hay, which was loaded, but not secured, on the flatbed and trailer. The driver of the truck made a sharp turn to avoid a possible collision and the trailer wheels went off the road, causing the workers and the hay load to fall. Jesus Fletes was fatally injured and Gabriel Alvarez Lopez suffered various injuries.

Later that same day, Hayes gave $215 in cash to Joel Regalado Camerena to pay the workers. The money was divided among the workers according to how much work each had performed. Jesus Fletes' share was given to his brother.

Hayes gave Joel $195 for the work done (for nine loads at $5 per load per worker), plus an additional $20 to pass on to the workers "to buy groceries or whatever" because he felt badly about the accident.

The Department of Insurance and Finance (now the Department of Consumer and Business Services) investigated the working arrangement to determine whether Hayes had complied with the workers' compensation coverage laws. The Department determined that Hayes was a subject and noncomplying employer and that the injured men were subject employees of Hayes. The Department issued an order referring the claims to SAIF for acceptance and processing. SAIF accepted both claims. Hayes requested a hearing, contesting both the Department's order and SAIF's claim acceptances.

CONCLUSIONS OF LAW AND OPINION

In affirming the Department's order, the ALJ found that Hayes was in the cattle ranching business and that he was a "subject employer" under ORS 656.023 because he employed "subject workers" under former ORS 656.027. Contrary to Hayes' contention, the ALJ found that the crew

[1] See Jesus Fletes, 45 Van Natta 2252 (1993), on recon 45 Van Natta 2376 (1993)).

workers were not "casual" employees exempt from the workers compensation laws under former ORS 656.027(3) because the "total labor cost" of the employment exceeded the then statutory limit of $200.[2]

On review, Hayes argues that the SB 369 amendment to ORS 656.027(3)(b), which increased the statutory amount to $500, applies retroactively to this case. Hayes further contends that under the amended law, the work crew members were "casual" employees rather than subject workers because their employment involved a total labor cost of less than $500. In the alternative, Hayes argues that even under former ORS 656.027(3)(b), the crew workers were "casual" employees because the total labor cost for the work done in September 1991 was only $195.[3]

Since it is determinative regardless of whether the extra $20 is considered part of the total labor cost, we first address the retroactive application of amended ORS 656.027(3)(b) to this case. Based on the following reasoning, we hold that the amended statute is applicable.

In the absence of a specific exception, the changes to the Workers' Compensation Law made by Senate Bill 369 apply to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act (June 7, 1995). Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 569 (1995). Here, our prior order of dismissal was appealed and the case has been remanded to us from the court. Since there is no specific exception to the retroactive application of amended ORS 656.027(3) and no final order has issued in this case, we apply the new law.[4]

Because the employment arrangement at issue involved a total labor cost of less than $500, claimants fit within the exception for "casual" workers under amended ORS 656.027(3) and are not subject to the workers' compensation laws. Moreover, because Hayes did not employ "subject workers" he is not a "subject employer" under ORS 656.023.

Notwithstanding the legislative mandate to apply the new law retroactively, claimants Lopez and Fletes (deceased) make several constitutional arguments against the application of amended ORS 656.027(3)(b) to this case. We address each argument in turn.

Claimants first contend that the retroactive application violates their due process rights. Claimant Lopez asserts that when his injuries occurred, his right to compensation under the law then in effect became a "vested property right." Claimant Lopez further contends that retroactive application of amended ORS 656.027(3) deprives him of this vested right and leaves him without a substantial remedy for his injury. Similarly, claimant Fletes' estate argues that it has a protected property interest in the workers' compensation benefits received, and application of the new statute jeopardizes those benefits in violation of the Fourteenth Amendment of the United States Constitution.[5]

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[2] Former ORS 656.027(3)(b) provided: "For purposes of this section, 'casual' refers only to employments where the work in any 30-day period, without regard to the number of workers employed, involves a total labor cost of less than $200." SB 369 amended this provision to increase the total labor cost threshold to "less than $500." Or Laws 1995, ch 332, § 6 (SB 369, § 6).

[3] In his reply brief, Hayes moves to strike the Department's brief on the ground that it offers unauthorized legal argument. Because the Department appeared at hearing without objection, we are not inclined to preclude its participation on review. We note, however, that the Department's brief focuses primarily on the contention that the additional $20 paid to the work crew was part of the "total labor cost," an issue that we did not need to address on review. In other words, even if we were to consider the Department's brief, it would not alter our determination in this case. Consequently, we need not resolve Hayes' motion.

[4] On November 6, 1995, the Board granted the parties an opportunity to file supplemental briefs following the issuance of the court's remand order. All of the parties have submitted supplemental briefs concerning the retroactive application of SB 369 as well as on the merits.

[5] Claimant Fletes cites Carr v. SAIF, 65 Or App 110 (1983), rev dismissed 297 Or 83 (1994), in support of his due process challenge. As we explained in Ralph I. Pingle, 47 Van Natta 2155 (1995), Carr is a procedural due process case. The court in Carr held that the claimant's right to continuing temporary disability benefits was a property interest encompassed by the Fourteenth Amendment and the Director's termination of those benefits did not comply with procedural due process guarantees because claimant was not afforded notice and an opportunity to be heard before his benefits were suspended. Here, claimant Fletes has not identified any procedural process he believes is constitutionally defective. Carr is therefore inapposite.

The primary problem with claimants' due process arguments is that they do not have a "vested right" to compensation, which is an essential element of a substantive due process violation. First, claimants do not have a vested right to litigate their claims under the former law. See Hall v. Northwest Outward Bound School, 280 Or 655, 662 (1977) (mere fact that a statute is retroactive in its application does not make it repugnant to the Fourteenth Amendment). See also Kirby v. Sonville, 286 Or 339 (1979) (where statute expressly provided that it be applied retroactively, court gave effect to that expression regardless of the enactment's effect on the legal relationship or expectations of the parties). Second, in the absence of a final order concerning their entitlement, claimants do not have a vested right to the benefits received. See Kathleen M. Butler, 47 Van Natta 2202 (1995) (rejecting claimant's contention that she had a vested right in the benefits ordered by a non-final ALJ order); Ralph I. Pingle, supra (same).

Moreover, as we held in Betty S. Tee, 47 Van Natta 2396 (1995), retroactive application of the provisions of SB 369 does not violate a claimant's substantive due process rights because there is a legitimate legislative purpose for the retroactive legislation: workers' compensation premium reduction. Therefore, we conclude that retroactive application of amended ORS 656.027(3) does not violate claimants' federal constitutional guarantee of substantive due process in this case.

Claimants also contend that retroactive application of amended ORS 656.027(3) leaves them without a remedy for their loss in violation of Article I, Section 10 of the Oregon Constitution.[6] We disagree.

Article I, section 10 of the Oregon Constitution "was not intended to give anyone a vested right in the law either statutory or common; nor was it intended to render the law static." Noonan v. City of Portland, 161 Or 213, 249 (1938). The only limitation this constitutional provision places on the legislature is that it cannot abolish a remedy and at the same time recognize the existence of a right. Id; see also Neher v. Chartier, 319 Or 417, 428 (1994). In this case, as explained above, claimants did not have a "vested right" to recovery under the workers' compensation system. By amending ORS 656.027(3), the legislature merely enlarged the definition of "casual employment" and, in the process, eliminated certain individuals' rights to recover benefits under the workers' compensation laws. The legislature did not, however, recognize a right while abolishing a remedy. Accordingly, we find that retroactive application of amended ORS 656.027(3) does not violate the remedies guarantee of Article I, section 10.

Claimant Fletes also argues that retroactive application of the new law violates the Contracts Clause of the Oregon and United States Constitutions.[7] We rejected a similar challenge in Kathleen M. Butler, supra, and do so again here.[8]

As we explained in Kathleen M. Butler, determining whether a law violates the contract clause involves a two-step process: Ascertaining whether a contract exists to which the person asserting impairment is a party; and ascertaining whether the challenged law has impaired an obligation of that contract. Hughes v. State of Oregon, 314 Or 1, 13-14 (1992). In this case, we find no evidence of a specific employment contract to which claimants were a party.[9] In any event, in Kathleen M. Butler, we

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[6] This section provides, in pertinent part, "every man shall have remedy by due course of law for injury done him in his person, property, or reputation."

[7] Oregon Constitution, Article I, section 21 and United States Constitution, Article 1, section 10.

[8] In Kathleen M. Butler, we analyzed whether the retroactive application of amended ORS 656.260(6) violated the Contracts Clause of the Oregon Constitution. We note, however, that Oregon's contract clause has as its source the federal provision, and that the two clauses are interpreted similarly. See Eckles v. State of Oregon, 306 Or 380, 390 (1988).

[9] Indeed, the record establishes the informality of the parties' employment arrangement. Hayes, who spoke little or no Spanish, arranged the job through Joel Regalado Camerena. Hayes did not know the members of the work crew. Hayes and Mr. Camerena did not discuss who would comprise the work crew or how much the workers would be paid. Moreover, even if the parties' employment arrangement could constitute a "contract" under the first prong of the Contract Clause test, claimant Fletes has not shown how that contract would be impaired by application amended ORS 656.027(3). See Kathleen M. Butler, supra.

specifically rejected the contention that the Workers' Compensation Act itself (or any of its provisions) constitutes a contract for purposes of the Contract Clause.[10] Under such circumstances, claimants' Contract Clause argument must fail.

Finally, conceding there is nothing per se unconstitutional about the change made to ORS 656.027(3)(b), claimant Fletes contends that other provisions of SB 369 are unconstitutional. Claimant Fletes further contends that these other, allegedly unconstitutional parts are so interrelated with the remaining parts that they cannot be severed and therefore all of SB 369, including amended ORS 656.027(3)(b), is void.[11]

It is well settled that a person to whom a statute may be constitutionally applied lacks standing to challenge the law on the grounds that it may be unconstitutionally applied to others. See Bopp v. State, 18 Or App 347, 349 (1974)(citing Broadrick v. Oklahoma, 413 US 601, 610-11 (1973))("Embedded in the traditional rules governing constitutional adjudication is the principle that a person to whom a statute may constitutionally be applied will not be heard to challenge that statute on the ground that it may conceivably be applied unconstitutionally to others, in other situations not before the court"); accord State v. Schulman, 6 Or App 81, 84 (1971) (citing United States v. Raines, 362 US 17 (1960)). Having conceded that the amendment to ORS 656.027(3)(b) is constitutional, claimant Fletes' lacks standing to challenge the validity of other provisions of SB 369 not pertinent to this case.

Moreover, even if other sections of SB 369 were found to be constitutionally infirm, we do not consider the amendment to ORS 656.027(3)(b), which merely increases the threshold total labor cost for subject employees to $500, so "essentially and inseparably connected with and dependent upon" other parts of SB 369 that it is apparent that amended ORS 656.027(3)(b) would not have been enacted in their absence. See ORS 170.040.

In sum, we find no constitutional impediment to the retroactive application of amended ORS 656.027(3)(b) in this case. Under the new law, Hayes is not a noncomplying employer because he did not employ subject workers. Consequently, the Department's order and SAIF's claim acceptances must be set aside.

Because Hayes has prevailed against the Department's order on appeal, his counsel is entitled to a reasonable attorney fee for services at hearing and on review to be paid by the Director. ORS 656.740(5); see also John W. Bones, Jr., 47 Van Natta 1498 (1995).

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 Hayes' attorney's services at hearing and on appellate review before the Board and court for prevailing against the Department's order is $20,000, payable by the Director from the Consumer and Business Services Fund.[12] In reaching this conclusion, we have particularly considered the time devoted to the "noncomplying employer" issues (as represented by the record, Hayes' appellate briefs and his counsel's statement of services), the complexity of these issues, the value of the interest involved, the nature of the proceedings, the skill of the attorneys and the risk that counsel may go uncompensated.

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[10] Although a signatory to this order and required by the doctrine of stare decisis to follow the Board's holding in Kathleen M. Butler, supra, Member Gunn directs the parties to his dissenting opinion in that decision.

[11] ORS 174.040, which governs decisions regarding the severability of statutes, sets forth the legislative preference for severing the unconstitutional part and keeping the remainder of the statute in force unless: (1) the statute provides otherwise; (2) the remaining parts are so "essentially and inseparably connected with and dependent upon" the unconstitutional part that the remaining parts would not have been enacted without the constitutional part; or (3) the remaining parts, standing alone, are incomplete and incapable of being executed in accordance with legislative intent.

[12] Hayes' attorney's services directed toward prevailing against the Department's order include two days of hearing, months apart, in 1992, a request for Board review of the ALJ's order (which we dismissed for lack of jurisdiction in 1993), judicial review of our dismissal order and, on remand from the Court of Appeals, Board review of the ALJ's order in 1995.

Accordingly, on reconsideration, the ALJ's July 30, 1993 order is reversed. The Department's December 16, 1991 Proposed and Final Order Declaring Noncompliance and Assessing A Civil Penalty, Order No. 20202-AB, is also reversed. The SAIF Corporation's claim acceptances are set aside. Hayes' attorney is awarded $20,000, payable by the Director.

IT IS SO ORDERED.

January 31, 1996 Cite as 48 Van Natta 201 (1996)

In the Matter of the Compensation of
RICHARD R. HILLS, Claimant
WCB Case No. 94-11389
ORDER ON REVIEW (REMANDING)
Ransom & Gilbertson, Claimant Attorneys
Robert J. Yanity (Saif), Defense Attorney

Reviewed by Board Members Hall and Neidig.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order which: (1) declined to award interim compensation; and (2) declined to assess penalties for the SAIF Corporation's allegedly unreasonable claims processing. On review, the issues are interim compensation and penalties. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's "Ultimate Finding of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a work-related injury on July 11, 1994. That day, claimant was seen at a hospital emergency room for a jaw injury. While at the emergency room, claimant was given a urine drug test for which he tested positive for marijuana use. (Ex. 5).

On July 13, 1994, claimant was examined by Dr. Lewis, who diagnosed TMJ strain and soft tissue inflammation. (Ex. 9). On July 22, 1994, Dr. Lewis released claimant to full time modified work.

The employer offered claimant work consistent with Dr. Lewis' work release, which claimant accepted. (Ex. 12). On July 25, 1994, claimant came to work and was fired for violating the employer's alcohol/drug policy.

Claimant was paid interim compensation prior to his termination on July 25, 1994. SAIF accepted claimant's claim for fracture of the left coronoid process of the mandible on July 27, 1994. (Ex. 13). SAIF did not pay interim compensation between July 25, 1994 and July 27, 1994.

The ALJ found that claimant was not entitled to temporary partial disability (TPD) from the date he was fired to the time SAIF accepted his claim. Relying on Viking Industries v. Gilliam, 118 Or App 183, rev den 316 Or 529 (1993), the ALJ reasoned that when claimant chose to violate the employer's alcohol/drug policy, claimant in effect chose to voluntarily terminate his employment. Further, the ALJ determined that, pursuant to OAR 436-60-030(11)(b), claimant was deemed to have failed to begin employment for violating a normal employment standard. See ORS 656.268(3)(c).

On review, claimant contests the ALJ's finding that claimant "voluntarily" quit his job when he breached the employer's no alcohol/drug policy. As such, claimant asserts that he is entitled to interim compensation (which would consist of temporary disability benefits from the date he was terminated to the date his claim was accepted). See Bono v. SAIF, 298 Or 405, 407 n.1 (1984) (interim compensation is temporary disability payments made between the employer's notice of injury and the acceptance or denial of the claim). We decline to address at this time the propriety of the ALJ's decision regarding whether claimant "voluntarily quit" his employment. We reach such a conclusion because we hold that remand is warranted.

Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.325(5)(b) to read: "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." Or Laws 1995, ch 332, § 40 (SB 369, § 40) (Emphasis added).

Except as provided otherwise, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565, 572-73 (1995). Because amended ORS 656.325(5)(b) is not among the exceptions to this general rule, see SB 369, § 66 (listing exceptions to general retroactivity provision), and because this matter has not been finally resolved on appeal, the amended version of the statute applies here.[1]

We may remand a case for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate on a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986). A compelling basis for remand exists when the record is devoid of evidence regarding a legal standard that goes into effect while Board review of a case is pending. See, James Edmonds, 47 Van Natta 2283 (1995); Helen M. Callander, 47 Van Natta 1626 (1995) (the record was incomplete and insufficient to determine whether the claimant's low back condition "actually worsened," therefore, a compelling reason existed to remand).

Here, claimant accepted modified work. Therefore, claimant's return to modified work is a basis for terminating temporary disability benefits. ORS 656.268(3); Stanley Smith Security v. Pace, 118 Or App 602 (1993); Manual Altamirano, 47 Van Natta 1499 (1995). Claimant was terminated for violation of his employer's alcohol/drug policy. ORS 656.268(3).

Under amended ORS 656.325(5)(b), SAIF could terminate claimant's TTD. However, ORS 656.325(5)(b) also states that SAIF was to commence payment of TPD to claimant when his attending physician approved modified work (that would have been offered had claimant remained employed), provided that claimant's employer had a written policy of offering modified work to injured workers. The record contains no evidence of whether "the employer ha[d] a written policy of offering modified work to injured workers." See ORS 656.325(5)(b). As such, we consider the record to be incompletely and insufficiently developed to determine whether claimant's employer could have commenced payments of temporary partial disability after claimant was terminated for breaching its employment policy. Moreover, in light of the retroactive application of the amended statute, we find that there is a compelling reason to remand this matter for the submission of additional evidence regarding whether the employer had a written policy of offering modified work to injured workers. See James Edmonds, supra.

Accordingly, we vacate the ALJ's order and remand this case to ALJ Hoguet's for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order addressing all of the relevant issues.

IT IS SO ORDERED.

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[1] Under § 66(6) of SB 369, amendments that alter procedural time limitations with regard to action on a claim taken before the effective date of the Act do not apply retroactively. Motel 6 v. McMasters, 135 Or App 583, 587 (1995). Because ORS 656.325(5)(b) does not alter a procedural time limitation, § 66(6) does not apply to this case.

In the Matter of the Compensation of
PAUL R. HUDDLESTON, Claimant
WCB Case Nos. 94-09872, 94-03882, 94-09344, 94-09346, 94-09347, 94-09348 & 94-09342
ORDER ON RECONSIDERATION
Robert J. Guarrasi, Claimant Attorney
Lundeen, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys
Thomas Castle (Saif), Defense Attorney

Claimant requests reconsideration of those portions of our January 5, 1996 Order on Review that: (1) reduced claimant's attorney fee for services at hearing from $10,000 to $5,500; and (2) awarded a $500 attorney fee pursuant to ORS 656.382(2) for services on review but did not refer to such a fee in the "Order" portion of the Order on Review.

After conducting our additional review and considering claimant's submissions, we adhere to our conclusion that the compensability issue is of a medical, legal and factual complexity not unlike such issues which are generally presented in workers' compensation proceedings. In reaching this conclusion, we do not challenge claimant's counsel's assertion that numerous hours were required processing the numerous claims with an assortment of carriers who were involved in this dispute at various times during this proceeding, preparing for litigation of this dispute, and presenting claimant's case at the hearing. Nevertheless, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we continue to find that a reasonable fee for such services at the hearings level is $5,500, payable by Aetna. As noted in our previous decision, of particular interest to us in reaching our determination has been the time devoted to the case (as represented by the hearing record and counsel's statement of services), the complexity of the issue, the value of the interests involved, the skill of the attorneys, the nature of the proceedings and the risk that counsel may go uncompensated.

Finally, we agree with claimant that the "Order" portion on our January 5, 1996 Order on Review did not refer to the $500 attorney fee that we awarded pursuant to ORS 656.382(2) for claimant's attorney's services on review regarding the compensability issue. We correct the "Order" portion of our order by adding the following sentence: "Claimant's attorney is also awarded $500 under ORS 656.382(2), to be paid by Aetna."

Accordingly, we withdraw our January 5, 1996 order. On reconsideration, as supplemented herein, we republish our January 5, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Members Gunn and Hall concurring in part and dissenting in part.

For the reasons previously expressed in our dissenting opinion in the prior order, we adhere to our position that the ALJ's attorney fee award should be affirmed.

We agree, however, that the "Order" portion of the order should be corrected to refer to the $500 attorney fee that was awarded pursuant to ORS 656.382(2).

In the Matter of the Compensation of
MARGIE L. BRAME, Claimant
WCB Case No. C600139
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Estell & Bewley, Claimant Attorneys
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Member Neidig and Gunn.

On January 12, 1996, 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 the compensable injury. We approve the proposed disposition.

On January 17, 1996, we requested an addendum concerning language in the CDA that the carrier agreed to "waive an overpayment * * * as part of the compensation for this [CDA]." In that letter, we explained that an offset could not service as consideration underlying a CDA. E.g., Timothy W. Moore, 44 Van Natta 2060 (1992).

On January 23, 1996, after further consideration, we replaced the prior addendum letter with a request that the parties address the impact, if any, of the Board's order in Roy D. Welty, 47 Van Natta 1544 (1995), in the context of the "waiver of payment" language in the CDA. Having received claimant's response, we have proceeded with our review.

In Roy D. Welty, supra, we considered a CDA which provided for the payment of a lump sum and the carrier's "release of all claims to" an overpayment. After noting that a carrier's contractual relinquishment to pursue an overpayment could not serve as consideration for a CDA, we interpreted the CDA's total consideration as consisting of the lump sum and not including the overpayment. 47 Van Natta 1544.

The CDA here is similar to that in Welty since it provides for the payment of a lump sum of $8,000, as well as indicating that "part of the compensation" includes SAIF's agreement to waive an overpayment. Thus, pursuant to Welty, we construe the consideration underlying the CDA as being limited to the $8,000 lump sum.

Accordingly, we conclude that the CDA is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. ORS 656.236; OAR 438-009-0020. Therefore, the parties' claim disposition agreement is approved. An attorney fee of $2,000, payable to claimant's counsel, also is approved. The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035(1).

IT IS SO ORDERED.

As I have indicated in past dissents, I believe that our interpretation of "good cause" for failure to file a hearing request within 60 days should comport with appellate case law regarding the "good cause" requirement. See, e.g., Debra A. Gould, supra, (Board Member Hall, dissenting). The courts have held that "good cause" means "mistake, inadvertence, surprise or excusable neglect," as those terms are used in ORCP 71B(1). Brown v. EBI Companies, 289 Or 455 (1980); Hempel v. SAIF, 100 Or App 68, 70 (1990).

Here, claimant has established actual and reasonable confusion regarding the proper addressee of her request for hearing. She sent the request to the McGilchrist Street address which is, in fact, the Board's address. Under these circumstances, I would hold that claimant's use of the wrong addressee on the request for hearing mailed to the correct address is a mistake or excusable neglect and that claimant has established "good cause" for filing an untimely hearing request. For these reasons, I respectfully dissent.

February 2, 1996 Cite as 48 Van Natta 207 (1996)

In the Matter of the Compensation of
STEVE FRIEND, Claimant
WCB Case No. 94-02656
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Norman Cole (Saif), Defense Attorney

Reviewed by Board Members Hall, Christian and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the SAIF Corporation's partial denial of his right shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSION OF LAW AND OPINION

In 1988, claimant was in a motorcycle accident in which he injured his right shoulder. A significant contusion of the acromial process was diagnosed. Other than a March 1989 inquiry into a lump on claimant's right shoulder, claimant had no shoulder problems prior to his September 21, 1993 on-the-job truck accident.

The work-related truck accident occurred when the truck claimant was driving blew a left tire, causing the truck to veer off the shoulder of the road. After an intense struggle to steer the truck back onto the main highway, the truck became airborne for 50 to 100 feet before nose diving into the road to an abrupt stop. The impact bounced claimant around inside the cab, and slammed claimant's arms into the truck seats. Upon impact, claimant heard a loud pop in his right shoulder. By the next day, claimant was unable to move his arm beyond head level. Following conservative treatment, claimant eventually underwent surgery in February 1994 to repair a third degree right acromioclavicular (AC) separation.

The ALJ found that claimant had a preexisting right shoulder condition (chronic acromioclavicular separation) that combined with the September 1993 work-related motor vehicle accident (MVA) resulting in a complete acromioclavicular (AC) separation requiring treatment and resulting in disability. Relying on the opinions of Drs. Brockman, Strukel, and Brack, the ALJ found that claimant's September 1993 MVA was the precipitating cause, but was not the major contributing cause of claimant's right shoulder condition.[1] We disagree.

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[1] Subsequent to the ALJ's order, Senate Bill 369 was enacted, which amended ORS 656.005(7)(a)(B). Or Laws 1995, ch 332, § 1 (SB 369, § 1). Because we find that the evidence preponderates in favor of compensability of claimant's post-MVA shoulder condition and the need for treatment of that condition (as required under the amended law), we need not decide whether the new law applies.

Claimant contends that the September 1993 MVA caused a pathological worsening of the shoulder condition and was the major contributing cause of the need for treatment. We find that the MVA was the major contributing cause of claimant's post-MVA right shoulder condition (complete right AC separation with additional separation of the coracoclavicular ligament with a small bony fragment avulsed from the clavicle) and the major contributing cause of the treatment for that condition.

In light of claimant's prior medical history, we find that the causation issue for claimant's current condition is a complex medical question requiring expert medical opinion for its resolution. Uris v. Compensation Department, 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Several doctors rendered opinions on causation. Dr. Brockman, orthopedic surgeon, examined claimant on December 27, 1993 at the request of SAIF. He reasoned that bouncing around inside the cab of a truck would be inconsistent with causing an AC separation, but that trying to control the truck with a blown out tire would be consistent with aggravating the preexisting AC separation. He concluded that the preexisting condition was the major cause of claimant's current condition and need for treatment. (Ex. 38).

We find Dr. Brockman's opinion, that bouncing around in a truck cab would not cause an AC separation, unpersuasive because it is inadequately explained. See Denise L. Kolousek, 47 Van Natta 727 (1995).

Dr. Strukel, SAIF medical consultant, performed a records review. He concluded that the injury was a material contributing cause, but that the preexisting injury was the major contributing cause of the need for treatment. In reaching this conclusion, Dr. Strukel applied a "but for" analysis, i.e., if the AC joint had not been dislocated, the MVA would not have injured the shoulder. Because Dr. Strukel's opinion is analytically flawed, we give it little weight. See Phillip A. Kister, 47 Van Natta 905 (1995)(doctor's reasoning that "but for" the work exposure, the claimant would not have developed carpal tunnel, was insufficient to establish that the work was the major contributing cause).

Dr. Brack, who performed claimant's right shoulder surgery, essentially concurred with Dr. Brockman's opinion and with Dr. Strukel's analysis. Since we have given little weight to their opinions regarding causation, we likewise find Dr. Brack's opinion unpersuasive. (Exs. 40, 46).

Claimant's initial treating physician, Dr. Allott, disagreed that the preexisting shoulder condition was the major cause of claimant's current condition. Dr. Allott reasoned that claimant was functional prior to the September 1993 accident and that the accident caused more than a temporary or symptomatic worsening of claimant's preexisting shoulder condition. (Ex. 39). Dr. Allot concluded that the September 1993 MVA was the major contributing cause of claimant's current right shoulder condition. (Exs. 34, 36).

After reviewing the medical evidence, we find no persuasive reason not to defer to the opinion of Dr. Allot, claimant's treating physician immediately after the injury. Given this opportunity to examine claimant, we find that he was in the best position to render an opinion on causation. See Kienow's Food Stores, Inc. v. Lyster, 79 Or App 416 (1986). We are also persuaded by Dr. Allott's analysis concerning the post-injury changes in claimant's condition. See Dale B. Farrar, 47 Van Natta 874 (1995). We, therefore, find that the September 1993 truck accident was not merely the precipitating cause, but the major cause of claimant's right shoulder condition and the need for treatment. Consequently, the condition is compensable regardless of what compensability standard is applicable.

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 $2,475 payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's appellate briefs and claimant's counsel's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated March 13, 1995 is reversed. The SAIF Corporation's denial is set aside and the claim remanded to SAIF for processing according to law. For services at hearing and on Board review, claimant's attorney is awarded an assessed fee of $2,475, to be paid by SAIF.

Board Member Haynes dissenting.

The majority finds fault with all the medical evidence, except Dr. Allott's inconsistent opinion, to determine that claimant's injury is the major contributing cause of his current right shoulder condition. Because the majority's interpretation of the medical evidence is erroneous, I dissent.

In order to achieve its conclusion, the majority exercises the Board's de novo review authority and effectively changes the issue from one of law to one of fact. The majority conveniently ignores claimant's concession that he has a preexisting right shoulder condition and that ORS 656.005(7)(a)(B) applies. Claimant's arguments do not focus on the medical evidence or on which doctor's opinion is or is not persuasive. Rather, he argues that the ALJ applied an incorrect legal standard. Specifically, claimant contends that, under ORS 656.005(7)(a)(B), he need only prove that the September 1993 MVA was the major contributing cause of the disability or need for treatment. (Claimant's emphasis). Claimant argues that he need not prove that the injury was the major contributing cause of the shoulder condition and the need for treatment.[1] Claimant's argument, however, fails under amended ORS 656.005(7)(a)(B), in which he is required to prove that the September 1993 injury was "the major contributing cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

However, because claimant's legal argument fails, the majority nonetheless concludes that claimant has met the major contributing cause standard. In reaching this conclusion, the majority misconstrues the medical evidence.

Because the majority's interpretation of Dr. Allott's opinion is the most egregious, I address his opinion first. Dr. Allott first saw claimant on September 28, 1993. He diagnosed thoracic and cervical strain and prescribed physical therapy. Dr. Allott did not know that claimant had an AC sprain until so advised by the physical therapist.

Dr. Allott initially opined that the September 1993 MVA was the major contributing cause of claimant's current right shoulder condition. Dr. Allott, however, provided no explanation for this opinion.[2] Yet, Dr. Allott subsequently agreed with Dr. Strukel's analysis and conclusion that the preexisting shoulder condition was the major cause of claimant's current condition and need for treatment. Dr. Allott's initial opinion and his agreement with Dr. Strukel's opinion are inconsistent. Furthermore, Dr. Allott failed to explain his changed opinion. See Moe v. Ceiling Systems, 44 Or App 429 (1980); see also Kelso v. City of Salem, 87 Or 630 (1987). Given Dr. Allot's conclusory and inconsistent opinions, I would find them not persuasive.

Drs. Brockman, Strukel, and Brack all opined that claimant's preexisting AC separation[3] was the major contributing cause of claimant's right shoulder condition. The majority discounts Dr. Brockman's opinion, finding it inadequately explained. Dr. Brockman had a complete and accurate description of claimant's truck accident. He explained the mechanism of injury (the truck accident) was insufficient, in itself, to cause an AC separation. His explanation on causation is more than adequate.

The majority faults Dr. Strukel's opinion, reasoning that the doctor applied a "but for" analysis. Dr. Strukel agreed with Dr. Brockman that the preexisting AC separation was the major cause of

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[1] Claimant concedes that "the truck accident may not have been the major cause of the entire shoulder condition." App Brief at 4.

[2] In rendering this opinion, Dr. Allott qualified that he had last seen claimant on October 13, 1993 and that he did not know the result of the orthopedic consultations by Dr. Brack and Dr. Bulley.

[3] The majority discounts these doctors' opinions in order to decline to find that claimant had a preexisting shoulder condition. Even assuming that these opinions are not persuasive, the opinion of Dr. Bulley cannot be ignored. Dr. Bulley has treated claimant since 1988 for right shoulder complaints. In March 1989, Dr. Bulley reexamined claimant's right shoulder and diagnosed "a chronic acromioclavicular separation, with the clavicle and over-riding the acromion." Considering Dr. Bulley's opportunity to examine claimant both before and after the September 1993 MVA and, thus, to compare claimant's condition, I would find that claimant did have a preexisting AC separation condition. See Roff v. Georgia Pacific Corporation, 80 Or App 78 (1986)(afford weight to the opinion of a physician who had an opportunity to examine the claimant at critical times).

claimant's current right shoulder condition. He noted that, based on the surgical report, claimant had impingement (causing discomfort) that had been going of for a long time. In rending his opinion, Strukel assumed that claimant used both arms to wrestle control of the truck, but that only the right shoulder was injured. (Ex. 45).

Dr. Strukel's analysis is consistent with claimant's description of the truck accident. Claimant testified that it was more difficult to steer the truck with a blown steer tire and that he manhandled his truck to keep it upright. (Tr. 14-15). Rather than a "but for' analysis, I would interpret Dr. Strukel's analysis as an explanation of the combined effect of claimant's preexisting shoulder condition and the truck accident on claimant's current shoulder condition. Dr. Strukel viewed the truck accident as a precipitating cause, but not the major contributing cause of claimant's right shoulder condition. He, therefore, appropriately assessed the relative contribution of the different causes of claimant's shoulder condition. See Stacy v. Corrections Division, 131 Or App 610 (1994)(because a determination of major contributing cause requires the assessment of the relative contribution of different causes, it is necessary to consider the effect of all possible causes of a condition, including the contribution of the preexisting condition).

Dr. Brack concurred with the opinions of Dr. Brockman and Dr. Strukel. Dr. Brack diagnosed claimant's condition as chronic third degree right acromioclavicular separation, degenerative joint disease, right acromioclavicular joint. Dr. Brack opined that, although the September 1993 accident caused a temporary or symptomatic worsening of claimant's condition, the preexisting condition was the major contributing cause of the right shoulder condition and need for treatment. As the physician who performed claimant's right shoulder surgery, I would find Dr. Brack in the best position to provide an opinion regarding the cause of claimant's condition. Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988).

I cannot accept the majority's conclusion that the opinions of Drs. Brockman, Strukel and Brack are unpersuasive and that the opinion of Dr. Allott is persuasive. I would find that the opinions of Drs. Brockman, Strukel and Brack persuasively establish that claimant's preexisting shoulder condition is the major contributing cause of his current shoulder condition. Alternatively, even assuming for the sake of argument that none of the medical evidence is persuasive, then claimant has failed to carry his burden of proof. Accordingly, I respectfully dissent.

In the Matter of the Compensation of
DANNY R. FULLER, Claimant
WCB Case No. 93-12935
ORDER ON REVIEW
Schneider, Hooton, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Garaventa's order which: (1) set aside its denial of claimant's aggravation/current condition claim for an upper neck condition; (2) set aside its partial denial of claimant's right shoulder impingement syndrome; and (3) assessed a penalty for an allegedly unreasonable denial. On review, the issues are compensability, aggravation, and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In February 1990, claimant was injured at work when he slipped and fell. While falling, claimant attempted to catch himself by grabbing onto a piece of equipment with his right hand. Claimant sustained injury to his neck and right shoulder. Dr. Waller, attending physician, diagnosed cervical radiculopathy. (Ex. 5). A MRI revealed a disc herniation on the right C5-6. (Ex. 7). The insurer accepted a claim for cervical strain. (Ex. 3).

In June 1990, Dr. Waller performed surgery to repair the C5-6 herniated disc. However, at surgery, Dr. Waller determined that claimant did not have a disc herniation. Instead, Dr. Waller observed an osteophyte (bone spur) causing compression of the C6 nerve root at the point of entrance into the intervertebal foramen. (Ex. 8). A laminotomy and foraminotomy were performed to decompress the C6 root.

In October 1990, Dr. Morris examined claimant on behalf of the insurer. Dr. Morris diagnosed claimant's right shoulder pain as either a rotator cuff injury or possible impingement syndrome. Claimant's neck condition was diagnosed as residual right cervical radiculopathy. (Ex. 14). Dr. Waller concurred with Dr. Morris' findings. (Ex. 16).

In January 1991, Dr. Waller opined that claimant was medically stationary and released him to regular work. Dr. Waller noted that claimant had no significant arm discomfort, mild neck pain and normal strength in his arms. (Ex. 19). A Determination Order closed claimant's claim awarding 21 percent permanent disability for surgery and foraminal stenosis. (Ex. 25).

In August 1992, claimant temporarily moved to California. While in California, claimant was examined by Dr. Houston for neck problems. (Ex. 27). He diagnosed right and left arm radiculopathy. (Ex. 30). Dr. Stevenson, on referral by Dr. Houston, reported that claimant's right grip strength was weaker than on the left, a right triceps that was 40 percent impaired, and paraspinous muscle spasm. (Ex. 29). Believing that claimant may have a herniated disc, Dr. Stevenson ordered a cervical MRI. (Ex. 29). The MRI revealed degenerative narrowing at C5-6 with anterior and posterior bone spurs. (Ex. 39). The insurer issued an aggravation and current condition denial in October 1993. (Ex. 32). In December 1993, claimant returned to Oregon. (Tr. 11).

On May 20, 1994, Dr. Waller related claimant's need for treatment in California to his 1990 work injury. (Ex. 40). Dr. Waller examined claimant in June 1994, finding weakness in his right arm in all muscle groups. (Ex. 42). Dr. Gerry, on referral by Dr. Waller, related claimant's neck pains to a muscular problem. He attributed claimant's right shoulder and arm condition to impingement syndrome. (Ex. 43-2). Dr. Gerry was of the opinion that claimant's impingement syndrome was possibly caused by his 1990 work injury. (Ex. 51-25). Dr. Gerry agreed with claimant's counsel that the work injury probably caused claimant's impingement syndrome. (Ex. 51-66). In December 1994, the insurer issued a denial of claimant's right shoulder impingement syndrome. (Ex. 49-1).

The ALJ found that claimant had established an aggravation of his compensable condition. In so doing, the ALJ determined that the insurer was precluded from denying the compensability of claimant's foraminal stenosis when it did not contest the Determination Order. The ALJ applied the court's reasoning in Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) rev den, 320 Or 507 (1995). Additionally, the ALJ concluded that claimant's industrial injury materially caused his current condition (impingement syndrome).

On review, the insurer contends that payment of permanent disability benefits for claimant's foraminal stenosis does not preclude it from contesting the compensability of that condition. Further, the insurer asserts that the compensability of claimant's current condition should be analyzed under ORS 656.005(7)(a)(B). Specifically, according to the insurer, claimant's impingement syndrome combined with degenerative bone spurs to result in his current condition.

Subsequent to the date of the ALJ's decision, the legislature enacted SB 369, which amended ORS 656.262(10) (formerly ORS 656.262(9)). Or Laws 1995, ch 332, § 28 (SB 369, §28). According to § 66(5)(b) of SB 369, ORS 656.262(10) applies retroactively to all claims "without regard to any previous order or closure." Under § 66(5)(a) of SB 369, the amendments to ORS chapter 656 apply only to those matters for which an order or decision has not become final on or before the effective date of the Act.

Inasmuch as there has been no final order or decision in this case and because the statute does not alter procedural time limitations, amended ORS 656.262(10) applies retroactively. See Volk v. America West Airlines, 135 Or App 565 (1995); Motel 6 v. McMasters, 135 Or App 583 (1995). Amended ORS 656.262(10) provides:

> "Merely paying or providing compensation shall not be considered acceptance of a claim or an admission of liability, nor shall mere acceptance of such compensation be considered a waiver of the right to question the amount thereof. Payment of permanent

disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted." (Emphasis added).

Here, the insurer accepted claimant's injury claim for cervical strain. A Determination Order awarded permanent disability benefits for claimant's surgery and foraminal stenosis. Based on the clear language of amended ORS 656.262(10), payment of a DO award, "shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein * * *." According to § 66(5)(b), the statute applies retroactively regardless of any previous order or closure. Therefore, the insurer is not precluded from denying claimant's foraminal stenosis by failing to contest the Determination Order. Craig L. Hiatt, 47 Van Natta 2287 (1995). Additionally, under ORS 656.262(10), the insurer is not precluded from denying the compensability of claimant's foraminal stenosis by paying for medical treatment (i.e. surgery) to treat this condition.

Since the insurer is not precluded from contesting the compensability of the denied condition, we turn to the issue of what is the appropriate legal standard of proof. Based on the following reasoning, we conclude that claimant's compensable injury must be the major contributing cause of his current neck condition.

Amended ORS 656.273(1) now provides, in pertinent part:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." (Emphasis added).

The statute requires proof of two specific elements in order to establish a worsened condition: (1) "actual worsening;" and (2) a compensable condition. Both elements must be satisfied in order to establish "a worsened condition resulting from the original injury."

In Gloria T. Olson, 47 Van Natta 2348 (1995), we determined that under the former version of ORS 656.273, the burden of proof to establish a "worsened condition resulting from the original injury" was whether the original compensable injury was a material contributing cause of the worsened condition. See Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994). However, we further noted that the legislature inserted the phrase "of an actual worsening of the compensable condition" following the phrase "[a] worsened condition resulting from the original injury is established by medical evidence. . ." In light of such circumstances, we reasoned that the plain meaning of the inserted language is to define what evidence constitutes proof of "a worsened condition resulting from the original injury." Further noting that the term "compensable condition" had been added to the aggravation statute, we concluded that a condition which has not already been found compensable must be established as compensable in order to prove "a worsened condition resulting from the original injury" under ORS 656.273). We turn to an application of the Olson rationale.

Here, claimant's accepted right shoulder condition was diagnosed as cervical radiculopathy. (Ex. 5). Thus, the worsened condition is a right shoulder impingement syndrome. (Exs. 14, 43, 44). The right shoulder impingement syndrome is not an accepted condition. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the impingement syndrome is a compensable condition.

We find that, whether under a material or major cause standard claimant has failed to prove the compensability of his impingement syndrome. If it is a direct causation theory, the material contributing cause standard applies. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). If it is a consequential or resultant condition theory, the major contributing cause standard applies. ORS 656.005(7)(a)(A), (B); see Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod on recon 120 Or App 590, rev den 318 Or 27 (1993); Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

Dr. Waller, attending physician, opined that claimant's impingement syndrome was not related to the 1990 work injury. Because Dr. Waller is the only physician to have examined claimant for his initial injuries and his current condition, he was in the best position to evaluate the cause of claimant's impingement syndrome. Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986). Further, we find

Dr. Waller in the best position to render an opinion because he was claimant's surgeon. See Argonaut Ins. Co. v. Mageske, 93 Or App 698 (1988).

In contrast, we find the opinion of Dr. Gerry inconsistent and, therefore, unpersuasive. On deposition, Dr. Gerry stated that impingement syndrome is most often associated with repetitive overuse. However, when asked if claimant's "fall" could have caused his impingement syndrome, Dr. Gerry stated that it was a "possible cause." (Ex. 51-25). Then, later in the deposition, Dr. Gerry agreed with claimant's counsel that claimant's impingement syndrome is "probably" related to his work incident. Because we find Dr. Gerry's opinions inconsistent with no explanation for the inconsistencies, we decline to give it persuasive force. See Moe v. Ceiling Systems, 44 Or App 429 (1980); see also Kelso v. City of Salem, 87 Or 630 (1987).

In conclusion, based on the persuasive opinion offered by Dr. Waller, we conclude that claimant has failed to prove that his impingement syndrome is related to his February 1990 work injury. Finally, because claimant's aggravation claim was based on the compensability of his impingement syndrome and since we have found that condition not compensable, it follows that claimant's compensable condition has not worsened since the last award or arrangement of compensation. See ORS 656.273.

Penalty

A penalty may be assessed when an employer "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(1)(a). The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the employer had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the employer at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988): Price v. SAIF, 73 Or App 123, 126 n.3 (1985).

In light of the fact that we have reinstated and upheld SAIF's October 22, 1993 and December 6, 1994 denials, we find that a penalty under ORS 656.262(10) is unwarranted.

ORDER

The ALJ's order dated June 5, 1995 is reversed. The SAIF Corporation's denials of October 22, 1993 and December 6, 1994, are reinstated and upheld. The ALJ's penalty and attorney fee awards are reversed.

Board Chair Hall dissenting.

The resolution of this case depends upon the majority's interpretation of amended ORS 656.262(10), to find that the insurer is not precluded from contesting the compensability of claimant's foraminal stenosis even though it failed to appeal the Determination Order which awarded disability benefits for this condition. Because I find that amended ORS 656.262(10) does not overturn Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), I respectfully dissent.

Initially, I point out the dissent in Craig L. Hiatt, 47 Van Natta 2287 (1995). In the dissent, Board Member Gunn and I recognize that amended ORS 656.262(10) allows a carrier to pay disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order and still retain its right to contest the compensability of the condition rated therein. The dissent also explores the court's ruling in Messmer, which held that a carrier must appeal an order making an award for a noncompensable condition or face the effects of claim preclusion.

Again I emphasize that the payment of an award, in regard to amended ORS 656.262(10) is quite different from the issue of claim preclusion which was addressed by the court in Messmer. As such, I reiterate that amended ORS 656.262(10) does not address or overturn the issue of claim preclusion as addressed by the court in Messmer.[1]

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[1] I acknowledge the legislative history surrounding amended ORS 656.262(10), which included specific reference to Messmer, supra. Nevertheless, while I respect the intent of the legislature to overturn Messmer, the actual language of amended ORS 656.262(10) does not accomplish the intended result, since the amended law continues to address payment of benefits but fails to address issue preclusion which was the cornerstone of the Messmer decision.

Therefore, in this case, since the insurer did not appeal the Determination Order which awarded benefits for claimant's foraminal stenosis, the insurer is precluded from contesting the compensability of claimant's foraminal stenosis. In so determining, I recognize that payment of benefits, in and of itself does not mean that the insurer has accepted claimant's foraminal stenosis. However, as was true prior to SB 369, the failure to appeal an order still acts (by way of claim preclusion) to bar the insurer from contesting the compensability of the condition rated in the "order."

February 2, 1996 Cite as 48 Van Natta 214 (1996)

In the Matter of the Compensation of
MICHAEL R. GALLAGHER, Claimant
WCB Case No. 94-05020
ORDER ON REVIEW
Cobb & Woodworth, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

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

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

The ALJ found claimant's claim for a psychological condition compensable as a consequence of claimant's February 23, 1993 compensable neck and shoulder injury. See ORS 656.005(7)(a)(A).[1]

On review, the employer argues that this claim should be analyzed under the occupational disease statute rather than as a consequence of the compensable injury. In support of its contention, the employer contends that there is no link between claimant's panic/anxiety attacks and the February 1993 compensable injury. We disagree. The medical evidence relates claimant's psychological condition to the compensable injury.

In this regard, claimant's attending physician, Dr. Sabo, has opined that the February 1993 compensable injury was the major contributing cause of the panic disorder. (Exs. 17; 32; 36-36). Dr. Sabo, D.O., treated claimant for his anxiety and panic attacks as well as for his February 1993 injury. Dr. Sabo believed that claimant's panic attacks were directly related to the injury. Dr. Sabo noted that, during his recovery, claimant had fears of possibly losing his job and being unemployed; as a result of his fears, Dr. Sabo concluded that claimant developed anxiety.

Dr. Turco, a psychiatrist, examined claimant on behalf of the employer. Dr. Turco opined that claimant's February 23, 1993 injury was not a contributing cause of his mental condition, but that a meeting claimant had in March 1993, with his supervisors and the employer's light duty coordinator, was the cause of claimant's disorder.

Dr. Sabo related claimant's psychological condition directly to the February 1993 injury. We note that Dr. Turco also related claimant's psychological condition to a meeting which pertained to claimant's light duty work as a result of the February 1993 injury. Given that the medical evidence focuses on the February 1993 injury, as opposed to claimant's work activities or environment, as the source of claimant's psychological condition, we are persuaded that the compensability of claimant's psychological condition should be analyzed under ORS 656.005(7)(a)(A). See Daniel S. Field, 47 Van Natta 1457 (1995) (it is the Board's obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim); see also Arnold D. Schaffer, 47 Van Natta 1667 (1995).

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[1] ORS 656.005(7)(a)(A) was not changed by the 1995 amendments to the workers' compensation law.

Under such circumstances, it was appropriate for the ALJ to analyze the claim under the statute pertaining to consequences of compensable injuries. That statute provides that no injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition. Where the major contributing cause of a claimant's psychological condition is a compensable injury or its sequelae (including injury-related job loss and loss of self-esteem), we have held that the claimant has established compensability of a consequential psychological condition. See Albert H. Olson, 46 Van Natta 1848 (1994); see also SAIF v. Freeman, 130 Or App 81 (1994) (psychological condition remained compensable because the medical evidence established that the claimant became depressed and lost self esteem and confidence as a result of his compensable injury).

After reviewing this medical evidence, we find no persuasive reason not to rely on the opinion of Dr. Sabo. Weiland v. SAIF, 64 Or App 810 (1983).[2] Dr. Sabo treated claimant for his February 1993 injury and for his panic disorder. Dr. Sabo opined that the February 1993 injury was the major contributing cause of claimant's psychological condition. Given his experience with the development of claimant's physical and psychological conditions, we find Dr. Sabo's causation opinion persuasive. Moreover, we note that even Dr. Turco related claimant's psychological condition to an event associated with his compensable injury, i.e., claimant's March 1993 meeting with the employer over light duty. Under such circumstances, we conclude that claimant has established compensability of his panic disorder.[3] Accordingly, we affirm the ALJ's opinion finding claimant's psychological condition compensable.

In reaching this decision, we note that a claimant's reaction to a carrier's claims processing is not caused by the compensable injury. Roseburg Forest Products v. Zimbelman, 136 Or App 75, 79 n. 2 (1995). In Zimbelman, the court indicated in a footnote that a claimant's reaction to claims processing cannot be said to be caused by the compensable injury; instead, it is caused by the process by which the claimant is compensated for the injury. The court further noted that, because these processes are collateral to the injury, conditions caused by them are not caused by the compensable injury. Id.

Here, however, based on Dr. Sabo's opinion, we conclude that claimant's condition was caused in major part by the compensable injury itself, as opposed to the employer's processing of claimant's claim. In other words, Dr. Sabo did not relate claimant's psychological condition to the employer's processing of claimant's neck/shoulder claim. See also Curtis R. Pothier, 47 Van Natta 617 (1995) (compensability of consequential psychological condition established where the compensable injury, itself, was the major contributing cause); compare Douglas R. Baar, 46 Van Natta 763, on recon 46 Van Natta 963 (1994) (atttending physician's opinion that the major contributing cause of the claimant's hypertension condition was the compensable injury and the attendant claims processing, failed to meet the claimant's burden of proving that the injury was the major contributing cause of that condition).

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

ORDER

The ALJ's order dated May 16, 1995 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the employer.

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[2] We note that Dr. Sabo confused claimant's February 1993 injury with a prior 1990 compensable injury. However, after the confusion was cleared up, Dr. Sabo continued to opine that claimant's psychological condition was related to the February 1993 compensable injury. Dr. Sabo's opinion is consistent with his contemporaneous chart notes which had related the anxiety/panic condition to the February 1993 injury.

[3] Claimant was also examined, on the employer's behalf, by Drs. McKillop and Reimer. These physicians opined that the connection between claimant's compensable injury and his panic attacks was unclear. We are not persuaded by the opinion of Drs. McKillop and Reimer because we find it to be conclusory and lacking in explanation and medical analysis.

In the Matter of the Compensation of
EARIN J. HADLEY, Claimant
WCB Case No. 95-01763
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Peter C. Davis (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order which found that the SAIF Corporation had properly calculated the rate of claimant's temporary disability benefits. On review, the issue is rate of temporary disability benefits.

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

In November 1993, claimant began working for his employer, a logging company. Claimant and his employer realized that the logging business was seasonal and that lay-offs were likely during the winter months due to wet and snowy weather conditions. (Tr. 4).

Claimant did not work the first three weeks of January 1994 and from February 19, 1994 through March 10, 1994. Additionally, (because of the weather conditions), claimant did not work from March 15, 1994 through May 6, 1994. When the March 15, 1994, lay-off began, claimant received unemployment compensation until he resumed work in May 1994.

On June 7, 1994, claimant sustained a compensable injury. The injury was disabling and claimant was eligible for temporary total disability (TTD). SAIF computed claimant's TTD based on claimant's previous 26 weeks average weekly wages prior to his compensable injury. Claimant disagreed with SAIF's calculation of his TTD and requested a hearing.

The ALJ found that claimant's temporary disability rate was properly calculated using claimant's previous 26 weeks average weekly wages prior to his injury. In so doing, the ALJ determined that there were no "extended gaps" in employment within the meaning of OAR 436-60-025(5)(a). Specifically, the ALJ determined that the breaks in claimant's employment did not "change his work relationship" with his employer. Steven V. Caldwell, 44 Van Natta 2566 (1992). Therefore, the ALJ concluded that claimant's time loss rate could not be calculated using the previous 4 weeks average wages prior to his injury.

On review, claimant contends that there was a change in his work relationship with his employer and, therefore, there were "extended gaps" in his employment within the meaning of OAR 436-60-025(5)(a). According to claimant, his disability rate should be calculated using the 4 weeks of employment prior to his injury. Further, claimant asserts that unemployment benefits should be used in calculating his time loss rate. Finally, claimant contends that OAR 436-60-025(5)(a) is "clear on its face." As such, according to claimant, by having to prove that there has been a "change in his work relationship" the Board has placed a greater burden on claimant than the administrative rule intended.

We adopt and affirm the ALJ's conclusion that there were no "extended gaps" within the meaning of OAR 436-60-025(5)(a). However, we supplement to address claimant's remaining contentions.

Claimant contends that the Board's requirement to prove a "change in the work relationship" is a burden not intended by the administrative rule. In effect, claimant requests disavowal of a line of Board cases which have interpreted the meaning of "extended gaps" as used in OAR 436-60-025(5)(a). For the following reasons, we decline claimant's request.

OAR 436-60-025(5)(a) is not "clear on its face," because the administrative rule fails to define "extended gaps" within its text. As such, a line of cases have been issued interpreting "extended gaps" and applying that standard to the facts as presented in each particular case. Since a break in the performance of work activities might be significant or "extended" for one worker in a particular employment relationship, whereas not significant for another worker in a different employment relationship, we have reasoned that the particular work relationship must be examined to determine whether the break in the performance of the work activities constitutes a change in that work relationship; i.e., an "extended gap." Such a determination is made on a case-by-case basis. Steven Caldwell, supra (an extended gap must include a break in work, and the "break" must cause a change in the work relationship between the employer and employee). After further consideration of the

reasoning represented by the Caldwell holding, we decline claimant's request to disavow our longstanding interpretation of "extended gaps" as used within administrative rule OAR 436-60-025(5)(a).

Finally, claimant contends that unemployment benefits he received during the previous 26 weeks prior to his injury should be used to calculate his TTD. We disagree.

In David D. Plueard, 47 Van Natta 1364 (1995), we determined that total temporary disability compensation was to be equal to 66 2/3 percent of a claimant's "wages." ORS 656.210(1). Further, we found that OAR 436-60-025(5) provides in part: "The rate of compensation for workers employed with unscheduled, irregular or no earnings shall be computed on the wages determined by this section." (Emphasis added). Finally, we found that the definition of "wages" under ORS 656.005(29) did not include unemployment benefits. Therefore, we held that the claimant's unemployment benefits should not be considered for calculating the rate of time loss.

Similarly, in this case claimant's unemployment benefits are not "wages" as defined by ORS 656.005(29). Claimant cites no statutory or administrative authority for his argument. Accordingly, the rate of time loss compensation calculated pursuant to OAR 436-60-025(5)(a) shall not include claimant's unemployment benefits.

ORDER

The ALJ's order dated May 31, 1995 is affirmed.

Board Chair Hall dissenting.

Claimant contends that by having to prove that there has been a "change in the work relationship" and thus an "extended gap" in employment, the Board has placed a greater burden on claimant than the administrative rule intended. Because I agree with claimant's contention, I respectfully dissent.

The dispute in this case involves the calculation of claimant's time loss benefits. As such, time loss benefits represent wage replacement that claimant is entitled, due to sustaining a compensable industrial injury.

ORS 656.210(2)(c) provides:

> "As used in this subsection, 'regularly employed' means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the director, by rule, may prescribe methods for establishing the worker's weekly wage."

OAR 436-60-025(5)(a) provides:

> "For workers employed on call, paid by piece work or with varying hours, shifts or wages, insurers shall use the worker's average weekly earnings for the previous 26 weeks unless periods of extended gaps exist. When such gaps exist, insurers shall use no less than the previous four weeks of employment to arrive at an average. For workers employed less than four weeks, or where extended gaps exist within the four weeks, insurers shall use the intent at time of hire as confirmed by the employer and the worker."

In promulgating OAR 436-60-025(5)(a) the Director has not defined the term "extended gaps." As such, the Board has relied on a lineage of cases which have defined what an "extended gap" means within the administrative rule. See Harold Underwood, 47 Van Natta 77 (1995); Steven Caldwell, 44 Van Natta 2566 (1992) (an extended gap must include a break in work, and the "break" must cause a change in the work relationship between the employer and employee); Adam J. Delfel, 44 Van Natta 524 (1992); Dena L. Barnett, 43 Van Natta 1776 (1991); Sally M. Turpin, 37 Van Natta 924, 926 (1985).

In determining what is an "extended gap" a prior Board (in 1987) considered such factors as the length of the break in work and whether the break has caused a change in the work relationship between the claimant and the employer. See Craig E. Hobbs, 39 Van Natta 690 (1987). The prior Board's decision in Craig E. Hobbs, supra, to require that a claimant prove "a change in the work relationship" was made without any statutory, court, or regulatory authority. Not only was the Board in Hobbs without authority to place an "additional" burden upon claimant, the Board offered no reasoning for its actions. See Craig E. Hobbs, supra. I find this lack of reasoning disturbing eight years later.

Time loss benefits represent wage replacement for an injured worker. As such, wage replacement should be based on the wages claimant would have received but for his industrial injury. The Director's rule recognizes that "extended gaps" in earnings would dilute the "average weekly earnings." To address that potential outcome, the rule provides for exclusion of those gaps by using "no less than the previous four weeks of employment to arrive at an average." Indeed, the Director has recognized that "extended gaps" may occur even within a period of four weeks. Again, such recognition reflects the fact that gaps in employment (which necessarily result in lost earned wages) will dilute the average weekly wage and, thus, should not be used in calculating the average weekly wage.

In requiring a change in the employment relationship before excluding "extended gaps" from the calculation, the majority defeats the apparent goal of the Director's rule to not dilute the average weekly wage through consideration of extended "non-work" periods. While it may be permissible for the Board to define a term which the Director has neglected to define, the Board cannot impose greater restrictive burdens in doing so. Here, the majority's interpretation of what an "extended gap" entails should be consistent with a determination of an average weekly wage commensurate with a worker's actual employment. Since the majority's definition of "extended gap" necessarily results in temporary disability rate calculations which consider extensive periods of idle, non-wage earning time, I submit that such reasoning is inconsistent with the fundamental premise of the rule which is to provide a rate of temporary disability based on a fair appraisal of the worker's average weekly wage while working for the employer.

February 2, 1996 Cite as 48 Van Natta 218 (1996)

In the Matter of the Compensation of
RICHARD L. HEADLEY, Claimant
WCB Case No. 95-06954
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that: (1) declined to award temporary disability benefits allegedly arising out of an earlier ALJ's order; and (2) declined to award an attorney fee or penalties for allegedly unreasonable claims processing. On review, the issue is entitlement to procedural temporary disability benefits and penalties.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated July 28, 1995 is affirmed.

Board Chair Hall specially concurring.

I write separately to address an argument raised by claimant and to explain that despite claimant's contention, I agree with the ALJ's conclusion in this case.

In a prior Opinion and Order, ALJ Marshall determined that the insurer was not obligated to pay interim compensation because "claimant has not shown that the insurer received a medical verification of an inability to work due to a worsening of his compensable condition." (Ex. 52-6) In making this determination, ALJ Marshall found that (1) Dr. Neal's off-work authorizations did not clearly establish that claimant's compensable condition had worsened; and (2) claimant presented no evidence that the insurer ever received the off-work authorizations.

Based on this prior order, ALJ Garaventa found that it was the "law of the case" that there was no adequate medical verification as of April 7, 1995 and, in the absence of any subsequent medical verifications, the employer remained under no duty to pay time loss.

Claimant argues on review that temporary disability benefits are different from interim compensation benefits and therefore the prior ALJ's findings concerning his entitlement to interim compensation cannot operate to prevent him from proving an entitlement to procedural temporary disability benefits. I agree that there are differences between these two forms of benefits and that a final order denying a worker interim compensation does not necessarily preclude litigation concerning that worker's entitlement to temporary disability benefits.[1] The problem in this case stems from the fact that in determining claimant's entitlement to interim compensation, the prior ALJ made a factual determination regarding the adequacy of specific exhibits which are again in issue.

ALJ Marshall actually decided that Dr. Neal's initial off-work authorizations were insufficient as proof that claimant's compensable condition had worsened. Claimant is relying on those very same authorizations in this case to establish his procedural entitlement to temporary disability benefits (i.e., Exs. 19, 24 and 25A). The exhibits are no more persuasive now than in the first hearing before ALJ Marshall. To the extent that ALJ Marshall passed judgment as to the substantive merits of these exhibits and to the extent that this evidence remains the same, ALJ Marshall's factual determination is the "law of the case." See Susan E. Kristch, 46 Van Natta 1495 (1994) (where prior order determined that the claimant was not entitled to "interim time loss," the claimant was precluded from later relitigating the same factual transaction in context of establishing his entitlement to temporary disability benefits).

Had ALJ Marshall decided the insurer was not obligated to pay interim compensation solely on the basis that it had not received "notice" of claimant's inability to work, then claimant would not be prevented from litigating the legal sufficiency of Dr. Neal's off-work authorizations in this case. Similarly, if additional evidence verified claimant's inability to work (for the same time period) due to his compensable conditions, then claimant could have proven his procedural entitlement to temporary disability benefits notwithstanding the prior order concerning interim compensation. Because neither of the above occurred in this case, I agree that claimant's request for relief was properly denied.

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[1] In the aggravation context, interim compensation is paid while the claim is deferred where the carrier has notice of a medically verified inability to work as a result of a worsening of the compensable condition. See ORS 656.273(6).

February 2, 1996 Cite as 48 Van Natta 219 (1996)

In the Matter of the Compensation of
BARBARA J. LLOYD, Claimant
WCB Case No. 94-00752
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its partial denial of claimant's claim for a current right knee condition; and (2) assessed a penalty for the employer's 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, except for his finding that the 1986 left foot injury was the major contributing cause of claimant's current right knee condition.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's accepted left foot injury in 1986 was the major contributing cause of her need for right knee surgery, and therefore concluded that the right knee condition was a compensable consequence of the 1986 injury. On review, the employer contends that the medical record is insufficient to carry claimant's burden of proving, under ORS 656.005(7)(a)(A), that the accepted 1986 injury was the major contributing cause of her current right knee condition and resultant need for surgery.

In response, claimant agrees that it is her burden to prove that the 1986 injury was the major contributing cause of her current knee condition. She contends that she has carried her burden of proof. Alternatively, citing Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995), claimant contends that the employer is precluded from denying that her preexisting, degenerative knee condition is a compensable component of the accepted 1986 injury claim.[1]

Inasmuch as the right knee condition allegedly arose as a result of the accepted foot injury, rather than the industrial accident itself, claimant must establish compensability of the knee condition as a consequential condition under ORS 656.005(7)(a)(A). See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). She must prove that the accepted foot injury was the major contributing cause of the right knee condition. Based on our review of the medical record, we conclude that she has not carried her burden of proof.

We begin with a summary of the relevant facts. Claimant compensably injured her left foot in April 1986 when she stepped in a hole at work. The diagnosis was a fracture of the left 5th metatarsal, and her left leg was placed in a short cast for more than four weeks. Upon removal of the cast, claimant continued to have severe left foot pain which caused her to bear most of her weight on the right side. Her doctor diagnosed reflex sympathetic dystrophy and treated conservatively. Claimant improved and was released for work in October 1986.

In November 1986, claimant began developing pain and stiffness in the right knee. X-rays revealed degenerative arthritic changes with spurring in the right knee, particularly in the medial compartment. In June 1987, claimant underwent arthroscopic right knee surgery for a cartilage shave. Dr. Bachhuber, the treating orthopedic surgeon, found chondromalacia of the patella and the medial compartment. Several months later, Dr. Bachhuber declared her condition medically stationary and concluded that she had permanent impairment of the right knee due to "medial compartment degenerative changes and chondromalacia." The claim was subsequently closed by Determination Order on November 20, 1987 with an award of 5 percent scheduled permanent disability for the right leg (knee). That award was not appealed and became final.

Claimant continued to have problems with the right knee and, in November 1992, was referred to Dr. Hanley, orthopedic surgeon, with symptoms of severe right knee pain with give-way and locking. An arthroscopic examination revealed profound degenerative arthritis, and claimant underwent right total knee replacement surgery in March 1993. She sought reopening of her 1986 claim. Because the aggravation rights on the claim had expired, her reopening request was referred to the Board pursuant to our "own motion" authority under ORS 656.278. The employer recommended against claim reopening. Subsequently, claimant filed a request for hearing.

Because claimant's right knee problems did not appear immediately following the foot injury, and there are multiple potential causes for the condition, we find that the causation issue is a complex medical question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Department, 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993). The medical evidence consists of opinions by Drs. Marble and Hanley.

Dr. Marble, orthopedic surgeon, reviewed claimant's medical records at the employer's request. Based on the documented findings of significant degenerative changes in June 1987 and claimant's obesity, Dr. Marble opined that claimant had preexisting degenerative changes in the right knee that were aggravated by the prolonged period of partial weight bearing on the left, brought about by the foot injury and subsequent complication of reflex sympathetic dystrophy. He did not feel that the 1986 injury was the most significant factor in her current condition. He felt, instead, that her condition was more the result of her obesity and preexisting degenerative condition. (Ex. 12-3).

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[1] The employer argues that claimant cannot rely on Messmer because she conceded in her respondent's brief that the "major contributing cause" standard must guide the Board's compensability determination. We disagree. Claimant's "Messmer" argument was clearly intended as an alternative basis for finding the current right knee condition to be compensable, in the event the Board concluded the medical evidence was insufficient to carry her burden of proof under the "major contributing cause" standard. We conclude, therefore, that claimant did not "waive" or otherwise relinquish her argument that the employer is barred, by claim preclusion, from denying the degenerative knee condition.

Dr. Hanley, the treating orthopedic surgeon, initially opined: "[Claimant's] need for a knee replacement is not related to any specific injury but is related to accumulated wear and tear over the years. The need, however, for the arthroscopic surgery was probably precipitated by her industrial injury." (Ex. 13). Dr. Hanley later concurred that "it is unlikely that [claimant's] 1986 foot injury had any significant impact to her right knee condition or need for surgery," though he added that the injury "may have been 'the straw that broke the camel's back' so to speak." (Ex. 18). In his deposition, Dr. Hanley reiterated that the major cause of the need for knee replacement was the accumulated wear and tear over the years, not the 1986 foot injury. (Ex. 19, pp. 21-22). He felt, however, that the 1986 injury was the major contributing cause of the acceleration of degenerative changes in the right knee, and that the knee replacement would not have been needed but for the injury. (Ex. 19-33).

The ALJ relied on Dr. Hanley's opinion in finding that claimant has carried her burden of proof. However, Dr. Hanley specifically stated that the 1986 injury was not the major cause of the need for knee replacement surgery. (Ex. 19-21). At most, he felt that the 1986 injury was the major cause of the acceleration of degenerative changes in the knee. (Ex. 19-33). ORS 656.005(7)(a)(A) requires more; claimant must prove the injury was the major cause of the consequential (right knee) condition, not just the worsening of the preexisting condition. Compare Stacy v. Corrections Division, 131 Or App 610, 613-14 (1994) (in an occupational disease claim for the worsening of a preexisting condition, the claimant must still prove that the employment activities were the major contributing cause of his new condition). Therefore, we conclude Dr. Hanley's opinion does not carry claimant's burden of proof by a preponderance of the evidence in the record. See ORS 656.266; See also Dan J. Cone, 47 Van Natta 2220 (1995) (to establish a compensable occupational disease claim under amended ORS 656.902(2)(6) for a "combined condition;" claimant must prove that work activities were the major contributing cause "the combined condition and pathological worsening of the disease.") Inasmuch as there is no other medical opinion which supports claimant's claim under the major contributing cause standard, we conclude there is a failure of proof.

We turn to claimant's alternative contention that the employer is precluded from denying the right knee condition. The issue is whether the unappealed November 1987 Determination Order award of permanent disability for the degenerative right knee condition precluded the employer from denying compensability of the degenerative knee condition. We conclude it did not.

Claim preclusion bars litigation of a claim based on the same factual transaction as was or could have been litigated between the parties in a prior proceeding that has reached a final determination. Drews v. EBI Companies, 310 Or 134, 142-43 (1990). In Messmer v. Deluxe Cabinet Works, supra, the court held that a carrier could have litigated the scope of the accepted claim in an appeal from a determination order. There, the carrier failed to appeal a Determination Order award of permanent disability for a condition which was not accepted and for which the claimant subsequently sought treatment. The court concluded that claim preclusion barred the carrier from later arguing that the condition for which the award was made is not part of the compensable claim. 130 Or App at 258.

This case is similar to Messmer. Although the employer neither accepted nor denied the degenerative right knee condition, it failed to appeal the November 20, 1987 Determination Order which awarded permanent disability for the knee condition. However, in Craig L. Hiatt, 47 Van Natta 2287 (1995), we concluded that the Messmer rule has been overturned by the 1995 amendments to ORS 656.262 (Or Laws 1995, ch 332, § 28 (SB 369, § 28)).[2] Amended ORS 656.262(10) now provides:

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

In Hiatt, we concluded that amended ORS 656.262(10) applies retroactively to any matter for which an order or decision has not become final. See SB 369, § 66. Because there has been no final

[2] Although a signatory to this order, Member Gunn refers the parties to his dissenting opinion in Hiatt.

order or decision in this case, we conclude amended ORS 656.262(10) applies retroactively to this case. See Volk v. America West Airlines, 135 Or App 565 (1995); Motel 6 v. McMasters, 135 Or App 583 (1995).

The employer accepted only the left foot injury and did not formally accept a right knee condition. (Ex. 1). Based on the clear language of amended ORS 656.262(10), payment of a Determination Order award "shall not preclude an insurer or self-insured employer from subsequently contesting the compensability of the condition rated therein * * *." According to § 66 of SB 369, the statute applies retroactively regardless of any previous order or closure. Thus, notwithstanding the November 1987 Determination Order which awarded permanent disability benefits for the right knee condition and became final by operation of law, the amended statute expressly permits the employer to deny the right knee condition. Therefore, the employer was not precluded from denying that condition. See Craig L. Hiatt, supra. Accordingly, since we have previously determined that the persuasive medical opinions do not support the compensability of claimant's current right knee condition, the employer's denial is reinstated and upheld.

Inasmuch as we have concluded that claimant's right knee claim is not compensable, she is not entitled to a penalty or penalty-related attorney fee for the allegedly unreasonable processing of that claim. See Ellis v. McCall Insulation, 308 Or 74 (1989); Randall v. Liberty Northwest Ins. Corp., 107 Or App 599 (1991).

ORDER

The ALJ's order dated October 18, 1994 is reversed. The self-insured employer's "de facto" denial of claimant's right knee condition is reinstated and upheld. The ALJ's assessed fee award and penalty assessment are also reversed.

February 2, 1996 Cite as 48 Van Natta 222 (1996)

In the Matter of the Compensation of
FLOYD B. TALLEY, JR., Claimant
WCB Case Nos. 93-08692, 93-06477 & 93-07900
ORDER ON REMAND
Bennett & Hartman, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney
John M. Pitcher, Defense Attorney
David O. Horne, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Weyerhaeuser Company v. Talley, 321 Or App 550 (1995). Pursuant to its September 13, 1995 decision, the court has remanded for reconsideration of our prior order (which affirmed an Administrative Law Judge's (ALJ) order which: (1) found that claimant's bilateral hearing loss condition was compensable; and (2) held that Weyerhaeuser was responsible for the claim.).[1] In resolving the compensability issue, we relied on Dr. Hodgson's opinion concerning causation and determined that claimant's 30-year work exposure was the major contributing cause of his hearing loss.

The court reversed, reasoning that our conclusion concerning compensability was not supported by a proper reading of Dr. Hodgson's reports. Specifically, the court concluded that it was apparent that the physician's opinion supported work-related hearing loss during a period of employment, but that the physician could not determine whether hearing loss before or after that period was caused by occupational exposure. Accordingly, the court has remanded for reconsideration.

FINDINGS OF FACT

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

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[1] In adopting the ALJ's Opinion and Order, we also addressed other issues which are not before us on remand.

CONCLUSIONS OF LAW AND OPINION

In this case, both compensability and responsibility are at issue.[2] In order to establish that his hearing loss is an occupational disease, claimant must show that it arose "out of and in the course of employment" and was "caused by substances or activities to which [he was] not ordinarily subjected or exposed other than during a period of regular actual employment * * *." ORS 656.802(1). "In other words, he must show that work was the major contributing cause of his disease. * * * In determining whether a claimant's occupational disease is work-related, [we] consider all employment exposure * * *." Beneficiaries of Strametz v. Spectrum Motorwerks, 135 Or App 67, 70 (1995) (citations omitted) (emphasis added).[3]

Here, claimant worked at various jobs in the same paper plant for 31 years.[4] During that time, claimant experienced bilateral hearing loss, greater than expected from presbycusis alone. All experts agree that claimant has hearing loss due to excessive noise exposure. (See Exs. 10-3; 12-5; 25-2; 27-1; 28-46). Thus, the question is whether claimant's hearing loss was caused in major part by exposure to noise at work.

The medical evidence concerning causation is provided primarily by Dr. Hodgson and Mr. Ediger, audiologist.

We agree with the ALJ that Mr. Ediger's hearing test results regarding the extent of claimant's hearing loss are not persuasive because they differ materially from all other tests in the record. (See Ex. 25-2). In addition, we find that Mr. Ediger's opinion that claimant's work exposure to noise was not asymmetrical is unpersuasive because it is contrary to claimant's reporting (which we have no reason to doubt or discount).[5] With these reservations in mind, we agree with the ALJ that claimant's hearing loss is primarily related to his work exposure. Accordingly, we adopt the ALJ's opinion in this regard, with the following supplementation.

Dr. Hodgson opined that claimant's work exposure from 1971 through 1979 was the major contributing cause of the hearing loss which occurred during that time. (Ex. 26-2). He was unable to determine the major cause of losses before or after that time period. (Id). However, he also stated, based on claimant's lifetime noise exposure: "When comparing [claimant's] activities of shooting guns throughout his entire lifetime with his work-related activities of full-time work for thirty years in a paper mill, then in my view, the work-related noise exposure represents more than 51% of [claimant's] total lifetime noise exposure." (Ex. 10-3).

Dr. Hodgson further opined that claimant suffered more left ear loss because he most often stood with his left side closest to noisy machinery at work and shot guns right-handed off-work.[6] (Ex. 16-2).

Claimant's recreational shooting involved 10-12 rifle rounds per year and target shooting with a pistol 3-4 times per year. He regularly wore hearing protection when shooting guns off-work (since he

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[2] "The threshold question whenever compensability is at issue [in an occupational disease claim] is whether employment was the major contributing cause of the condition." Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71, 76 (1994).

[3] Weyerhaeuser contends that the claim is not compensable because claimant cannot show that his exposure during its coverage, was the major contributing cause of his hearing loss. However, as the court has explained, claimant's reliance on the "last injurious exposure" rule of proof relieves him of the burden of proving medical or "actual" causation as to a particular employment exposure. Strametz v. Spectrum Motorwerks, Ltd., supra at 71. Thus, "it is immaterial for purposes of establishing the compensability of the claim" that claimant's exposure while Weyerhaeuser was self-insured may not have been the actual cause of claimant's hearing loss. Id.

[4] Coverage was provided by Employers Insurance of Wausau (Wausau) from 1973 to 1975, by the SAIF Corporation in 1976, and by Wausau from 1977 to 1981. Weyerhaeuser has been self-insured since 1981.

[5] In other words, we find that claimant's left side was exposed to louder noise over time, when working for Weyerhaeuser, as well as when shooting firearms off work.

[6] Dr. Hodgson and Mr. Ediger agree that the left ear suffers the most acoustic trauma when a right-handed shooter fires a gun, because the left ear is nearest to the gun's muzzle. (Exs. 16-2, 17-2).

left the military in 1963, except occasionally when hunting). Although he wore hearing protection at work in recent years, the noise at work was so bothersome[7] that claimant sometimes wore both earplugs and noise barriers to combat it. (Tr. 32).

Mr. Ediger reasoned that the symmetrical nature of claimant's noise exposure at work compels a conclusion that only 1/4 percent of claimant's hearing loss in each ear was caused in major part by his overall work exposure to noise. (See Exs. 12-4-5; 28-61). As we have stated, Mr. Ediger's conclusions regarding the extent of claimant's hearing loss are not persuasive (because his test results are unreliable) and his opinion that claimant's noise exposure at work was symmetrical is similarly unpersuasive because it contradicts claimant's history (that his work exposure was asymmetrical). On the other hand, we find no reason to discount Mr. Ediger's conclusion that a portion of claimant's hearing loss (as a whole) was caused in major part by noise exposure to work, because it is consistent with the remainder of the record (particularly Dr. Hodgson's opinion regarding claimant's overall noise exposure and claimant's work and off-work history).

Accordingly, in reaching our conclusion, we have considered Mr. Ediger's opinion (that claimant's work exposure was the major contributing cause of some of claimant's hearing loss), along with Dr. Hodgson's opinion (that claimant was exposed to more noise at work than anywhere else),[8] and the amount of time claimant was subjected to excessive work noise at his full-time job compared with that spent engaged in occasional recreational shooting. After considering the medical and lay evidence, we conclude that it is more likely than not that claimant's work exposure (as a whole) was the major contributing cause of his bilateral hearing loss. Consequently, we find that claimant has successfully invoked the last injurious exposure rule of proof and established that the major contributing cause of his bilateral hearing loss condition is employment exposure. Thus, we hold that claimant has proven the compensability of his bilateral hearing loss claim.

The ALJ found Weyerhaeuser responsible for the claim. We adopt the ALJ's conclusions concerning the responsibility issue,[9] with the following modification and supplementation.

The "last injurious exposure rule" provides that where, as here, a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982).

If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 82 (1994). The dispositive date is the date the claimant first sought treatment for the compensable condition. SAIF v. Kelly, 130 Or App 185, 188 (1994).

We find that claimant first sought treatment for his hearing loss condition on February 1, 1993. (Ex. 10). Although claimant previously sought treatment for an ear infection (and hearing loss was identified and discussed) (see Ex. 27), he did not actually seek treatment for hearing loss until he saw Dr. Hodgson on February 1, 1993. Consequently, February 1, 1993 is the date of disability for purposes of assigning liability under the last injurious exposure rule. See Norman L. Selthon, 45 Van Natta 2358 (1993).

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[7] For example, claimant described standing next to a jet plane as preferable to working next to the paperwinder in the production department. Claimant worked at the paperwinder for many years, without regular effective hearing protection. After that, he trained in the maintenance department and worked his way up to journeyman millwright. The noise level depended on the job he did, but he continued to be exposed to loud noise. (See Tr. 17-19).

[8] We acknowledge Dr. Hodgson's opinions that claimant's gun usage contributed "substantially" to his hearing loss, that it is "extremely" unlikely that post-1981 work exposure contributed to claimant's hearing loss, and that it is "highly unlikely" that claimant's post-1981 work exposure was the major cause of his hearing loss. (See Exs. 10-3, 26-2, 28-36). However, these opinions do not persuade us that claimant's work as a whole was less than the major cause of claimant's overall hearing loss.

[9] ORS 656.308 does not apply, because there is no accepted claim in this case. See SAIF v. Yokum, 132 Or App 18, 23 (1994). We find nothing in amended ORS 656.308 (or any other statute) suggesting that the Yokum rationale no longer applies when there is no accepted claim.

Weyerhaeuser may shift responsibility to Employers Insurance of Wausau (Wausau) (an earlier carrier) by showing that claimant's work exposure while Wausau was on the risk was the sole cause of claimant's hearing loss or that it was impossible for claimant's exposure while the employer was on the risk to have caused claimant's hearing loss. See FMC Corporation v. Mutual Ins. Co., 70 Or App 370 (1984).

Considering claimant's testimony regarding his continuing exposure to noise at work and the persuasive evidence indicating continuing hearing loss, (see Ex. 25-3), we agree with the ALJ[10] that Weyerhaeuser has not established that it was impossible that claimant's later work during its coverage contributed to his hearing loss (or that prior exposure was the sole cause).[11] Consequently, Weyerhaeuser, in its self-insured employer capacity, remains responsible for claimant's hearing loss condition.

Claimant has finally prevailed after remand with respect to his hearing loss claim. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum.[12] At hearing, the ALJ awarded claimant's counsel an assessed fee of $3,200. We reinstate that award. In addition, we reinstate our prior $1,200 attorney fee award for services at Board level in the first instance. Since claimant's counsel also provided services before the court and the Board (on remand), a reasonable fee for such services shall be awarded (in addition to those fees which we have reinstated).[13]

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services before the Court of Appeals and on remand is $4,250, payable by Weyerhaeuser. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Finally, no fee is awarded for services devoted to claimant's unsuccessful argument to the court that Weyerhaeuser's appeal was frivolous.

Accordingly, on reconsideration, the ALJ's order dated April 21, 1994 is affirmed. For services before the court and before the Board on remand, claimant's counsel is awarded $4,250, to be paid by Weyerhaeuser, the self-insured employer. This attorney fee is in addition to the $3,200 granted by the ALJ's order and the $1,200 granted by our prior order.

IT IS SO ORDERED.

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[10] In addition, we adopt the ALJ's reasoning regarding Weyerhaeuser's "impossibility defense."

[11] In reaching this conclusion, we acknowledge that Dr. Hodgson's opinion is that work exposure from 1971 through 1979 was the major contributing cause of claimant's hearing loss. However, such an opinion does not mean that it was impossible for claimant's subsequent exposure to noise at work (while Weyerhaeuser was self-insured) to have contributed or that exposure with another carrier was the sole cause.

[12] Weyerhaeuser argues that claimant is not entitled to a fee for services before the court under ORS 656.382(2), because the court did not find on the merits that claimant's compensation should not be disallowed or reduced. However, amended ORS 656.388(1) authorizes an attorney fee for services before every prior forum ("as authorized under ORS 656.307(5), 656.308(2), 656.382, or 656.386"), even if claimant does not "finally prevail" until after remand. In reaching this conclusion, we note that amended ORS 656.388(1) expressly refers to cases "in which the claimant finally prevails after remand," as did former ORS 656.388(1). Applying former ORS 656.388(1), we previously held that a claimant's counsel is entitled to an attorney fee for services before the court when it is ultimately determined on remand that the compensation awarded by the prior appealed Board order has not been disallowed or reduced. Doris A. Pace, 45 Van Natta 2383, 2384 (1993). Because the amended statute, like the former statute, applies to cases in which the claimant prevails after remand, we conclude that the Pace rationale remains applicable (especially since amended ORS 656.388(1) expressly refers to ORS 656.382 in the "after remand" context).

[13] Claimant's attorney submitted a statement of services seeking fees totaling $12,484. The statement lists services at hearing and on Board review, as well as before the court and on remand. Since claimant did not previously challenge the ALJ's or the Board's prior awards, we now consider only those services expended before the court and on remand. Such services total 39.5 hours.

In the Matter of the Compensation of
CHARLES C. TAYLOR, Claimant
WCB Case No. 91-16775
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
William J. Blitz, Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The Department of Consumer and Business Services (DCBS) requests review of Administrative Law Judge (ALJ) Galton's order that: (1) found that the Hearings Division had jurisdiction over claimant's request for hearing concerning his subjectivity status; (2) found that claimant was not precluded by res judicata from contesting his subjectivity status; and (3) set aside DCBS's determination that claimant was not a subject worker of Fred W. Jack and Charles McGlinchey (J & M). J & M, claimant's alleged employer, has also requested review of the ALJ's order and raises the same issues that were raised in DCBS's request for review. On review, the issues are jurisdiction, res judicata, and subjectivity. We affirm in part and reverse in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

We adopt the conclusions and reasoning concerning the jurisdiction/timeliness issue as set forth in the ALJ's order.

Res Judicata

We adopt the conclusions and reasoning concerning the res judicata issue as set forth in the ALJ's order.

Subjectivity

The ALJ concluded that claimant was a subject worker of J & M at the time he was injured in the motor vehicle accident. We disagree.

The first determination to be made in a subjectivity case is whether claimant was a "worker" within the meaning of ORS 656.005(30) (formerly ORS 656.005(28)). See S-W Floor Cover Shop v. Natl. Council on Comp. Ins., 318 Or 613, 630 (1994). The Court explained:

> "The initial determination of whether one is a 'worker' under ORS 656.005(28) continues to incorporate the judicially created 'right to control' test. One who is not a 'worker' under that test is not subject to workers' compensation coverage, and the inquiry ends. The 'nonsubject worker' provisions of ORS 656.027 never come into play. If the initial determination made under 656.005(28) is that one is a worker because one is subject to the direction and control under the judicially created 'right to control' test, then one goes on to determine under ORS 656.027 whether the worker is 'nonsubject' under one of the exceptions of that statute." Id. at 630-31.

The factors to be considered under the traditional "right to control" test include: (1) direct evidence of the right to, or the exercise of control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire. Woody v. Waibel, 276 Or 189 (1976); Castle Homes v. Whaite, 95 Or App 269, 272 (1989).

Here, the only connection between claimant and J & M was the furnishing of equipment in that the truck claimant was driving belonged to J & M. However, the keys to the truck were kept in Mr. Miller's store and were furnished to claimant by Mr. Miller. There is no evidence that J & M had the right to, or exercised, control over claimant's task. Rather, claimant was contacted by Mr. Miller, who arranged for claimant to pick up a load of hay for the Miller's store. Mr. Miller also provided a credit

card for fuel and a blank check to be given to the hay provider by claimant. Similarly, J & M did not agree to pay claimant for this task. In contrast, Mr. Miller agreed to pay claimant $8.00 per hour for picking up and delivering the hay. Finally, there is no evidence that J & M had the right to fire claimant had he not picked up and delivered the hay, particularly since the enterprise was undertaken at the request of Mr. Miller.

Under these circumstances, we conclude that claimant was not a subject worker of J & M when he was injured in the motor vehicle accident. ORS 656.005(30). Consequently, DCBS's determination that claimant was not a subject worker of J & M must be upheld.

ORDER

The ALJ's order dated May 25, 1995 is reversed in part and affirmed in part. DCBS's March 15, 1991 non-subject worker determination is reinstated and affirmed. The remainder of the ALJ's order is affirmed.

February 2, 1996 Cite as 48 Van Natta 227 (1996)

In the Matter of the Compensation of
CHERYL T. TORKKO, Claimant
WCB Case No. 95-01511
ORDER ON REVIEW
Foss, Whitty, et al, Claimant Attorneys
Debra Ehrman (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's head and neck injury claim. On review, the issue is whether claimant's injury arose out of the course and scope of her employment. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

On December 6, 1994, claimant drove into a parking lot owned and maintained by the school district for which she taught elementary school. Claimant parked in her customary spot near the entrance to her classroom. She exited the car and closed the driver's door. She then opened the left rear door to retrieve a bag containing classroom materials. After getting the bag, she closed the door and turned to her left to enter the school, striking her head on the side mirror of a van that was parked in the space next to her car. Claimant reported her injury to the custodian and her supervisor and subsequently sought medical attention for her head and neck.

To establish the compensability of an injury, including an injury that occurs on an employer-controlled parking lot, claimant must establish that the injury: (1) occurred "in the course of employment," which concerns the time, place and circumstances of the injury; and (2) "arose out of employment," which concerns the causal connection between the injury and the employment. Norpac Foods, Inc., v. Gilmore, 318 Or 363, 366 (1994). In assessing the compensability of an injury, neither element is dispositive. Id. Therefore, all of the circumstances must be considered to determine whether claimant has shown a sufficient work connection.

Citing Gilmore, the ALJ reasoned that, because claimant's injuries were sustained on the employer's parking lot while claimant was preparing to enter the school, those injuries were deemed to have sufficient connection to the work to have occurred "in the course of employment." The ALJ also reasoned that, "but for" claimant's employment, e.g., her need to retrieve her school materials out of her car, she would not have been placed in the position of being injured by a hazard contained within

the parking lot under the employer's control, and that, therefore, claimant's injury "arose out of" her employment. Finally, the ALJ reasoned that application of the factors set forth in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571 rev den 300 Or 249 (1985), also favored compensability.[1]

SAIF does not dispute the ALJ's finding that claimant satisfied the "in the course of" element of the Gilmore test. Rather, SAIF argues that, although claimant sustained an injury, the injury did not arise out of her employment. Consequently, the issue before us is whether claimant has established that there was some causal connection between the injury and her employment. We conclude that she has not.

In a "parking lot" case, that causal connection exists when the claimant's injury is brought about by a condition or hazard associated with premises over which the employer exercises some control. See Montgomery Ward v. Malinen, 71 Or App 457 (1984) (Fall on icy pavement employer had a legal duty to maintain); Ronald R. Nelson, 46 Van Natta 1094 (1994) (Fall on rough pavement on employer-controlled driveway); see also Margaret Scott, 47 Van Natta 938 (1995) (Eye injury sustained after walking into a pillar in employer's parking lot not compensable, as it did not arise from a hazard over which the employer had control); and William F. Gilmore, 46 Van Natta 999, 1000 (1994) (order on remand) (Injury sustained while the claimant entered his vehicle on employer's parking lot held not compensable, because it did not arise from risk associated with the lot).

Here, claimant walked into a mirror on a van that was parked in an adjacent parking place by another school employee. There is nothing in the record to indicate that the employer had any control over the type of vehicles parked in the parking lot, which was open to the public. The fact that the van was parked in the employer's parking lot does not make it an employer-controlled hazard. Consequently, as in Scott, the incident did not arise from a hazard over which the employer had control. Therefore, we conclude that claimant has failed to prove a sufficient causal connection between her injuries and her employment.

We distinguish this case from Ramon M. Marin, 46 Van Natta 1691 (1994). There, the cause of the claimant's injuries was attributable to a hazard on the employer's parking lot: the employer placed a flower box in the parking lot and the flower box was pushed into the claimant. Since the claimant's injuries arose as the result of a hazard on the employer's parking lot (the flower box over which the employer had control), we held in Marin that the injuries "arose out of" the employment.

Here, in contrast, claimant simply walked into an object that was not under control of the employer. Moreover, there is no evidence that the parking lot was poorly designed or lit, or deficient in any way that would link claimant's injury to the employer's control of the parking lot. Therefore, we conclude that her injuries did not "arise out of" her employment. Consequently, considering the totality of the circumstances, we conclude that claimant has failed to establish a sufficient connection between her employment and the injury to establish compensability.

ORDER

The ALJ's order dated June 5, 1995 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

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[1] We note that, although these factors are helpful inquiries, they do not necessarily allow a meaningful consideration of each of the two elements of the inquiry or consideration of the totality of the circumstances. See First Interstate Bank v. Clark, 133 Or App 712, 717 (1995).

Board Member Gunn dissenting.

The majority concludes that claimant's injury did not "arise out of her employment." I disagree with their analysis and therefore respectfully dissent.

Claimant's injury occurred in the employer's parking lot just after claimant reached into the back seat of her car to retrieve school papers and teaching materials. When claimant turned to enter the school, she was injured by a hazard in the employer's parking lot which was under the employer's

control, namely, a van parked in the space next to her car. Moreover, I agree with the ALJ's application of the Mellis factors insofar as they aid us in determining whether the claim is compensable. Here, the activity in which claimant was engaged was of benefit to the employer, was contemplated by the employer, was acquiesced in by the employer, and was an ordinary risk of her employment, in that she routinely took teaching materials home with her in her car as a condition of her employment. Additionally, claimant was not on a personal mission of her own. In assessing the compensability of an injury, neither the "in the course of employment" nor the "arose out of employment" element is dispositive. Norpac foods, Inc., v. Gilmore, supra. I conclude that all of the circumstances, taken together, establish that claimant has shown a sufficient work connection and would therefore affirm the ALJ's order.

February 6, 1996 Cite as 48 Van Natta 229 (1996)

In the Matter of the Compensation of
BRET CLAUSSING, Claimant
WCB Case No. 95-04958
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that: (1) found it responsible for claimant's low back injury claim under ORS 656.029(1); (2) set aside its denial of the claim; and (3) assessed a penalty for its alleged failure to timely accept or deny the claim. On review, the issues are whether the employer was a subject employer under ORS 656.029(1) and, if so, whether the employer is responsible for the claim as well as penalties for unreasonable claim processing. We reverse.

FINDINGS OF FACT

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

K-Mart (the employer) is a retail store.

CONCLUSIONS OF LAW AND OPINION

Claimant, an employee of CP Janitorial (CP), a janitorial service, was injured in the course and scope of his employment while performing janitorial duties at K-Mart. CP had a contract with K-Mart to perform janitorial services after store hours. That contract provided that CP was to maintain workers' compensation insurance as required by applicable laws. (Ex. A-2). CP did not provide workers' compensation coverage for its employees.

The ALJ found that store maintenance was part of the customary trade or business of K-Mart. Therefore, the ALJ reasoned that, under ORS 656.029(1), K-Mart, as the general contractor, was responsible for claimant's work injury. We disagree.

ORS 656.029(1) provides:[1]

> "If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all individuals, other than those exempt under ORS 656.027, who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person who is charged with the responsibility for providing such coverage before labor under the contract commences, that person shall be treated as a noncomplying employer and

[1] This statute was not amended by Senate Bill 369.

benefits shall be paid to the injured worker in the manner provided in this chapter for the payment of benefits to the worker of a noncomplying employer." (Emphasis added).

It is undisputed that K-Mart awarded a contract to CP for janitorial services, and that CP did not have workers' compensation coverage before labor under the contract commenced. Under such circumstances, if the labor was a normal and customary part of its trade or business, K-Mart would be responsible for workers' compensation coverage for claimant, pursuant to ORS 656.029(1). See Caddy v. SAIF, 110 Or App 353, 357 n.3 (1991) (medical professionals letting contract for construction of their own residence were not responsible for workers' compensation coverage under ORS 656.029(1) because they were not in the business of home construction).

We find that janitorial services performed after business hours were not a "normal and customary part of the trade or business" of K-Mart, a retail store.[2] Therefore, K-Mart is not responsible for workers' compensation coverage for claimant under ORS 656.029(1).

We have previously stated that the purpose of ORS 656.029 is to provide coverage to subcontractors who are hired by the general contractor to do its work. Robert J. Hunt, 42 Van Natta 1047 (1990) (distinguishing contract for supply of temporary employee from the type of relationship contemplated in ORS 656.029). The typical general contractor-subcontractor relationship referred to in ORS 656.029 occurs in the construction business, where a contract involves performance of the work that is part of the general contractor's business. See, e.g., Berkey v. Dept. of Ins. and Finance, 129 Or App 494, 499 (1994) (general contractor, a pole barn builder, contracted for construction of a pole barn); Liberty Northwest Ins. Corp v. Hegerberg, 118 Or App 282 (1993) (general contractor, in the business of building a hospital, contracted for electrical work); Nelander v. Dept. of Ins. and Finance, 112 Or App 419 (1992) (general contractor, in the business of building apartments, contracted for roof construction); Larry G. Falls, 47 Van Natta 234 (1995) (general contractor, in the construction business, contracted to have a building painted).

We have also held that where the general contractor is in the business of transporting mobile homes, leasing of the claimant's trucks involved the performance of labor that is a normal and customary part of the general contractor's business. Richard D. Ray, 42 Van Natta 2781 (1990). In Ray, we stated that since the general contractor's business purpose would not be accomplished if the leased trucks were not driven, the labor of the drivers was a normal and customary part of the general contractor's business. Id. We concluded that the general contractor in Ray was required to provide workers' compensation coverage under ORS 656.029.

We distinguish the above-cited relationships from the general contractor-subcontractor relationship in the present case. Here, the general contractor, K-Mart, is in the retail sales business. K-Mart contracted with CP for janitorial services that were to be provided in its building after business hours. CP agreed to provide workers' compensation insurance for its employees. K-Mart had no control or supervisory responsibility over how CP's employees performed their services. K-Mart is not in the janitorial or building maintenance business; its business is retail sales. There is no evidence that K-Mart employed any janitors or maintenance people. K-Mart's business purpose - retail sales - could be accomplished without janitorial service that was provided after business hours.

The provision of after-hours janitorial service accomplished no business purpose for K-Mart. While the maintenance of a clean and safe store may be a necessary element of its business, the same can be said for any business. All businesses must, to one degree or another, provide a clean and safe work environment, if only for liability purposes. However, that does not make janitorial service part of the normal and customary business of a retailer like K-Mart.

Accordingly, we conclude that since the labor performed by claimant under K-Mart's contract with CP was not a normal and customary part of K-Mart's trade or business, K-Mart is not responsible for providing workers' compensation coverage for claimant under ORS 656.029(1).

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[2] CP provided janitorial services for K-Mart, which included nightly sweeping and cleaning the sales floor, cleaning the restrooms, cleaning windows and doors, and waxing the floor as needed. (Tr. 24). CP was to supply the personnel to perform its responsibilities under the service contract. (Id.) K-Mart had no authority to supervise, evaluate, or control the manner of working of CP employees. (Tr. 25, 28, 32-33). K-Mart apparently had no janitorial staff, as store associates were responsible for cleaning up spills and other hazards that occurred during the business day. (Tr. 30-31, 33). Based on these facts, we conclude that the provision of janitorial services was not a "normal and customary" part of K-Mart's business as a retail store.

Since we have found K-Mart not responsible for workers' compensation coverage for claimant under ORS 656.029(1), we need not address K-Mart's alternative argument that it is not responsible under ORS 656.029(2).[3]

Because we have found K-Mart not responsible for workers' compensation coverage for claimant, there are no amounts due on which to base a penalty. Ellis v. McCall Insulation, 308 Or 74 (1989). Accordingly, no penalty will be assessed.

ORDER

The ALJ's order dated August 8, 1995 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee is reversed.

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[3] We have found that K-Mart is not responsible for providing workers' compensation coverage under ORS 656.029(1). However, CP may be responsible for providing such coverage, if it was a subject employer. ORS 656.023. Since it appears from the record in this case that CP was a subject employer but did not provide worker's compensation coverage at the time of claimant's injury (Ex. 4-2, 4-7), the Director is required to investigate CP's noncomplying status and, if warranted, serve on it a proposed order declaring CP to be a noncomplying employer, consistent with ORS 656.052. The Director is required to refer the claim to an assigned claims agent for processing on behalf of the noncomplying employer, pursuant to ORS 656.054(1). A compensable injury to a subject worker employed by a noncomplying employer is compensable to the same extent as if the employer had complied with the Workers' Compensation Law. ORS 656.054(1).

February 6, 1996 Cite as 48 Van Natta 231 (1996)

In the Matter of the Compensation of
LANCE J. FLAGLER, Claimant
WCB Case No. 95-04026
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Cowling & Heysell, Defense Attorneys

Reviewed by Board Members Niedig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) reinstated a Determination Order award which had been previously eliminated by an Order on Reconsideration; and (2) reduced claimant's unscheduled permanent disability award from 26 percent (83.2 degrees), as awarded by the Determination Order, to zero. On review, the issue is extent of permanent disability.

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

A Determination Order awarded claimant 26 percent unscheduled permanent disability. On January 9, 1995, claimant requested reconsideration of the award. In response, the Department issued a letter indicating that an Order on Reconsideration, or a postponement letter, would be mailed by February 7, 1995, but the reconsideration order might be postponed an additional 60 days. Additionally, the letter provided that if the Department failed to timely mail a reconsideration order or notice of postponement by February 7, 1995, the reconsideration request would be automatically deemed denied and the closure affirmed, pursuant to former ORS 656.268(6)(a).

On January 27, 1995, the Department issued a notice of postponement, which notified the parties that the Order on Reconsideration would be issued by April 8, 1995, and if a reconsideration order was not mailed by that date, the reconsideration was deemed denied. On March 31, 1995, an Order on Reconsideration issued, which reduced claimant's permanent disability award to zero. Claimant requested a hearing.

The ALJ agreed with claimant that the Order on Reconsideration was not timely issued, as the Department's order was not issued within 75 days after claimant's request for reconsideration.

Accordingly, the ALJ agreed with claimant that the Order on Reconsideration was invalid, and the Determination Order should be restored. However, the ALJ agreed with the insurer that, because claimant had requested a hearing, the insurer could seek a reduction of the award, even though it did not file a cross-request for hearing.

Claimant does not assert that, based on the merits of his claim, he has suffered 26 percent permanent disability. Instead, he argues that, following the ALJ's decision that the Order on Reconsideration was untimely and the prior Determination Order should be reinstated, the ALJ should not have then permitted the insurer to seek a reduction in claimant's permanent disability award. Claimant contends that, because the Order on Reconsideration reduced his award to zero, and since claimant believed that the order was invalid because it was not timely issued by the Department, claimant was forced to seek a hearing.

Claimant concedes that Board precedent permits a non-appealing party to challenge a permanent disability award, even in the absence of a formal cross-request for hearing, provided that the appealing party's request for hearing from the Order on Reconsideration has not been dismissed. See Zigurds Laurins, 46 Van Natta 1238 (1994). Also see Duncan v. Liberty Northwest Ins. Corp.,133 Or App 605 (1995) (If a reconsideration order changes a determination order, the propriety of that change can be raised by either party at a hearing). Nevertheless, claimant argues that, in this case, he was only seeking a hearing on the issue of the Department's authority to act on the prior award. As such, claimant contends that a "procedural trap" was created, because the request for hearing permitted the insurer to seek a reduction of his award. Claimant argues that if he had withdrawn his request for hearing, he would have been left without a remedy in this case.

We disagree with claimant's reasoning. To begin, we do not consider the Order on Reconsideration to be invalid. In reaching this conclusion, we rely on the rationale expressed by the court in Guardado v. J. R. Simplot Company, 137 Or App 95 (1995). In Guardado, the Department had denied a claimant's request for reconsideration which had been filed after the Department issued its Order on Reconsideration. The Guardado court reversed, reasoning that neither the text nor context of former ORS 656.268(5) supported a contention that the Department lacked jurisdiction to address a second request which was timely filed under former ORS 656.268(6)(b).

Here, as in Guardado, both parties timely sought reconsideration of the Determination Order. Thus, consistent with the Guardado reasoning, the requests were each subject to the time limits set forth in the statutory scheme. Although the March 31, 1995 Order on Reconsideration issued more than 75 days after claimant's request, the order issued prior to the expiration of 75 days from the insurer's January 18, 1995 request. See former ORS 656.268(6)(a). Thus, insofar as the Order on Reconsideration pertained to the insurer's request for reconsideration, the order was timely issued.

In light of such circumstances, claimant's withdrawal of his hearing request would merely have left standing a validly issued Order on Reconsideration which, in response to the insurer's request for reconsideration, had eliminated his permanent disability award. Consequently, in light of the Department's decision, claimant's only alternative was to challenge that ruling before the Hearings Division.

Finally, even assuming that the Order on Reconsideration was invalidly issued, claimant could not limit the ALJ's review to merely the validity of the order. We have previously ruled that the appealing party's withdrawal of an issue, while still asserting other issues regarding a closure order does not deprive the ALJ of authority to consider the non-appealing party's challenge to the closure order. See Zigurds Laurins, supra; Judith L. Duncan, 45 Van Natta 1457, 1459 (1993), aff'd Duncan v. Liberty Northwest, supra; James S. Franklin, 43 Van Natta 2323 (1991).

ORDER

The ALJ's order dated August 23, 1995 is affirmed.

In the Matter of the Compensation of
GLORIA GARCIA, Claimant
WCB Case Nos. 94-11660 & 94-06739
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) affirmed an Order on Reconsideration that set aside as premature the employer's notice closing claimant's psychological condition; and (2) awarded claimant temporary total disability (TTD) benefits beginning May 6, 1994. Claimant cross-requests review of that portion of the ALJ's order that declined to assess a penalty or a penalty-related attorney fee for the employer's allegedly unreasonable failure to pay TTD. On review, the issues are premature closure, temporary disability and penalties and attorney fees. We affirm in part, modify in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

We adopt the ALJ's reasoning and conclusion regarding this issue, with the following supplementation.

The employer asserts that it is law of the case that claimant's psychological condition was not separately disabling from a compensable low back condition. Therefore, it asserts, because the low back condition has become medically stationary, claimant's psychological condition has also become medically stationary. We disagree.

The basis for the employer's "law of the case" argument is a prior ALJ's 1992 opinion and order, which stated, in relevant part, that the ALJ was "not persuaded that claimant is psychologically disabled separate from being physically disabled pursuant to her low back condition." (Ex. 26-12). The employer's argument is without merit. The prior ALJ's statement, made in the course of determining which carrier was responsible for claimant's psychological condition, is dictum. As such, it cannot be law of the case. In re Norton's Estate, 177 Or 342, 345 (1945). Moreover, in affirming the prior ALJ's order, the Board did not adopt the ALJ's reasoning; rather, it offered its own reasoning, which did not address the separately-disabling issue. (See Ex. 32-3 to -5). For these reasons, we reject the employer's "law of the case" argument.

The employer also asserts that, even if claimant's psychological condition is not medically stationary, it was entitled to close the claim under amended ORS 656.268(1)(a). We disagree.

Amended ORS 656.268(1)(a) provides, in part, that "[c]laims shall not be closed if the worker's condition has not become medically stationary unless: (a) The accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005 (7) * * *." Amended ORS 656.262(7)(b), however, provides that, once a carrier accepts a worker's claim, the carrier "must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed." Therefore, to be entitled to close a non-stationary accepted claim under amended ORS 656.268(1)(a), the carrier must first issue a written denial of the claim.[1] Here, the employer has not issued such a denial. Therefore, it is not entitled to close the claim under amended ORS 656.268(1)(a).

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[1] We recognize that amended ORS 656.268(1)(a) refers to both combined and consequential condition, while amended ORS 656.262(7)(b) refers only to combined conditions. We do not find that distinction material in this claim because of our finding that the psychological condition is compensable.

Alternatively, we reject the employer's amended ORS 656.268(1)(a) argument on the merits. That argument relies on the reports of examining psychiatrists Drs. Glass and Parvaresh. Dr. Glass concluded that the major contributing cause of claimant's psychological condition was claimant herself. (Ex. 41-1). Dr. Parvaresh concluded that claimant's work injury was never a major contributing cause of her psychological condition. (See Ex. 41A). In a later report, Parvaresh concluded that "perhaps medically one can assume that [claimant's] industrial injuries ceased to be a material contributing factor in her psychiatric disorder." (Ex. 42-2). In rendering those opinions, both Glass and Parvaresh appear to be revisiting the initial compensability of claimant's psychological condition. That has already been established. The issue, under amended ORS 656.268(1)(a), is whether claimant's work injury has ceased to be the major contributing cause of her psychological condition. Glass does not address that issue at all; moreover, to the extent that Parvaresh does address it, it is in speculative terms. Their reports do not support the employer's argument under amended ORS 656.268(1)(a).

The employer also asserts that the failure of Dr. Johnson, treating psychiatrist, to conclude that claimant's current condition was due to her work injury justified its notice of closure under amended ORS 656.268(1)(a). We disagree. The statute requires affirmative proof that claimant's work injury is no longer the major contributing cause of her psychological condition. Dr. Johnson's silence is not proof of that issue. Consequently, we reject the employer's assertion.

In sum, for the reasons stated in the ALJ's order, as supplemented here, we agree that the employer prematurely closed claimant's psychological condition claim.

Temporary Disability

The ALJ concluded that the employer's procedural obligation to pay TTD benefits was triggered by Dr. Johnson's May 6, 1994 report that found claimant totally disabled as a result of her psychological condition. (Ex. 35A). The employer asserts that, because claimant was released to regular work in March 1991, under ORS 656.268(3)(b), it was not obligated to pay any time loss benefits. We disagree. That claimant was released to regular work several years ago does not address the import of Dr. Johnson's subsequent report finding claimant presently totally disabled. Because there is no evidence controverting Dr. Johnson's report, the ALJ did not err in concluding that the report established claimant's present entitlement to TTD benefits.

On review, claimant concedes that she is only entitled to TTD benefits that accrued from the date of the Order on Reconsideration, May 25, 1994, until claim closure or until the Order on Reconsideration is reversed. ORS 656.313(1)(a). Consequently, we modify the ALJ's order to award TTD benefits beginning on May 25, 1994.

Penalties and Attorney Fees

Claimant asserts that the ALJ erred in failing to assess a penalty or penalty-related attorney fee for the employer's allegedly unreasonable failure to pay TTD benefits following the issuance of the Order on Determination that set aside the employer's closure notice. We agree.

If a carrier "unreasonably delays or refuses to pay compensation," it shall be liable for a penalty of up to 25 percent of the "amounts then due." ORS 656.262(11)(a). Unreasonable resistance to payment of compensation exists when, from a legal standpoint, the carrier had no legitimate doubt about its liability at the time of resistance. E.g., International Paper Co. v. Huntley, 106 Or App 107, 110 (1991).

Here, the ALJ reasoned, and the employer asserts, that the prior ALJ's "finding" in a 1992 order regarding the conjoined nature of claimant's low back and psychological conditions created a legitimate doubt about the employer's obligation to pay TTD benefits following the issuance of the May 1994 Order on Reconsideration. We disagree. As we stated earlier, the "finding" on which the employer relies is dictum and was not adopted by the Board on subsequent review. Under the circumstances, that "finding" was insufficient to create a legitimate doubt about the employer's obligation to pay claimant TTD after the issuance of the May 1994 Order on Reconsideration.

Accordingly, we assess a penalty against the employer in the amount of 25 percent of the late TTD awarded by the ALJ. ORS 656.262(11)(a). Because we award a penalty, claimant is not entitled to a penalty-related attorney fee for the same conduct. ORS 656.382(1); Martinez v. Dallas Nursing Home, 114 Or App 453, 456, rev den 315 Or 271 (1992).

Claimant's attorney is entitled to an assessed fee for services on review concerning the premature claim closure issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the premature closure issue is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We have not considered claimant's attorney's services regarding the penalty or attorney fee issues. Saxton v. SAIF, 80 Or App 631, rev den 302 Or 159 (1986); Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated July 6, 1995 is affirmed in part, modified in part and reversed in part. In lieu of that portion of the ALJ's order ordering the self-insured employer to commence payment of temporary disability compensation, calculated beginning May 6, 1994, we order the employer to commence such payments beginning May 25, 1994. That portion of the ALJ's order declining to assess a penalty is reversed, and the employer is ordered to pay claimant and her attorney (in equal shares) a penalty in the amount 25 percent of the late TTD awarded by the ALJ. The remainder of the ALJ's order is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the employer.

February 6, 1996 Cite as 48 Van Natta 235 (1996)

In the Matter of the Compensation of
JAIRO J. GARCIA, Claimant
WCB Case Nos. 94-10986 & 94-10985
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board en banc.

The insurer requests review of Administrative Law Judge (ALJ) Menashe's order that set aside its denial of claimant's right shoulder and right finger injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In May 1994, claimant filed work accident reports for his right shoulder and right finger. On June 17, 1994, claimant sought treatment from Dr. Battalia. The ALJ concluded that claimant proved compensable injuries. In reaching this conclusion, the ALJ determined that there was medical evidence supported by objective findings. ORS 656.005(7)(a).

Relying on amended ORS 656.005(19), the insurer asserts that the medical evidence is not sufficient to provide "objective findings." The insurer argues that, thus, claimant did not prove compensable injury claims. We agree.

ORS 656.005(7)(a) provides, in part, that a "compensable injury" must be "supported by objective findings[.]" Former ORS 656.005(19) defined "objective findings" as including, but not limited to "range of motion, atrophy, muscle strength, muscle spasm and diagnostic evidence substantiated by clinical findings." In Suzanne Robertson, 43 Van Natta 1505, 1507 (1991), we found that, in order to satisfy the statutes, the claimant must offer evidence that a physician has examined him and determined that he suffers from a disability or a physical condition that requires medical services. That determination could be based on purely objective factors, as set out in former ORS 656.005(19), or on the worker's description of the pain he was experiencing, as long as the physician indicated that the worker in fact experienced symptoms and did not merely recite the worker's complaints of pain. Id. See also Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992) (worker established compensable injury supported by objective findings when physicians diagnosed the worker with a cervical dorsal sprain based on their objective evaluations of pain complaints and muscular responses during physical examinations).

Effective June 7, 1995, the legislature amended ORS 656.005(19) to provide:

> "'Objective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable." Or Laws 1995, ch 332, § 1 (SB 369, § 1).

Inasmuch as the new law is not exempt from the general provision fully retroactively applying the Act, it is applicable to this case. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995) (retroactively applying amended ORS 656.386(2)).

Our next task is to determine what the legislature intended by amending ORS 656.005(19). We begin with the text and context of the provision, resorting to extrinsic aids only if those sources are unavailing. PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993). The statute defines "objective findings" as "verifiable indications of injury or disease," then provides examples that satisfy or are not sufficient to meet the definition. Because we find that such language is ambiguous, we look to legislative history for guidance.

In a joint session before the Senate Labor and Government Operations Committee and the House Labor Committee, Representative Mannix testified:

> "The change to ORS 656.005, sub (19), tightens the definition of objective findings. There is a requirement here that there must be actual visible or measurable findings to support a worker's claim of injury of disability. This has to do with the physician's examination of the patient and what the physician determines to reflect injury. The difficulty we have right know with court cases is there is more and more of a tendency to allow the physician's interpretation of subjective complaints to, in effect, to be an objective finding. Now, that means the doctor says this worker tells me that he or she hurts and I believe it, therefore we have an objective finding. This goes back to say with technology and science you can objectively confirm whether or not an injury has occurred and that we need a tightened up definition, so that subjective complaints don't become a substitute for an actual verification by a physician." January 30, 1995, Tape 16A.

Representative Mannix later stated:

> "[T]he [present] case law is saying, if the doctor says the worker told that he or she hurts and, gee, it seems okay with me, or I believe it, that has been treated by many as being objective, because the physician has reported it and confirmed it. We are trying to get away from such subjectivity. What did the physician observe, was there discoloration, was there increased temperature, was there swelling? * * *" January 30, 1995, Tape 18A.

Representative Mannix made similar remarks before subsequent meetings of the Senate Committee on Labor and Government Operations and the House Committee on Labor.[1]

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[1] Before the Senate committee, Representative Mannix stated:

"In terms of this particular discussion of the objective findings, I think it is important to note though that the effort here is to have a brighter line than we have had in the past. And there was a lot more subjectivity interpreted into the current statutory language. And this is an effort to push us towards more objectivity and away from subjectivity. * * *" February 17, 1995, Tape 47A.

Testifying before the House committee, Representative Mannix explained:

"The 1990 reforms raised the question of objective findings and what you need in order to verify whether or not an injury has occurred or whether or not a disease an occupational disease has occurred. The case law has moved in the direction of saying that the physician says that the physician believes the patient's complaints of pain, that that in effect is an objective finding. This will change that. This says that you have to have verifiable pathologic indication of injury or disease, and then we give examples. * * *" March 1, 1995, Tape 39A-259.

Governor Kitzhaber also offered testimony with regard to "objective findings," stating:

> "And I understand that the Suzanne Robertson case and others have essentially said that verification of a worker's subjective responses, as opposed to verifiable medical evidence, should be used in determining compensability. I believe that we should have verifiable medical evidence as the standard, not simply the subjective responses of the patient." House Committee on Labor, March 13, 1995, Tape 53A-162.

Governor Kitzhaber then provided an illustrative example:

> "If someone were to come to see me [when I worked as an emergency room physician] who's injured their back by pulling on a green chain, one of the forms of evaluation would be to check their range of motion. And generally they have a restricted range of motion because of pain. So pain is a subjective complaint, but, in this case, it would be an objective finding because it is supported by medical evidence. In other words, a subjective response like pain is an objective finding supported by medical evidence if it can be observed or measured, in this case by a reduction in the range of motion. So, clarifying this fact by stating that the subjective response to physical examination must be measurable or observable, which is part of the amendment that was put in, I think does in fact clarify this." Id. at 172-189.

During the same session, Representative Mannix later testified that, as a result of discussions with the Governor and his staff, the bill's definition of "objective findings" was made "tighter" so as to exclude findings that "are not reproducible, that are not measurable, or that are not observable." Id. at Tape 62A.

Based on such testimony, we find clear evidence of a legislative intent to overrule the holding in Suzanne Robertson, supra. Thus, we conclude that only a physician's indication that the worker experiences pain no longer is sufficient to be "objective findings."

Here, Dr. Battalia initially reported that claimant had pain in his right shoulder and diagnosed right shoulder bursitis and right finger arthralgia. (Ex. 3). Dr. Battalia later concurred with a letter drafted by the insurer's attorney stating that claimant "did not have any objective findings of injury either in his shoulder or his finger" and his "representations of 'tenderness' in both the shoulder and finger areas are subjective symtoms, and [] all other findings were normal." (Ex. 6-1 (emphasis in original)). During a deposition, Dr. Battalia explained that, although he had believed claimant's reports of pain, his diagnoses had been "working" rather than "true". (Ex. 17-6, 17-8). He also stated that there were no "objective findings" and characterized the findings of pain as subjective and not objective. (Id. at 17).

We conclude that, on this record, there are no "objective findings." Dr. Battalia reported only pain in the right shoulder and right finger; claimant exhibited full range of motion and there was no swelling, crepitus, crackling, or discoloration. (Ex. 7-7). No studies, such as x-rays, revealed a dislocation or fracture. Thus, because Dr. Battalia found only "pain," claimant's findings essentially fit the kind of proof intended to be excluded from ORS 656.005(19); that is, because Dr. Battalia indicated only that claimant had pain and all other findings were normal, there are no "verifiable indications of injury" as now required by the statute. Instead, Dr. Battalia reported only a "subjective response" in that claimant showed no findings that were "reproducible, measurable or observable."[2] Therefore, there is an absence of "medical evidence supported by objective findings," and the claim fails. ORS 656.005(7)(a).

Claimant asserts that, if we retroactively apply the new law to this case, he requests remand because the "evidence and testimony presented at hearing were prepared by both parties under the definition in force at the time and both parties argued using this statutory definition." We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely

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[2] Some examples of "reproducible" findings could be x-rays, MRI's or CT scans. Some examples of "measurable" findings could be those identified during an examination or testing, such as reduced range of motion, hearing tests, or EMG nerve/sensory loss studies. Some examples of "observable" findings could be those that are apparent on observation, such as swelling, discoloration or lacerations.

or otherwise insufficiently developed. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding, including a reasonable likelihood that the evidence will affect the outcome of the hearing. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Here, although only Dr. Battalia gave an opinion, he provided ample evidence concerning his findings, including a concurrence with a letter from the insurer's attorney. Moreover, Dr. Battalia participated in a deposition, during which he was questioned by both parties' attorneys. This evidence contains a thorough explanation of Dr. Battalia's examination findings.

Thus, we find no compelling reason for remanding this case for further developments. Specifically, we do not consider the record as improperly, incompletely or otherwise insufficiently developed. On the contrary, because the parties fully litigated the issue of objective findings, there is no reasonable likelihood that any additional evidence would affect the outcome reached here. Consequently, we deny claimant's motion for remand.

Finally, we reject claimant's argument that he has a vested right in the benefits awarded by the ALJ and, thus, a contrary result violates the federal and state constitutions. Because an order regarding claimant's benefits has yet to become final, claimant's entitlement to such benefits has not yet matured into a vested right. See, e.g., State ex rel. v. Kiessenbeck, 167 Or 25, 30 (1941) (the first and essential quality of a judgment or decree that gives rise to a vested right is that it be a final determination of the rights of the parties); see also Roberts et al v. State Tax Comm., 229 Or 609, 614 (1962) ("vested right" is an immediate right to present enjoyment, or a present fixed right to future enjoyment).

ORDER

The ALJ's order dated May 24, 1995 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

Board Chair Hall specially concurring.

I agree with the majority's conclusion that claimant's injury claim is not "supported by objective findings" because the records lacks medical evidence of a verifiable indication of injury or disease as required by amended ORS 656.005(19). However, I write separately to address the inclusion of examples for "reproducible," "measurable," and "observable" findings in footnote 2 of the majority opinion.

Since the outcome of this case is not dependent on whether which, if any, of these classes of "objective findings" was established by medical evidence, the majority's decision to provide examples for such findings is merely dicta. As such, those examples neither have precedential value nor should they be interpreted as a limitation concerning whether findings in a future case (which were not provided as examples in this case) constitute "reproducible," "measurable," or "observable" findings as prescribed in the statute.

Notwithstanding the aforementioned dicta, I am troubled by the majority's efforts to begin delineating categories by setting forth "some examples." By doing so, the majority inevitably leaves the inference that other "findings" which neither directly nor indirectly satisfy the parameters of the examples described in the footnote will not constitute "reproducible," "measurable," or "observable" findings. For the following reason, I consider the majority's action unwarranted and, at least potentially, inconsistent with the statute, as well as the legislative intent.

The legislative history documents the drafter's intentions to clarify the definition of "objective findings" in a manner that was not merely dependent on a physician's acceptance of a claimant's subjective complaints. Nonetheless, the history further establishes that the statutory amendments were designed to focus on "verifiable indications" from the medical evidence. Indeed, by framing the term "objective findings" in the negative (that is, "objective findings do not include"), the legislature recognizes that physical findings and subjective responses which are reproducible, measurable, or observable do satisfy the statutory definition.

The following scenario illustrates the potential limiting effect the majority's example could have on future "objective findings" cases. Assume several different examining physicians confirm the same reflex to pressure on a trigger response. Since such medical evidence would provide a "verifiable indication" (i.e., reproducible findings), it would appear that the "objective findings" requirement has been established. Yet, because there is no "example" of such a finding in their footnote, it is unclear that the majority would agree with such an assessment. Moreover, because the majority's examples of "reproducible" findings are confined to items such as x-rays, MRI's, and CT scans, I submit that the majority exceeds the statutory requirements for "objective findings."

Board Member Gunn dissenting.

I disagree with the majority that the language in ORS 656.005(19) is ambiguous. The statute provides a clear definition of "objective findings", then gives specific examples of what do, and do not, meet that definition. I have difficulty conceiving how the legislature could have provided a more exact meaning of the term.

In my opinion, the majority simply declares the statute ambiguous in order to examine legislative history. Those comments then allow the majority to very strictly construe the statute and deem that Suzanne Robertson, supra, no longer is good law.

The treating physician in this case found pain in claimant's right shoulder and provided a diagnosis of right shoulder bursitis and right finger arthralgia. Based on the plain meaning of ORS 656.005(19), such evidence constitute "objective findings" since they are "verifiable indications of injury." Thus, claimant satisfied the statute.

The plain meaning of the statute is supposed to guide us. Because the majority wrongly looks beyond the statute's words, I disagree with its analysis of ORS 656.005(19). Accordingly, I dissent.

February 6, 1996 Cite as 48 Van Natta 239 (1996)

In the Matter of the Compensation of
CONNIE M. JOHNSON, Claimant
WCB Case No. 92-06467
SECOND ORDER ON REMAND
Lavis, Alvey, et al, Claimant Attorneys
Creel, et al, Defense Attorneys
Malagon, Moore, et al, Attorney

On December 8, 1995, we abated our Order on Remand holding that claimant had implicitly waived a medical services issue while litigating at hearing an aggravation issue. We abated our order to allow the parties to submit supplemental briefs. Having received the supplemental briefs, we proceed with our reconsideration.

Claimant has a compensable left knee injury. After the insurer denied claimant's request for surgery authorization, claimant filed a request for hearing; on the form she indicated that the issues were aggravation and medical services. At the beginning of hearing, however, claimant's attorney and the insurer's attorney agreed with the ALJ's statement that the "sole issue in this proceeding is the compensability of an alleged aggravation." The ALJ upheld the insurer's denial of claimant's aggravation claim without addressing a medical services claim under ORS 656.245.

On review, we affirmed and adopted the ALJ's order, adding:

> "By agreeing with the [ALJ's] conclusion that claimant has failed to prove a compensable aggravation claim, we do not mean to suggest that claimant cannot assert a valid medical services claim under ORS 656.245."

After claimant requested reconsideration, we found that claimant had sufficiently raised the medical services issue and had not waived the issue at hearing. Thus, we proceeded to the merits and concluded that claimant proved entitlement to medical services. Connie M. Johnson, 44 Van Natta 495 (1994).

The court reversed and remanded for reconsideration. Wright Schuchart Harbor v. Johnson, 133 Or App 680 (1995). After discussing the legal test for waiver, the court found that our order failed to determine "whether claimant actually intended to waive a known right to assert a claim for medical services" and remanded for such a conclusion.

On remand, we concluded that, because claimant's attorney agreed with the ALJ's statement that the "sole issue" was aggravation, claimant implicitly waived the medical services claim raised by the request for hearing form. Connie M. Johnson, 47 Van Natta 2191 (1995). Consequently, we affirmed the ALJ's order.

In her supplemental brief, claimant asserts that we misread the court's holding in our Order on Remand. Specifically, according to claimant, the court instructed the Board to determine only whether claimant explicitly waived the medical services issue. Claimant relies on that portion of the court's decision instructing us to determine, based on the totality of the circumstances, "whether claimant actually intended to waive a known right to assert a claim for medical services."

We disagree with claimant's interpretation of the court's decision. In discussing waiver, the court stated that, generally, waiver may be explicit or implicit. 133 Or App at 686. Furthermore, the court expressly found that the Board "erred in deviating from that general, but not absolute, principle by requiring an explicit disclaimer in this case." Id. The court further found that, when "[s]tripped of its erroneous legal premise that claimant was required to explicitly disavow any entitlement to medical services," the Board's order did not comply with the requirements set forth in Armstrong v. Asten-Hill Co., 90 Or App 200 (1988). Id. at 687.

Such language clearly indicates that the Board legally erred in requiring an explicit waiver and that, absent any Board policy or practice supporting such an absolute requirement, the proper inquiry is whether any waiver was explicit or implicit. The court's subsequent instruction to determine "whether claimant actually intended to waive a known right to assert a claim for medical service" must be read in the context of this discussion. Thus, as we did in our first Order on Remand, we continue to read this instruction as requiring us to find whether claimant actually intended, either explicitly or implicitly, to waive the medical services claim.

We continue to conclude that the totality of circumstances show that claimant implicitly waived the medical services claim. As we explained in our Order on Remand, because claimant's attorney agreed with the ALJ's statement that the "sole" issue at hearing was aggravation, counsel impliedly evinced an intent to seek medical services based only on a theory of aggravation under ORS 656.273 rather than ORS 656.245 and, thus, waived a claim for medical services pursuant to ORS 656.245.[1]

Finally, claimant contends that there exists a "special consideration of workers' compensation policy or practice" mandating a requirement of explicit waiver. According to claimant, allowing for implicit waiver will extinguish "the days of holding an off the record conference and then having the [ALJ] recite the issues on the record." Furthermore, claimant contends that "practitioner's [sic] will be hard pressed to limit or drop issues at the time of hearing for fear of having 'impliedly' waived this issue for all time" and "practitioners will be safer to raise any and all viable issues and let the finder of fact rule on which were proven and which were not."

We understand claimant to assert that our order will impede an expeditious hearing by encouraging claimants to raise all conceivable issues. We disagree. As discussed by the court, a party must first raise an issue before subsequently waiving it, whether by explicit or implicit conduct. 133 Or App at 685. Thus, although claimant's contentions may relate to preservation of issues, we find little relevance to waiver. Furthermore, contrary to claimant's argument, we find a beneficial policy in holding parties to implicit waiver since it will encourage them to declare any intention of litigating at hearing an issue raised pre-hearing. In this way, there is more likelihood that the parties will clarify issues at hearing, thus encouraging an expeditious process.

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[1] Citing Drews v. EBI Companies, 310 Or 134 (1990), claimant asserts that, as a matter of law, "silence is not capable of proving an actual intention to waive or relinquish a statutory right" and that, at most, "claimant was silent" at the hearing. Whatever the legal merits of claimant's argument, we disagree with the characterization of her behavior at hearing. Claimant was not merely silent since, through counsel, she vocally agreed with the ALJ that the "sole issue" was aggravation.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 9, 1995 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

February 6, 1996 Cite as 48 Van Natta 241 (1996)

In the Matter of the Compensation of
DARLENE J. KEEFE, Claimant
WCB Case No. 94-15282
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Bonnie V. Laux, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that affirmed an Order on Reconsideration that did not award any additional scheduled permanent partial disability for her right wrist condition. On review, the issue is extent of permanent disability.

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

Although the medical evidence established that claimant was unable to perform activities which involve the repetitive use of her hands and wrists, the ALJ found that claimant had already been compensated for this loss pursuant to the parties' September 1989 Stipulation and Order. The ALJ determined that the stipulation, in which claimant was awarded 10 percent scheduled permanent disability, was unambiguous and that the award made was for the then-accepted condition of bilateral carpal tunnel syndrome.[1]

On review, claimant contends that the 1989 stipulation and award concerned the left wrist only and did not encompass her right wrist. Claimant contends that the extent of permanent disability of her right wrist was not an issue "raised or raisable" at that time. We disagree.

Claimant filed a Form 801 on April 26, 1988 for an injury to both the left and right wrist. On the Form 827, Dr. Origer diagnosed claimant as having "carpal tunnel syndrome bilaterally." In July 1988, the SAIF Corporation accepted the claim for bilateral carpal tunnel syndrome. The 1989 Stipulation and Order also refers to the accepted claim for bilateral carpal tunnel syndrome, and provides that claimant is allowed a total award of 10 percent scheduled permanent disability.

Given that claimant had experienced symptoms of carpal tunnel syndrome in her right wrist prior to September 1989 (see, e.g., exs. 3, 3B-1, 3C), and the condition of bilateral carpal tunnel syndrome was accepted by SAIF, we conclude that the issue of the extent of permanent partial disability in the right wrist was raised or raisable at the time of the 1989 stipulation. See Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994); John P. Robinson, 46 Van Natta 738 (1994).

Moreover, we note that in affirming SAIF's Notice of Closure in the Order on Reconsideration, the Appellate Unit concluded, based on the impairment findings of Dr. Warren at the time of claim closure,[2] that claimant is only entitled to 5 percent for each forearm for loss of repetitive use under

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[1] The September 7, 1989 Stipulation and Order settled "all issue(s) raised or raisable at this time" and indicated that claimant "is allowed an additional scheduled permanent partial disability of 10 percent equal to 15 degrees, for a total award of scheduled permanent partial disability of 10 percent equal to 15 degrees." (Ex. 10).

[2] Dr. Warren declared claimant medically stationary on September 6, 1994, "with no change in permanent disability from previously." His findings indicated that claimant experienced increased symptoms with increased activity although her grip strength and range of motion were normal bilaterally. (Ex. 9-3). Claimant did not challenge these impairment findings in requesting reconsideration from SAIF's notice of closure. (Ex. 15).

OAR 436-35-010(6). Because the combined award (5 percent for each wrist) indicated by Dr. Warren's findings does not exceed the 10 percent award set forth in the 1989 stipulation, we conclude that claimant is not entitled to any additional permanent disability.

ORDER

The ALJ's order dated December 7, 1994 is affirmed.

February 6, 1996 Cite as 48 Van Natta 242 (1996)

In the Matter of the Compensation of
NANCY C. PREVATT-WILLIAMS, Claimant
WCB Case No. 95-04881
ORDER DENYING MOTION TO DISMISS
Bischoff & Strooband, Claimant Attorneys
VavRosky, et al, Defense Attorneys

The self-insured employer has requested review of Administrative Law Judge (ALJ) Black's order that set aside its partial denial of claimant's foot condition. Contending that a copy of the request was not timely served on all parties, claimant has moved the Board for an order dismissing the employer's request for review. The motion is denied.

FINDINGS OF FACT

Claimant requested a hearing regarding the employer's partial denial of claimant's foot condition. Pursuant to the ALJ's December 21, 1995 order, the employer's denial was set aside and claimant's counsel was awarded an attorney fee. Copies of the ALJ's order were mailed to claimant, her attorney, the self-insured employer, its claims administrator (Sedgwick James), and their attorney.

On January 5, 1996, the employer's attorney mailed to the Board, by certified mail, a request for review of the ALJ's order. The request included a Certificate of Mailing stating that a copy had been mailed to claimant's counsel; the request did not include any such certification establishing similar service on claimant, Sedgwick James, or the employer. See OAR 438-005-0046(2)(b).

A computer-generated acknowledgment of the employer's request for review was mailed by the Board on January 11, 1996. The acknowledgment was mailed to claimant, claimant's attorney, the employer, Sedgwick James, and their attorney.

CONCLUSIONS OF LAW

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. ORS 656.289(3). Requests for Board review shall be mailed to 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 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 v. King, supra.

"Party" means a claimant for compensation, the employer of the injured worker at the time of injury, and the insurer, if any, of such employer. ORS 656.005(21). Attorneys are not included within the statutory definition of "party." Robert Casperson, 38 Van Natta 420, 421 (1986). Yet, in the absence of prejudice to a party, timely service of a request for review on an employer's insurer or the attorney for the party is sufficient compliance with ORS 656.295(2) to vest jurisdiction with the Board. Argonaut Insurance v. King, supra, page 850-51; Nollen v. SAIF, 23 Or App 420, 423 (1975), rev den (1976); Daryl M. Britzius, 43 Van Natta 1269 (1991).

Here, the 30th day after the ALJ's December 21, 1995 order was Saturday, January 20, 1996. Therefore, the final day to perfect a timely appeal of the ALJ's order was Monday, January 22, 1996, the first business day following the expiration of the statutory 30-day appeal period. See Anita L. Clifton, 43 Van Natta 1921 (1991).

Based on the employer's counsel's unrebutted January 5, 1996 Certificate of Mailing, we are persuaded that claimant's attorney was notified of the request for Board review prior to the expiration of the aforementioned 30-day period. Harold E. Smith, 47 Van Natta 703 (1995); Argonaut Insurance v. King, supra. Inasmuch as no contention has been made that claimant has been prejudiced by not directly receiving a copy of the employer's request for review, we hold that the employer's timely service by mail upon claimant's counsel is adequate compliance with ORS 656.295(2). See Argonaut Insurance v. King, supra; Nollen v. SAIF, supra; Franklin Jefferson, 42 Van Natta 509 (1990); Denise M. Bowman, 40 Van Natta 363 (1988).

Finally, even if we had considered the employer's notice of its appeal to have been defective, we would still conclude that we retained jurisdiction over this case. Because the Board's January 11, 1996 acknowledgment letter was mailed to all parties to the hearing within 21 days after the ALJ's order, we conclude that it is more probable than not that all parties received actual notice of the employer's request for Board review within the statutory 30-day period. See Patricia A. Voldbaek, 47 Van Natta 702 (1995); Wayne V. Pointer; 44 Van Natta 539 (1992); Denise M. Bowman, supra. In light of these circumstances, we are persuaded that the non-served parties and / or their legal representatives received actual notice of the employer's appeal within the 30-day statutory period. See Zurich Ins. Co. v. Diversified Risk Management, supra; Argonaut Insurance v. King, supra.

Accordingly, claimant's motion to dismiss is denied. In light of these circumstances, the briefing schedule shall be revised as follows. The employer's appellant's brief shall be due 21 days from the date of this order. Claimant's respondent's brief shall be due 21 days from the date of mailing of the employer's brief. The employer's reply brief shall be due 14 days from the date of mailing of claimant's brief. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

February 6, 1996 Cite as 48 Van Natta 243 (1996)

In the Matter of the Compensation of
LYNDA D. STREETER, Claimant
WCB Case No. 94-11192
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Balasubramani's order that affirmed an Order on Reconsideration awarding 14 percent (44.8 degrees) unscheduled permanent disability for a low back condition.[1] In her brief, claimant contends that she is entitled to payment of the award at an increased rate of permanent disability. On review, the issues are extent of unscheduled permanent disability and rate of permanent disability. We reverse.

FINDINGS OF FACT

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

Claimant, a Certified Nurse Assistant (CNA), compensably injured her low back on November 2, 1990. Her claim was closed by an August 19, 1991 Notice of Closure that awarded no permanent disability. On June 28, 1993, claimant compensably reinjured her low back. Her aggravation claim was closed by a February 3, 1994 Determination Order that awarded no permanent disability. Claimant sought reconsideration; a September 7, 1994 Order on Reconsideration affirmed the February 1994

[1] Two orders on reconsideration were before the ALJ. Only the April 11, 1995 Order on Reconsideration is before us. (Claimant's brief at 1).

Determination Order. Meanwhile, the claim had been reopened again in May 1994. The claim was reclosed by a December 29, 1994 Determination Order that awarded 20 percent unscheduled permanent disability. The insurer requested reconsideration and an April 11, 1995 Order on Reconsideration reduced claimant's unscheduled permanent disability award to 14 percent. Claimant requested a hearing, raising the issue of extent of unscheduled permanent disability.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

The ALJ declined to award claimant additional unscheduled permanent disability beyond the 14 percent awarded by the Order on Reconsideration. Claimant requests reinstatement of the 20 percent unscheduled disability awarded by the December 29, 1994 Determination Order, contending that the Order on Reconsideration misclassified her job at injury. The insurer argues that, although claimant raised the issue of the extent of unscheduled permanent disability at hearing, she failed to raise the "theory" of an allegedly incorrect Dictionary of Occupational Titles (DOT) classification until her request for reconsideration of the ALJ's order and she should, therefore, be barred from raising the issue on review. We disagree.

The December 29, 1994 Determination Order awarded 20 percent unscheduled permanent disability. Claimant's strength at the time of injury was classified as heavy, based on claimant's job as an Orderly (CNA with heavy lifting), DOT 355.674-018[2], which resulted in an adaptability value of 5. (Exs. 53 and 54). The insurer requested reconsideration, in part challenging claimant's adaptability, and specifically objecting to the DOT classification. (Ex. 55-2 and -4). On reconsideration, the Appellate Division changed claimant's strength classification for her job at injury to medium, based on the job title Nurse's Aide (DOT 355.674-014). (Ex. 57-3).

Claimant sought a hearing by submitting a standard "Request for Hearing" form. On that form, she checked several boxes, including the box for unscheduled permanent disability. At hearing, the parties agreed that one of the issues was extent of permanent partial disability. (Tr. 3). As part of her written closing argument, claimant provided a worksheet to assist in determining claimant's unscheduled permanent disability award. Although claimant did not argue for a change in her DOT classification in the body of the text of her closing argument, her worksheet indicated that the evaluator's classification should be relied on to establish her strength category at the time of injury.

Claimant's request for hearing put the insurer on notice that the extent of unscheduled permanent disability was at issue. A claimant is entitled to unscheduled permanent partial disability benefits based on her loss of earning capacity due to the compensable injury. ORS 656.214(5). Earning capacity is calculated using the standards, which rate unscheduled permanent partial disability as impairment modified by age, education and adaptability. Id.; OAR 436-35-270(2). Thus, adaptability, which includes the establishment of the correct DOT classification, is necessarily one aspect of the issue of unscheduled permanent partial disability. See Freres Lumber Co., Inc. v. Murphy, 101 Or App 92, rev den 310 Or 195 (1990). Moreover, nothing in the record suggests that claimant conceded either adaptability or the DOT classification at hearing or that the insurer objected to consideration of those aspects of the determination of unscheduled permanent partial disability. See Elmer F. Knauss, 47 Van Natta 826, on recon 47 Van Natta 949, on recon 47 Van Natta 1064 (1995).

In Knauss, the claimant appealed an Order on Reconsideration. The insurer, relying on the hearing record, argued that the claimant had waived his right to litigate the issues of social and adaptability values. At hearing, the claimant identified the issue as unscheduled permanent disability, in particular, whether the claimant was a Class I or a Class III under the cardiovascular ratings of the disability rating guide. The record did not show that claimant was not contesting the social and adaptability values. Thus, we concluded that the claimant had not waived his right to contest those values, which were used in rating his permanent disability.

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[2] The evaluator's worksheet for the DO listed the DOT number as 355.674.010, which is the classification for Child-care Attendant. (See Dictionary of Occupational Titles, Vol. 1, Fourth Ed., Rev. 1991, page 258). However, the worksheet also identified claimant's job at injury as Orderly (CNA with heavy lifting). (Ex. 53). It is unquestioned that claimant's job title and duties at the time of injury were those of Certified Nurse Assistant, not child-care attendant. (Exs. 2, 17-3 and passim). We therefore consider the reference to DOT 355.674-010 to be a scrivener's error and that the appropriate number is Orderly, DOT 355.674-018.

Here, as in Knauss, where the record does not show that claimant specifically and intentionally relinquished her right to litigate adaptability, that issue is appropriately before us. We therefore turn to the merits.

Claimant became medically stationary on October 27, 1994 and her claim was closed on December 29, 1994. Therefore, the applicable standards which apply to rating claimant's unscheduled permanent partial disability are set forth in WCD Admin. Order 93-056.

Adaptability is measured by comparing claimant's base functional capacity (BFC) to her residual functional capacity (RFC) at the time of becoming medically stationary. OAR 436-35-310(2). BFC means the individual's demonstrated physical capacity before the injury or disease. OAR 436-35-310(3). The determination of a worker's BFC is evidenced by the highest strength category assigned in the DOT for the most physically demanding job that the worker has successfully performed in the five years prior to determination. OAR 436-35-310(4)(a). When a combination of DOT codes most accurately described a worker's duties, the highest strength for the combination of codes shall apply. Id.

In determining claimant's adaptability value, we use the job title in the DOT which appropriately describes claimant's job at injury based on her actual duties and physical demands. William L. Knox, 45 Van Natta 854 (1993); Arliss J. King, 45 Van Natta 823 (1993).[3]

Claimant worked for five years as a Certified Nursing Assistant (CNA), providing a variety of services and care, including weighing, transferring, bathing, dressing and transporting, to patients who were combative, obese and/or totally dependent/non-responsive. (Ex. 31B). In 1990, claimant injured her back while catching and lifting a patient who collapsed. (Ex. 2). The employer's assessment of weights claimant lifted and carried were 75 to 100 pounds about 30 times a day, and 125 pounds for the heaviest patient. (Ex. 31B-7 and -8). Under this assessment, claimant's work is "heavy." At the time of her compensable injury, the record indicates that claimant performed aspects of both Nurse Assistant (DOT 355.674-014) and Orderly (DOT 355.674-018) duties. The latter position constituted "heavy" work, while the former involved "medium" work. Thus, the highest strength for the combination of codes, "heavy," applies here to establish claimant's BFC. See OAR 436-35-310(4)(a).

The preponderance of medical opinion, as established by the physical capacity evaluation of October 18, 1994 and confirmed by the medical arbiters' review, established that claimant's RFC is medium/light with restrictions, or light work. OAR 436-35-310(5) and (7). Consequently, in comparing claimant's BFC (heavy) to her RFC (light), she is assigned a value of 5 for adaptability. OAR 436-35-310(6).

The parties do not contest the age value of 0 (age 34 at closure), formal education value of 0 (high school diploma), education/skills value of 3 (SVP 4) or impairment value of 5 (chronic condition).

We now assemble the factors to determine claimant's permanent disability. OAR 436-35-280. Adding the age (0) and education (3) factors results in a value of 3. OAR 436-35-280(4). That value is multiplied by the adaptability factor of 5, resulting in a value of 15. OAR 436-35-280(6). That value is added to the impairment value of 5 for a total of 20 percent unscheduled permanent disability under the standards. We consequently reverse that portion of the ALJ's order that affirmed the April 11, 1995 Order on Reconsideration and reinstate the unscheduled permanent disability awarded by the December 29, 1994 Determination Order.

Rate of Unscheduled Permanent Partial Disability

Claimant contends that she is entitled to have her award of permanent partial disability paid at the rate of $117.47 per degree under the retroactivity provisions of Senate Bill 369. This issue pertains

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[3] We note that, at the time of hearing, the parties could present "post-reconsideration" evidence regarding adaptability, although the ALJ was nevertheless required to evaluate disability as of the date the reconsideration order issued. See Safeway Stores v. Smith, 122 Or App 160 (1993), as clarified in Roseburg Forest Products v. Owen, 129 Or App 442, rev den 320 Or 271 (1994) (there is no limitation on evidence regarding adaptability that the ALJ can consider at hearing). Subsequent to the hearing, the law changed regarding the evidence that can be considered at hearing to establish extent of disability. See ORS 656.283 (7). However, we need not determine whether the amendments to ORS 656.283(7) apply to this claim because, whether we limit our consideration to the "reconsideration record," or, alternatively, the entire record, we would reach the same conclusion: that the disability "standards" were incorrectly applied in the reconsideration order.

not to the extent of disability, but rather to the insurer's eventual actions in processing the claim, i.e., the rate at which the permanent partial disability award shall be paid.

Because the insurer has yet to process the claim in response to our order, any ruling regarding the applicable rate for claimant's permanent disability benefits would be premature and advisory in nature. See e.g., James J. Sheets, 44 Van Natta 400 (1992). If claimant subsequently disagrees with the insurer's actions in paying the permanent disability award granted by our order, she may seek a hearing concerning that matter. See ORS 656.283(1). The issue will be ripe at that time. David J. Aronson, 47 Van Natta 1948 (1995).

Attorney Fee

Because we have reinstated the unscheduled permanent disability awarded by the Determination Order, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation fee equal to 25 percent of the increased compensation created by this order (the 6 percent "increase" between the 14 percent Order on Reconsideration award and our 20 percent award), not to exceed $3,800. See ORS 656.386(2); OAR 438-015-0055(1). In the event that this substantively increased permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), aff'd Volk v. America West Airlines, 135 Or App 565 (1995).

ORDER

The ALJ's order dated June 15, 1995 is reversed in part and affirmed in part. In addition to the Order on Reconsideration, which awarded 14 percent (44.8 degrees) unscheduled permanent disability, claimant is awarded 6 percent (19.2 degrees) for a total award to date of 20 percent (64 degrees). Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the "increased" compensation awarded by this order (6 percent), not to exceed $3,800. In the event that this "increased" unscheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk, supra. The remainder of the ALJ's order is affirmed.

February 7, 1996 Cite as 48 Van Natta 246 (1996)

In the Matter of the Compensation of
LISA R. DAWSON, Claimant
WCB Case Nos. 95-02106 & 94-13267
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Robert J. Yanity, Defense Attorney

Reviewed by Board Members Hall and Neidig .

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the SAIF Corporation's denials on behalf of American Cleaning Service, Inc. and Rafiti's on the Waterfront Restaurant (SAIF/Rafiti) of claimant's current low back condition. On review, the issues are compensability and, alternatively, responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Relying on Dennis L. Keller, 47 Van Natta 734 (1995), claimant asserts that SAIF/Rafiti is precluded from denying that her current low back condition is part of her 1987 accepted low back injury claim because it did not contest a Determination Order awarding permanent disability benefits for the 1987 injury. We disagree.

Keller is based on Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 120 Or 507 (1995). Messmer held that claim preclusion barred a carrier from denying that a noncompensable condition that served as a basis for a final permanent disability award was part of the claimant's compensable claim. Relying on that holding, Keller held that a carrier was precluded from denying the compensability of a condition that had caused another condition, which was identified in an uncontested Determination Order. As we will explain below, Messmer and Keller are no longer good law.

The legislature recently amended ORS 656.262(10) (formerly ORS 656.262(9)). Or Laws 1995, ch 332, § 28. As amended, ORS 656.262(10) provides:

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

Because there has been no final order or decision regarding this case, amended ORS 656.262(10) applies retroactively to it. Craig L. Hiatt, 47 Van Natta 2287 (1995) (Order on Remand). The next question concerns the effect of amended ORS 656.262(10) on Messmer and Keller.

The highlighted text of amended ORS 656.262(10) reveals the legislature's intent to overrule Messmer. That text plainly states that, when a carrier pays permanent disability benefits pursuant to an order or notice of closure, the carrier is not precluded from contesting the compensability of a worker's claim, unless it has formally accepted the claim. See Craig L. Hiatt, supra, 47 Van Natta at 2288 (payment of permanent disability award shall not preclude carrier from subsequently contesting compensability of condition). Because Messmer conflicts with amended ORS 656.262(10), that case is no longer good law. See id.[1] Consequently, to the extent that Keller relied on Messmer, it also is no longer good law. For these reasons, claimant's Keller argument fails.

The remaining question is whether, under amended ORS 656.262(10), SAIF/Rafiti is precluded from denying that claimant's current low back condition is part of her 1987 compensable claim with SAIF/Rafiti. The answer is "no."

In 1987, SAIF/Rafiti accepted a lumbosacral strain/sprain. (Ex. 3B). Before that claim was closed, claimant was diagnosed with L4-5 paracentral disc protrusion and posterior facet syndrome. (Exs. 3C-1; see Exs. 4A-2, 4AA, 4B-4). Thereafter, a 1988 Determination Order awarded claimant unscheduled permanent partial disability. (Ex. 4C). Claimant currently seeks compensation for an L4-5 disc herniation. Although SAIF/Rafiti evidently paid claimant permanent disability benefits under the 1988 Determination Order, it never formally accepted an L4-5 disc herniation. Therefore, under amended ORS 656.262(10), it is not precluded from denying that that condition is part of claimant's 1987 lumbosacral strain/sprain claim. Accordingly, we proceed to address the compensability of the L4-5 condition.

We are obligated to apply the appropriate legal standards to determine the compensability of a worker's claim. Dibrito v. SAIF, 319 Or 244, 248 (1994); Arnold D. Schaffer, 47 Van Natta 1096 (1995). To accomplish that, we consider the parties' arguments and the medical evidence.

Claimant asserts that her 1987 work injury is the major contributing cause of her current low back condition. Neither the parties' arguments nor the medical evidence clarify the statutory basis of claimant's theory. We need not resolve that issue, because there is insufficient evidence regarding the primary cause of claimant's current low back condition.

Claimant relies on the reports of examining physicians, Drs. Duff, Snodgrass and Duncan, and Drs. Edmonds and Geist. The former three concluded that the major contributing cause of claimant's ongoing back pain was her L4-5 disc herniation. (Ex. 42-7). Edmonds and Geist determined that the major contributing cause of her current low back condition was prolonged sitting in 1994. (Ex. 48-5). Those reports do not establish that claimant's current low back condition was caused, in major part, by

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[1] The legislative history supports this conclusion. Craig L. Hiatt, supra, 47 Van Natta at 2288 n 1.

her 1987 compensable injury with SAIF/Rafiti. There being no other persuasive evidence to support claimant's theory, we agree with the ALJ that claimant has failed to establish the compensability of her current low back condition. Consequently, we affirm the ALJ's decision upholding SAIF's denials of claimant's current low back condition.

Because we reach this conclusion, we do not address the responsibility issue.

ORDER

The ALJ's order dated June 7, 1995 is affirmed.

Board Chair Hall specially concurring.

I continue to disagree with the majority's conclusion that amended ORS 656.262(10) overrules Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 120 Or App 507 (1995), for the reasons stated in my and Member Gunn's dissent in Craig L. Hiatt, 47 Van Natta 2287 (1995). In view of the principles of stare decisis, however, I concede that the majority's position currently is the law. Accordingly, for that reason, and because I agree with the analysis of the merits of this case, I specially concur with the lead opinion here.

It should also be noted, however, that the holding in Messmer was predicated on the contested condition being a basis for the permanent disability award. If there is no evidence that the contested condition was a basis for the award, then the rule of issue preclusion set forth in Messmer does not apply. Here, it is unclear whether permanent disability benefits were awarded for the contested condition, namely, claimant's 1987 L4-5 disc abnormality. In view of that uncertainty, Messmer arguably does not even apply. If that were the case, I would avoid the Messmer issue entirely and proceed directly to the merits. Because I agree that, in any event, claimant's claim fails substantively, I specially concur.

In the Matter of the Compensation of
THERON N. JULE, Claimant
WCB Case No. 94-02789
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's right L4-5 disc herniation. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on the reports and deposition of Dr. Korpa, treating physician, the ALJ concluded that claimant had established the compensability of his right L4-5 disc herniation. The employer asserts that, because the contrary reports of examining physician, Dr. Dickerman, are more persuasive, claimant's claim fails. We disagree.

Claimant has preexisting degenerative lumbar disc disease. He sustained a compensable lumbar strain in August 1991. Dr. Korpa has been his treating physician from August 1991 forward. Korpa reported that claimant experienced right lower lumbar pain and pain radiating to both groins and to his left buttock and leg. (Ex. 11-1, -2). During subsequent office visits, claimant complained mostly of left-sided radicular pain. Korpa, however, also recorded that claimant had pain radiating to both buttocks, but not down his "legs." (Id. at 7; emphasis added). Thereafter, on November 1, 1991, Korpa reported that claimant was experiencing bilateral "migratory" back pain that, at times, radiated to the left thigh. (Id. at 9). In late November 1991, Korpa reported that claimant no longer had shooting pains in his "legs" or buttocks. (Id. at 10; emphasis added).

A September 1991 MRI revealed, among other things, an L4-5 right posterolateral disc prolapse or herniation. (Ex. 13; see Ex. 14-2).

In January 1994, Dr. Dickerman examined claimant on the employer's behalf. Dickerman concluded that the major cause of claimant's ongoing back pain was his degenerative disc disease. (Ex. 28-10).

Dr. Peterson, consulting physician, confirmed that claimant sought treatment in 1991 for initially bilateral radicular pain and then primarily left-sided radicular pain. (Ex. 34-1; see Ex. 14). Peterson then concluded that, if claimant experienced radicular symptoms following the August 1991 injury, that injury probably was the cause of the L4-5 herniation. (Id.)

In deposition, Dr. Korpa stated that, if claimant did not have radicular symptoms before August 1991, then the August 1991 accident was probably "the one" that herniated the L4-5 disc. (Ex. 35-20). Korpa also agreed that the August 1991 injury was the major cause of claimant's disability and need for treatment thereafter. (Id. at 40). Korpa's conclusion was based on claimant's history of the onset of persistent radicular symptoms following the 1991 injury. (See id. at 30, 46).

In a supplemental report, Dr. Dickerman concluded that, based on claimant's history of predominately left-sided symptoms in 1991, the right L4-5 disc herniation was an asymptomatic condition caused by his degenerative disc condition. (Ex. 38). In his final report, Dr. Korpa disagreed with Dr. Dickerman. (Ex. 39).

Last, at hearing, claimant testified that he had experienced bilateral radicular leg pain following the August 1991 accident. (Tr. 28, 30, 36).

On this record, we find that claimant's 1991 work accident injury combined with his preexisting lumbar degenerative disc disease, resulting in the right L4-5 disc herniation. To prevail, then, claimant must establish that the 1991 injury was the major contributing cause of his disability and need for treatment related to the L4-5 disc herniation. ORS 656.005(7)(a)(B);[1] see Beth D. Moore, 47 Van Natta 2178 (1995) (ORS 656.005(7)(a)(B) does not apply absent a combination of compensable injury and preexisting condition). Claimant has met that burden.

When the medical evidence is divided, we tend to give greater weight to the opinions of the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reasons not to rely on Dr. Korpa's opinions. On the basis of his treatment of claimant from 1991 forward, Korpa concluded that, based on claimant's persistent radicular symptoms following the August 1991 injury, the injury was the major contributing cause of claimant's right L4-5 disc herniation. That conclusion finds support in Dr. Peterson's complimentary reports. On the basis of that evidence, we conclude the claimant has established the compensability of his L4-5 disc herniation under ORS 656.005(7)(a)(B).[2]

The employer makes numerous arguments in opposition to Dr. Korpa's reports.[3] Those arguments center around the lack, in the employer's view, of evidence that claimant experienced right leg radicular pain after the August 1991 accident. Although the 1991 medical reports contain more references to left- than right-sided radicular symptoms, there is sufficient evidence to establish that claimant experienced some right leg radicular pain after the August 1991 accident. Dr. Korpa initially reported that, following that accident, claimant experienced bilateral groin, buttock and hip pain, along

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[1] The legislature amended ORS 656.005(7)(a)(B) in June 1995. Or Laws 1995, ch 332, § 1. Now, the statute refers to a "combined", rather than a "resultant" condition. The other amendments are not germane here.

[2] In reaching this conclusion, we have discounted claimant's complaints of groin pain which, according to Dr. Dickerman, are the result of pathology at the L1, not the L4-5 level. (Ex. 38-8).

[3] The employer argues that Dr. Korpa "candidly reported he really did not know what caused claimant's disc herniation." Employer's Appellant's Brief at 7. That assertion is based on part of Korpa's deposition testimony, in which he agreed that he did not know "absolutely for sure" what had caused claimant's disc herniation. (Ex. 35-62). That does not mean that Dr. Korpa did not know the probable cause of claimant's disc herniation; it only means that he could not state, with absolute certainty, the cause of that condition. Because claimant need not establish causation with absolute certainty, we disregard Dr. Korpa's statement and reject the employer's argument.

with left leg radicular pain. In two later reports, however, Korpa noted that claimant no longer complained of radicular pain to his "legs," suggesting that, at some point, claimant had experienced left and right radicular leg pain. That proposition is borne out by the history set forth in Dr. Peterson's reports and by claimant's testimony at hearing. Because we find the record, as a whole, sufficient to establish that claimant experienced at least some right leg radicular pain after the 1991 accident, we decline to discount Dr. Korpa's conclusions based on the presence of such pain.

The employer also asks us to discount Dr. Korpa's reports, because they lack an accurate history of claimant's back pain before 1991. That argument is based on Dr. Korpa's characterization of that pain as "relatively minor." (Ex. 35-9). We need not address that issue. The pre-1991 reports contain no references to radicular leg pain. Because Dr. Korpa's ultimate conclusion is based, in large part, on the onset of right leg radicular pain in 1991, and because the record contains no persuasive that claimant had experienced that type of pain before then, any dispute regarding the quality of claimant's pre-1991 back pain is of little import.

In sum, we agree with the ALJ that claimant has established the compensability of his right L4-5 disc herniation. Accordingly, we affirm the ALJ's decision setting aside the employer's denial of that condition.

Claimant presses several constitutional and statutory arguments on review, in the event that we reversed the ALJ's decision. Because we have not reversed that decision, we do not address those arguments.

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

ORDER

The ALJ's order dated August 14, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

February 7, 1996 Cite as 48 Van Natta 250 (1996)

In the Matter of the Compensation of
TAMMY LOCKE, Claimant
WCB Case Nos. 95-05771, 95-01900, 95-05770 & 94-13483
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Roberts, et al, Defense Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board en banc.

Bi-Mart Corporation (Bi-Mart) requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its responsibility denial of claimant's current low back condition; and (2) upheld Wal*Mart Stores, Inc.'s (Wal*Mart's) responsibility denial of the same condition. Claimant cross-requests review of the ALJ's attorney fee award. Wal*Mart moves to strike Bi-Mart's reply brief as untimely. On review, the issues are motion to strike, responsibility and attorney fees. We grant the motion, affirm in part and modify in part.

FINDINGS OF FACT

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

The hearing lasted one and one-half hours. The transcript is 40 pages long. The record consists of 26 exhibits, including one 50-minute deposition taken on behalf of Wal*Mart.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Bi-Mart filed its appellant's reply brief 15 days after the mailing of respondent Wal*Mart's brief. OAR 438-011-0020(2) allows an appellant to file a reply brief within 14 days after the date of mailing of the respondent's brief. Wal*Mart moves to strike Bi-Mart's reply brief, contending that Bi-Mart failed to file its reply brief within that 14-day period. We agree that Bi-Mart's reply brief was untimely and grant the motion.

Responsibility

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

Attorney Fees

The ALJ awarded claimant a $1,000 attorney fee for her counsel's services at hearing. Claimant asserts that she is entitled to a larger fee. We disagree.

ORS 656.308(2)(d)[1] states:

> "Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances." (Emphasis added).

Accordingly, notwithstanding ORS 656.386(1) (which entitles claimant to an attorney fee for prevailing over a compensability denial), and ORS 656.382(2) (which provides for an attorney fee for successfully defending against a carrier's request for hearing or review from an ALJ order awarding compensation), ORS 656.308(2)(d) limits claimant to a maximum $1,000 attorney fee for "finally prevailing against a responsibility denial," absent a showing of extraordinary circumstances. Julie M. Baldie, 47 Van Natta 2249 (1995).

Claimant's counsel (with contribution from a paralegal) expended approximately 11 hours of service at the hearings level and successfully argued that Bi-Mart was the responsible carrier. Nevertheless, this is a standard responsibility case involving two carriers. The hearing lasted one and one-half hours. Claimant was the only witness. The transcript is 40 pages long. The record consists of 26 exhibits, including one 50-minute deposition taken on behalf of Wal*Mart; claimant's counsel apparently did not procure any of the exhibits. Under these circumstances, we find that there were no "extraordinary circumstances" sufficient to justify a greater fee than the statutory maximum. Accordingly, we conclude that the ALJ did not err in limiting the award for claimant's counsel's services at hearing to $1,000.

The remaining issue concerns whether claimant is entitled to an additional attorney fee for her counsel's services on review. For the following reasons, we answer that query, "no."

This issue involves a question of statutory interpretation. In interpreting ORS 656.308(2)(d), our task is to discern legislative intent. ORS 174.020. We begin with the statutory text and context. PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993). Only if those sources are unavailing to we resort to legislative history and other extrinsic aids. Id.

On its face, ORS 656.308(2)(d) provides that, subject to the $1,000 cap in cases involving other than extraordinary circumstances, "a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial." (Emphasis added). The statute does not distinguish between various levels of appellate review. Facially, then, the statute appears to authorize a maximum cumulative attorney fee of $1,000 for legal services at all levels of litigation, except in cases involving extraordinary circumstances.

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[1] That statute was added as part of Senate Bill 369, which became effective June 7, 1995. Or Laws, ch 332, § 37 (SB 369, § 37).

The statutory context supports that conclusion. Amended ORS 656.386(1) provides, in part:

> "In all cases involving denied claims where a claimant prevails finally against the denial in an appeal to the Court of Appeals or petition for review to the Supreme Court, the court shall allow a reasonable attorney fee to the claimant's attorney. In such cases involving denied claims where the claimant prevails finally in 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." SB 369, § 43 (emphasis added).

Amended ORS 656.386(1)'s disjunctive language reveals the legislature's intent to authorize a separate attorney fee as each level of adjudication when a claimant prevails finally over a denied claim.

In contrast, amended ORS 656.388(1) provides, in part:

> "In such cases in which a claimant finally prevails after remand from the Supreme Court, Court of Appeals or board, then the Administrative Law Judge, board or appellate could shall approve or allow a reasonable attorney fee for services before every prior forum as authorized by ORS 656.307(5), 656.308(2), 656.382 or 656.386." SB 369, § 44 (emphasis added).

That statute authorizes an attorney fee for service before every prior forum when a claimant finally prevails with respect to any claim or award for compensation after remand from the Supreme Court, Court of Appeals or Board.

Amended ORS 656.386(1) and 656.388(1) reveal the legislature's ability to specify with particularity at which level (or levels) of litigation attorney fees may be awarded. See Jones v. OSCI, 107 Or App 78 (court recognized that legislature had distinguished between the two types of attorney fee cases, allowing a claimant an insurer-paid attorney fee for pre-hearing services under former ORS 656.382(2), but not under former ORS 656.386(1)), recon 108 Or App 230 (1991). In drafting ORS 656.308(2)(d), the legislature did not specify that separate fees may be awarded on the various levels of appellate review. Consequently, in light of the statutory context provided by amended ORS 656.386(1) and 656.388(1), we are compelled to conclude that the legislature intended, in cases in which a claimant finally prevails against a responsibility denial, to authorize a maximum cumulative attorney fee of $1,000 for services at all levels of litigation, except in cases involving extraordinary circumstances.

Because the text and context of ORS 656.308(2)(d) support this conclusion, we need not resort to the legislative history or any other extrinsic aids. PGE v. Bureau of Labor and Industries, supra, 317 Or at 611-12. As an aside, however, we note that the legislative history is silent on this point.

Further, we note that, under prior law, if claimant had a higher temporary disability rate with the appealing carrier, she would have been entitled to a carrier-paid attorney fee under former ORS 656.382(2) for services on review, because her compensation would have been at risk. See Ancil R. Honeywell, 46 Van Natta 2378 (1994). Amended ORS 656.308(2)(d) now provides that, notwithstanding ORS 656.382(2) and 656.386, the maximum attorney fee award in responsibility denial cases is $1,000, absent a showing of extraordinary circumstances. Consequently, ORS 656.382(2) and 656.386(1) do not apply here.

In sum, for prevailing against Bi-Mart's responsibility denial, and in the absence of any extraordinary circumstances, under amended ORS 656.308(2)(d), claimant is entitled a maximum cumulative attorney fee award of $1,000 for her counsel's services at hearing and on review. Accordingly, in lieu of the ALJ's $1,000 fee award for claimant's counsel's services at hearing, we award $1,000 for counsel's services at hearing and on review, payable by Bi-Mart. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearings record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated August 21, 1995 is affirmed in part and modified in part. In lieu of the ALJ's $1,000 fee award for claimant's counsel's services at hearing, we award $1,000 for counsel's services at hearing and on review, payable by Bi-Mart Corporation. The remainder of the order is affirmed.

Board Member Gunn concurring.

In light of the language, context and (lack of) legislative history, I am compelled to agree with the lead opinion that ORS 656.308(2)(d) limits to $1,000 the attorney fee that may be awarded under that statute for all levels of litigation, except in cases involving extraordinary circumstances. That reflects, in my view, a very poor choice on the Legislature's part.

Most people at all familiar with the workers' compensation system recognize the value of claimants' attorneys, who assist in the rapid resolution of many compensability and responsibility disputes. ORS 656.308(2)(d)'s attorney fee cap will likely act to the detriment of all parties in the system because, now, there will be virtually no incentive for attorneys to help claimants -- and, indirectly, carriers -- resolve responsibility disputes. Because, sadly, the lead opinion reaches the only reasonable construction of amended ORS 656.308(2)(d) I have discovered, I reluctantly concur with it.

Board Chair Hall concurring.

I agree that the text and context of ORS 656.308(2)(d) limits to $1,000 the attorney fee that may be awarded under that statute for all levels of litigation, except in cases involving extraordinary circumstances. I write separately to express the following:

ORS 656.308(2)(d) applies only to pure responsibility cases; that is, cases in which compensability has been conceded. This is such a case. (Tr. 2, 3; see Exs. 14, 23). See Paul R. Huddleston, 48 Van Natta 4 (1996) (attorney fee awarded under ORS 656.308(2)(d) is separate from, and in addition to, an attorney fee awarded under ORS 656.386(1) or 656.382(2)).

February 7, 1996 Cite as 48 Van Natta 253 (1996)

In the Matter of the Compensation of
JON O. NORSTADT, Claimant
WCB Cases No. 94-10782, 94-10781, 94-10773, 94-10774 & 94-05124
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Lundeen, et al, Defense Attorneys
Kevin L. Mannix, Defense Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) upheld the denials and disclaimers of claimant's occupational disease claim for bilateral hearing loss issued by Murphy Plywood Company/Liberty Northwest Insurance Corporation (Liberty), Parkway Ford/Liberty, Able Temporary/ Health Future Enterprises, Inc., Douglas County Forest Products/Liberty, and Huffman and Wright Logging/Liberty; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claims processing. Claimant has moved to: (1) strike portions of several carrier's briefs that address the compensability of his claim; and (2) dismiss his appeal insofar as it pertains to his claim with Able Temporary/ Health Future Enterprises, Inc. In its respondent's brief, Huffman and Wright Logging/Liberty argues that claimant's claim was untimely filed. Douglas County Forest Products/Liberty contends that claimant's hearing request regarding its denial was untimely filed. On review, the issues are motions to dismiss/strike, timeliness of claimant's request for hearing, timeliness of claims filing, responsibility, penalties and attorney fees. We affirm the ALJ's ultimate decision that the remaining denials and disclaimers should be upheld, but we base our conclusion on different grounds.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Untimely Claim Filing

Huffman and Wright Logging/Liberty contends that claimant's claim should be barred because he did not file his claim within the time frame required by ORS 656.807(1)(a).[1] According to Huffman and Wright Logging/Liberty, claimant should have filed his claim on or before October 13, 1987, one year from the date he discovered, or with reasonable care, should have discovered that he had an employment-induced hearing loss.

Claimant contends that he was not informed by a physician that his hearing loss arose from his employment until October 1993. Because he filed his claim against Huffman and Wright Logging/Liberty on March 7, 1994, he argues that he satisfied the one-year time limit in ORS 656.807(1).

In order for a physician to inform a claimant that he is suffering from an occupational disease under the statute, the physician must have told the claimant "'simply and directly' that his disease arose out of his employment." Liberty Northwest Ins. Corp. v. Meeker, 106 Or App 411, 414-15 (1991). Here, although claimant was informed by Dr. Scott that he had hearing loss in October 1986, (Ex. 1), there is no evidence that Dr. Scott told claimant "simply and directly" that his hearing loss was caused by his employment. See Ralph T. Masuzumi, 45 Van Natta 361 (1993). The record establishes that claimant was not informed that his hearing loss arose from his employment until Dr. Owens so informed him in October 1993. (Ex. 10). Consequently, we conclude that claimant's March 7, 1994 claim against Huffman and Wright Logging/Liberty was timely filed.

Untimely Request for Hearing

Douglas County Forest Products/Liberty contends that claimant's hearing request regarding its denial was not timely. Douglas County Forest Products/Liberty issued a denial on March 31, 1994. Claimant has not yet appealed that denial, although his attorney filed a request for hearing for a "de facto" denial on September 8, 1994.

A request for a hearing must be filed not later than the 60th day after claimant is notified of a denial of the claim.[2] ORS 656.319(1)(a). A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if claimant had good cause for the late filing. ORS 656.319(1)(b).

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[1] ORS 656.807(1) provides:

"All occupational disease claims shall be void unless a claim is filed with the insurer or self-insured employer by whichever is the later of the following dates:

"(a) One year from the date the worker first discovered, or in the exercise of reasonable care should have discovered, the occupational disease; or

"(b) One year from the date the claimant becomes disabled or is informed by a physician that the claimant is suffering from an occupational disease."

[2] After the ALJ's order, the legislature enacted Senate Bill 369. Amended ORS 656.319(1)(a) provides that a request for hearing must be filed not later than the 60th day after the mailing of the denial to claimant. Or Laws 1995, ch 332, § 39 (SB 369; § 39). A hearing request that is filed after 60 days, but within 180 days after mailing of the denial, confers jurisdiction if claimant had good cause for the late filing. Amended ORS 656.319(1)(b).

Generally, the changes made to the Workers' Compensation law by SB 369 apply to cases in which the Board has not issued a final order or for which the time to appeal the Board's order has not expired on the effective date of the Act. Volk v. America West Airlines, 135 Or App 565, 569 (1995). However, one exception to the retroactive effect of SB 369 applies here. Subsection (6) of section 66 of SB 369 provides:

"The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not extend or shorten the procedural time limitations with regard to any action on a claim taken prior to the effective date of this Act."

Because the issue of the timeliness of claimant's request for hearing involves a procedural time limit, the changes made by SB 369 do not apply to this case. See Motel 6 v. McMasters, 135 Or App 583 (1995). We note that, in any event, application of the amendments to ORS 656.319(1) would not affect the outcome in this case.

Claimant has the burden of proving good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). The test for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized under ORCP 71B or former ORS 18.160. Hempel v. SAIF, 100 Or App 68 (1990).

Claimant argues that Douglas County Forest Products/Liberty violated ORS 656.331(1)(b) because it did not provide a copy of its denial to claimant's attorney. ORS 656.331(1)(b) provides that, if an attorney has given written notice of the attorney's representation of an injured worker, an insurer or self-insured employer "shall not contact the worker without giving prior or simultaneous written notice to the worker's attorney if the contact affects the denial, reduction or termination of the worker's benefits."

Here, claimant asserted his claim against Douglas County Forest Products/Liberty by letter from his attorney on March 7, 1994. (Ex. 19). Douglas County Forest Products/Liberty issued a denial to claimant and did not simultaneously provide a copy to claimant's counsel. (Ex. 26B).

Douglas County Forest Products/Liberty argues that there is no evidence that claimant's attorney submitted a retainer agreement with its letter. However, ORS 656.331(1)(b) does not require that an attorney submit a retainer agreement to the carrier. Rather, the statute refers to "written notice of [the attorney's] representation." Douglas County Forest Products/Liberty was aware of claimant's attorney's representation. We conclude that claimant's attorney provided written notice of his representation when he submitted claimant's claim to Douglas County Forest Products/Liberty on March 7, 1994.

Claimant testified that he had been told by his attorney that his attorney would have received anything that claimant received. (Tr. 24). Claimant assumed that his attorney had received a copy of the denial from Douglas County Forest Products/Liberty. (Tr. 23, 24). Although the record does not establish that claimant specifically instructed his attorney to contest any denial that issued, his attorney had taken steps to protect his rights. Claimant's attorney had filed at least 15 claims on claimant's behalf and presumably was monitoring the responses. Under these circumstances, claimant had reason to believe that his attorney would receive the denial and that he need do nothing further. We conclude that claimant had good cause for late filing of his request for hearing. See Freres Lumber Co. v. Jegglie, 106 Or App 27 (1991); Cowart v. SAIF, 94 Or App 288 (1988); Julio R. Sanchez, 42 Van Natta 533 (1990).

Employment-Related Claim

To begin, we note that claimant has moved to withdraw his request for hearing against Able Temporary/Health Future Enterprises, Inc. None of the parties object to claimant's request. Therefore, we do not address claimant's claim against Able Temporary/Health Future Enterprises, Inc.

Claimant argues that the ALJ erred by concluding that Dr. Owens' opinion was not persuasive.[3] Claimant contends that the medical evidence establishes that his employment activities were the major contributing cause of his bilateral hearing loss.

At the beginning of the hearing, claimant said that he had submitted a Disputed Claim Settlement (DCS) with WRP, Inc., SAIF's insured, for approval.[4] (Tr. 2). Based on Bennett v. Liberty Northwest Insurance Corp., 128 Or App 71 (1994), we must examine the language in the DCS to determine whether claimant agreed that his work for that employer did not contribute in any way to his condition. See Kristin Montgomery, 47 Van Natta 961 (1995).

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[3] Claimant moves to strike portions of some carrier's briefs that address the compensability of his claim. Claimant argues that, since those carriers conceded compensability in their respective denials, they are not permitted to challenge the compensability of the claim. We need not address claimant's motion because the result in this case would be the same whether or not we consider those portions of the carriers' briefs.

[4] Claimant also moved to dismiss his requests for hearing against all of the other SAIF insureds. (Tr. 2). ALJ Livesley issued an Order of Dismissal as to Cooper-Wheeler Logging, C & D Lumber, Woody Woodward Logging, Mobile Tune, Herbert Lumber Co., Gregory Timber, Mico Logging, Inc., Simons Log Co., and Lauren Young Tire Center.

Although claimant's DCS with WRP, Inc. and the Order of Dismissal are not a part of this record, we may take official notice of any fact that is "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned." ORS 40.065(b); see Lola K. Springer, 46 Van Natta 2213 (1994) (taking official notice of disputed claim settlements).

In the DCS, claimant agreed that WRP, Inc.'s denial "shall remain in full force and effect" and that he "shall have no further entitlement to compensation or any other legal right related to the denied treatment or conditions(s) or to the denied injury or occupational disease in this claim." Claimant stated that he would continue to pursue the hearing claim against other employers. Claimant agreed to withdraw his request for hearing against WRP, Inc. and to dismiss the request for hearing with prejudice.

Based on Bennett v. Liberty Northwest Ins. Corp., supra, we find that claimant's DCS with WRP, Inc. evidenced an agreement by claimant that his work with WRP, Inc. did not contribute to his hearing loss and that he elected to prove actual causation against the remaining employers. See Lola K. Springer, supra; Kristin Montgomery, supra. Therefore, claimant cannot rely on his employment exposure with WRP, Inc. to establish whether his bilateral hearing loss was work-related.[5] Rather, claimant must prove that his other employment conditions were the major contributing cause of the hearing loss. Amended ORS 656.802(2)(a).[6]

Claimant sought treatment from Dr. Scott on October 13, 1986 for loss of hearing. (Ex. 1). An audiogram was performed and claimant was fitted for a hearing aid on his left ear. (Exs. 2, 2A, 3). Claimant was also to receive a hearing aid for his right ear. (Ex. 3). Another audiogram was performed in 1990. (Exs. 5, 6).

On October 11, 1993, claimant was examined by Dr. Owens, who performed an audiogram and reported that claimant had a bilateral hearing loss. (Ex. 10). Dr. Owens notified claimant that his hearing loss was due to noise exposure. (Id.) On May 25, 1994, Dr. Owens reported that claimant had a significant history of noise exposure in the timber industry and that was the primary cause of his hearing loss. (Ex. 36). Dr. Owens noted, however, that he did not have access to audiometric studies obtained before, during or after claimant's noise exposure or after his 1988 head injury. (Id.)

On June 13, 1994, Dr. Owens reported to SAIF that, based on claimant's history, claimant's hearing loss was most likely due to noise exposure sustained in his employment. (Ex. 37). Dr. Owens commented that claimant had bilateral tinnitus after a significant injury in 1988 in which he had sustained a head injury. Dr. Owens did not know the extent of the head injury claimant sustained in 1988 or whether that injury could have been responsible for the hearing loss. Dr. Owens said that he would need to review audiometric studies taken before and after that injury to make that determination. (Id.)

Dr. Ediger, audiologist, reviewed claimant's October 13, 1986 and October 1993 audiograms. Dr. Ediger reported that claimant's hearing change from 1986 to 1993 did not exceed the amount expected from the normal aging process. (Ex. 43). Dr. Ediger also reported that claimant's hearing did not change between 1986 and 1990.

Dr. Owens reviewed Dr. Ediger's report, as well as Dr. Scott's October 13, 1986 chart notes, and an audiogram of the same date. (Ex. 43A). On October 13, 1994, Dr. Owens reported that claimant's noise exposure in the timber industry was probably the major contributing factor in his hearing loss. (Ex. 49). He noted, however, that he would be more comfortable in making that opinion if he had access to audiometric studies obtained prior to claimant's work as a timber faller. Dr. Owens acknowledged that it was possible that there might be other factors in claimant's hearing loss, but he believed it was reasonable that the noise exposure was the major factor. (Id.) Dr. Owens referred to Dr. Ediger's report and the audiograms in 1986 and 1993 and said "there has probably been no significant change other than that attributable to presbycusis between those years." (Id.) In response to claimant's attorney's question whether claimant's employment since 1988 had contributed to claimant's hearing loss, (Ex. 43A), Dr. Owens reported that there had not been any significant change in claimant's hearing since he left the timber industry in 1988.

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[5] The record indicates that claimant worked for WRP, Inc. from "10/10-10/18/88." (Ex. A).

[6] After the ALJ's order, the legislature enacted Senate Bill 369, which amended ORS 656.802. Or Laws 1995, ch 332, § 56 (SB 369, § 56). We note that the outcome in this case would be the same under either the former or amended versions of ORS 656.802.

Although Dr. Owens' June 13, 1994 report indicated that he was concerned about the extent of claimant's 1988 head injury and whether it could have been responsible for the hearing loss, his October 13, 1994 report makes no mention of that injury. In light of Dr. Owens' comment that "there has probably been no significant change other than that attributable to presbycusis between those years," (i.e., 1986 and 1993), we conclude that, even if claimant sustained a head injury in 1988, that injury did not have an impact on claimant's hearing loss. We are persuaded by Dr. Owens' reports that claimant's employment conditions were the major contributing cause of bilateral hearing loss. In making this determination, we did not rely on claimant's work activities at WRP, Inc.

Disclaimer of Responsibility

Claimant contends that Huffman and Wright Logging/Liberty, Douglas County Forest Products/Liberty, Parkway Ford/Liberty and Murphy Plywood Company/Liberty all failed to timely comply with the statutory requirements of former ORS 656.308(2).[7] Thus, according to claimant, none of those carriers have the defense of responsibility available.

In Donald A. James, 46 Van Natta 1898 (1994), the claimant moved for dismissal of all insurers except one, arguing that since the remaining carrier had not issued a timely disclaimer of responsibility under former ORS 656.308(2), it was precluded from denying responsibility as to any other insurers. The other insurers joined the claimant's motion for dismissal.

In James, we referred to our decision in Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994), where we held that the carrier's failure to comply with the disclaimer notice of former ORS 656.308(2) precluded the carrier from attempting to shift responsibility for the claim to another carrier. However, we concluded in Hamrick that the carrier's violation did not preclude the claimant from pursuing the compensability of her claim against the other carrier. See also Jon F. Wilson, 45 Van Natta 2362 (1993).

In Donald A. James, supra, unlike Hamrick, the claimant was no longer asserting a claim against other insurers. Consequently, we held that the remaining carrier was precluded from attempting to shift responsibility for the claimant's condition to another carrier.

In contrast to Donald A. James, supra, claimant in this case has not moved to dismiss all other carriers. Rather, he continues to pursue his claims against Huffman and Wright Logging/Liberty, Douglas County Forest Products/Liberty, Parkway Ford/Liberty and Murphy Plywood Company/Liberty. Therefore, even if we assume, without deciding, that Huffman and Wright Logging/Liberty, Douglas County Forest Products/Liberty, Parkway Ford/Liberty and Murphy Plywood Company/Liberty all failed to comply with former ORS 656.308(2), those alleged violations do not preclude claimant from pursuing the compensability of his claim against those carriers. Even if the carriers cannot attempt to shift responsibility, the carriers' alleged violations do not preclude claimant from pursuing the claim with other carriers. See Penny L. Hamrick, supra.

Responsibility

In determining which carrier is responsible for claimant's condition, we must first decide whether this case is governed by ORS 656.308 or the last injurious exposure rule. Since there is no accepted hearing loss claim in this case, we do not apply ORS 656.308. When ORS 656.308(1) does not apply, the last injurious exposure rule applies to assign responsibility. SAIF v. Yokum, 132 Or App 18 (1994).

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[7] After the ALJ's order, the legislature amended ORS 656.308(2). Or Laws 1995, ch 332, § 37 (SB 369, § 37). The statute, as amended, no longer requires a carrier to issue a timely "disclaimer" of responsibility. On review, Douglas County Forest Products/Liberty argues that the amendments in Senate Bill 369 apply to this case. Claimant contends that the amendments should not be applied retroactively.

Because the issue of the timeliness of the carriers' disclaimers involves a procedural time limit, we conclude that the changes made by Senate Bill 369 do not apply to this case. See Or Laws 1995, ch 332, § 66(6) (SB 369, § 66(6)); Motel 6 v. McMasters, supra.

The "last injurious exposure rule" provides that where, as here, a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982).

If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first began to receive treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994). The dispositive date is the date the claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

Claimant first sought treatment for his compensable hearing loss on October 13, 1986, when he was examined by Dr. Scott. (Ex. 1). See Timm v. Maley, supra; SAIF v. Kelly, supra. Dr. Scott reported that claimant was then working at Douglas County Forest Products. (Exs. 1, A). In October 1986, Douglas County Forest Products was insured by Lumbermen's Underwriting Alliance. Therefore, we would ordinarily assign presumptive responsibility for claimant's compensable condition to Douglas County Forest Products/ Lumbermen's Underwriting Alliance. We note that, although the disclaimer from Parkway Ford/Liberty notified claimant of a potential claim against Douglas County Forest Products/ Lumbermen's Underwriting Alliance, (Ex. 51), claimant apparently did not file a claim against that carrier and it was not a party to the hearing.[8]

In the usual situation, since Douglas County Forest Products/ Lumbermen's Underwriting Alliance is presumptively responsible for claimant's hearing loss, it could attempt to shift responsibility to an earlier or later carrier. Here, however, claimant has chosen not to pursue his claim against Douglas County Forest Products/ Lumbermen's Underwriting Alliance. Consequently, Douglas County Forest Products/ Lumbermen's Underwriting Alliance cannot be held responsible for claimant's condition since claimant did not join Douglas County Forest Products/ Lumbermen's Underwriting Alliance in the litigation.[9]

In this proceeding, claimant has chosen to pursue his claim for the bilateral hearing loss with Murphy Plywood Company/Liberty, Parkway Ford/Liberty, Douglas County Forest Products/Liberty, and Huffman and Wright Logging/Liberty. Since claimant has chosen to advance his claim against those carriers, he can attempt to shift responsibility to those carriers. See Kristin Montgomery, supra (although presumptive responsibility was assigned to a carrier not joined in the litigation, the claimant could attempt to shift responsibility to another "joined" carrier).

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[8] In his reply brief, claimant contends that the employer on the risk in 1986, Douglas County Forest Products, was joined as a party. If claimant had filed a claim for his entire period of employment with Douglas County Forest Products, claimant would be correct. However, claimant made a limited claim to a specific period of employment. In his notice of claim to Douglas County Forest Products, claimant asked the employer to "submit to the comp carrier insuring you for the period of exposure stated in the enclosed letter from SAIF." (Ex. 19). Earlier in the letter, claimant referred to SAIF's disclaimer letter dated February 17, 1994. SAIF's February 17, 1994 letter referred specifically to Douglas County Forest Products, insured by Liberty Northwest "for the date of injury/period of exposure of September of 1991 to April 1992." (Ex. 13).

By referring to a particular period of exposure, claimant's "claim" is limited to that exposure. There is no indication in the record that claimant filed a claim against Douglas County Forest Products for the earlier employment period. Claimant's earlier employment with Douglas County Forest Products was not the subject of this litigation.

[9] For purposes of our analysis, we emphasize that Douglas County Forest Products/ Lumbermen's Underwriting Alliance is only presumptively responsible for claimant's condition. Since claimant is pursing the claim only with Murphy Plywood Company/Liberty, Parkway Ford/Liberty, Douglas County Forest Products/Liberty, and Huffman and Wright Logging/Liberty, our review is limited to addressing whether those carriers are responsible for claimant's condition.

Claimant worked for three of the employers after the October 1986 date of disability, i.e., Murphy Plywood Company/Liberty (September 1992 to July 1993), Parkway Ford/Liberty (October 13, 1992 to November 2, 1992) and Douglas County Forest Products/Liberty (October 16, 1991 to March 16, 1992). (Ex. A). In order to shift responsibility to a later carrier, the later employment conditions must "contribute to the cause of, aggravate, or exacerbate the underlying disease." Bracke v. Baza'r, supra, 293 Or at 250; Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992) (later employment conditions must have actually contributed to a worsening of the condition). A claimant must suffer more than a mere increase in symptoms. Timm v. Maley, 1340 Or App 245, 249 (1995); see Bracke v. Baza'r, supra, 293 Or at 250 ("A recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer").

Dr. Ediger reported that claimant's hearing change from 1986 to 1993 did not exceed the amount expected from the normal aging process. (Ex. 43). Dr. Ediger also reported that claimant's hearing did not change between 1986 and 1990. Dr. Owens referred to Dr. Ediger's report and the audiograms in 1986 and 1993 and said "there has probably been no significant change other than that attributable to presbycusis between those years." (Ex. 49). Dr. Owens also reported that there had not been any significant change in claimant's hearing since he left the timber industry in 1988.

Based on the opinions of Drs. Owens and Ediger, we conclude that claimant's later employment conditions at Murphy Plywood Company/Liberty, Parkway Ford/Liberty and Douglas County Forest Products/Liberty did not actually contribute to the cause of, aggravate, or exacerbate claimant's hearing loss. See Bracke v. Baza'r, supra; Oregon Boiler Works v. Lott, supra. Therefore, responsibility does not shift to those carriers.

Claimant was employed by Huffman and Wright Logging from December 1985 to January 1986. (Ex. A). Responsibility can be shifted from Douglas County Forest Products/ Lumbermen's Underwriting Alliance to Huffman and Wright Logging/Liberty, a prior carrier, by showing that claimant's work activity while Huffman and Wright Logging/Liberty was on the risk was the sole cause of claimant's bilateral hearing loss, or that it was impossible for conditions while Douglas County Forest Products/ Lumbermen's Underwriting Alliance was on the risk to have caused that condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985). Here, however, there is no evidence in the record to support shifting responsibility to Huffman and Wright Logging/Liberty. Accordingly, responsibility for claimant's hearing loss does not shift to Huffman and Wright Logging/Liberty.

Since responsibility for claimant's condition does not shift to Murphy Plywood Company/Liberty, Parkway Ford/Liberty, Douglas County Forest Products/Liberty, or Huffman and Wright Logging/Liberty, none of those carriers is responsible for claimant's hearing loss.

Penalties

Claimant argues that all four carriers should be penalized for unreasonable delay in claim processing. However, in light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. See Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Ins.Corp., 107 Or App 599 (1991). Accordingly, no penalties or related attorney fees are warranted.

ORDER

The ALJ's order dated March 17, 1995 is affirmed.

In the Matter of the Compensation of
TERRELL SCHIFFER, Claimant
WCB Case No. 95-02354
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Mills' order which: (1) disapproved the insurer's unilateral offset of overpaid proceeds of a Disputed Claim Settlement (DCS) against proceeds from a Claim Disposition Agreement (CDA); and (2) awarded an out-of-compensation attorney fee. Claimant cross-requests review of those portions of the ALJ's order which: (1) approved the offset of the overpaid DCS proceeds against the CDA proceeds; and (2) declined to award penalties or attorney fees for the insurer's allegedly unreasonable claim processing. On review, the issues are offset, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable low back injury on or about November 5, 1993, that was accepted by the insurer. (Ex. 4-2). Claimant also alleged that he sustained a separate injury to his ribs and anterior chest on September 29, 1994. (Ex. 2-1). That claim was not accepted.

Claimant and the insurer agreed to a "global" settlement of his workers' compensation claims for the sum of $15,000. The settlement proceeds were allocated in the following manner: $2,500 were applied to a DCS of the September 29, 1994 injury claim, $2,500 were applied to an employment release, and the remaining $10,000 were allocated to a CDA pertaining to the accepted November 1993 low back claim.

An ALJ approved the DCS on December 6, 1994, after which the insurer paid $1,875 to claimant and $625 to claimant's counsel. Shortly thereafter, the insurer received another copy of the signed DCS, along with the signed employment release. The insurer mistakenly paid the DCS proceeds again.

Claimant's counsel contacted the insurer upon noticing the double payment. After discussing the matter with Ms. Altenhofen, the insurer's claims supervisor, counsel agreed to return the check for his attorney fees. In the same conversation, Ms. Altenhoven requested that claimant's counsel contact his client to convince him to return the overpaid DCS proceeds. Ms. Altenhoven indicated that, if repayment did not occur, she would simply deduct the overpayment from the CDA proceeds. There was apparently no explicit agreement reached with regard to deducting the overpayment from the CDA proceeds, but claimant's counsel did not object. Ms. Altenhoven interpreted counsel's silence as "acquiescence" to her plan. (Tr. 19).

Claimant did not return the additional DCS funds. When the Board approved the CDA, Ms. Altenhoven deducted the $1,875 overpayment from claimant's share of the CDA proceeds. Claimant then requested a hearing, alleging that the CDA had been underpaid and that the insurer's unilateral offset was unreasonable.

The ALJ determined that the insurer's unilateral recovery of the double "DCS" payment by deducting the money from the CDA was improper. The ALJ, however, granted the insurer's request to approve an offset. The ALJ concluded that the "double paid" DCS proceeds could be offset against the CDA proceeds. The ALJ then awarded claimant's counsel an out-of-compensation attorney fee for his efforts in establishing that claimant was entitled to additional compensation prior to the authorization of the offset. Finally, the ALJ rejected claimant's request for penalties with respect to the insurer's unilateral offset, concluding that the insurer's action was not unreasonable in light of the unusual facts of the case.

On review, the insurer contends that the ALJ erroneously awarded an additional attorney fee to claimant's counsel, arguing that it could unilaterally offset overpaid DCS proceeds under the facts of this case. Claimant contests the ALJ's decision to allow the insurer to offset the overpaid DCS proceeds against the amounts in the CDA, as well as the ALJ's refusal to award a penalty. For the following reasons, we conclude that, although the insurer did not act unreasonably, it is not entitled to "offset" the "double DCS" payment.

We first examine the issue of whether overpaid DCS monies can be "offset" against amounts awarded in a CDA. In this regard, we note that payments made under a CDA are "compensation." Turo v. SAIF, 131 Or App 572, 575 (1994). However, inasmuch as the parties have agreed that claimant's rib and right anterior chest conditions are not compensable, any settlement proceeds paid pursuant to the DCS are not compensation. See Robert D. Surina, 40 Van Natta 1855, 1857 (1988). Since the DCS proceeds are not compensation, those monies cannot be offset against future awards of "compensation." Id.

We recognize that proceeds paid pursuant to a subsequently disapproved or "set aside" DCS can be offset against future permanent disability benefits. See Pruitt Watson, 45 Van Natta 1633, on recon 45 Van Natta 2227 (1993). In other words in Watson, once the DCS was disapproved, its proceeds were transformed from noncompensation into compensation. In contrast, the DCS in this case was not set aside and expressly provides that the denial of claimant's September 29, 1994 injury is affirmed and becomes "final." (Ex. 2-2). Thus, we find Watson distinguishable because the present DCS has not been set aside and its proceeds are not compensation and, as such, cannot be offset against compensation. Robert D. Surina, supra.

Accordingly, we conclude that, based on our reasoning in Surina, neither the insurer nor the ALJ could offset the noncompensation paid pursuant to the DCS against the compensation granted in the CDA. It, therefore, follows that the insurer must pay the full amount of the benefits awarded in the CDA.[1]

The insurer contends, however, that claimant is estopped from denying that it had the legal authority to deduct the overpaid DCS moneys from the CDA. The insurer asserts that claimant's counsel "induced" it to believe that an informal adjustment of the CDA would not be contested. While acknowledging that estoppel principles have not been equally available to employers as to workers under Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992), the insurer notes that amended ORS 656.012(3) now requires impartial interpretation of workers' compensation law.

Even assuming that the insurer is correct that estoppel is equally available to employers and insurers in light of amended ORS 656.012(3), we do not find that claimant's counsel induced the insurer to believe that claimant would not contest its informal adjustment of the CDA. Ms. Altenhoven testified that she could not remember if there was an agreement as to how the overpaid DCS proceeds would be recouped, but that she assumed that an informal adjustment would be acceptable since she had suggested this method in her conversation with counsel. (Trs. 18, 19, 24). Ms. Altenhoven also testified, however, that she was aware that overpayment recovery could not be done unilaterally, but instead required authorization. (Trs. 24, 25). Inasmuch as Ms. Altenhoven was a claim supervisor who understood the requirements of the law with respect to recovery of overpayments, we do not find that she was induced by claimant's counsel's silence into believing that she had authority to alter the terms of the CDA in order to recover the overpaid DCS funds.[2]

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[1] Although no contention has been made that claimant engaged in any inappropriate conduct in obtaining the extra DCS payment, the record lacks any justification on claimant's part for retaining the proceeds. Under such circumstances, an available route for recovery would appear to be in the procedures set forth in ORS 656.268(14).

[2] The insurer also asserts that ORS 656.268(15) authorizes the insurer's offset. It provides that an insurer or self-insured employer "may offset any compensation payable to the worker to recover an overpayment from a claim with the same insurer or self-insured employer from a claim with the same insurer or self-insured employer." (emphasis added). Even assuming that this statute applies to this claim, it does not change the result because the DCS moneys are not compensation. Robert D. Surina, supra.

We now turn to the issue of whether the insurer's unilateral offset of the DCS proceeds against the CDA was unreasonable. We agree with the ALJ that it was not.

A penalty may be assessed when an employer "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(10). The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991) (citing Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990)). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the insurer at the time it refused to pay compensation. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988);

Although Surina was controlling precedent at the time the insurer unilaterally reduced the amount it paid pursuant to the CDA, that case did not involve double payment of DCS proceeds or a CDA. Moreover, there were discussions between the insurer and claimant's counsel that could have reasonably led the insurer to believe that it could recover the overpayment by reducing its payment of the CDA proceeds. Therefore, we agree with the ALJ that the insurer's claim processing was not unreasonable.

Finally, we note that an offset for overpayment against future compensation is not considered a threat to the award of compensation since the offset only allows the employer to recover the amount that claimant was not entitled to receive. See Strazi v. SAIF, 109 Or App 105, 108 (1991). Therefore, claimant is not entitled to an attorney fee pursuant to ORS 656.382(2) for counsel's services on review regarding the offset issue. Id. Moreover, because disallowance of an offset does not "increase" a claimant's compensation for benefits that he has already been granted, the ALJ erroneously awarded an out-of-compensation fee for claimant's counsel's efforts in establishing that the insurer's unilateral offset was improper. ORS 656.386(2). Consequently, we reverse that portion of the ALJ's order which awarded an "out of compensation" attorney fee.

ORDER

The ALJ's order dated May 31, 1995 is reversed in part and affirmed in part. That portion of the ALJ's order which authorized the insurer's requested offset is reversed. The insurer shall pay the full amount of the compensation granted in the CDA. The ALJ's out-of-compensation attorney fee award is also reversed. The remainder the ALJ's order is affirmed.

Board Member Neidig specially concurring.

My concurrence with this decision should not be interpreted as granting some type of approval for claimant's conduct in this matter. Rather, for the reasons expressed, in my opinion I am compelled to conclude that this Board is without statutory power to authorize an offset of overpaid DCS payments against CDA compensation benefits. Notwithstanding this conclusion, it is my hope that claimant will immediately return the admittedly overpaid DCS proceeds without the need for further legal action. However, if he refuses to adhere to his moral and legal obligations, I would trust that the insurer would initiate additional legal proceedings designed to prosecute him for his unjustified conduct to the furthest extent of the law. See ORS 656.268(14).

In the Matter of the Compensation of
KATHY D. ELKINS, Claimant
WCB Case No. 94-03145
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order which: (1) found that the self-insured employer was not responsible for certain medical bills for claimant's current right hip condition; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claims processing. On review, the issues are compensability, penalties and attorney fees. We reverse

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact." We do not adopt the ALJ's "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

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

Claimant sustained a compensable right hip injury in April 1992. The employer accepted a claim for right hip strain, lumbar strain and trochanteric bursitis. Claimant's claim was closed in January 1993. From August 1993 to October 1993, claimant received medical treatment for pain in her right buttock, hip, thigh and knee.

In September 1993, the employer issued a Notice of Intent to Disclaim Responsibility for claimant's ongoing right hip complaints. Claimant requested a hearing, and the parties entered into a Disputed Claim Settlement (DCS). The employer contended, in the DCS, that claimant's current right hip condition was not compensably related to her accepted injury. Further, the DCS stated that the employer's denial, "as supplemented by the contentions of the employer stated herein, "shall remain in full force and effect..." should the ALJ approve the agreement. (Ex. 46-3) (emphasis added) The DCS further provided that the parties desired "to settle all issues, raised or raisable, at this time by entering into the "settlement" (Id.) (emphasis added). On December 30, 1993, the DCS received ALJ approval.[1]

On June 30, 1994, claimant received physical therapy for pain in the right buttock, hip, thigh and knee. The employer denied payment for claimant's medical services during August 1993 to October 1993 and for treatment on June 30, 1994. Claimant requested a hearing regarding the employer's failure to pay for the above mentioned medical billings.

The ALJ found that the parties agreed in the DCS that claimant's then current right hip condition was not compensably related to her accepted injury of April 1992. Further, the ALJ determined that claimant's medical services claim was for that "unchanged" right hip condition. (In reaching this conclusion, the ALJ noted that claimant had not asserted that her hip condition had changed since the DCS). As such, the ALJ concluded that the parties dispute was precluded by the DCS.

On review, claimant does not challenge the employer's contention that the ALJ did not have jurisdiction to review this dispute. Nevertheless, because the dispute involves the question of whether the medical service claims for a disputed condition are causally related to claimant's compensable injury, we retain jurisdiction over this matter. See Richard L. Wheeler, 47 Van Natta 2011 (1995).

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[1] The dissent charges that the DCS was confined to resolution of the parties' dispute regarding an aggravation claim. The emphasized portions of the settlement confirms that the parties wished to resolve all "raised or raisable" issues which expressly extended to the employer's contention that claimant's then current right hip condition was not compensably related to her accepted injury. In light of such circumstances, the parties' expressed intentions in the DCS do not support the dissent's interpretation of the agreement.

Generally, the changes made to the Workers' Compensation law made by SB 369 apply to cases in which the Board has not issued a final order or for which the time to appeal the Board's order has not expired on the effective date of the Act. Volk v. America West Airlines, 135 Or App 565, 569 (1995).

In Walter L. Keeney, 47 Van Natta 1387 (1995), we concluded that the amendments to ORS 656.327, as well as the new provision, ORS 656.245(6), apply to claims currently pending before the Board. We held that the language of ORS 656.327(1) and ORS 656.245(6) clearly revealed the legislature's intent that medical services disputes be resolved exclusively by the Director, not the Board or Hearings Division. Accordingly, based on the text and context of amended ORS 656.327(1), as read in conjunction with SB 369's retroactivity provisions, we concluded that the Director has exclusive jurisdiction over ORS 656.327(1) medical services disputes, including those presently pending before the Board.

In Lynda J. Zeller, 47 Van Natta 1581 (1995), relying on ORS 656.245(6), we held that the Board retained jurisdiction to determine whether a claimant's current condition was related to her compensable injury. However, once that determination was resolved, we further concluded that, under ORS 656.327(1) and Keeney, the Board is without authority to address the propriety of a proposed surgery for that disputed condition. Thus, in Zeller, having found that the claimant's current condition was compensable, we then dismissed the claimant's hearing request insofar as it sought resolution of a dispute regarding whether the proposed medical treatment was reasonable and necessary. See also Janet Anderson, 47 Van Natta 1692 (1995).

Here, as in Zeller and Anderson, and unlike Keeney, the parties' dispute concerns whether medical treatment for claimant's current condition is causally related to her compensable injury. Inasmuch as such a dispute necessarily involves the compensability of the condition on which the medical treatment is based, we find that the employer's formal denial pertained to the "compensability of the underlying claim."[2] See Richard Wheeler, supra. Consequently, we retain jurisdiction to consider the parties' dispute. See ORS 656.245(6); Janet Anderson, supra; Lynda J. Zeller, supra.

We turn to the merits of the parties' dispute. After conducting our review of this record, we adopt and affirm the ALJ's order in regard to the compensability to claimant's current condition. Therefore, because claimant's medical services claim for her current hip condition is not causally related to her compensable injury, the employer is not responsible for payment of medical bills to treat claimant's non-compensable condition.

ORDER

The ALJ's order dated April 27, 1995 is affirmed.

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[2] Although not determinative, we note that our rationale that jurisdiction over causation disputes regarding medical treatment rests with the Board is consistent with the Director's administrative rules. OAR 436-10-046(3)(a) provides that, when compensability of treatment is at issue before another adjudicative body, any party may request Director review within 30 days after the order deciding compensability becomes final.

Board Chair Hall dissenting.

The majority, in adopting and affirming the decision of the ALJ, has misconstrued the very nature and purpose of the Disputed Claim Settlement and, in so doing, had prevented the payment of claimant's "post-DCS" medical bills relating to her compensable injury. For the following reasons, I respectfully dissent.

Claimant sustained a compensable right hip injury in April 1992. The employer accepted a claim for right hip strain, lumbar strain and trochanteric bursitis. Claimant's claim was closed in January 1993. From August 1993 to October 1993, claimant received medical treatment for pain in her right buttock, hip, thigh and knee.

In September 1993, the employer issued a Notice of Intent to Disclaim Responsibility for claimant's ongoing right hip complaints.[1] Claimant requested hearing, and the parties entered into a Disputed Claim Settlement (DCS) which set forth the "issue" as "compensability of the aggravation of

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[1] This statement is accepted as fact based upon its inclusion in the Disputed Claim Settlement agreed to by the parties, though the Notice of Intent to Disclaim Responsibility itself is not in the record. (Ex. 4b-2).

claimant's right hip condition." (Ex. 43). The DCS included language of a denial, issued by the employer, in response to "claimant's claim for aggravation." (Ex. 4b-2,3). The denial reads in pertinent part:

> "Claimant is now seeking reopening of her right hip condition claim. [The employer] hereby issues a denial of the current right hip aggravation claim on the basis that the accepted injuries of April 13, 1992 have not compensably worsened." (Emphasis added) (Ex. 4b-2).

The DCS then set forth the contentions of the parties as follows:

> "Claimant contends that her right hip condition has worsened and the [employer] is responsible. She relies upon her anticipated lay testimony in support of her position."
>
> "The employer contends that claimant's right hip condition has not compensably aggravated, that her current right hip condition is not compensably related to the accepted April 13, 1992 injury and that a later employer is responsible for her current right hip condition. The employer relies upon expected lay testimony in support of its position."

Further, the DCS contained the basis of the bona fide dispute upon which the DCS was premised:

> "The parties agree that a bona fide dispute exists between them as to the compensability of claimant's current right hip aggravation claim.... Claimant shall have no further entitlement to compensation, or any other legal right, relating to the denied aggravation claim. However, the parties acknowledge that claimant retains all rights that may later arise under ORS 656.245, 656.273, 656.278, and 656.340 insofar as these rights may be related to the original accepted right hip sprain, trochanteric bursitis, and lumbar strain condition. " (Emphasis added) (Ex. 46).
>
> "The parties further agree that, since claimant's accepted condition has not compensably worsened, there is no responsibility issue at this time and the employer's Notice of Intent to Disclaim Responsibility date September 17, 1993 is null and void and is withdrawn in its entirety, without monetary consideration." Id. (Emphasis added)

On its face, in unambiguous terms, the DCS resolved a disputed aggravation claim, nothing more and nothing less. In fact, the employer's disclaimer of further responsibility for claimant's claim was withdrawn.

On December 30, 1993, the DCS received ALJ approval. On June 30, 1994, claimant received physical therapy for pain in the right buttock, hip, thigh and knee. The employer, thereafter, denied payment for claimant's medical services during August 1993 to October 1993 and for treatment on June 30, 1994. Claimant requested a hearing regarding the employer's failure to pay for the above mentioned medical billings.

The ALJ found that claimant's medical services claim for treatment prior to the DCS were resolved by that settlement. In so doing, the ALJ determined that the parties agreed that claimant's then current condition was not compensable. As such, the ALJ found that claimant's "post-DCS" medical services were also precluded by the DCS because claimant's need for medical services in August 1993 to October 1993 and in June 1994 were for the "same condition."[2] The majority has adopted and affirmed the ALJ's findings and analysis.

ORS 656.289(4) authorizes settlement of a claim when there is a bona fide dispute as to compensability. Roberts v. Willamette Industries, 82 Or App 188 (1986); Pruitt Watson, 45 Van Natta 1633 (1993). In other words, a bona fide dispute as to compensability is a prerequisite to a valid DCS. See Pruitt Watson, supra.

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[2] We note that the only evidence that claimant's need for medical services was for the "same condition," is to compare the August 1993 to October 1993 chart notes with the comments of claimant's physical therapist in June 1994. (Exs. A-14; B).

In the present case, the DCS was entered into by the parties because of claimant's claim for medical services, from September 1993 through October 1993, which the employer characterized as an aggravation claim. The DCS settled the parties' dispute over claimant's then current aggravation claim. By the very terms of the DCS, no other dispute existed. Consequently, as a matter of law, any attempt to settle any issue other than the disputed aggravation claim would be invalid. Thus, interpreting the DCS to cover more than the then existing (disputed) aggravation claim is error.

Given the existence of the medical bills for treatment in August 1993 through October 1993, and given that such treatment gave rise to the disputed aggravation claim, then it is factually and legally correct to find that such medical services and billings were subject to (and indeed the subject of) the DCS. See Good Samaritan Hospital v. Stoddard, 126 Or App 69, 73 (1994).

In order for the DCS to preclude claimant's June 1994 medical services bill, and/or claimant's condition in June 1994, the DCS would need to be interpreted as having settled a dispute over the future-ongoing compensability and responsibility of claimant's accepted condition. Given the specific language of the DCS, limiting the bona fide dispute to claimant's aggravation claim and preserving claimants' rights under the original claim, such an interpretation is error. Consequently, the compensability of claimant's June 1994 medical services claim must be analyzed separately.

Medical services "for conditions resulting from the injury" are compensable if the need for treatment bears a material relationship to the compensable condition. ORS 656.245(1); Beck v. James River Corp., 124 Or App 484, 487 (1993), rev den 318 Or 478 (1994). If the prescribed medical services constitute an integral part of the total medical treatment for the condition due to the compensable injury, the medical services are compensable. Williams v. Gates McDonald & Co., 300 Or 278 (1985); Van Blokland v. Oregon Health Sciences University, 87 Or App 694 (1987).

Here, Dr. Browning (in the June 1994 chart note) diagnosed chronic right gluteal/hip pain. (Ex. A-13). Dr. Browning noted the etiology of the onset of claimant's chronic condition as her April 1992 industrial accident. Id. Absent contrary evidence, I find that claimant's April 1992 compensable injury is at least materially related to her need for medical services in June 1994. Such services are, therefor, compensable.

January 26, 1996 Cite as 48 Van Natta 266 (1996)

In the Matter of the Compensation of
FREDRICK W. VANHORN, JR., Claimant
WCB Case No. 94-14625
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that modified a Director's order which had found that claimant was not eligible for vocational assistance. On review, the issues are jurisdiction and vocational assistance. We vacate.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In modifying a Director's vocational assistance order, the ALJ found that claimant is able to return to available and suitable employment with the employer at injury and, as a result, he is not eligible for vocational assistance.

At the time of the ALJ's order, the Hearings Division and Board had jurisdiction to review vocational assistance disputes pursuant to former ORS 656.283. With the subsequent enactment Or Laws 1995, ch 332 § 34(2) (SB 369, § 34(2)), however, we no longer have such authority. Amended ORS 656.283 (2)(c) now provides, among other things, that when the Director issues an order regarding vocational assistance after administrative review of the matter, "the order shall be subject to review only by the director." (Emphasis added).

We held in Ross M. Enyart, 47 Van Natta 1540 (1995), that the legislature expressly intended that this provision apply retroactively and that the Director now has exclusive jurisdiction over all vocational assistance disputes, including those presently pending before the Board. See also Robert B. Enders, 47 Van Natta 1651 (1995).

Accordingly, because neither the Hearings Division nor the Board have jurisdiction to review the Director's action regarding this vocational services dispute, we vacate the ALJ's order that modified the Director's vocational assistance order and we dismiss claimant's hearing request from the Director's order. Amended ORS 656.283(2)(c).

Claimant challenges the retroactive application of amended ORS 656.283(2) on two grounds. First, claimant argues that because the Act "does not extend the procedural time limit in which the claimant may seek a contested case proceeding before the Director" retroactive application of the new law will lead to an absurd result. We reject claimant's argument. We have previously held that because the legislature has explicitly authorized the Director to address vocational assistance disputes, the question of whether a request for Director review of a vocational assistance order is timely rests with the Director and not with this forum. Ross M. Enyart, supra; see also, Walter L. Keeney, 47 Van Natta 1387 (1995). We further note that, consistent with that authority, the Director adopted Temp. OAR 436-01-015 (WCD Admin. Order 95-061 (August 18, 1995), which addressed the Director's consideration of requests initially filed with the Board or its Hearing Division.[1]

Claimant also argues that retroactive application of the new law violates the Oregon Constitution, Article I, Section 10 because it deprives him of a remedy. Specifically, claimant contends that he will be left without a forum to review his vocational assistance dispute. We reject this contention because, as noted above, claimant is not being deprived of any remedy and there is no constitutional impediment preventing the retroactive application of amended ORS 656.283(2) in this case. See Liberty Northwest Insurance Corp. v. Yon, 137 Or App 413 (1995) (although SB 369 eliminated the claimant's right to have his medical services disputes resolved by the Board, retroactive application of the new law does not violate due process because the claimant may request a contested case hearing with the Director).

ORDER

The ALJ's order dated May 16, 1995 is vacated. Claimant's hearing request from the Director's vocational assistance order is dismissed.

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[1] Although bound by principles of stare decisis, Member Gunn refers the parties to his dissent in Walter L. Keeney, supra, discussing his concern that SB 369, § 66(6) (providing that the amendments and new provisions added by the Act are not to extend or shorten any procedural time limits with regard to any action on a claim taken prior to the effective date of the Act) may prohibit the Director from issuing a rule tolling the time period for requesting Director review. See 47 Van Natta at 1391 (Member Gunn, dissenting).

In the Matter of the Compensation of
ANTONIO G. ARANDA, Claimant
WCB Case Nos. 94-12354 & 94-10057
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Neidig and Christian.

The SAIF Corporation, on behalf of employer McGrath's Publick Fish House, seeks review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) set aside its denial of claimant's occupational disease claim for Kienbock's disease of the right wrist; and (2) referred the claim to the Director for apportionment of responsibility between it and SAFECO Insurance Co., on behalf of employer Deschutes Brewery. SAFECO cross-requests review of that portion of the order that set aside its denial of claimant's right wrist condition. On review, the issues are compensability and apportionment. We reverse.

FINDINGS OF FACT

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

Claimant has worked as a restaurant cook for the past 12 years. During 1993 and 1994, claimant was concurrently employed by Deschutes Brewery, on a full time basis, and McGraths, on a part time basis. Claimant has not experienced a specific traumatic injury to his right wrist on or off the job.

In 1994, claimant began experiencing pain in his right wrist with use at work. He was diagnosed with Kienbock's disease, a rare condition, which occurs when there has been an interruption in the blood flow to the lunate bone, causing the bone to decay and collapse.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, although claimant's disease was not initially caused by his repetitive work activity,[1] his work with Deschutes Brewery and McGraths was the major contributing cause of a pathological worsening of the disease and his need for treatment. The ALJ further found that apportionment of responsibility for the compensable condition was appropriate because both of claimant's work exposures contributed to the worsening of his condition, and referred the matter to the Director.

On review, both SAIF and SAFECO argue that claimant has failed to prove the compensability of his Kienbock's disease under amended ORS 656.802(2).[2] Specifically, the carriers argue that a preponderance of the medical evidence supports the conclusion that claimant's employment activity was not the major contributing cause of the pathological worsening of his Kienbock's disease. We agree.

Amended ORS 656.802(2)(b) provides that "[i]f the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that the employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." Pursuant to amended ORS 656.005(24), a "preexisting condition" includes any injury or disease that contributes to the worker's disability or need for treatment and that precedes the onset of the initial claim for an injury or occupational disease.

Several physicians have rendered opinions in this case regarding the cause and progression of claimant's right wrist condition. What is most clear from these opinions is that the exact cause of Kienbock's disease is still unknown and the progression of the disease, once diagnosed, is

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[1] Considering the complete and well-reasoned opinions of Drs. Button and Wigle regarding the current accepted theory on the etiology of Kienbock's disease, the ALJ was not persuaded by Dr. Thayer's theory that the repetitive micro-traumas of claimant's work activity caused the disease itself. We adopt the ALJ's reasoning and conclusion in this regard.

[2] ORS 656.802(2) was amended by 1995 Or Laws, ch 332 § 56 (SB 369, § 56). These amendments apply retroactively to cases currently pending before the Board. Volk v. America West Airlines, 135 Or App 656 (1995).

unpredictable. Dr. Button, who examined claimant at SAIF's request, is of the opinion that there is no direct causal relationship between claimant's current condition and his work activities. Dr. Button explained that when the condition is progressive, as it is in claimant's case, there is an increase in level of symptoms which correlates with physical activities. The basic, underlying pathology is not, however, "affected by . . . work exposure in a sense of substantially changing the natural history of the condition." (Ex. 14-4).

Treating physician Dr. Wigle agreed with Dr. Button's conclusion that "[claimant's] wrist problem is not related to any occupational exposure." (Ex. 16). Dr. Nathan, who examined claimant at SAFECO's request, also expressed his "essential agreement" with Dr. Button regarding the etiology of Kienbock's disease. (Ex. 24-5). Dr. Nathan noted that it is "pure speculation" to state that any one factor is the major contributing cause of the disease or its worsening "in the absence of some outstanding significant well-documented single traumatic episode, which is not the case here." (Ex. 24). Even claimant's primary treating physician, Dr. Thayer, also agreed with Dr. Button's assessment, noting that it was "fair and his logic is well thought out."[3] (Ex. 17).

On this record, we are unable to conclude that claimant's work activity is the major contributing cause of a pathological worsening of his Kienbock's disease.[4] A preponderance of the medical evidence establishes that Kienbock's disease is an inherently degenerative condition, possibly caused by a significant traumatic event or an anatomic predisposition (i.e., a negative ulnar variance). The evidence also indicates that although hand and wrist activity may contribute to the deterioration of the lunate bone to a certain extent,[5] such activity is not recognized as a major contributory factor to the worsening of the disease.

In sum, we conclude that claimant has failed to establish the compensability of his Kienbock's disease or its worsening. We therefore reinstate the carriers' denials of this condition. In light of this conclusion, the "apportionment" issue is moot.

ORDER

The ALJ's order dated April 3, 1995, as corrected April 7, 1995, and reconsidered April 25, 1995 is reversed. SAIF's and SAFECO's denials of claimant's right wrist condition are reinstated and upheld. The ALJ's attorney fee awards are also reversed.

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[3] As noted above, Dr. Thayer believed that the disease could be caused by repetitive micro-trauma alone and that claimant's work activity would fit within this description. He also admitted: "While I personally believe in the micro-trauma theory, it certainly isn't fixed in stone." (Ex. 17-2).

[4] As discussed above, because claimant cannot prove that his work activity caused the disease itself, he must prove that his work caused a pathological worsening of the disease, which was necessarily preexisting. Amended ORS 656.802(2)(b), amended ORS 656.005(24); see also, Wheeler v. Boise Cascade Corp., 298 Or 452, 457-58 (1985); Weller v. Union Carbide, 288 Or 27, 35 (1979) (symptomatic worsening is not sufficient; there must be proof of a pathological worsening of the disease).

[5] For example, Dr. Button acknowledged that the level of wrist activity after the onset of the disease would affect the progression of the breakdown of the lunate bone. (Ex. 25-17). He concluded, however, that claimant's work activities (chopping food and lifting plates) is not the kind of repetitive activity that would pathologically worsen his condition. (Ex. 25-32, 25-33). Dr. Wigle agreed that wrist use could affect the deterioration of the ulnate, but that as a general rule there is no occupational correlation between the disease and the degenerative process. (Ex. 26-12, 26-25). Dr. Wigle also noted that once the disease developed, the condition will progress even in the absence of hand and wrist activity. (Ex. 26-28).

In the Matter of the Compensation of
DUWAYNE E. BLUM, Claimant
WCB Case No. 95-02056
ORDER ON REVIEW
Foss, Whitty, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Revewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Baker's order that found that the SAIF Corporation was not barred by the principles of res judicata from recalculating claimant's temporary disability rate at the time of claim closure. On review, the issue is res judicata. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. SAIF closed claimant's claim with a November 2, 1994 Notice of Closure, which: (1) declared claimant medically stationary on April 20, 1993; (2) stated that claimant's aggravation rights ran from November 2, 1994; (3) awarded various periods of temporary total and temporary partial disability; and (4) awarded 34 percent unscheduled permanent partial disability. (Ex. 14). On December 12, 1994, SAIF issued a corrected Notice of Closure that was the same as the November 2, 1994 Notice of Closure in all aspects except for the addition of the following sentence: "DEDUCTION OF OVERPAID BENEFITS, IF ANY, FROM UNPAID PERMANENT DISABILITY IS APPROVED." (Ex. 11).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the principles of res judicata did not bar SAIF from recalculating claimant's temporary disability rate at the time of claim closure. On review, claimant argues that an April 29, 1993 Stipulation and Order precludes SAIF from redetermining his temporary disability rate. For the reasons discussed below, we agree with the ALJ that SAIF is not barred from recalculating claimant's temporary disability rate at claim closure.

The April 29, 1993 Stipulation provided, in pertinent part, that: (1) claimant had requested a hearing raising the issues of temporary disability rate and penalties for late payment of temporary disability; (2) the "parties agree to settle the penalty issue at this time" by granting claimant a 20 percent penalty for late payment of temporary disability benefits, such penalty totaled $691.93 and was to be split equally with claimant's attorney as an attorney fee; and (3) claimant's request for hearing was dismissed with prejudice. (Ex. 6).

The doctrine of res judicata applies to workers' compensation cases and precludes relegation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 48, modified 305 Or 468 (1988). The doctrine of res judicata has two aspects: "claim preclusion" and "issue preclusion." Id.

Under the res judicata doctrine of claim preclusion, litigation of a claim or cause of action to final judgment precludes a subsequent action between the same parties on the same claim or any part thereof. Drews v. EBI Companies, 310 Or 134 (1990); Carr v. Allied Plating Co., 81 Or App 306, 309 (1986). For claim preclusion to apply, the subsequent litigation must include: (1) the same parties (or those in privity); (2) the same claim (or a second claim arising from the same transaction or series of connected transactions out of which the first claim arose); and (3) a valid and final judgment on the first claim. Drews v. EBI Companies, supra at 140. The opportunity to litigate is required, whether or not that opportunity is used. Id.

The key elements of issue preclusion are: (1) the same parties; (2) a valid and final judgment: (3) actual litigation of an issue of fact or law: and (4) a determination of that issue which is essential to the judgment. Jimmy M. Campoz, 42 Van Natta 903 (1990). Finality is required for either claim or issue preclusion to apply.

We find Cravens v. SAIF, 121 Or App 443 (1993), dispositive regarding the issue of whether the principles of res judicata preclude SAIF from redetermining claimant's temporary disability rate at the time of claim closure. In Cravens, a prior ALJ's order had determined that SAIF had been paying temporary disability at the correct rate. However, subsequent to that hearing, SAIF mistakenly began paying temporary disability at a higher rate. The claimant requested a hearing seeking penalties and attorney fees because of SAIF's late payment of the recalculated temporary disability. SAIF and the claimant agreed that SAIF would pay a penalty for its late payment. The ALJ entered a Stipulation and Order to that effect and dismissed the claimant's hearing request with prejudice. SAIF discovered its error before the claim was closed and took an offset against the permanent disability award for the overpayment when it issued its notice of claim closure. Id. at 445.

The claimant relied on the doctrine of res judicata, contending that SAIF's stipulation to a penalty for late payment of temporary disability necessarily determined that the amount of temporary disability was correct. The court disagreed. First, the court held that claim preclusion did not apply, stating that

> "TTD [temporary total disability] is not, by itself, a 'claim' that is precluded by former adjudication purposes. Drews v. EBI Companies, supra. Rather, it is an issue included in the claim for compensation. Consequently, claim preclusion analysis of the res judicata doctrine does not apply in these circumstances." Id. at 446. (Emphasis in the original).

Second, the court held that issue preclusion did not apply because the amount of temporary disability "was not actually litigated in relation to claimant's request for penalties for late payment. * * * The stipulated settlement of the penalty issue provided for a penalty that was related only to the timeliness of the payments and was not dependent on the amount of TTD." Id.

Finally, the court held that the finality required for the application of either claim or issue preclusion was not present, stating that:

> "Here, as in Drews, even if SAIF could and should have raised the issue of the correct TTD rate, there is not the finality of adjudication that is required for either claim or issue preclusion to apply. The amounts of compensation are, under former ORS 656.268(10) (renumbered ORS 656.268(13))[1], subject to adjustment until final closure. See Drews v. EBI Companies, supra. It was pursuant to that statute that SAIF made the adjustment in the permanent partial disability award. The statute would have little meaning if the adjustment could be precluded because the correct amount of compensation should have been litigated during the progression of the claim to final closure." Id. at 447.

Applying the reasoning in Cravens to the present case, we find that the April 29, 1993 Stipulation does not bar SAIF from recalculating the temporary disability rate at claim closure. In this regard, the parties explicitly stated that only the penalty issue was resolved by the stipulation. (Ex. 6-1). Thus, the temporary disability rate issue was not actually litigated. The only issue actually litigated was the issue of penalties on late payment of temporary disability. Furthermore, the issue of the rate of temporary disability was not essential to that judgment. Therefore, as in Cravens, issue preclusion does not bar SAIF from redetermining the temporary disability rate at claim closure.

Claimant argues that SAIF is barred from redetermining the temporary disability rate at claim closure because the stipulation dismissed his hearing request "with prejudice" and that hearing request included the issue of rate of temporary disability. Essentially, claimant is arguing that, because SAIF could have raised and litigated the issue of rate of temporary disability at the time of the stipulation but did not do so, it is barred by claim preclusion from redetermining that rate at claim closure.

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[1] The legislature has subsequently amended ORS 656.268(13). Or Laws 1995, ch 332, § 30(13) (SB 369, § 30(13)). The result would be the same under either version of the statute.

In Drews, the Court held that claim and issue preclusion are subject to a number of exceptions, stating that "[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. In this regard, the Court stated that "a statutory scheme of remedies may expressly contemplate that successive proceedings may be brought, notwithstanding the finality of the first proceeding." Id. at 143.

In Cravens, the court interpreted ORS 656.268(13) as providing just such a statutory scheme in regard to adjusting temporary disability until final closure. Therefore, in light of ORS 656.268(13), the required finality has not attached for either claim or issue preclusion to bar SAIF from redetermining the temporary disability rate at claim closure. Cravens, supra at 447; see also V. W. Johnson & Sons v. Johnson, 103 Or App 355 (1990) (no waiver of offset issue where the carrier did not raise that issue until Board review because ORS 656.268(10), renumbered ORS 656.268(13), creates a right to an offset).

Accordingly, for the above reasons, we find that SAIF is not precluded from redetermining claimant's temporary disability rate at claim closure.

ORDER

The ALJ's order dated July 26, 1995 is affirmed.

February 12, 1996 Cite as 48 Van Natta 272 (1996)

In the Matter of the Compensation of
MARY E. CALVERT, Claimant
WCB Case Nos. 94-10828 & 94-04715
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that upheld the SAIF Corporation's denial of claimant's bilateral carpal tunnel syndrome (CTS).[1] On review, the issue is compensability.

We adopt and affirm the ALJ's order, except for the last sentence of the third paragraph in the "Compensability" section, and with the following factual clarification and supplementation.

Between December 1989 and June 1991, Dr. Aaronson diagnosed claimant's hand tingling and numbness as right and left CTS. Claimant began working for the employer in July 1991. Claimant's CTS symptoms increased in September 1993.

Finding that work activity for the employer was not the major contributing cause of a pathological worsening of claimant's preexisting CTS, the ALJ upheld SAIF and Sedgwick James' denials. On review, claimant argues that, because Dr. Aaronson did not treat her CTS or inform her that she had CTS, her CTS is not a "preexisting" condition. Claimant further argues that, although it is likely that a prior employment "started" her CTS, inasmuch as work activity for the employer caused her CTS to become more painful, she has nonetheless established a compensable occupational disease claim under former ORS 656.802(2)[2] and Weller v. Union Carbide Company, 288 Or 27 (1979).

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[1] Claimant initially also requested Board review of that portion of the ALJ's order that upheld Sedgwick James' denial of the same condition. However, prior to conducting our review, claimant and Sedgwick James submitted a "Disputed Claim Settlement," designed to resolve all issues raised or raisable between them. By interim order, on November 8, 1995, we approved the parties' settlement. By this reference, we incorporate our interim order into this order.

[2] After the ALJ's order issued, the legislature amended ORS 656.802. Or Law 1995, ch 332, §§ 56, 66(1) (SB 369, §§ 56, 66(1)). The outcome in this case would be the same whether we apply the former or current version of the statute.

Claimant does not cite, and we have not found, any authority for the proposition that treatment and diagnosis are required for a condition to preexist work exposure. In any event, claimant concedes that a prior employment probably precipitated her CTS. After reviewing the medical record, we too are persuaded that claimant has failed to established that work activity after July 1991 was the major contributing cause of a pathological worsening of her preexisting bilateral CTS. The ALJ's decision upholding SAIF's denial is therefore affirmed.

ORDER

The ALJ's order dated May 26, 1995 is affirmed, subject to our November 8, 1995 interim order.

February 12, 1996 Cite as 48 Van Natta 273 (1996)

In the Matter of the Compensation of
LISA L. DAULTON, Claimant
WCB Case No. 95-01320
ORDER ON REVIEW (REMANDING)
Ackerman, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside the insurer's denial of claimant's right carpal tunnel surgery; and (2) found claimant's bilateral carpal tunnel syndrome (CTS) claim was prematurely closed. In its brief, the insurer contends that, under the legislative changes to ORS 656.327(1)(a) and 656.245 by Senate Bill 369 (SB 369), the Board no longer has jurisdiction over disputed medical service claims. On review, the issues are jurisdiction and premature closure. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly recite the pertinent facts. On March 17, 1994, claimant sought treatment for bilateral upper extremity symptoms. On June 2, 1994, the insurer accepted claimant's claim as disabling bilateral tenosynovitis. Claimant's symptoms persisted. On August 4, 1994, Dr. Radecki diagnosed mild CTS, right greater than left. Dr. Radecki concluded that claimant was medically stationary. On September 7, 1994, the insurer issued a Notice of Closure, finding claimant medically stationary on August 30, 1994. Claimant requested reconsideration.

On October 26, 1994, the insurer accepted claimant's bilateral CTS. On November 16, 1994, Dr. Hacker recommended right carpal tunnel surgery.

On November 28, 1994, Drs. Burr, Fry and Watson performed an arbiter examination. A December 9, 1994 Order on Reconsideration found claimant medically stationary on August 4, 1994, based on the opinions of Dr. Radecki and the medical arbiters.

On January 5, 1995, the insurer denied Dr. Hacker's recommendation of right carpal tunnel surgery for claimant's accepted condition. No party requested Director review of the medical services dispute. Instead, claimant requested a hearing on medical services, the Order on Reconsideration, and premature claim closure.

Jurisdiction - Medical Services Dispute

The ALJ concluded that the proposed CTS surgery for claimant's accepted condition was reasonable and necessary. Subsequent to the ALJ's order, the legislature amended ORS 656.327(1) and added ORS 656.245(6). Both statutes require review of medical services disputes by the Director, unless a claim for medical services is denied on the basis that the underlying claim is not compensable. Or Laws 1995, ch 332, §§ 41, 25, (SB 369, §§ 41, 25); Thomas L. Abel, 47 Van Natta 1571 (1995). In Walter L. Keeney,

47 Van Natta 1387, 1389, recon den 47 Van Natta 1525 (1995), we concluded that these statutes apply retroactively to pending cases and that the Director now has exclusive jurisdiction over such medical services disputes. See also Newell v. SAIF, 136 Or App 280 (1995); Volk v. American West Airlines, 135 Or App 565 (1995). Because the insurer's January 5, 1995 denial is a denial of proposed medical services, not a denial of the compensability of claimant's underlying claim for her accepted condition, review of this dispute lies with the Director, not the Hearings Division. We accordingly vacate that portion of the ALJ's order that set aside the insurer's denial regarding the propriety of the proposed surgery and dismiss claimant's request for hearing on that issue for lack of jurisdiction.

Premature Closure

The ALJ concluded that claimant's claim was prematurely closed on the basis of the medical evidence. The insurer argues that, because the ALJ no longer has jurisdiction over the surgery issue, that portion of the order finding that the claim was prematurely closed must be vacated. Claimant contends that, because the surgery is reasonable and necessary, the claim was prematurely closed.

The parties do not dispute the ALJ's statement that the outcome of the premature closure issue is contingent upon the outcome of the dispute over the reasonableness and necessity of the requested surgery. (Tr. 2, 3; O&O at 5). Accordingly, under these particular circumstances, we vacate the ALJ's "premature closure" decision and remand that portion of the claimant's hearing request to the ALJ to await resolution of the surgery question.[1] See generally, Gary Waldrupe, 44 Van Natta 702 (1992).

In Waldrupe, we held that where a decision regarding reopening a claim is contingent on a matter that is within the original jurisdiction of the Director, litigation regarding reopening the claim must be deferred pending Director resolution of that matter.[2] 44 Van Natta at 704.

In the present case, by virtue of the parties lack of objection to the ALJ's characterization of the issue, the premature closure issue, like the aggravation issue in Waldrupe, is unequivocally contingent on whether the proposed surgery is reasonable and necessary, a matter within the original jurisdiction of the Director. Consequently, it follows that consideration of the premature closure issue must await the Director's determination regarding a request for review of the proposed surgery dispute. Therefore, litigation of that portion of the Order on Reconsideration which pertains to the premature closure issue based on the proposed surgery must be deferred pending Director resolution of the dispute.

We contrast this case with Thomas A. Yoney, 47 Van Natta 2185 (1995). In Yoney, we declined to vacate an ALJ's "premature closure" order and remand the matter for hearing pending a final determination of a medical services issue by a different forum. In Yoney the insurer had argued that the premature closure decision turned on whether the proposed surgery was appropriate treatment. However, unlike in Waldrupe and the case before us, there was no acquiescence by the parties that the outcome of the premature closure issue was solely contingent upon the outcome of the medical services dispute.

We thus reiterate that the Hearings Division may consider a premature closure issue based on a theory that claimant's claim was prematurely closed irrespective of a proposed surgery. Should such a

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[1] We recognize there is a potential problem in the retroactive application of amended ORS 656.245(6) where, as here, an issue that is to be reviewed by the Director was initially filed with the Board's Hearings Division. On August 18, 1995, the Director adopted OAR 436-01-015, which is designed to address "medical services/ jurisdictional" cases where a hearing request was initially filed with the Board's Hearings Division. WCD Admin. Order 95-061 (Temp). In the event that the Director refuses to consider this dispute as untimely under these rules, the Director's decision would likely be considered "resolution" of the surgery question.

[2] We also held in Waldrupe that the Board and its Hearings Division may proceed to consider an aggravation issue based on a theory that a claimant's current condition (irrespective of a proposed surgery) constitutes a worsening of a compensable injury since the last award or arrangement of compensation. 44 Van Natta at 705. Similarly, had claimant here proceeded on a theory that her claim was prematurely closed irrespective of the proposed surgery, we would have proceeded to address the merits of the issue. See Kelly M. Davis, 44 Van Natta 2352 (1992) (where the issue of premature claim closure is not contingent upon a matter under the Director's original jurisdiction, the resolution of the medically stationary date is primarily a medical question to be decided on competent medical evidence; therefore, no deferral of decision).

theory be advanced, it would be unnecessary to defer the hearing. Here, however, as previously noted, there were no grounds other than claimant's surgery request that was asserted as the basis for premature closure.

Accordingly, we vacate the ALJ's order and remand that portion of claimant's hearing request which pertained to the premature closure issue to ALJ Livesley for further proceedings consistent with this order. Upon Director resolution of the surgery dispute, the parties should notify ALJ Livesley. Thereafter, the ALJ shall conduct further proceedings in any manner that the ALJ determines will achieve substantial justice. Following these proceedings, the ALJ shall issue a final, appealable order.

ORDER

The ALJ's order dated May 18, 1995 is vacated in part and remanded in part. That portion of the order regarding the reasonableness and necessity of the proposed lumbar surgery is vacated and claimant's hearing request regarding that issue is dismissed for lack of jurisdiction. That portion of the order that set aside the September 7, 1994 Notice of Closure and the December 9, 1994 Order on Reconsideration as being prematurely issued is vacated and the case is remanded to ALJ Livesley, who will defer further action pending notice from the parties that the proposed surgery request has been resolved.

February 12, 1996 Cite as 48 Van Natta 275 (1996)

In the Matter of the Compensation of
ROBERT W. GOODWIN, Claimant
WCB Case No. 93-10033
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Steven A. Wolf, Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order that: (1) upheld the SAIF Corporation's denial of his claims for DeQuervain's tenosynovitis and a left thumb injury; and (2) declined to assess a penalty for allegedly unreasonable claim processing. On review, the issues are compensability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

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

Claimant, age 65, has worked in a variety of occupations. He began working for the employer, a school district, in 1990. Beginning in September 1990, he worked as a truck driver, delivering food products between the employer's main and satellite school kitchens.

In March and April 1993, claimant sought treatment for pain in his left wrist and thumb. He was diagnosed with tendinitis of the first dorsal compartment and given a splint to wear on his thumb. When asked by his supervisor, claimant denied that his symptoms were work related.

On May 6, 1993, claimant slipped on a wet area while returning to his truck from a school kitchen. He fell, and struck the pavement with his left hand while wearing the splint. He went to the occupational health clinic and was diagnosed with a contusion/strain of the left thumb in addition to his first dorsal compartment tendinitis. No time loss was authorized.

Dr. Ushman examined claimant on May 13, 1993 and diagnosed deQuervain's tendinitis of the left wrist. Claimant was released for work, but restricted from lifting the tailgate of his delivery truck. Claimant did not, however, return to work because none was immediately available and he sustained a serious off-the-job back injury on May 17, 1993.

Dr. Denker found claimant's DeQuervain's tendinitis to be medically stationary on June 14, 1993, without any permanent impairment.

Claimant returned to Dr. Ushman on July 20, 1993, complaining of renewed pain in his left wrist. Dr. Ushman was unsure as to the cause of claimant's wrist pain because claimant was no longer working or engaging in strenuous activity. He was doing well by September 20, 1993 and was again declared medically stationary.

When claimant returned to Dr. Ushman on October 22, 1993, he reported increased pain. Dr. Ushman referred claimant to Dr. Long for a surgical consultation.

Claimant was examined by Dr. Long on February 22, 1994, who recommended a surgical release. Claimant had surgery on April 5, 1994, which confirmed the pre-surgery diagnosis of DeQuervain's tenosynovitis.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had not sustained his burden of proving that his work activity was the major contributing cause of his DeQuervain's tenosynovitis. Specifically, the ALJ found that while on the job, claimant did not raise and lower the delivery truck's tailgate in the unnatural manner that he had demonstrated on the videotape, and therefore his job duties were not the cause of his left hand problem. In so finding, the ALJ relied on the testimony of three co-workers, who reported observing claimant operate the tailgate by placing the weight on his palms rather than on his thumbs, as he had demonstrated in the videotape. The ALJ also relied on the assessment of Dr. Ushman, who began to doubt that claimant's condition was work related when claimant's symptoms spontaneously worsened in July and October 1993 even though he was not working.

On review, claimant contends that his videotape accurately portrays how he operated the tailgate, and that a preponderance of the medical evidence establishes that operation of the tailgate in this manner is the major cause of his DeQuervain's tenosynovitis. In addition, claimant argues that his left thumb contusion/strain of May 6, 1993 is compensable as an injury separate and apart from his deQuervain's tenosynovitis and that he is entitled to a penalty for SAIF's unreasonable denial of that injury.

Compensability - DeQuervain's Tenosynovitis

We adopt and affirm that portion of the ALJ's order finding that claimant has failed to prove the compensability of his occupational disease claim for DeQuervain's tenosynovitis of the left wrist and thumb.[1]

Compensability - Left Thumb Injury[2]

Although we find that SAIF properly denied claimant's occupational disease claim for tendinitis and tenosynovitis of the left wrist and thumb, we agree with claimant that he has established the compensability of a discrete injury, a contusion/strain of his left thumb, as a result of a slip and fall accident on May 6, 1993.

Claimant testified that he slipped and fell in some muddy water while making a delivery, and that his thumb hit the pavement. He reported the incident to his employer, verified where the fall had occurred and sought treatment for pain in his left wrist later that same day. Claimant was examined by Dr. Denker, who diagnosed a contusion/strain of the left thumb separate from claimant's preexisting tendinitis of the first dorsal compartment of the left wrist. Without authorizing any time loss, Dr.

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[1] Because we find the cause of claimant's DeQuervain's tenosynovitis to be a medically complex question, our resolution of the issue turns on an analysis of the expert medical evidence. See Uris v. Compensation Dept., 247 Or 420 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). Therefore, claimant's statements to his supervisor denying that his wrist and thumb symptoms were work related are not probative and do not add to or detract from our analysis.

[2] Because there is no medical evidence establishing that claimant's left thumb contusion/strain "combined" with his preexisting tendonitis/tenosynovitis to cause or prolong disability or a need for treatment, we analyze the injury claim separate from the occupational disease claim.

Denker recommended ice, exercise and continued physical therapy for the tendinitis. Dr. Denker also reported that the thumb injury resulting from the fall would likely resolve by the time claimant returned for a follow-up exam in three weeks.[3]

Accordingly, we set aside SAIF's denial insofar as it denies compensability of a left thumb contusion/strain occurring on May 6, 1993.

Penalties - Left Thumb Injury Claim

Claimant also argues that SAIF's denial of his left thumb injury claim was unreasonable given the medical evidence linking his fall to the strain/contusion. Specifically, claimant argues that any legitimate doubt SAIF may have had about its liability for claimant's thumb injury was destroyed when it received the IME report of Drs. Duff and Snodgrass, who concluded that claimant's May 6, 1993 fall was the major cause of his thumb injury and disability for two weeks thereafter. We agree.

If a carrier "unreasonably delays or refuses to pay compensation," it shall be liable for a penalty of up to 25 percent of the "amounts then due." Amended ORS 656.262(11)(a) (formerly numbered ORS 656.262(10)(a)). Unreasonable resistance to payment of compensation exists when, from a legal standpoint, the carrier had no legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). Moreover, even after a carrier reasonably denies a claim, continuation of that denial may become unreasonable if new medical evidence destroys any legitimate doubt about liability. Brown v. Argonaut Ins. Co., 93 Or App 588 (1988).

Here, claimant submitted an 801 Form and an 827 Form indicating that he had injured his thumb in a slip and fall accident. Both treating Dr. Denker and examining Drs. Duff and Snodgrass related claimant's left thumb contusion and strain to this reported slip and fall. There is no evidence in the record to the contrary. Thus, SAIF's continuing denial of compensability of claimant's thumb contusion and strain injury was unreasonable.

Accordingly, we assess a penalty against SAIF in the amount of 25 percent of the amounts due (as a result of this order) at the time of hearing relating to treatment of the thumb contusion and strain only.

Attorney Fee

laimant's attorney is entitled to an assessed fee for services at hearing and on review relating to the compensability of the thumb contusion and strain. 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 on this issue is $2,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated July 10, 1995 is affirmed in part and reversed in part. That part of the order that upheld SAIF's denial of July 27, 1993, as amended March 16, 1994, is reversed insofar as the denial denied the compensability of claimant's left thumb injury. SAIF's denial of a left thumb injury occurring on May 6, 1993 is set aside, and the injury claim is remanded to SAIF for processing according to law. SAIF is further ordered to pay to claimant and claimant's attorney a penalty in the amount of 25 percent of all amounts due (as a result of this order) at the time of hearing relating to claimant's left thumb contusion and strain. This penalty shall be shared equally between the claimant and his attorney. In addition, claimant's counsel is awarded an assessed attorney fee of $2,000 for services at hearing and on review relating to the compensability of the left thumb injury, payable by SAIF. The remainder of the ALJ's order is affirmed.

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[3] Drs. Duff and Snodgrass, who examined claimant on August 30, 1993 at SAIF's request, similarly reported that the contusion and strain resulting from claimant's fall completely resolved after two weeks.

In the Matter of the Compensation of
ROBERT A. McMAINS, Claimant
WCB Case No. 95-04456
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order which assessed the SAIF Corporation a penalty for its failure to timely accept or deny claimant's claim. SAIF cross-requests review of that portion of the ALJ's order which assessed a penalty for an allegedly unreasonable delay in the payment of compensation. On review, the issue is 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

Penalty/Failure To Timely Accept

The ALJ found that SAIF failed to timely accept claimant's claim. See ORS 656.262(6). As such, the ALJ assessed SAIF a penalty for its untimely acceptance. The ALJ determined that the amount of SAIF's penalty be based on a medical billing for $43.72. In so doing, the ALJ ruled that ORS 656.262(6) was inconsistent with OAR 436-10-100(10)(f) and therefore, finding the statute controlling, the ALJ found that SAIF had timely paid all of claimant's medical billings with the exception of the medical bill for $43.72.

On review, claimant essentially argues that the ALJ erred in not including several additional medical bills in the "amounts then due" upon which he should have based the penalty. Claimant contends that OAR 436-10-100(10) required SAIF to timely process his medical billings within 45 days of receipt. Therefore, according to claimant, at the time of SAIF's acceptance it had failed to timely process several of his medical billings.

OAR 436-10-100(10) states, "Payment of medical bills in the following situations is required within 14 days of the action causing the service to be payable, or within 45 days of the insurer's receipt of the bill, whichever is later." A "situation" in which OAR 436-10-100(10) would become applicable is "[w]hen medical benefits become due upon claim acceptance following a claim deferral period." OAR 436-10-100(10)(f).

Here, the "action" which required SAIF to process claimant's medical billings was its acceptance of claimant's claim. See OAR 436-10-100(10). SAIF then had either 14 days to pay any medical billing it had received or 45 days from the date it received the billing, whichever was the later date. See OAR 436-10-100(10)(f). The medical bill for $43.72 was received by SAIF on January 11, 1995. As such, 45 days from receipt of the bill would have been on February 28, 1995.

SAIF accepted claimant's claim on March 28, 1995. Therefore, the latest date SAIF could have paid the medical bill would have been 14 days from the date of acceptance because this would have been the "later" of the two dates. See OAR 436-10-100(10). SAIF paid the bill on April 14, 1995, seventeen days after acceptance. Accordingly, because SAIF did not comply with OAR 436-10-100(10) in paying the bill for $43.72, we affirm the assessment of a penalty based on that amount. Moreover, since, SAIF otherwise timely paid other medical bills, the $43.72 bill is the only one upon which a penalty may be assessed.

Alternatively, even if we were to apply OAR 436-10-100(10)(f) as claimant contends, SAIF paid all of claimant's medical billings within 45 days of receipt except the bill for $43.72. (Ex. 32). As such, the only amount on which to base a penalty was the medical bill for $43.72.

Penalty/Unreasonable Delay

The ALJ assessed a penalty for SAIF's unreasonable delay in the payment of claimant's temporary disability benefits. We find (and the parties agree) that the ALJ erred in assessing such a penalty. The ALJ determined that SAIF should have calculated claimant's temporary disability using his weekly earnings for the 26 weeks prior to claimant's injury. However, the administrative rule in effect at the time of claimant's injury (November 28, 1994) required SAIF to calculate claimant's temporary disability based on claimant's weekly earnings for the 52 weeks prior to his injury. See OAR 436-60-025(5)(a). SAIF complied with the Director's rule. As such, SAIF properly processed claimant's temporary disability. Accordingly, a penalty is not warranted.

ORDER

The ALJ's order dated August 18, 1995 is reversed in part and affirmed in part. That portion of the order which assessed SAIF a penalty for unreasonable delay in the payment of compensation is reversed. The remainder of the ALJ's order is affirmed.

February 12, 1996 Cite as 48 Van Natta 279 (1996)

In the Matter of the Compensation of
JOSEPH PARRY, Claimant
WCB Case No. 93-14867
ORDER ON REMAND
Silven, Schmeits, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Parry v. Marvin Wood Products, Inc., 136 Or App 536 (1995). In our prior order, we held that the parties' dispute concerned the compensability of claimant's current low back condition and need for treatment and, therefore, that the major contributing cause standard of ORS 656.005(7)(a)(B) applied. Joseph Parry, 46 Van Natta 2318 (1994). Concluding that claimant had not satisfied that standard, we reversed the Administrative Law Judge's (ALJ's) order setting aside the self-insured employer's denial of that condition. Reasoning that the amended version of the statutes applied, the court has remanded for reconsideration in light of the new law.

In our prior order, we analyzed this case under former ORS 656.005(7)(a)(B), concluding that claimant's claim failed, because the evidence established that his current disability and need for treatment was caused, in major part, by his underlying degenerative disc condition. Joseph Parry, supra, 46 Van Natta at 2319. The legislature has since amended ORS 656.005(7)(a)(B).[1] As amended, that statute still requires proof under the major contributing cause standard. Therefore, because there is insufficient evidence to satisfy that standard, we adhere to our conclusion that claimant's claim fails under ORS 656.005(7)(a)(B).

Claimant asserts that, under Beck v. James River Corp., 124 Or App 484 (1993), rev den 318 Or 478 (1994), and Jocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), he need only satisfy the material contributing cause standard. We disagree.

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[1] As amended, 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 need for treatment, the combined condition is compensable 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." Or Laws 1995, ch 332, § 1 (SB 369, § 1).

That statute applies retroactively to this case. SB 369, § 66(5)(a); e.g., Robert F. Shelton, 48 Van Natta 133 (1996).

Claimant persists in characterizing this case as a medical services case. We rejected that argument in our prior order, and do so again. Accordingly, Beck, a medical services case, is inapposite.[2]

Claimant's reliance on Jocelyn is similarly misplaced. Jocelyn concerned an aggravation claim; this case does not.[3] In any event, even if it did, ORS 656.005(7)(a)(B)'s major contributing cause standard now applies to aggravation claims in which a compensable injury combines with a preexisting condition to produce a worsened condition. Amended ORS 656.273(1); Gloria T. Olson, supra n 2. Assuming that this is such a claim, it fails because, for the reasons stated in our prior order, the evidence does not satisfy that standard.[4]

In sum, on reconsideration, we continue to conclude that claimant has failed to establish a compensable claim. Accordingly, we republish our November 3, 1994 order in its entirety, as supplemented herein.

IT IS SO ORDERED.

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[2] As an aside, we note that amended ORS 656.245(1)(a), the medical services statute, now provides that, "for consequential and combined conditions described in ORS 656.005(7), the insurer or self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury." SB 369, § 25 (emphasis added). That suggests that, even if this is a medical services case, claimant must satisfy the major contributing cause standard. Cf. Gloria T. Olson, 47 Van Natta 2348 (1995) (major contributing cause standard of ORS 656.005(7)(a)(B) now applies to aggravation claims under amended ORS 656.273(1)).

Relying on section 66(13) of Senate Bill 369, claimant asserts that amended ORS 656.245 does not apply to this case. Claimant is wrong. Section 66(13) pertains to section 25a of the Act, which is a "sunset" clause relating to ORS 656.245. The current amendments to ORS 656.245 are set forth in section 25 of the Act.

[3] Claimant did not contest the ALJ's statement that claimant was not pursuing an aggravation claim. See 46 Van Natta at 2319 n 2. Moreover, claimant does not dispute the employer's assertion that, at oral argument before the Court of Appeals, claimant specifically denied that he was asserting an aggravation claim. (Oral Argument Tr. 7).

[4] Claimant also asserts that his claim prevails under ORS 656.225, which was added to the Workers' Compensation Act as part of Senate Bill 369. Or Laws 1995, ch 332, § 3. We disagree. That statute applies "[i]n accepted injury or occupational disease claims * * *." (Emphasis added). Here, the parties' dispute concerns the compensability of claimant's current low back condition, which the evidence establishes was caused, in major part, by his underlying degenerative condition. Neither of those conditions has been accepted. Therefore, ORS 656.225 does not apply.

February 12, 1996 Cite as 48 Van Natta 280 (1996)

In the Matter of the Compensation of
WINFRED L. SWONGER, Claimant
WCB Case Nos. 95-01035 & 93-14711
ORDER ON REVIEW
Bennett & Hartman, Claimant Attorneys
Roberts, et al, Defense Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Balasubramani's order that: (1) set aside Farmers Insurance Group's (Farmers') responsibility denials of claimant's occupational disease claim for a binaural hearing loss condition; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) responsibility denials of claimant's occupational disease claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. Claimant has been employed in the trucking industry since 1951. Claimant worked for Consolidated Freightways from 1951 to 1964. From 1964 to 1984, claimant worked for Widing Transportation (Widing), Farmers' insured. While working at Widing, claimant did not wear any ear plugs and was exposed to the noise from heavy machinery and trucks he drove.

In 1984, Gresham Transfer (Gresham), Liberty's insured, bought Widing. Claimant continued to work for Gresham Transfer and performed essentially the same functions as at Widing. Since 1985 or 1986, claimant has worn ear protection when exposed to loud noises.

On August 9, 1993, while working for Gresham Transfer, claimant was driving with the windows of his cab down. A Volkswagen Bug with large exhaust pipes pulled up next to claimant's truck and back-fired loudly on three occasions. After claimant arrived at his destination, he was unable to hear a friend calling to him. Claimant's hearing problems persisted and he sought medical treatment. Claimant was diagnosed with binaural hearing loss.

The ALJ found that there were no medical opinions supported by objective evidence stating that the August 1993 backfiring incident caused claimant's binaural hearing loss. The ALJ analyzed the claim as an occupational disease and concluded that claimant's occupational noise exposure prior to 1981 was the major contributing cause of his hearing loss.

Claimant and Farmers argue that claimant's hearing loss condition should be analyzed as an injury, rather than an occupational disease. We disagree.

In determining the appropriate standard for analyzing compensability, we focus on whether claimant's hearing loss condition was an "event," as distinct from an ongoing condition or state of the body, and whether the onset was sudden or gradual. Mathel v. Josephine County, 319 Or 235, 240 (1994); James v. SAIF, 290 Or 343 (1981); Valtinson v. SAIF, 56 Or App 184, 187 (1982).

The issue of whether claimant's hearing loss is related to his work exposure is a complex medical question. Thus, although claimant's testimony is probative, the resolution of this issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 420, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985), rev den 300 Or 546 (1986).

After reviewing the record, we agree with the ALJ that there are no medical opinions that indicate that the August 1993 incident caused claimant's current hearing loss condition. Rather, the medical evidence establishes that claimant's hearing loss arose gradually and the hearing loss was an ongoing condition, rather than a sudden event. Consequently, we agree with the ALJ that the claim should be analyzed as an occupational disease.

On review, Liberty distinguishes between claimant's high frequency and low frequency hearing loss. Liberty asserts that there is no evidence that claimant's low frequency hearing loss was the result of any work exposure and it argues that the low frequency hearing loss is not compensable. On the other hand, Liberty contends that responsibility for the high frequency hearing loss should be assigned under the last injurious exposure rule.

There is no indication in the record that Liberty's "low frequency hearing loss" argument was raised at hearing and the ALJ did not address it.[1] We have consistently held that we will not consider an issue raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Although Liberty's argument could be characterized as merely a different theory of contesting compensability, rather than a separate issue, fundamental fairness dictates that the parties have a reasonable opportunity to present evidence on an issue. See Clive G. Osbourne, 47 Van Natta 2291 (1995); Robert L. Tegge, 47 Van Natta 1973 (1995). Accordingly, we decline to consider Liberty's "low frequency hearing loss" argument.

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[1] Furthermore, even if it were determined that Liberty raised the "low frequency hearing loss" argument in closing argument, we will not consider on review an issue raised for the first time during closing argument. See Clive G. Osbourne, supra.

Disclaimer of Responsibility

At hearing, Farmers argued that Liberty failed to issue a timely disclaimer of responsibility pursuant to former ORS 656.308(2) and, therefore, Liberty could not shift responsibility to Farmers. The ALJ reasoned that since amended ORS 656.308(2) does not require a timely disclaimer of responsibility, Liberty was not precluded from arguing that responsibility should be assigned to Farmers. On review, Farmers argues that former ORS 656.308(2) applies to this case and Liberty is barred from contesting responsibility.

As the ALJ pointed out, amended ORS 656.308(2) no longer requires a carrier to issue a timely "disclaimer" of responsibility. Or Laws 1995, ch 332, § 37 (SB 369, § 37). Generally, the changes made to the Workers' Compensation law made by SB 369 apply to matters for which the time to appeal the Board's decision has not expired, or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 135 Or App 565, 569 (1995). However, one exception to the retroactive effect of SB 369 applies here. Subsection (6) of section 66 of SB 369 provides:

> "The amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not extend or shorten the procedural time limitations with regard to any action on a claim taken prior to the effective date of this Act." SB 369, § 66.

In Motel 6 v. McMasters, 135 Or App 583 (1995), the carrier argued that the claimant's aggravation claim was time-barred under former ORS 656.308(2) because it was not filed within 60 days of another carrier's disclaimer notice to the claimant. The court held that, because the case involved a procedural time limit, the changes made by Senate Bill 369 did not apply.

Here, the issue is whether Liberty issued a timely disclaimer pursuant to former ORS 656.308(2), which provided that a carrier that intended to disclaim responsibility for a claim on the basis of an injury or exposure with another carrier "shall mail a written notice to the worker as to this position within 30 days of actual knowledge of being named or joined in the claim." Because the issue of the timeliness of Liberty's issuance of a disclaimer involves a procedural time limit, we conclude that the changes made by Senate Bill 369 do not apply to this case. See Motel 6 v. McMasters, supra; John W. Gray, Jr., 47 Van Natta 2303 (1995).

In this case, however, the timeliness of Liberty's disclaimer is irrelevant. A carrier's violation of the disclaimer notice requirement does not preclude a claimant from pursuing the claim with another carrier. See Daral T. Morrow, 47 Van Natta 2030, on recon 47 Van Natta 2384 (1995); Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994); Jon F. Wilson, 45 Van Natta 2362 (1993).

Here, claimant filed claims with both Liberty and Farmers. According to Farmers, since claimant has appealed the ALJ's order and is asserting responsibility against Liberty, claimant is no longer asserting responsibility against Farmers. Although claimant asserts on review that the Board should find Gresham Transfer, Liberty's insured, responsible for his hearing loss condition, claimant has not moved to dismiss Farmers from this case. See Donald A. James, 46 Van Natta 1898 (1994). Therefore, we do not agree with Farmers that claimant is no longer pursuing a claim against Farmers. Consequently, even if we assume, without deciding, that Liberty failed to issue a timely disclaimer of responsibility under former ORS 656.308(2), that does not preclude claimant from pursuing a claim with Farmers.

Responsibility

No carrier has accepted claimant's hearing loss condition. Therefore, ORS 656.308 does not apply. SAIF v. Yokum, 132 Or App 18, 23 (1994). Instead, we analyze this case under the last injurious exposure rule, unless actual causation is proved with respect to a particular carrier. E.g., Eva R. Billings, 45 Van Natta 2142 (1993).

The last injurious exposure rule is applied in situations involving successive employers, where each employment is capable of contributing to the disease and the finder of fact is unable to determine which employment actually caused the condition. Bracke v. Baza'r, 293 Or 239, 248-49 (1982); Eva R. Billings, supra. On the other hand, where actual causation is established with respect to a specific employer, it is not necessary to rely on judicially created rules of assignment pertaining to successive employments in determining responsibility. See Runft v. SAIF, 303 Or 493, 501-02 (1987); Renee M. Willshire, 47 Van Natta 1339 (1995).

Here, Liberty argues that there is no proof that claimant's employment exposure with its insured could have contributed to his hearing loss. Liberty asserts that the medical evidence establishes that claimant's hearing loss occurred before 1979, when claimant was working for Farmers' insured.

In 1979, claimant was treated by Dr. Epley for an ear infection. In the course of treatment, Dr. Epley performed a hearing test on February 2, 1979. (Ex. 16-16). On September 16, 1994, Dr. Richard Hodgson reviewed Dr. Epley's chart notes and the 1979 hearing test and compared the 1979 test to a hearing test performed on November 15, 1993. (Ex. 17). Dr. Richard Hodgson found that the 1979 test was quite similar to the 1993 test. (Id.) He concluded that claimant's hearing loss was not caused by his employment at Gresham Transfer (Liberty's insured) between 1981 to the present. (Id.)

Dr. R. Sterling Hodgson also reviewed Dr. Epley's chart notes and the 1979 hearing test and reported that "the full cause of [claimant's] occupational hearing loss is noise exposure prior to February 2, 1979." (Ex. 20). At a deposition, Dr. R. Sterling Hodgson reiterated that opinion. (Ex. 22-10). Dr. R. Sterling Hodgson explained that the 1979 hearing test and the 1993 and 1994 hearing tests were not substantially different in the frequencies that were tested. (Id.) Dr. R. Sterling Hodgson agreed that there was no evidence of additional hearing loss in the industrial noise range since 1979, although he noted that there was some evidence of low frequency hearing loss in the right ear since 1979.[2] (Id.)

Claimant worked for Widing from 1964 to 1984. Based on Dr. R. Sterling Hodgson's opinion that the full cause of claimant's occupational hearing loss was noise exposure prior to February 2, 1979, we are persuaded that claimant's work activities at Widing (Farmers' insured) were the major contributing cause of his binaural hearing loss condition. Dr. R. Sterling Hodgson's opinion is also supported by the opinion of Dr. Richard Hodgson. Because we conclude that claimant's work with Farmers' insured is the actual cause of his hearing loss condition, we find that the last injurious exposure rule does not apply. See Renee M. Willshire, supra; Antonio J. Lopez, 47 Van Natta 1304 (1995) (since the injury was the major contributing cause of the claimant's condition, the carrier was responsible regardless of the analysis adopted). Accordingly, we conclude that the ALJ properly assigned responsibility for claimant's condition to Farmers.

Alternatively, even if we applied the last injurious exposure rule, we would continue to find Farmers, on behalf of Widing, responsible for the claim. The last injurious exposure rule provides that when a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, supra, 293 Or at 248.

If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994). The dispositive date is the date the claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

Here, claimant sought treatment from Dr. Epley in 1979 for an ear infection and Dr. Epley performed a hearing test. However, there is no evidence that claimant sought treatment related to his hearing loss in 1979. Claimant testified that he did not have difficulty hearing until after the August 1993 incident. (Tr. 14, 15). Claimant said that, when he saw Dr. Epley in 1979 for an ear infection, Dr. Epley told him that he might have some hearing loss but he said it was "nothing to worry about." (Tr. 19). Claimant testified that Dr. Epley did not mention that the 1979 hearing loss was related to his employment. (Id.) Under these circumstances, we find that claimant did not receive treatment related to his compensable hearing loss condition in 1979. See Norman L. Selthon, 45 Van Natta 2358 (1993).

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[2] Dr. R. Sterling Hodgson testified that claimant's right ear had deteriorated somewhat at 2,000 hertz between 1979 and 1994. (Ex. 22-10). He testified that generally, a change of 2,000 hertz with further noise exposure is accompanied by changes in the higher frequencies as well. (Exs. 22-10, 22-11). However, Dr. R. Sterling Hodgson said that an isolated change of 2,000 hertz unassociated with changes in higher frequencies is more typically associated with other idiopathic or degenerative changes rather than continued noise exposure. (Ex. 22-11). Later in the deposition, Dr. R. Sterling Hodgson said that the difference of 2,000 hertz had not shown up in other hearing tests and he acknowledged that his test might have been in error. (Ex. 22-21).

Rather, we conclude that claimant first sought treatment related to the hearing loss condition on August 27, 1993, after the "backfiring incident." (Ex. 1). On that date, Dr. Hosko diagnosed claimant with hearing loss and cerumen impaction. (Id.) At that time, claimant was employed at Gresham Transfer. Therefore, responsibility is initially assigned to Liberty, on behalf of Gresham Transfer. See Timm v. Maley, supra .

Liberty can shift responsibility to Farmers, the prior carrier, by showing that claimant's work activity while Farmers was on the risk was the sole cause of claimant's hearing loss condition, or that it was impossible for conditions while Liberty was on the risk to have caused that condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985).

At deposition, Dr. R. Sterling Hodgson was asked whether claimant's employment after 1979 actually contributed to his hearing loss. Dr. R. Sterling Hodgson responded that claimant's employment after 1979 did not contribute to his hearing loss. (Ex. 22-17). Furthermore, as we discussed earlier, Dr. R. Sterling Hodgson concluded that the "full cause" of claimant's occupational hearing loss was the noise exposure before 1979, while working for Farmers' insured. (Ex. 20). Similarly, Dr. Richard Hodgson concluded that claimant's hearing loss was not caused by his employment at Gresham Transfer, Liberty's insured, between 1981 to the present. (Ex. 17). Based on the opinions of Drs. Richard Hodgson and R. Sterling Hodgson, we are persuaded that claimant's work activity at Widing (Farmers' insured) was the sole cause of claimant's binaural hearing loss.[3] (Exs. 17, 20, 22). Consequently, even if the last injurious exposure rule was applicable, responsibility for claimant's condition would shift to Farmers and Farmers would be responsible for claimant's binaural hearing loss.

ORDER

The ALJ's order dated June 28, 1995 is affirmed.

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[3] In light of our conclusion that claimant's employment at Widing (Farmers' insured) was the sole cause of claimant's hearing loss, we do not address whether it was impossible for conditions while Liberty was on the risk to have caused claimant's condition. See FMC Corp. v. Liberty Mutual Ins. Co., supra.

In the Matter of the Compensation of
ANNETTE E. FARNSWORTH, Claimant
WCB Case No. 94-14877
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) found that the self-insured employer did not issue a "back-up" denial; (2) upheld the employer's denial of claimant's right shoulder condition; and (3) declined to assess a penalty for the employer's allegedly unreasonable claim processing. On review, the issues are "back-up" denial, compensability and penalties.

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

Claimant asserts that, by virtue of a "1502" form indicating that she had had right shoulder surgery and that she was temporarily disabled, the employer accepted her right shoulder condition. Therefore, by subsequently denying the right shoulder condition, claimant asserts that the employer issued a "back-up" denial. We disagree.

A "1502" form does not constitute an acceptance. EBI Co. v. CNA Insurance, 95 Or App 448, 451 (1989); Donna J. Calhoun, 47 Van Natta 454, 455 n 1 (1995). Consequently, there being no other

probative evidence that the employer had accepted claimant's right shoulder condition, we agree with the ALJ that the employer did not issue a "back-up" denial when it denied that condition.[1]

ORDER

The ALJ's order dated March 23, 1995 is affirmed.

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[1] Claimant asserts that, because the employer issued a "back-up" denial, it has the burden of establishing, by clear and convincing evidence, that her right shoulder condition was not compensable. In view of our agreement that the employer did not issue a "back-up" denial, we need not address that issue. We note, however, that the Legislature amended ORS 656.262(6) to lower a carrier's burden of proof in "back-up" denial cases to a "preponderance of the evidence." Or Laws 1995, ch 332, § 28.

Board Member Gunn dissenting.

Because I disagree with the Administrative Law Judge's (ALJ's) reasoning, which the Board adopts and affirms, I dissent.

Claimant relies on two reports of Dr. Carlson, treating surgeon. In the first, Carlson states that he reviewed claimant's chart notes, which stated that claimant had related her right shoulder condition to work activities and that Carlson believed that the right shoulder condition was "most likely related to work by [claimant's] history." (Ex. 37A). Carlson then stated, based on the lack of any other identified potential causes for the condition, that it appeared that claimant's work activities were the major contributing cause of her right shoulder condition, and that the surgical findings supported this conclusion. (Id.)

In his final report, Dr. Carlson stated that claimant had given him a history that her right shoulder condition was due to repetitive overuse, which Carlson thought was "plausible." (Ex. 39-1). Carlson also reported that claimant denied any non-work activities that could have contributed to the development of her symptoms. (Id.) Finally, Carlson disagreed with examining physician Dr. Farris' conclusion that claimant's right shoulder condition occurred spontaneously; Carlson believed that there was a "much greater likelihood" that claimant had developed the condition from overuse. (Id.)

In my view, those reports are sufficient to meet claimant's burden of proof. First, although Dr. Carlson reiterates claimant's beliefs regarding the cause of her right shoulder condition, Carlson reaches his own conclusion that that condition is related to claimant's work as a checker. Further, although Carlson's first report is rather conclusory, in light of his status as treating surgeon, his conclusion that the surgical findings support his "major contributing cause" opinion, and the lack of any other identified potential causes of claimant's shoulder condition, brevity is permissible. Cf. Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988) (opinion of worker's treating surgeon entitled to particular deference). That is enough to establish the compensability of claimant's right shoulder condition.

Dr. Carlson's final report supports that conclusion. In that report, Carlson initially states that it is "plausible" that claimant's condition is work-related. Later, in the same report, however, Carlson states that there is a "much greater likelihood" that claimant's right shoulder condition is work-related rather than the result of a spontaneous process. In my view, that is sufficient to establish that it is medically probable that claimant's condition is work-related. For all these reasons, I disagree with the ALJ,[1] and the Board, that claimant has failed to establish a compensable occupational disease. Accordingly, I dissent.

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[1] I also note the ALJ's statement that claimant must establish the compensability of her claimant by "expert" medical evidence. Although the Board and courts' cases repeatedly use the term "expert" in this context, that term does not appear in ORS 656.802(2). It is unclear what that term adds to the analysis; therefore, I place no value upon it.

In the Matter of the Compensation of
MICHAEL W. KOSS, Claimant
WCB Case No. 95-06361
ORDER ON REVIEW
Schneider, Hooton, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Schultz's order that: (1) concluded that the Hearings Division has jurisdiction to assess an attorney fee under ORS 656.382(1) for an alleged discovery violation; and (2) assessed an attorney fee for the same alleged infraction. On review, the issues are jurisdiction and, if jurisdiction rests with the Hearings Division, attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

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

On January 10, 1995, SAIF accepted claimant's claim for bilateral carpal tunnel syndrome. On March 9, 1995, claimant retained counsel, who wrote to SAIF requesting copies of all relevant claims documents. SAIF received the request on March 10, 1995. SAIF provided discovery on May 8, 1995. On May 25, 1995, claimant filed a request for hearing. The sole issue at hearing was penalties and attorney fees for untimely provision of discovery. (Tr. 4). SAIF had paid for all compensation to which claimant was entitled through the time of hearing. (Tr. 11, 12, 15).

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The ALJ concluded that the Hearings Division had jurisdiction over the assessment of an attorney fee under ORS 656.382(1) for untimely provision of discovery. Citing Jimmie Jordan, 44 Van Natta 889 (1992), SAIF contends that, because the only matter before the ALJ involved claimant's request for an attorney fee for a discovery violation, jurisdiction is vested with the Director pursuant to ORS 656.262(11). We disagree.

In Jordan, the sole issue was the assessment of a penalty and a separate attorney fee based on the same conduct. Because claimant raised a viable request for a penalty under ORS 656.262(10)(a) (renumbered (11)(a)), and because we could not assess penalty-related attorney fees based on the same conduct for which penalties are assessed under that statute, we concluded that we had no jurisdiction over the penalty matter. Consequently, we dismissed the claimant's request for hearing. The case before us differs, in that, although the alleged misconduct for which the penalty and attorney fee are based is the same, claimant has not raised a viable request for a penalty, as there are no "amounts due."

In contrast, ORS 656.382(1) authorizes the assessment of an attorney fee if an insurer unreasonably resists the payment of compensation, provided that there are no amounts of compensation "then due" upon which to base a penalty or the unreasonable resistance is not the same conduct for which a penalty has been assessed under ORS 656.262(11). Corona v. Pacific Resource Recycling, 125 Or app 47 (1993); Oliver v. Norstar, Inc., 116 Or App 333 (1993); Martinez v. Dallas Nursing Home, 114 Or App 453, rev den 315 Or 271 (1992). Inasmuch as there is no compensation due upon which to base a penalty, claimant is entitled to a separate attorney fee under ORS 656.382(1), provided that there is unreasonable resistance to the payment of compensation. See Aetna Casualty Co. v. Jackson,. 108 Or App 253 (1991) (failure to provide discovery could be considered an unreasonable delay or refusal to pay compensation and is within the Board's authority). Consequently, the Hearings Division does have jurisdiction over the matter. See also Ronald A. Stock, 43 Van Natta 1889 (1991) (if claimant cannot establish all of the elements necessary to prove entitlement to a penalty, Hearings Division has authority to consider request for an attorney fee award under ORS 656.382 (1)); Lawrence A. Durette, 42 Van Natta 413 (1990) (a request for hearing on an issue of discovery is a matter concerning a claim).

Attorney Fee

The ALJ's attorney fee award is based on SAIF's failure to timely provide discovery, which "could have" resulted in a delay in the payment of compensation. SAIF asserts that, because it had paid claimant all the compensation to which he was entitled before the discovery violation occurred, the ALJ's attorney fee award was improper. We agree.

Even if SAIF's conduct was unreasonable, the record does not establish that any compensation was unpaid at the time of SAIF's conduct. Because SAIF cannot unreasonably resist the payment of compensation that has been paid, SAIF v. Condon, 119 Or App 194, rev den 317 Or 162 (1993), no basis exists for an attorney fee award under ORS 656.382(1). See Michael J. Pelcin, 47 Van Natta 1380 (1995); Bruce Hardee, 46 Van Natta 2261 (1994) (in absence of any evidence of unpaid compensation at the time of carrier's allegedly unreasonable conduct, no fee is warranted under ORS 656.382(1)). Accordingly, we reverse the ALJ's attorney fee award.

ORDER

The ALJ's order dated August 30, 1995 is affirmed in part and reversed in part. That portion of the order that directed the SAIF Corporation to pay an assessed fee of $500 under ORS 656.382(1) is reversed. The remainder of the order is affirmed.

February 13, 1996 Cite as 48 Van Natta 287 (1996)

In the Matter of the Compensation of
KAREN HUDSON, Claimant
WCB Case No. 94-13996
ORDER DENYING RECONSIDERATION
Craine & Love, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Pursuant to our January 19, 1996 Order on Review, we reversed an Administrative Law Judge (ALJ) order that had set aside the self-insured employer's denial of claimant's injury claim for stress-related physical symptoms. In response to our decision, claimant, through her attorney, has submitted a letter. Noting that her counsel is "in the process of preparing her motion [for reconsideration] at this time", claimant requests abatement of our decision so that we may retain jurisdiction to consider the forthcoming motion.

The motion is denied. In the event that claimant subsequently files a motion for reconsideration which includes a concise statement of the reason or reasons reconsideration is requested, we will then determine whether further consideration of this matter is warranted. See OAR 438-011-0035(2).

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIA LEYVA, Claimant
WCB Case No. 93-13180
ORDER ON REVIEW
Adams, Day, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Garaventa's order that: (1) upheld the self-insured employer's partial denial of claimant's current low back condition and; (2) upheld the employer's denial of her cervical sprain/strain. In its respondent's brief, the employer contends that: (1) the ALJ erred in admitting certain exhibits; (2) portions of claimant's appellant's brief should be stricken; and (3) claimant is precluded from contesting the compensability of her cervical sprain/strain. On review, the issues are the propriety of the ALJ's evidentiary ruling, motion to strike, res judicata, jurisdiction and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, as clarified and supplemented.

We replace the seventh paragraph on page two with: On September 17, 1993, Dr. Bright, claimant's then-attending physician, reported that he "believe[d]" claimant's continuing low back problems were related to her pregnancy and would disappear completely after delivery. However, in the event claimant's back pain continued, Bright recommended that lumbosacral studies (which could not be performed during claimant's pregnancy) be obtained. (Ex. 28).

We replace the fourth paragraph on page three with: On January 27, 1994, Dr. Bright repeated that, based on his examinations of claimant in October and November 1993, her continued low back symptoms were due to her pregnancy. Claimant delivered her baby on January 15, 1994; her low back pain persisted. Dr. Bright did not thereafter examine claimant or review her later medical records.

A lumbar spine CT scan was performed on September 23, 1994. No significant abnormalities were identified.

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, claimant's reply brief was rejected as untimely. See OAR 438-005-0046(1)(c); OAR 438-011-0020(2). Consequently, we have not considered claimant's reply brief in our deliberations.

Evidence

Claimant was compensably injured when she fell off a ladder at work on June 1, 1993. At the time, claimant was approximately six weeks pregnant. Claimant's request for hearing from the employer's current low back condition denial was first set for hearing on February 2, 1994. On January 11, 1994, claimant requested that the matter be rescheduled until after she gave birth. Claimant explained that inasmuch as Dr. Bright attributed her low back pain to pregnancy, she should be permitted to obtain and submit post-pregnancy evidence, including the diagnostic testing recommended by Dr. Bright. A prior ALJ denied the motion for postponement.[1]

The parties appeared for the February 1994 hearing. Claimant renewed her motion to postpone; the prior ALJ again denied the motion. The parties then entered into settlement negotiations and tentatively resolved their dispute. No hearing was held and no exhibits were admitted. Claimant later declined to sign the Disputed Claim Settlement and Claim Disposition Agreement that were drafted. Claimant retained other counsel, and the hearing was rescheduled for April 11, 1995.

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[1] Were the propriety of the prior ALJ's ruling contested before the Board, Chair Hall would find the ALJ's denial of the motion for postponement constituted an abuse of discretion. Because this entire case turned on "post-delivery" medical analysis, Chair Hall would conclude that the need to wait until after delivery was an extraordinary circumstance beyond claimant's control, justifying postponement. See OAR 438-006-0091(4), 438-006-0081(2) and (4); Georgia-Pacific Corporation v. Kight, 126 Or App 244 (1994).

At the April 1995 hearing, the employer objected to the admission of all medical reports dated or created after February 2, 1994. Finding that the record had not been frozen at the time the parties entered into settlement negotiations, and in the interests of substantial justice, the ALJ admitted the disputed reports. On review, the employer continues to object to the admission of all exhibits prepared after February 2, 1994.

ORS 656.283(7) provides that ALJs are not bound by common law or statutory rules of evidence and may conduct hearings in any manner that will achieve substantial justice. The statute has been interpreted as giving ALJs broad discretion with regard to the admissibility of evidence. See e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). An ALJ's decision to admit an exhibit will be upheld as long as the evidence has some probative value and achieves substantial justice. See Lucke v. Compensation Dept., 254 Or 439, 442-43 (1969). We review the ALJ's evidentiary rulings for abuse of discretion. William J. Bos, 44 Van Natta 1691 (1992).

The disputed medical reports primarily pertain to claimant's post-pregnancy low back condition. We find those reports, which include the diagnostic lumbosacral studies recommended by Dr. Bright, probative of whether claimant's current low back condition is related to pregnancy or the compensable injury.

Consequently, we do not consider it to be an abuse of discretion for the ALJ to have admitted the disputed exhibits. Thus, we have considered all exhibits admitted at hearing in conducting our de novo review. We note, parenthetically, that Exhibits 1 through 43, rather than Exhibits 1 through 48, were admitted by the ALJ into the record.

Motion to Strike

On review, the employer moves to strike those portions of claimant's appellant's brief that reference medical "bulletins" concerning pregnancy that were not admitted into the record. We grant the employer's motion.

Accordingly, in our review of this matter, we have not considered any arguments based upon material that was not admitted into evidence at hearing. See ORS 656.295(5); Haribu R. Steward, 45 Van Natta 2086 (1993) (Board will not consider any evidence that was not previously made a part of the record).

Compensability / Cervical Strain/Sprain

The employer renews its contention that the doctrine of claim preclusion bars claimant from arguing she sustained a cervical strain/sprain as part of her June 1, 1993 work injury. We adopt and affirm the ALJ's reasoning and conclusion that claimant is not precluded from litigating the compensability of her cervical condition.

Finding that chiropractic physician Bhasin, the doctor who first diagnosed a cervical strain/sprain, did not examine claimant and make objective findings, the ALJ concluded there was insufficient medical evidence to establish that, as a result of the June 1, 1993 work incident, claimant sustained a neck injury. The ALJ therefore upheld the employer's denial of claimant's neck injury claim. On review, claimant argues that her claim is compensable. We agree with claimant.

Unlike the ALJ, we find that Dr. Bhasin examined claimant and recorded objective findings. Specifically, Dr. Bhasin found limited cervical spine ranges of motion. We conclude that Dr. Bhasin's findings regarding claimant's limited range of motion constitute "objective findings."[2]

We now turn to whether claimant has established that the June 1, 1993 work injury was a material contributing cause of her neck disability and need for treatment. For the following reasons, we conclude that claimant has satisfied this statutory prerequisite. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991).

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[2] The employer argues that amended ORS 656.005(19) should be applied retroactively in this case. However, we find that the result in this case would be the same under either version of the statute. Thus, the statutory amendments are not determinative of the outcome.

On July 13, 1993, claimant sought treatment from Dr. Bhasin for neck pain. Dr. Bhasin diagnosed and treated claimant for a cervical sprain/strain, which he attributed to the June 1993 work injury. Dr. Verzosa became claimant's treating physician in December 1993. She too diagnosed and treated claimant for cervicothoracic sprain/strain. Further, Dr. Verzosa agrees claimant sustained the cervical strain as a result of the June 1993 work injury. There is no contrary medical opinion.

Accordingly, we find that claimant has established that the June 1993 work injury is a material contributing cause of her neck disability and need for treatment. We therefore reverse the ALJ's order upholding the employer's denial of claimant's cervical condition.

Compensability / Current Low Back Condition

Claimant was compensably injured on June 1, 1993. The employer accepted a "low back strain." By Notice of Closure, on September 30, 1993, the employer found claimant medically stationary on July 29, 1993 and closed the claim without an award of permanent disability. Claimant continued to treat for low back symptoms.

On October 27, 1993, the employer partially denied the compensability of claimant's low back condition, stating, in relevant part:

> "It appears from the records that you recovered from [the compensable] injury and your condition stabilized as of July 29, 1993. Please be advised that we must deny responsibility for your current condition and treatment as it appears the need for this treatment is unrelated to your injury of June 1, 1993."

At hearing, the parties identified the issue for resolution as the employer's low back compensability denial. The ALJ concluded that claimant's current medical treatment is not compensable under ORS 656.245. On review, claimant argues that the ALJ misconstrued the employer's denial. Specifically, claimant argues that the employer's denial is not a denial of medical services, but rather a denial of the compensability of the condition for which claimant is receiving treatment.

Subsequent to the ALJ's order, the legislature amended ORS 656.327(1) and added ORS 656.245(6), each of which requires review of medical services disputes by the Director, unless a claim for medical services is denied on the basis that the underlying claim is not compensable. Newell v. SAIF, 136 Or App 280 (1995); Walter L. Keeney, 47 Van Natta 1387, 1389, recon den 47 Van Natta 1525 (1995).

The Board retains jurisdiction to determine whether a claimant's current condition is related to the compensable injury. ORS 656.245(6); Janet Anderson, 47 Van Natta 1692 (1995). In addition, because a dispute that concerns whether medical treatment for a claimant's current condition is causally related to the compensable injury necessarily involves the compensability of the condition on which the medical treatment is based, the Board also retains jurisdiction to resolve such disputes. Richard L. Wheeler, 47 Van Natta 2011 (1995).

Consequently, whether the employer's denial is viewed as a denial of claimant's current low back condition or a denial that medical treatment for claimant's current condition is related to the compensable injury, we retain jurisdiction over this matter. We turn to the merits of the parties' dispute.

The medical opinions are divided between Dr. Bright, who treated claimant from July 29 through November 1, 1993, and Dr. Verzosa, who has treated claimant since December 1993. When there is a dispute between medical experts, the greater weight will be given to those medical opinions which are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 262 (1986).

Dr. Bright opined that the low back symptoms claimant was experiencing on her initial visit were related to her pregnancy and would disappear completely after delivery. Dr. Bright added, however, that if claimant's back pain continued, lumbosacral studies (which could not be performed during her pregnancy) should be obtained. Claimant delivered her baby on January 15, 1994; her low back symptoms persisted. On January 27, 1994, without reexamining claimant, Dr. Bright again indicated that claimant's low back condition was due to her pregnancy.

When claimant's low back symptoms did not subside after delivery, Dr. Verzosa referred claimant for physical therapy. Dr. Verzosa also obtained the lumbar studies recommended by Dr. Bright. A lumbar spine CT scan revealed no significant abnormalities. Based on examinations of claimant both during and after her pregnancy, as well as review of the radiological studies, Dr. Verzosa opined that the major contributing cause of claimant's back condition and need for treatment was the June 1993 work injury.

Inasmuch as Dr. Bright's most recent opinion was authored without reexamining claimant or reviewing the lumbosacral studies, it is based on incomplete information and is not persuasive. We therefore discount his opinion accordingly.

Instead, we find Dr. Verzosa's opinion more persuasive. Based on that opinion (which was based on a "post-pregnancy" examination and lumbar studies), we find that claimant has established that her current disability and need for treatment are related to the June 1993 work injury. We therefore reverse the ALJ's order upholding the employer's denial of claimant's current low back condition.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for establishing the compensability of her cervical and low back conditions. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by the hearing record and claimant's appellant's brief), the complexity of the issues, the value of the interests involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated April 25, 1995 is reversed in part and affirmed in part. The employer's denials of claimant's low back and cervical conditions are set aside and the claims remanded to the employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $3,000, to be paid by the employer. The remainder of the order is affirmed.

February 13, 1996 Cite as 48 Van Natta 291 (1996)

In the Matter of the Compensation of
ROBERT B. MANNING, Claimant
WCB Case No. 95-03465
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Balasubramani's order that affirmed an Order on Reconsideration that awarded no unscheduled permanent disability for a left mandible fracture injury. On review, the issue is extent of unscheduled permanent disability.

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

Claimant sustained a compensable left mandible fracture, which was accepted by the insurer. (Ex. 11). On October 21, 1994, the claim was closed by Determination Order, which awarded temporary disability but no permanent disability. (Ex. 14). Claimant sought reconsideration, raising the issue of unscheduled permanent disability and requesting appointment of a medical arbiter. (Ex. 17). Dr. Bouneff, D.M.D., was appointed medical arbiter. On March 7, 1995, following consideration of Dr. Bouneff's report, an Order on Reconsideration issued affirming the Determination Order in all respects. (Ex. 21). On March 27, 1995, claimant's accepted claim was reopened as an aggravation of the mandible fracture injury claim. (Ex. 23).

At hearing, the parties agreed that: (1) the only issue to be litigated was the extent of claimant's unscheduled permanent disability resulting from the accepted mandible fracture injury; (2) claimant's bilateral jaw joint condition was still within the 90 period within which the insurer had to accept or deny that condition; and (3) the hearing would not preclude any action by claimant arising from the insurer's reopening of his claim on an aggravation basis. (Tr. 2-3, 19-23).

On review, claimant argues that the closing examination report from Dr. Layman, treating physician, establishes his entitlement to an award for a chronic condition impairment. We disagree.

A worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. OAR 436-35-320(5); WCD Admin. Order No. 6-1992. This determination requires a medical opinion of the medical arbiter or claimant's attending physician, or a medical opinion with which the attending physician has concurred, from which it can be found that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition. ORS 656.245(3)(b)(B), renumbered 656.245(2)(b)(B); 656.268(7); Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995). There must be medical evidence of at least a partial loss of ability to repetitively use the body part. See Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993). Claimant has the burden of proving a chronic condition impairment. ORS 656.266.

Here, we find no persuasive medical evidence of a partial loss of claimant's ability to repetitively use his mandible. Dr. Layman stated that claimant had "[n]o further pain residual in his jaw, although if he tries to use a jack hammer he does get some vibration transmitted to his face which causes some discomfort so he has avoided that activity." (Ex. 13). This statement does not establish a partial loss of ability to repetitively use the mandible. See Rae Holsapfel, 45 Van Natta 1748, 1749 (1993), aff'd mem 127 Or App 208 (1994) (recommendation that the claimant avoid repetitive strenuous work with her hands in order to prevent an increase in symptoms insufficient to establish a permanent and chronic impairment of the wrists). Accordingly, claimant has failed to establish a chronic condition impairment relating to the accepted mandible fracture. James R. Dryden, 47 Van Natta 1328 (1995).

Alternatively, claimant argues that if we find that the rules do not provide for a rating of permanent disability for a mandible fracture, then the claim should be remanded to the Director to adopt a temporary rule. For the reasons explained below, we find that remand is not warranted.[1]

In determining entitlement to an unscheduled permanent disability award, the threshold issue is whether the compensable injury has caused permanent impairment. If there is no permanent impairment due to the compensable injury, no award of unscheduled permanent disability shall be made. OAR 436-35-007(1); 436-35-270(2). Under ORS 656.726(3)(f)(C), the Director shall stay further proceedings and shall adopt temporary rules when "it is found the worker's disability is not addressed by the standards adopted pursuant to this paragraph." The Board has authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability. Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993). Claimant has the burden of proving that his disability is not addressed by the standards. See ORS 656.266; Susan D. Wells, 46 Van Natta 1127 (1994).

Here, the medical evidence does not establish that the compensable mandible fracture resulted in permanent impairment. In this regard, Dr. Bouneff noted that claimant's ability to open his mandible was limited to approximately 25 mm, whereas normal opening is between 40 and 50 mm. (Ex. 20-3). Dr. Bouneff also noted that claimant can chew all foods that do not require opening his mandible past 25 mm. Id. However, Dr. Bouneff attributed these limitations to the right and left jaw joints themselves, opining that the articular discs within the jaws had become displaced. Id. Thus, Dr. Bouneff did not attribute any limitation to the mandible fracture.

Dr. Layman indicated that claimant's ability to open his mouth was limited to "3 cm between the incisors anteriorly and normal would probably be about 4 cm, but it appears that he does not have any ratable impairment at this time." (Ex. 13).

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[1] Claimant notes that, at hearing, he specifically preserved his alternative request for remand to the Director for a temporary rule. (Tr. 2). The insurer responds that "claimant did not first request the Director to adopt a temporary rule." (Respondent's Brief, page 2). The legislature has enacted Senate Bill 369, adding amended ORS 656.268(8) which provides that "[n]o hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing." Or Laws 1995, ch 332, § 30(8) (SB 369, § 30(8)). We need not resolve the applicability of this amendment because, under either version of the statute, the result would be the same.

Dr. Layman did not indicate the cause of claimant's limited ability to open his mouth. However, given Dr. Bouneff's well-reasoned opinion that this limitation is due to the displacement of the right and left jaws themselves, we conclude that claimant's limitation is due to the jaw joint condition and not due to the compensable mandible fracture itself. Somers v. SAIF, 77 Or App 259, 263 (1986). Thus, on this record, claimant has not established any permanent impairment due to the compensable mandible fracture.[2]

Because there is no medical evidence establishing permanent impairment due the compensable mandible fracture, claimant has not met his burden of proving that he has a disability that is not addressed by the standards. Therefore, remand to the Director for promulgation of a temporary rule to address this "impairment" is not warranted.[3]

ORDER

The ALJ's order dated June 15, 1995 is affirmed.

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[2] As noted above, the parties agreed that any impairment due to the jaw condition was not yet ripe because that condition was still within the 90 day statutory period the insurer had to accept or deny that condition.

[3] In making this determination, we have considered claimant's argument that the rule for unscheduled chronic condition impairment does not include the mandible as a covered "body area." OAR 436-35-320(5). However, because the medical evidence does not establish that claimant has a chronic condition impairment due to the compensable mandible fracture, it is not necessary to remand this case to the Director to implement a rule that includes the mandible as a covered "body area" in chronic condition impairment.

February 13, 1996 Cite as 48 Van Natta 293 (1996)

In the Matter of the Compensation of
RONALD M. ROSS, Claimant
WCB Case No. 95-02458
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James Thwing (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Gunn.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) denied its motion to dismiss claimant's hearing request concerning the propriety of cervical disc surgery; and (2) set aside its partial denial of claimant's claim for a cervical disc condition. On review, the issues are jurisdiction and compensability. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's conclusions and opinion regarding this issue.

Jurisdiction

The issue is whether the ALJ had jurisdiction to review the propriety of cervical disc surgery (anterior discectomy and fusion at C4-5, C5-6 and C6-7) which was ultimately performed on March 6, 1995. Reasoning that the surgery was subsumed in the cervical disc condition claim which SAIF denied by letter dated February 1, 1995, the ALJ concluded that the surgery was disapproved based on the

formal denial of the compensability of the underlying cervical claim and, therefore, amended ORS 656.245(6)[1] did not apply to deprive the Hearings Division of jurisdiction over the surgery claim.

On review, SAIF contends that the cervical surgery was not disapproved on compensability grounds, but rather, it was disapproved by the managed care organization (MCO), Caremark Comp, because it was deemed not medically necessary or appropriate. Hence, SAIF argues, claimant was required to seek administrative review by the Director pursuant to amended ORS 656.245(6). We agree and vacate this portion of the ALJ's order.

By letter dated January 18, 1995, Caremark Comp responded to Dr. Brett's request for certification of proposed cervical disc surgery. The letter advised Dr. Brett that Caremark Comp was unable to approve the certification request because "[t]he procedure you proposed did not meet Caremark Comp's screening criteria, and therefore [was] found not to be medically necessary or appropriate given the medical information provided." (Ex. 28).

Subsequently, by letter dated February 1, 1995, SAIF advised claimant that it was denying treatment and disability relating to seven enumerated cervical conditions because they were preexisting conditions and unrelated to either the accepted September 1994 injury or an occupational disease. (Ex. 32).

Claimant argues that the cervical surgery request was disapproved because the compensability of the underlying cervical condition was denied. However, claimant overlooks the express language of Caremark Comp's January 18, 1995 letter which disapproves the surgery request on the basis that it was not medically necessary or appropriate. Based on that letter, and our earlier conclusion that claimant's cervical condition is compensable, we find that the disapproval of surgery was for a reason "other than the denial of the compensability of the underlying claim." Thus, in accordance with amended ORS 656.245(6), jurisdiction over this medical services dispute lies with the Director, not the Board or its Hearings Division. Marilyn Y. McIntire, 47 Van Natta 1712 (1995); Walter L. Keeney, 47 Van Natta 1387 (1995).

Furthermore, amended ORS 656.260(6) provides, in part, that "[a]ny issue concerning the provision of medical services to injured workers subject to a managed care contract * * * shall be subject solely to review by the director or the director's designated representatives, or as otherwise provided in this section." SB 369, § 27 (emphasis added). We have held that this amended statute applies retroactively to MCO or "MCO-related" medical service disputes currently pending before the Board. Ronald R. Streit, 47 Van Natta 1577 (1995); Theresa G. Peterson, 47 Van Natta 1612 (1995). Inasmuch as the present dispute arose from the disapproval of proposed surgery by Caremark Comp, an MCO, we conclude that exclusive jurisdiction of this dispute lies with the Director. Accordingly, insofar as claimant's hearing request pertains to the disapproval of surgery, the request is dismissed.

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $800, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 21, 1995 is vacated in part and affirmed in part. That portion of the order that set aside SAIF's "denial" of claimant's medical services claim for cervical disc surgery is

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[1] Amended ORS 656.245(6) provides:

"If a claim for medical services is disapproved for any reason other than the formal denial of the compensability of the underlying claim and this disapproval is disputed, the injured worker, the insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or 656.327. The decision of the director is subject to the contested case review provisions of ORS 183.310 to 183.550."

The parties do not dispute that the amended statute applies to this case. See Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565 (1995).

vacated. Claimant's hearing request concerning the surgery claim is dismissed for lack of jurisdiction. The remainder of the order is affirmed. For services on Board review, claimant's counsel is awarded an assessed fee of $800, to be paid by SAIF.

Board Member Gunn dissenting in part and concurring in part.

I disagree with the majority's decision that it lacks jurisdiction to decide claimant's entitlement to medical services for the cervical disc condition. The ALJ correctly concluded that jurisdiction of the dispute was with the Hearings Division and not the Director based on SAIF's denial of the compensability of the underlying cervical claim.

After a CT scan revealed a herniation, claimant's treating physician recommended neck surgery. CareMark Comp, the MCO, refused to approve the requested surgery. SAIF subsequently issued a denial of claimant's treatment and disability relating to several cervical conditions.

The majority first errs when it defines the issue as whether we have jurisdiction to review the "propriety of cervical disc surgery." The parties simply have not parceled out the issues in such a narrow manner. Claimant's request for hearing challenged SAIF's denial, not CareMark's disapproval. At hearing, claimant's attorney stated that the medical services issue "flows from compensability." (Tr. 4). I find such evidence makes it obvious that the parties were litigating only SAIF's denial which, on its face, included treatment for the cervical condition, thus extending to the cervical surgery.

Inasmuch as CareMark's correspondence is not at issue in this proceeding, neither Marilyn Y. McIntire, supra, nor Ronald R. Streit, supra, are applicable. Rather, because SAIF formally denied the compensability of the underlying cervical condition, we have jurisdiction under ORS 656.245(6).

In summary, I think that SAIF's denial and claimant's challenge of that denial at hearing put compensability of the underlying cervical condition at issue. Thus, we have jurisdiction to address that issue. Finally, because the majority and I agree that claimant proved compensability of his condition, SAIF is liable for the surgery. Inasmuch as the majority holds differently, I dissent.

February 13, 1996 Cite as 48 Van Natta 295 (1996)

In the Matter of the Compensation of
BRIAN L. SCHMITT, Claimant
WCB Case No. 94-10599
ORDER ON REVIEW
Black, et al, Claimant Attorneys
Cowling, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) McCullough's order that: (1) found that claimant timely requested a hearing from a December 31, 1991 Order on Reconsideration; and (2) set aside a September 30, 1991 Notice of Closure and the Order on Reconsideration as premature. In its brief, the insurer challenges the validity of claimant's hearing request. On review, the issues are timeliness, validity of the hearing request, and premature closure.

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

Timeliness of Request for Hearing

A copy of claimant's January 6, 1992 request for hearing from the September 30, 1991 Notice of Closure and December 31, 1991 Order on Reconsideration was received by the Board on September 6, 1994. At the time, former ORS 656.319(4) required that a hearing request from a Notice of Closure or Determination Order be filed within 180 days of the closure notice or order (excluding the time tolled by claimant's request for reconsideration of the Notice of Closure). Former ORS 656.268(6)(b); Nowak v. SAIF, 121 Or App 563 (1993). Claimant's request for hearing was not mailed by registered or certified

mail. Accordingly, the filing of the hearing request is presumed to be untimely. See former OAR 438-005-0046(1)(b). However, this presumption of untimeliness may be rebutted if the filing party establishes that the mailing was timely. See Richard S. Olson, 43 Van Natta 657 (1991).

Based on: (1) the receipt by the insurer of a copy of claimant's January 6, 1992 request for hearing on January 9, 1992 (within the 180-day filing period); and (2) evidence concerning claimant's counsel's customary procedure of mailing the original request for hearing to the Board and a copy to the opposing party on the same date they are prepared, the ALJ found the factual circumstances sufficient to overcome the presumption of untimeliness set forth in OAR 438-005-0046(1)(b). The ALJ concluded, therefore, that claimant had timely filed his request for hearing. We agree.

We distinguish the circumstances of this case from those presented in Barry A. Howarth, 39 Van Natta 281 (1987). In Howarth, the critical issue was whether an insurer had received actual notice of a claimant's request for Board review within the statutory period. The claimant's request was not mailed by registered or certified mail nor was an acknowledgment of service or certificate of personal service by mail provided with the request.

We found that a computer-generated letter from the Board acknowledging the claimant's request for review was the insurer's first notice that the claimant had filed a request for review. There was no contention that the insurer had received actual notice of the claimant's request for Board review within the statutory period. Rather, the claimant's attorney asserted only that it was his office's policy to send copies of all correspondence to all interested parties. Other than that representation, the claimant provided no evidence to support his contention that a copy of the request for Board review had been timely provided to the insurer. On that "sparse evidence," we were unable to conclude that the claimant had timely complied with the statutory notice requirements. 39 Van Natta at 282.

Here, by contrast, in addition to the undisputed stipulation concerning claimant's counsel's office's policy of mailing the original request for hearing to the Board and a copy to the opposing parties on the same date they are prepared, there is no dispute the insurer received actual notice of claimant's request for Board review within the statutory period. Indeed, the insurer concedes that it received a copy of claimant's January 6, 1992 request for hearing on January 9, 1992. In light of such circumstances, we too are persuaded that claimant's counsel mailed the January 6, 1992 request for hearing to the Board between January 6, 1992 and January 9, 1992. Accordingly, we conclude, distinguishing Howarth, that claimant in this case has overcome the presumption of untimeliness and, therefore, the hearing request was timely filed.

Validity of Request for Hearing

Claimant requested reconsideration from the insurer's Notice of Closure, identifying the issues for resolution as premature closure and extent of permanent partial disability. After the Order on Reconsideration affirmed the Notice of Closure, claimant requested a hearing, raising as the sole issue, premature claim closure. At the first hearing, claimant identified the issue as premature closure, contending that his claim should remain open. The insurer did not dispute claimant's statement. The insurer, however, moved to dismiss claimant's request for hearing as untimely. A prior ALJ granted claimant's motion for postponement. At the second hearing, the parties agreed with the ALJ's statement that timeliness was a threshold issue, while the sole issue on the merits was premature closure. The insurer did not otherwise challenge claimant's request for hearing.

On review, the insurer first contends that claimant's hearing request is invalid on its face because it was not signed by either claimant or his attorney. See ORS 656.283(3); OAR 438-005-0070. As the insurer did not raise this challenge at hearing, we are not inclined to consider it on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (Board will not review issues which were not raised at hearing). Nevertheless, even if we considered the contention, it would be rejected since the cover letter which accompanied the hearing request was from an employee of claimant's attorney's firm, i.e., on claimant's "behalf."

Citing amended ORS 656.268(8) (which provides that "no hearing shall be held on any issue that was not raised or preserved before the Department at reconsideration)," the insurer next argues that claimant is somehow precluded from pressing his claim. Enclosing a photocopy of claimant's request for

reconsideration (a document which was not submitted for admission into the record at hearing), the insurer notes that, although claimant checked the box on the request for reconsideration form concerning premature closure, he premised his premature closure challenge on the contention that his wrist condition has never become medically stationary. Consequently, inasmuch as claimant did not also check the box concerning medically stationary date, the insurer contends that he cannot request review of the medically stationary date.

Inasmuch as this form was not presented for admission as evidence at the hearing and since it is unclear whether this form was part of the Director's reconsideration record, questions arise regarding whether the reconsideration form can be considered. See ORS 656.283(7); ORS 656.295(5). Nevertheless, we need not resolve those questions because, even if we considered the request for reconsideration form, we would reject the insurer's contention.

As noted, claimant's sole contention is that his claim was closed prematurely, viz., that his condition has never become medically stationary. Claimant does not seek to establish a later medically stationary date but, rather, to establish that his claim should remain in open status. Consequently, we are persuaded that claimant raised the issue of premature closure during the reconsideration proceeding as well as at the hearing.

Premature Closure

The ALJ found that, at the time of claim closure, there was a reasonable expectation of further material improvement of claimant's compensable right wrist condition with treatment. The ALJ concluded, therefore, that claimant was not medically stationary as of the September 1991 Notice of Closure. Again, we agree.

The insurer contends that further treatment is not expected to improve claimant's compensable condition but, rather, only to reduce claimant's pain. Therefore, because further treatment is not intended to improve the function of claimant's wrist, the insurer argues that his condition was medically stationary at claim closure. See Bill H. Davis, 45 Van Natta 773 (1993) (a physician's recommendation of a pain management program is not sufficient to establish premature closure); Diane L. Hoyt, 46 Van Natta 424 (1994) (a physician's recommendation of physical therapy was held not sufficient to establish premature closure).

As did the ALJ, we find persuasive the testimony of Dr. Appleby, claimant's treating hand surgeon, that further treatment will ameliorate claimant's pain, which in turn will improve claimant's level of functioning by increasing his strength and ability to work. We conclude, therefore, that further treatment is expected to materially improve claimant's compensable wrist condition.

In sum, for the reasons stated in the ALJ's order, as supplemented herein, we agree that claimant's claim was prematurely closed. Accordingly, we affirm the ALJ's order setting aside the Order on Reconsideration.

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

ORDER

The ALJ's order dated June 13, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
KEVIN P. SILVEIRA, Claimant
WCB Case No. 91-05623
SECOND ORDER ON REMAND
Coughlin, et al, Claimant Attorneys
Thomas Castle (Saif), Defense Attorney

Claimant requests reconsideration of that portion of our December 11, 1995 Order on Remand that awarded a $3,500 insurer-paid attorney fee for claimant's counsel's services before the court and before the Board on review and remand. Submitting an affidavit and time records from his counsel, claimant asks that our $3,500 attorney fee award be increased.

In order to further consider claimant's motion, we withdrew our December 11, 1995 order. SAIF was granted an opportunity to respond. Having received SAIF's response and considered the parties' arguments and the record, we now proceed with our reconsideration.

On reconsideration, claimant requests that the assessed fee for all levels of review be increased to $9,112 based on his statement of services. SAIF contests claimant's request, challenging claimant's counsel's hourly rate.

In determining a reasonable attorney fee award, we consider the factors set forth in OAR 438-015-0010(4). Those factors include: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the 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.

Neither party challenges the ALJ's attorney fee award of $2,200 for services at hearing which we affirmed in our Order on Remand. After considering the factors set forth in OAR 438-015-0010(4), we continue to find that award to be reasonable. We turn to an evaluation of the record for purposes of determining a reasonable attorney fee award for claimant's counsel's services before the Board on review, before the Court of Appeals, and before the Board on remand.

As demonstrated by the number of appellate decisions (culminating in our Order on Remand), the compensability issue presented a complex legal question. In light of such circumstances, the risk that claimant's counsel might go uncompensated was high. On the other hand, the medical question regarding the causal relationship between claimant's work activities and his condition was less complex than most medical service disputes presented for Board resolution. The value to claimant of the interest, as well as the benefit secured (in the form of a compensable low back condition) are similar to those in cases which the Board normally confronts. Claimant's appellate briefs establish that his arguments were presented in an articulate and skillful manner.

After considering the factors set forth in OAR 438-015-0010(4), we find that a reasonable assessed attorney fee for claimant's counsel's services before the Board on review/remand and the court is $7,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the nature of the proceedings, the complexity of the issues, the benefit secured by claimant, the time devoted to the case (as represented by the record and claimant's appellate briefs), and the risk that claimant's counsel might go uncompensated. In addition, we note that claimant is not entitled to an attorney fees for services devoted to obtaining an attorney fee award. See Amador Mendez, 44 Van Natta 736 (1992).

Accordingly, on reconsideration, as supplemented and modified herein, we republish our December 11, 1995 order. For services before the Board and before the Court of Appeals (in lieu of our prior attorney fee award for those services), claimant's attorney is awarded $7,500, also payable by SAIF.[1] (This fee is in addition to the ALJ's $2,200 award). The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

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[1] We note that claimant was represented by an attorney at hearing, who subsequently associated with a second attorney to represent claimant before the Board and the Court of Appeals. Thus, it would appear that each of the attorneys is entitled to a share of the attorney fee award. Nevertheless, SAIF is required to pay the entire award to claimant's current attorney of record. Thereafter, the manner in which the fee is shared by claimant's two attorneys is a matter to be decided among them, not this forum. Gabriel Zapata, 46 Van Natta 403 (1994); Fred L. Snider, 43 Van Natta 577 (1991).

In the Matter of the Compensation of
NENITA STOCKIE, Claimant
WCB Case No. 95-01830
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) declined to award temporary disability benefits for the period beginning August 29, 1994; and (2) declined to assess a penalty for the insurer's allegedly unreasonable failure to pay those benefits. On review, the issues are temporary disability and penalties.

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

On review, claimant concedes that whatever entitlement she had to temporary disability compensation ended when Dr. Marie released her to return to regular work as of May 16, 1994 (see Ex. 4). (Appellant's Brief, pp. 5, 7). However, she argues that she subsequently became entitled to temporary disability benefits on August 29, 1994, based on a "Form 827" filled out by Mr. Blaker, Dr. Bolz' physician's assistant, or on Dr. Lundquist's subsequent opinions regarding claimant's work capabilities and limitations. We disagree.

Claimant was not entitled to temporary disability compensation when she quit her job on May 18, 1994, for two reasons. First, as we have previously noted, claimant concedes that her prior entitlement to temporary disability benefits ended when she was released to her regular work as of May 16, 1994. See ORS 656.268(3)(b). Second, because claimant quit her job for reasons unrelated to her compensable condition, her prior entitlement would have ended when she stopped working (on May 18, 1994). We base these conclusions on the following reasoning.

A worker whose temporary disability has been properly terminated becomes procedurally entitled to resumption of temporary total disability payments if, prior to claim closure, the attending physician again authorizes time loss. See Rodgers v. Weyerhaeuser Company, 88 Or App 458, 460 (1987); Robert D. Gudge, 42 Van Natta 812, 814 (1990). In other words, since claimant acknowledges that she was released to regular work on May 16, 1994 (thereby authorizing termination of temporary disability), her entitlement to temporary disability benefits for periods after she quit working (for reasons unrelated to her compensable condition) depends on whether she was subsequently disabled as a result of her compensable injury. See Gray v. SAIF, 70 Or App 313 (1984). However, only an attending physician can authorize payment of temporary disability compensation. ORS 656.245(2)(b)(B) (formerly 656.245(3)(b)(B)); see First Interstate v. Morris, 132 Or App 98 (1994); Food Services of America v. Ewen, 130 Or App 297 (1994). An attending physician may not delegate "time loss" authority. See Francisco I. Delacerda, 46 Van Natta 1021 (1994). Moreover, even if such responsibility could be delegated, we would agree with the ALJ that this record does not reveal that time loss was authorized by anyone for any time period after claimant quit her job.

Alternatively, even if claimant had only returned to modified work (and was not released to regular work), her temporary partial disability benefits were properly computed at "zero," because her return-to-work wages were the same as her at-injury wages. See ORS 656.210(2)(b)(A); Lonnie L. Dysinger, 47 Van Natta 2282 (1995). Accordingly, although claimant would have been entitled to temporary partial disability when she left her return-to-work job (for reasons unrelated to her injury[1]), the amount would have been zero. See Vincent L. Thompson, 42 Van Natta 1921 (1990); 41 Van Natta 1821 (1989); compare Carmen Gusman, 42 Van Natta 425 (1990).

Under these circumstances, we agree with the ALJ that claimant has not established entitlement to temporary disability benefits (total or partial) for the period beginning August 29, 1994.

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[1] Dr. Lundquist's opinion regarding claimant's work limitations and capabilities establishes that claimant was physically able to perform the modified work which she had been performing when she quit her job. We agree with the ALJ's finding that this job remained available to claimant after she stopped working.

ORDER

The ALJ's order dated May 30, 1995 is affirmed.

February 13, 1996 Cite as 48 Van Natta 300 (1996)

In the Matter of the Compensation of
PATRICK M. WILSON, Claimant
WCB Case No. 94-02443
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its partial denial of claimant's claim for asthma. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Relying on the opinion of Dr. Morton, the ALJ found that claimant had work-related asthma. The ALJ, however, found claimant's sleep apnea not compensable. The insurer contends that claimant failed to prove, based on objective findings, that he has asthma. We disagree.

Claimant need not prove a specific diagnosis in order to establish compensability, if he shows that his respiratory symptoms, whether diagnosed as asthma or hypersensitivity pneumonitis, are related to his accepted respiratory condition. Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988); Aaron D. Harris, 46 Van Natta 2229, 2230 (1994). We find that claimant's current respiratory condition (excluding sleep apnea) is the same condition accepted by the insurer, even though different diagnoses have been used to describe his condition. See Leslie C. Muto, 46 Van Natta 1685 (1994) (despite differing diagnoses, there was no medical evidence that the claimant sought treatment for a new or different condition). We base this conclusion on the following reasoning.

Claimant sought treatment in May 1990 for shortness of breath from breathing bark dust at work. Claimant's treating doctor, Dr. Counts, diagnosed bronchitis and referred him to Dr. Vitums for pulmonary function testing, which was normal.

Dr. Morton examined claimant in June 1990 and opined that claimant had occupational asthma related to his exposure to bark dust. Dr. Morton noted that claimant had a particular intolerance to alder bark dust and chainsaw exhaust fumes, but that claimant had also become sensitive to other irritant fumes. He diagnosed claimant's condition as occupational asthma. (Exs. 4, 5).

On September 13, 1990, Dr. Montanaro performed immunological studies and diagnosed hypersensitivity pneumonitis caused by claimant's exposure to moldy conditions at work. Dr. Montanaro reported that, because of claimant's allergen precipitating antibodies, claimant was at risk of experiencing a recurrence of his condition if he was exposed to similar moldy conditions. (Exs. 7, 11).

The insurer accepted claimant's claim for hypersensitivity pneumonitis as an occupational disease. Claimant's claim was closed on December 12, 1990 with an award of unscheduled permanent disability.

Claimant's respiratory complaints (shortness of breath, cough and wheezing) have been fairly consistent since he first sought treatment. As both Drs. Counts and Montanaro expected, claimant experienced recurrent symptoms when he was exposed to irritants. However, spirometry and methacholine challenge testing were not performed when claimant experienced these acute flare-ups.

Dr. Ironside examined claimant in April 1993 at the insurer's request. Dr. Ironside felt that Dr. Montanaro's diagnosis of hypersensitivity pneumonitis was tenuous and also felt that there was no objective laboratory evidence to support Dr. Morton's diagnosis of asthma. Dr. Ironside opined that if claimant had hypersensitivity pneumonitis, it had very little impact on claimant's current symptoms. Dr. Ironside suspected that claimant's respiratory problems were due to obstructive sleep apnea and possible esophageal reflux. He did not believe that these conditions were work related. (Exs. 28, 41). Dr. Ironside recommended a sleep study. Dr. Gabr performed the sleep evaluation and felt that claimant's history was consistent with obstructive sleep apnea syndrome with progressive symptomatology. Claimant's obstructive sleep apnea was partially corrected with application of a nasal C-PAP.

Based upon Dr. Ironside's report, the insurer issued a partial denial of claimant's asthma and sleep apnea. Claimant requested a hearing challenging the denial.

Dr. Ironside's conclusion that claimant's problems are not work-related is largely based on his belief that claimant does not have asthma. However, because claimant need not establish a specific or certain diagnosis in order to have a compensable claim, Dr. Ironside's opinion does not weigh against the claim. See Tripp v. Ridge Runner Timber Services, supra; Rita C. Shambow, 46 Van Natta 1174 (1994). In addition, Dr. Morton disagreed that claimant's problems were entirely due to sleep apnea because Dr. Ironside failed to account for claimant's daytime pulmonary intolerance to smoke and dust and because claimant did not experience relief from C-PAP use. (Ex. 49). We find Dr. Morton's opinion persuasive because it is both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

Based on our review of the medical evidence, (particularly Dr. Morton's opinion), we conclude that claimant's current respiratory condition is the same condition since the original claim acceptance, whether or not diagnosed as hypersensitivity pneumonitis or asthma.

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

ORDER

The ALJ's July 21, 1995 order is affirmed. For services on review, claimant's attorney is awarded $1,000 attorney fee to be paid by the insurer.

February 14, 1996 Cite as 48 Van Natta 301 (1996)

In the Matter of the Compensation of
DAVID M. FIVECOATS, Claimant
WCB Case No. 94-06523
ORDER ON REVIEW
Frank J. Susak, Claimant Attorney
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Balasubramani's order that: (1) upheld the self-insured employer's denial of claimant's cervical conditions; and (2) declined to assess a penalty for the employer's allegedly unreasonable claim processing. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

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

After reviewing Dr. Johnson's medical report, Dr. Grewe, treating surgeon, concluded that claimant's work injury was the major contributing cause of his need for medical treatment. (Ex. 27). Grewe acknowledged that claimant's cervical stenosis probably was a preexisting congenital condition. (Id. at 1).

CONCLUSIONS OF LAW AND OPINION

Concluding that no medical opinion considered claimant's preexisting cervical conditions and supported compensability of claimant's current cervical condition, the ALJ held that claimant's claim failed. Claimant asserts that, in light of Dr. Grewe's final medical report, the ALJ erred. We disagree.

The parties do not dispute that this claim is governed by ORS 656.005(7)(a)(B).[1] Under that statute, claimant must establish that his February 24, 1994 work injury was the major contributing cause of his disability or need for treatment. Claimant relies on Dr. Grewe's reports. On this record, we conclude that those reports do not meet claimant's burden of proof.

Claimant has had a long history of neck problems requiring treatment since 1978, when claimant was diagnosed with cervical spondylosis with anterior osteophytosis at C4-5 and C5-6. (Ex. D-2). After a work injury on February 24, 1994, claimant experienced increased neck symptoms. Claimant did not, however, seek treatment for those symptoms until March 22, 1994. (Ex. 3). On April 7, 1994, claimant consulted Dr. Grewe, who diagnosed cervical myeloradiculopathy with severe stenosis at C4-C5, secondary to osteophytic disease in combination with a disc herniation. (Ex. 10-3). Grewe recommended emergent decompression. (Id.) He performed a disc removal and fusion two days later. (Ex. 16-1).

The parties dispute the cause of claimant's need for surgery. Dr. Johnson, who had performed a myelogram on claimant in 1978 and examined him in August 1994, first concluded that claimant's current symptoms were related to the February 1994 injury. (Ex. 25-3). After considering claimant's history of neck problems since 1978, however, Johnson changed his opinion, concluding that it was unlikely that claimant's work injury had caused the disc herniation. (Ex. 26). In reaching that conclusion, Johnson noted that claimant's disc herniation could be due to the injury, to a natural progression of his spinal stenosis or to spontaneous factors. (Id. at 2). Johnson also determined that claimant's ability to continue working for several weeks after the February incident militated against compensability. (Id.)

After reviewing his initial report and Dr. Johnson's reports, Dr. Grewe issued a final opinion. He concluded that, based on claimant's history and sudden onset of symptoms after the February 24 incident, the work injury was the major contributing cause of his need for medical treatment. (Ex. 27-1). Grewe acknowledged that claimant's cervical stenosis was probably a preexisting congenital condition. (Id.)

Although we would ordinarily defer to Dr. Grewe as the treating surgeon, here, we find compelling reasons not to. First, we are not convinced that Dr. Grewe was aware of the extent of claimant's neck problems before February 24, 1995; there is no persuasive evidence that Grewe reviewed claimant's medical records from 1978 forward. Second, Dr. Grewe never addresses the significance of claimant's one-month delay in seeking treatment for what turned out to be an emergent cervical disc herniation. In view of Dr. Johnson's final report, which states that claimant's failure to seek treatment quickly weighed against the disc herniation being work-related, we find that Dr. Grewe's failure to address that issue renders his opinion unpersuasive. Last, although he acknowledges that claimant's cervical stenosis was probably a preexisting congenital condition, Grewe does not analyze the role that condition played in claimant's need for surgery.

For all these reasons, we agree with the ALJ that claimant has failed to establish the compensability of his cervical conditions. Consequently, we affirm the ALJ's decision upholding the employer's denial of those conditions. Because we reach that conclusion, we do not address the penalty issue.

ORDER

The ALJ's order dated May 5, 1995 is affirmed.

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[1] The Legislature recently amended that statute. Or Laws 1995, ch 332, § 1. Those amendments are not relevant here.

Board Member Gunn dissenting.

By mischaracterizing the medical evidence, the majority concludes that claimant has failed to establish the compensability of his cervical conditions. Specifically, the majority finds fault with Dr. Grewe, treating surgeon, for: (1) not being aware of the extent of claimant's preexisting neck problems before February 24, 1995, the date of claimant's work injury; (2) failing to address claimant's one-month delay in seeking medical treatment for his current cervical condition; and (3) failing to analyze the role that claimant's preexisting condition played in his current condition. Because I read that evidence otherwise, I dissent.

First, Dr. Grewe was sufficiently aware of claimant's preexisting neck condition to conclude that it was likely a preexisting congenital disorder. That is, in my view, enough to establish that Grewe was aware of the extent of that disorder well before February 24, 1995.

Second, Dr. Grewe diagnosed claimant's current cervical disc herniation and recommended emergency surgery, which Grewe eventually performed. Then, notwithstanding claimant's one-month delay in seeking treatment, Grewe concluded that the herniation was work-related. In contrast, Dr. Johnson, treating physician, concluded that claimant's delay in seeking treatment suggests that there was no connection between claimant's work and his herniation. For reasons that I cannot fathom, the majority sides with Johnson. I find no persuasive reason for giving more weight to Dr. Johnson's reports. Rather, I would conclude that, as the treating surgeon, Dr. Grewe is entitled to more deference. Consequently, I would give his reports greater weight.

Last, in my view, Dr. Grewe's conclusion that claimant's current cervical conditions are work-related reflects, at least implicitly, Grewe's belief that the preexisting neck condition is less than the major contributing cause of claimant's current cervical conditions. That is a sufficient analysis of the role of claimant's preexisting condition vis-a-vis his current cervical conditions.

In sum, for these reasons, I disagree with the majority's conclusion that claimant has failed to establish the compensability of his current cervical conditions. Before closing, however, I wish to express what is, perhaps, my greatest dissatisfaction with this case: It is part of a disturbing trend in which this Board has, without any statutory or case law foundation, steadily increased the burden of proof imposed on injured workers. During the past several years, the Board's analysis has become more and more exacting, thus ensuring that virtually no injured worker will ever receive any of the compensation to which he or she may be due. Because that analysis has, in my view, no legal foundation and is contrary to the general policies underlying the workers' compensation system, see ORS 656.012, and because I disagree with the majority's hypercritical reasoning in this particular case, I dissent.

February 14, 1996 Cite as 48 Van Natta 303 (1996)

In the Matter of the Compensation of
JAMES D. JOHNSON, Claimant
WCB Case No. 94-05835
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Roberts, et al, Defense Attorney

Reviewed by Board Members Neidig, Christian and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Nichols' order that: (1) upheld the insurer's denial of claimant's left knee injury claim; and (2) declined to assess penalties and attorney fees for the allegedly unreasonable denial of that claim. On review, the issues are compensability, penalties, and attorney fees.

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

While taking a step at work on the level floor of the plant, claimant's left knee buckled with a popping feeling. There was no evidence that claimant slipped, twisted, or tripped over anything on the floor. Subsequently, claimant was diagnosed with a left medial meniscus tear.

At hearing and on review, claimant relies on Hubble v. SAIF, 56 Or App 154 (1982), to support compensability of his left knee injury claim. However, Hubble was decided before the enactment of ORS 656.266. We agree with the ALJ that ORS 656.266 requires that claimant do more than rule out idiopathic or other non-work causes of his injury; it requires that claimant affirmatively prove that his injury was, in fact, related to his working environment. Ruben G. Rothe, 45 Van Natta 369 (1993). We also agree with the ALJ that, on this record, claimant has failed to meet that burden of proof.

In addition, in Hubble, the claimant presented medical evidence that walking was a cause of torn knee cartilage and his job required extensive walking. Even if we agree with claimant's argument that his job required regular walking, climbing, and kneeling activities, there is no medical evidence that these activities contributed to claimant's left knee condition. In this regard, neither Dr. Gambee, examining orthopedist, nor Dr. Carlsen, treating orthopedist, explained the contribution, if any, of the work environment to claimant's injury. (Exs. 4-4, 15). Instead, they simply concluded that the injury was work-related because it occurred while claimant took a step at work.

Specifically, Dr. Gambee stated that "by description certainly the January 18, 1994 injury would appear to be the most likely cause of [claimant's] problem." (Ex. 4-4). Dr. Carlsen initially stated that claimant "didn't really have an injury. He was standing and talking to somebody. He went to take a step and his knee gave out on him. Again, there was nothing antecedent and no significant injury." (Ex. 5-1). Dr. Carlsen later stated that "I know of no preexisting problems with [claimant's] left knee and feel that the major contributing cause for treatment was his January 18, 1994, accident, which I believe occurred at work." (Ex. 15). The reference to the January 18, 1994 "injury/accident" in both Gambee's and Carlsen's reports is to the step claimant took at work when his knee gave out. Without some explanation of a work-connection other than the fact that the step occurred at work, claimant has not proved the requisite causal connection between his injury and the work activity.

In this regard, we find Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), on remand 46 Van Natta 999 (1994), analogous. In Gilmore, the Supreme Court re-examined the work-connection standard under ORS 656.005(7)(a) and clarified the proper analytical framework. The Court reiterated that, to establish the compensability of an injury, the claimant must show that the injury: (1) occurred in "in the course of employment," which concerns the time, place and circumstances of the injury; and (2) "arose out of employment," which concerns the causal connection between the injury and the employment. Id. at 366. As the Court explained, neither element is dispositive; rather, one must consider "all the circumstances" to determine if the claimant has satisfied the work-connection test. Id. at 366, 369.

Quoting Phil A. Livesley Co. v. Russ, 296 Or 25, 29 (1983), the Gilmore Court noted that an "employer * * * is not liable for any and all injuries to its employe[es] irrespective of their cause, and the fact that an employe[e] is injured on the premises during working hours does not of itself establish a compensable injury. The employe[e] must show a causal link between the occurrence of the injury and a risk connected with his or her employment." Gilmore at 368.

In Gilmore, the claimant injured his knee as he entered his car, which was parked in the employer's parking lot. The claimant did not slip on ice in the parking lot or step in a pothole, his knee simply "locked up" as he was sliding into the driver's seat. The Court found that the course of employment element was met under the "parking lot rule" because the claimant's injury occurred on the employer's premises. However, the Court remanded the case to the Board to determine whether there was a sufficient causal connection between the claimant's employment and the injury to satisfy the "arising out of employment" element.

On remand, we found that other than the mere fact that the claimant's injury occurred on the employer's premises, there was no other "risk" connected with his employment. 46 Van Natta 1000. Therefore, we concluded that the claimant's injury did not result from an act which was an ordinary risk of, or incidental to, his employment and, thus, did not "arise out of" his employment. Id.

Here, the course of employment element is met because claimant's injury occurred on the employer's premises during working hours. However, like Gilmore, there is no evidence of the requisite causal connection to satisfy the "arising out of employment" element. Claimant did not stumble or trip over anything on the plant floor. Instead, his knee went out as he was taking a step. Furthermore, the medical evidence established no causal connection other than the fact that claimant's

knee went out at work, which is insufficient to meet claimant's burden. Gilmore, supra. Consequently, we agree with the ALJ that claimant has failed to establish a sufficient causal connection between his employment and the injury to justify compensability.

ORDER

The ALJ's order dated April 24, 1995, as amended April 26, 1995, is affirmed.

Board Chair Hall dissenting.

I agree with the majority that claimant's injury occurred within the course of his employment because it happened on the work site. However, the majority also concludes that claimant failed to establish that the injury arose out of his employment, i.e., claimant failed to establish the requisite causal connection between the injury and the work environment. Because I find that claimant established that his injury arose out of his employment and, therefore, established that his left knee injury is compensable, I must respectfully dissent.

To establish a compensable injury, a worker must prove that his injury arose out of and in the course of employment. ORS 656.005(7)(a); Norpac Foods v. Gilmore, 318 Or 363 (1994). The first prong of the inquiry is whether the injury occurred in the course of employment, which concerns the time, place and circumstances of the injury. The second prong is whether the injury arose out of the employment, that is, whether a causal connection existed between the injury and the employment. Id. In assessing the compensability of an injury, the work-connection of both elements must be evaluated; neither is dispositive. Claimant has the burden of proving that an injury is compensable. ORS 656.266.

While acknowledging that claimant's injury occurred in the course of his employment in its summary of the facts of this case, the insurer also argues that claimant had not yet returned to work at the time he was injured. I find that the undisputed testimony of claimant and coworker Mr. Wisecarver establish that claimant had returned to work at the time of his injury. (Tr. 6-7, 19, 20, 21, 32). Specifically, although there are some minor discrepancies between the testimony of claimant and Mr. Wisecarver, they both testified that they met at the parts bin after break to get supplies for work. Although Mr. Wisecarver did not remember what they discussed at that time, claimant testified that he responded to Mr. Wisecarver's inquiry about how to install a "marine plug" in a motor home. (Tr. 10, 19). Both testified that claimant's left knee "popped" when claimant took a step to return to work. (Tr. 6-7, 19-21). On this record, I find that claimant's injury occurred at the work site while claimant was on duty. Thus, claimant has established that his injury occurred in the course of employment.

Based on the following reasoning, I also find that claimant has established that his injury arose out of his employment. Claimant's undisputed testimony is that his work installing the "front cap," windshield, and related devices on motor homes required walking, climbing, and kneeling. (Tr. 17, 18, 20, 21, 32-33). Furthermore, the medical evidence establishes that claimant's left knee injury was caused by the January 18, 1994 walking incident at work.

The medical causation opinions are provided by Dr. Gambee, examining orthopedist, and Dr. Carlsen, treating orthopedist. Both identified the January 18, 1994 walking injury as the major cause of claimant's left knee injury. (Exs. 4-4, 15). It is important to note that this is not a case involving an idiopathic cause, i.e., a cause "peculiar to the individual." Neither Dr. Gambee nor Dr. Carlsen identified any preexisting conditions or problems with claimant's left knee. More to the point, here, the cause of claimant's left knee injury is known; it was caused by claimant's taking that step at work on January 18, 1994. (Exs. 4-4, 15).

Here, claimant's job requires walking and the undisputed medical evidence establishes that the cause of his left knee injury was the walking at work, i.e., taking a specific step at work. As the court held in Folkenberg v. SAIF, 69 Or App 159, 165 (1984), "[w]here a specific work activity, whether isolated or repetitive, is a part of a claimant's job, the risk of injury from that activity is a risk of that job." Here, as in Folkenberg, the evidence establishes that walking was part of claimant's job. Therefore, the risk of injury from that walking was a risk of the job. It is this risk (along with the medical evidence regarding the cause of the injury) that establishes the necessary causal connection between claimant's injury and his employment.

On this record, I find that claimant has met his burden of proving that his injury arose out of and in the course of employment. ORS 656.005(7)(a); Norpac Foods v. Gilmore, supra.

February 14, 1996 Cite as 48 Van Natta 306 (1996)

In the Matter of the Compensation of
PAUL J. LA FRANCE, Claimant
WCB Case No. C502321
ORDER DENYING RECONSIDERATION
Michael G. Balocca, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

On August 25, 1995, the Board approved the parties' Claim Disposition Agreement (CDA). Pursuant to that agreement, in consideration of the payment of a stated sum, claimant released his rights to future workers' compensation benefits, except medical services, for his compensable injury.

On January 31, 1996, we received claimant's attorney's letter seeking amendment of the previously approved CDA. On February 5, 1996, we received a letter from the insurer's counsel joining in the request. Inasmuch as the CDA has been approved in a final order, the Board regards this letter as a motion for reconsideration of the previously approved CDA. The motion for reconsideration is denied, based on the following reasoning.

In requesting reconsideration, the parties seek to incorporate language more specifically excluding a right shoulder condition from the scope of the CDA. In order to be considered, the request for reconsideration must be timely filed with the Board. OAR 438-009-0035(1), (2) (motion for reconsideration must be filed within 10 days of date of mailing of final order).

Here, the CDA was approved in a final order on August 25, 1995. The parties' letters requesting reconsideration were received by the Board on January 31, 1996 and February 5, 1996, more than 5 months after the time for requesting reconsideration expired. Accordingly, we find that the parties' motion for reconsideration was not timely filed. Therefore, the Board cannot consider the parties' motion for reconsideration.[1] See Carl E. Worley, 47 Van Natta 1636 (1995); Viola Scover, 46 Van Natta 121, 122 (1994).

IT IS SO ORDERED.

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[1] We note that there would appear to be no statutory or administrative prohibitions preventing the parties from interpreting their CDA in a particular manner or, for that matter, from reaching a separate agreement, such as a Stipulation, concerning the scope of the CDA and its application to the right shoulder condition.

In the Matter of the Compensation of
HARRY N. CRANE, Claimant
WCB Case Nos. 95-02523 & 95-00120
ORDER ON REVIEW
Neil Jackson & Associates, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Neidig and Christian.

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

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

The ALJ found that claimant had failed to prove that the major contributing cause of his psychological condition (depression) was his compensable back injury or his work activities. In so doing, the ALJ discounted the opinion of Dr. Weinstein because it was conclusory and unexplained.

On review, claimant contends that the medical reports of Drs. Weinstein and Klecan prove that his employment was that major cause of his mental condition.

To establish compensability of a stress-related mental disorder, the worker must prove that employment conditions were the major contributing cause of the mental disorder and establish its existence with medical evidence supported by objective findings. ORS 656.802(2). There must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(d).

Because Drs. Weinstein and Klecan have identified several potential causes for claimant's mental condition, we find that causation is a complex medical question, the resolution of which turns on the medical evidence. Kassahn v. Publishers Paper Co., 76 Or App 259, 263 (1986); Uris v. Compensation Dept., 247 Or 420 (1967). We rely on those medical opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986).

On February 9, 1995, Dr. Weinstein, examining psychologist, opined that claimant's work related accident, as well as stressors in his personal life were responsible for causing claimant's depression. (Ex. 39A). However, Dr. Weinstein was unsure whether claimant's work accident was the major cause of his mental condition. Id. In March 1995, Dr. Weinstein (after evaluating claimant on February 21, 1995) opined that the major contributing factor in the development of claimant's depression was his employment. (Ex. 41).

In February 1995, Dr. Klecan, psychologist, examined claimant on behalf of SAIF. Dr. Klecan opined that claimant's work activities and his anger over a forced job change (due to Measure 5 which produced budgetary constraints) were the major contributing causes of claimant's depression. (Ex. 39-19). On March 24, 1995, Dr. Klecan clarified his February 1995 opinion, stating that claimant's depression was the result of multiple stressors some work related and some not. (Ex. 43-1). As such, Dr. Klecan opined that no single factor was the major cause of claimant's depression. Id.

Here, we concur with the ALJ that Dr. Weinstein's medical opinion is unpersuasive both because it is unexplained and conclusory. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Somers v. SAIF, supra. Initially, Dr. Weinstein stated that he was unsure whether claimant's industrial accident was the major contributing factor in the development of his depression. (Ex. 39A). Subsequently, Dr. Weinstein opined that claimant's employment was the major cause of his depression. (Ex. 41). However, Dr. Weinstein offers no explanation for his "subsequent opinion" other than to state that he examined claimant again. As such, we find Dr. Weinstein's opinion conclusory and therefore, unpersuasive. See Moe v. Ceiling Systems, supra.[1] Accordingly, we cannot rely on Dr. Weinstein's conclusory and unexplained opinion to support the compensability of claimant's claim.

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[1] Further, we note that other medical reports from Dr. Weinstein which may have strengthened his opinion were not admitted into evidence.

Finally, we find that Dr. Klecan's opinion does not support claimant's burden of proof because he was unable to determine that the major cause of claimant's depression was due to claimant's compensable injury and/or his work activities. Consequently, there are no other persuasive medical opinions which support claimant's claim. ORS 656.802.[2]

ORDER

The ALJ's order dated July 31, 1995 is affirmed.

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[2] We note that there is no persuasive medical opinion which could support a conclusion that the major contributing cause of claimant's depression was his compensable injury. ORS 656.005(7)(a)(A).

In the Matter of the Compensation of
MARVIN G. CALHOUN, Claimant
WCB Case No. C5-03688
ORDER CORRECTING ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Emmons, et al, Claimant Attorneys
Kenneth P. Russell, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

On December 19, 1995 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 for the compensable injury. We disapprove the proposed disposition.

The proposed agreement provides that the accepted condition is a "Resolved adjustment disorder." (Emphasis added).

Generally, we disapprove CDAs pertaining to "resolved" conditions because such agreements can be interpreted as limiting the continuing right to medical services under ORS 656.245. See Linda K. Perini, 46 Van Natta 2349 (1994). When the parties expressly provide, however, that such language should not be interpreted as indicating that claimant has no remaining compensable condition for which to seek future medical treatment, we find the agreement is not unreasonable as a matter of law. Id.

Here, on December 28, 1995, we requested an addendum from the parties concerning the "resolved" accepted condition. Neither party responded to our request, as required by OAR 438-009-0020(4)(a). Consequently, because the parties have not provided any indication that the agreement is not intended to limit claimant's right to future medical services, we find that the proposed disposition is unreasonable as a matter of law. See Linda K. Perini, supra; OAR 438-009-0020(4)(b).

Accordingly, the proposed CDA is disapproved. The parties may move for reconsideration of the final Board order by filing a motion for reconsideration within 10 days of the date of mailing of this order. OAR 438-009-0035(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
JACK W. GEHRKE, Claimant
WCB Case Nos. 95-05317 & 95-04525
ORDER ON REVIEW
Susak, Dean & Powell, Claimant Attorneys
Wallace & Klor, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation (on behalf of Jarrell's Heating) requests review of Administrative Law Judge (ALJ) Neal's order that: (1) set aside its denial of claimant's right chest wall strain and contusion claim; and (2) upheld SAIF's denial (on behalf of Allied Mechanical Contractors) of the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We affirm the ALJ's conclusion. However, we do so based on the following reasoning.

Claimant worked as a furnace and air duct cleaner for Jarrell's Heating from October 1994 to January 28, 1995. On January 6, 1995, claimant hit his lower right ribs on a dumpster arm while attempting to clean vacuum hoses. Claimant was knocked to the ground, and experienced severe pain and shortness of breath. Claimant reported the injury to the dispatcher. Claimant did not seek medical attention or file an injury claim at that time. Although claimant continued to have pain, he worked for Jarrell's for another three weeks.

Claimant then began working as a heating and air conditioning installer for Allied Mechanical on February 14, 1995. Claimant advised Allied Mechanical that he had injured his ribs at his previous employment and could only perform limited duties while his ribs continued to heal. On February 16, 1995, claimant twisted, felt a "pop" in his right side, had spasms, difficulty breathing and was unable to move. Claimant went to the emergency room that same date.

Claimant filed claims against both employers. At hearing, the sole issue was responsibility for claimant's chest wall condition. The ALJ concluded that, because the January 1995 incident was the major contributing cause of claimant's disability and need for treatment after the February 1995 incident and the February 1995 incident merely worsened claimant's symptoms, under the last injury rule, SAIF/Jarrell's is responsible for claimant's right chest wall strain and contusion.

On review, SAIF/Jarrell's asserts that the ALJ erred in assigning it responsibility for claimant's right chest wall condition. We disagree.

Here, there is no prior accepted claim for a right chest wall condition and a determination must be made regarding the assignment of initial responsibility for that condition. Therefore, ORS 656.308(1) is not applicable. SAIF v. Yokum, 132 Or App 18 (1994) (ORS 656.308(1) does not apply to initial claim determinations); Eva R. Billings, 45 Van Natta 2142 (1993). Instead, we resort to the judicially created rules governing the initial assignment of responsibility in successive employment cases, e.g., the last injury rule (for injury claims) and the last injurious exposure rule (for occupational disease claims). See John J. Saint, 46 Van Natta 2224 (1994); Eva R. Billings, supra. Where, however, actual causation is proved with respect to a specific employment, we need not resort to those rules. See Eva R. Billings, supra; see also Runft v. SAIF, 303 Or 493, 502 (1987). Rather, we will assign responsibility to the carrier with respect to whom actual causation has been established. Eva R. Billings, supra.

The undisputed medical evidence establishes that claimant's chest wall condition resulted in major part from the January 1995 injury with SAIF/Jarrell's. Dr. Pitt, claimant's treating physician, found that the January 1995 injury was the only injury involving direct trauma to the chest. He further found that the February 1995 injury only contributed to a symptomatic worsening of claimant's chest wall condition. Dr. Pitt opined, therefore, that the January 1995 injury was the major cause of claimant disability and need for treatment after the February 1995 twisting incident.

In light of this evidence, we conclude that actual causation has been established with respect to SAIF/Jarrell's. See Ronny L. Breshears, 47 Van Natta 182 (1995). Therefore, we affirm the ALJ's decision assigning responsibility for claimant's right chest wall condition to SAIF/Jarrell's.

ORDER

The ALJ's order dated October 25, 1995 is affirmed.

February 15, 1996 Cite as 48 Van Natta 310 (1996)

In the Matter of the Compensation of
LARRY A. HARNSBERGER, Claimant
WCB Case Nos. 95-00559, 95-00335 & 95-00558
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Administrative Law Judge (ALJ) Myzak's order which: (1) set aside its denial of claimant's back condition; and (2) upheld the SAIF Corporation's responsibility denial for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact." We do not adopt her "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that responsibility for claimant's condition shifted from Liberty to SAIF. In so doing, the ALJ determined that claimant sustained a new injury while SAIF was on the risk. The ALJ then determined that the major cause of claimant's new injury was not the work accident at SAIF's insured. Therefore, the ALJ shifted responsibility for claimant's current condition back to Liberty.

On review, Liberty contends that the ALJ erred in finding that responsibility for claimant's condition shifted from SAIF to Liberty. According to Liberty, once responsibility for claimant's condition shifted, SAIF remains responsible, as long as claimant's injury (while SAIF was at risk) remains the major cause of her disability or need for treatment. We agree.

ORS 656.308(1) operates to shift responsibility from a carrier with an accepted condition to a subsequent carrier only if a worker sustains a "new compensable injury involving the same condition." (Emphasis added). See Smurfit Newsprint v. DeRosset, 118 Or App 368, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993).

Therefore, in order to shift responsibility, Liberty must show that claimant sustained a new compensable injury during his employment with SAIF's insured. E.g., SAIF v. Drews, 318 Or 1 (1993); Shelly K. Funkhouser, 47 Van Natta 126 (1995). In particular, Liberty must prove that the major contributing cause of claimant's low back condition or its worsening occurred while SAIF's insured was at risk. Id.

In December 1992, claimant sustained a compensable back injury. He underwent back surgery. Liberty accepted claimant's claim for disc herniation and back surgery. In October 1993, claimant was declared medically stationary.

In October 1994, claimant re-injured his low back. The employer was insured by SAIF at this time. Both SAIF and Liberty denied responsibility for claimant's current low back condition. (Exs. 41, 41A).

Dr. Donahoo performed a medical examination on behalf of SAIF, and stated that claimant's preexisting conditions (disc herniation and surgery) were "the major contributing cause of [claimant's] underlying back problem and residual impairment." (Ex. 40). Dr. Donahoo opined that the "episode of [October 24, 1994] did cause a temporary worsening which was [claimant's] immediate need for treatment subsequent to that date." Id.

In a deposition, Dr. Kirkpatrick explained that claimant's back surgery, associated with his 1992 compensable injury, produced scar tissue around the nerve so that it could not move. (Ex 44-16). As such, Dr. Kirkpatrick stated, "[T]he tethering of the nerve root by the scar tissue was there, but it was a minor factor compared to the actual fall that [claimant] had in October of '94." Id. Accordingly, Dr. Kirkpatrick opined that the major contributing cause of claimant's current condition was the October 24, 1994 work accident. (Exs. 43, 44-13).

Here, we find no persuasive reason not to defer to the opinion of Dr. Kirkpatrick, which supports a finding that claimant's October 24, 1994 work incident was the major contributing cause his current low back condition. See Weiland v. SAIF, 64 Or App 810 (1983). Therefore, we conclude that the major cause of claimant's current low back condition was the October 24, 1994 work incident. Consequently, responsibility for claimant's condition shifts from Liberty to SAIF. ORS 656.308. Moreover, as the insurer responsible for the most recent compensable claim for claimant's current low back condition, SAIF is also responsible for future compensable medical services and disability for the compensable low back condition. ORS 656.308(1); Bonnie J. Mead, 46 Van Natta 775, on recon 46 Van Natta 1185 (1994). In other words, in the absence of a "new compensable injury," responsibility for claimant's current low back condition rests with SAIF.

Finally, the ALJ's order divided the $1,000 attorney fee award between SAIF and Liberty. Inasmuch as we have found that SAIF is solely responsible for claimant's current low back condition, we find that SAIF is responsible for the entire $1,000 attorney fee award.

ORDER

The ALJ's order dated July 19, 1995 is reversed. Liberty's responsibility denial is reinstated and upheld. SAIF's responsibility denial is set aside and the claim is remanded to SAIF for processing according to law. In lieu of the ALJ's attorney fee award, claimant is awarded a $1,000 attorney fee, entirely payable by SAIF.

February 15, 1996 Cite as 48 Van Natta 311 (1996)

In the Matter of the Compensation of
LAVERN E. JONES, Claimant
WCB Case Nos. 95-01022, 94-07604 & 94-09490
ORDER ON REVIEW
Francesconi & Busch, Claimant Attorneys
Wallace & Klor, Defense Attorneys
Steven T. Maher, Defense Attorney
Cummins, Brown, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Liberty Northwest Insurance Corporation (Liberty) requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's "new injury" claim for claimant's low back strain condition; (2) upheld Cigna Insurance Companies' denial of claimant's aggravation claim for the same condition; (3) upheld Geisy Greer & Gunn's denial of claimant's aggravation claim for the same condition; and (4) awarded a $6,128.25 attorney fee to be paid by Liberty. On review, the issues are compensability, responsibility, and attorney fees. We modify in part and affirm in part.

FINDINGS OF FACT

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

We do not find that claimant had "very little trouble" with his back for two years before the May 20, 1994 back strain injury. (See O&O pp. 4, 6). Instead, we find that claimant had fewer back problems during the two year period before the May 20, 1994 incident than he did before that period and immediately after the 1994 strain injury.

As of October 19, 1994, the May 20, 1994 back strain injury had resolved. Thereafter, claimant's ongoing low back problems resulted from noncompensable causes.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's May 20, 1994 incident at work was the major contributing cause of his disability and need for treatment for a low back strain. In reaching this conclusion, the ALJ relied on the opinion of Dr. Wagner, treating physician. The ALJ also found that claimant's obesity, degenerative disc disease, and history of back injuries predisposed him to back symptoms and "played a greater role in claimant's recovery from the strain than in its cause." (O&O p. 6).

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

Liberty did not deny that the May 20, 1994 strain injury occurred. Instead, it denied that the strain was the major contributing cause of claimant's low back problems within weeks after the injury. (Exs. 204, 211, 219).

Claimant's counsel stated at hearing that the compensability of claimant's current condition was not before the ALJ. (Tr. 8-11). However, contrary to that assertion, Liberty's denial expressly referred to claimant's "current condition" and asserted that claimant's preexisting degenerative condition is the major contributing cause of his disability and need for treatment. (Ex. 219). Moreover, it is undisputed that claimant suffers from preexisting conditions which combined with his work-related strain to cause his disability and need for treatment for his low back after May 20, 1994. Under these circumstances, we find that the compensability of claimant's "current" condition, including his ongoing low back problems, is at issue in this case under ORS 656.005(7)(a)(B).[1] See Pedro C. Rodriguez, on recon 47 Van Natta 871 (1995) (Where the claimant's current condition is at issue, as well as his original injury, the compensability of the current condition is properly addressed); Danny B. Conner, 47 Van Natta 705 (1995) ("Combined" condition found compensable until the date that compensable injury was no longer the major contributing cause of ongoing problems); see also ORS 656.308(1).

Based on the medical evidence, we conclude, as did the ALJ, that the May 20, 1994 incident at work was the major contributing cause of claimant's proximate disability and need for treatment for a "new injury," an acute low back strain. (Exs. 210-6, 216A-7-8; 221-13, 223-6; 224-10). However, because claimant's current and ongoing low back problems are also denied, that does not end the inquiry.

Drs. Wagner and Ono, treating physicians, explained that the cause of claimant's back condition changed over time. (See Exs. 216, 221, 23). Specifically, Dr. Ono distinguished between claimant's 1994 work-related acute strain injury and his continuing problems (on and after November 20, 1994), based on the type and longevity of symptoms following the strain and on claimant's particular circumstances (including obesity and preexisting degeneration). (Exs. 221-7-9; -13-14; -21-22; -28; see Ex. 216-2). Dr. Wagner similarly differentiated between the cause of claimant's back problems before, immediately after, and months after the 1994 work injury. (See Ex. 223-6-18).

We find these opinions persuasive because they are well-reasoned and based on materially accurate information. Accordingly, based on the opinions of Drs. Wagner and Ono, we further find that by November 20, 1994, claimant's low back condition was primarily related to noncompensable causes, including obesity, degenerative disc disease, and prior noncompensable injuries. Consequently, claimant has not established that his low back condition was compensable on and after November 20, 1994. See Pedro C. Rodriguez, supra; Danny B. Conner, supra.

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[1] This conclusion is further supported by claimant's position on review that he suffered a "new temporary strain" on May 20, 1994. (Claimant's Appellant's brief, pp.2&4).

Under these circumstances, Liberty's denial of claimant's new injury claim is set aside insofar as it pertains to claimant's treatment and disability up to November 20, 1994. The denial is upheld as to disability and treatment after that date. See ORS 656.005(7)(a)(B).

Because we have partially upheld Liberty's denial, we modify the ALJ's attorney fee award as follows. 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 under ORS 656.386(1) for the "pre-November 20, 1994" compensability issue is $3,000 payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the "pre-November 20, 1994" compensability issue is $1,000, payable by Liberty. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review regarding the "post-November 20, 1994" compensability issue and the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 27, 1995 is modified in part and affirmed in part. That portion of the order that set aside Liberty Northwest Insurance Corporation's denial is modified. Liberty Northwest's denial is reinstated and upheld insofar as it denies claimant's low back condition after November 20, 1994. That portion of Liberty Northwest's denial which denied claimant's low back condition before November 20, 1994 is set aside and the claim is remanded to Liberty Northwest for processing according to law. In lieu of the ALJ's attorney fee award, claimant is awarded a $3,000 attorney fee for services at hearing, payable by Liberty. The remainder of the order is affirmed. For services on review, claimant's counsel is awarded a $1,000 attorney fee, payable by Liberty.

February 15, 1996 Cite as 48 Van Natta 313 (1996)

In the Matter of the Compensation of
RUSSELL L. LAMB, Claimant
WCB Case No. 95-01799
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order which awarded temporary total disability (TTD) benefits after December 20, 1993. On review, the issue is temporary disability.

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

The ALJ determined that claimant was not released to regular employment. In so doing, the ALJ declined to interpret the work release of Dr. Morrell, psychologist, as a return to regular employment. See ORS 656.268(3)(b). Therefore, the ALJ found that the employer did not properly terminate TTD benefits after December 20, 1993.

On review, the employer contends that the ALJ incorrectly found that Dr. Morrell did not authorize claimant to return to regular employment. Further, the employer asserts that claimant's attending physician, Dr. Naugle, concurred with Dr. Morrell's work release. As such, the employer contends that claimant was not entitled to TTD benefits subsequent to December 20, 1993.

ORS 656.268(3)(b) provides that temporary total disability benefits shall continue until "[t]he attending physician advises the worker and documents in writing that the worker is released to return to regular employment." We have previously held that the requirements of ORS 656.268(3)(b) are clear, unambiguous and specific in what is required before an employer may unilaterally terminate TTD benefits. See generally Trevor E. Shaw, 46 Van Natta 1821, 1821, on recon 46 Van Natta 2168 (1994).[1] Those requirements were not met here.

On August 18, 1993, Dr. Morrell, psychologist, recommended that claimant return to regular work (as of August 1993) subject to being professionally monitored. (Exs. 25, 27).

In January 1994 Dr. Naugle, attending physician, co-authored a report with Dr. Morrell which provided that claimant should not be returned to truck driving without a two week driver monitoring program. (Ex. 33).

We find that claimant's attending physician did not advise and document in writing that claimant was released to regular employment. We disagree with the employer's contention that the January 1994 report, co-authored by Drs. Naugle and Morrell, qualified as a return to regular employment. In fact, the physicians specifically stated that claimant "should not return to truck driving without a two week driver monitoring program." Further, assuming without so deciding that Dr. Morrell released claimant to regular employment, we would still find that the employer failed to comply with ORS 656.268(3)(b) because the statute is clear that the work release must come from claimant's attending physician. Jennifer M. Badeau, 47 Van Natta 1670 (1995). Accordingly, we conclude that the attending physician did not give claimant a written release to regular employment within the meaning of ORS 656.268(3)(b). See generally Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986).

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

ORDER

The ALJ's order dated June 21, 1995, as amended on July 5, 1995 and July 25, 1995, is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

[1] We note that ORS 656.268(3)(b) was amended by Senate Bill 369. However, because we find that claimant's attending physician did not give claimant a written release (e.g. document in writing) to work (which is required under both former and amended ORS 656.268(3)(b)), claimant would prevail under either version of the statute.

February 15, 1996 Cite as 48 Van Natta 314 (1996)

In the Matter of the Compensation of
CAROL L. LESTER, Claimant
WCB Case No. 95-02900
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order which set aside its denial of claimant's aggravation claim. On review, the issue is aggravation.

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

Claimant, a secretary, sustained a compensable low back injury on August 5, 1987, lifting a box of computer paper. After undergoing multiple low back surgeries in 1987 and 1988, her claim was closed by Determination Order in June 1990, with an award of 43 percent unscheduled permanent disability for injury to her low back and 8 percent scheduled permanent disability for loss of use or function of the right leg.

On August 7, 1993, claimant was injured in an off-the-job motor vehicle accident (MVA), which resulted in a significant exacerbation of her low back pain. Claimant eventually underwent additional surgery, consisting of lumbar laminectomies at L3-4 and L4-5, in August 1994. On January 17, 1995, the insurer denied reopening of claimant's claim on the ground that her compensable 1987 injury was not the major contributing cause of her need for surgery.

The ALJ set aside the insurer's aggravation denial and ordered it to reopen the claim. In doing so, the ALJ rejected the insurer's argument that claimant's worsening was not compensable because the major contributing cause of her worsened condition was the August 1993 off-the-job MVA. See ORS 656.273(1).[1] On review, the insurer contends that the medical evidence establishes that the intervening off-the-job accident was the major contributing cause of claimant's worsened condition. We disagree.

The ALJ found, and there is no dispute, that claimant's low back condition has pathologically worsened. Therefore, claimant has satisfied the "actual worsening" requirement of amended ORS 656.273(1). See Carmen C. Neill, 47 Van Natta 2371 (1995) (An "actual worsening," as required to prove an aggravation claim under amended ORS 656.273(1), may be established by showing either a pathological worsening of the compensable condition or by showing a symptomatic worsening in excess of waxing and waning contemplated by a prior permanent disability award). The issue in this case concerns whether claimant's off-the-job MVA was the major contributing cause of the "worsened condition." If so, then claimant's "worsening" is not compensable. ORS 656.273(1).

The insurer has the burden of proving that an injury not occurring within the course and scope of employment was the major contributing cause of the worsened condition. Fernandez v. M & M Reforestation, 124 Or App 38 (1993); Roger D. Hart, 44 Van Natta 2189 (1992), aff'd Asplundh Tree Expert Company v. Hart, 132 Or App 494 (1995). The question is not whether an off-the-job injury is the major contributing cause of the worsening (i.e., the exacerbation itself), but whether that injury is the major contributing cause of the worsened condition (i.e., the claimant's condition after the exacerbation). James M. Pumpelly, 44 Van Natta 991, aff'd mem 117 Or App 543 (1992).

With these standards in mind, we agree with the ALJ that the insurer has failed to sustain its burden of proving that claimant's off-the-job accident was the major contributing cause of claimant's worsened condition. Dr. Louie, claimant's attending surgeon, provided the most probative evidence on the causation issue.[2] Dr. Louie opined that claimant's MVA pathologically worsened claimant's low back condition. (Ex. 100-16). However, Dr. Louie, also stated that claimant's original compensable injury and subsequent surgeries in 1987 and 1988 caused joint instability in claimant's lumbar spine. (Ex. 100-9). According to Dr. Louie, "the majority of the underlying pathology and need for surgery was her [claimant's] previous injury and previous surgery." (Ex. 100-12). Dr. Louie emphasized that the "major cause" of claimant's total pathology which required surgery in 1994 was claimant's previous surgery for her compensable 1987 low back injury. (Ex. 100-26). Dr. Louie drew an analogy between this case and a building with a faulty foundation that collapses when too many people enter the building. Although the precipitating cause of the collapse was the overloaded building (the MVA in this case), the underlying or major cause of the collapse was the faulty foundation (in this case, the prior injury and previous surgeries). (Ex. 100-32).

Although the question is a close one, given Dr. Louie's opinion that the MVA caused some pathological worsening of claimant's low back condition, we, nonetheless, conclude that the insurer has

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[1] ORS 656.273(1) provides, in part: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. However, if the major contributing cause of the worsened condition is an injury not occurring within the course and scope of employment, the worsening is not compensable."

[2] Dr. Purtzer, claimant's previous neurosurgeon who also treated claimant after the MVA, submitted a "check-the-box' medical report in which he agreed that claimant's condition pathologically worsened as a result of the August 1993 MVA. (Ex. 98). However, Dr. Purtzer provided no reasoning to support this conclusion. Moreover, Dr. Purtzer agreed that Dr. Louie was in the best position to address the etiology of claimant's current complaints, as well as the contribution of the August 1993 MVA. For these reasons, we find Dr. Purtzer's "check-the-box" report of little or no assistance in resolving the causation issue.

failed to sustain its burden of proving that the MVA is the major contributing cause of claimant's "worsened condition," i.e., her condition after the August 1993 exacerbation. James M. Pumpelly, supra. We, therefore, agree that the insurer's denial should be set aside.

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

ORDER

The ALJ's order dated September 15, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, payable by the insurer.

February 15, 1996 Cite as 48 Van Natta 316 (1996)

In the Matter of the Compensation of
TINA McCURDY, Claimant
WCB Case Nos. 94-14597 & 94-13728
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

Liberty Northwest Insurance Corporation (Liberty), on behalf of Cascade Wood Products (Cascade), requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition; and (2) upheld the denial of EBI Companies (EBI), on behalf of Temp Source, Inc., of the same condition. On review, the issue is responsibility.

We adopt and affirm the ALJ's order, except for the next-to-last sentence, with the following supplementation.

The last injurious exposure rule of assignment of liability provides that where, as here, an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease.[1] See Boise Cascade Corp. v. Starbuck, 296 Or 238, 241 (1984); see also Beneficiaries of Strametz, 135 Or App 67, on recon, 138 Or App 9 (1995).

Because Cascade provided the last employment conditions which could have caused claimant's CTS, responsibility is initially assigned with Liberty, its insurer. Moreover, because Liberty/Cascade has not established that prior work exposure (with EBI's insured) was the sole cause of claimant's condition or that it was impossible for claimant's work exposure with Cascade to cause this condition, responsibility remains with Liberty/Cascade. (See Exs. 22-13, 23-10). See FMC Corporation v. Liberty Mutual Insurance Co., 70 Or App 370 (1984), clarified, 73 Or App 223 (1985).

ORDER

The ALJ's order dated August 31, 1995 is affirmed.

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[1] Liberty argues that the ALJ misapplied the last injurious exposure rule, because actual causation is established as to the earlier employer, EBI's insured. Such an argument might be persuasive where claimant proved causation as to a particular employer. Here, however, compensability is conceded. The only issue is which insurer is responsible. Under these circumstances, neither the last injurious exposure's rule of proof nor "actual causation" are determinative. See Boise Cascade Corp. v. Starbuck, supra at 243 ("The last employment providing [potentially causal] conditions is deemed proved to have caused the disease even though the claimant has not proved that the conditions of the last employment were the actual cause of the disease. . . ."); Carrie L. Smith, 47 Van Natta 115 (1995).

In the Matter of the Compensation of
PATRICIA L. McVAY, Claimant
WCB Case No. 94-15088
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

On January 19, 1996, we withdrew our December 22, 1995 order which had reinstated claimant's scheduled permanent disability awards for his right arm (19 percent) and left arm (21 percent) as granted by an Order on Reconsideration, whereas an Administrative Law Judge's (ALJ's) order had reduced both awards. We took such an action to consider claimant's request for an insurer-paid attorney fee award pursuant to ORS 656.382(2). Having received the SAIF Corporation's response and claimant's reply, we proceed with our reconsideration.

SAIF requested a hearing from an Order on Reconsideration which had granted claimant 19 percent scheduled permanent disability for loss of use or function of the right arm and 21 percent scheduled permanent disability for loss of use or function of the left arm. At hearing, claimant sought an insurer-paid attorney fee in the event that the Order on Reconsideration awards were not disallowed or reduced. See ORS 656.382(2).

When the ALJ reduced the awards to 12 percent for the right arm and 14 percent for the left arm, claimant requested Board review. On review, we reinstated the Order on Reconsideration awards for both arms. In addition, we awarded "out-of-compensation" attorney fees payable from the increased compensation created between the ALJ's permanent disability awards and our awards.

Asserting that she has successfully defended the Order on Reconsideration awards from SAIF's request for hearing, claimant seeks an insurer-paid attorney fee under ORS 656.382(2) for her counsel's services at both the hearing and on review. We conclude that claimant is entitled to such an award, but that such an award is limited to claimant's attorney's services at the hearings level. We base this conclusion on the following reasoning.

ORS 656.382(2) provides:

> "If a request for hearing, request for review, appeal or cross-appeal to the Court of Appeals or petition for review to the Supreme Court is initiated by an employer or insurer, and the [ALJ], board or court finds that the compensation awarded to a claimant should not be disallowed or reduced, the employer or insurer shall be required to pay to the claimant or the attorney of the claimant a reasonable attorney fee in an amount set by the [ALJ], board or the court for legal representation by an attorney for the claimant at and prior to the hearing, review on appeal or cross-appeal."

Here, SAIF requested a hearing, seeking reduction of the permanent disability awards granted by the Order on Reconsideration. Although SAIF was initially successful in its quest for a reduction of those awards, it has been ultimately unsuccessful by virtue of our order. Since our order replaces the ALJ's order, it necessarily follows that claimant is entitled to an insurer-paid attorney fee for her counsel's services at the hearings level. Because claimant's attorney is already receiving a fee payable from the "increased" compensation created by our modification of the ALJ's order under ORS 656.386(2) and OAR 438-015-0055(1), it likewise follows that her counsel is not entitled to an insurer-paid attorney fee for such efforts on Board review.

Any other conclusions would be contrary to the statutory and administrative rule schemes. Were we to award claimant's counsel an insurer-paid attorney fee for services on Board review, we would be granting claimant's attorney a double fee ("out-of-compensation" and insurer-paid) for services performed on Board review. Such an approach would be contrary to ORS 656.386(2) and OAR 438-015-0055(1). Likewise, were we to limit claimant's counsel's fee to an "out-of-compensation" award, claimant's attorney would not be receiving a fee for services rendered at the hearings level. Such a result would be inconsistent with ORS 656.382(2) and OAR 438-015-0065.[1]

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[1] We recognize that OAR 438-015-0065 provides that the carrier-paid attorney fee is granted should the ALJ find that claimant's compensation should not be reduced. In light of our de novo review authority under ORS 656.295(5) and (6), we do not interpret the aforementioned rule as a limitation on our ability to grant an insurer-paid attorney fee under ORS 656.382(2) particularly when, on review of the appealed ALJ's order, we have made the precise requisite findings necessary for such an award.

SAIF contends that an insurer-paid attorney fee award for claimant's counsel's services at hearing would be contrary to prior Board decisions. In particular, SAIF cites Jay A. Nero, 45 Van Natta 1082(1993), and Mauricio Estrada-Pacheco, 46 Van Natta 2350 (1994). For the following reasons, we do not consider either decision to be controlling.

In Nero, as in the present case, we reinstated permanent disability awards granted by an Order on Reconsideration, whereas an ALJ had reduced those awards. As with this case, we also granted an "out-of-compensation" attorney fee award. Turning to claimant's entitlement to "an assessed fee for services on Board review," we concluded in Nero that because the carrier had not requested Board review, claimant was not entitled to a carrier-paid attorney fee. Such a conclusion is consistent with our decision today. As in Nero, claimant's attorney fee for services rendered on Board review is limited to an "out-of-compensation" fee payable from the increased compensation created between the ALJ's order and our order.[2]

Likewise, our decision in Estrada-Pacheco, supra, is not inconsistent with today's decision. In Estrada-Pacheco, we reinstated an Order on Reconsideration permanent disability award, whereas an ALJ had eliminated the award. Without addressing the question of claimant's entitlement to an insurer-paid attorney fee, we granted an "out-of-compensation" attorney fee award. Since our decision in Estrada-Pacheco did not expressly consider the precise question posed in this order, today's decision is not contrary to the Estrada-Pacheco holding.

Having concluded that claimant's counsel is entitled to an insurer-paid attorney fee for services rendered at the hearings level, we proceed to a determination of a reasonable award. In determining an appropriate fee for claimant's attorney's services at hearing, we consider the factors set forth in OAR 438-015-0010(4). Those factors include: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the 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 file consists of 15 exhibits, one of which was generated by claimant's counsel. The hearing lasted 30 minutes, consisting of 7 pages of hearing transcript. One witness, claimant, testified at the hearing. Oral closing arguments were presented.Although no statement of services was provided to the ALJ, claimant's counsel submitted such a statement on appeal for services rendered at both the hearings level and on Board review. That statement, which seeks a total attorney fee award of $4,800, sets forth "estimated and approximate" hours for attorney services at the hearings level of 15 hours and "paralegal" / "other" services of approximately 4 hours.[3] In response, SAIF asserts that considering the brevity of the hearing, the limited exhibits, the "not complex" issue, and the experience of claimant's attorneys, a $4,800 attorney fee was not warranted.

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[2] We acknowledge that we further reasoned in Nero that, although the Order on Reconsideration had been reinstated, it had not been reinstated by the ALJ in response to the carrier's hearing request. Admittedly, such a statement could be interpreted as inconsistent with our conclusion in this order. However, we would not interpret the statement in such a manner. Of foremost importance, the precise question addressed in Nero was the claimant's entitlement to a carrier-paid attorney fee under ORS 656.382(2) for services on Board review, not at the hearings level. Thus, considering the context surrounding the statement, the reference to the carrier's hearing request must be analyzed in a manner consistent with the question of whether claimant should receive an attorney fee award for services on Board review. Because the question of claimant's counsel's entitlement to a fee under ORS 656.382(2) for services performed at the hearings level was not specifically addressed in Nero, our decision in this case is not contrary to our holding in Nero. In any event, to the extent that any of the reasoning expressed in Nero could be considered inconsistent with our decision in this case, the Nero rationale should be considered to be disavowed.

[3] "Paralegal" time generally represents a cost incurred by an attorney in pursuing a matter on behalf of a party. When viewed in such a context, these costs are not directly considered as fees paid to an attorney. See OAR 438-015-0005(6); Candace L. Spears, 47 Van Natta 2393 (1995). Nevertheless, to the extent that reference to "paralegal" time represents hours of research and investigation subject to supervision of an attorney, such efforts have been considered in evaluating a reasonable attorney fee. Candace L. Spears, supra. Of course, in light of the indirect involvement of the attorney, such services are accorded less significance than efforts directly expended by the attorney. Id. Here, we have interpreted claimant's counsel's references to "paralegal" and "other" services as time expended in research and investigation subject to the supervision of an attorney. Consistent with Spears, in determining a reasonable attorney fee, we have also accorded limited significance to such hours.

The issue in this case involved the extent of claimant's scheduled permanent disability. Such an issue presents factual and medical questions of a complexity similar to those generally submitted for Board consideration. However, unlike many "extent" cases, this case potentially involved remanding to the Director for promulgation of a temporary rule. The value of the interest to claimant is high in that the entire permanent disability award granted to her by the Order on Reconsideration is secure. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner, identifying the relevant factual and legal issues for our resolution. Finally, there was a risk that claimant's counsel's efforts in defending the Order on Reconsideration awards might have gone uncompensated.

After consideration of the aforementioned factors in conjunction with the parties' respective positions, we find that a reasonable attorney fee award for claimant's counsel's services at the hearings level in defense of the Order on Reconsideration permanent disability awards is $1,500, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services and after considering SAIF's objections to that statement), the complexity of the issue, the value of the interest involved, the nature of the proceedings, and the risk that claimant's counsel might go uncompensated. Finally, we have not considered claimant's counsel's services rendered on Board review.

Accordingly, on reconsideration, as supplemented herein, we republish our December 22, 1995 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

February 15, 1996 Cite as 48 Van Natta 319 (1996)

In the Matter of the Compensation of
BYRON L. MOORE, Claimant
WCB Case No. 95-04401
ORDER ON REVIEW
Allen, Stortz, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Gunn, Christian and Neidig.

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

We adopt and affirm the ALJ's order.

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

ORDER

The ALJ's order dated September 18, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

Board Member Neidig dissenting.

The majority has adopted and affirmed the ALJ's order which set aside the insurer's denial of claimant's right foot injury claim. Because, unlike the majority, I cannot conclude that claimant has sustained his burden of proof on medical causation, I respectfully dissent.

The record establishes that claimant has congenital or developmental preexisting conditions in his right foot which predispose him to injury, including abnormally high arches (pes cavus) and metatarsals that are angled towards the midline of the body (metatarsus adductus). These conditions shift claimant's weight to the outside of his feet and cause him to walk with a somewhat altered gait. Claimant is also overweight, at five feet eleven inches tall and about 290 pounds.

On January 5, 1995, claimant was walking on a flat floor at work when he stepped quickly to the side to avoid bumping into a co-worker. He shifted his weight onto the outside of his right foot, causing it to twist. He heard and felt a "popping" or snapping in his right foot, which was followed immediately by severe pain in the lateral aspect if his right foot. He was subsequently diagnosed with a fracture of the accessory ossicle bone of the right foot.

On July 1, 1994, six months prior to the January 5, 1995 incident, claimant twisted his foot and was diagnosed with a right foot strain with chronic mechanical foot dysfunction. Although he did not seek treatment for this strain after July 28, 1994, he continued to experience intermittent aching in his right foot.

Because the medical evidence establishes that claimant's right foot fracture results from a combination of his quick step to the side at work on January 5, 1995 and other preexisting conditions affecting his right foot, the compensability of his condition is properly analyzed under the "major contributing cause" standard set forth in amended ORS 656.005(7)(a)(B).

On this record, I would find that claimant has not met the major contributing cause standard because there is no persuasive evidence that his misstep at work on January 5, 1995 was the *primary* cause of his fractured foot. See Dietz v. Ramuda, 130 Or App 397 (1994) (determining the "major contributing cause" of an injury or disease involves evaluating the relative contribution of different causes and deciding which is the primary cause); see also McGarrah v. SAIF, 296 Or 145, 166 (1983) ("major contributing cause" means an activity or exposure or combination of activities or exposures which contributes more to causation than all other causative agents combined).

The only physician to offer a comprehensive opinion on the cause of claimant's right foot fracture was Dr. Geister.[1] In his deposition, Dr. Geister testified that the January 5, 1995 work incident was a "significant" contributing factor to the fracture itself. Dr. Geister explained, however, that in relation to the other contributing factors, the January 5 incident was really "the straw that broke the camel's back." The doctor reported that claimant's fracture was the "culmination of a process" that was set up by his preexisting foot deformities and his July 1, 1994 injury. (Ex. 23). Dr. Geister further reported that claimant's significant metatarsus adductus deformity caused a foot imbalance which tended to shift extra weight to the lateral aspect of the foot. He explained that claimant's pes cavus deformity also caused him to roll his feet to the outside when he walked, resulting in an abnormal gait. Further, claimant's obesity tended to aggravate the problem by loading more stress onto the lateral aspect of his feet. Dr. Geister acknowledged that these preexisting conditions as well as his prior strain injury were "important components" that contributed to claimant's fracture. In fact, he ultimately admitted that given the process at work before the January 5, 1995 incident, it would be difficult to identify which of the many contributing factors was the most important. (Ex. 23).

Based on Dr. Geister's report and testimony, I would find that claimant's misstep at work on January 5, 1995 was not the major contributing cause of his fractured right foot. Rather, as I read Dr. Geister's testimony, it was the combination of noncompensable preexisting conditions (the congenital abnormalities, prior injury to his right foot and obesity) that was the major cause. The January 5, 1995 misstep, on the other hand, was only the immediate or precipitating cause of the injury (i.e., "the straw that broke the camel's back"). See Dietz v. Ramuda, supra (a work incident that precipitates a condition or symptoms is not necessarily always the major cause of the condition or symptoms).

Because I believe that claimant has not established by a preponderance of the evidence that his January 5, 1995 misstep at work was the major contributing cause of his foot fracture, I respectfully dissent.

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[1] Claimant's treating physician, Dr. Neuberg, concurred with Dr. Geister's findings, and opined that claimant sustained a separate injury on January 5, 1995 and that this injury was the cause of his need for treatment. Dr. Neuberg did not address the relative causes of claimant's fracture, however.

In the Matter of the Compensation of
RAY A. NARDO, Claimant
WCB Case No. 94-12243
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Odell's order that increased claimant's unscheduled permanent disability award for a right shoulder injury from 5 percent (16 degrees), as awarded by an Order on Reconsideration, to 17 percent (54.4 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ rated claimant's impairment value as 17 percent, based on lost ranges of shoulder motion (7 percent), resection of the clavicle (5 percent) and chronic condition impairment (5 percent). In concluding that claimant was entitled to the 5 percent chronic condition award, the ALJ declined to apply the Director's rule, OAR 436-35-320(5)(a), which provides:

> "Unscheduled chronic condition impairment is considered after all other unscheduled impairment within the body area, if any, has been rated and combined under these rules. Where the total unscheduled impairment within a body area is equal to or in excess of 5%, the worker is not entitled to any unscheduled chronic condition impairment."[1]

The ALJ reasoned that, although claimant's shoulder impairment had already been rated at 5 percent (based on the clavicle resection), he was entitled to the additional 5 percent chronic condition award under the statutory criteria for rating unscheduled permanent disability. The ALJ noted that the scheduled chronic condition rule (OAR 436-35-010(6)) does not contain a similar limitation. Finding the limitation on unscheduled chronic conditions to be arbitrary, the ALJ concluded that the Director exceeded his statutory authority in promulgating OAR 436-35-320(5)(a).

On review, SAIF contends that the ALJ was bound by statute to apply the standards adopted by the Director. Alternatively, SAIF argues that the Director's promulgation of OAR 436-35-320(5)(a) did not exceed the authority delegated to him by the legislature.

Subsequent to the ALJ's order, in Gregory D. Schultz, 47 Van Natta 2265 (1995) corrected, 47 Van Natta 2297 (1995), we held that neither the Board nor the ALJ is authorized to invalidate or ignore any standard adopted by the Director for the evaluation of permanent disabilities. Rather, we held that ORS 656.283(7) and 656.295 require the Board and the ALJ to apply the standards adopted by the Director. Id. Alternatively, we held that OAR 436-35-320(5)(a) did not exceed the Director's statutory authority to provide standards pursuant to ORS 656.726(3)(f). Id.

Our holding in Schultz is controlling in this case. Hence, we conclude that the 5 percent limitation in OAR 436-35-320(5) is neither arbitrary nor inconsistent with the statutory directives under ORS 656.726(3)(f). Accordingly, we reverse the ALJ's unscheduled chronic condition award pursuant to OAR 436-35-320(5)(a).

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[1] A worker may be entitled to unscheduled chronic condition impairment where a preponderance of medical opinion establishes that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. OAR 436-35-320(5). "Body area" means the cervical/upper thoracic spine (T1-T6)/shoulders area and the lower thoracic spine (T7-T12)/low back/hips area. Id.

SAIF also contends that the ALJ erred in relying on the range-of-motion (ROM) findings by the medical arbiter, Dr. Fry, rather than the ROM findings by the attending physician, Dr. Filarski. SAIF argues that Dr. Fry used a different testing method than Dr. Filarski and that Dr. Fry's findings are unreliable because they were attributable to pain behavior. We disagree.

SAIF's first argument relies on mere speculation. Other than differences in ROM findings,[2] there is no basis for finding that Drs. Filarski and Fry used different testing methods. Lacking such a basis, we decline to speculate. Instead, we find that the differences in ROM findings reflect an actual decrease in claimant's shoulder ROM between Dr. Filarski's examination in April 1994 and Dr. Fry's examination in October 1994.

We are similarly unpersuaded by SAIF's argument that Dr. Fry's ROM findings are unreliable because they were attributable to pain behavior. As supporting evidence, SAIF points to a letter, apparently written on Dr. Fry's behalf, which states that loss of shoulder strength findings were not included in the medical arbiter's report because claimant's pain behavior rendered them invalid. (See Ex. 19). However, there is no basis for concluding that the ROM findings are also invalid. Indeed, the fact that Dr. Fry included ROM findings in his medical arbiter's report, while not including the loss of strength findings, indicates that he did not believe the ROM findings were attributable to pain behavior.

Finally, SAIF argues that Dr. Filarski's ROM findings are more reliable because he has been claimant's attending physician since he performed shoulder surgery in 1993. We generally give greater weight to the attending physician's opinion, absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810, 814 (1983). In this case, we agree with the ALJ that Dr. Filarski's ROM findings were less reliable evidence of claimant's permanent impairment because, at the time of his closing examination in April 1994, claimant was working as a bus driver only four hours a day, with the remaining four hours spent on light duty tasks. (Ex. 10; Tr. 13-14). By contrast, when claimant was examined by Dr. Fry in October 1994, he had returned to full-time bus driving and was experiencing increased pain and fatigue associated with his regular duties. (Ex. 16; Tr. 15-16). Like the ALJ, we are persuaded that Dr. Fry's ROM findings are a more reliable indicator of claimant's permanent impairment while maintaining his full-time, regular job. Accordingly, we rely on Dr. Fry's ROM findings.

After combining the 7 percent ROM impairment rating with the 5 percent impairment rating for resection of the clavicle, we conclude that claimant is entitled to an unscheduled permanent disability award of 12 percent for his right shoulder injury. We modify the ALJ's order accordingly.

ORDER

The ALJ's order dated May 26, 1995 is modified. In addition to the Order on Reconsideration award of 5 percent (16 degrees) unscheduled permanent disability, and in lieu of the ALJ's award, claimant is awarded 7 percent (22.4 degrees) unscheduled permanent disability, for a total unscheduled disability award of 12 percent (38.4 degrees) for the right shoulder injury. The ALJ's out-of-compensation attorney fee award to claimant's attorney is reduced accordingly.

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[2] As supporting evidence of different testing methods, SAIF points to Dr. Fry's measurement of abduction in claimant's uninjured left shoulder (150 degrees), which was 30 degrees less than Dr. Fry's abduction measurement in the same shoulder (180 degrees). (Exs. 12-2, 16-3). However, Dr. Fry's abduction finding correlates to no impairment rating under the standards. OAR 436-35-330(5). Therefore, we find the different abduction measurements to be of little significance; it is certainly insufficient evidence that Dr. Fry used incorrect ROM testing methods.

In the Matter of the Compensation of
JON S. O'SHANE, Claimant
WCB Case Nos. 95-00427, 94-12011, 95-00425 & 95-00426
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer (Albertsons, Inc.) requests review of Administrative Law Judge (ALJ) Schultz's order that: (1) set aside its denial of claimant's low back condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of the same condition. On review, the issue is responsibility.[1] We reverse.

FINDINGS OF FACT

We adopt the first five paragraphs of the ALJ's findings of fact. We do not adopt the findings of ultimate fact. We change the first paragraph of the findings of fact to show that claimant was examined by Dr. Robert Davis on January 26, 1994, rather than January 26, 1995.

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. Claimant suffered a compensable low back injury on January 19, 1994, while working for Liberty's insured. The injury occurred when claimant fell approximately 12 feet off a roof, landing on both feet and injuring his back. Claimant was diagnosed with a lumbosacral spine strain. The claim was closed without an award of permanent disability.

Claimant began working for Albertsons on May 26, 1994. Claimant injured his back on June 26, 1994, while lifting a 50 pound bag of onions.

The ALJ found that ORS 656.308(1) applied to this case and that Liberty had the burden of shifting responsibility to Albertsons. The ALJ found that claimant had sustained two distinct injuries, one on January 19, 1994 and one on June 26, 1994. The ALJ concluded that the June 26, 1994 injury was a new injury involving a different part of claimant's spine. The ALJ assigned responsibility for claimant's current condition to Albertsons.

Albertsons argues that claimant's June 1994 injury involved the "same condition" as the January 1994 injury claim accepted by Liberty. Albertsons contends that ORS 656.308(1) applies to this claim and it asserts that the medical evidence does not establish that claimant sustained a "new injury." On the other hand, Liberty argues that the medical evidence shows that claimant's second injury was to a different area of his spine.

ORS 656.308(1) provides, in part: "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition."[2] We consider first whether ORS 656.308(1) applies to this claim. We need to determine if claimant's current condition for which he seeks compensation is the "same condition" as the prior accepted low back claim processed by Liberty. See Smurfit Newsprint v. DeRosset, 118 Or App 371-72, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993).

Claimant has an accepted low back condition with Liberty stemming from a January 19, 1994 injury. Claimant testified that, by the time he went to work for Albertsons on May 26, 1994, he had not experienced low back pain for approximately four weeks. (Tr. 6). However, claimant testified that he had not totally recovered from the January 1994 injury. (Tr. 13). Claimant said that, before the June 26,

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[1] We note that, under amended ORS 656.307(2), we review this matter de novo. Or Laws 1995, ch 332, § 36 (SB 369, § 36); see Dan J. Anderson, 47 Van Natta 1929 (1995).

[2] We note that ORS 656.308(1) was amended by the 1995 Legislature. Or Laws 1995, ch 332, § 37 (SB 369, § 37). However, the amended version of the statute would not change our analysis or result in this case.

1994 injury, he still had occasional problems sleeping and continued to experience some low back pain while lifting his daughter. (Tr. 11). Claimant testified that the pain after the June 26, 1994 injury was approximately the same spot as the January 1994 injury. (Tr. 8, 13).

The ALJ found claimant to be a credible witness based upon observations of claimant's demeanor at hearing. Since the ALJ's credibility finding was based upon the observation of claimant's demeanor, we defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990). Moreover, based on our de novo review of the substance of claimant's testimony, we agree that claimant is a credible witness. See Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987).

Dr. Eubanks was claimant's treating physician for the June 26, 1994 injury. On March 23, 1995, Dr. Eubanks initially agreed that the June injury appeared to have been a "new and separate event." (Ex. 27). At a post-hearing deposition, however, Dr. Eubanks testified that his initial opinion was based on his understanding that the effects of the January 1994 incident had resolved by March 1994. (Ex. 28-5). Dr. Eubanks said that, given claimant's testimony about continuing symptoms and trouble sleeping and carrying his daughter, that would indicate that claimant had not fully recovered from the initial injury. (Exs. 28-28, 28-29, 28-36). Furthermore, Dr. Eubanks agreed that, based on claimant's testimony of continuity of symptoms, the June incident was probably a continuation of the January 1994 injury which had never completely resolved. (Ex. 28-36).

Based on a medical report from Dr. Davis, Dr. Eubanks said that claimant's first injury in January 1994 appeared to be lower than the clinical findings in June 1994. (Ex. 28-42). However, Dr. Eubanks admitted that he did not know whether Dr. Davis had referred to the same area that was symptomatic in June 1994 or some other area. (Exs. 28-13, 28-14). Dr. Eubanks noted that many physicians do not identify the exact segments of the spine involved. (Ex. 28-12). Dr. Eubanks testified that "there is enough overlap here and a predominance of the injury down to the mid to low lumbar spine area that certainly if someone was being less distinct, he could identify it as lumbosacral." (Id.) Dr. Eubanks testified that he had no reason to disagree with claimant's statement that he was hurt in the same area in both injuries. (Exs. 28-11, 28-14).

Since Dr. Eubanks' March 23, 1995 opinion on causation was not based on an accurate understanding of claimant's symptoms after the January 1994 injury, we do not find it persuasive. However, Dr. Eubanks' deposition testimony was based on a more accurate understanding of claimant's symptoms. Consequently, we find Dr. Eubanks' change of opinion to be reasonable. See Kelso v. City of Salem, 87 Or App 630, 633 (1987). Therefore, his prior inconsistent opinion does not undermine his current medical opinion.

The only other medical opinion on causation is from Dr. Farris. However, since Dr. Farris did not comment whether claimant's January 1994 and June 1994 injuries involved the same condition, his opinion is not particularly helpful.

Based on claimant's testimony and Dr. Eubanks' deposition testimony, we conclude that claimant's current low back condition is the "same condition" as the condition for which Liberty is responsible. Therefore, ORS 656.308(1) is applicable to this claim. Under that statute, Liberty remains responsible for claimant's future compensable medical services and disability relating to the compensable condition unless claimant sustains a "new compensable injury" involving the same condition. To establish a new injury, Liberty has the burden to prove that the major contributing cause of claimant's current disability or need for treatment was due to his work activities while Albertsons was on the risk. ORS 656.308(1); SAIF v. Drews, 318 Or 1 (1993).

The only medical opinion that can arguably support Liberty's position is Dr. Eubanks' March 23, 1995 opinion on causation. In the March 23, 1995 report, Dr. Eubanks agreed that "if this was a re-injury of the prior injured body part, the June event would become the major contributing cause, or more than 51 percent of claimant's need for treatment for the June, 1994 injury." (Id.) As we mentioned above, Dr. Eubanks' initial opinion on causation was based on his impression that the January 1994 injury had resolved and the June 1994 injury had involved a different area of the spine. (Ex. 27).

Dr. Eubanks subsequently testified that he had no reason to disagree with claimant's statement that he was hurt in approximately the same area in both injuries and he agreed that the June incident was probably a continuation of the January 1994 injury which had never completely resolved. In light of Dr. Eubanks' subsequent deposition testimony, Dr. Eubanks' March 23, 1995 opinion on causation is insufficient to shift responsibility for claimant's current low back condition to Albertsons. Therefore, responsibility remains with Liberty. See ORS 656.308(1).

ORDER

The ALJ's order dated August 29, 1995 is reversed. Albertsons' denial of claimant's low back condition is reinstated and upheld. Liberty's denial of claimant's low back condition is set aside, and the claim is remanded to Liberty for processing according to law. The ALJ's assessed fee award of $2,000 shall be paid by Liberty, rather than Albertsons.

February 15, 1996 Cite as 48 Van Natta 325 (1996)

In the Matter of the Compensation of
JOE R. RAY, Claimant
WCB Case No. 95-02305
ORDER ON REVIEW
Coons, Cole & Cary, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by the Board en banc.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) declined to exclude claimant's testimony concerning the extent of his unscheduled permanent disability; and (2) increased claimant's award of unscheduled permanent disability for a low back injury from 5 percent (16 degrees), as awarded by an Order on Reconsideration, to 25 percent (80 degrees). On review, the issues are evidence and extent of permanent disability. We modify.

Unless authorized by the Board, supplemental briefs are not considered on review. OAR 438-011-0020(2); Betty L. Juneau, 38 Van Natta 553 (1986). Here, the Board requested supplemental briefs from the parties as well as amicus briefs from any interested parties. The parties' supplemental briefs and the amicus briefs submitted by the Oregon Trial Lawyers Association/Oregon Workers' Compensation Attorneys and the SAIF Corporation were considered on review.

Furthermore, the Board will not ordinarily entertain oral argument. OAR 438-011-0015(2). Because this case presents an issue of first impression that could have a substantial impact on the workers' compensation system, however, the Board determined that oral arguments were an appropriate method of assisting the members in conducting their review. See id.; Ruben G. Rothe, 44 Van Natta 369 (1992). Consequently, on January 10, 1996, recorded oral arguments were heard by the Board en banc. After considering those arguments, the parties' appellate briefs, and the amicus briefs, the Board issues the following decision.

FINDINGS OF FACT

Claimant worked for the employer as a certified nurse's aide (CNA). On July 15, 1993, he sustained an injury to his low back while attempting to reposition and lift a patient. The insurer accepted claimant's injury as a disabling lumbar sprain.

Dr. Stanford, orthopedist, at the request of the insurer. Dr. Stanford diagnosed low back strain and exogenous obesity with significant deconditioning. Dr. Willey, treating physician, concurred with Dr. Stanford's report. Thereafter, Dr. Farris, orthopedic surgeon, examined claimant on the insurer's behalf. Farris opined that claimant did not have any permanent impairment due to his compensable injury. Dr. Willey also concurred with that report.

On June 10, 1994, the insurer issued a Notice of Closure, which found claimant medically stationary as of May 10, 1994 and awarded temporary disability benefits only. Claimant requested reconsideration of the Notice of Closure and sought the appointment of a medical arbiter.

On January 23, 1995, claimant underwent a medical arbiter examination, which was performed by Dr. Smith, orthopedic surgeon. Dr. Smith reported that claimant had reduced range of motion attributable equally to the compensable injury and other factors, including claimant's weight, as well as a chronic condition limiting repetitive use. On February 15, 1995, an Order on Reconsideration issued, which awarded claimant 5 percent unscheduled permanent disability. Thereafter, claimant requested a hearing concerning the reconsideration order. At hearing, claimant testified regarding the extent of his disability.

At the time of the reconsideration order, claimant was 45 years old and had completed three years of college. Prior to working for the employer, he had worked as a laboratory technician and as a supervisor for a wood products company. Claimant was also self-employed as the operator of a sports card shop.

As a result of the compensable injury, claimant has a chronic low back condition, which prevents partial repetitive use.

CONCLUSIONS OF LAW AND OPINION

Relying on claimant's hearing testimony concerning his job duties and weight loss (subsequent to the medical arbiter's examination), the ALJ concluded that claimant was entitled to 20 percent unscheduled permanent disability. We modify.

Evidence

Citing amended ORS 656.283(7), the insurer contends that the ALJ erred in relying on claimant's testimony at hearing to determine the extent of his permanent disability. We agree.

Except as otherwise provided, Senate Bill 369 applies to matters for which the time to appeal the ALJ's decision has not expired or, if appealed, has not been finally resolved on appeal. Newell v. SAIF, 136 Or App 280, 282 (1995); Volk v. America West Airlines, 115 Or App 565, 572-73 (1995). Amended ORS 656.283 is not among the exceptions to the general rule. See Or Laws, ch 332, § 66 (SB 369, § 66) (enumerating exceptions to general retroactivity provision). Consequently, because this matter has not been finally resolved on appeal, amended ORS 656.283(7) applies here.[1]

This case involves an issue of statutory interpretation. To interpret amended ORS 656.283(7), we must discern legislative intent. ORS 174.020. We begin by examining the text and context of amended ORS 656.283(7). ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). The context includes other statutes relating to the same subject matter. PGE v. Bureau of Labor and Industries, supra, 317 Or at 611. If those sources do not reveal legislative intent, we resort to legislative history and other extrinsic aids. Id. at 611-12.

As amended, ORS 656.283(7) provides, in part:

> "**Evidence on an issue regarding a notice of closure or determination that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself.**
>
> "**However,** nothing in this section shall be construed to prevent or limit the right of the worker, insurer or self-insured employer to present [evidence] **the reconsideration record** at hearing [and] to establish by a preponderance of [the] **that** evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268." SB 369, § 55 (added words are in bold face type, deleted words are in brackets).

On its face, the first paragraph of this provision indicates that evidence that was not submitted at reconsideration is not admissible at a subsequent hearing regarding the extent of permanent disability. This interpretation is supported by the amended language in the second paragraph of the provision, which references "the reconsideration record." Eliminating the parties' right to present "evidence" at hearing and replacing it with the right to present "the reconsideration record" at hearing is consistent with the first paragraph's prohibition of post-reconsideration evidence. Similarly, replacing the word

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[1] In his respondent's brief, claimant asserted that amended ORS 656.283(7) should not be applied retroactively. In his supplemental brief, however, as well as at oral argument, claimant conceded that the provision is retroactively applicable. (See Claimant's Respondent's Supplemental Brief at 2). Moreover, claimant acknowledged that he was not asserting that retroactive application of amended ORS 656.283(7) would create an absurd and unjust result. See Rick A. Webb, 47 Van Natta 1550 (1995); Ida M. Walker, 43 Van Natta 1402 (1991).

"the" with "that" prior to the word "evidence" in the second paragraph clearly refers to the reconsideration record as opposed to the evidentiary record developed at hearing.[2]

In light of the clear language of amended ORS 656.283(7), we conclude that evidence that was not submitted at reconsideration, and not made a part of the reconsideration record, is statutorily inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability.[3]

The context of amended ORS 656.283(7) supports that conclusion. Amended ORS 656.268(6)(b) authorizes the Department to postpone reconsideration proceedings for not more than 60 calendar days for inclusion of "additional medical or other information." SB 369, § 30.[4] Pursuant to amended ORS 656.268(7)(a), the Director is now authorized to refer a claim to a medical arbiter if the Director "determines that sufficient medical information is not available to estimate disability[.]" SB 369, § 30. Moreover, amended ORS 656.268(7)(g) now states that, after reconsideration, no subsequent medical information of a worker's impairment is admissible before the Department or on appeal. SB 369, § 30; see note 2, supra. Further, amended ORS 656.268(7)(h)(B) currently authorizes the Director to postpone a reconsideration proceeding if the worker's condition has substantially changed since claim closure. SB 369, § 30. Last, amended ORS 656.268(8) now provides that "[n]o hearing shall be held on any issue that was not raised and preserved before the department at reconsideration." SB 369, § 30.

Those statutes give Director significant control over the development of a record during the reconsideration process and clearly proscribe the admission of subsequent medical evidence after reconsideration. As such, they provide contextual support for our conclusion; viz., that, under amended ORS 656.283(7), evidence that was not submitted at reconsideration, and included in the reconsideration record, is now inadmissible at a subsequent extent of permanent disability hearing.

Although we need not consider the legislative history to amended ORS 656.283(7), PGE v. Bureau of Labor and Industries, supra, 317 Or at 611-12, it also supports that conclusion. Representative Mannix, a sponsor of Senate Bill 369, testified before the Senate Labor Committee that amended ORS 656.283(7)

> "sets up a system where the Department and the Director can meet the Supreme Court requirements without having to have a whole litigation ground in the Hearings Division. It pretty much limits the standards of review and there is a discussion here of 656.283(7). It modifies rules of evidence at hearing and limits review of reconsideration order [sic] and gets back to the issue we talked about before as to not bringing in new stuff at the hearing on reconsideration * * *." Tape Recording, House Committee on Labor, March 6, 1995, Tape 45B.

Virlena Crosley, the Workers' Compensation Division Administrator, testified that SB 369

> "requires that evidence and issues must be presented at the reconsideration proceeding before they could be introduced at a hearing. * * * [O]ne of the intentions of the 1990 reforms was to make sure that the record didn't completely start over again, that the same facts would be heard all the way through. And so the language proposed in this bill addresses both of these concerns by constricting the issues at hearing to those raised at reconsideration and limiting the record under review at hearing to the record that we considered on reconsideration." Tape Recording, Senate Labor and Government Operations Committee, February 8, 1995, Tape 34A (emphasis added).

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[2] Claimant asserts that the word "evidence" in amended ORS 656.283(7) is ambiguous and should be read to mean "medical evidence," the term used in amended ORS 656.268(7)(g). See SB 369, § 30. ORS 656.268(7)(g), however, only addresses evidentiary limitations regarding "findings of impairment" where a medical arbiter has been appointed. Moreover, ORS 656.283(7) provides that "any finding of fact regarding a worker's impairment must be established by medical evidence supported by objective findings." Therefore, with regard to "impairment," only medical evidence is relevant; it necessarily follows that any limitation relating to medical evidence would only be imposed on "medical evidence." Consequently, we are not persuaded by claimant's assertion.

[3] Claimant also contends that, because the insurer did not object to his testimony at hearing, it has waived its right to object to the testimony on review. Given, however, the express statutory limitation on evidence provided by amended ORS 656.283(7), we may consider the admissibility of the evidence even if a party does not object to it at hearing. See David J. Rowe, 47 Van Natta 1295 (1995).

[4] We recognize that the amendments to ORS 656.268(6) apply only to claims that become medical stationary on or after the effective date of the Act. SB 369, § 66(4).

Thereafter, Crosley testified that Senate Bill 369

> "requires that evidence and issues must be presented at the reconsideration process before they can be introduced at hearing. And it corrects a major litigation area created by the appellate courts. It can reduce litigation costs. It is important that the issues be raised at the lowest possible level for resolution -- that the record under review be the same at all levels of appeal. And this is our understanding of what the 1990 reforms intended on the mandatory reconsiderations. The language proposed in this bill addresses both of these concerns by restricting the issues at hearing to those raised at reconsideration in limiting the record under the -- at a hearing to the record at reconsideration." Tape Recording, House Committee on Labor, March 8, 1995, Tape 48A.

Jerry Keene, a workers' compensation insurance defense attorney and drafter of some of Senate Bill 369's text, testified that the amendments to ORS 656.283 were intended to overrule court cases that had allowed the admission of further evidence after reconsideration, including Leslie v. U. S. Bancorp, 129 Or App 1 (1994) (holding that former ORS 656.283(7) did not preclude the claimant from raising an issue for the first time at hearing), and Safeway Stores, Inc. v. Smith, 122 Or App 160 (1993) (holding that former ORS 656.283(7) allowed the ALJ to consider evidence that could not have been submitted on reconsideration). Keene stated that the amendments were intended "to restore the integrity of the reconsideration process in claims closures." Tape Recording, Senate Labor and Government Operations Committee, February 1, 1995, Tape 19A.

Similarly, Chris Davie, a SAIF Corporation representative, testified that amended ORS 656.283(7) was designed to overrule Safeway Stores, Inc. v. Smith, supra, a case that "meant the reconsideration process could hear one set of evidence, and then new evidence could come in at a hearing on any issue." Tape Recording, Senate Labor and Government Operations Committee, February 1, 1995, Tape 20A. Davie also testified, "I don't think it's what the original intent was, and the system needs to be fixed to take care of that." Id.

In a related vein, Representative Mannix testified that Safeway v. Smith, supra, and its progeny

> "allowed you to bring in more and more at hearing, so the whole intention of this reconsideration process, in the opinion of those of us who were involved in the 1990 bill, was lost, which was that in effect you have your notice of closure, or determination order, either way, then you want to go through reconsideration. The one thing that would be a viable, changeable factor would be a medical arbiter to avoid dueling doctors, but not a whole bunch of new evidence. You may bring in some earlier evidence that was overlooked, but don't create new evidence. Go to the medical arbiter and then have that whole record reviewed at the order on reconsideration. When you go to hearing, you are supposed to use what you have developed during your reconsideration process. Well, that is no longer the case. Now, you can bring, I don't want to overstate it, but you bring in almost everything imaginable if you're smart enough about it, at hearing. And you are supposed to be reviewing the closure, but you are bringing in, in effect, new medical opinion evidence or new vocational evidence and this is a fluid argument going on about how much more can come in at the hearing. This eliminates all that argument and says, no, if it wasn't in the reconsideration process, don't take it to hearing." Tape Recording, House Committee on Labor, March 6, 1995, Tape 45B (emphasis added).

Finally, regarding ORS 656.268(8),[5] Representative Mannix testified that the amendments

> "[r]einforce[] the limits on hearings on claims closure issues. The intent in 1990 was to stop the screwing around on litigation at hearings with new evidence and what we call dueling doctors and bringing in all kinds of additional information. The whole point was to get the award to the worker up front with a notice of closure or the determination order. Then the worker was allowed, in effect, a free shot at a free physician through the reconsideration process, where you could ask for a medical

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[5] Amended ORS 656.268(8) provides that "[n]o hearing shall be held on any issue not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing." SB 369 § 30.

arbiter; you can get another doctor and the worker doesn't have to pay for it. Well, what's happened is the courts are allowing in all kinds of additional evidence at the hearing, and you are no longer having a clean record going back to the notice of closure or determination order, plus what happened in reconsideration. This says, no, you don't get to bring in all kinds of new evidence at hearing, you have the record that was established previously. If you think something was done wrong, you can still take that to hearing, but you don't manufacture new evidence after the reconsideration process." Tape Recording, Senate Labor and Government Operations Committee, January 30, 1995, Tape 15B (emphasis added).

Considering the clear language of amended ORS 656.283(7), as well as the related statutes and the legislative history, there can be little doubt that the legislature intended to limit evidence concerning issues arising from a Notice of Closure or Determination Order to that evidence submitted at reconsideration and made a part of the reconsideration record. We construe amended ORS 656.283(7) accordingly.

That does not end our inquiry. Claimant also asserts that the application of amended ORS 656.283(7) to this case violates his procedural due process rights under the Fourteenth Amendment to the United States Constitution.[6] In particular, he asserts that he is entitled to a full evidentiary hearing regarding the extent of his disability. We disagree.[7]

States may not deprive citizens of life, liberty or property without due process of law. US Const, amend XIV. For these purposes, the term "property" includes interests in tangible property and certain interests in benefits, such as Social Security or temporary disability benefits. E.g., Mathews v. Eldridge, 424 US 319, 96 S Ct 893 (1976); Carr v. SAIF, 65 Or App 110 (1983). A constitutionally significant interest in benefits exists when a recipient's claims of entitlement to the benefits are grounded in the statutes and rules defining eligibility for them. See Carr v. SAIF, supra, 65 Or App at 117 (noting that, in Mathews v. Eldridge, supra, and Goldberg v. Kelly, 397 US 254, 90 S Ct 1011 (1970), Supreme Court held that procedural due process requirements applied, because recipients' claims to entitlement to benefits were grounded in statutes defining eligibility for them).

This case concerns permanent partial[8] disability benefits. Claimant's claims of entitlement to those benefits are grounded on the disability standards promulgated pursuant to ORS 656.726(3)(f), the law defining eligibility for them. See OAR Chapter 436, Division 35 (setting forth disability standards). That is sufficient to establish that claimant has a constitutionally significant interest in those benefits. See Carr v. SAIF, supra, 65 Or App at 117-18.

The next issue concerns what process is due. Governmental[9] deprivation of a protected property interest must be accompanied by minimal procedural protections, including an opportunity to

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[6] Claimant also bases his due process arguments on the Fifth Amendment to the federal constitution. The Fifth Amendment's due process clause restricts federal action, while the Fourteenth Amendment's due process clause restricts state action. See Lenrich Associates v. Heyda, 264 Or 122, 130 (1972) (Fifth Amendment applies to federal government; Fourteenth Amendment applies to states). This case involves the actions of a state agency; therefore, we limit our consideration to the Fourteenth Amendment.

[7] Ordinarily, we would begin any constitutional analysis with the state constitution. The Oregon Constitution, however, contains no due process clause. E.g., State v. Clark, 291 Or 231, 235 n 4, cert den 454 US 1084 (1981). Accordingly, we proceed directly to the parties' federal constitutional arguments.

[8] Claimant asserts that because, in his view, applying amended ORS 656.283(7) to temporary disability or permanent total disability cases violates due process, the statute necessarily violates his due process rights regarding the extent of his permanent partial disability. That argument fails, because claimant lacks standing to challenge amended ORS 656.283(7) on the ground that it may be unconstitutional as applied to persons who are temporarily disabled or permanently and totally disabled. See Bopp v. State, 18 Or App 347, 349 (1974) (quoting Broadrick v. Oklahoma, 413 US 601, 610, 93 S Ct 2908 (1973), where the Supreme Court said, "Embedded in the traditional rules governing constitutional adjudication is the principle that a person to whom a statute may constitutionally be applied will not be heard to challenge that statute on the ground that it may conceivably be applied unconstitutionally to others, in other situations not before the court."); accord State v. Schulman, 6 Or App 81, 84 (1971).

[9] No one disputes that this case involves governmental action. See Flagg Brothers, Inc. v. Brooks, 436 US 149, 156, 98 S Ct 1729 (1978) (most constitutional rights are protected only against governmental infringement).

be heard if the action is contested. E.g., Tupper v. Fairview Hospital, 276 Or 657, 662 (1982); see also Mathews v. Eldridge, supra, 424 US at 333.[10] The particular protections required depend on the circumstances and interests involved. E.g., Tupper v. Fairview Hospital, supra, 276 Or at 662.

In Goldberg v. Kelly, supra, the United States Supreme Court held that due process requires an evidentiary hearing before a welfare recipient's benefits could be terminated; a post-termination hearing was not sufficient. In so holding, the Court balanced the parties' interests, concluding that, because welfare benefits are need-based, 397 US at 264, and because the drain on governmental resources resulting from improperly paid benefits could have been reduced through skillful administration, id. at 266, the recipient was entitled to a pre-termination hearing that included the right to confront and cross-examine adverse witnesses and to present oral testimony. Id. at 268-69. With respect to the latter right, the Court said that affording a welfare recipient the opportunity to present his or her position in writing was not enough, because such persons often lack the education to write effectively and may lack the resources to obtain professional assistance. Id. at 269. Moreover, welfare hearings often implicate issues of credibility and veracity. Id. Last, in the Court's view, written submissions in the welfare context "do not permit the recipient to mold his argument to the issues the decision maker appears to regard as important." Id. For those reasons, the Court held that the recipient was entitled to an evidentiary hearing before the government terminated his welfare benefits.

In Mathews v. Eldridge, supra, the Court fashioned a three-part balancing test for determining what will satisfy due process. The Court said:

> "'(D)ue process is flexible and calls for such procedural protections as the particular situation demands.' Morrissey v. Brewer, 408 U.S. 471, 481 (1972). * * * [I]dentification of the specific dictates of due process generally requires consideration of three distinct factors: First, the private interest that will be affected by the official action; second, the risk of erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail." 424 US at 334-35.

Applying that test, the Mathews Court held that an evidentiary hearing was not required before the government terminated a worker's Social Security disability benefits. In so holding, the Court noted that eligibility for those benefits is based on periods of complete disability, not financial need, 424 US at 323, 340, that the extensive pre-termination procedures minimized the risk of wrongful termination of benefits, see id. at 343-47, and that "the ultimate additional cost in terms of money and administrative burden [wrought by requiring pre-termination hearings] would not be insubstantial." Id. at 347. The Court also noted that the worker had the right to a post-deprivation evidentiary hearing, as well as to subsequent judicial review. Id. at 349.

The Court distinguished its holding from Goldberg v. Kelly, supra, on the grounds that disability determinations involve routine medical reports that do not usually implicate questions of credibility and veracity, that the procedures afforded in Mathews ensured that the parties would be able to communicate effectively in writing and that the worker would have ample opportunity to challenge directly the correctness of the agency's conclusions. Id. at 344-46.

This case is more like Mathews than Goldberg. Here, claimant's interest is his entitlement to increased permanent partial disability benefits. The state's interest is the efficient and economical resolution of permanent disability disputes. Although claimant's interest is significant, it is not as significant as, for example, welfare benefits based on financial need. See Mathews v. Eldridge, supra, 424 US at 340 (private interest in Social Security disability benefits less significant than private interest in welfare benefits, which are based on financial need); see also Carr v. SAIF, supra, 65 Or App at 120 (claimant's interest in temporary disability benefits less significant than person's interest in Social

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[10] Procedural due process also requires notice of the contemplated action. E.g., Tupper v. Fairview Hospital, supra, 276 Or at 662. Claimant concedes that issue. (Claimant's Respondent's Supplemental Brief at 14).

Security disability benefits).[11] Moreover, the state's interest in administrative efficiency and cost-effectiveness, while compelling, is less so than its interest, for example, in the health and safety of its citizens. On balance, we are unwilling to say that either of those interests outweighs the other, because each is significant to the party asserting it. Accordingly, we focus on the "risk of erroneous deprivation" of claimant's interest through the procedures used. See Maddox v. Clack. Co. Sch. Dist. No. 25, 293 Or 27, 38 (1982) (finding parties' interests in equipoise, court focused on risk of erroneous deprivation of protected interest).

Here, claimant received a written Notice of Closure, explaining his disability award and affording him an opportunity to seek reconsideration of that award before the Appellate Unit of the Department of Insurance and Finance. (Ex. 33-1).[12] That process gave claimant the right to "correct information in the record that is erroneous and [to] submit any medical information that should have been but was not submitted by the physician serving as the attending physician at the time of claim closure." Former ORS 656.268(5) (since renumbered ORS 656.268(6)(a)); see OAR 436-30-115(2) (all information to correct or clarify record must be submitted during reconsideration proceeding).[13] It also afforded claimant the right to seek the appointment of a medical arbiter if he was dissatisfied with his treating physician's impairment findings, ORS 656.268(7)(a), and gave him full access to all information submitted to the Department during the reconsideration process. OAR 436-30-135(1)(d); see ORS 656.268(2)(b), 656.268(4)(c) (requiring disclosure of medical and vocational rehabilitation reports to worker or employer on request). Claimant also could have obtained assistance from the Department to perfect his request for reconsideration. OAR 436-30-135(2).

Next, the reconsideration process directed the Department to create a record of all documents submitted on reconsideration, OAR 436-30-155, and to address all issues raised by the parties. OAR 436-30-135(7). Last, it vested in the Director the discretion to abate, withdraw and/or amend the Order on Reconsideration within the time limit permitted to appeal the Notice of Closure, until a hearing was requested. OAR 436-30-008(1)(b); see OAR 436-30-115(3) (Director has discretion to abate, withdraw and/or amend Order on Reconsideration).

Taken together, those procedures, which enabled claimant to present his position fully in writing, were adequate to guard against the erroneous deprivation of his interest in additional permanent partial disability benefits. First, the determination of the extent of claimant's permanent disability is based mostly on medical reports written by experts, which, in this case, included a medical arbiter. Those reports generally do not implicate questions of veracity and credibility, which might warrant a full evidentiary hearing. See Mathews v. Eldridge, supra, 424 US at 344 (credibility and veracity generally not at issue in cases involving discontinuance of benefits based on routine medical reports). In any event, to the extent that claimant's credibility was at issue with respect to the extent of his permanent disability, that issue could have been adequately addressed through impairment validity findings.

Similarly, the insurer refers us to the Department's proposed rules under amended ORS 656.283(7). Because this case involves the constitutionality of procedures already applied in this case, those rules are irrelevant. Consequently, we do not consider them.

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[11] Claimant analogizes this case to Carr v. SAIF, supra, in which the Court of Appeals held that suspension of temporary disability benefits for failure to attend a medical examination, without any pre-suspension opportunity to contest the action, violated the claimant's procedural due process rights. Carr is inapposite. That case involved the termination of benefits that the claimant was already receiving, the deprivation of which could have threatened the health and safety of the worker and his dependents. 65 Or App at 120-21. Here, in contrast, claimant seeks additional permanent disability benefits beyond that which he has already been awarded. Because claimant has not yet received those benefits, their deprivation does not pose the same threat as that addressed in Carr. On that ground, we distinguish Carr from this case.

[12] The Department has been renamed the Department of Consumer and Business Services.

[13] Unless stated otherwise, all citations to the administrative rules are to Workers' Compensation Department Administrative Order No. 94-059.

Claimant had 180 days from the mailing date of the Notice of Closure to request reconsideration. OAR 436-30-115(1). The parties then had six working days from the Director's receipt of the request to submit information into the reconsideration record. The Department had the discretion to extend that timeline. OAR 436-30-145(2)(b). Claimant's due process challenge is not specifically based on these timelines. Therefore, we do not address that issue.

Second, the Department was directed to create a record on reconsideration and to address all issues raised by the parties. Because claimant had access to all the evidence submitted on reconsideration, he could tailor his arguments to the precise issues raised during the reconsideration process. See id. (summary of relevant evidence and right to review file enabled worker to mold arguments to precise issues decision maker regarded as crucial).

Third, claimant had the right to present additional evidence on reconsideration to correct any errors in the Notice of Closure; moreover, until he requested a hearing, claimant could have asked the Director to abate, withdraw and/or amend the order to correct any errors in the reconsideration order itself. See id. (opportunity to present additional evidence and arguments weighed against finding informal procedure in violation of worker's due process rights).

Last, as an injured worker generally, claimant was entitled to legal services regarding the claim without out-of-pocket expense to him. ORS 656.386(2). Moreover, he could have obtained specific assistance from the Department to perfect his request for reconsideration.

Because claimant had the opportunity to present his position fully in writing and with professional legal assistance, we conclude that there was a low risk of erroneous deprivation of his interest in permanent partial disability benefits,[14] and that there would be little value, if any, in providing additional or substitute safeguards to protect that interest. In light of that conclusion, and the parties' other countervailing interests, we further conclude that the procedures afforded during the reconsideration process were sufficient to protect claimant's interest in an increased permanent partial disability award.[15]

Claimant asserts that due process mandates that the state afford him the opportunity to present oral testimony and to cross-examine witnesses before it determines the extent of his permanent disability. We disagree. We have already recognized, in determining whether a hearing order must be written by the ALJ before whom a hearing has been held, that "[d]ue process does not require that an administrative decision maker have an opportunity to hear and see the witnesses at hearing." Roderick A. Mespelt, 42 Van Natta 531 (1990). In light of that proposition, and the procedures detailed above, we now hold that due process does not require that the state afford claimant an opportunity to present oral testimony regarding the extent of his disability.

We reach the same conclusion regarding claimant's cross-examination argument. Cross-examination is designed to test the credibility, perception and memory of the witness, State v. Farber, 295 Or 199, 207 (1983) (citing Davis v. Alaska, 415 US 308, 315-16, S Ct 1105 (1974)), as well as the accuracy of the opposing party's evidence. State v. Jacobs, 252 Or 433, 436, 438 (1969). Because credibility is not usually an issue in permanent disability cases, see Mathews v. Eldridge, supra, 424 US at 344, and because the reconsideration process already affords claimant the opportunity to test the accuracy of the insurer's evidence, e.g., former ORS 656.268(5) (since renumbered ORS 656.268(6)(a)),

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[14] Claimant asserts that, because the ALJ awarded him 25 percent permanent disability, whereas the Order on Reconsideration had awarded him only 5 percent permanent disability, he has demonstrated a high risk of erroneous deprivation of his interest in a disability award. We disagree. That assertion is based on patently post hoc reasoning. Moreover, because "procedural due process rules are shaped by the risk of error inhered in the truth-finding process as applied to the generality of cases, not the rare exceptions[,]" Mathews v. Eldridge, supra, 424 US at 344, we focus on the risk of error in extent of permanent partial disability cases generally, not the risk of error in this particular case.

[15] Claimant asserts that his inability to cross-examine the medical arbiter violates his procedural due process rights. The ban on such cross-examination existed at the time of the reconsideration process, e.g., Daniel L. Bourgo, 46 Van Natta 2505, 2508 n 1 (1994), claimant could have asserted that argument on reconsideration or at hearing. He did not; consequently, we do not consider it now. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991) (Board properly refused to address issue not raised at hearing).

Claimant also asserts that Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526 (1993), supports his due process arguments. We disagree. In Colclasure, the court held that, in the absence of any statute mandating the Director to develop an evidentiary record or hold an evidentiary hearing in a vocational assistance entitlement case, it was proper to construe former ORS 656.283 to authorize a full evidentiary hearing after the Director informally investigated the matter and issued an order. 317 Or at 537. Here, in contrast, amended ORS 656.283(7) specifically mandates that the Director develop a record on reconsideration, albeit without oral testimony unless requested. See OAR 436-30-115(2) (no personal appearance on reconsideration unless requested by Department). That is a sufficient basis on which to distinguish Colclasure.

we conclude that there is no right to cross-examine witnesses in hearings concerning the extent of permanent partial disability.

The changes wrought by amended ORS 656.283(7) are less concerned with the scope of the litigants' rights than they are with timing. The parties still have the opportunity to submit essentially the same evidence, albeit in somewhat different form (for example, by affidavit instead of by oral testimony). Moreover, they now must submit all evidence on which they intend to rely on appeal during the reconsideration process, instead of at a hearing before the Hearings Division. Those changes may afford the parties less process than that available before Senate Bill 369 went into effect; however, they do not violate the principles of due process enunciated by the Supreme Court in Mathews and Goldberg.

In reaching this conclusion, we recognize that both Goldberg and Mathews involved post-deprivation full evidentiary hearings, whereas this case does not. That distinction is immaterial.

In Walters v. Nat. Assn. of Radiation Survivors, 473 US 305, 105 S Ct 3180 (1985), the Court applied the Mathews test to a veterans' disability benefits case. There, the administrative process consisted of several levels of informal ex parte proceedings that included no formal questioning or cross-examination and no judicial review. 473 US at 309-11. Attorney fees related to that process were limited to $10 per case. Id. at 308. The plaintiffs, representing veterans' interests, argued that the attorney fee limitation denied them a realistic opportunity to obtain legal representation in veterans' disability cases, in violation of their due process rights. The Court disagreed. Applying the Mathews balancing test, the Court concluded that the government's interest in ensuring that veterans received their full disability awards was more significant than the claimants' interest in disability benefits and, hence, held that the fee limitation passed constitutional muster. See id. at 326.

Walters establishes that the Mathews balancing test is not limited to cases that involve post-deprivation full evidentiary hearings and that the entitlement to such a hearing is but one factor to be considered in evaluating whether, in any particular case, due process has been violated. For the reasons stated above, we conclude that the absence of a full evidentiary hearing in this case does not render amended ORS 656.283(7) constitutionally infirm. Hence, we reject claimant's arguments to the contrary.

Because claimant's testimony was not submitted at the reconsideration proceeding, it cannot be considered in determining the extent of his permanent disability. Therefore, we have not considered it on review.

In reaching this conclusion, we acknowledge that, under the statute and case law applicable at the time of hearing, certain evidence that was not submitted at the reconsideration proceeding, was admissible at hearing. See Leslie v. U. S. Bancorp, supra; Safeway Stores v. Smith, supra. Therefore, the parties may have prepared their respective cases under the now misguided impression that such evidence would be admissible. Nevertheless, the current law now prohibits the admission of "post-reconsideration" evidence at extent hearings; moreover, nothing precluded the parties from presenting such evidence during the reconsideration process. Although we understand the parties' expected frustration concerning evidence that was admissible at the time of the hearing, but is no longer admissible, it is not within our purview to ignore a clear legislative mandate, despite an arguably harsh result. See Southwood Homeowners v. City Council of Philomath, 106 Or App 21, 24 (1991).[16]

Extent of Permanent Disability

The ALJ found that claimant was entitled to a total of 25 percent unscheduled permanent disability. We modify.

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[16] Board Chair Hall's dissent is not well-taken. First, it's reliance on the belief that claimant could not have been expected to foresee the enactment of amended ORS 656.283(7)'s evidentiary ban is tantamount to an "absurd and unjust" line of reasoning. As the dissent correctly states, that issue is not disputed in this case. See note 1, supra. Second, in our view, claimant's due process argument focuses wholly on the nature of the process that he was afforded; he concedes that he received adequate notice of the proceedings. See note 9, supra. Therefore, to the extent that the dissent is based on the adequacy of notice, it fails for lack of a factual or legal predicate.

The extent of claimant's permanent disability is determined by an application of the "standards." Claimant became medically stationary on May 10, 1994 and his claim was closed on June 10, 1994. Accordingly, the disability standards contained in Workers' Compensation Department Administrative Orders Nos. 6-1992 and 93-056 apply to claimant's claim. OAR 436-35-003(2).

The parties do not contest the values assigned for claimant's age (1), education (0), or skills (3). Consequently, we do not address these values; instead, we proceed to address the values for impairment and adaptability.

Dr. Farris, who examined claimant at the request of the insurer on May 10, 1994, reported that claimant did not have any objective signs of permanent impairment. Dr. Willey, claimant's attending physician, concurred with that report. Dr. Smith, medical arbiter, examined claimant on January 23, 1995, and reported that claimant had lost range of motion, as well as a chronic condition that limited repetitive use. Because Dr. Smith's opinion is well-reasoned and closer in time to the February 15, 1995 Order on Reconsideration, we find it persuasive and base claimant's impairment on it.

Dr. Smith's report indicates that claimant had lost ranges of extension, right lateral flexion and left lateral flexion, which the parties agree equal an 8 percent value under the standards. Smith, however, also reported that the lost ranges of motions were 50 percent due to the injury and 50 percent due to claimant's preexisting degenerative changes, obesity, and deconditioning. No persuasive admissible evidence contravenes that opinion. Consequently, pursuant to OAR 436-35-007(1) and (2), claimant is only entitled to an impairment value of 4 percent. Nevertheless, Dr. Smith also indicated that claimant had a chronic condition due to the injury that prevents partial repetitive use, which would entitle claimant to an impairment value of 5 percent in lieu of other impairment values. OAR 436-35-320(5)(b). The insurer does not dispute that value. Consequently, we conclude that claimant's impairment value is 5 percent. We now turn to the adaptability value.

Under the applicable standards, adaptability is measured by comparing base functional capacity (BFC) to the worker's residual functional capacity (RFC) at the time of becoming medically stationary. OAR 436-35-310(2). BFC is determined by the highest strength category assigned to any job the worker performed during the five years prior to the time of determination. OAR 436-35-310(4)(a).

The heaviest job that claimant performed in the past five years was his at-injury job as a nurse's aide. (DOT # 355.674-014).[17] That job is assigned a strength of medium. With regard to claimant's residual functional capacity (RFC), Dr. Smith opined that claimant could lift 20 to 25 pounds frequently and 60 to 80 pounds, occasionally. That opinion establishes that claimant's RFC is medium. OAR 436-35-310(3)(g). OAR 436-35-280(1)(a) provides for an adaptability value of zero when a worker's RFC is equal to or greater than his BFC.

The Court of Appeals, however, recently determined that a former Director's rule, which also gave a zero adaptability value in certain circumstances, were inconsistent with ORS 656.726(3)(f)(A). In Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996), the court held that former OAR 436-35-310(2), which gave a zero adaptability value when a worker had returned to regular work, conflicted with ORS 656.214(5) and 656.726(3)(f)(A) and was, therefore, invalid. The court relied on the Supreme Court's decision in England v. Thunderbird, 315 Or 633 (1993), which had invalidated a similar rule because it conflicted with a prior version of ORS 656.214, which mandated that age, education, impairment, adaptability and factors with similar characteristics be considered in determining earning capacity for purposes of evaluating unscheduled permanent disability.

The Carroll court noted that the only discernible difference between former ORS 656.214(5) and current ORS 656.726(3)(f)(A) was that, under the former statute, earning capacity was calculated "taking into consideration" age, education, and adaptability, whereas the current statute provided that earning capacity is impairment "as modified by" those factors. Carroll, supra, 138 Or App at 615. The court perceived no significant difference between the two statutory mandates and concluded that an assignment of a zero value for adaptability, when a worker returns to regular work, was inconsistent with the statutes. Id.

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[17] There is no persuasive admissible evidence that nurse's aide is not the appropriate DOT job description for claimant's at-injury job.

As noted above, claimant is subject to a different administrative rule than that at issue in Carroll. The result, however, is the same. That is, because claimant's RFC is equal to his BFC, he is also assigned an adaptability value of zero. Because the adaptability value is used as a multiplier, under OAR 436-35-280(1), claimant is not allowed a value for age, education, or skills. Accordingly, because the Director's statutory authority under ORS 656.726(3)(f)(A) is unchanged, we, like the Carroll court, conclude that OAR 436-35-280(1) is also inconsistent with ORS 656.726(3)(f)(A). Therefore, that rule cannot be used in determining the extent of claimant's unscheduled permanent disability.[18]

Rather, we find that, pursuant to OAR 436-35-280(7), the value for the other societal factors should be added to the value for impairment to arrive at the percentage of unscheduled permanent disability to be awarded. See Donna J. England, 45 Van Natta 1480 (1993) (former OAR 436-35-280(7) used to evaluate unscheduled permanent disability when Supreme Court had invalidated former OAR 436-35-280(6), which did not allow a value for adaptability when a worker had returned to regular work). This analysis is essentially the same as assigning an adaptability value of one. Because claimant's social and vocational factors would be considered under this analysis, we consider this formula to be consistent with the Director's standards, as altered by the court's holding in Carroll.

Applying this analysis, the total value of claimant's age, education and skills is (4) is multiplied by the adaptability value of (1) for a total of 4. OAR 436-35-280(6). When this value is added to the value for impairment (5), the result is 9. OAR 436-35-280(7). Therefore, claimant's unscheduled permanent disability is 9 percent.

Because we have reduced claimant's disability award, he is not entitled to an assessed fee for his counsel's services on Board review. See ORS 656.382(2); Ivan G. Dooley, 46 Van Natta 859, 862 (1994).

ORDER

The ALJ's order dated June 9, 1995 is modified. In lieu of the ALJ's award, and in addition to the Order on Reconsideration award of 5 percent (16 degrees), claimant is awarded 4 percent (12.8 degrees) for a total award of 9 percent (28.8 degrees) unscheduled permanent partial disability. We modify the ALJ's "out-of-compensation" attorney fee accordingly.

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[18] ORS 656.726(3)(f)(D) now provides:

"Notwithstanding any other provision of this section, impairment is the only factor to be considered in evaluation of the worker's disability under ORS 656.214 (5) if:

"(i) The worker returns to regular work at the job held at the time of injury;

"(ii) The attending physician releases the worker to regular work at the job held at the time of injury and the job is available but the worker fails or refuses to return to that job; or

"(iii) The attending physician releases the worker to regular work at the job held at the time of injury but the worker's employment is terminated for cause unrelated to the injury." SB 369, § 55.

That statute applies only to claims that become medically stationary on or after June 7, 1995, the effective date of the Act. SB 369, § 66(4). Therefore, it does not apply here.

Board Chair Hall concurring in part and dissenting in part.

I agree with the majority that the legislature intended amended ORS 656.283(7) to be applied retroactively and intended that it operate as a total ban on the admissibility of all post-reconsideration evidence on any issue regarding a notice of closure or determination order. I disagree, however, with the majority's conclusion that the statute, as so interpreted, does not violate claimant's right to an adequate, quasi-judicial decisional process. Accordingly, I dissent. In doing so, I will not address amended ORS 656.283(7) as applied to cases that arose after it went into effect on June 7, 1995, or with respect to temporary disability or permanent total disability cases.[1] Rather, my analysis is limited to a single inquiry: Whether the retroactive application of amended ORS 656.283(7) to this case violates claimant's right to an adequate, quasi-judicial decisional process.

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[1] Such cases bring into question issues not present in the instant case.

At oral argument, the parties agreed to the following common ground: that Senate Bill 369, including amended ORS 656.283(7), applies retroactively to this case; that claimant has a property interest in the permanent disability benefits involved in this case; that some form of process is required before the government could deprive claimant of those benefits; and that the principal issue in this case concerns the adequacy of that process. I focus on the last issue.

Before addressing that issue, however, I briefly summarize what each party advocates in this case: Claimant requests the Board to hold that amended ORS 656.283(7) violates his procedural due process rights and, therefore, that the ALJ was entitled to consider claimant's hearing testimony regarding the extent of his permanent disability. In contrast, the insurer asks the Board to hold that amended ORS 656.283(7) is constitutional and, consequently, that the ALJ was barred from considering any post-reconsideration evidence, including claimant's hearing testimony.[2]

States may not deprive citizens of life, liberty or property without due process of law. US Const, amend XIV.[3] As the majority correctly states, in this context, the term "property" includes interests in certain benefits, such as the permanent partial disability benefits in dispute here. See, e.g., Mathews v. Eldridge, 424 US 319, 96 S Ct 893 (1976) (Social Security disability benefits); Carr v. SAIF, 65 Or App 110 (1983) (temporary total disability benefits). The primary issue here is what process is due to claimant before the government may deprive him of his interest in the disputed benefits.

The majority accurately summarizes the administrative process in this case. It concludes that, because that process did not prevent claimant from submitting during the reconsideration process the substance of the evidence he presented at hearing, no due process violation occurred. In my view, that conclusion is based on the wrong premise; viz., the absence of a legal barrier to claimant's presentation on reconsideration of the disputed evidence. The correct premise is, in my estimation, that claimant could not reasonably have been expected to foresee that, by virtue of Senate Bill 369's enactment after the reconsideration proceedings in this case, he would be prevented from relying on the evidence that he submitted at hearing. Analyzing this case in light of that premise leads to only one conclusion: That claimant's procedural due process rights were violated when he was deprived, post hoc, of the right to present the evidence on which he now relies.

I recognize that the analysis of procedural due process challenges generally involves the weighing of the parties' interests in accord with Mathews v. Eldridge, supra. This case, however, does not concern the application of amended ORS 656.283(7), in the first instance; that is, to a reconsideration process that arose after the amended statute went into effect. If that were the case, I would not hesitate to apply the Mathews rationale here. The issue, however, is whether the retroactive application of a new evidentiary law to a pending case satisfies the requirements of procedural due process. As such, I believe that the key issue concerns the notice requirements of procedural due process, not the nature of the process itself.

"The heart of procedural due process is (1) notice of the charge and (2) an opportunity to be heard." OSEA v. Rainier School Dist. No. 13, 311 Or 188, 195 (1991) (citing Tupper v. Fairview Hospital, 276 Or 675, 662 (1982)). Logic dictates that, if one is not apprised in advance of the particulars of the government's actions, the opportunity to be heard regarding those actions will likely be of little value. See Bell v. Burson, 402 US 535, 91 S Ct 1586 (1971) (due process normally requires that, prior to any license suspension, licensee be given notice of intent to suspend and notice of the availability of a hearing). In other words, for due process purposes, the "opportunity to be heard" is, in part, contingent on notice regarding the scope of that opportunity. To pass constitutional muster, then, due process

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[2] At oral argument, the insurer's attorney suggested that, even considering claimant's testimony, the claim fails and, therefore, that we need not address the parties' constitutional arguments. I disagree. As discussed later in this opinion, the evidence, including claimant's testimony, supports an increased permanent disability award. Therefore, we are compelled to address the due process issue. In any event, the issue does not concern the quantity or quality of evidence claimant presented at hearing, rather, it concerns the adequacy of claimant's opportunity to present whatever evidence he had at his disposal.

At oral argument, claimant conceded that the retroactive application of amended ORS 656.283(7) would not create an absurd and unjust result. I agree with the majority that, in view of that concession, we should not address that issue. Instead, we are bound to address the parties' constitutional arguments.

[3] I direct the reader to Administrative Law Judge (ALJ) Howell's opinion and order in Joshua V. Sol, WCB No. 92-06831 (November 2, 1995), which holds that, at least in a "pre-Senate Bill 369" case, amended ORS 656.283(7)'s ban on post-reconsideration evidence violates procedural due process.

notice should include information about the particulars of the opportunity to be heard. Imposing such a requirement serves to warn the affected party of his or her obligation to take certain actions within an established time frame, or to risk the governmental deprivation of a benefit.

Here, arguably, nothing prevented claimant from presenting during the reconsideration proceeding the evidence on which he now relies. He was not, however, apprised of his obligation to present during that proceeding all evidence on which he intended to rely henceforth until after the hearing on the reconsideration order, when amended ORS 656.283(7) went into effect. This is a case where the proverbial goal posts were moved after the fact. Because claimant was not notified of the limitation on the hearing until after the fact, in my view, his procedural due process rights were violated.

This holding comports with the Oregon Supreme Court's reasoning in Colclasure v. Wash. County School Dist. No. 48-I, 317 Or 526 (1993). There, the court construed former ORS 656.283(2) to authorize a full evidentiary hearing regarding vocational assistance entitlement issues, although the statute was silent on the issue. There, as here, the issue was the adequacy of process. Quoting Neuberger v. City of Portland, 288 Or 155, 161 (1980), the court said that, "'when a particular action by * * * government is directed at a relatively small number of identifiable persons, and when that action also involves the application of existing policy to specific factual setting, the requirement of quasi-judicial procedures has been implied from governing law.'" 317 Or at 535-36. In light of that principal, the court construed former ORS 656.283 to contemplate an informal investigation and order by the Director; a hearing at which the parties develop a record and on the basis of which, an ALJ finds facts to determine whether the Director's order survives review; and, finally, further review by the Workers' Compensation Board. Id. at 537. The court adopted such a construction to avoid the constitutional litigation that any other holding would have invited. Id. Because the Director had not developed an evidentiary record or held an evidentiary hearing, the court concluded that the ALJ was permitted to find facts on a record developed at hearing. Id. at 531, 537. The court recognized that "[a] different result would have obtained had the director conducted a contested case hearing, made a record, and entered findings of fact thereon." Id. at 535 n 4.

Although Colclasure is not, per se, a constitutional case, it supports the holding that I propose. The reconsideration procedures used in this case are directed at a relatively small number of identifiable persons; moreover, they involve the application of existing policy to specific factual settings. On those grounds alone, Colclasure is analogous to this case.

Colclasure is also illustrative, because it manifests the court's belief that, to avoid constitutional challenges, it is better to require full evidentiary hearings in workers' compensation matters, even in the face of legislative silence on the issue. Surely, the court would require no less when the legislature attempts to prohibit any decision maker from conducting a contested case hearing at which the parties would be entitled to present oral and written evidence and to cross-examine adverse witnesses, thereby preventing anyone from making a meaningful record and entering findings of fact thereon. See id. at 535 n 4.

Here, the reconsideration process to which this case was subjected did not satisfy the Colclasure requirements. Nevertheless, before Senate Bill 369 went into effect, the parties were entitled to a post-reconsideration contested case hearing, which included presentation of testimony, subject to cross-examination, and which, arguably, did satisfy the Colclasure requirements. Thus, the notice of the procedural opportunity to be heard in this case included notice of the opportunity to present testimony in a contested case hearing after reconsideration. The notice of an opportunity to be heard cannot be amended after the opportunity has passed. To hold otherwise would mean that a claimant in a "pre-Senate Bill 369" extent of permanent disability case would not know that she had been denied procedural due process until after she had completed the reconsideration process.

Having concluded that amended ORS 656.283(7) violates claimant's procedural due process rights, I would apply the former version of the statute to determine the extent of claimant's disability.

Consequently, I would consider the entire record developed at hearing, including claimant's testimony.[4]

On the merits, the parties' dispute centers around claimant's impairment and adaptability values. I agree that the correct impairment value is 5. Dr. Smith, medical arbiter, examined claimant shortly before the Order on Reconsideration issued, reporting range of motion findings that support a 4 percent value under OAR 436-35-007(1) and (2).[5] (See Ex. 35-2, -4). Dr. Smith also indicated, however, that claimant had a chronic condition due to the injury that prevents partial repetitive use. (Id. at 4). That entitles claimant to an impairment value of 5 percent in lieu of other impairment values. OAR 436-35-320(5)(b).[6]

Turning to the adaptability issue, I agree with, and would adopt, the ALJ's conclusion that claimant's base functional capacity (BFC) was heavy. That conclusion was based on claimant's hearing testimony that three-fourths of his work duties involved lifting up to 100 pounds, which led the ALJ to conclude that the correct occupational code was Orderly, DOT # 355.674-081, a heavy strength job. I would also conclude that, based on Dr. Smith's opinion that claimant could now lift 20 to 25 pounds frequently and 60 to 80 pounds occasionally, his residual functional capacity (RFC) is medium. OAR 436-35-310(3)(g). Consequently, because claimant's BFC was heavy and his RFC is medium, his adaptability value is 3. OAR 436-35-310(6).

I assemble all the factors as follows: Adding claimant's age (1) and education (3) values equals 4. OAR 436-35-280(4). Multiplying that sum by claimant's adaptability value (3) equals 12. OAR 436-35-280(6). Finally, I add that sum to claimant's impairment value (5), for a total of 17 percent unscheduled permanent disability. OAR 436-35-280(7). I would modify the ALJ's 25 percent award accordingly.

In sum, I agree with the majority that the legislature intended amended ORS 656.283(7) to be applied retroactively and intended that it operate as a total ban of post-reconsideration evidence in extent of permanent disability cases. I disagree, however, with its due process analysis. I would hold that the statute, as applied here, violates claimant's procedural due process rights. Therefore, I would analyze this case under former ORS 656.283(7). Under that version of the statute, we are permitted to

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[4] I disagree with the majority's characterization of this dissent as being "tantamount to an 'absurd and unjust' line of reasoning." See note 16, supra. That line of reasoning provides that, although a law otherwise passes muster legally, the courts may decline to apply it if to do so would lead to an absurd or unjust result. E.g., McKean-Coffman v. Employment Div., 312 Or 543, 549, on recon 314 Or 645 (1992); Ida M. Walker, supra n 1. In my view, the law under question -- amended ORS 656.283(7) -- does not legally pass muster (because its application violates claimant's procedural due process rights). Consequently, there is no basis for the application of the "absurd and unjust" rationale. To characterize my dissent as doing so fails to recognize this distinction.

Second, I disagree with the majority's response to the merits of my dissent. The majority notes that claimant has conceded that he received adequate notice of the proceedings. See note 10, supra. The majority fails to note, however, that claimant's concession is ambiguous: In his supplemental brief, claimant "concedes that his notice is constitutionally adequate to protect his due process rights." (Claimant's Respondent's Supplemental Brief at 14). Claimant does not, however, clarify what particular aspect of notice his concession addressed. He may have been conceding that, before the goal posts were changed by Senate Bill 369, the notice of his entitlement to a full evidentiary hearing after reconsideration was constitutionally adequate. Or, he may have simply been addressing the constitutional sufficiency of notice with respect to when and where the various proceedings would transpire. Last, he may have been conceding that, notwithstanding the enactment of Senate Bill 369, the notice he received was constitutionally adequate. All of these possibilities convince me that claimant's concession is ambiguous. Therefore, in view of that concession, and the breadth of the parties' due process arguments, I find both factual and legal predicates to my addressing the notice issue as I have in this dissent.

More important, however, the majority apparently does not appreciate that, for procedural due process purposes, notice and the adequacy of the process are inseparable issues. As my dissent indicates, without adequate advance notice of the abolition of the long-standing right to a full evidentiary contested case hearing after reconsideration, the remaining process cannot pass constitutional muster.

[5] Henceforth, references to the administrative rules are to Workers' Compensation Division Administrative Orders Nos. 6-1992 and 93-056.

[6] The insurer does not dispute that value.

consider the entire record developed at hearing, including any hearing testimony. The hearing record reveals that claimant is entitled to 17 percent permanent unscheduled disability. The majority concludes otherwise. Therefore, I respectfully dissent.

Board Member Gunn dissenting.

I join Chair Hall's dissent as I, too, disagree with the majority's conclusion that the application of amended ORS 656.283(7) does not violate claimant's procedural due process rights. My disagreement, however, is not limited to those cases that arose prior to June 7, 1995. Rather, I believe that the application of amended ORS 656.283(7) does not afford the parties' sufficient due process in all instances. I write separately to raise additional concerns that I have with the results of the majority's decision.

This case involves testimony presented by claimant. However, amended ORS 656.283(7) does not make a distinction concerning which party is offering the evidence. Consequently, the evidentiary ban would also apply to evidence submitted by employers/insurers. In this regard, I believe that an employer/insurer also has a "property right" in an extent of permanent disability hearing that also should be afforded due process. Whether it is an injured worker who does not receive an award or an insurer/employer who is ordered to pay the award, the outcome of a dispute involving extent of permanent disability is significant to both sides.

By statute, any party that objects to an Order on Reconsideration may request a hearing before the Hearings Division pursuant to ORS 656.283. See ORS 656.268(6)(f). However, the effect of the majority's decision is to turn the "hearing" into an appellate review. That is, the record that is made before the Department cannot be supplemented, even if the supplementation was solely to correct obvious errors made by the Order on Reconsideration. If, for instance, a medical arbiter rates the wrong body part and the reconsideration order makes an award for that body part, how can that error be corrected if no evidence that would establish the error can be considered? In a normal workers' compensation case, the Board has the authority to remand the case for submission of further evidence, if it determines that the record has been "improperly, incompletely, or otherwise insufficiently developed." ORS 656.295(5). Now, in an extent of permanent disability case, neither the Hearings Division nor the Board has the authority to remand the case to the Department even if it is clear to all concerned that the record is incomplete or insufficient.

This brings me to the Department's "process." The majority goes to great lengths to illustrate how much "process" is given the parties under the Department's rules. While the "process" afforded the parties by the Department's rules appears on the surface to be adequate, it clearly is not when one takes into account the time limitations within which the Department process takes place. Under the rules applicable to this case, neither party could appear, in person, on reconsideration unless requested by the Department. Former OAR 436-30-050(2). Each party was required to copy any documents submitted to the Department to the other party. Former OAR 436-30-050(5)(d). All information, however, had to be submitted by the parties within six days of the Department's receipt of the request for reconsideration. Former OAR 436-30-050(7)(a). Those limitations did not give either party a realistic opportunity to thoroughly review evidence submitted by the other party, much less rebut such evidence.

Like Chair Hall, I would advocate an approach similar to that taken by the Supreme Court in Colclasure v. Wash. County School Dist. No. 48-J, 317 Or 526 (1993). I believe that this approach is particularly appropriate in light of the fact that ORS 656.268(6)(f) gives the parties a right to a hearing. In recent cases, I have dissented on decisions where I thought that the results under Senate Bill 369 were particularly harsh to injured workers. This case presents a situation where the result is harsh to both carriers and injured workers alike.

For the foregoing reasons, I respectfully dissent.

In the Matter of the Compensation of
STEPHEN A. ROSE, Claimant
WCB Case Nos. 94-10352 & 94-10351
ORDER ON REVIEW
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Gunn and Neidig.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Otto's order that: (1) declined to set aside two Disputed Claim Settlements (DCSs); and (2) held that the Hearings Division was without authority to set aside a Resignation of Employment and Release of Claims (R & R) document. On review, the issues are validity of the DCSs and jurisdiction to consider the propriety of a release of reemployment rights agreement.

We adopt and affirm the ALJ's order, with the following supplementation to address claimant's arguments on review.

In his brief on review, claimant contends that he requested postponement twice in order to obtain representation, and that both requests were rejected. The administrative record reveals that claimant requested and received a postponement in November 1994. At that time, ALJ Thye postponed the November 28, 1994 hearing, and it was rescheduled for April 14, 1995. Claimant was advised in writing several times how to obtain counsel, and was urged to do so by the ALJs assigned to his case. On March 20, 1995, ALJ Balasubramani denied claimant's second request for postponement, this one for the rescheduled April 14, 1995 hearing. Claimant did not pursue another postponement request at the hearing before ALJ Otto. Under these circumstances, we find that claimant had adequate opportunity to obtain counsel prior to the rescheduled April 14, 1995 hearing. We find no error in the ALJ's denial of claimant's second request for postponement.

Claimant also contends that he was discouraged from requesting a recess to obtain representation during the April 14, 1995 hearing. We disagree. ALJ Otto orally advised claimant of his rights in a contested case administrative hearing under ORS 183.413, including an unrepresented party's right to request a recess during the hearing if that party determines that representation is necessary. (Tr. 1-5). Claimant specifically questioned the ALJ about his right to request a recess. (Tr. 7). The ALJ responded, "[I]f you want to seek a lawyer, that's fine, we can do that. . . . So, sure, if at some point in the hearing something happens that makes you really think that you need to get a lawyer, no problem, we can take a recess and you can do that." (Tr. 8). Claimant acknowledged that his question had been answered. (Tr. 8). Claimant did not request a recess during the hearing. Accordingly, we conclude that claimant was given the opportunity, consistent with his contested case hearing rights, to request a recess during the hearing in order to obtain representation.

We proceed to the merits of the DCS issue. The grounds for setting aside a DCS are mistake, inadvertence, surprise, excusable neglect, fraud misrepresentation or other misconduct of an adverse party. William J. Knight, 46 Van Natta 2488, 2489 (1994). We agree with the ALJ that none of those grounds was present in this case. Indeed, claimant testified that he did not have a problem with signing the DCSs. (Tr. 23).

Finally, we agree with the ALJ that neither the Hearings Division nor the Board has any authority to set aside the "R & R" document. We have previously noted that the authority of the Board and its Hearings Division is confined to workers' compensation matters under ORS Chapter 656. John T. Caylor, 47 Van Natta 977, 977 n1 (1995). Therefore, our authority does not extend to issues pertaining to employment rights. Id.; Evelyn Christenson, 43 Van Natta 819, 820 (1991) (Board has no authority to approve a release of reemployment rights in a claim disposition agreement). Accordingly, the ALJ did not err in declining to set aside the "R & R" document.[1]

ORDER

The ALJ's order dated May 15, 1995 is affirmed.

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[1] It appears that claimant's dispute is actually with his former counsel that could be addressed by another forum, such as the Oregon State Bar or the Professional Liability Fund. In any event, such a reason is not an adequate ground for setting aside an approved DCS or for authorizing this agency to consider the invalidation of the "R & R" document for which it has no jurisdiction.

In the Matter of the Compensation of
BUTCH P. SALOOM, Claimant
WCB Case No. 94-09160
ORDER ON REVIEW
Moscato, Byerly, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Marshall's order that: (1) set aside its alleged "de facto" denial of claimant's claim for a left shoulder condition; (2) assessed a penalty for its failure to accept or deny that claim; and (3) assessed a penalty for an allegedly unreasonable termination of temporary disability compensation. Claimant cross-requests review of those portions of the order that: (1) found no claim for a sternocleidomastoid muscle condition; (2) found that his upper back (parascapular) condition was part of an accepted claim for a neck and right shoulder condition; and (3) did not award penalties or attorney fees regarding the alleged "de facto" denials of those claims. The insurer argues that claimant's appeal regarding alleged "de facto" denials of claims for left shoulder, sternocleidomastoid and upper back or parascapular conditions should be dismissed for failure to comply with the procedural requirements of amended ORS 656.262(6). On review, the issues are claim processing, compensability, penalties, and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant's regular work as a crane operator and iron worker involved overhead lifting. (Tr. 65-66).

On August 3, 1995 (after the ALJ's order), the insurer notified claimant that his left shoulder impingement syndrome condition was denied and that it considered his sternocleidomastoid and parascapular conditions to be part of the accepted claim (for left subcondylar and mandibular fracture; mandibular and nasal laceration; right wrist, right shoulder, and C5-6 strains; and left knee contusion conditions).

CONCLUSIONS OF LAW AND OPINION

As a preliminary matter, we address the insurer's contention that claimant's request for hearing regarding alleged "de facto" denials of claims for left shoulder, sternocleidomastoid and parascapular conditions should have been dismissed because claimant did not comply with the procedural requirements of amended ORS 656.262(6)(d).[1]

In this case, the insurer accepted claimant's claim for left subcondylar and mandibular fracture; mandibular and nasal laceration; right wrist, right shoulder, and C5-6 strains; and left knee contusion conditions. (Ex. 20). Claimant requested a hearing, contending (among other things) that the insurer had "de facto" denied claims for left shoulder, sternocleidomastoid, and parascapular conditions.

The insurer took the position at hearing that if those conditions are compensable (i.e., the sternocleidomastoid, parascapular, and left shoulder conditions), they are compensable as part of the accepted neck and right shoulder claims. (Tr. 14, emphasis added). The insurer asserted that claimant's left shoulder impingement was not due to the March 1993 injury.[2]

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[1] ORS 656.262(6)(d), as amended, provides, in part, that a worker who believes that a condition has been incorrectly omitted from a notice of acceptance must first communicate in writing to the carrier the worker's objection to the notice. OR Laws 1995, ch 332, §28(6)(d) (SB 369, §28(6)(d)). The amended statute also provides that the worker may initiate objection to the notice of acceptance at any time. Id.

[2] It explained:

"I just want you to know that our position is -- is really two-fold, and -- and that is that there's probably insufficient evidence, particularly on the left shoulder and the parascapular and -- certainly, if I'm wrong in that regard, all three of these conditions alleged by claimant to be de facto denial -- denied fall within -- are subsumed within the acceptance. . . ." (Tr. 15).

Considering the insurer's failure to respond to claims for medical services for the left shoulder, in conjunction with the above assertion that the left shoulder condition is not related to the work injury, we agree with the ALJ's conclusion that the claim for left shoulder condition was denied at the time of hearing. See Guillermo Rivera, 47 Van Natta 1723 (1995). Moreover, in our view (and despite the insurer's purported "two-fold" position[3]), the insurer consistently opposed claimant's claim for a left shoulder condition. Under these circumstances, we conclude that substantial justice would not be served by remanding the case for compliance with the procedural requirements of amended ORS 656.262(6)(d). See Gerald A. Keipinger, 47 Van Natta 1509, 1512 (1995); Renee M. Wilshire, 47 Van Natta 1339 n.1 (1995).

As a second preliminary matter, we consider the effect of the insurer's "post-order" partial acceptance of claims for parascapular and sternocleidomastoid conditions on claimant's request for review challenging the ALJ's conclusions regarding those alleged claims.

A carrier is bound by the express language of the acceptance. SAIF v. Mize, 129 Or App 636 (1994). In Mize, prior to petitioning for judicial review of a Board order, the carrier accepted the claimant's claim by a clear and unqualified Notice of Acceptance. The court held that the carrier's acceptance rendered moot any controversy over the compensability of the claimant's claim, and dismissed the employer's petition for judicial review. Id.; see Scott C. Clark, 47 Van Natta 133 (1995); Timothy L. Williams, 46 Van Natta 2274 (1994).

Here, as in Mize, supra, the insurer accepted claims after issues arising under those claims had been litigated at hearing. In our view, the partial acceptance in this case is similarly clear and unqualified.[4] Thus, the compensability issues raised by claimant's appeal from the ALJ's order regarding the compensability of the parascapular and sternocleidomastoid conditions are moot (i.e., no longer viable) because the parties are no longer adverse to each other on these issues.

However, the issues of whether claims for parascapular and sternocleidomastoid conditions were made and denied at hearing (prior to the insurer's "post-hearing" acceptance) is still viable to the extent that they must be addressed to resolve the penalty and attorney fee questions. Accordingly, we address those issues in the section entitled "Penalties and Attorney Fees."

Compensability/Left Shoulder Condition

We agree with the ALJ that claimant established at hearing that his left shoulder condition is compensable as a direct result of the March 29, 1993 work injury. Accordingly, we adopt the ALJ's opinion and conclusions on this issue, including the related attorney fee award.

Penalties and Attorney Fees

We adopt the ALJ's opinion and conclusion regarding the unreasonableness of the insurer's termination of the temporary disability benefits, with the following modification and supplementation.

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[3] We do not find the second prong of the insurer's "two-fold" position --that all three of the disputed conditions are "subsumed" within its acceptance (see n.3, supra) -- to be a realistic or practical "alternative." Instead, we find it to be irreconcilably inconsistent with the insurer's specific assertion that the left shoulder condition is not injury-related. The insurer cannot have it both ways. If a claim was made, it was either accepted or denied. Accordingly, as explained above, we conclude that the claim for a left shoulder condition was more likely denied than accepted.

[4] The insurer's August 3, 1995 letter states in part:

"Please understand that your accepted neck and right shoulder conditions remain accepted. Your sternocleidomastoid and parascapular symptoms are considered part of the accepted neck and right shoulder conditions and all bills received for treatment of these symptoms, as well as treatment provided for symptoms at the base of your neck near the shoulder joint but not in the shoulder joint itself, have been paid, The only condition we are denying at this time is the condition in your left shoulder joint itself." (See Exhibit C, attached to claimant's Respondent's/Cross-Appellant's Brief).

Subsequent to the ALJ's order in this matter, the Legislature amended ORS 656.268, which sets out the requirements for unilateral termination of temporary disability benefits.[5]

Assuming (without deciding) that the amended version of ORS 656.268(3)(b) applies to this case, the result would be the same, because we agree with the ALJ that claimant was not released to his regular work (without restrictions) before claim closure. We reach this conclusion based on the following reasoning.

On June 23, 1994, Dr. Grewe released claimant to return to work as of June 24, 1994. (Exs. 64, 64A).[6] The release included explicit restrictions: "Avoid overhead activities and heavy lifting." Id. Considering these restrictions, in light of the fact that claimant's regular work (as a crane operator and iron worker) involved overhead lifting, we are not persuaded that the June 23, 1994 release amounted to a release to "regular" work. We find no subsequent work release which would support the insurer's unilateral termination of temporary disability benefits prior to claim closure under either version of the statute. (See Ex. 66A-1-2; see also Exs. 62-7, 69A-1). Under these circumstances, we agree with the ALJ that the August 30, 1994 termination of temporary disability compensation was unreasonable and a penalty was appropriate on that basis. Former ORS 656.262(10)(a); see also amended ORS 656.262(11)(a).

We also agree with and adopt the ALJ's reasoning and conclusion concerning the unreasonableness of the insurer's processing of claimant's claim for a left shoulder condition.

Finally, as we previously noted, although compensability of the parascapular and sternocleidomastoid conditions is moot, that does not necessarily mean that the related penalty and attorney fee issues are also moot. However, we need not determine whether the insurer's conduct regarding the alleged claims for parascapular and/or sternocleidomastoid conditions was unreasonable because there is no evidence of a penalty basis (i.e., "amounts then due" upon which a penalty might be based). See ORS 656.262(11)(a). Further, even if the insurer's conduct was unreasonable, we find no evidence of unpaid compensation for these alleged claims, and therefore conclude that claimant is not entitled to an attorney fee under ORS 656.382(2). See SAIF v. Condon, 119 Or App 194, rev den 317 Or 162 (1993); Bruce Hardee, 46 Van Natta 261 (1994).

Claimant also seeks attorney fees regarding the compensability of his claims for parascapular and/or sternocleidomastoid conditions, based on the insurer's "post-order" acceptance of those conditions. (See n.5, supra). We award a fee for claimant's counsel's services at hearing regarding the sternocleidomastoid muscle condition only, as explained below.

We agree with the ALJ that there is no new claim for a parascapular condition which is separable from the accepted claim. Consequently, claimant has not prevailed over a denied claim for a parascapular condition and no fee is available under ORS 656.386. See Gates v. Liberty Northwest Ins. Corp., 131 Or App 164 (1994).

The ALJ also found that no claim for a sternocleidomastoid condition had been filed (in the absence of related medical services or disability). We disagree.

"'Claim' means a written request for compensation . . .or any compensable injury of which a subject employer has notice or knowledge." ORS 656.005(6). An insurer is not obligated to accept or deny a claim until it has notice or knowledge sufficient to prompt a reasonable belief that workers' compensation liability is a possibility. See ORS 656.262(6); William H. Waugh, 45 Van Natta 919 (1993).

On the other hand, when a worker suffers a work-related injury, he or she is entitled to know how badly he or she was hurt and whether any treatment would be appropriate. Kelly Barfuss, 44 Van Natta 239 (1992); see Finch v. Stayton Canning Co., 93 Or App 168, 173 (1988).

In this case, the employer had knowledge of claimant's compensable injury. The mass, or bulge, on claimant's neck did not preexist the injury, it was not accepted prior to hearing, and there is

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[5] ORS 656.268(3)(b) now provides, in relevant part, that temporary total disability benefits shall continue until "[t]he attending physician advises the worker and documents in writing that the worker is released to return to regular employment." Or Laws 1995, ch 332, § 30(3)(b) (SB 369, § 30 (3)(b)).

[6] The next-to-last sentence of the first full paragraph on page 6 of the Opinion and Order is modified to reflect that Dr. Grewe's release to work was dated June 23, 1994, rather than August 23, 1994.

no evidence or argument that it was anything but injury-related. Claimant was concerned about the nature and extent of an injury evinced by the bulge. His physical therapist and a co-worker discussed the bulge and "encouraged [claimant] to speak with his physician about this injury." (Ex. 75). Claimant raised the issue with Dr. Freeman, who discussed the bulge with claimant's radiologist. "[T]he swelling in the neck was thought to be due to intra-muscular scarring in the sternocleidomastoid, probably secondary to bleeding in the muscle related to the injury of record. . . ." (Ex. 34). In a section entitled "Treatment," in the same report, Dr. Freeman interpreted the "mass as being due to scarring, presumably an organized hematoma or intra-musculure [sic] hemorrhage in the sternocleidomastoid." (Id). Conservative treatment was recommended, apparently for claimant's right shoulder and neck. (Id).

On this evidence, we find that claimant did perfect a separate claim for his sternocleidomastoid muscle condition, which the insurer failed to timely accept or deny. Further considering the insurer's opposition to the claim at hearing, we conclude that the claim for a sternocleidomastoid muscle condition was in denied status at hearing. In addition, based on Dr. Freeman's uncontradicted opinion and the mechanism of claimant's injury, we conclude that the condition was proven compensable.[7] Accordingly, claimant is entitled to an attorney fee for his counsel's services at hearing associated with prevailing over this denied 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 the hearings level regarding the sternocleidomastoid muscle condition is $750, payable by insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

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

ORDER

The ALJ's order dated May 10, 1995 is reversed in part and affirmed in part. That portion of the order that found that there was no sternocleidomastoid claim and declined to award an attorney fee is reversed. The insurer's denial of that claim is set aside and the claim is remanded to it for processing according to law. For services at hearing regarding the claim for a sternocleidomastoid muscle condition, claimant is awarded a $750 attorney fee, payable by the insurer. The remainder of the ALJ's order is affirmed. For services on review regarding the claim for a left shoulder condition, claimant is awarded a $1,000 attorney fee, payable by the insurer.

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[7] Specifically, we find that claimant established that his work injury caused his sternocleidomastoid muscle condition. See OR 656.005(7)(a).

February 15, 1996 Cite as 48 Van Natta 344 (1996)

In the Matter of the Compensation of
LISA M. SCHLECHT, Claimant
WCB Case No. 94-01791
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) dismissed claimant's hearing request as untimely; and (2) found that the insurer did not "de facto" deny claimant's lumbar disc herniations. On review, the issues are timeliness of hearing request, "de facto" denial and, alternatively, compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the first finding of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Hearing Request

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

"De Facto" Denial / Compensability

Reasoning that the insurer's denial encompassed claimant's entire back condition, the ALJ concluded that the insurer did not "de facto" deny claimant's lumbar disc herniations.[1] Claimant asserts that the ALJ erred, because the denial was limited to a lumbar strain. We need not address that issue, because, as explained below, claimant's disc herniation claim is not compensable.

The evidence establishes that claimant had preexisting degenerative disc disease. (Ex. 20-3; see Exs. 25, 28-7, 32-1). Because her work injury combined with the preexisting disease, she must establish that her work injury was the major contributing cause of her lumbar disc herniations. ORS 656.005(7)(a)(B).[2] Claimant relies on the reports of Drs. Wagner, Platt and Peterson, and Ostrander. Those reports do not suffice under that statute.

In a conclusory concurrence report, Dr. Wagner, a treating physician, stated that claimant did not have a preexisting spinal condition and that her L5-S1 disc herniation was caused, in major part, by her work injury. (See Exs. 27-1). Drs. Platt and Peterson, examining physicians, concluded that claimant had low back strain, but not a L5-S1 disc herniation, and that "[t]emporally, the job injury is the major cause for the need for treatment * * *." (Ex. 28-7; emphasis added). Last, Dr. Ostrander, another treating physician, concluded that it was more likely than not that claimant's current condition was related to or a result of her work injury. (Ex. 35-2).

We find those reports unpersuasive for the following reasons. Dr. Wagner's report is conclusory. Moreover, to the extent that it states that claimant has no preexisting degenerative spinal condition, it belies persuasive evidence to the contrary. (Ex. 20-3; see Exs. 25, 28-7, 32-1).

Next, Drs. Platt's and Peterson's report is based on a temporal relationship between claimant's work injury and her need for treatment. Because Platt and Peterson believed that claimant only had a low back strain, at most, their report stands for the proposition that claimant's low back symptoms were chronologically related to her work injury. That is not enough to meet her burden of proof. See ORS 656.266; Allie v. SAIF, 79 Or App 284, 288 (1986) (court declined to infer causation from chronological sequence of injury and symptoms).

Last, Dr. Ostrander's report is unpersuasive, because it fails to address the role, if any, claimant's degenerative condition played in her current condition. Lacking that analysis, we conclude that, at most, Ostrander identified the precipitating cause of claimant's lumbar disc condition. That is not sufficient to establish the major contributing cause of that condition. Dietz v. Ramuda, 130 Or App 397, 401 (1994) (precipitating cause of condition not necessarily major cause of condition).

In sum, none of the reports on which claimant relies is sufficient to establish a compensable claim under ORS 656.005(7)(a)(B). In light of that conclusion, we need not address the "de facto" denial issue.

ORDER

The ALJ's order dated August 4, 1995 is affirmed.

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[1] Claimant has been diagnosed with both L4-5 and L5-S1 disc herniations. It is unclear which herniation claimant seeks compensation for. In view of our conclusion regarding compensability, we need not resolve that issue.

[2] The Legislature amended ORS 656.005(7)(a)(B) in 1995. Or Laws 1995, ch 332, § 1. Those amendments are not germane here.

Board Member Gunn dissenting.

Four physicians relate claimant's low back condition to her work. Dr. Wagner, treating physician, concluded that claimant did not have a preexisting spinal condition and that her L5-S1 disc herniation was caused, in major part, by her work injury. (Ex. 27-1). Two examining physicians dispute whether claimant has a disc herniation, but nevertheless conclude that, based on the temporal relationship between claimant's work injury and symptoms, her work injury is the major cause of her need for treatment. (See Ex. 28-7). Last, Dr. Ostrander, another treating physician, concluded that, on a more-likely-than-not basis, that claimant's current condition was related to, or the result of, her work injury. (Ex. 35-2).

I agree with the majority that claimant has a disc herniation and a preexisting spinal condition. I disagree, however, with its conclusion regarding the cause of the herniation. Taken as a whole, I would find that the medical evidence is sufficient to establish that claimant's work is the major contributing cause of her disc herniation. Three physicians specifically use the "major cause" lingo; the other couches his report in terms of medical probability. In light of the consistency with which all the medical experts relate claimant's work injury and her current condition, I would conclude that claimant has established a compensable claim.

The examining physicians' reliance on a temporal relationship between claimant's work injury and need for treatment does not convince me otherwise; there is more than enough other evidence to establish the requisite level of causation. Moreover, Dr. Wagner's erroneous conclusion that claimant did not have a preexisting spinal condition does not, in my estimation, undercut the persuasiveness of Wagner's causation opinion, because that opinion comports with the other expert evidence.

The majority, yet again, engages in a hyper-technical review of the evidence to reject this claim. Because I decline to impose such a high burden on this, or any other, claimant, I dissent.

February 15, 1996 Cite as 48 Van Natta 346 (1996)

In the Matter of the Compensation of
SUSAN SCHWARTZ, Claimant
WCB Case No. 94-11502
ORDER ON REVIEW
Glenn M. Feest, Claimant Attorney
Bostwick, et al, Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order which: (1) upheld the insurer's denial of claimant's left hand and forearm condition; and (2) declined to assess a penalty for the insurer's allegedly untimely denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. However, we do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a fine jewelry sales associate, sought treatment in June 1994 for left thumb numbness and left arm pain of approximately three weeks duration. Claimant's work activity involved unlocking jewelry cases and reaching in and out of the cases to show customers pieces of jewelry. She estimated that she assisted an average of 35 customers in an eight-hour day, spending about 10 minutes per customer, reaching in and out of jewelry cases an average of 16 times with each customer. (Tr. 12-13). In July 1994, nerve conduction studies suggested mild bilateral carpal tunnel syndrome at the wrist.

On June 24, 1994, the insurer acknowledged receipt of claimant's occupational disease claim for left thumb and arm numbness and pain. (Exs. 4, 5, 5A). The insurer denied the claim on February 24, 1995. (Ex. 24).

Compensability

The ALJ evaluated the medical opinions and concluded that the opinion of examining physician Dr. Duff was more persuasive. Based on Dr. Duff's opinion, the ALJ upheld the denial of claimant's occupational disease claim. We disagree.

In order to establish a compensable occupational disease claim, claimant must prove that employment conditions were the major contributing cause of the disease. Amended ORS 656.802(2)(a); see also amended ORS 656.802(1)(a)(C); Or Laws 1995, ch 332 § 56 (SB 369, § 56).[1] In addition, the existence of an occupational disease must be established by medical evidence supported by objective findings. Amended ORS 656.802(2)(d).

We agree with the ALJ's determination that there is sufficient objective evidence in the form of nerve conduction studies to support the existence of an occupational disease. (Ex. 6).

Because numerous factors could potentially contribute to claimant's condition, the cause of her occupational disease is a complex medical question which requires expert medical opinion to resolve. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985). Drs. Gill, Seymour and Duff offered differing opinions regarding the cause of claimant's condition.[2] When medical opinions differ, we generally give greater weight to the treating doctor's opinion, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We find no such reasons in this case.

Dr. Gill, a hand surgeon who began treating claimant in August 1994 on referral from her initial treating physician, Dr. Seymour, opined that claimant's work activities were the primary cause of her bilateral upper extremity problems. (Ex. 22-2). He diagnosed claimant's condition as atypical carpal tunnel syndrome (CTS), noting that she did not have nighttime symptoms. (Ex. 8). He considered claimant's work activity to be moderately repetitive, but sufficiently repetitive and unusual in nature to be the primary agent responsible for her symptoms. (Exs. 8, 22-2). He noted that claimant had bilateral symptoms which were "a bit" worse on the left. (Ex. 8). In treating claimant, Dr. Gill noted that her symptoms improved when she was off work, but flared up after her work evaluation. (Ex. 13). Based on the nature of claimant's activities, her response to rest, and the absence of any other activity which might have appreciably contributed to her condition, Dr. Gill opined that claimant's work activities were the major contributing cause of her condition. (Ex. 22-2).

Dr. Seymour, claimant's initial treating physician, also opined that work activity was the major contributing cause of claimant's condition. (Ex. 11). He based his opinion on his understanding that claimant's work required "almost constant" wrist flexion to reach in for jewelry, and on the absence of any other history that would have contributed to her condition. (Id.).

Dr. Duff, an orthopedist who examined claimant at the insurer's request, opined that work activity was not the major contributing cause of claimant's condition, which he diagnosed as mild bilateral median neuropathy. (Ex. 9 at 5-6). Instead, he opined that idiopathic causes were responsible for about 90 percent of the cause of claimant's problem. (Ex. 26 at 34-35). He opined that causes unrelated to work, such as age, gender, general health, hormonal variations, and anatomy, were probably together the major cause of claimant's condition, while manual activity was probably a minor contributor. (Ex. 26 at 6-20, 29). He based his opinion on the following considerations: (1) that claimant's symptoms were worse in her non-dominant left hand; (2) that claimant's symptoms came on at night, which is uncharacteristic of work-induced CTS; and (3) that claimant had no history of the kind of repetitive, hand-intensive work activity that is associated with work-induced CTS. (Ex. 26 at 21-23). Dr. Duff's understanding of the nature of claimant's work activity was based on his own observation of the activities of fine jewelry salespeople and on his belief that claimant would slide trays out to demonstrate the jewelry. (Ex. 26 at 24-29).

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[1] Since there are no relevant exceptions, the statutes as amended by Senate Bill 369, effective June 7, 1995, apply to this case. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995).

[2] Drs. Podemski and Marble also offered opinions after examining claimant at the insurer's request. However, we agree with the ALJ's assessment that their opinions are entitled to little weight because they believed claimant had only a subjective condition, a proposition which we believe is inconsistent with the rest of the record. (Ex. 18-3).

We find Dr. Gill's opinion to be well-reasoned and based on complete information, including an accurate understanding of the nature of claimant's work activity. In addition, Dr. Gill, as the treating physician, had the advantage of observing claimant's response to being off work. Finally, Dr. Gill's opinion is supported by the opinion of the initial treating physician, Dr. Seymour.

On the other hand, Dr. Duff's opinion suffers from several infirmities. Dr. Duff found it significant that claimant's symptoms were worse in her non-dominant left hand, reasoning that therefore manual activity was a minor factor in the cause of her condition. However, this reasoning is inconsistent with Dr. Duff's own diagnosis of bilateral median neuropathy, the nerve conduction studies which revealed bilateral neuropathies, and Dr. Gill's observation that claimant's symptoms were only "a bit" worse on the left. Also, Dr. Duff believed claimant had night symptoms, which he explained was uncharacteristic of work-induced CTS. However, Dr. Gill noted that claimant did not have night symptoms, a finding that Dr. Duff concedes is characteristic of work-induced CTS. (Ex. 26-22). In addition, Dr. Duff did not have an accurate understanding of the nature of claimant's particular work activities, since he based his understanding on his personal observation of the activities of jewelry salespeople, rather than on claimant's particular work activities, and since he erroneously believed that claimant removed jewelry by sliding drawers out of the cabinets. Finally, although Dr. Duff believed that idiopathic factors contributed 90 percent to the cause of claimant's problem, his estimate of the percentage contribution of particular factors was merely speculative, based on statistical correlations rather than on claimant's particular situation. For these reasons, we conclude that Dr. Duff's opinion is entitled to little weight.

Accordingly, we rely on the more persuasive opinion of treating physician Dr. Gill, as well as the supporting opinion of Dr. Seymour, and find that claimant's left hand and forearm condition is compensable as an occupational disease.

Penalty and Attorney Fees

Claimant also contends that she is entitled to a penalty and penalty-related attorney fee for the insurer's late denial of her claim. The insurer concedes that the denial was not timely. (Exs. 5A, 24); amended ORS 656.262(6)(a) (SB 369, § 28). Inasmuch as the insurer offered no justification for its untimely claim processing, we find that its delay in denying the claim was unreasonable. Accordingly, since we have found the claim compensable and, therefore, there are amounts due, claimant is entitled to a penalty under amended ORS 656.262(11)(a). This penalty (which shall be shared equally between claimant and her attorney) shall be based on 25 percent of the compensation due (as a result of this order) as of the date of hearing (May 19, 1995).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability issue is $3,510, payable by insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellate briefs, and claimant's attorney's statement of services), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated June 19, 1995 is reversed. The insurer's February 24, 1995 denial is set aside, and the claim is remanded to the insurer for processing in accordance with law. A penalty is assessed in the amount of 25 percent of amounts due (as a result of this order) as of the date of hearing (May 19, 1995), payable by the insurer, one half to claimant and one half to her attorney. Claimant's attorney is awarded $3,510 for services at hearing and on Board review, to be paid by the insurer.

In the Matter of the Compensation of
ARTHUR R. MORRIS, Claimant
WCB Case No. 93-04870
ORDER ON RECONSIDERATION
Brothers, et al, Claimant Attorneys
David O. Horne, Defense Attorney

On November 22, 1995, we abated our October 27, 1995 Order on Review which held that we lacked jurisdiction over claimant's request for medical services. Having received responses from the parties, we proceed with our reconsideration.

In our prior order, we vacated the ALJ's order and dismissed claimant's request for hearing. On reconsideration, claimant contends that we erred in concluding that we lacked jurisdiction over the medical services dispute. Claimant also contends that the Board retains jurisdiction because the dispute concerned causation, not merely the appropriateness of proposed surgery. In the alternative, if causation is not still in dispute, claimant requests an affirmative finding of compensability and an associated attorney fee award.

Along with his motion for reconsideration, claimant submitted an August 28, 1995, Director's medical services order of dismissal. Specifically, claimant asks that we supplement the record with this document. We may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned," such as a Department order or filing with the Board. See e.g., Grace B. Simpson, 43 Van Natta 1276, 1277 (1991). The Director's order is the type of document of which we may take administrative notice. Accordingly, on reconsideration, we will consider the Director's August 28, 1995 order.

For the following reasons, we adhere to our prior conclusion that we lack jurisdiction over the medical services dispute. In addition, we find that we retain jurisdiction over that portion of the claimant's hearing request that concerned compensability of his current, underlying condition, and we conclude that claimant's current low back condition is compensable.

In our prior order, we held that the provisions of ORS 656.327(1) and ORS 656.245(6), as amended by Senate Bill 369, applied retroactively to this case and deprived the Board of jurisdiction over the parties' medical services dispute. The court has held that absent a specific exception, SB 369 applies to matters for which the time to appeal the Board's decision has not expired or, if appealed, has not been finally resolved on appeal. Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 573 (1995); see also Walter L. Keeney, 47 Van Natta 1387 (1995).

We have previously held that, pursuant to amended ORS 656.327 and ORS 656.245(6), the Board lacks jurisdiction over the propriety of proposed medical services. John L. Willhite, 47 Van Natta 2334 (1995); Lynda J. Zeller, 47 Van Natta 1581, on recon 47 Van Natta 2337 (1995); Thomas L. Abel, 47 Van Natta 1571 (1995). Here, the principal issue involves the reasonableness and necessity of proposed surgery. Since the question concerns the appropriateness of medical services, the Director has exclusive jurisdiction over this portion of the parties' dispute. Amended ORS 656.327(1); amended ORS 656.245(6); Newell v. SAIF, supra.

Claimant contends that the Board retains jurisdiction because compensability of the underlying condition is in dispute. Alternatively, if compensability is no longer in dispute, claimant requests that we affirmatively find his condition compensable and award an attorney fee.

We have jurisdiction to decide the compensability of the underlying condition (causation). We have previously held that we retain jurisdiction over a medical treatment dispute where the issue concerns whether treatment for a worker's condition was causally related to his compensable injury. Richard L. Wheeler, 47 Van Natta 2011 (1995). However, once we have resolved the compensability issue, we have held that the Director has exclusive jurisdiction over the issue of the propriety of proposed medical treatment. Lynda J. Zeller, supra.

Accordingly, we reinstate claimant's hearing request to the extent that it concerned the compensability of his underlying condition.

Here, compensability of the underlying condition was apparently resolved in the course of the hearing in this matter. At hearing, the insurer's counsel appeared to concede that compensability of the underlying condition was not in dispute. (Tr. 11). On reconsideration, claimant agreed that the insurer conceded causation during the hearing. In response to claimant's motion for reconsideration, the insurer explicitly stated that compensability was not in dispute. Thus, we find that the compensability of the underlying condition is no longer in dispute in this case.

A Director's medical services order issued in this case on August 28, 1995, dismissing the medical services dispute for lack of jurisdiction. The basis for the Director's order was his finding that compensability of the underlying condition was in issue and litigation was still pending on that matter. Specifically, the Director found that the insurer issued a formal denial of the compensability of the condition for which claimant was seeking surgery; that the denial was set aside by the Board's ALJ in an order that issued December 5, 1994; that the insurer appealed that order; and that the appeal was still pending before the Board on August 28, 1995, the date of the Director's order. The Director concluded that he lacked jurisdiction over the medical services dispute until the compensability issue was resolved.

Based on the following reasoning, it is apparent that the issue of whether claimant's current condition (for which the proposed medical treatment is in dispute) is causally related to his compensable low back condition has been resolved. On April 13, 1993, the insurer denied compensability of claimant's low back condition as not causally related to the accepted 1977 claim, as well as authorization for the L4-5, L5-S1 decompression surgery requested by Dr. Nash. (Ex. 88). At hearing, the insurer conceded that compensability (causal relationship) was not in issue, confirming this position in writing in response to claimant's motion for reconsideration. Accordingly, we conclude that the insurer rescinded its compensability denial at hearing, conceding that claimant's current low back condition was causally related to his accepted 1977 claim.

On reconsideration, claimant contends that if we find the current condition compensable, he is entitled to an attorney fee under ORS 656.386(1) for his counsel's services in prevailing on the compensability issue. Since we retain jurisdiction over the compensability (causation) aspect of claimant's hearing request, we also retain jurisdiction to award an attorney fee for prevailing on the compensability issue.

Inasmuch as we have found that this case involved a "denied claim" and the insurer rescinded its denial prior to the ALJ's decision, claimant is entitled to an attorney fee, to be paid by the insurer, if his attorney was instrumental in obtaining rescission of the denial. Amended ORS 656.386(1); Guillermo Rivera, 47 Van Natta 1723 (1995). Although the record is scant on this issue, we find that claimant's attorney was instrumental in obtaining rescission of the denial. Specifically, we note that claimant's attorney identified the compensability issue in his opening remarks, to which the insurer's attorney responded by effectively rescinding the compensability denial. (Tr. 10, 11). Under such 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 regarding the pre-hearing rescission of the denial is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Accordingly, we withdraw our October 27, 1995 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our October 27, 1995 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
MICHAEL J. GALBRAITH, Claimant
WCB Case No. 95-03825
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by the Board en banc.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that declined to award an attorney fee under amended ORS 656.386(1). On review, the issue is attorney fees.

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

At the June 19, 1995 hearing, claimant's counsel sought an attorney fee pursuant to ORS 656.386(1) for obtaining compensation for claimant without a hearing. Applying amended ORS 656.386(1), the ALJ found that there was no express denial of claimant's right femur fracture and that no attorney fee was awardable under that statute. We agree.

In the absence of a specific exception, the changes to the Workers' Compensation Law made by SB 369 apply to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act (June 7, 1995). Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 569 (1995). Because there has been no final decision in this matter and because none of the other exceptions to retroactive application of the statute are applicable, we conclude that amended ORS 656.386(1) applies to claimant's claim. See Or Laws 1995, ch 332, § 66 (SB 369, § 66); Guillermo Rivera, 47 Van Natta 1723 (1995) (applying amended ORS 656.386(1) retroactively).

Under amended ORS 656.386(1), claimant's attorney is entitled to an attorney fee "in cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge." SB 369, § 43(1). Here, we must determine whether claimant's right femur fracture claim was a "denied claim." Amended ORS 656.386(1) defines a "denied claim" as:

> "[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. A denied claim shall not be presumed or implied from an insurer's or self-insured employer's failure to pay compensation for a previously accepted injury or condition in a timely fashion." (Emphasis added).

There is no evidence in this record that SAIF "refused to pay" any compensation. In addition, there is no evidence of a "denied claim" as contemplated by the statute. In this regard, we previously addressed the question of whether there was a "denied claim" for purposes of amended ORS 656.386(1) in Guillermo Rivera, supra. In Rivera, the employer's attorney had acknowledged that there would be an attorney fee for a "de facto" denial of a cervical condition. In addition, in its appellant's brief, the employer contended that it had "reason to question the causation" of the cervical claim. Based on those portions of the record, we determined that there was a "denied claim" pursuant to amended ORS 656.386(1). Thus, we concluded that the claimant had established an entitlement to an attorney fee under the statute.

We find the present case to be distinguishable from Rivera. First, the record does not contain evidence that SAIF refused to pay compensation. To the contrary, the record establishes that all benefits for claimant's fractured femur were paid under his compensable paraplegia claim. Furthermore, unlike Rivera, there is no concession that a fee should be awarded and no acknowledgment in the record that SAIF questioned the causal relationship of the femur fracture to the compensable injury. Likewise, there is no other evidence in the record that SAIF questioned the causation of claimant's right femur

fracture.[1] Under such circumstances, the record does not establish that SAIF refused to pay compensation on the express ground that the femur fracture was not compensable or did not give rise to an entitlement to any compensation. Consequently, we conclude that a "denied claim" has not been established. Accordingly, we agree with the ALJ that an attorney fee may not be awarded under amended ORS 656.386(1).[2]

Claimant argues that he secured entitlement to an attorney fee under former ORS 656.386(1) when he requested a hearing on a "de facto" denial of the femur fracture (prior to the passage of SB 369). Claimant further contends that § 66(6) of SB 369 prevents the retroactive application of SB 369 in this case. We disagree with claimant's reasoning.

SAIF did not accept the femur fracture condition until the date of hearing, June 19, 1995, after the passage of SB 369. (Tr. 1). Thus, claimant's attorney did not obtain rescission of the "de facto" denial (and secure the right to an attorney fee) until after amended ORS 656.386(1) was in effect. Thus, we do not agree with claimant's argument that he had perfected his entitlement to an attorney fee prior to the effective date of the Act.

Moreover, even assuming that SAIF had accepted the femur fracture prior to the passage of SB 369, the Act is retroactive and applies to all cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act, unless there is a specific exception to retroactive application. Because this matter is not final, and because there are no applicable exceptions to retroactive application of the Act, amended ORS 656.386(1) governs whether a fee is awardable. Thus, it is not material that an attorney fee would have been available under the former statute since that statute does not apply to this case.

Claimant next argues that § 66(6) of SB 369 prevents the retroactive application of amended ORS 656.386(1). Section 66(6) provides that the amendments to the Act do not extend or shorten the procedural time limitations with regard to any action taken prior to the effective date of the Act. Inasmuch as amended ORS 656.386(1) does not contain any provisions which extend or shorten any procedural time limitations, § 66(6) does not prevent the retroactive application of the statute.

Finally, claimant contends that "due process dictates that SB 369 cannot retroactively extinguish an attorney fee that had previously been perfected prior to its passage." First, we note that no attorney fee had been awarded prior to the new law. Consequently, there was no final attorney fee award prior to the effective date of SB 369. Under such circumstances, there was no vested right to an attorney fee. See Kathleen M. Butler, 47 Van Natta 2202 (1995) (Where order entitling a claimant to benefits had not become final, there was no "vested right" to such benefits). In any case, claimant does not further elaborate on or explain his constitutional argument. Because claimant's constitutional argument is not adequately developed for our review, we are not inclined to address it further. See Ronald B. Olson, 44 Van Natta 100 (1992) (Board declined to address unspecified constitutional challenges to the 1990 amendments).

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[1] The only portion of the record which could arguably support a conclusion that this is a "denied claim" is SAIF's response to claimant's requests for hearing. In its response to claimant's hearing requests, SAIF stated: "The claimant is entitled to no relief." According to ORS 656.386(1), a "denied claim is one in which the carrier "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." Given that this record does not establish any refusal to pay any compensation, we do not consider SAIF's responsive pleading, on its own, sufficient to manifest a "denied claim."

[2] The dissent argues that our interpretation of the statutory scheme allows a carrier to escape penalties for failure to process a claim. Here, there is no evidence that any benefits have not been paid. Thus, there are no amounts "then due" upon which to base a penalty under ORS 656.262 (11)(a) and no unreasonable resistance to payment of compensation under ORS 656.382(1). However, this does not mean that in another such case, penalties and fees will not be available should a carrier unreasonably or untimely process a claim.

The dissent also argues that our decision has not resulted in reduced litigation. We disagree. Although this matter ultimately proceeded to hearing, the hearing was limited to the issue of claimant's counsel's entitlement to an attorney fee. Thus, the amended statute has obviated the need to litigate the compensability of claimant's femur fracture. The litigation of the attorney fee is issue far less onerous and time consuming than litigation of the compensability issue would have been.

ORDER

The ALJ's order dated June 27, 1995 is affirmed.

Board Member Gunn dissenting.

As a result of his compensable injury, claimant is paraplegic and is confined to a wheelchair. On November 4, 1994, claimant fell from his wheelchair and fractured his femur. Claimant's physicians indicated that the fracture was a result of the paraplegia. Although SAIF received the x-ray report showing the fracture on November 20, 1994 (Ex. 5C), the fracture claim was not accepted or denied within 90 days as required by the law. Claimant's attorney filed a hearing request on June 8, 1995 raising as an issue a "de facto" denial of the fracture. SAIF accepted the fracture the day of the scheduled hearing.

Pursuant to ORS 656.262(6)(a), the insurer has the duty to process the claim and issue an acceptance or denial within 90 days of notice or knowledge of the claim. The majority's interpretation of amended ORS 656.386(1) would excuse carriers from complying with ORS 656.262(6)(a). In other words, based on the majority's interpretation of amended ORS 656.262(6)(a), a carrier may take no action on a claim and escape all penalties for its failure to process the claim. This interpretation of amended ORS 656.386(1) makes no sense and gives no effect to ORS 656.262(6)(a).

Another problem I see with the majority's interpretation of the statute is that it fails to achieve the goal of reduced litigation. In this case, SAIF received the x-ray report showing the fracture on November 20, 1994. Nevertheless, in spite of uncontroverted evidence linking the fracture to the compensable condition, the case did not settle until June 19, 1995, the date of hearing. As this case illustrates, amended ORS 656.386(1) as the majority interprets it, does not reduce litigation. Rather, the majority's interpretation of the statute will only encourage carriers to take no action and force litigation.

It is my belief that SAIF's inaction with regard to the hip fracture claim manifests an intent to deny that condition. I believe that SAIF's inaction entitles claimant's attorney to a fee. It is evident that the claim was accepted only because of the hearing request filed by claimant's lawyer. The carrier has a duty to process the claim and cannot simply choose to take no action and escape all liability for its unreasonable actions by accepting the claim at the last moment. By its conduct, I believe that SAIF has manifested its intent to deny the compensability of the fracture. Furthermore, given these circumstances, where the carrier clearly had notice of the fracture and its relationship to the compensable injury, I believe that the carrier's inaction rises to the level of an "express" denial of the claim. As such, I would find that there was a "denied claim" here and would award claimant's attorney a reasonable attorney fee pursuant to amended ORS 656.386(1). For these reasons, I respectfully dissent.

Board Chair Hall dissenting.

Amended ORS 656.386(1) defines a "denied claim" as "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). Here, there was a series of written requests for hearing from claimant (specifically raising the issue of compensability of fractured right femur and "introchanteric right hip fracture"). In response to those requests, the carrier (through counsel) filed a written response to the request for hearing which stated: "The claimant is entitled to no relief."

While I recognize that the carrier's response is set forth in a pleading, I nevertheless believe that the response satisfies the requirement of an express denial of the femur fracture claim. Given these circumstances, I believe the claim has been expressly denied and the statute has been satisfied. While the evidence reflects no current benefits owed (i.e., the insurer has paid benefits up to the date of hearing), the insurer has nevertheless expressly refused the relief claimant seeks. This is tantamount to refusing to pay any future benefits for the claimed condition. Thus, both elements of amended ORS 656.386(1) (refusal to pay and expressed denial) have been satisfied, and there are grounds for an award of attorney fees. Accordingly, I respectfully dissent from the majority opinion.

In the Matter of the Compensation of
SHELLEY A. AUFEROTH, Claimant
WCB Case No. 95-00160
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney

Reviewed by Board Members Gunn and Neidig.

The self-insured employer requests review of Administrative Law Judge (ALJ) McWilliams' order that set aside its denial of claimant's occupational disease claim for a left neck, shoulder and arm condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following modification.

The ALJ found: "The requested changes were not made with the exception of claimant being given a lower foot stool. A wrist pad, chair and movement of the terminal was not supplied or done." (Opinion and Order at 4-5). In lieu of that finding, we find: Emmens moved claimant's terminal and raised her chair; thereafter, claimant was given a lower footstool. Otherwise, the changes that Emmens requested were not made. (See Ex. 4A; Tr. 15, 31).

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's Conclusions of Law and Reasoning, with the following modification and supplementation.

The ALJ concluded: "Claimant credibly testified only that her terminal had been lowered and a lower foot stool provided." (Opinion and Order at 7). In lieu of that conclusion, we conclude: Claimant credibly testified that her terminal had been lowered or otherwise moved, that her chair had been moved up and that she had been provided with a lower foot stool.

The employer asserts that, based on the reports and deposition of Dr. Fergusson, who treated claimant three or four times, claimant's claim fails. We disagree. As the ALJ points out, Fergusson initially supported compensability. (Ex. 1F). Thereafter, Fergusson changed his mind, concluding that, because claimant's work station had been altered without any effect on her symptoms, her left shoulder and neck condition must have been the result of something other than her work activities. (Exs. 9-2, 10, 11-8, -32-37, -43). We disagree with that analysis. Particularly, we note that at least some of the proposed changes to claimant's worksite were never made. Moreover, the record is silent regarding the anticipated efficacy of the changes that were made. For that additional reason, we agree with the ALJ that Dr. Fergusson's report is unpersuasive.

The parties also dispute whether a mere combination or constellation of symptoms can constitute a "disease" for purposes of the occupational disease statute, ORS 656.802. We need not address that issue. The record reveals that claimant's condition is more than a set of symptoms; rather, she has several specific diagnoses: Muscle strain, musculoligamentous neck/shoulder strain/sprain, left neck and upper back strain, upper trapezius strain, with myofascial pain, and upper extremity overuse and strain. (Exs. 1A, 1B, 1C, 1E-3, 1G). That is sufficient to establish a "disease" under ORS 656.802. See Mathel v. Josephine County, 319 Or 235, 240 (1994) (ordinary meaning of the term "disease" is "an impairment of the normal state of the * * * body").

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

ORDER

The ALJ's order dated July 5, 1995, as amended July 12, 1995, is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
JEROME M. BALDOCK, Claimant
WCB Case No. 95-02778
ORDER ON REVIEW
Foss, Whitty, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Gunn.

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

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

The SAIF Corporation accepted claimant's claim for a June 9, 1994 right shoulder injury. The claim was initially accepted as a nondisabling right shoulder strain and was later reclassified as disabling. Claimant's attending physician, Dr. Bert, indicated that claimant's condition was degenerative joint disease of the right AC joint aggravated by the injury. SAIF received Dr. Bert's diagnosis and opinion by September 8, 1994.

On October 14, 1994, claimant's attorney forwarded an October 10, 1994 opinion letter from Dr. Bert to SAIF. Dr. Bert indicated that the compensable injury was the major contributing cause of a pathological worsening of the degenerative joint disease in claimant's right shoulder. (Ex. 11). Claimant's attorney's October 14, 1994 letter asked SAIF to "process the claim" within 90 days. (Ex. 13).

On March 8, 1995, claimant requested a hearing asserting that SAIF had "de facto" denied his claim for degenerative AC joint disease. SAIF's response to claimant's hearing request asserted that claimant was not entitled to penalties or attorney fees and that "all benefits have been paid." On April 14, 1995, prior to the scheduled hearing, SAIF accepted claimant's worsened right shoulder degenerative disease. The parties have stipulated that all workers' compensation benefits due to claimant were paid in a timely fashion and that SAIF never issued a written denial of claimant's right shoulder degenerative joint disease.

At the June 7, 1995 hearing, claimant's counsel sought an attorney fee pursuant to ORS 656.386(1) for obtaining compensation for claimant without a hearing. Applying amended ORS 656.386(1), the ALJ found that claimant's right shoulder claim was not a "denied claim" and that no attorney fee was awardable under that statute.

In the absence of a specific exception, the changes to the Workers' Compensation Law made by SB 369 apply to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act (June 7, 1995). Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 569 (1995). Because there has been no final decision in this matter and because none of the other exceptions to retroactive application of the statute are applicable, we conclude that amended ORS 656.386(1) applies to claimant's claim. See Or Laws 1995, ch 332, § 66 (SB 369, § 66); Guillermo Rivera, 47 Van Natta 1723 (1995) (applying amended ORS 656.386(1) retroactively).

The dispute in this case is limited to whether claimant has established entitlement to an attorney fee under amended ORS 656.386(1) for obtaining rescission of a "de facto" denial of claimant's right shoulder degenerative condition.[1]

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[1] SAIF does not assert on review that claimant did not comply with amended ORS 656.262(6)(d) which prohibits a worker from alleging a "de facto" denial at any hearing or other proceeding on the claim if the worker did not provide a written objection to the carrier's notice of acceptance. It appears that claimant's attorney's October 14, 1994 letter to SAIF which asked SAIF to "process the claim" and which contained a report from Dr. Bert indicating that the compensable injury pathologically worsened claimant's right shoulder AC joint disease satisfied amended ORS 656.262(6)(d). Even assuming that the October 14, 1994 letter did not satisfy the requirement of amended ORS 656.262(6)(d), claimant's hearing request did. See Guillermo Rivera, supra.

Under amended ORS 656.386(1), claimant's attorney is entitled to an attorney fee "in cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge." SB 369, § 43(1). We must determine whether claimant's right shoulder degenerative condition claim was a "denied claim." Amended ORS 656.386(1) defines a "denied claim" as:

> "[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. A denied claim shall not be presumed or implied from an insurer's or self-insured employer's failure to pay compensation for a previously accepted injury or condition in a timely fashion." (Emphasis added).

Claimant argues that, by ignoring a request to accept claimant's right shoulder degenerative condition, SAIF expressly denied the claim for that condition. In response, SAIF asserts that there is no "denied claim."

In Guillermo Rivera, supra, we addressed the question of whether there was a "denied claim" for purposes of amended ORS 656.386(1). In Rivera, the employer's attorney had acknowledged that there would be an attorney fee for a "de facto" denial of a cervical condition. In addition, in its appellant's brief, the employer contended that it had "reason to question the causation" of the cervical claim. Based on those portions of the record, we determined that there was a "denied claim" pursuant to amended ORS 656.386(1). Thus, we concluded that the claimant had established an entitlement to an attorney fee under the statute.

We find the present case to be distinguishable from Rivera. First, the record does not contain evidence that SAIF "refused to pay" any compensation. To the contrary, the parties have stipulated that all benefits were timely paid. Furthermore, unlike in Rivera, there is no concession that a fee should be awarded and no acknowledgment in the record that SAIF questioned causation of the worsened right shoulder degenerative condition. Likewise, there is no other evidence in the record that SAIF questioned the causation of claimant's worsened right shoulder degenerative condition. Under such circumstances, we conclude that a "denied claim" has not been established. Accordingly, we agree with the ALJ that an attorney fee may not be awarded under amended ORS 656.386(1).

In reaching this decision, we note that claimant was apparently entitled to request a hearing on a "de facto" denial since more than 90 days had passed from the date he notified SAIF of his objection to its notice of acceptance (under amended ORS 656.262(6)(d) the employer has 30 days from the date of receipt of a claimant's objection to the notice of acceptance to revise the notice or to make other written clarification in response). However, the right to request a hearing does not necessarily mean that there is a "denied claim." In this case, for the reasons previously expressed, there is insufficient evidence to establish a denied claim. In addition, because all benefits were paid in a timely manner, no penalties or attorney fees are awardable since there are no amounts "then due" on which to base a penalty and no unreasonable resistance to the payment of compensation.

ORDER

The ALJ's order dated June 29, 1995 is affirmed.

Board Member Gunn dissenting.

Here, SAIF had notice of claimant's claim for worsened degenerative joint disease in claimant's right AC joint. SAIF also had Dr. Bert's October 10, 1994 letter which stated that the compensable injury was the major contributing cause of a pathological worsening of the degenerative disease in claimant's right shoulder. Finally, SAIF had claimant's attorney's October 14, 1994 letter forwarding Dr. Bert's October 10, 1994 letter and asking SAIF to "process the claim."

In spite of all of this notice, SAIF took no action to process the claim for degenerative disease worsened by the compensable injury. SAIF did not accept or deny the claim within 90 days as the law requires. Prior to the hearing, SAIF finally accepted the claim. This action was taken in response to claimant's attorney's request for hearing.

Pursuant to ORS 656.262(6)(a), the insurer has the duty to process the claim and issue an acceptance or denial within 90 days of notice or knowledge of the claim. The majority's interpretation of amended ORS 656.386(1) excuses carriers from complying with ORS 656.262(6)(a). In other words, based on the majority's interpretation of amended ORS 656.262(6)(a), a carrier may take no action on a claim and escape all penalties for its failure to process the claim. This interpretation of amended ORS 656.386(1) makes no sense and gives no effect to ORS 656.262(6)(a).

The majority's interpretation of the statute also fails to achieve the goal of reduced litigation. Although SAIF received claimant's attorney's letter forwarding Dr. Bert's opinion in October 1994, SAIF did not accept the claim until April 14, 1995. As this case illustrates, amended ORS 656.386(1) as the majority interprets it, does not reduce litigation. Rather, the majority's interpretation of the statute encourages carriers to take no action and force litigation.

I believe that, by ignoring the claim, SAIF manifested its intent to deny the compensability of this condition. The fact that there was no written denial does not persuade me otherwise. Clearly, SAIF had notice of the claim and knew that the condition was causally related to the compensable injury. It simply did not wish to take responsibility for the condition, so took no action. I believe that this constitutes a "denied claim."

Any other interpretation of the law would allow carriers to intentionally ignore claims and take no action to accept or deny unless forced. Moreover, by declining to award attorney fees in these situations, we take away the incentive for attorneys to help claimants get carriers to accept compensable conditions. In addition, we reward the carrier for ignoring the legal requirement to process the claim within 90 days.

For the reasons expressed above, I would conclude that there is a "denied claim" and would award an attorney fee to claimant's counsel under amended ORS 656.386(1). Accordingly, I dissent.

February 16, 1996 Cite as 48 Van Natta 357 (1996)

In the Matter of the Compensation of
RODNEY V. BOQUA, Claimant
WCB Case No. 95-04209
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that declined to reopen the record to determine whether claimant's injury claim had been prematurely closed as a result of the employer's "post-hearing" acceptance of claimant's cervical condition. Claimant cross-requests review of those portions of the order that: (1) reduced claimant's scheduled permanent disability award for loss of use or function of his left forearm (wrist) from 17 percent (25.5 degrees), as granted by an Order on Reconsideration, to 12 percent (18 degrees); (2) declined to award claimant an attorney fee under ORS 656.382(2) for his counsel's services at hearing regarding the employer's unsuccessful attempt to reduce claimant's scheduled permanent disability award for loss of use or function of his right forearm (wrist); (3) declined to award claimant's counsel an "out-of-compensation" attorney fee; (4) reopened the record to consider the employer's "post-hearing" contention that a penalty under ORS 656.268(4)(g) assessed by the Order on Reconsideration was not warranted; and (5) reversed the aforementioned penalty assessment. On review, the issues are the ALJ's procedural rulings, extent of scheduled permanent disability, penalties, and attorney fees. We reverse in part, modify in part, and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Motion to Reopen the Record

The employer argues that the ALJ erred in denying its motion to reopen the record to determine whether claimant's injury claim had been prematurely closed as a result of its "post-hearing" acceptance of claimant's cervical condition. Claimant responds that the ALJ properly refused to reopen the record on this basis and further asserts that the employer advocates reopening of the record only to forestall paying claimant's permanent disability award.

We adopt the ALJ's opinion and conclusion on this issue which is set out on page 3 of his Order on Reconsideration. We offer the following supplementation.

Premature closure was neither raised as an issue in the employer's hearing request nor at the hearing. Although the employer accepted claimant's cervical condition 6 days after hearing, such an event does not automatically mean that the claim was prematurely closed 8 months previously.[1] Rather, pursuant to its "post-hearing" acceptance, the employer must process the cervical claim as required by law. See generally, ORS 656.262; 656.245. Such processing will necessarily include the payment of any compensation to which claimant is entitled as a result of his accepted cervical condition.

Scheduled Permanent Disability for Right Forearm (wrist)

Claimant seeks an award for a right forearm (wrist) chronic condition. However, because we agree with the ALJ that there is no persuasive evidence establishing that claimant has a chronic right wrist condition (which renders him at least partially unable to use his right forearm repetitively), we adopt the ALJ's opinion on this issue which is set out on page 7 of his Opinion and Order.

Penalty under ORS 656.268(4)(g)

Claimant objects to the ALJ's reopening of the record to consider the employer's "post-hearing" contention that the reconsideration order's "ORS 656.268(4)(g) penalty" was not warranted. Claimant also challenges the ALJ's reversal of that penalty assessment.

The ALJ noted that amended ORS 656.268(4)(g) precludes a penalty when the increased permanent disability awarded on reconsideration is based on "new information obtained through a medical arbiter." Finding that the Order on Reconsideration's increased permanent disability award in this case was based on such new information, the ALJ reversed the penalty.

We need not address claimant's contention that the ALJ improperly reopened the record to address the penalty issue, because we find that the penalty assessment was proper. The amended statute only applies to "claims that become medically stationary on or after the effective date of the [1995] act." Or Laws 1995, ch 332, § 66(4) (effective June 7, 1995). In this case, the amended statute does not apply because claimant's medically stationary date was June 9, 1994.

We further find that claimant is entitled to a penalty under former ORS 656.268(4)(g), because the Order on Reconsideration increased claimant's compensation by at least 25 percent, claimant was found to be at least 20 percent permanently disabled, and these circumstances still exist. See Linda D. Merrit, 46 Van Natta 1720, 1722 (1994) (citing Vena K. Mast, 46 Van Natta 34 (1994) aff'd Mast v. Cardinal Services, Inc., 132 Or App 108 (1994). Consequently, the penalty assessment was proper under former ORS 656.268(4)(g). However, because we have affirmed the ALJ's reduction in claimant's permanent disability, the amount of the penalty must be adjusted accordingly. Id. Specifically, the penalty shall be 25 percent of 83.6 degrees of permanent disability.[2]

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[1] On the contrary, even if the employer's challenge to its Notice of Closure was properly before us, we would reach the same result. In other words, finding no evidence of a reasonable expectation of material improvement in claimant's cervical condition, we would conclude that the claim was not prematurely closed.

[2] 41.6 degrees (13 percent unscheduled permanent disability for the right shoulder) + 18 degrees (12 percent scheduled permanent disability for the left forearm [wrist]) + 24 degrees (16 percent scheduled permanent disability for the right forearm [wrist] = 83.6 degrees of permanent disability.

Attorney Fees

The ALJ found that claimant was not entitled to an assessed attorney fee under ORS 656.382(2) for successfully defending against that portion of the employer's request for hearing which sought reduction of claimant's scheduled permanent disability award for his right wrist. We disagree and reverse.

When conditions are considered separately for purposes of rating permanent disability, the carrier appeals the compensation awarded for every condition, and the compensation for at least one condition is not reduced, we award an assessed attorney fee for the claimant's counsel's efforts with regard to that condition. See Edgar L. Edington, 47 Van Natta 1466, 1467 (1995); Debra Cooksey, 44 Van Natta 2197, 2198 (1992). We take this approach even though compensation for the other conditions is reduced, because claimant must defend each condition's award separately. Id.

In this case, claimant's compensable left wrist, right wrist, and right shoulder conditions are considered separately for purposes of rating permanent disability. The employer sought reduction in claimant's awards for all three conditions at hearing. The ALJ reduced the awards for the left wrist and right shoulder, but did not disturb the award for the right wrist. Under these circumstances, claimant is entitled to an assessed attorney fee under ORS 656.382(2) for successfully defending against the employer's challenge to the right wrist award. See id.

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 claimant's scheduled disability award for his right wrist is $500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review concerning his appeal of this attorney fee issue. See Amador Mendez, 44 Van Natta 736 (1992).

Finally, claimant asserts entitlement to an "out-of-compensation" attorney fee based on increased permanent disability compensation awarded since the Notice of Closure. See ORS 656.268(6)(c).

An Order on Reconsideration increased claimant's permanent disability compensation and awarded an attorney fee equal to 10 percent of the additional compensation awarded. (Ex. 48-2).[3] The employer does not contest the fee award. Moreover, although the ALJ reduced claimant's permanent disability compensation from that awarded on reconsideration, claimant's current award represents a net gain since the Notice of Closure.[4] Consequently, claimant's "out-of-compensation" attorney fee should be reduced to equal 10 percent of the net increase in claimant's permanent disability compensation from that awarded by the Notice of Closure. Thus, the fee will be 10 percent of 71.6 degrees of permanent disability (the net increase awarded since the Notice of Closure).[5]

Claimant's attorney is entitled to an assessed fee for services on review regarding the "reopening"/premature closure issue, because the compensation awarded by the ALJ's order has not been reduced or disallowed. 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 "reopening"/premature closure issue is $500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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[3] The reconsideration order also purported to subject the 10 percent attorney fee to the limit or "cap" set out in OAR 436-30-050(14), the rule delineating the Board's maximum award for fees awarded under ORS 656.388(1). However, we have held that the "Board rule" cap on attorney fees does not limit fees awarded by the Director. Timothy H. Krushwitz, 47 Van Natta 2207 (1995). Because the 10 percent attorney fee in this case was awarded by the Director (not the Board), we do not apply the "Board rule" cap. In any event, the "cap" would not be determinative in this case.

[4] The Board's rules do not provide for an "out-of-compensation" attorney fee in this case because no additional permanent disability has been awarded by the ALJ or Board order. See OAR 438-015-0040; 438-015-0055(1). However, ORS 656.268(6)(c) does provide for such a fee and the fee has been awarded.

[5] 83.6 degrees permanent disability (total current award) - 12 degrees (awarded by the Notice of Closure) = 71.6 degrees (net increase since the Notice of Closure)

ORDER

The ALJ's order dated July 14, 1995, as reconsidered August 29, 1995, is reversed in part, modified in part and affirmed in part. The penalty assessed and the "out-of-compensation" attorney fee awarded by the Order on Reconsideration are reinstated and affirmed. That penalty and attorney fee are modified to be based on the "increased" permanent disability between the Notice of Closure and the ALJ's order. Claimant is awarded a $500 attorney fee for services at hearing concerning his right wrist condition and a $500 fee for services on review regarding the "reopening"/premature closure issue, both payable by the employer. The remainder of the order is affirmed.

February 16, 1996 Cite as 48 Van Natta 360 (1996)

In the Matter of the Compensation of
BRENDAN T. BOYD, Claimant
WCB Case No. 95-06060
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that dismissed its request for hearing from a Director's vocational assistance order for lack of jurisdiction. On review, the issue is the propriety of the dismissal order.

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

The employer agrees that the Hearings Division lacks jurisdiction over vocational assistance disputes. See Ross M. Enyart, 47 Van Natta 1540 (1995). Nevertheless, the employer asserts that the ALJ should have made it clear that the order of dismissal "was in no way an adjudication of, or a determination about, the parties' substantive rights or the issues in the dispute." Specifically, the employer argues that instead of dismissing its hearing request, the ALJ should have "transferred" the dispute to the Director.

There is no provision in the statutes for "transfer" of hearing requests to the Board regarding vocational assistance disputes to the Director.[1] In addition, there is likewise no statutory authority to "remand" to the Director in such cases. See e.g., Pacheco Gonzales v. SAIF, 124 Or App 312 (1993) (Board lacked statutory authority to remand claim to Department for issuance of a valid reconsideration order). Since the Hearings Division is without jurisdiction over the parties' dispute, it logically follows that the ALJ was without authority to make any substantive decision on the merits. Accordingly, we find the employer's concern that the ALJ's dismissal order could be interpreted as a decision on the substantive issues to be unwarranted.

Finally, as an alternative to "transferring" the case, the employer argues that the ALJ could have "cast the Order of Dismissal as one without prejudice to the rights the parties may possess outside of the Hearings Division." Because the ALJ's order did not expressly dismiss claimant's hearing request with prejudice, the dismissal order was without prejudice. See Julie Mayfield, 42 Van Natta 871 (1990) (an ALJ's order of dismissal is interpreted by the Board as a dismissal "without prejudice" unless the order otherwise specifies). Likewise, where an order is dismissed without prejudice, the dismissal order lacks preclusive effect on subsequent litigation. See Glenn L. Woodraska, 41 Van Natta 1472, 1476 (1989).

ORDER

The ALJ's order dated August 22, 1995 is affirmed.

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[1] In August 1995, the Director did, however, promulgate a temporary administrative rule which provides, in certain circumstances, that timely filing of a request for hearing or review with the Board or Hearings Division is considered timely filing with the Director. OAR 436-01-015. The employer has apparently already filed a request for hearing with the Director.

In the Matter of the Compensation of
GARY L. BRENNER, Claimant
WCB Case Nos. 94-05388, 94-02694, 94-02693 & 94-02692
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Kevin L. Mannix, Defense Attorney

Reviewed by Board Members Neidig and Hall.

Liberty Northwest Insurance Corporation, on behalf of its insured, Dean Warren Plumbing Company (hereafter Liberty/Warren), requests review of Administrative Law Judge (ALJ) Herman's order which: (1) set aside its denial of responsibility for claimant's left knee injury claim; (2) upheld the responsibility denial of the same condition issued by Liberty on behalf of its insured, Fullman Company (hereafter Liberty/Fullman); (3) awarded an assessed attorney fee of $3,500 pursuant to ORS 656.307(5); and (4) denied Liberty/Warren's motion to strike claimant's testimony. On review, the issues are responsibility, attorney fees and motion to strike.

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

Responsibility

We adopt the ALJ's reasoning on this issue.

Evidence/Motion to Strike

The ALJ denied Liberty/Warren's motion to strike claimant's testimony, which was made in closing argument. Liberty/Warren had contended that it had been denied the right to cross-examine claimant on an issue of bias or motive when the ALJ refused to direct claimant to answer the question whether claimant would like to receive more money for his knee injury claim. (Tr. 32). The ALJ reasoned that Liberty/Warren's motion was not well taken because it was untimely raised during closing argument and, alternatively, because Liberty/Warren's right to cross-examine was not abridged.

We review the ALJ's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991). Considering the circumstances surrounding Liberty/Warren's inquiry, we agree with the ALJ that the question no longer served any relevant purpose. Therefore, we do not find that the ALJ abused her discretion in declining to order claimant to answer Liberty/Warren's question. Moreover, even if the ALJ had permitted claimant to answer Liberty/Warren's question, and assuming, further, that claimant had replied affirmatively, this would not alter our decision concerning the merits of the responsibility issue.

Finally, we are unpersuaded by Liberty/Warren's contention that its right to cross-examination was abridged. When the ALJ refused to direct claimant to answer its question, Liberty/Warren declined to ask further questions. (Trs. 32, 33). Under such circumstances, we conclude that Liberty/Warren voluntarily chose to no longer cross-examine claimant regarding bias or motive and that its right to cross-examination was not impaired. Therefore, the ALJ properly denied Liberty/Warren's motion to strike.

Attorney Fees

Citing Dan J. Anderson, 47 Van Natta 1929 (1995), the ALJ awarded claimant's counsel a $3,500 attorney fee in accordance with ORS 656.307(5) for services rendered on claimant's behalf regarding the responsibility issue. On review, Liberty/Warren requests that we reconsider our decision in Anderson, contending that claimant's counsel's attorney fee should be limited to $1,000 pursuant to ORS 656.308(2)(d). Alternatively, Liberty/Warren asserts that, even if Anderson is controlling, the ALJ's attorney fee award was excessive and should still be limited to $1,000. We disagree with Liberty/Warren's contentions.

In Dan J. Anderson, supra, we held that amended ORS 656.308(2)(d) applies retroactively to cases pending on Board review, but that it does not limit assessed fees awarded under ORS 656.307(5) for services rendered in a "307" responsibility proceeding. In reaching our conclusion, we relied on the fact that ORS 656.307 was not included among the statutes listed in amended ORS 656.308(2)(d). After considering Liberty/Warren's arguments, we decline to depart from our reasoning in Anderson. See Allen T. Knight, 48 Van Natta 30 (1996).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that the ALJ's assessed fee award of $3,500 for claimant's attorney's services at the responsibility proceeding was reasonable.[1] In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue and the value of the interest involved. Finally, we note that claimant is not entitled to an attorney fee award under ORS 656.307 for his counsel's services on review. See Lynda C. Prociw, 46 Van Natta 1875 (1994); Ernest C. Blinkhorn, 42 Van Natta 2597 (1990).

Claimant's compensation was at risk for a reduction due to Liberty/Warren's appeal on the responsibility issue.[2] Therefore, inasmuch as claimant's compensation was not reduced on appeal, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2); Michael J. Joseph, 47 Van Natta 2043, 2050 (1995) .

In determining the amount of the assessed fee under ORS 656.382(2), we note amended ORS 656.308(2)(d), which provides:

> "Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the insured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances." SB 369, § 37 (Emphasis supplied.)

As previously mentioned, the attorney fee available to claimant's counsel under ORS 656.307(5) pertains only to services rendered at hearing. Lynda C. Prociw, supra. The authority for a Board-review attorney fee in a ".307" responsibility case arises under ORS 656.382(2). Michael J. Joseph, supra. ORS 656.382(2), however, is included among the statutes listed in amended ORS 656.308(2)(d). Whether the $1,000 cap in amended ORS 656.308(2)(d) limits assessed fees awardable under ORS 656.382(2) for services rendered on Board review in defense of compensation awarded by the ALJ in a ".307" responsibility proceeding is a question we need not decide in this case, however, because we conclude that, based on the factors listed in OAR 438-015-0010(4), claimant's counsel is entitled to $1,000 for services on review regarding the responsibility issue.[3] Inasmuch as our attorney fee award is not greater than the $1,000 fee cap in ORS 656.308(2)(d), we need not determine the applicability of that statute.

ORDER

The ALJ's order dated October 5, 1995, as reconsidered on October 16, 1995, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by Liberty/Warren.

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[1] Liberty/Warren does not contend that claimant's counsel did not "actively and meaningfully" participate in the responsibility proceedings. See ORS 656.307(5); Darrell W Vinson, 47 Van Natta 356 (1995).

[2] In a Claim Disposition Agreement which the Board approved in March 1992, claimant released his rights to workers' compensation benefits concerning his 1989 Liberty/Fullman claim with the exception of medical benefits. It follows that, had we reversed the ALJ's responsibility finding and determined that Liberty/Fullman was responsible for claimant's current left knee condition, claimant's benefits would have been reduced because his claim with Liberty/Warren would include benefits such as temporary and permanent disability, as well as vocational assistance.

[3] In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved. In determining a reasonable fee, we did not consider claimant's attorney's services rendered in defense of the ALJ's " 307(5)" assessed fee award. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986) ("compensation" does not include attorney fees).

In the Matter of the Compensation of
NANCY G. BROWN, Claimant
WCB Case No. 95-04167
ORDER ON REVIEW (REMANDING)
Swanson, Thomas & Coon, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Neidig and Christian.

The self-insured employer requests review of Administrative Law Judge (ALJ) Schultz' order which: (1) set aside its "de facto" denial of claimant's mental disorder claim; and (2) awarded penalties and attorney fees for the employer's allegedly unreasonable claim processing. On review, the employer seeks remand for the admission of a medical report that the ALJ excluded from the record. On review, the issues are remand and evidence (potentially compensability, penalties and attorney fees). We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and offer the following brief summary of the procedural background of the claim.

On April 6, 1995, claimant filed a request for hearing in which she raised the issue of "de facto denial of depression." Claimant filed a supplemental hearing request on June 29, 1995, again alleging "de facto" denial of a depression claim. A hearing was scheduled and convened on July 6, 1995, at which time the hearing was postponed/continued over claimant's objection on the ground that the 90-day period in which to accept or deny the mental disorder claim had not expired. The ALJ placed no limit on evidence that could be obtained during the period of the continuance. (Tr. 25).

After the postponement/continuance of the July 6, 1995 hearing, the employer scheduled an evaluation by an examining psychiatrist, Dr. Glass, for July 27, 1995. Claimant requested that the employer produce Dr. Glass for cross-examination at the rescheduled hearing on August 1, 1995. The employer did not subpoena Dr. Glass.

CONCLUSIONS OF LAW AND OPINION

Counsel for the employer offered Dr. Glass' July 27, 1995 medical report into evidence at the August 1, 1995 rescheduled hearing, representing that Dr. Glass was unavailable to attend the hearing, but would make himself available for a deposition. (Trs. 1, 4). Claimant moved to exclude Dr. Glass' July 27, 1995 medical report on the ground that the employer had failed to subpoena Dr. Glass or otherwise make him available for cross-examination at the hearing. (Tr. 2). Although rejecting claimant's contention that Rosemary E. Szabo-Berry, 43 Van Natta 2606 (1991), and Gordon P. Kight, 46 Van Natta 1508 (1994), require a carrier to subpoena expert witnesses to a hearing, the ALJ nonetheless granted claimant's motion to exclude Dr. Glass' medical report. (Tr. 7).

The ALJ noted that, to admit the medical report would require a continuance of the hearing. Reasoning that he was not allowed to continue or postpone a hearing because of incomplete case preparation in the absence of due diligence, the ALJ found that the record could have been completed with due diligence had the employer promptly scheduled an "IME" after claimant's April 6, 1995 hearing request raising the issue of a mental disorder claim.

After ruling on the evidentiary issue, the ALJ proceeded to conduct the hearing on the merits of the mental disorder claim, as well as on several penalty and attorney fee issues relating to the employer's claim processing. The ALJ set aside the employer's "de facto" denial of claimant's claim and assessed penalties and attorney fees for various claim processing violations.

On review, the employer contests the ALJ's evidentiary ruling, contending that the ALJ abused his discretion in excluding Dr. Glass' medical report. It requests that we remand for admission of the report and for any cross-examination desired by claimant. The employer also requests that the merits of the compensability issue be reconsidered in light of the "new" evidence. We agree that the ALJ abused his discretion in excluding Dr. Glass' medical report and that remand is appropriate.

An ALJ may continue a hearing under certain conditions, within the exercise of his or her discretion. See OAR 438-006-0091; Sue Bellucci, 41 Van Natta 1890 (1989). Furthermore, ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence, but may conduct a hearing in any manner that will achieve substantial justice. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary ruling for abuse of discretion. William J. Bos, 44 Van Natta 1691 (1992); James D. Brusseau II, 43 Van Natta 541 (1991).

An ALJ has discretion to allow and deny admission of evidence at hearing. Shirlene E. Volcay, 42 Van Natta 2773 (1990). Nevertheless, that discretion is not unlimited. See Jack R. Cooper, 47 Van Natta 678, on recon 47 Van Natta 863 (1995) (claim remanded to ALJ to reconsider the claimant's denied motion for a continuance to cross-examine medical experts). Here, based on the following reasoning, we hold that the ALJ's exclusion of Dr. Glass' medical report was not justified.

The ALJ reasoned that Dr. Glass' medical report should not be admitted because the employer did not exercise due diligence in completing the record. The ALJ ruled that the employer should have obtained an "IME" report sooner in light of claimant's April 1995 hearing request. However, there is no contention that the employer did not furnish Dr. Glass' medical report within seven days of its receipt of the report, as required by OAR 438-007-0015(4).[1] That rule provides that documents acquired after the initial exchanges of discovery materials shall be provided to other parties within seven days after the disclosing party receives the documents. Documents submitted within the seven-day limit may not be excluded. Phyllis J. Wheeler, 44 Van Natta 970, 971 (1992); Oliver F. Coon, 42 Van Natta 1845 (1990). In light of this legal authority, we find that the ALJ abused his discretion in not admitting Dr. Glass' medical report. In addition, because Dr. Glass' medical report should have been admitted, this case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5); Oliver F. Coon, supra.

Accordingly, the ALJ's order is vacated and the case is remanded to ALJ Schultz for further proceedings consistent with this order. The ALJ is directed to admit Dr. Glass' medical report and to grant claimant the opportunity for cross-examination.[2] These proceedings shall be conducted in any manner that the ALJ deems will achieve substantial justice. The ALJ, upon receipt of this additional evidence, shall reconsider the merits of the issues raised by the parties. The ALJ shall then issue a final, appealable order.

IT IS SO ORDERED

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[1] Although it is not clear when employer's attorney received Dr. Glass' report, the July 27, 1995 report was generated within seven days of the August 1, 1995 rescheduled hearing, at which time it was offered into evidence.

[2] We do not agree with claimant's contention that an employer or insurer must subpoena its expert witnesses to a hearing. Although claimant relies on Szabo-Berry, supra, as authority for her position, that case concerned the circumstances under which the author of a medical report "refuses" to make himself available for cross-examination. It does not stand for the proposition that an employer's or insurer's expert must be subpoenaed or made available for testimony at a hearing. In fact, it has been the Board's policy to encourage use of written interrogatories and/or depositions as a means of avoiding unnecessary costs and delays in the procurement of medical expert testimony. See Marta I. Gomez, 46 Van Natta 1654 (1994) (citing OAR 438-007-0005(4)). Although claimant asserts that the employer effectively refused her right to cross-examination by failing to subpoena Dr. Glass, the employer offered at the hearing to make Dr. Glass available for a deposition and has renewed that offer on review. Under these circumstances, we do not agree with claimant that the employer has denied her the right to cross-examine Dr. Glass.

In the Matter of the Compensation of
RONALD E. CASSELMAN, Claimant
WCB Case Nos. 94-14893 & 94-12305
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Gunn.

The City of Burns (the City), a self-insured employer, requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's left foot injury claim. The SAIF Corporation cross-requests review of that portion of the ALJ's order that set aside its denial of claimant's current low back injury claim. On review, the issues are compensability and, alternatively, responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Left Foot Condition

Relying primarily on claimant's testimony, the ALJ concluded that claimant had established the compensability of his left foot injury claim. The City asserts that, because this is a complex claim, medical evidence of causation is necessary. Lacking that evidence, the City asserts, claimant's foot injury claim fails. We agree.

Medical evidence of causation is not required in simple cases. The relevant factors for determining whether expert testimony of causation is required are: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker promptly consults with a physician; (4) whether the worker promptly reports the occurrence to a superior; (5) whether the worker previously was free from disability of the kind involved; and (6) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury. Uris v. Compensation Department, 247 Or 420, 426 (1967); Barnett v. SAIF Corp., 122 Or App 279, 283 (1993), on remand Betty Barnett, 46 Van Natta 9 (1994).

Here, claimant fell at work sometime in early May 1994. He did not, however, notice left foot symptoms until somewhere between three to five days and two weeks later, or consult with a physician until two weeks after the work incident. (Exs. 18-1, 22-1, 24-1, 25B; see Ex. 31-1). Thereafter, claimant's physicians suggested several diagnoses for claimant's condition, including meralgia parethetica, nerve compression and tarsal tunnel syndrome. (Exs. 18-4, -5, 25C-1, 22-3). Those diagnoses reveal that this is, at least clinically, a complicated case. Further, claimant did not report the May 1995 work occurrence until sometime later, when he allegedly asked a co-worker to tell his supervisor that he would not be in to work because he had hurt his back. Under the circumstances, we conclude that this is not a simple case. Therefore, medical evidence of causation is required. Barnett, supra.

There is insufficient medical evidence in this case. Dr. Holmboe, a treating physician, concluded that claimant did not injure his foot during the May 1994 incident and diagnosed "[d]irect nerve compression without mass lesion and without immediate underlying cause to the left ankle." (Ex. 18-5; Ex. 25C-1). Dr. Ireland, consulting neurologist, diagnosed tarsal tunnel syndrome of unknown cause. (Ex. 22-3). That evidence is insufficient to establish that claimant's left foot condition was caused by this May 1995 work accident.[1] Consequently, we reverse the ALJ's decision setting aside the City's denial of that condition.

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[1] Claimant asserts that three exhibits that the ALJ excluded, but accepted as an offer of proof, support the compensability of his left foot condition. We review evidentiary rulings for abuse of discretion. E.g., Penney S. Orcutt, 47 Van Natta 1057, 1058 (1995). Claimant does not argue that the ALJ abused his discretion in any way by excluding the exhibits. Consequently, we will not consider them on review. Further, we decline claimant's invitation to remand this case under ORS 656.295(5), because he has failed to establish that the record was improperly, incompletely or otherwise insufficiently developed.

Current Low Back Condition

The ALJ concluded that, because there is medical evidence that claimant sustained a back injury in May 1994, he has established the compensability of his current low back condition. We disagree.

Claimant sustained a compensable acute back strain in 1986 while SAIF was on the risk. Claimant has had ongoing low back complaints since then. His current low back claim arose as a result of a fall at work in early May 1994. In view of claimant's history of low back problems, this is a complex case requiring medical evidence of causation. Barnett, supra, 122 Or App 283.

There is no persuasive medical evidence that claimant's current low back condition was caused, even in material part, by his 1986 accepted low back condition.[2] Therefore, the current condition is compensable, if at all, if the May 1994 work injury was the major contributing cause of claimant's current disability and need for treatment. ORS 656.005(7)(a)(B).

Claimant has failed to meet that burden. Dr. MacCloskey, who initially saw claimant after the May 1994 work injury, diagnosed a degenerative arthritis and probable partial herniated nucleus pulposus. (Ex. 18-1; see id. at 3). Dr. Johnson later diagnosed nondisabling, secondary low back pain. (Id. at 6). A lumbar MRI revealed lumbar discogenic degenerative changes and mild L5-S1 facet syndrome. (Ex. 21). Dr. Ireland speculated that claimant's back pain was "most likely of musculo-skeletal etiology." (Ex. 22-3).

Although the medical evidence suggests various diagnoses for claimant's current low back condition, none of it specifically addresses the role claimant's May 1994 work accident played in the onset of his current low back problems. Because the record fails to disclose the major or primary cause of claimant's current low back condition, we are compelled to conclude that claimant has failed to establish the compensability of that condition. Consequently, we reverse that portion of the ALJ's decision setting aside SAIF's denial of claimant's low back condition.

ORDER

The ALJ's order dated May 31, 1995 is reversed. The City of Burns' denial of claimant's left foot condition is reinstated and upheld in its entirety. The SAIF Corporation's denial of claimant's low back condition is reinstated and upheld in its entirety. The ALJ's attorney fee awards are also reversed.

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[2] Claimant's counsel drafted a letter to Dr. Holmboe, stating that claimant's 1986 injury continued to play a role in his ongoing symptoms. (Ex. 31-1). Holmboe's response, if any, is not in the record.

Board Member Gunn concurring in part and dissenting in part.

I agree with the majority that claimant's left foot condition is not compensable. I disagree, however, with its analysis and conclusions regarding claimant's low back condition. Accordingly, I dissent from that part of its decision.

The majority concludes that, in view of claimant's preexisting low back problems, his current low back condition involves a complex medical question that requires medical evidence. I disagree. Uris v. Compensation Department, 247 Or 420, 426 (1967), and Barnett v. SAIF Corp., 122 Or App 279, 283 (1993), on remand Betty Barnett, 46 Van Natta 9 (1994), set forth six factors for determining whether expert testimony of causation is required. A worker's history of disability of the kind presently involved is but one of those factors. In my opinion, the presence of a single Uris/Barnett factor is not sufficient to convert a case from simple to complex. Rather, I would require that a preponderance of the factors support a complexity finding before we require expert testimony of causation. This requirement would avoid a perennial problem: The Board's habit of labeling almost all cases "complex" on the basis of scant evidence regarding one or two of the Uris/ Barnett factors.

In most situations, our goal is to simplify complex facts and issues. Yet, with respect to medical issues, the Board tends to make the simple more complex. In my view, that tendency exists for one reason: It enables the Board to deny claims. Because I disagree with that reasoning, I would analyze this case under the proposed "preponderance" test.

My review of this case fails to disclose that a preponderance of the Uris/ Barnett factors favor labeling this case complex. Hence, I would find that this is a simple case and, based on claimant's credible testimony, would hold that the claim is compensable. Because the majority concludes otherwise, I dissent.

February 16, 1996 Cite as 48 Van Natta 367 (1996)

In the Matter of the Compensation of
ARTHUR B. CONNELLY, Claimant
WCB Case No. 95-04720
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Livesley's order which: (1) affirmed an Order on Reconsideration that awarded 17 percent (32.64 degrees) scheduled permanent disability for loss of use or function of his right arm; (2) assessed a penalty for allegedly unreasonable claim processing; and (3) awarded a $1,000 carrier-paid attorney fee under ORS 656.382(2). On review, the issues are extent of permanent disability, penalties, and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

On January 27, 1994, claimant sustained a neck injury which resulted in C5-6 surgery and right C6 radiculopathy. Claimant's claim was closed by Determination Order (DO) on November 8, 1994 which awarded 19 percent unscheduled permanent disability. Claimant requested reconsideration.

On March 21, 1995, an Order on Reconsideration issued, reducing claimant's unscheduled permanent disability award to 18 percent, and awarding 17 percent scheduled permanent disability for the right arm. SAIF requested a hearing, seeking reduction of the scheduled and unscheduled awards. Relying on ORS 656.313(1)(a), SAIF did not pay any of the permanent disability awarded by the reconsideration order.

At hearing, relying on amended ORS 656.283(7), claimant objected to all of the exhibits that were submitted into evidence because the parties did not know "what the evidence [was]" before the Director on reconsideration. (Tr. 7). After considerable discussion, the parties agreed that the 801 form, the medical arbiter's report from Dr. Bald, the Order on Reconsideration and the DO should be received into evidence. (Tr. 19, 21). Admission of all other exhibits was taken under advisement by the ALJ. In his order, the ALJ admitted only the DO, the medical arbiter's report, and the Order on Reconsideration. The ALJ affirmed the reconsideration order in its entirety. SAIF requested Board review. On review, the parties do not dispute the ALJ's evidentiary ruling.

CONCLUSIONS OF LAW AND OPINION

Permanent Disability

SAIF argues that claimant's scheduled permanent disability award should be reduced from 17 percent to 12 percent. Specifically, SAIF asserts that the Director based the 17 percent award, in part, on a value for a 4/5 loss of strength, whereas Dr. Bald, medical arbiter, found only a 5-/5 loss of strength. See OAR 436-35-007(14); (Ex. 19-3). We agree with SAIF's contention.

Board review is based on the record of exhibits received by the ALJ and submitted on review. See ORS 656.295(3), (5). Here, the parties agreed that claimant's "801" form, the medical arbiter's report, Order on Reconsideration, and Determination Order were admissible. Moreover, the parties do not challenge the ALJ's decision to exclude the remainder of the submitted evidence. In light of such circumstances, we shall not disturb the ALJ's evidentiary rulings. See James D. Brusseau II, 43 Van Natta 541 (1991) (we review ALJ's evidentiary rulings for abuse of discretion). Accordingly, we conduct our review based on only those exhibits admitted by the ALJ.

The Director specifically referred to Dr. Bald's findings in determining loss of strength impairment. (Ex. 20-4). Dr. Bald, medical arbiter, found very mild weakness, measured as 5-/5. (Ex. 19-3). Nevertheless, the Director assigned 20 percent impairment, pursuant to OAR 436-35-007(14), which corresponds to a strength of 4/5 on the "Grading System." Because we find no evidence in this record to support an award of 20 percent impairment due to loss of strength, we modify the Director's award.

Dr. Bald found "very definite and reproducible weakness" that he measured as very mild, 5-/5. (Ex. 19-3). Thus, because Grade 5/5 results in no impairment under OAR 436-35-007(14), and Grade 4/5 results in 20 percent impairment, we agree with SAIF's alternative argument, and conclude that an appropriate rating for claimant's loss of strength is 10 percent. See OAR 436-35-010(4); Sharon M. Brewer, 44 Van Natta 343 (1992) (proportional award made when loss is less than complete).

OAR 436-35-110(7) provides a chart for determining arm impairment based on loss of strength due to specific nerve root damage. According to Dr. Bald's examination, claimant has weakness in the right upper extremity. Relying on Dr. Bald's report, the Director based claimant's award on weakness involving the right elbow which follows along the C5 and C6 dermatome patterns that enervate the biceps and brachio radialis nerve distribution. (Ex. 20-4). The parties do not dispute the nerve distribution upon which the award was based.

Complete loss of strength in the C5 nerve root is equal to 30 percent arm impairment. See OAR 436-35-110(7). Claimant's 10 percent impairment multiplied by 30 percent equals 3 percent. See OAR 436-35-007(14). Complete loss of strength in the C6 nerve root is equal to 35 percent arm impairment. OAR 436-35-110(7). Claimant's 10 percent impairment multiplied 35 percent equals 3.5 percent. See OAR 436-35-110(8). 3.5 percent is rounded to the next whole number, 4. OAR 436-35-007(11).

Combining claimant's 3 percent impairment for loss of strength in the C5 nerve root, and 4 percent impairment for loss of strength in the C6 nerve root, equals 7 percent total loss of strength in the right arm. When this 7 percent is combined with the undisputed 5 percent award for a chronic condition, claimant's total scheduled permanent disability equals 12 percent. Accordingly, claimant is entitled to 12 percent scheduled permanent disability for loss of use or function of his right arm. Thus, the ALJ's order which affirmed the Order on Reconsideration award of 17 percent is modified.

Penalty

The DO awarded 19 percent unscheduled permanent disability and no scheduled permanent disability. The Order on Reconsideration decreased claimant's unscheduled permanent disability award to 18 percent, and awarded 17 percent scheduled permanent disability for the right arm. At hearing, SAIF sought to reduce the unscheduled permanent disability award to 17 percent, and the scheduled award to 12 percent. Relying on ORS 656.313, SAIF had stayed payment of all permanent disability.

ORS 656.313(1)(a) states in part: "Filing by an employer or the insurer of a request for hearing on a reconsideration order * * * stays payment of the compensation appealed, * * *." (Emphasis added). The ALJ assessed a penalty, pursuant to ORS 656.262(11), for SAIF's allegedly unreasonable failure to pay that portion of the permanent disability awards not in dispute. Reasoning that, because SAIF sought only to reduce the unscheduled disability award by 1 percent, and the scheduled disability award by 5 percent, those amounts were the "compensation appealed" which payments SAIF was allowed to stay, whereas the remainder of the awards was not stayed pending hearing. We disagree.

Subsequent to the ALJ's order, we held that, when a carrier appeals a reconsideration order, there is no legal obligation to pay compensation awarded by the reconsideration order until after a final order has issued. See Kenneth E. Awmiller, 47 Van Natta 2053 (1995).

In Awmiller, the claimant argued that a carrier should be assessed a penalty for its failure to pay 5 percent permanent partial disability that it did not challenge at hearing. We disagreed, reasoning that, pursuant to former ORS 656.313(1)(a),[1] the carrier's filing of a request for hearing on the reconsideration order stayed payment of all additional compensation awarded by that order.[2]

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[1] Although ORS 656.313(1)(a) was amended by SB 369, § 38, the amendments are not relevant to the outcome in this case.

[2] In Awmiller, we noted a distinction between staying payment of permanent partial disability awards and temporary disability benefits. Specifically, we reasoned that, in the case of permanent partial disability, the entire award qualifies as "compensation appealed" even though the carrier objects to only a portion of the award. 47 Van Natta 2054, n. 5.

Thus, in the present case, until the litigation authorizing permanent disability becomes final, SAIF has no legal duty to pay any portion of the additional compensation. See OAR 436-60-150(6)(c), (d). Kenneth E. Awmiller, supra. Accordingly, no penalty is warranted under ORS 656.262(11).

Attorney Fee

On reconsideration, claimant was awarded 17 percent (32.64 degrees) scheduled permanent disability for loss of use or function of his right arm, and 18 percent (57.6 degrees) unscheduled permanent disability for his cervical condition. SAIF appealed both awards. At hearing, the ALJ affirmed the Order on Reconsideration, and awarded a $1,000 attorney fee for prevailing on both issues. On review, SAIF objected only to the scheduled disability award. Inasmuch as we have modified the ALJ's order and reduced claimant's scheduled disability award, we also reduce the ALJ's attorney fee award.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this issue, we find that a reasonable fee for claimant's attorney's services at hearing for prevailing against SAIF's request for reduction of his unscheduled permanent disability award is $750, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearing record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated August 9, 1995 is modified in part and reversed in part and affirmed in part. That portion of the order that affirmed an Order on Reconsideration that awarded 17 percent (32.64 degrees) scheduled permanent disability for loss of use or function of the right arm is modified. Claimant's award is reduced to 12 percent (23.04 degrees) scheduled permanent disability. In lieu of the ALJ's $1,000 attorney fee award, claimant's counsel is awarded $750, to be paid by SAIF. The portion of the ALJ's order that assessed a penalty pursuant to ORS 656.262(11) is reversed. The remainder of the ALJ's order is affirmed.

February 16, 1996 Cite as 48 Van Natta 369 (1996)

In the Matter of the Compensation of
RANDALL DAVIS, Claimant
WCB Case Nos. 95-03702 & 95-03701
ORDER ON REVIEW
W. Daniel Bates, Jr., Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Odell's order that dismissed his hearing request concerning the SAIF Corporation's denial of claimant's left knee injury as a new injury, on the basis that the hearing request was untimely. On review, the issue is timeliness of the hearing request and, alternatively, compensability.

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

On June 8, 1994, claimant filed an 801 form for an injury to his left heel. SAIF accepted claimant's claim as nondisabling left heel plantar fasciitis on July 19, 1994.

While at work on October 1, 1994, claimant injured his left knee. He was exiting out of a van on the employer's car lot when his knee gave way. Claimant heard a loud popping noise, then experienced excruciating pain.

Dr. Arbeene, who examined claimant at SAIF's request, opined that claimant's findings were consistent with internal derangement in his left knee. On November 18, 1994, Dr. Schroeder performed an arthroscopy, finding a degenerative tear of the lateral meniscus and suprapatellar plica.

On December 6, 1994, claimant contacted SAIF claims examiner Bill Bennett, who was handling his left heel condition. Although he was aware that his left knee injury claim was being handled by another SAIF claims examiner, claimant alleged a correlation between his left heel condition and his left knee injury.

SAIF denied claimant's left knee "new injury" claim on December 7, 1994. Claimant received the denial on December 8, 1994, read it and understood his hearing rights. Claimant then again called claims examiner Bennett, who indicated he would defer any decision on whether claimant's left knee injury was compensably related to his accepted left heel condition until after claimant had seen a gait specialist.

SAIF reclassified claimant's June 8, 1994 left heel claim as disabling on December 14, 1994. Following an examination by gait specialist Dr. Thompson on January 5, 1995, SAIF denied claimant's left knee meniscal tear because it was not a compensable consequence of his accepted left heel claim.

Claimant filed his hearing request more than 60 days after SAIF's December 7, 1995 denial of his left knee injury claim. Claimant asserts that he failed to timely file a hearing request on this new injury claim denial because he mistakenly understood that his left knee injury claim would be processed as part of his left heel claim.

Finding Debra A. Gould, 47 Van Natta 1072 (1995) and Joan C. Gillander, 47 Van Natta 391 (1995), analogous and controlling, the ALJ determined that claimant's confusion over the need to file a hearing request, coupled with his inaction in the face of this confusion, prevented a finding of good cause for the late filing of request for hearing.

On review, claimant contends that his case is distinguishable from Gould and Gillander because he was "mistaken" rather than "confused." Claimant asserts that after receiving the denial, he took immediate action by contacting Mr. Bennett and that he understood from his conversation with Mr. Bennett that his benefits would continue despite the denial because his two claims were being consolidated and processed together. Claimant argues that this "mistaken understanding" that his condition would be covered caused him not to appeal the new injury denial.

Contrary to claimant's contention, we see no meaningful distinction between claimant's alleged "mistaken understanding" in this case and the claimants' confusion or mistaken beliefs in Gould and Gillander.[1] We have consistently found that a claimant's misunderstanding of the carrier's claims processing actions does not establish good cause under amended ORS 656.319(1)(b) where there is no evidence the claimant was misled. See Ronald G. Dorry, 47 Van Natta 1707 (1995) (the claimant's mistaken conclusion, based on conversation with one of the carrier's claims examiners and the text of denial, that he did not need to take any action regarding the carrier's new injury denial analogous to confusion about the carrier's claim processing activities and not grounds for good cause); see also Wayne A. Moltrum, 47 Van Natta 955 (1995) (claimant's former attorney's mistaken belief that carrier had already been ordered to accept claim attributable to claimant and did not establish good cause); Roger Eli, 47 Van Natta 1938 (1995) (claimant's erroneous belief that claim would be covered by one of two carriers did not establish good cause where record did not indicate that either carrier misled claimant).

In this case, there is no evidence that claimant was misled into believing that his left knee injury claim would be accepted as part of his left heel claim. Rather, claimant testified that when he called Mr. Bennett, his primary concern was continuing the time loss on his left heel claim. Claimant further admitted, on cross-examination, that he understood that a determination regarding the compensability of his knee injury as a consequence of his left heel condition would be deferred until he saw a "gait specialist." (Tr at 43-46). Although he contends on review that he mistakenly understood that his knee injury claim would be covered, the record establishes that claimant was not so advised by Mr. Bennett.

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[1] In Debra A. Gould, supra, the claimant was "confused" by the employer's denial of her current carpal tunnel syndrome (CTS) condition as a new occupational disease and its reopening of her accepted CTS claim. There was no evidence that claimant exercised any diligence in attempting to resolve her confusion until after the employer closed the reopened claim several months after the denial issued. In Joan C. Gillander, supra, the claimant mistakenly believed she had an accepted out-of-state claim as a result of her receipt of temporary disability benefits. We held that claimant's mistaken belief that her other claim had been accepted did not constitute "good cause" for her untimely hearing request from SAIF's denial of her Oregon claim.

Accordingly, like the ALJ, we conclude that under Gillander, Gould and their progeny, claimant has not established good cause for failing to timely file his request for hearing on SAIF's December 7, 1994 denial of his left knee injury.

ORDER

The ALJ's order dated August 4, 1995 is affirmed.

Board Chair Hall dissenting.

This case presents yet another example of the Board's overly narrow interpretation of the phrase "good cause" in amended ORS 656.319(1)(b). As set forth in my dissenting opinions in Joan C. Gillander, 47 Van Natta 391, 393, on recon 47 Van Natta 789 (1995) (Board Member Hall, dissenting) and Debra A. Gould, 47 Van Natta 1072 (1995) (Board Member Hall, dissenting), I believe that "good cause" can be established by showing actual and reasonable confusion regarding particular claims processing activities. This interpretation of "good cause" comports with appellate case law construing the terms "mistake, inadvertence, surprise or excusable neglect" and the long standing policy favoring resolution of matters on the merits. See, e.g., Wagar v. Prudential Ins. Co., 276 Or 827, 832 (1976) (statute allowing for setting aside of default judgments is to be liberally construed); King v. Mitchell, 188 Or 434 (1950) (same).

In this case, claimant has established that he mistakenly believed that his knee injury claim would be consolidated with his heel injury claim, and therefore he did not need to request a hearing on SAIF's first denial of his knee injury claim. His understanding of the situation, although erroneous, was confirmed when his time loss payments continued after the first denial and when SAIF paid medical bills relating to treatments of his knee. Under these circumstances, I would find that claimant has established reasonable confusion about SAIF's claim processing activities to sustain a finding of "good cause" for failing to timely file a hearing request on SAIF's December 7, 1994 denial.

Because I believe that claimant in this case is entitled to go forward on the merits of his knee injury claim, I respectfully dissent.

February 16, 1996 Cite as 48 Van Natta 371 (1996)

In the Matter of the Compensation of
SOLIO C. DIAZ, Claimant
WCB Case No. 94-06260
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Kenneth P. Russell (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order which: (1) upheld the SAIF Corporation's denial of his aggravation claim for a low back condition; and (2) upheld SAIF's denial of a L5-S1 disc herniation. On review, the issues are aggravation and compensability.

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

Aggravation

The ALJ upheld SAIF's denial of claimant's low back aggravation claim, finding insufficient medical evidence that claimant's compensable low back condition had worsened. On review, claimant contends that a compensable worsening of his low back condition is established by an MRI scan in March 1993, which a radiologist interpreted as showing a more prominent L5-S1 disc herniation. (Ex. 21). We disagree.

Former ORS 656.273(1) provided:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation, including medical services, for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence supported by objective findings." (Emphasis supplied).

Under that statute, "worsened conditions" occurred when a claimant's physical condition or symptoms became exacerbated and caused increased disability or diminished earning capacity. Perry v. SAIF, 307 Or 654, 657 (1989). A claimant could establish a "worsened condition" by showing worsened symptoms without showing a worsening of the underlying condition. Consolidated Freightways v. Foushee, 78 Or App 509 (1985), rev den 301 Or 388 (1986). Finally, if the last award or arrangement of compensation included consideration of anticipated future exacerbations of the condition or symptoms, the claimant had to prove that the "worsening" was greater than anticipated. Gwynn v. SAIF, 304 Or 345 (1987).

Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.273(1) to read, in part:

"After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence **of an actual worsening of the compensable condition** supported by objective findings." Or Laws 1995, ch 332, § 31 (SB 369, § 31) (added language in bold-face type).

In addition, SB 369 added 656.214(7), which provides that "all permanent disability contemplates future waxing and waning of symptoms of the condition. The results of waxing and waning may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability, or inpatient hospitalization."

Except as provided otherwise, SB 369 applies retroactively to matters for which the time to appeal the Board's decision has not expired, or if appealed, has not been finally resolved on appeal. Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565 (1995). Because amended ORS 656.273(1) and 656.214(7) are not among the exceptions to this general rule, see SB 369, § 66 (listing exceptions to general retroactivity provision), the amended version of the statute now governs this matter.

In Carmen C. Neill, 47 Van Natta 2371 (1995), we examined the legislative history pertaining to amended ORS 656.273(1). Based on our review of the legislative history, we reached the following conclusions with regard to what constitutes an "actual worsening" under amended ORS 656.273(1). A pathological worsening of the underlying condition is sufficient to establish an actual worsening. In addition, a symptomatic worsening of the condition, that is greater than anticipated by the prior award of permanent disability, is also sufficient to establish an actual worsening.

In this case, we find insufficient evidence of a pathological worsening of claimant's L5-S1 disc condition or of a symptomatic worsening greater than anticipated by claimant's prior award of 50 percent unscheduled permanent disability for his compensable low injury of August 25, 1991. We reach these conclusions for the following reasons.

A radiologist, Dr. Veverka, based on his interpretation of a March 12, 1993 MRI scan, opined that a small central herniation at L5-S1 appeared "more prominent" than it did in a March 27, 1992 MRI scan taken prior to claimant's worsening in November 1992. (Ex. 21). However, Dr. Flemming, who treated claimant both before and after claimant's alleged worsening, could detect no difference in the appearance of claimant's herniation after reviewing the same MRI scans. (Ex. 24). Moreover, Dr. Dunkley, another radiologist, performed another MRI scan on February 21, 1994. Dr. Dunkley compared this scan with the March 1992 MRI scan and concluded that the abnormality at L5-S1 had not "markedly deteriorated." (Ex. 38).[1]

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[1] Dr. Brett, who performed a L5-S1 discectomy on February 21, 1994, interpreted the 1992 and 1993 MRI scans as showing some left sided annular bulging at L5-S1, but no significant neural impingement. (Ex. 25A).

Based on the medical evidence comparing claimant's various MRI scans, we conclude that a preponderance of medical evidence establishes that claimant's disc abnormality did not pathologically worsen. We, accordingly, reject claimant's argument based on Dr. Veverka's radiology report.

Moreover, we find, based on Dr. Flemming's August 30, 1993 opinion, that claimant experienced only a symptomatic worsening. Dr. Flemming reported that, while claimant was subjectively worse, his objective findings on examination had not changed. (Ex. 24). Because Dr. Flemming treated claimant both before and after his alleged worsening, we find his opinion to be persuasive. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986) (more weight given to report of physician who had opportunity to observe the claimant before onset of symptoms). Inasmuch as claimant has received a total of 50 percent unscheduled permanent disability, and because ORS 656.214(7) specifically provides that all awards of permanent disability contemplate waxing and waning of symptoms, the results of which include hospitalization, temporary disability and lost earning capacity, we conclude that claimant's symptomatic worsening constitutes a waxing and waning of symptoms no greater than was contemplated by claimant's award of permanent disability.[2]

Accordingly, we find that claimant has failed to sustain his burden of proving that his compensable low back condition "actually worsened." The ALJ's decision upholding SAIF's denial of claimant's aggravation claim is affirmed.

Compensability

The ALJ upheld SAIF's denial of claimant's L5-S1 disc condition, finding insufficient medical evidence that this condition was attributable to his compensable 1991 injury. On review, claimant contends that the ALJ misinterpreted the medical evidence and that his L5-S1 disc herniation is compensable. We disagree.

Claimant bears the burden of proving that his L5-S1 disc condition is compensably related to his August 15, 1991 lifting injury at work. See ORS 656.005(7)(a); ORS 656.266. Considering the passage of time since the 1991 injury, we conclude that the causation issue is a complex medical question which must be resolved by expert evidence. See Barnett v. SAIF, 122 Or App 279 (1993). In evaluating the medical evidence, we rely on those opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983).

Here, claimant has had two attending physicians: Dr. Flemming, who treated claimant from October 1991 until November 1993, a period both before and after claimant's alleged worsening in November 1992, and Dr. Brett, claimant's current attending neurosurgeon. Because Dr. Flemming treated claimant both before and after claimant's alleged worsening, and because of the length of his treatment, we find that he was in an especially advantageous position to comment on the etiology of claimant's current low back condition. See Kienow's Food Stores v. Lyster, supra.

Dr. Flemming emphasized in November 1993 that claimant demonstrated a great deal of functional overlay and that he did not have a surgical lesion. (Ex. 4-10). In December 1993, Dr. Flemming referred claimant to Dr. Brett, who later assumed primary responsibility for claimant's treatment. Dr. Brett ultimately performed surgery at L5-S1 in February 1994. However, claimant's pain returned within two days of the surgery. (Ex. 44-1). Given the results of claimant's surgery, Dr. Flemming's November 1993 report supports a finding that claimant's low back symptomatology is attributable to functional overlay rather than disc pathology related to claimant's compensable 1991 injury.

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[2] In reaching this conclusion, we acknowledge that the record was developed, closed and the ALJ's order was issued prior to the June 7, 1995 effective date of Senate Bill 369. We have remanded for further development of the record in claims in which there is an issue regarding whether a symptomatic worsening constitutes an "actual worsening" under amended ORS 656.273(1). See e.g. Carmen C. Neill, 47 Van Natta 2371 (1995). However, in this case, SAIF argued at hearing that claimant's symptomatic worsening did not exceed the "waxing and waning" contemplated by his prior permanent disability award. (Tr. 10). Thus, whether analyzed under the former or current legal standard, the question remains whether claimant's symptomatic increase exceeded the "waxing and waning" contemplated by his prior permanent disability award. Under such circumstances, we find no compelling basis to remand. See Clifford E. Clark, 47 Van Natta 2310, 2312 n. 2 (1995) (distinguishing Troy Shoopman, 46 Van Natta 21 (1994) and Betty S. Tee, 45 Van Natta 289 (1993), where we found compelling basis to remand where the record was devoid of evidence regarding a legal standard which had changed while Board review was pending).

Dr. Brett has consistently opined that claimant's original injury is the major contributing cause of claimant's L5-S1 disc abnormality. (Exs. 25B, 34, 52, 59, 61). However, his analysis is based in significant part on the sequential relationship between claimant's original injury and his subsequent symptoms. (Ex. 52, 59). For this reason, we tend to discount Dr. Brett's opinion. See Allie v. SAIF, 79 Or App 284 (1986).

Moreover, we are troubled by an apparent inconsistency in Dr. Brett's opinion. After claimant's unsuccessful surgery in February 1994, claimant returned to Dr. Brett, who opined that claimant had a "recurrent" disc herniation attributable to the original 1991 injury. (Ex. 52). However two radiologists, Drs. Dunkley and Dr. Burke, opined that claimant did not have a recurrent disc pathology at L5-S1. (Exs. 43, 48). In addition, a consulting neurosurgeon, Dr. Franks, stated that a post-operative MRI did not show any evidence of a significant recurrent disc. (Ex. 44-2).

Given the considerable medical evidence contradicting his opinion, we find Dr. Brett's medical opinion unpersuasive with respect to determining causation of claimant's L5-S1 disc condition. We, therefore, do not rely on it. Inasmuch as Dr. Brett's is the only opinion which relates claimant's L5-S1 disc condition to the original injury in 1991, and because we conclude that opinion is unpersuasive, we find that claimant has failed to sustain his burden of proof.[3] We, therefore, affirm the ALJ's decision upholding SAIF's denial of claimant's L5-S1 disc condition.[4]

ORDER

The ALJ's order dated January 24, 1995 is affirmed.

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[3] Claimant was also evaluated by two panels of examining physicians. Drs. Wilson and Strum opined that claimant's 1991 injury was not a contributing cause of claimant's current need for treatment. (Ex. 55-9). Drs. Platt and Case found strong evidence of functional overlay but did not comment directly on the causal relationship between claimant's current low back condition and the 1991 injury. (Ex. 60-8).

[4] SAIF does not allege on review that an off-the-job incident in Idaho in November 1992, in which claimant experienced increased back symptoms lifting four cans of grocery items, was the major contributing cause of claimant's worsened condition. See ORS 656.273(1). We, therefore, do not address that issue.

In the Matter of the Compensation of
ROBERT J. DOUGLASS, Claimant
WCB Case Nos. 94-09117 & 94-06308
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
Williams, Zografos, et al, Defense Attorneys

Reviewed by Board Members Neidig and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's denial of his occupational disease claim for a mental disorder and its denial of his mental condition as a consequence of his compensable right foot injury. On review, the issue is compensability.

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

Claimant asserts two separate theories to support the compensability of his mental stress condition. First, claimant argues that his condition is a compensable consequence of his accepted August 16, 1993 right foot injury pursuant to ORS 656.005(7)(a)(A). Alternatively, claimant argues that his condition is compensable as an occupational disease under amended ORS 656.802(2). Claimant further contends that under either theory, the opinion of his treating psychologist, Dr. Campbell, is sufficient to establish medical causation. We disagree.

Under either theory, the applicable standard is major contributing cause. In other words, to prove the compensability of his claim, claimant must show that either his accepted foot injury or his employment conditions were the major contributing cause of his mental condition. ORS 656.005(7)(a)(A); ORS 656.802(2).

Dr. Campbell cited to three factors which he determined "played a significant role" in claimant's depression: (1) a history of depression and anxiety which predisposed him to another episode of depression; (2) job stress and changes in the workplace; and (3) some organic brain dysfunction. Dr. Campbell reported that while "[i]t is difficult to say which of these three causes was the major contributing cause," the stress of claimant's job and changes in his work assignments "were the contributors to his depression that precipitated his seeking treatment for depression."[1] (Ex. 35).

Determining the "major contributing cause" of a disease or injury involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the primary cause. See Dietz v. Ramuda, 130 Or App 397 (1994) (the "precipitating" or immediate cause of an injury may or may not be the "major contributing cause"); see also Alec E. Snyder, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned).

Here, although Dr. Campbell identified job stress and workplace changes as factors that "precipitated" claimant's seeking treatment, he did not identify claimant's employment conditions as the primary or major cause of claimant's depression. On the contrary, after evaluating the various factors, Dr. Campbell specifically refused to weigh their relative contribution or identify which was "major contributing cause." He simply found that all three causes were "significant."[2] While a physician is not required to use "magic words," see McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986), we are unable to conclude from Dr. Campbell's medical opinion that claimant's employment conditions were the major contributing cause of his mental disorder.

Finally, even if Dr. Campbell's report was persuasive evidence that claimant's employment conditions were the major cause of his mental disorder, we agree with the ALJ that claimant's condition is not compensable because the conditions allegedly producing his depression are generally inherent in every working situation. See amended ORS 656.802(3)(b) (claimant must establish, among other things, that employment conditions producing the mental disorder are conditions other than conditions generally inherent in every working situation).

Claimant contends on review that his depression was brought on by his "unexpected and unwanted transfer from one department to another," and that the employer's decision to make the transfer was "arbitrary and irrational." While claimant's transfer to a job in the shop from his position as a millwright in the fence post area may have been unexpected or unwanted from his standpoint, the record does not support a finding that the employer acted unreasonably or outside the course of ordinary business in making this decision. Claimant's supervisor testified that claimant was transferred to the shop out of concern that he might reinjure himself continuing to work in the fence post area. Claimant's supervisor had previously found claimant asleep on the job and had noticed that, following his foot injuries, claimant was exhibiting slower reaction times and believed that a new position might help his job performance. Accordingly, we conclude that the actions taken by the employer were not unusual and constitute conditions generally inherent in every working situation.[3]

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[1] Because Dr. Campbell did not mention claimant's right foot injury as a contributory factor, his opinion does not support claimant's theory that his condition is compensable under ORS 656.005(7)(a)(A) as consequence of that accepted injury.

[2] Moreover, to the extent Dr. Cambpell employed a "but for" analysis (that is, concluding that but for claimant's frustrations with work claimant would not have required psychological counseling) his report is not well reasoned. See Alec E. Snyder, supra.

[3] We note that claimant worked in the shop for only a few days before he was transferred back to his regular position. To the extent claimant contends that once he returned to the fence post job he was concerned about being transferred again or laid off, we do not find this concern, in and of itself, a condition of employment for which claimant may be compensated. See Bogle v. Dept. of General Services, 136 Or App 351 (1995) (a claimant's uncertainty regarding his employment picture cannot be regarded as a condition of employment).

ORDER

The ALJ's order dated June 26, 1995 is affirmed.

February 16, 1996 Cite as 48 Van Natta 376 (1996)

In the Matter of the Compensation of
DAVID GONZALEZ, Claimant
WCB Case No. 94-09333
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Neidig and Hall.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Johnstone's order that: (1) increased claimant's unscheduled permanent disability award for a low back condition from 17 percent (54.4 degrees), as awarded by the Order on Reconsideration, to 23 percent (73.6 degrees); (2) reversed a Director's order finding claimant is not eligible for vocational assistance; and (3) awarded an attorney fee pursuant to former ORS 656.386(1) for the employer's alleged "de facto" denial of claimant's herniated disc condition. On review, the issues are extent of unscheduled permanent disability, jurisdiction and vocational assistance, and attorney fees. We modify in part, vacate in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of Ultimate Findings of Fact Nos. 2 through 5. We briefly summarize the pertinent facts as follows:

Claimant sustained a compensable low back strain, with pain radiating to his right leg, on September 16, 1993 while working for the employer, a cabinet manufacturer, as a line unloader. He was found to be medically stationary by his then-treating physician, Dr. Sohriakoff, on January 6, 1994.

On February 23, 1994, claimant sought treatment with Dr. Peterson, who diagnosed degenerative disc disease with a herniated nucleus pulposus at L5-S1 with minor right-sided sciatica.

In March 1994, the employer offered claimant a permanent position as a paint room associate at the same rate of pay as his job at injury. As a paint room associate, claimant was required to stand for an entire eight hour shift to sand cabinet doors and frames on an assembly line. Claimant had difficulty completing his eight hour shifts due to continuing leg pain, and asked to sit down from time to time. Rather than being given permission to sit down, claimant was sent to the employer's personnel office and then sent home. Claimant voluntarily left his employment with the employer because he was unable to complete an entire shift without sitting down.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

Relying on the findings of Dr. Sohriakoff, claimant's treating doctor at the time of claim closure, the ALJ found that claimant was entitled to an unscheduled permanent disability award of 23 percent, an increase of 6 percent above that awarded by the Order on Reconsideration. Specifically, based on the report of Dr. Sohriakoff, the ALJ determined that claimant had reduced range of motion equivalent to 7 percent impairment and physical restrictions equivalent to a residual functional capacity (RFC) of "medium/light."

The employer argues on review that the ALJ should have accepted the impairment findings of the medical arbiter, made closer to the time of reconsideration, instead of the findings of claimant's attending physician, which were made five months prior. We agree.

Under OAR 436-35-007(9), on reconsideration, impairment is determined by a medical arbiter where one is used "except where a preponderance of medical evidence establishes a different level of impairment." The disability standards define "preponderance of medical evidence" as meaning "the more probative and more reliable medical opinion based upon the most accurate history, on the most objective principles and expressed with clear and concise reasoning." OAR 436-35-005(10). See also Carlos S. Cobian, 45 Van Natta 1582 (1993) (Board will rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

Here, in his January 1994 closing examination, Dr. Sohriakoff made the following findings: "[claimant] has normal range of motion, with 90° forward bending in the standing position, with little difficulty. Hyperextension is accomplished to 15° and side bending right/left to about 15°." Dr. Sohriakoff released claimant to work "with limitation of his lifting, pushing, and pulling to about 25 lb with no repetitive bending." (Ex. 13-2).

Five months later, the medical arbiter measured claimant's range of motion of the lumbar spine using the double inclinometers. The arbiter found 60 degrees lumbar flexion, 13 degrees lumbar extension, 35 degrees right lateral flexion and 23 degrees left lateral flexion. The arbiter also reported that claimant "should be limited to lifting 50 pounds occasionally" and that "stooping, bending, twisting, climbing, pushing and pulling should be restricted to occasional." (Ex. 20).

Because the arbiter's examination was conducted closer in time to the reconsideration order and his report is a thorough and well-reasoned evaluation of claimant's injury-related impairment,[1] we rely on the arbiter's findings over those of Dr. Sohriakoff. See Kenneth W. Matlack, 46 Van Natta 1631 (1994) (Board does not automatically rely on a medical arbiter's opinion in evaluating a worker's permanent impairment, but on the most thorough, complete and well-reasoned evaluation of the claimant's injury- related impairment); See also Somers v. SAIF, 77 Or App 259 (1986).

We find, however, that based on the findings of the medical arbiter, the 17 percent permanent disability awarded by the Order on Reconsideration should be increased 4 percent for a total award of 21 percent. As claimant correctly argues, the reviewer on reconsideration erred in categorizing claimant's maximum Residual Functional Capacity (RFC) as "medium" rather than "medium/light." Because the medical arbiter limited claimant to "occasional" stooping, bending and twisting, we conclude that claimant has "restrictions" as defined by OAR 436-35-310(3)(l)(C) which move him into the "medium/light" RFC category under OAR 436-35-310(3)(g).[2] Comparing claimant's Base Functional Capacity of "heavy" work to his RFC of "medium/light" entitles him to an adaptability value of 4, rather than the value of 3 used to calculate the award in the Order on Reconsideration. Accordingly, we modify the ALJ's order and find that claimant is entitled to 21 percent unscheduled permanent disability for his low back condition.[3]

Vocational Assistance

Contrary to the Director's order, the ALJ found that claimant was not physically capable of performing the job of paint room associate and therefore claimant was eligible for vocational assistance. On review, the employer argues that under amended ORS 656.283(2)(c), the Board lacks jurisdiction to review vocational assistance disputes and therefore the ALJ's determination on this issue must be vacated. We agree.

ORS 656.283(2)(c) was amended by Or Laws 1995, ch 332, § 34(2) (SB 369, § 34(2)), and now provides, among other things, that when the director issues an order regarding vocational assistance after administrative review of the matter, "the order shall be subject to review only by the director." (Emphasis added). We held in Ross M. Enyart, 47 Van Natta 1540 (1995), that the legislature expressly

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[1] Unlike the medical arbiter, there is no indication that Dr. Sohriakoff measured claimant's range of motion using the double inclinometers.

[2] OAR 436-35-310(g) provides, in part, that a worker's capacity is medium/light "if the worker can perform the full range of medium activities, but with restrictions." The reviewer on reconsideration erred by not recognizing that the restrictions identified by the medical arbiter placed claimant in the "medium/light" category despite the fact that claimant is able lift up to 50 pounds occasionally. (See Exs. 20, 21).

[3] 4 (Age/Education value) x 4 (Adaptability value) = 16 + 5 (Impairment) = 21 percent permanent disability.

intended that this provision apply retroactively and that the Director now has exclusive jurisdiction over all vocational assistance disputes, including those presently pending before the Board. See also Robert B. Enders, 47 Van Natta 1651 (1995).

Because neither the Hearings Division nor the Board has jurisdiction to review the Director's action regarding this vocational services dispute, we vacate that portion of the ALJ's order that reversed the Director's vocational assistance order and we dismiss the hearing request from the Director's order. Amended ORS 656.283(2)(c).

Claimant challenges the retroactive application of amended ORS 656.283(2), contending that it violates the contract clause of the Oregon Constitution, Article I, Section 21. We have previously held that if we lack jurisdiction over an issue, we also lack the authority to address constitutional challenges to the lack of jurisdiction. See, e.g., Mary S. Leon, 45 Van Natta 1023 (1993). Notwithstanding our disinclination to address constitutional challenges to our lack of jurisdiction, we have specifically found that retroactive application of the provisions of SB 369 which vest exclusive jurisdiction over certain disputes with the Director do not impair the obligation of any contract under the Oregon Constitution. See Kathleen M. Butler, 47 Van Natta 2202 (1995) (specifically rejecting due process and Article I, Section 21 challenges to the retroactive application of amended ORS 656.260(6)). We therefore reject claimant's Article I, section 21 challenge to the retroactive application of amended ORS 656.283(2).[4]

"De Facto" Denial of Herniated Disc Condition

The ALJ found that the employer had notice of claimant's claim for a herniated disc when it received Dr. Peterson's February 24, 1994 chart note on March 15, 1994 and that its failure to accept the claim within 90 days resulted in a "de facto" denial of that condition. The ALJ further found that claimant's attorney was instrumental in obtaining rescission of the "de facto" denial before hearing, and awarded a carrier-paid attorney fee pursuant to former ORS 656.386(1).

The employer argues on review that Dr. Peterson's February 24, 1994 chart note did not constitute a claim for compensation under amended ORS 656.262, and the first notice it had of a "claim" for this condition was claimant's November 3, 1994 amended request for hearing on the "de facto" denial. The employer further contends that its February 2, 1995 acceptance of the herniated disc condition was timely and that no "de facto" denial in fact occurred.

Rather than determining when claimant made a "claim" for his herniated disc condition, we look to whether this claim constitutes a "denied claim" under amended ORS 656.386(1) because the new statute limits entitlement to attorney fees to "cases involving denied claims" where the claimant's attorney "is instrumental in obtaining a recision of the denial prior to a decision by the Administrative Law Judge."[5] Amended ORS 656.386(1) defines a "denied claim" as:

> "[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. A denied claim shall not be presumed or implied from an insurer's or self-insured employer's failure to pay compensation for a previously accepted injury or condition in a timely fashion."

Here, the employer did not expressly deny claimant's herniated disc condition. On the contrary, the employer acknowledged that the condition was compensable and paid compensation on this

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[4] To the extent claimant's argument may be construed as asserting that the retroactive application of amended ORS 656.283(3) violates her due process rights, we reject it based on Liberty Northwest Insurance Corp. v. Yon, 137 Or App 413 (1995) (retroactive application of the amendments to ORS 656.245, 656.327 and 656.704 eliminated the claimant's choice of having medical services dispute resolved by Board, but did not deny him an opportunity to have his claim reviewed).

[5] We have previously held that amended ORS 656.386(1) also applies retroactively to all cases pending before the Board. See Guillermo Rivera, 47 Van Natta 996 (1995).

condition.[6] Because there is no evidence that the employer "refused" to pay any compensation on the express ground that the condition was not compensable, we conclude claimant's herniated disc condition does not constitute a "denied claim" under amended ORS 656.386(1).[7] See Michael Galbraith, 48 Van Natta 351 (1996).

In the absence of a "denied claim" for claimant's herniated disc condition, claimant's attorney is not entitled to an assessed attorney fee based on the employer's pre-hearing acceptance of that condition. We therefore reverse that part of the ALJ's order that awarded a $500 carrier-paid attorney fee.

ORDER

The ALJ's order dated May 12, 1995, as amended May 19, 1994, is modified in part, vacated in part and reversed in part. In lieu of the ALJ's award of unscheduled permanent disability and in addition to the 17 percent (54.4 degrees) unscheduled permanent disability awarded by the June 8, 1994 Order on Reconsideration, claimant is awarded 4 percent (12.8 degrees) unscheduled permanent disability, giving him a total award of 21 percent (67.20 degrees) unscheduled permanent disability. The ALJ's "out-of-compensation" attorney fee award is modified accordingly. That portion of the ALJ's order that reversed the Director's vocational assistance order is vacated and claimant's request for hearing on this issue is dismissed for lack of jurisdiction. That portion of the order that awarded a $500 attorney fee pursuant to ORS 656.386(1) is reversed.

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[6] Indeed, at hearing, the employer's attorney acknowledged: "There's no question [claimant] had a herniated disc. There's no question that it was related to the injury. And there is also no question that he's received all the compensation which is due because of the herniated disc, including permanent partial disability." (Tr. at 18).

[7] Cf. Guillermo Rivera, supra (finding a "denied claim" where the employer initially questioned compensability of the claimant's cervical condition, but accepted the claim on the day of hearing).

February 16, 1996 Cite as 48 Van Natta 379 (1996)

In the Matter of the Compensation of
GAYLE S. JOHNSON, Claimant
WCB Case No. 95-04457
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Odell's order which awarded claimant 8 percent (25.6 degrees) unscheduled permanent disability for a low back injury (for a total award of 29 percent (92.8 degrees)), whereas an Order on Reconsideration had not granted permanent disability beyond the 21 percent (67.2 degrees) claimant had been previously awarded by a prior closure order. 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 her low back on October 11, 1989, which resulted in SAIF accepting a left disc herniation at L5-S1. Claimant's claim was initially closed on October 17, 1990, with an award of 5 percent unscheduled permanent disability. The claim was later reopened for surgery and reclosed by a March 4, 1992 Determination Order, which awarded 21 percent unscheduled permanent disability. At the time of the March 1992 closure, Dr. Hacker, claimant's attending physician, had released claimant to modified work with a lifting limitation of 20 pounds. (Ex. 18).

In April 1994, the claim was again reopened, this time for a lumbosacral fusion performed by Dr. Hacker. In October 1994, Dr. Hacker declared claimant medically stationary and released her for work at her time-of-injury job. (Ex. 42A). The claim was then closed by Notice of Closure on November 17, 1994. No additional permanent disability was awarded.

Claimant requested reconsideration. On April 6, 1995, an Order on Reconsideration issued, which did not award additional permanent disability and affirmed the Notice of Closure. (Ex. 47). The evaluator's worksheet stated that claimant's unscheduled permanent disability could not be redetermined under OAR 436-35-005(9)[1] because there had been no permanent worsening of claimant's compensable low back condition. (Ex. 47-4). Claimant requested a hearing.

The ALJ concluded that claimant was entitled to have her unscheduled permanent disability redetermined. The ALJ reasoned that OAR 436-35-005(9) was inconsistent with amended ORS 656.726(3)(f)(D)(i) and, was, therefore, invalid.[2] Applying the disability standards in effect at the time of the November 1994 closure, the ALJ calculated claimant's unscheduled permanent disability to be 29 percent. Accordingly, the ALJ increased claimant's total unscheduled permanent disability award by 8 percent.

On review, SAIF contends that the ALJ erred in concluding that claimant was entitled to a redetermination of her unscheduled permanent disability. We agree.

Although most provisions of Senate Bill 369 were intended to apply retroactively to all claims or causes of action existing or arising on or after its June 7, 1995 effective date, certain provisions were exempted from retroactive application. See Or Laws 1995, ch 332, § 66 (2)-(6). One such provision concerns the amendments to ORS 656.726(3)(f) contained in § 55 of Senate Bill 369. According to § 66(4), the amendments to ORS 656.726(3)(f) only apply to claims that become medically stationary on or after the effective date of the Act. Inasmuch as claimant became medically stationary on October 24, 1994, prior to the June 7, 1995 effective date of Senate Bill 369, amended ORS 656.726(3)(f) is inapplicable to this claim. Therefore, we analyze this claim without regard to that provision.[3]

A claimant cannot relitigate extent of disability in the guise of an aggravation claim when there has been no permanent worsening of the claimant's condition. Stepp v. SAIF, 304 Or 375 (1987); Calvin L. Williams, 47 Van Natta 444 (1995). In this case, there has been a reduction in claimant's low back range of motion, comparing claimant's low back condition at the time of claim closure in March 1992 with her condition in October 1994. (Exs. 20, 42A). We also recognize that claimant would ordinarily be entitled to an impairment value under the standards for her lumbosacral fusion. OAR 436-35-350(2).

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[1] OAR 436-35-005(9) provides:

"'Permanently Worsened' is established by a preponderance of medical evidence concerning the worker's current injury-caused health condition compared to the worker's condition as it existed at the time of the last arrangement of compensation. A worker has permanently worsened when the changes in condition result in a loss of earning capacity for unscheduled claims, or when the loss of use or function for scheduled claims is greater than previously. An increase in impairment for unscheduled injuries does not mean that the worker has permanently worsened unless that additional impairment reduces earning capacity."

[2] The ALJ incorrectly referred to the administrative rule as OAR 436-35-007(5).

[3] Moreover, even if we were to apply ORS 656.726(3)(f) retroactively, we would not conclude that it is inconsistent with OAR 436-35-005(9).

However, OAR 436-35-005(9) provides that an increase in impairment does not mean that a worker's condition has permanently worsened unless that impairment reduces earning capacity.[4]

Here, claimant was released to light work at the time of the March 1992 closure and was released to her time of injury employment (also light employment) in October 1994, before this aggravation claim was closed. Thus, there has been no permanent reduction in claimant's earning capacity due to her increased impairment. Consequently, under OAR 436-35-005(9), claimant is not entitled to a redetermination of her permanent disability because she has not established a "permanent worsening," i.e., a reduction in earning capacity. Since the record does not support a finding of a permanent worsening, we conclude that the Department properly refused to redetermine claimant's unscheduled permanent disability in the reconsideration order.[5]

ORDER

The ALJ's order dated August 14, 1995 is reversed. The April 6, 1995 Order on Reconsideration is reinstated and affirmed. The ALJ's out-of-compensation attorney fee is also reversed.

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[4] In Stepp, supra, the Court held that, in order to recover additional permanent disability in conjunction with an aggravation claim, the worker is required to demonstrate a permanently reduced earning capacity. 304 Or at 380-81. OAR 436-35-005(9), which requires that additional impairment reduce earning capacity, is consistent with the Court's analysis in Stepp. See also Dennis L. Beamer, 44 Van Natta 972, 974 (1992) (To prove entitlement to additional permanent disability based on an aggravation under ORS 656.273(1), where worsening of the condition resulting from the original compensable condition involves an unscheduled body part, such worsening must result in a further reduction in the claimant's earning capacity).

The dissent argues that an increase in permanent impairment necessarily constitutes a reduction in earning capacity. The dissent's argument assumes that a worker's permanent disability will be rated because of an increase in permanent impairment. However, the Stepp analysis is a prelude to the rating of permanent disability under the "standards." In other words, if the "permanent worsening" threshold in Stepp is not satisfied, ORS 656.214(5) and former ORS 656.726(3)(f) never come into play and the worker does not have his or her permanent disability redetermined under the "standards."

[5] Dr. Hacker does not conclude that claimant's condition had permanently worsened, nor does his opinion support such a conclusion. (Ex. 42A).

Board Chair Hall dissenting.

The majority finds that claimant sustained a permanent reduction in low back range of motion, but reverses the ALJ's redetermination of her permanent disability because it concludes that there has been no reduction in claimant's earning capacity as required by OAR 436-35-005(9). I believe that an increase in permanent impairment necessarily means that there has been a reduction in earning capacity. Accordingly, I conclude that the ALJ properly redetermined claimant's unscheduled permanent disability.

As the ALJ noted, ORS 656.214(5) provides that the criteria for rating of unscheduled permanent disability is permanent loss of earning capacity. That statute specifically provides that "earning capacity" is to be calculated using the "standards" specified in ORS 656.726(3)(f). Former ORS 656.726(3)(f) provides that the criteria for evaluation of permanent disability is permanent impairment due to the industrial injury as modified by the factors of age, education, and adaptability to perform a given job.

Therefore, the statutes applicable to this claim specifically provide that permanent impairment is a factor in "earning capacity." Therefore, an increase in permanent impairment resulting from claimant's compensable aggravation claim necessarily means that claimant has experienced a reduction in earning capacity. Thus, the fact that claimant in this case returned to light work does not preclude a redetermination of claimant's unscheduled permanent disability. See Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996) (invalidating former OAR 436-35-310(2) which required an adaptability value of zero if a worker has returned to work).

Inasmuch as OAR 436-35-007(5) conflicts with ORS 656.214(5) and former ORS 656.726(3)(f), I would not apply the rule. Instead, I would redetermine claimant's unscheduled permanent disability as required by the applicable statutes. Therefore, I must respectfully dissent.

In the Matter of the Compensation of
RALPH E. MELINE, JR., Claimant
WCB Case No. 95-06250
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that: (1) found that the SAIF Corporation had not issued a denial of claimant's previously accepted left knee chondromalacia patella condition; (2) declined to award an attorney fee for rescission of the denial of the same condition; and (3) upheld SAIF's denial of claimant's consequential condition claim for a left knee medial meniscus tear. In his brief, claimant contends that he is entitled to an attorney fee for SAIF's acceptance of his left knee synovitis and plica condition at hearing. On review, the issues are compensability and attorney fees.

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

The ALJ found that there was no issue regarding the compensability of claimant's plica condition because SAIF agreed that it was a compensable consequence of the chondromalacia condition.

Claimant contends that he is entitled to an attorney fee for SAIF's acceptance of the left knee synovitis and plica condition. Claimant argues that SAIF's May 18, 1995 denial served as a "de facto" denial of that condition and he asserts that his attorney's efforts resulted in the withdrawal or rescission of a denial of compensability. We disagree.

On June 1, 1995, Dr. Bert performed arthroscopic surgery on claimant's left knee. Dr. Bert's preoperative diagnosis was internal derangement, left knee. (Ex. 17). The postoperative diagnosis was degenerative tear, medial meniscus, lateral meniscus, synovial plica, moderate chondromalacia patellae. (Id.) Dr. Bert found considerable synovitis throughout the knee and also removed a large superior medial synovial plica. (Id.) In a deposition on July 31, 1995, Dr. Bert agreed that the major cause of claimant's chondromalacia and the synovial plica was the June 18, 1988 injury. (Ex. 18-13).

SAIF asserts that its May 18, 1995 denial could not have included the left knee synovitis and plica condition because that condition was not diagnosed until the June 1, 1995 surgery. SAIF argues that claimant had not made a formal request to accept that condition pursuant to ORS 656.262(7)(a) and there was no "de facto" denial of that condition.

Under ORS 656.262(7)(a), a worker must clearly request formal written acceptance of any new medical condition from the carrier. The carrier must provide written notice of acceptance or denial within 90 days after receipt of the claim. In this case, there is no evidence that claimant requested formal written acceptance of the left knee synovitis and plica condition that was diagnosed as a result of his June 1, 1995 surgery.

In any event, claimant is not entitled to an attorney fee for SAIF's acceptance of the left knee synovitis and plica condition. Under amended ORS 656.386(1), claimant's attorney is entitled to a reasonable attorney fee in cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge. A "denied claim," is defined, in part, as 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."

Here, there is no evidence that SAIF denied a claim for claimant's left knee synovitis and plica condition. SAIF did not refuse to pay any compensation for that condition, nor did it deny that condition for lack of compensability or entitlement to compensation. We conclude that claimant's attorney did not obtain a rescission of a "denied claim" and claimant is not entitled to an attorney fee under ORS 656.386(1). See Michael Galbraith, 48 Van Natta 351 (1996).

ORDER

The ALJ's order dated September 22, 1995 is affirmed.

In the Matter of the Compensation of
CARL H. MELUGIN, Claimant
WCB Case No. 95-03506
ORDER ON REVIEW (REMANDING)
Ransom & Gilbertson, Claimant Attorneys
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Poland's order that declined to assess an attorney fee pursuant to ORS 656.382(1) or .656.386(1). On review, the issue is attorney fees. We remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exception, correction and supplementation. As the record is currently developed, we do not adopt the second sentence of the ALJ's findings of ultimate fact.

Claimant filed a supplemental hearing request that raised the additional issue of "de facto" denial of right tibialis posterior partial tendon rupture on May 4, 1995, not May 4, 1994. The hearing was scheduled on June 14, 1995.

CONCLUSIONS OF LAW AND OPINION

Attorney Fee Pursuant to ORS 656.382(1)

Because the employer timely paid for all benefits associated with the tendon rupture, the ALJ found there had been no unreasonable resistance to the payment of compensation justifying an assessed attorney fee pursuant to ORS 656.382(1). We adopt the ALJ's reasoning and conclusion regarding this issue.

Attorney Fee Pursuant to ORS 656.386(1)

The ALJ declined to award an assessed attorney fee pursuant to amended ORS 656.386(1), concluding that there was no denied claim for the tendon rupture condition within the meaning that statute. For the following reasons, we find the record inadequately developed to determine claimant's entitlement to an attorney fee under amended ORS 656.386(1). Consequently, we remand to the ALJ.

On review, claimant appears to assert that, because he satisfied the requirements of amended ORS 656.262(6)(d) through his May 4, 1995 supplemental hearing request, and the employer failed to respond within 30 days, he has established a "denied claim" and is entitled to an attorney fee pursuant to amended ORS 656.386(1). Although we agree with claimant that his supplemental hearing request satisfies the requirements of amended ORS 656.262(6)(d), we disagree with claimant's assertion that this, in itself, results in entitlement to an attorney fee pursuant to amended ORS 656.386(1).

Amended ORS 656.262(6)(d) prohibits a worker from alleging a "de facto" denial at any hearing or other proceeding if the worker did not provide a written objection to the carrier's notice of acceptance. Or Laws 1995, ch 332, § 28(6)(d) (SB 369, § 28(6)(d)). The carrier has 30 days to respond in writing to this written objection. Id.

Amended ORS 656.386(1) provides for a reasonable attorney fee in cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge. SB 369, § 43(1). Amended ORS 656.386(1) defines a "denied claim" as:

> "[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. A denied claim shall not be presumed or implied from an insurer's or self-insured employer's failure to pay compensation for a previously accepted injury or condition in a timely fashion."

Subsequent to the ALJ's order, we decided Guillermo Rivera, 47 Van Natta 1723 (1995), in which we determined that the amended provisions of ORS 656.262(6)(d) apply retroactively to disputes pending before the Board. In addition, we explained the relationship between amended ORS 656.262(6)(d) and amended ORS 656.386(1). In this regard, we determined that the provisions of amended ORS 262(6)(d) must be satisfied before a worker can allege entitlement to an assessed attorney fee under amended ORS 656.386(1). After the provisions of amended ORS 656.262(6)(d) are met, the provisions of amended ORS 656.386(1) must be met in order to establish entitlement to an attorney fee where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge.

In Rivera, two days before hearing, the claimant filed a supplemental request for hearing, which alleged a "de facto" denial of a cervical strain. All compensation for the cervical condition had been paid. Id. at 1725 n.2. On the date of hearing, the employer accepted the cervical strain. We found that the claimant's supplemental request for hearing constituted "communication in writing" to the employer of the claimant's objections to the notice of acceptance pursuant to amended ORS 656.262(6)(d). Id. at 1724. We noted that this supplemental hearing request was a written communication that effectively challenged the scope of the notice of acceptance with regard to the cervical strain. Id. In addition, since the employer responded to claimant's written communication within 30 days by accepting the cervical condition on the date of hearing, we concluded that the provisions of amended ORS 656.262(6)(d) were satisfied. Id. In reaching this conclusion, we noted that, had the employer not accepted the cervical condition on the date of hearing (two days after the claimant's "written communication"), it could have challenged the claimant's cervical "de facto denial" allegation as premature, since the employer had 30 days to respond to the claimant's written communication pursuant to amended ORS 656.262(6)(d).

After finding that the provisions of amended ORS 656.262(6)(d) were satisfied, we proceeded to determine whether the provisions of amended ORS 656.386(1) were met. Based on undisputed representations made by the parties at hearing and on review, we concluded that the claimant's cervical condition constituted a "denied claim" pursuant to amended ORS 656.386(1). Id. at 1725. Consequently, since the claimant's attorney was instrumental in obtaining a rescission of the denial prior to the hearing, we found the claimant entitled to a reasonable attorney fee pursuant to amended ORS 656.386(1).

Here, on May 4, 1995, claimant filed a supplemental hearing request that raised the additional issue of "de facto" denial of right tibialis posterior partial tendon rupture. As in Rivera, we find that claimant's supplemental hearing request constitutes "communication in writing" to the employer of the claimant's objections to the notice of acceptance pursuant to amended ORS 656.262(6)(d). The employer had 30 days within which to respond to this written communication. The employer did not respond within 30 days. However, on June 14, 1995, the scheduled date of hearing, the employer conceded that the tendon rupture condition is compensable.[1] Because the employer had a full 30 days from the date of claimant's written communication within which to respond before the scheduled date of hearing, we conclude that the provisions of amended ORS 656.262(6)(d) are satisfied. Therefore, claimant may allege entitlement to an attorney fee for obtaining a rescission of a "de facto" denial without a hearing. Amended ORS 656.386(1).

However, to determine whether claimant is entitled to an attorney fee under amended ORS 656.386(1), we must determine whether claimant's tendon rupture condition was a "denied claim," as that term is defined in amended ORS 656.386(1).

Here, the parties waived hearing and submitted the matter on the written record. Closing arguments were subsequently held by telephone and were not recorded. Therefore, no oral proceedings were recorded and no transcript was produced. However, there was apparently some discussion regarding compensability of the partial tendon rupture condition because the ALJ made a finding that "[o]n the scheduled date of hearing, the employer conceded compensability of the right tibialis posterior partial tendon rupture." This concession is not part of the written record.

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[1] We note that the parties do not dispute that, on the scheduled hearing date, the employer conceded that the tendon rupture condition is compensable. The parties' dispute centers on the representations, if any, made by the employer in addition to this concession.

On review, the parties disagree with the ALJ's characterization of the employer's concession. Claimant contends that "[o]n 06/14/95, the date of hearing, the employer acknowledged that the condition had been improperly omitted." (Claimant's Opening Brief, page 2). The employer disagrees with claimant's contention, stating that "[t]hose are claimant's words, not ours." (Respondent's Brief). Instead, the employer contends that "at the time of hearing the parties agreed that the posterior tibial tendon rupture was compensable and that the compensability of that condition was not and had never been disputed." Id. Thus, here, unlike Rivera, the parties' representations at hearing are not undisputed. In addition, because there are no recorded proceedings in the present case, we are unable to determine on our de novo review whether claimant's tendon rupture condition was a "denied claim" pursuant to amended ORS 656.386(1).

Our review is limited to the record developed at hearing. However, we may remand a case to the ALJ for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5). Remand is appropriate upon a showing of good cause or some other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, although written evidence was admitted into the record, no oral proceedings were recorded. On the other hand, although unrecorded, the parties made oral representations on the scheduled date of hearing. On review, the parties dispute the content of these oral representations. However, because these representations were not recorded, we are unable to properly assess them in determining whether claimant's tendon rupture condition constitutes a "denied claim" pursuant to amended ORS 656.386(1). Under these circumstances, we find a compelling basis to remand.

Accordingly, we remand this matter to ALJ Poland. The parties shall have the opportunity to present evidence regarding claimant's entitlement to an attorney fee under amended ORS 656.386(1), including the issue of whether claimant's ruptured tendon condition constitutes a "denied claim" pursuant to amended ORS 656.386(1). The ALJ shall have the discretion to proceed in any manner that will achieve substantial justice, and will insure a complete and accurate record of all exhibits, examination, and/or testimony. Thereafter, the ALJ shall issue a final, appealable order.

ORDER

The ALJ's order dated September 21, 1995, as amended by the October 11, 1995, is affirmed in part and vacated in part. That portion witch declined to award an attorney fee pursuant to ORS 656.386(1) is vacated and this matter is remanded to ALJ Poland for further proceedings consistent with this order. The remainder of the ALJ's order is affirmed.

February 16, 1996 Cite as 48 Van Natta 385 (1996)

In the Matter of the Compensation of
WILLIAM L. KARNATH, Claimant
WCB Case Nos. 94-10309 & 94-03828
CORRECTED ORDER ON REVIEW
Ginsburg, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Jim Thwing (Saif), Defense Attorney

It has come to our attention that our prior Order on Review, which was mailed on January 30, 1996, contained a clerical error. The "Order" paragraph referred to Administrative Law Judge (ALJ) Poland's order dated March 20, 1994. This is an incorrect date. The correct date should read March 20, 1995.

In order to correct this error, we withdraw our prior order. In its place, as supplemented herein, we adhere to and republish our prior order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
SHANON M. OLIVER, Claimant
WCB Case No. 95-03474
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Neidig and Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Neal's order that: (1) declined to award temporary disability compensation after February 23, 1995; and (2) declined to assess a penalty for allegedly unreasonable claim processing. On review, the issues are interim compensation and penalties. We affirm.

FINDINGS OF FACT

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

Claimant was taken off work by her attending physician, Dr. Mears, in late December 1994, after she experienced left knee pain. (Ex. 1). In early January 1995, claimant was released to return to light duty work, 6 hours per day. (Exs. 5, 8). On February 9, 1995, Dr. Mears issued a release limiting claimant to work six hours per day for two weeks. (Ex. 8; Ex. 17-41). The next written work release by Dr. Mears was dated April 27, 1995, when she indicated that claimant had been off work full time since February 23, 1995, at the doctor's recommendation. (Ex. 15).

The insurer paid temporary disability benefits through February 23, 1995. (Ex. 3a-7). Thereafter, it did not pay temporary disability through the date of its March 20, 1995 denial.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that she is entitled to interim compensation from February 23, 1995, when the insurer stopped paying temporary disability compensation, to March 20, 1995, when the insurer denied her left knee claim. The ALJ held that, under amended ORS 656.262(4), all temporary disability compensation, including that characterized as interim compensation, must be authorized by claimant's attending physician. The ALJ further found that the work release issued on April 27, 1995, which purported to be retroactive to February 23, 1995, could only be effective to retroactively authorize temporary disability compensation for 14 days prior to its issuance, consistent with amended ORS 656.262(4)(f). Therefore, since there was no work release effective for the period prior to March 20, 1995, the date of the denial, the ALJ concluded that claimant was not entitled to interim compensation for the period from February 23, 1995 to March 20, 1995. We agree with the ALJ's reasoning and conclusion, and we offer the following supplementation.

Claimant received interim compensation payments, pursuant to her attending physician's authorizations, until February 23, 1995. Beginning in early January 1995, those payments were for temporary partial disability, since claimant had been released to and returned to modified work. On February 23, 1995, the insurer unilaterally terminated claimant's temporary disability benefits, prior to issuing a denial on March 20, 1995. Claimant contends that she is entitled to the payment of interim compensation until March 20, 1995, the date of the denial. Accordingly, the issue on review is whether the insurer could unilaterally terminate temporary partial disability compensation, characterized as interim compensation, prior to issuing its denial.

ORS 656.262(4) provides for the payment of temporary disability compensation, while ORS 656.268(3) specifies the conditions under which temporary total disability benefits may be unilaterally terminated. Both statutes were amended by Senate Bill 369, effective June 7, 1995. Since there is no relevant exception, the amended statutes apply to this case. Or Laws 1995, ch 332, § 66 (SB 369, § 66); Volk v. America West Airlines, 135 Or App 565 (1995).

Amended ORS 656.262(4) provides, in relevant part:

> "(a) The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation* * *.

"* * * * *

"(f) 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."

Amended ORS 656.268(3) provides, in relevant part:

"Temporary total disability benefits shall continue until whichever of the following events first occurs:

"* * * * *

"(d) Any other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4) or other provisions of this chapter."

Here, the attending physician authorized temporary disability compensation, but only for a limited period. The last authorization prior to February 23, 1995, when the insurer terminated payments, was on February 9, 1995, when the attending physician authorized release to modified work for two weeks. (Exs. 8, 17-41).

Although amended ORS 656.268(3) does not expressly authorize the termination of temporary partial disability, as distinct from temporary total disability, we have previously held that temporary partial disability could be terminated when a worker was released to regular work, under former ORS 656.268(3). Thomas W. Lundy, 43 Van Natta 2307 (1991); see also Alda S. Carbajal, 47 Van Natta 1596, 1600 (1995).

We find no basis not to apply this reasoning to the termination of temporary partial disability when the attending physician ceases to authorize temporary disability. Thus, we hold that temporary partial disability is not due and payable under amended ORS 656.268(3) and 656.262(4)(f) when the attending physician ceases to authorize temporary disability, or for any period not authorized by the attending physician.

In support of our holding, we note that both amended ORS 656.262(4)(f) and 656.268(3)(d) refer to "temporary disability" benefits, which encompasses both temporary total and temporary partial disability benefits. Furthermore, amended ORS 656.268(3)(d) specifically references amended ORS 656.262(4) as providing one ground for terminating, suspending or withholding temporary disability benefits.

Here, the attending physician authorized temporary partial disability on February 9, 1995 for two weeks, or until February 23, 1995. The insurer ceased paying temporary disability on February 23, 1995. Pursuant to amended ORS 656.262(4)(f) and 656.268(3)(d), we conclude that the insurer properly terminated payment of temporary partial disability benefits on February 23, 1995, when the attending physician ceased to authorize temporary disability.

The attending physician again authorized temporary disability on April 27, 1995, stating that claimant had been temporarily totally disabled since February 23, 1995. (Ex. 15). However, amended ORS 656.262(4)(f) provides that no authorization shall be effective to retroactively authorize temporary disability more than 14 days prior to its issuance. We recently applied this provision in Delores L. Holmes, 47 Van Natta 2359 (1995), holding that a physician's authorization of temporary disability, purportedly retroactive for two years, was effective to retroactively authorize temporary disability for only 14 days prior to its issuance.

Here, too, we hold that the attending physician's April 27, 1995 authorization was retroactive for 14 days. In other words, it was effective to authorize temporary disability from April 13, 1995. Since interim compensation is due only until the claim is denied, and the insurer issued a denial on March 20, 1995, no interim compensation is due.

On review, claimant contends that, in addition to interim compensation, she is entitled to temporary disability until April 13, 1995. At hearing, claimant argued only that she was entitled to interim compensation (that is, compensation up to the date of denial). Our review is confined to the issues presented at hearing. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Since entitlement to temporary disability for the period after March 20, 1995, the date of the denial, was not raised at hearing, we are not inclined to address that issue on review.

Moreover, were we to address the issue of claimant's entitlement to temporary disability prior to April 13, 1995, we would hold that she is not entitled to temporary disability for that period. Amended ORS 656.262(4)(f); Delores L. Holmes, supra.

Finally, we emphasize that our conclusions pertain only to claimant's entitlement to procedural temporary disability during an open claim. While a worker's procedural entitlement to temporary disability is contingent on the attending physician's authorization, there is no such requirement for determining substantive entitlement to temporary disability. Rather, a worker's substantive entitlement to temporary disability is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the worker was disabled due to the compensable claim before being declared medically stationary. ORS 656.210; SAIF v. Taylor, 126 Or App 658 (1994); Esther C. Albertson, 44 Van Natta 2058, 2059 (1992).

ORDER

The ALJ's order dated June 16, 1995 is affirmed.

February 16, 1996 Cite as 48 Van Natta 388 (1996)

In the Matter of the Compensation of
SHELLEY A. PATEE, Claimant
WCB Case No. 95-07060
ORDER ON REVIEW
Schneider, Hooton, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order which increased claimant's award of scheduled permanent disability, for loss of use or function of the right wrist, from zero, as determined by an Order on Reconsideration, to 6 percent (9 degrees). On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the exception of any findings based on claimant's testimony. We do not adopt the ALJ's "Ultimate findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable claim for bilateral wrist conditions arising out of an April 1991 claim. Claimant eventually received a total of 7 percent scheduled permanent disability for her right wrist and 7 percent scheduled permanent disability for the left wrist.

The claim was reopened for right and left carpal tunnel releases in January and March 1994. The claim was reclosed by Notice of Closure of October 26, 1994, with no further award of permanent disability. An Order on Reconsideration affirmed the permanent disability portion of the Notice of Closure. Claimant then requested a hearing.

The ALJ concluded that claimant was not entitled to a 5 percent award for an alleged "chronic" condition limiting repetitive use of her right wrist. However, the ALJ found that claimant was entitled to an additional award of scheduled permanent disability for loss of use or function of her right wrist. Relying on the opinion of the medical arbiter, Dr. Weller, the ALJ determined that claimant had a 20

percent loss of right grip strength. Identifying the specific nerve affected by claimant's injury as the ulnar nerve, the ALJ then rated claimant's loss of strength pursuant to the table in OAR 436-35-110(8) and concluded that claimant had 6.2 percent loss of strength in the right wrist/forearm. Combining that impairment with 1 percent impairment for loss of range of motion, the ALJ determined that claimant's total right wrist impairment was 7 percent.

Having determined claimant's permanent impairment, the ALJ then addressed the effect of OAR 436-35-007(3), which requires consideration of prior permanent disability awards in rating disability in subsequent claims. Applying this administrative rule, the ALJ reasoned that claimant was not entitled to any award for her loss of range of motion, inasmuch as she had previously received 2 percent permanent disability for loss of range of motion of her right wrist. The ALJ, however, noted that claimant had never previously received an award of permanent disability for loss of strength. Thus, the ALJ concluded that claimant was entitled to 6 percent[1] scheduled permanent disability for loss of strength in her right wrist.

On review, SAIF contends that the ALJ erred in awarding additional scheduled permanent disability. SAIF asserts that the medical evidence from claimant's attending physician and the medical arbiter does not establish that claimant has loss of grip strength and, even if she does, it is not ratable under OAR 436-35-110(8). SAIF also asserts that the ALJ erred in allowing claimant to testify regarding her permanent impairment, citing ORS 656.283(7). For the following reasons, we agree with SAIF that claimant is not entitled to additional scheduled permanent disability. However, we need not decide the issue of whether the ALJ erred in allowing claimant's testimony.

"Loss of strength" is rated "when the cause is a peripheral nerve injury" or "due to loss of muscle or disruption of the musculo tendonous unit." OAR 436-35-110(8), 436-35-110(8)(a). Here, claimant's attending physician, Dr. Layman, reported in his closing examination that claimant's grip strength "could be considered" as grade 5/5. (Ex. 41). The medical arbiter, Dr. Weller, also reported grade 5/5 muscle strength in claimant's upper extremities, with the exception of "perhaps 10 to 20 percent loss of grip strength in the right grip by estimation." Ex. 50-4). SAIF contends that, based on these reports, claimant has no loss of grip strength. We need not decide that issue. Even if claimant does have loss of grip strength, we find insufficient evidence that it is related to claimant's injury.

Dr. Weller wrote the following regarding the causation of claimant's loss of grip strength:

> "There appears to be no clear atrophy or fasciculation in either hand, albeit muscle bulk overall is in the lower range of normal. This did not conform to any specific nerve distribution and certainly not to the median or radial nerve distribution. If anything, there may have been some reduction in the fluid of the first dorsal interossei bilaterally, innervated by the ulnar nerves." Ex. 50-4).

Noting claimant's concession that the ALJ erred in attributing her loss of strength to the ulnar nerve, SAIF emphasizes that there was no injury to claimant's ulnar nerve. SAIF contends that Dr. Weller's arbiter's report does not establish that claimant's grip strength loss, if it exists, is due to her compensable carpal tunnel condition, given his comment that claimant's loss of muscle bulk does not conform to either the median or radial nerve or any specific nerve distribution. We agree with SAIF's argument that Dr. Weller's arbiter's report does not prove that claimant has grip strength loss due to her compensable carpal tunnel condition.

Asserting that her grip strength weakness is due to median nerve damage, claimant argues, however, that we should infer that Dr. Weller's findings are due to the compensable carpal tunnel condition because of the fact that Dr. Weller rated her impairment. We are not persuaded by claimant's argument.

We have held that, if a treating physician or medical arbiter makes impairment findings consistent with a claimant's compensable injury, and does not attribute the impairment to causes other than the compensable injury, we will construe the findings as showing that the claimant's impairment is due to the compensable injury. Kim E. Danboise, 47 Van Natta 2163 (1995); Edith N. Carter, 46 Van Natta 2400 (1994); David J. Schafer, 46 Van Natta 2298 (1994). However, under the circumstances of this case, we decline to infer that any loss of grip strength is due to median nerve damage in light of Dr. Weller's specific comment that claimant's loss of muscle bulk does not conform to the median nerve.

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[1] Claimant's 6.2 percent permanent impairment was rounded to the nearest whole number. See OAR 436-35-007(11).

Moreover, given claimant's concession that her loss of muscle bulk is not due to injury to the ulnar nerve, as well as the lack of evidence that claimant's ulnar nerve was injured, we find that the arbiter's impairment findings are not consistent with claimant's compensable carpal tunnel injury. Thus, claimant's loss of grip strength is not attributable to her ulnar nerve injury. It follows that the ALJ erred in awarding claimant additional scheduled permanent disability for loss of grip strength.[2] Accordingly, we reverse the ALJ's permanent disability award and reinstate and affirm the Order on Reconsideration.

ORDER

The ALJ's order dated September 12, 1995 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee award is reversed.

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[2] Effective June 7, 1995, Senate Bill 369 amended ORS 656.283(7) to provide that evidence on an issue regarding a Notice of Closure or Determination Order that was not submitted at the reconsideration is not admissible at hearing. Pursuant to Section 66(1) of that Act, amended ORS 656.283(7) is to be applied retroactively to claims pending on or after the Act's effective date. As previously noted, SAIF contends that the ALJ erred in allowing claimant to testify regarding her permanent impairment since this evidence was not submitted at the reconsideration proceeding. Claimant responds that the testimony of a claimant should be permitted and that application of the limitation on evidence contained in ORS 656.283(7) renders the entire reconsideration process unconstitutional.

We need not address these contentions. The ALJ did not rely on claimant's testimony regarding her permanent impairment, nor do the parties on review. Moreover, lay testimony is insufficient to establish permanent impairment under the "standards." See Patricia A. Avila, 45 Van Natta 2094 (1993); William K. Nesvold, 43 Van Natta 2767 (1991). In light of this, we do not find claimant's testimony to be probative regarding the issues to be decided in this case, even if it could be considered. Therefore, even if we were to limit our consideration to the "reconsideration record," or, alternatively, if we were to consider the entire record, including claimant's testimony, we would still conclude that claimant has not established her entitlement to additional scheduled permanent disability. See Darlene E. Parks, 47 Van Natta 2404 (1995); Duane B. Onstott, 47 Van Natta 1429 (1995).

February 16, 1996 Cite as 48 Van Natta 390 (1996)

In the Matter of the Compensation of
MARY J. RICHARDS, Claimant
WCB Case No. 95-03242
ORDER ON REVIEW
Hunnicutt, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that: (1) declined to admit an exhibit into the record; and (2) upheld the SAIF Corporation's denial of claimant's injury claim for a recurrent rectocele. On review, the issues are evidence and compensibility. We affirm.

FINDINGS OF FACT

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

On July 10, 1995, claimant's attorney received a letter dated July 5, 1995 from claimant's attending physician. Claimant provided a copy of this letter to SAIF on August 21, 1995, one day prior to the August 22, 1995 hearing. (Ex. 21, Tr. 2). SAIF objected to the admission of the letter on the basis that it was submitted untimely. (Tr. 2). The ALJ excluded the evidence (Exhibit 21) from consideration at hearing, but provided it in the hearings file under an offer of proof. (Ex. 9).

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling

The ALJ excluded Exhibit 21, submitted to SAIF one day prior to hearing, on the basis that the exhibit was not timely disclosed to SAIF, and good cause for the failure to disclose had not been shown. On review, claimant contends that the exhibit was improperly excluded and that the ALJ erred in refusing to grant claimant's request for a continuance. We review the ALJ's evidentiary ruling for abuse of discretion. James D. Brusseau, II, 43 Van Natta 541 (1991).

OAR 438-007-0015(4) requires the parties to disclose documents acquired after the initial exchanges within seven days of receipt. If there is material prejudice to the other party, OAR 438-007-0018(4) vests the ALJ with discretion to remedy the untimely disclosure by continuing the hearing or by excluding the documents not disclosed within the time prescribed by OAR 438-007-0015. See also OAR 438-007-0015(5).

Claimant concedes that Exhibit 21 was untimely produced (Appellant's Brief at 10), violating OAR 438-007-0015(4). Nevertheless, claimant argues that the ALJ should have continued the hearing at his request so that SAIF could respond to the exhibit. At hearing, the ALJ considered the arguments of both parties. The ALJ found that SAIF had been materially prejudiced by the untimely production because the letter addressed the question of causation, which was directly at issue in the proceeding before him, and SAIF did not have time to prepare its defense. (Tr. 8, 9). Additionally, the ALJ found that the reason for failure to disclose was inadvertence on the part of claimant, which did not rise to good cause that would outweigh prejudice to SAIF. (Tr. 9). Consequently, the ALJ excluded Exhibit 21.

We agree with the ALJ's ruling that SAIF has been materially prejudiced by the untimely disclosure and that claimant's inadvertence does not constitute good cause for untimely disclosure of documents. See Kenneth R. Bullion, 46 Van Natta 1262 (1994) (counsel's absence from the office did not constitute good cause for delay of production); Donald R. Dodgin, 45 Van Natta 1642 (1993) (untimely production impaired the insurer's ability to prepare its defense, and inadvertence was not good cause for untimely disclosure). Finally, SAIF objected to claimant's request that a continuance be granted to cure claimant's own failure to timely disclose.

Under these circumstances, we find that the ALJ did not abuse his discretion by choosing to exclude Exhibit 21 from the evidentiary record.

Compensability

We adopt and affirm the portion of the ALJ's order regarding compensability.

ORDER

The ALJ's order dated August 31, 1995 is affirmed.

February 16, 1996 Cite as 48 Van Natta 391 (1996)

In the Matter of the Compensation of
RICKY L. ROBINSON, Claimant
WCB Case No. 95-06096
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Neidig, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the SAIF Corporation's denial of claimant's left inguinal hernia. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant failed to establish a compensable left inguinal hernia claim under amended ORS 656.005(7)(a)(B). Claimant asserts that, because he did not have a preexisting left inguinal condition, the ALJ erred in applying that statute. We disagree.

Claimant experienced the sudden onset of left groin pain while lifting boards at work. He sought treatment from Dr. Scharpf, who diagnosed and repaired bilateral inguinal hernias. Claimant filed, and SAIF denied, claims for both conditions. At hearing, claimant conceded that he had not established a compensable right inguinal hernia. Accordingly, we consider only the left inguinal hernia.

The ALJ analyzed this case under amended ORS 656.005(7)(a)(B). Under that statute, a combination of an otherwise compensable injury with a preexisting condition is compensable "only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the combined condition or the major contributing cause of the need for treatment of the combined condition." For the statute to apply, then, there must be evidence that claimant had a preexisting condition and that that condition combined with an otherwise compensable injury.[1]

Here, the preponderance of the evidence establishes that claimant had a preexisting left inguinal condition. Dr. Scharpf initially concluded that, because claimant had bilateral inguinal hernias, his condition "was probably there for some time, but didn't become symptomatic until recently." (Ex. 5-1). In deposition, Scharpf was unable to state "for sure" whether claimant had a preexisting left inguinal hernia. (Ex. 9-12). Subsequently, however, Scharpf agreed that the presence of bilateral hernias suggested a preexisting congenital groin weakness. (Id. at 13). Scharpf also said, "[P]robably there was at least the potential for hernias on both sides that was there and existed probably for some time." (Id. at 15; see id. at 17, -19). He characterized this as a predisposition and agreed that, in terms of medical probability, claimant had such a predisposition. (Id. at 15). Thereafter, Scharpf testified:

> "I cannot tell you he did not have a hernia before whatever happened at work. I can't rule that possibility out.
>
> "Q. [By SAIF's attorney] And it was your opinion as you stated earlier that you felt that there was a preexisting condition or the word you used was a predisposition that existed before the work activity?
>
> "A. [Claimant] Yeah, I think he had some weakness in the groin area and possibly and probably some -- the beginning of a hernia forming in his groin on both sides." (Id. at 18).

That evidence establishes that claimant had a preexisting left inguinal condition. In reaching that conclusion, we rely on Dr. Scharpf's statements regarding claimant's bilateral hernias being evidence of a congenital groin weakness. We also rely on Scharpf's conclusion that claimant was predisposed to develop inguinal hernias. See amended ORS 656.005(24) (preexisting conditions includes predispositions); Darlene J. Reed, 47 Van Natta 1720 (1995) (Board applied amended ORS 656.005(7)(a)(B) to case involving preexisting or predisposing condition that combined with work incidents).

That Dr. Scharpf stated that he could not say "for sure" whether claimant had a preexisting condition and that he could not rule out the possibility of such a condition does not alter our conclusion. Scharpf need not know "for sure" whether claimant had a preexisting condition; he need only state an opinion in terms of medical probability. See Miller v. SAIF, 60 Or App 557, 561-62 (1982) (medical opinion couched in terms of possibility insufficient to establish compensable claim). Scharpf has done that; his statement about his inability to rule out a possible preexisting condition is outweighed by his other statements that it is medically probable that claimant had that condition. As a whole, the record establishes that claimant had a preexisting left inguinal condition.

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[1] The ALJ analyzed this case as an injury claim. Because the onset of claimant's left groin pain was sudden, we agree with that conclusion. Mathel v. Josephine County, 319 Or 235, 240 (1994).

Further, the evidence establishes that claimant's preexisting groin condition combined with his otherwise compensable work injury to produce a left inguinal hernia. (Ex. 9-11, -12, -13, -16, -20, -21). In view of that evidence, we agree with the ALJ that this case is governed by amended ORS 656.005(7)(a)(B). The remaining issue is whether claimant has established that his work injury was the major contributing cause of his left inguinal hernia. He has not.

Dr. Scharpf initially said that it was impossible to identify the cause of claimant's hernia. (Ex. 5-1). In deposition, Scharpf concluded that claimant's work injury was "the cause that brought him to [Scharpf's] office." (Ex. 9-12; see Ex. 9-16, -20). Scharpf then said that he could not "say what the major cause of [claimant's] groin weakness and hernia formation would be." (Id. at 18). Thereafter, however, Dr. Scharpf agreed that the major cause of "the symptoms and the problems" was claimant's work activity. (Id. at 22).

Taken together, Dr. Scharpf's opinions fail to establish a compensable claim under amended ORS 656.005(7)(a)(B). At most, his opinions establish that claimant's work injury was the precipitating cause of his left inguinal hernia. That is insufficient to meet claimant's burden of proof. See Dietz v. Ramuda, 130 Or App 397, 401 (1994) (precipitating cause of worker's condition not necessarily major or primary cause of condition). The remainder of Scharpf's opinions either specifically declined to identify the cause of claimant's hernia, or amounted to an unexplained conclusion to the contrary. We agree with the ALJ that, as a whole, Dr. Scharpf's opinions fail to establish that claimant's work injury was the major contributing cause of his left inguinal hernia. Therefore, we affirm the ALJ's decision upholding SAIF's denial of that condition.

ORDER

The ALJ's order dated September 8, 1995 is affirmed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that Dr. Scharpf's opinions establish, at most, that claimant's work injury was the precipitating cause of his left inguinal hernia. Scharpf initially said that claimant's work injury was what prompted him to seek medical treatment (see Exs. 9-12, -16, -20) and that he (Scharpf) could not identify the major cause of claimant's groin problems. (Id. at 18). Nevertheless, Scharpf eventually agreed that the major cause of claimant's "symptoms" and "problems" was claimant's work activity. (Id. at 22). The only condition claimant sought treatment for was his inguinal hernias. Therefore, in my view, Dr. Scharpf's final opinion is sufficient to establish that claimant's work injury was the major contributing cause of his left inguinal hernia.

In reaching this conclusion, I wish to emphasize that there is absolutely no evidence that claimant engaged in any outside activities that could have caused him to develop an inguinal hernia. Further, Dr. Scharpf, whose opinions stand unrebutted, has consistently related that condition to claimant's work activities, albeit perhaps not in terms that mirror the statutory language. Because we do not require medical experts to regurgitate "magic words," e.g., Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992), in view of the absence of any off-work causes, I would hold that claimant's left inguinal hernia is compensable. To conclude otherwise would mean that a condition that is supported by unrebutted medical evidence is no longer compensable. Because the majority does just that, I respectfully dissent.

In the Matter of the Compensation of
ERVEI F. SALAZAR, Claimant
WCB Case No. 95-06751
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.[1]

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) McWilliams' order that directed SAIF to arrange a medical arbiter's examination for claimant's "Inmate Injury Fund" claim. On review, the issue is whether claimant is entitled to a medical arbiter's examination. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside SAIF's Order on Reconsideration of Final Determination regarding claimant (an inmate) because he had not been afforded a medical arbiter's examination. Reasoning that claimant was entitled to such an examination under ORS Chapters 555[2] and 656, the ALJ remanded the claim to SAIF, directed it to acquire a medical arbiter's examination, and to subsequently redetermine claimant's permanent disability.

Since the ALJ's order, we held that only the Director may appoint a medical arbiter under ORS 656.268(7). Freddy Vasquez, 47 Van Natta 2159 (1995). In reaching this conclusion, we reasoned that neither the Board, its Hearings Division, nor SAIF have authority to appoint a medical arbiter. Id. Thus, as in Vasquez, because the Director's reconsideration process is not involved in this inmate injury claim, claimant is not entitled to a medical arbiter's examination.[3] Consequently, the ALJ's order must be reversed.

We turn to the merits. First, we note that claimant does not argue that the record, as presently developed, supports a permanent disability award. We further find that the record does not indicate that claimant has permanent disability resulting from his compensable injury. (See Ex. 1-3). Under these circumstances, we affirm the Order on Reconsideration which awarded no permanent disability.

ORDER

The ALJ's order dated September 29, 1995 is reversed. The SAIF Corporation's Order on Reconsideration of Final Determination is reinstated and affirmed. The ALJ's attorney fee award is reversed.

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[1] Although a signatory to this order, Member Gunn directs the reader to his dissent in Freddy Vasquez, 47 Van Natta 2159 (1995).

[2] We note that the 1995 Legislature amended ORS Chapter 655, which pertains to Inmate Injury Fund claims. The amended statutes and the ensuing administrative rules provide that an inmate contesting action taken on his or her claim is entitled to administrative review and a contested case hearing with the Department. See Or Laws 1995, ch. 384, §§ 22, 29; OAR Ch. 125, Div. 160, especially OAR 125-160-900, subsections 2&3 (temp. rules, effective September 28, 1995). The aforementioned rules are applicable to injuries which occurred on and after June 30, 1995. OAR 125-160-000 (temp. rule, effective September 28, 1995). Because amended Chapter 655 has no retroactivity provision and the injury in the present case occurred before June 30, 1995, the Hearings Division and the Board retain jurisdiction over this matter under former Chapter 655.525. See Freddy Vasquez, 47 Van Natta 2182 (1995).

[3] Claimant argues that, because he is no longer incarcerated (and therefore readily available for an arbiter's examination), the reasons for treating inmates differently from other claimants no longer exist. See Johnson v. SAIF, 267 Or 299 (1973). Claimant's arguments in this regard are inapposite. Rights under inmate injury claims do not depend upon the claimant being incarcerated throughout the claim. Because claimant was an inmate when he was injured, his claim was filed with the "Inmate Injury Fund" and his rights under the claim flow from his status as an inmate as of the date of injury.

In the Matter of the Compensation of
JOSE S. SANDOVAL-PEREZ, Claimant
WCB Case Nos. 95-04195 & 94-14974
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
James B. Northrop (Saif), Defense Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Neidig.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order which: (1) set aside its denial of responsibility for claimant's right leg/hip injury claim; and (2) upheld CNA Insurance Companies' (CNA) "back-up" denial of the same condition based on lack of coverage. On review, the issue is whether CNA's "back-up" denial is prohibited. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, but offer the following brief summary of the relevant facts.

Claimant suffered a compensable injury to his right thigh on October 6, 1992. SAIF concedes that it was providing coverage for the employer, Norrell Services, Inc., on the date of injury. However, a claim was not filed until March 1993, after CNA had assumed coverage of Norrell Services, Inc. on January 1, 1993. Claimant was mistakenly given a CNA claim form. CNA later accepted the claim as a nondisabling right thigh contusion on May 4, 1993. (Ex. 11).[1]

Noticing that claimant's injury had occurred during SAIF's coverage, Norrell Services Inc. later notified its parent corporation, Norrell Corporation, of the apparent claim processing error. Norrell Corporation then notified CNA's home office, which in turn notified CNA's Portland, Oregon branch office. In the meantime, CNA continued to provide workers' compensation benefits, including temporary disability, medical services and scheduled permanent disability.

In November 1994, the workers' compensation supervisor of the Portland branch of CNA, Mr. Baisch, determined that records maintained by the State of Oregon "employer's index" mistakenly showed that Norrell Services, Inc. and Norrell Corporation were the same entity and that CNA had been providing coverage for both entities since November 1, 1991. CNA then took steps to issue the appropriate guaranty contract with Norrell Services, with an effective date of January 1, 1993. CNA also issued a disclaimer of responsibility on November 30, 1994 and advised claimant to file a claim with SAIF. On February 17, 1995, CNA formally rescinded its acceptance of claimant's claim and denied responsibility for claimant's October 1992 injury. CNA requested designation of a paying agent pursuant to ORS 656.307.

On March 3, 1995, SAIF issued a denial of compensability and a responsibility disclaimer. As a result of SAIF's compensability denial, no ".307" order was issued. However, SAIF later rescinded its compensability denial on May 22, 1995 and requested designation of a paying agent.

CONCLUSIONS OF LAW AND OPINION

Citing SAIF v. Schaffer, 129 Or App 289 (1994), the ALJ determined that, under ORS 656.262(6), CNA could rescind its acceptance of claimant's claim if its rescission was issued within two years from the date of acceptance. Finding CNA's rescission to have been timely under the statute (a finding that SAIF does not challenge on review) the ALJ then determined that CNA was not prohibited from issuing a "back-up" denial on the merits. The ALJ reasoned that, regardless of whether CNA could have or should have more carefully investigated the claim prior to accepting it, CNA was not precluded from issuing a "back-up" denial under ORS 656.262(2), if it could prove that SAIF was on the risk when claimant was injured in October 1992. Satisfied that SAIF, not CNA, was the actual insurer when claimant was injured, the ALJ found SAIF responsible for claimant's injury and upheld CNA's "back-up" denial. The ALJ also ordered SAIF to reimburse CNA for its claim costs and awarded claimant's attorney an assessed attorney fee for prevailing against SAIF's denial.

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[1] In the same letter accepting claimant's right thigh contusion, CNA also denied "any effusions or hemorrhage or aseptic necrosis." On August 11, 1993, a prior ALJ set aside a "de facto denial" of "hematoma, scar tissue, tendon contracture, right thigh mass, or muscle rupture." (Ex. 51-3).

On review, SAIF makes two contentions: (1) that CNA's subsequent discovery that it did not provide coverage of the employer on the date of injury did not constitute "later obtained evidence" under amended ORS 656.262(6)(a);[2] and (2) that CNA's denial is barred by claim and/or issue preclusion. See SAIF v. Hansen, 126 Or App 662 (1994) (having fully litigated compensability of claim, carrier barred by claim preclusion from denying it for lack of coverage).[3]

ORS 656.262(6)(a) provides, in part, that:

> "If an insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance."

ORS 656.262(6) allows "back-up" denials based on lack of coverage, provided that the claimant's compensation is not at risk and the dispute is limited to which carrier is responsible for payment of benefits. SAIF v. Schaffer, supra; see also Garcia v. SAIF, 108 Or App 653 (1991). As previously noted, SAIF does not dispute that CNA's denial was issued timely under the statute. The question here is whether CNA's denial was based on "later obtained evidence." We agree with SAIF that it was not.

In Ralph E. Murphy, 45 Van Natta 725 (1993), we held that the legislative history behind ORS 656.262(6) supported an interpretation that evidence in support of a "back-up" denial must be obtained or discovered after acceptance of the claim. Such new evidence does not include a new analysis or legal conclusion based on the same information the carrier knew, or should have known, at the time of acceptance. Id. at 727 (emphasis added).

In this case, CNA's claim supervisor testified that CNA had possession of an insurance contract when claimant filed his claim in March 1993 that showed that its coverage did not commence until January 1, 1993. (Tr. 34). Although Mr. Baisch later testified that the only information available in the Portland, Oregon branch office when the claim was filed was that CNA insured Norrell Services Inc. (Tr. 35), we do not consider Mr. Baisch's discovery that CNA was not providing coverage on claimant's date of injury to be "later obtained evidence." Instead, based on Mr. Baisch's testimony, we find that CNA, as a corporate entity, knew or should have known that it was not providing coverage of Norrell Services, Inc. when claimant filed his claim. Although accurate coverage information may not have been available to the Portland branch office of CNA, we do not limit CNA's knowledge to information available in its local office. Cf. Nix v. SAIF, 80 Or App 656 (1986) (employer knowledge legally attributable to an insurer).

Moreover, we are not persuaded by CNA's contention that the erroneous information contained in the employer's index excused its failure to accurately determine insurance coverage when claimant filed his claim. The claims examiner who accepted the claim did not testify. There is no evidence in the record that CNA checked the employer index prior to accepting the claim or that CNA relied on the incorrect information in the employer index in deciding to accept responsibility for claimant's injury in May 1994.

When it accepted claimant's claim, CNA had in its possession an insurance contract which set out its period of coverage for this employer. (Tr. 34). CNA's subsequent discovery that it did not provide coverage on the day that claimant was injured does not constitute "later obtained evidence" sufficient to support issuance of its "back-up" denial of responsibility. See CNA Insurance v. Magnuson, 119 Or App 282, 286 (1993) (reevaluation of known evidence, for whatever reason, is not "later obtained evidence"); Michael J. Bollweg, 47 Van Natta 2168 (1995); Ralph E. Murphy, supra.

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[2] SAIF notes, and we agree, that the result in this case would be the same under either former or amended ORS 656.262(6)(a).

[3] Since we find SAIF's initial contention dispositive, we need not, and do not, address SAIF's claim/issue preclusion argument.

Accordingly, we reverse the ALJ's decision in setting aside SAIF's denial of claimant's right hip/leg injury and in upholding CNA's "back-up" denial. Moreover, given this conclusion, we also reverse the ALJ's order that SAIF reimburse CNA for its claim processing expenses,[4] as well as his assessment of a $1,000 attorney fee for claimant having prevailed against SAIF's responsibility denial.

However, by virtue of this order, CNA's responsibility denial has been overturned. Inasmuch as claimant has finally prevailed against CNA's responsibility denial, claimant's counsel is entitled to an attorney fee pursuant to ORS 656.308(2)(d). See Julie M. Baldie, 47 Van Natta 2249 (1995). Amended ORS 656.308(2)(d) limits claimant to a maximum $1,000 attorney fee "for finally prevailing against a responsibility denial," absent a showing of extraordinary circumstances.

While the legal issues presented in this case were somewhat unusual, the hearing lasted an hour and 40 minutes and produced a 36 page transcript. There was only one witness and the record consisted of 45 exhibits. Under these circumstances, we do not find that this case involves "extraordinary circumstances." We conclude that, considering the factors set forth in OAR 438-015-0010(4), such as the time devoted to the case (as represented by the record and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved, claimant is entitled to a $1,000 attorney fee for services at hearing and on review, payable by CNA. See Tammy Locke, 48 Van Natta 250 (1996) ($1,000 attorney fee limitation under ORS 656.308(2)(d) is cumulative for all levels of litigation).

ORDER

The ALJ's order dated July 31, 1995 is reversed in part and affirmed in part. Those portions which set aside SAIF's responsibility denial and upheld CNA's "back-up" denial are reversed. SAIF's responsibility denial is reinstated and upheld. CNA's "back-up" denial is set aside and the claim is remanded to it for further processing in accordance with law. The ALJ's assessment of a $1,000 attorney fee against SAIF for its responsibility denial and his order regarding reimbursement of claim expenses, are also reversed. Claimant's attorney is awarded $1,000, to be paid by CNA, for services at hearing and on review in finally prevailing over its responsibility denial. The remainder of the ALJ's order is affirmed.

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[4] Even if SAIF was responsible for claimant's injury, the ALJ had no jurisdiction to order it to reimburse CNA, inasmuch as reimbursement disputes between insurers are not "matters concerning a claim" over which the Hearings Division has jurisdiction. EBI Companies v. Kemper Group Ins., 92 Or App 319, 322, rev den 307 Or 145 (1988).

February 16, 1996 Cite as 48 Van Natta 397 (1996)

In the Matter of the Compensation of
DALE R. SHIPLEY, Claimant
WCB Case No. 95-02156
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Neidig and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Baker's order that: (1) found that claimant had established the compensability of medical services[1] for his left knee condition; and (2) awarded an assessed attorney fee. On review, the issues are compensability and attorney fees.

The Board adopts and affirm the order of the ALJ, with the following supplementation.

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[1] We conclude that the Hearings Division and the Board have jurisdiction over this medical services issue. See Richard L. Wheeler, 47 Van Natta 2011 (1995).

On review, SAIF argues that it issued denials of an aggravation, and therefore, claimant could not litigate only the issue of medical services at hearing. We disagree. At hearing, claimant stated that the sole issue was "the compensability of medical treatment." (Tr. 1, 2). SAIF did not disagree with claimant's statement of the issues. (Tr. 1). Accordingly, we conclude that the ALJ properly framed the issue to be decided as "medical services," rather than "aggravation." See e.g. Ronald A. Krasneski, 47 Van Natta 852 (1995)(When parties litigate an issue by implicit agreement, that issue properly is considered by the ALJ even though it was not a ground relied upon by the insurer in its denial).

SAIF next contends that the proper standard to be applied in this case is that of the "major contributing cause" standard, rather than a "material contributing cause." SAIF argues that the case should be analyzed pursuant to ORS 656.273(1). Alternatively, SAIF contends that this matter involves a consequential condition, and therefore, ORS 656.245(1) requires that the compensable injury must be the major contributing cause of claimant's need for treatment.

We disagree with SAIF's contention that ORS 656.273(1) is applicable. As noted above, claimant did not make a claim for aggravation. Rather, claimant's claim in this case is for medical services only. Accordingly, the major contributing cause standard set forth in ORS 656.273(1) does not apply.

With respect to SAIF's alternative argument, we do not find that this case involves a consequential condition. Following the compensable injury in 1989, SAIF accepted claimant's left knee strain condition. After claimant's slip and fall at home, claimant's knee condition was again diagnosed as a left knee strain.[2]

Finally, claimant's treating doctor, Dr. Jany, opined that claimant's slip and fall at home was the major cause of his current condition. However, Dr. Jany also testified that claimant's current problems were "still the sequela of the 9-14-89 injury and the subsequent degenerative changes . . . ." (Ex. 32).

After considering Dr. Jany's opinion, we conclude that claimant's condition is not a "consequential condition" as described in ORS 656.005(7)(a)(A). Therefore, the ALJ correctly applied a material contributing cause standard, pursuant to ORS 656.245. Additionally, we agree with the ALJ's conclusion that Dr. Jany's opinion supports a finding that claimant's compensable injury remains a material contributing cause of his current need for treatment and medical services. Therefore, we affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for defending against SAIF's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services on review is $900. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 28, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $900, to be paid directly to claimant's counsel by the SAIF Corporation.

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[2] We distinguish this case from Joseph R. Klinsky, 47 Van Natta 872 (1995). In Klinsky, we found that the condition requiring treatment had not been accepted. Consequently, the claimant was first required to establish the compensability of that condition under ORS 656.005(7)(a). However, in the present case, SAIF accepted a left knee strain, and claimant's current condition has been diagnosed as a left knee strain. Accordingly, because his condition was previously accepted, claimant is not required to establish compensability of the condition.

In the Matter of the Compensation of
ALEJANDRA R. TREVINO, Claimant
WCB Case No. 94-14503
ORDER ON REVIEW
Max Rae, Claimant Attorney
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Neidig and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that awarded temporary partial disability (TPD). On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, because claimant left work for a total of more than four hours to receive medical treatment, claimant was entitled to temporary disability benefits under ORS 656.210(4) for the time she received such treatment. The ALJ further found that claimant was entitled to TPD after she left work for reasons unrelated to her injury.

The employer argues that to be entitled to TPD under ORS 656.210(4), claimant must miss four or more hours in one period, rather than for periods totaling four hours as found by the ALJ. We agree.

In interpreting a statute, our task is to determine the intent of the legislature. We begin with the text and context of that provision including other provisions of the same statute and other related statutes. We resort to extrinsic aids only if those sources are unavailing. PGE v. Bureau of Labor and Industries, 317 Or 606, 611-12 (1993).

ORS 656.210(4) provides that:

> "[w]hen an injured worker with an accepted disabling compensable injury is required to leave work for a period of four hours or more to receive medical consultation, examination or treatment with regard to the compensable injury, the worker shall receive temporary disability benefits calculated pursuant to ORS 656.212 for the period during which the worker is absent, until such time as the worker is determined to be medically stationary. However, benefits under this subsection are not payable if wages are paid for the period of absence by the employer."

The text of the statute suggests that claimant must miss the four hours or more of work in a single period of time to be entitled to temporary disability benefits. The term "a period" is not ambiguous. When read in context with other provisions in the statute, particularly the singular use of "consultation, examination or treatment" and "for the period of absence," these terms indicate that claimant must be absent for four or more hours in one period of time while attending the consultation, examination or treatment. In addition, under the statute, the worker is entitled to TPD "for the period during which the worker is absent" indicating that the period is four hours or more. These terms indicate that where a worker leaves work for a particular doctor's examination or treatment, the worker must miss four or more hours of work before considered absent from work.[1] Therefore, the ALJ erred in determining that claimant's time off to attend physical therapy could be accumulated to satisfy the statutory four-hour requirement.

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[1] Additionally, this interpretation is consistent with the administrative rule interpreting the statute. OAR 436-60-020(7) provides that "[w]hen a worker with an accepted disabling compensable injury who has not been determined medically stationary is required to leave work for any single period of four hours or more to receive medical consultation, examination or treatment with regard to the compensable injury, the worker shall receive temporary disability benefits calculated pursuant to ORS 656. 212 for the period during which the worker is absent. However, such benefits are not payable if the employer pays wages for the period of absence."

We, therefore, conclude that, since claimant did not miss at least four hours of work at one time period while attending physical therapy, she is not entitled to TPD under ORS 656.210(4).

Nevertheless, claimant contends that her entitlement to TPD is made whether her diminished earnings result from medical appointments, unavailability of work, or any other reason related to the injury. Claimant asserts that she is entitled to TPD pursuant to ORS 656.212 based on a comparison between her actual earnings at modified work and her average weekly wage (AWW). Thus, she contends that since her actual earnings were less on the days that she attended physical therapy than her AWW, she is entitled to TPD. We disagree.

Claimant in essence is requesting recalculation of her TTD rate for purposes of determining entitlement to TPD. Generally, a claimant is entitled to procedural temporary disability for all periods in which a claim remains open and the attending physician has authorized benefits for temporary disability. OAR 436-30-036(1); Mary A. Lockwood-Pascoe, 45 Van Natta 355 (1993).

Here, on November 22, 1994, Dr. Wright, claimant's treating physician, released claimant to return to regular work with restrictions of no lifting more than 40 pounds. As a result of this lifting restriction, claimant was unable to stock freight. We conclude that Dr. Wright's release constituted a release to modified work. See Gary D. Smith, 45 Van Natta 298 (1993) (a restriction on a worker's ability to perform his regular work is not a release to return to regular work). Upon claimant's return to modified work, claimant was entitled to TPD. OAR 436-60-030(1). Claimant continued at modified work until she left work on December 30, 1994 for reasons unrelated to her injury.

Because her disability was partial, claimant is entitled, at least theoretically, to temporary partial disability benefits (TPD) during the period in question. Amended ORS 656.212; David L. Gooding, 47 Van Natta 1468 (1995); Ricardo Morales, 47 Van Natta 1394 (1995).

Here, claimant's wages at modified work were the same as her wages at the time of injury. Amended ORS 656.212(2) provides that TPD is calculated based on a comparison of claimant's wages at modified employment and her at-injury wages. Lonnie L. Dysinger, 47 Van Natta 2282 (1995). Therefore, a calculation of claimant's TPD equals zero. Consequently, we conclude that claimant has failed to prove greater entitlement to temporary disability.

Inasmuch as there is no compensation "then due" on which to base a penalty under amended ORS 656.262(11), we reverse the ALJ's penalty assessment.

ORDER

The ALJ's April 19, 1995 order, as reconsidered July 12, 1995, is reversed. The ALJ's award of temporary partial disability is reversed. The ALJ's award of a penalty and attorney fees is also reversed.

February 16, 1996 Cite as 48 Van Natta 400 (1996)

In the Matter of the Compensation of
JOANN VONDOLLEN, Claimant
WCB Case Nos. 95-02622 & 94-07143
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Spangler's order which set aside its denial of claimant's occupational disease claim for her bilateral thumb and wrist conditions. On review, the issue is compensability.

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

In setting aside SAIF's denial of claimant's occupational disease claim for bilateral thumb and wrist conditions, the ALJ relied on the medical opinion of Dr. Ellison, whom the ALJ described as claimant's attending physician, and who opined that claimant's "basic pathology" was caused in major part by claimant's repetitive work activity. (Ex. 39). The ALJ reasoned that Dr. Ellison's opinion was the most persuasive because he had the opportunity to observe claimant's condition, take a more thorough history and, most importantly, observe a videotape of claimant's job duties.

On review, SAIF observes that Dr. Ellison only examined claimant one time and that he had already formulated his medical opinion prior to watching the videotape of claimant's work activities. Thus, SAIF asserts that the ALJ erred in finding Dr. Ellison's opinion more persuasive than those of the examining physicians, Drs. Button and Duff, and Dr. White, who performed a records review.

Based on the evidence available in this record, we agree with SAIF that Dr. Ellison only examined claimant one time on referral from claimant's chiropractor, Dr. Saboe. (Ex. 38). Thus, we disagree with the ALJ's conclusion that Dr. Ellison was claimant's attending physician and, therefore, had a greater opportunity to observe claimant's condition. However, we still agree with the ALJ that Dr. Ellison's opinion is the most persuasive in this record because he was the only medical expert to actually observe claimant's work activities.[1]

SAIF contends that this advantage is not significant because Dr. Ellison formed his opinion prior to observing the videotape. However, Dr. Ellison issued another medical report after watching the videotape of claimant's work activities. In that report, he reiterated that claimant's work activities were responsible for the degenerative arthritis in claimant's joints. (Ex. 46). Although SAIF argues that this follow-up report does not significantly bolster Dr. Ellison's initial opinion, we are persuaded that it does enhance the persuasiveness of Dr. Ellison's opinion.

While Dr. Ellison does not use the "magic language" that claimant's work activities were the major contributing cause of a pathological worsening of claimant's preexisting degenerative thumb disease, see amended ORS 656.802(2), it is well-settled that a physician need not mimic statutory language in rendering a medical opinion. A physician need only provide an opinion from which it can reasonably be concluded that claimant's burden of proving medical causation has been satisfied. See McClendon v. Nabisco Brands, 77 Or App 412, 417 (1986). We are persuaded that, under this standard, Dr. Ellison's medical opinion establishes that claimant's work activity is the major contributing cause of claimant's bilateral thumb and wrist conditions and a pathological worsening of claimant's preexisting degenerative thumb disease. ORS 656.802(2). Therefore, the ALJ properly set aside SAIF's denial.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability issue 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 August 11, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,000, payable by SAIF.

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[1] SAIF does not dispute the accuracy of the depiction of claimant's job duties contained in the videotape.

In the Matter of the Compensation of
FRED A. WOODS, Claimant
WCB Case No. 95-05639
ORDER ON REVIEW
Douglas V. Osborne, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Neidig and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of claimant's face, upper back, chest, right knee and left arm injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant, a transportation outreach worker, had received several reprimands for his behavior toward clients. In April 1995, he was called into his supervisor's office in regard to another complaint. The supervisor informed claimant that he was being terminated. Shortly thereafter, a fight between the two men ensued. The noise of the fighting brought office personnel to the door, which was locked from the inside. Claimant opened the door, and, when the others came into the room and ordered claimant off the premises, claimant said, "I'm not leaving * * * until I'm done with him." No further blows were struck. As a result of the altercation, claimant sustained injuries which required medical treatment.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant was an active participant under ORS 656.005(7)(b)(A), which provides that a "compensable injury" does not include injury "to any active participant in assaults or combats which are not connected to the job assignment and which amount to a deviation from customary duties." The ALJ reasoned that it was more likely that claimant was the aggressor because he was the one being terminated and the injury occurred prior to the opening of the door. Claimant contends that he was not an active participant because his participation was involuntary and he withdrew at an opportune moment. We disagree with claimant's contentions.

An "active participant" under the statute is one who voluntarily assumes an active or aggressive role in the altercation or who has an opportunity to withdraw from the encounter and does not do so. Irvington Transfer v. Jasenosky, 116 Or App 635, 640 (1992). Moreover, although an aggressor is clearly an active participant, being the aggressor is not the only test of active participation. SAIF v. Barajas, 107 Or App 73 (1991). Thus, even if one is not the aggressor, we look at the facts to determine whether the claimant was an active participant. Id.

Here, even if claimant was not the aggressor, we are persuaded that he was an active participant in an assault or combat not connected to the job assignment and which amounted to a deviation from his customary duties. We base this conclusion on the following reasoning.

Claimant asserts that he withdrew from the encounter when he reached over to unlock the door to allow the others to enter and separate the parties. Nevertheless, he admitted that he actively participated in the conflict. In other words, rather than trying to avoid a confrontation with Mr. Collins, claimant engaged in a physical struggle which included shoving and the exchanging of blows. Moreover, after opening the door, in the presence of several witnesses, claimant threatened to continue the altercation. Based on these facts, we find that claimant assumed an active and aggressive role in the altercation. Accordingly, we conclude that the claim is not compensable. ORS 656.005(7)(b)(A).[1]

ORDER

The ALJ's order dated August 23, 1995 is affirmed.

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[1] The remaining elements of the statute are also satisfied. We agree with the ALJ that claimant's entry into his supervisor's office was connected with his job assignment. However, claimant's active participation in a fight with his supervisor was a deviation from his customary duties.

In the Matter of the Compensation of
RONALD L. ZIMMERMAN, Claimant
WCB Case Nos. 95-06487 & 94-14928
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Neidig, Christian and Gunn.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that awarded claimant's attorney an assessed fee of $2,800 under ORS 656.382(2) for prevailing against the employer's hearing request from the Order on Reconsideration. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded claimant's counsel an assessed fee of $2,800 under ORS 656.382(2) for prevailing against the employer's hearing request from the Order on Reconsideration. The employer contends that the fee award is excessive. On the other hand, claimant argues that the value of the interest involved, the benefit secured, the skill of his attorney, the contingent nature of the fee and the assertion of "near frivolous" issues by the employer weigh in favor of granting a sizable fee.

A reasonable amount for claimant's attorney fee is determined based on the following factors: (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 attorney; (5) the nature of the proceeding; (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. OAR 438-015-0010(4).

The record consists of 20 exhibits, none of which was generated by claimant's counsel. The transcript consisted of 19 pages and claimant's counsel offered no witnesses at hearing. According to the employer, the hearing lasted approximately 90 minutes. Claimant's counsel did not present a statement of services.

The Order on Reconsideration challenged by the employer awarded $6,390 in compensation. Claimant's counsel skillfully advocated claimant's position in defending the permanent disability award. There was a risk that claimant's counsel might go uncompensated for his services.

After considering all of the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's counsel's services at hearing concerning the extent of permanent disability issue is $1,500. We modify the ALJ's assessed fee award accordingly. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the limited nature of the proceedings, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated September 21, 1995 is modified. In lieu of the ALJ's $2,800 attorney fee award, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the self-insured employer. The remainder of the ALJ's order is affirmed.

Board Member Gunn dissenting.

Because I disagree with the majority's decision to second-guess the ALJ and reduce the attorney fee award, I respectfully dissent.

I believe that the ALJ, having dealt with the parties, is in the best position to judge the quality and efficacy of claimant's counsel's involvement in the case. I do not advocate second-guessing an ALJ's attorney fee award absent compelling reasons to do so. See, e.g., Paul R. Huddleston, 48 Van Natta 4 (1996) (Board Members Gunn and Hall, dissenting); Philip Estes, 47 Van Natta 624 (1995) (Board Member Gunn, dissenting); Richard E. Lester, 47 Van Natta 419 (1995) (Board Member Gunn dissenting).

I would find that, unless the factors in OAR 438-015-0010(4) were not considered, or unless there is some showing of abuse of discretion by the ALJ, the Board should not disturb the fees awarded by an ALJ. See Lois J. Schoch, 46 Van Natta 1816 (1994) (Board Member Gunn, dissenting). The Board's practice of modifying attorney fee awards merely encourages parties to bring these disputes to this forum, clogging the system with disputes that are not better decided at this level.

Because the ALJ's attorney fee award in this case was reasonable, taking into consideration all the factors in OAR 438-015-0010(4), I would affirm the ALJ's award.

February 21, 1996 Cite as 48 Van Natta 404 (1996)

In the Matter of the Compensation of
MARLENE J. ANDRE, Claimant
Own Motion No. 95-0458M
OWN MOTION ORDER
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for her compensable right knee and bilateral carpal tunnel syndrome injury. Claimant's aggravation rights expired on March 29, 1995. SAIF opposes the authorization of temporary disability compensation, contending that claimant was not in the work force at the time of current disability.

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

Claimant underwent right total knee replacement surgery on August 30, 1995. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

SAIF contends that claimant was not in the work force at the time of the current disability. Claimant was not working at the time of current disability. Thus, in order to satisfy one of the two remaining criterion set forth in Dawkins v. Pacific Motor Trucking, supra, she must establish that she was willing to work, and either seeking work or unable to work because of the compensable injury. In an October 4, 1995 letter, claimant, through her attorney, contends that "[d]uring the duration of this claim [claimant] has either been willing to work and has been unable to work because of physical injuries, or alternatively, she has been actively participating in vocational efforts." Claimant has the burden of proof on this issue, and must provide corroborative evidence to support her contention.

The record establishes that claimant received return-to-work vocational services periodically from 1989 through mid-1995. The record also establishes that claimant underwent several surgeries for compensable conditions during this time, one to her knee, and several to her hands. However, the record also indicates that claimant was disabled during this time due to noncompensable

injuries/conditions. The record does not establish that claimant's back condition, breast reduction and subsequent implant surgeries or her psychological condition have been determined a part of her 1987 injury claim. Thus, during several periods when claimant would otherwise have been capable of return-to-work efforts, these non-compensable conditions rendered her disabled. Claimant has not worked since her 1987 injury.

SAIF submitted an October 12, 1995 Vocational Summary issued by Mary d'Autremont, rehabilitation counselor, in which the counselor set forth claimant's vocational services history. In the summary, Ms. d'Autremont noted numerous instances between claimant's original 1991 referral to the vocational services agency and mid-1995 in which claimant was released to work by a physician, but either declined job offers or insisted that she was medically unable to participate in vocational services. There is no evidence to contradict Ms. d'Autremont's report in the record.

In claimant's October 4, 1995 response to SAIF's recommendation, claimant's attorney stated that "[t]he evidence in support of this claim is attached by way of the identified exhibits." No exhibits were attached to claimant's response. The only medical documents in the record are a February 23, 1995 medical arbiter examination report regarding claimant's hand pain, and a May 15, 1995 report from Dr. Manley, in which he opined that "[claimant] should be able to sit eight hours a day with breaks." Thus, the postulations of claimant's attorney are insufficient as evidence to support claimant's contentions. See Richard A. Wright, 46 Van Natta 84 (1994).

Notwithstanding the lack of medical evidence in the record, the Board has previously found that, even though a physician might opine that a claimant is unable to work due to an injury, if the claimant has demonstrated that he/she is unwilling to work, he or she is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. See Arthur R. Morris, 42 Van Natta 2820 (1990); Donald J. Fendrich, 44 Van Natta 773 (1992); Stephen v. Oregon Shipyards, 115 Or App 521 (1992); Katherine L. Hunt, 45 Van Natta 1166 (1993); Martin L. Moynahan, 48 Van Natta 103 (1996).

According to the vocational services summary, although referred for vocational services to that agency on December 3, 1991, asserting that she was medically unable to participate, claimant did not meet with a counselor until April 7, 1992. However, on February 20, 1992, Dr. Bald, claimant's then-treating physician, approved four job analyses as appropriate for claimant, and released claimant to participate in vocational services. On May 18, 1992, Dr. Bald approved three more job analyses.

Between June 19, 1992 and September 8, 1992, claimant was offered direct employment services and instruction. During that time, claimant submitted job search diaries which revealed a total of 91 employer contacts, which would suggest that she actively participated in her return-to-work plan. However, claimant was offered a telemarketing position (approved by Dr. Bald), but turned down the employment opportunity stating, "I can only afford to work a $10.00 an hour job to make up for my disability." See October 12, 1995 Vocational Summary, page 2.

Further, during the time claimant received vocational assistance services, feedback from employers and meetings between claimant and her counselors identified barriers to employment. Ms. d'Autremont noted that these barriers included: claimant's strong opinions regarding her inability to work; exaggeration of her disability (claimant presented at one job interview wearing arm braces, although Dr. Bald later noted that it was not necessary for her to wear the braces); missed or cancelled appointments; refusing suitable employment because it only paid $10.00 per hour (according to claimant's employment history, her job-at-injury paid $5.00 per hour); presenting herself as unable to work; stating to one prospective employer that she was only filling out applications for workers' compensation benefits; tardiness or refusal to attend interviews. See Vocational Summary, pages 2 and 3.

In June 1993, claimant was again referred to the same vocational services agency. On July 29, 1993, Dr. Nolan, claimant's then-treating physician, released claimant to work eight hours per day with limitations, and approved eight job analyses for claimant (the same jobs approved by Dr. Bald). There is no record of further employer contact by claimant during this time. Claimant was again referred for vocational services in June 1994, but citing psychological conditions, did not agree to meet with a counselor until August 23, 1994. At that time, Dr. Nolan released claimant to light work for eight hours per day. There is no record of further employer contact by claimant during this period. On October 7, 1994, claimant underwent revision of breast implant surgery.

Claimant began physical therapy for her right knee on November 10, 1994. She was subsequently released from work by Dr. Manley, claimant's current treating physician. Dr. Manley declared claimant medically stationary on April 16, 1995, and released claimant to return to work in a sedentary capacity. Claimant was again referred to the vocational services agency. The vocational agency received authorization to obtain GATB testing on claimant, however, claimant cancelled the appointment. On July 7, 1995, Dr. Manley advised that claimant would undergo right knee surgery on August 30, 1995.

Although claimant's job search diaries from 1992 indicate that she contacted 91 employers, the record establishes that her participation was not conducted in a positive manner. Even though each job contact was medically approved for her particular disabilities and tailored to include her abilities and interests, claimant presented herself as unable to work. The vocational counselor assigned to claimant at that time noted that she was repeatedly asked by employers to whom she referred claimant, why claimant was referred for a position that the claimant said she was unable to perform. A warning letter was sent to claimant on July 30, 1992 regarding her failure to cooperate in the job search.

The record does not establish claimant's willingness to work. As mentioned previously, the assertions made by claimant's attorney are insufficient to support claimant's contentions, in this case, her willingness to work. See Richard A. Wright, supra. To that effect, the vocational history provided by Ms. d'Autremont contraindicates any willingness to work on claimant's part. Because claimant is qualified for at least eight jobs, but presented herself as unable to perform those jobs, it appears that claimant is unwilling to accept employment within her limitations. Claimant was released to light or sedentary employment when she participated in return-to-work activities. There is no evidence in the record that Drs. Bald or Nolan changed their opinions regarding claimant's ability to do light or sedentary work, nor is there evidence that they changed their opinions regarding the types of jobs they had previously approved as suitable for claimant. Further, claimant refused at least one suitable position, indicating she was unwilling to accept employment for which she is qualified. Martin L. Moynahan, supra. Finally, subsequent to claimant's 1992 job search diaries, there is no mention of further job search by claimant.

Claimant contends that she requires formal vocational assistance to return to work. Claimant has been provided with vocational assistance since 1989. The record indicates that claimant's efforts with respect to job seeking were affected by her lack of motivation to return to work. See Katherine L. Hunt, supra.

In conclusion, based on this record, we are not persuaded that, at the time of her current disability, claimant was motivated or willing to work. Arthur R. Morris, supra; Donald J. Fendrich, supra; Stephen v. Oregon Shipyards, supra; Katherine L. Hunt, supra; Martin L. Moynahan, supra. Considering such a conclusion, it is unnecessary to determine whether it would have been futile for claimant to seek employment since 1987 because of the compensable injury, or whether, when released back to work, she was making reasonable efforts to obtain work via an authorized training program or otherwise.

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
SUSAN L. BARRON, Claimant
WCB Case No. C6-00063
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Jana Toran, Claimant Attorney
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

On January 5, 1996, we received the parties claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We approve the proposed disposition.

On January 25, 1996, we asked for clarification of language in the CDA (item 19) stating that "[t]his settlement is part of a global settlement, which includes the settlement of claimant's labor claim." We requested clarification in order to determine whether the CDA could be construed as approving or being contingent upon approval of a settlement of matters outside ORS Chapter 656.

Parties may dispose of "any or all matters regarding a claim, except for medical services," subject to the Board's rules. ORS 656.236(1)(a). The Board's approval of a CDA is limited to the disposition of "matters regarding a claim." Karen A. Vearrier, 42 Van Natta 2071 (1990). Matters outside ORS Chapter 656 are not a proper matter for disposition under ORS 656.236 and the rules promulgated thereunder. (Id.). We have specifically held that the release of employment rights is not a proper matter for disposition under ORS 656.236, nor do we have authority to approve a release of such rights. Mowena J. Martin, 45 Van Natta 1557 (1993); Mary A. Smith, 45 Van Natta 1014 (1993); Karen A. Vearrier, supra.

On February 13, 1996, we received the parties' addendum clarifying item 19 of the proposed CDA. The parties explained that claimant's "labor claim" had been settled prior to submittal of the CDA to the Board, monies had been paid under that agreement, and a judgment of dismissal had been entered in the employment matter in circuit court. The parties agreed that the proposed CDA concerns only matters related to claimant's workers' compensation claim, and that it releases only matters relating to ORS Chapter 656. The parties specifically agreed that the CDA does not affect claimant's employment rights with the employer.

Under such circumstances, we find that the proposed CDA, as clarified by the parties' addendum, cannot be construed as approving any matters outside ORS Chapter 656. We further find that the proposed CDA, as amended, cannot be construed as being contingent upon approval of a settlement concerning matters outside ORS Chapter 656. Therefore, we find that the agreement, as clarified by the parties' addendum and this order, is in accordance with the terms and conditions prescribed by the Board. ORS 656.236(1)(a); OAR 438-009-0020(1). Accordingly, the parties' claim disposition agreement, as amended, is approved. An attorney fee of $25, payable to claimant's counsel, is also approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
HENRY WILLIAMS, Claimant
Own Motion No. 90-0313M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Cigna Insurance, Insurance Carrier

Claimant requests review of the insurer's January 4, 1996 Notice of Closure which closed his claim with an award of temporary disability compensation from May 2, 1989 through December 24, 1995. The insurer declared claimant medically stationary as of December 11, 1995. 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 January 4, 1996 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).

Claimant's claim was reopened for temporary disability benefits for right knee replacement surgery. Subsequent to the surgery, claimant developed an allergy to the material of which his artificial knee cap was made. Claimant treated with a dermatologist for his allergic reaction.

In a December 11, 1995 letter, Dr. Landon, claimant's treating physician, opined that:

> "[Claimant] has reached a stationary status. He and I have talked many times about the possibility of further surgery, but he does not at the present time wish to consider this. It is however possible in the future that he may decide to do this if his pain becomes worse or if there are radiographic signs of loosening.
>
> "Our plan is to continue to observe him with periodic radiographic and clinical examination."

Based on Dr. Landon's opinion, the insurer closed claimant's claim.

On January 10, 1996, claimant appealed the insurer's closure, contending that he was not medically stationary because surgery for the compensable condition was scheduled for the summer of 1996.

The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. We may consider post-closure medical reports regarding the question of whether claimant was medically stationary at the time of closure. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

In a January 9, 1996 medical report, Dr. Landon noted that claimant was having increasing pain and wished to "pursue revision." The chart note stated that claimant would return in the Spring of 1996 for re-evaluation for surgery. Dr. Landon opined that claimant "remains disabled."

However, on January 26, 1996, Dr. Landon wrote to the insurer to clarify his January 9, 1996 medical report regarding claimant's current medical status. Dr. Landon opined that:

> "I am writing to clarify [claimant's] condition. Additional surgery would be done at his election since we are doing this for relief of pain and he is obviously the only one that can feel the pain. He has no evidence of infection or obvious evidence of loosening, so that there is not any medical necessity for doing surgery at the present time. Since this is an elective surgery, we would do so at his wish."

In cases where claimant's medically stationary status is contingent upon undergoing recommended surgery, we have held that a claim is not prematurely closed if claimant refuses the surgery. E.g. Stephen L. Gilcher, 43 Van Natta 319, 320 (1991); Karen T. Mariels, 44 Van Natta 2452, 2453 (1992). However, if postponement (as opposed to refusal) of surgery is beyond the claimant's control and is medically necessary for the compensable condition, we have held that the claim was closed prematurely since, at closure, there was still a reasonable expectation for improvement based on the surgery recommendation. See Bill H. Davis, 47 Van Natta 219 (1995) (although claimant's physician opined that claimant required surgery for one of his compensable conditions prior to claim closure, claimant was subsequently referred to another physician to perform surgery, thus delaying the surgery). Those cases are distinguishable from the present case in that, here, although surgery has been recommended and claimant has not refused surgery (although claimant has chosen not to undergo the proposed surgery since 1993), claimant's treating physician opined that it was not medically necessary at the present time.[1] Since only a few weeks had passed between the January 4, 1996 closure and Dr. Landon's January 26, 1996 letter, we are persuaded that claimant's compensable medical condition "at the present time" is essentially the equivalent to his condition at the time of claim closure.

Further, in his January 26, 1996 letter, Dr. Landon twice stated that the surgery is "elective" in nature, which suggests that the surgery might not be performed at all if claimant so chose. Dr. Landon reiterated that claimant had no evidence of infection (due to the previously-mentioned allergic reaction which had and might again cause delay of surgery) or evidence of loosening of the femoral component (necessitating further revision surgery).

Thus, although Dr. Landon did not repeat the magic words "medically stationary" in his January 26, 1996 letter, we are persuaded by his December 11, 1995 opinion that claimant had "reached a stationary status," as it is supported by his January 26, 1996 opinion that the proposed surgery was not a medical necessity. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991), rev den 312 Or 676 (1992), as cited in U Haul of Oregon v. Burtis, 120 Or App 353 (1993); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). In addition, although in his January 9, 1996 medical report, Dr. Landon opined, as he had previously, that claimant "remains disabled," we are not persuaded that claimant's disability (his compensable condition) was not medically stationary.[2] Thus, we are not persuaded that claimant's medically stationary status on January 4, 1996 was contingent upon undergoing the proposed surgery, and the carrier appropriately closed the claim.

Based on the evidence in the record, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that the insurer's closure was proper. Should claimant's compensable condition worsen requiring surgery in the future, he may again request reopening of his claim for the payment of temporary disability compensation.

Accordingly, we affirm the insurer's January 4, 1996 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] Dr. Landon has long treated claimant and, in 1993, recommended further surgery. Claimant was referred to several orthopedic surgeons, as well as to a neurologist, who disagreed not only on the kind of treatment that might be required, but questioned the medical basis for treatment. A December 29, 1993 letter from Dr. Landon indicates that he was aware of the controversy surrounding whether surgery was indicated for claimant, as he stated that: "[Claimant's] case is a very difficult one and it is certainly reasonable that many orthopedic surgeons who would review this case would feel that surgery either is or is not indicated for [claimant]." Dr. Landon opined that "[w]e will continue to follow [claimant], but the decision to perform surgery is based on pain and we must rely on him for some guidelines in this area." Thus, over the years, claimant, rather than his physician, continued to postpone any surgical intervention. See Dr. Landon's December 29, 1993 letter.

[2] Dr. Landon's December 29, 1993 letter also indicated that the physician understood the definition of "medically stationary" under ORS 656.005(17), although he continued to opine that claimant was "disabled." In that letter, Dr. Landon opined that: "The issue of maximum medical improvement however, is somewhat separate, and I think whether or not [claimant] decides to have surgery, which is basically a decision that he has to make regarding pain, he certainly will have reached maximum medical improvement although he will require further medical or surgical treatment."

In the Matter of the Compensation of
RONDY L. BECKER, Claimant
WCB Case No. 94-15148
ORDER ON REVIEW
Charles L. Lisle, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for right ulnar nerve neuropathy. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated June 19, 1995 is affirmed.

Board Chair Hall specially concurring.

I concur with the ALJ and the majority that the opinion of Dr. Van Allen, claimant's attending physician, is not persuasive on the question of causation. Thus, I agree that claimant has not sustained his burden of proving that his right ulnar nerve condition is compensable. I write to express my disagreement with the ALJ's analysis of and the SAIF Corporation's arguments concerning Dr. Van Allen's concurrence with a March 1, 1995 letter memorializing a telephone conversation between himself and claimant's counsel.

Dr. Van Allen's report is not merely a "check the box" report. As we acknowledged in Marta I. Gomez, 46 Van Natta 1654 (1994), sometimes, a physician's explanation may have to be articulated or summarized by someone other than the doctor, with the physician then adopting that explanation. Such was the case here. Therefore, I find Dr. Van Allen's report to be an adequate report under the criteria set out in Marta I. Gomez, supra.

Dr. Van Allen's report is premised on a hypothetical (that ulnar nerve neuropathy is often due to activities which require repetitive flexion/extension of the elbow joint and/or resting the elbow on hard surfaces). Thus, it requires supporting evidence in the record in accordance with the hypothetical. The ALJ found no evidence that claimant's work activities required repetitive flexion/extension of the right arm. Although the ALJ found evidence that claimant rested his elbows and arms on a hard platform when he was working, he found no evidence as to the duration or frequency that claimant's elbows and arms so rested.

There is no need for a worker to have told his physician directly what his work entailed. A hypothetical is satisfactory. On this record, I agree there is no evidence that claimant's work activities required repetitive flexion/extension of the right arm. Nonetheless, because Dr. Van Allen stated his hypothetical in the disjunctive, claimant also can establish the compensability of his condition if the evidence supports Dr. Van Allen's alternative hypothetical causation opinion.

There is some evidence that claimant rested his elbows on a hard surface when he was working. However, for the reasons expressed by the ALJ, I further agree the evidence is not sufficient to support Dr. Van Allen's causation hypothetical. Accordingly, I join in affirming the ALJ's decision to uphold SAIF's denial.

In the Matter of the Compensation of
JAMES C. BOWMAN, Claimant
WCB Case No. 94-05091
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Alan L. Ludwick (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) declined to authorize an offset for temporary total disability (TTD) overpayments that SAIF made before March 14, 1994; and (2) awarded claimant's attorney a fee under ORS 656.382(2) for defending claimant against the offset issue. On review, the issues are offset, claim preclusion and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Offset/Claim Preclusion

Based on the finality of SAIF's Notice of Closure, the ALJ concluded that SAIF was barred from contesting the rate of TTD awarded by the notice. SAIF asserts that, because ORS 656.268(13) authorized the ALJ to make necessary monetary adjustments in compensation, the ALJ erred by declining to address the TTD rate issue. We disagree.

Claimant originally filed a claim for a bilateral arm condition. SAIF accepted the claim. The "801" erroneously listed a wage rate of $8.00 per hour. (See Ex. 1). Claimant's actual wage was $6.25 per hour. (Ex. 34). That error resulted in a TTD overpayment from February 26, 1993 to August 11, 1993. (Id.) SAIF apprised claimant of the overpayment in August 1993. (Id.). SAIF paid claimant TTD benefits through April 5, 1994.

SAIF closed the claim by an April 18, 1994 Notice of Closure. (Ex. 60-2). The notice awarded TTD from February 26, 1993 through March 14, 1994. It also stated, "DEDUCTION OF OVERPAID BENEFITS, IF ANY, FROM UNPAID PERMANENT DISABILITY IS APPROVED." (Id.) The notice became final by operation of law.

The same day SAIF closed the claim, it denied further treatment of claimant's arm condition. (Ex. 62). Claimant requested a hearing regarding the denial; SAIF cross-requested a hearing seeking an offset of overpaid TTD benefits. After a hearing, the ALJ upheld the denial and authorized an offset of TTD benefits paid from March 14, 1994 through April 5, 1994.

When parties have had an opportunity to litigate a question along the road to a final determination and a final judgment is entered that disposes of the matter, the principles of claim preclusion bar those parties from further litigating it. Drews v. EBI Companies, 310 Or 134, 140 (1990). Finality attaches to uncontested closure orders for purposes of claim preclusion. Id. at 150 n 13; Michele S. Thomas-Finney, 47 Van Natta 174 (1995).

Here, before SAIF closed this claim, it had ample opportunity to litigate the TTD rate question; the record reveals that SAIF was aware of the overpayment in August 1993. On April 18, 1994, however, it chose to close the claim and award claimant TTD benefits from February 26, 1993 through March 14, 1994. That award became final by operation of law, because claimant did not appeal it.[1]

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[1] The Notice of Closure advised claimant that he had 180 days to appeal it. SAIF asserts that, because it filed its cross-request for hearing in this case within 180 days, the Notice of Closure has not become final. We disagree. SAIF cannot appeal its own Notice of Closure; only claimant can. See ORS 656.268(4)(e). Because claimant did not appeal the notice, it has become final.

We note that the 1995 Legislature shortened the appeal period for closure notices from 180 to 60 days. Or Laws 1995, ch 332, § 30. That amendment has no bearing on this case.

Consequently, the Notice of Closure has become, in effect, a "final judgment" that disposed of the TTD matter. Michele S. Thomas-Finney, supra, 47 Van Natta at 174. As such, the parties are barred from further litigating issues regarding claimant's TTD award of benefits from February 26, 1993 through March 14, 1994. Because the TTD rate dispute concerns an overpayment of TTD benefits from February 26, 1993 to August 11, 1993, SAIF is precluded from litigating that matter.[2]

That the Notice of Closure authorized SAIF to deduct overpaid benefits from unpaid permanent disability does not alter our conclusion. In view of the finality of the notice, we conclude that it now authorizes SAIF to seek an offset only as to payments before or after the period from February 26, 1993 through March 14, 1994. Consequently, we affirm the ALJ's authorization of an offset from March 14, 1994 through April 5, 1994.

Last, ORS 656.268(13) does not mandate a different conclusion. That statute creates a right to an offset. V. W. Johnson & Sons v. Johnson, 103 Or App 355, 358 (1990), rev den 311 Or 60 (1991). It says nothing about the preclusive effect of a final notice of closure on a carrier's right to seek an offset. Because we find that the principles of claim preclusion address that issue, and that ORS 656.268(13) is inapposite, for the reasons stated above, we affirm the ALJ's reasoning and conclusions regarding the offset issue.

Attorney Fees

Relying on Strazi v. SAIF, 109 Or App 105 (1991), SAIF asserts that the ALJ erred in awarding claimant's counsel an attorney fee under ORS 656.382(2) for defending claimant against the offset issue. We agree.

To be entitled to a fee under ORS 656.382(2), among other things, an ALJ must have found on the merits that a claimant's compensation award should not have been disallowed or reduced. Id. at 107, 108. An offset for overpayment of temporary disability benefits is not a reduction in a claimant's award of compensation. Id. at 108.

Here, the ALJ's attorney fee award is based on claimant's attorney's defense of claimant against SAIF's hearing request seeking an offset for overpaid temporary disability compensation. Because an offset does not reduce claimant's award of compensation, there is no basis for the ALJ to find on the merits that claimant's compensation award should not have been disallowed or reduced. Without that finding, there is no foundation for an attorney fee award under ORS 656.382(2). Consequently, we reverse the ALJ's attorney fee award.

ORDER

The ALJ's order dated May 19, 1995 is affirmed in part and reversed in part. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

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[2] In reaching this conclusion, we recognize that, several months before it issued the Notice of Closure, SAIF had advised claimant that it had overpaid him time loss compensation from February 26, 1993 through August 11, 1993 due to a TTD rate error. (Ex. 34). In the Notice of Closure, however, SAIF did not raise the TTD rate issue or otherwise qualify claimant's February 26, 1993 through March 14, 1994 TTD award. (See Ex. 60-2). Under the circumstances, SAIF could have noted the TTD rate issue and stated its intention to seek an offset of benefits paid from February 26, 1993 through August 11, 1993. Then, claimant could have appealed that portion of the Notice of Closure if he disagreed with SAIF's assertion. If, however, claimant did not appeal the closure notice, then he would be precluded from litigating the TTD rate issue and SAIF would have been entitled to seek an offset against unpaid permanent disability benefits.

Board Chair Hall concurring in part and dissenting in part.

I agree with the majority's decision on the merits. I write only to express my disagreement with its attorney fee analysis.

Relying on Strazi v. SAIF, 109 Or App 105 (1991), SAIF asserts that the ALJ erred in awarding claimant's counsel an attorney fee under ORS 656.382(2) for defending claimant against the offset issue. I disagree.

To be entitled to a fee under ORS 656.382(2), claimant must prove three things: One, that SAIF initiated a request for a hearing to obtain a disallowance or reduction of his award of compensation; two, that his attorney performed legal services in defending the compensation; and (3) the ALJ must have found on the merits that his compensation award should not have been disallowed or reduced. Strazi, supra, 109 Or App at 107, 108.

In Strazi, the court affirmed the Board's decision affirming the denial of the offset, and held that an offset for overpayment of temporary disability benefits is not a reduction in a claimant's award of compensation. Id. at 108. On that basis, the court affirmed the Board's decision not to award an attorney fee.

The dispute in Strazi appears to have revolved around the carrier's entitlement to assert an offset. Here, in contrast, the parties dispute the very existence of an overpayment. A finding on the overpayment issue in claimant's behalf will protect the amount of compensation that he has already been awarded.[1] In my view, such a finding would establish, on the merits, that his compensation award should not have been disallowed or reduced. Strazi, supra, 109 Or App at 107, 108. On that ground, I would find Strazi distinguishable.

SAIF initiated a request for hearing to obtain a disallowance or reduction in claimant's award of compensation by seeking to establish the existence of an overpayment. Moreover, claimant's attorney performed legal services in defending the compensation award. I submit that those factors, coupled with the overpayment finding, are sufficient to establish claimant's entitlement to an attorney fee under ORS 656.382(2). The majority concludes otherwise. Accordingly, I respectfully dissent.

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[1] ORS 656.382(2) allows carrier-paid attorney fees if the ALJ or board finds that "compensation awarded to a claimant should not be disallowed or reduced." Therefore, it does not concern future benefits. See Strazi, supra, 109 Or App at 108.

February 22, 1996 Cite as 48 Van Natta 413 (1996)

In the Matter of the Compensation of
JERRY W. DUEDE, Claimant
WCB Case No. 95-01519
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Gunn and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order which reduced claimant's unscheduled permanent disability award for a low back condition from 23 percent (73.6 degrees), as awarded by an Order on Reconsideration, to 15 percent (48 degrees). In the event that we reverse the ALJ's order, the insurer requests that this matter be held in abeyance pending the appeal of Daniel L. Bourgo, 46 Van Natta 2505 (1994). Additionally, the insurer requests remand to allow it to cross-examine the medical arbiter. On review, the issues are motion for abeyance, remand and extent of unscheduled permanent disability. We deny the motions for remand and abeyance and modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Initially, the insurer requests that we hold this matter in abeyance until the Court of Appeals issues its opinion in Daniel L. Bourgo, supra, which pertains to the admissibility of post-reconsideration medical arbiter reports. We decline to do so. See John B. Gordon, 44 Van Natta 1601 (1992); Alfonso S. Alvarado, 43 Van Natta 1303 (1991) (Board declined to hold review in abeyance pending Supreme Court decision because to do so would be inconsistent with its role as a decision maker or in furthering the dispute resolution process).

Remand

The insurer seeks remand in order to cross-examine the medical arbiter. We decline to remand, because inasmuch as the insurer's cross-examination of the medical arbiter would constitute medical evidence, generated subsequent to reconsideration (to contest claimant's impairment) it would be inadmissible. Daniel L. Bourgo, supra. Further, the insurer provides no explanation for its failure to cross-examine the medical arbiter prior to hearing. Under such circumstances, we do not find a compelling reason to remand this case for the introduction of this "evidence." Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Extent of Unscheduled Permanent Disability

Claimant worked as a millright. In February 1993, claimant sustained a compensable low back injury. A Determination Order awarded 9 percent unscheduled permanent partial disability (PPD). Claimant requested reconsideration and a panel of three medical arbiters examined claimant concerning the extent of his disability.

The medical arbiter panel's lumbar range of motion findings were as follows: extension 6 degrees, flexion 42 degrees, left lateral flexion 16 degrees and right lateral flexion 18 degrees. The arbiters stated that while claimant's lumbar ranges of motion were slightly reduced, achieving full ranges was merely a matter of stiffness and mild discomfort. (Ex. 32-3).

The arbiter panel reported that claimant could occasionally lift 72 pounds and carry 60 pounds. Frequently, claimant could lift and carry 25 percent of this weight (i.e. lift 18 and carry 12 pounds). The panel restricted claimant from sitting for more than 1/2 hour at a time and standing for no more than 1 hour at a time. An Order on Reconsideration issued, increasing claimant's PPD to 23 percent. The insurer requested a hearing.

The ALJ found that claimant was not entitled to PPD for loss of range of motion of his lumbar spine. In so doing, the ALJ determined that claimant's loss of range of motion was not permanent. Further, the ALJ found that claimant's residual functional capacity (RFC) was medium capacity.

On review, claimant contends that his loss of range of motion is permanent. Therefore, claimant contends that he is entitled to an additional 13 percent PPD. Further, claimant asserts that the ALJ erred in finding his RFC to be medium. According to claimant, his RFC is medium/light.

OAR 436-35-007(9) specifically provides that where a medical arbiter is used, impairment is determined by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. This "preponderance of the evidence" must come from the findings of the attending physician or other physicians with whom the attending physician concurs. See Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994). However, amended ORS 656.268(7)(g) provides that after reconsideration, no subsequent medical evidence of the worker's impairment is admissible before the Department, the Board or the courts for purposes of making findings of impairment on the claim closure.

Here, the arbiter panel found reduced range of motion in claimant's lumbar spine. The arbiter panel stated that claimant could "achieve" full range of motion with stiffness and mild discomfort. The ALJ interpreted this statement as meaning that the arbiter panel believed that the reduced range of motion findings were not permanent. Without some further evidence that the arbiter panel did not believe that the reduced range of motion findings it reported were not permanent, we decline to interpret the arbiter panel's statement to mean that the range of motion findings were not permanent.

The insurer contends that the ranges of lumbar motion reported by the medical arbiters were invalidated by the straight leg raising validity test. We disagree.

The Director's rules provide that only the methods described in the AMA Guides to the Evaluation of Permanent Impairment (3rd ed., 1990) and the methods the Director may prescribe by bulletin shall be used to measure and report impairment. OAR 436-35-007(4). The Director has prescribed, by Bulletin No. 242 (Rev.), methods for measuring mobility in the lumbar spine, including the straight leg raising (SLR) method for testing validity of lumbar flexion. Bulletin No. 242, supra, at 6-7. That bulletin also provides that, as a general principle, the medical examiner shall note measurements which do not meet the validity requirement. Id. at 2. The Director's bulletin contemplates that the validity determination will be made by the medical examiner performing the range of motion tests and that any invalid measurements will be identified by that emaminer.

Here, the medical arbiters did not note any measurements as being invalid. Under such circumstances, we find the reported measurements to be valid. See Michael D. Walker, 46 Van Natta 1914 (1994) (ALJ erred in excluding lumbar flexion measurement made by medical arbiter where medical arbiter did not indicate lumbar flexion measurement was invalid). Accordingly, we conclude that claimant has proven an entitlement to an award for loss range of motion of his lumbar spine.

The values for lumbar surgery and residual ranges of motion are as follows: L5-S1 laminotomy/discectomy 9 percent impairment, OAR 436-35-350(2)(a); loss of forward flexion (42 degrees retained) = 4 percent, OAR 436-35-360(19); loss of extension (6 degrees retained) = 5.8 percent, OAR 436-35-360(20); loss of lateral flexion (right 18 degrees retained and left 16 degrees retained) = 3.2, OAR 436-35-360(21). These values are added together and combined with the surgical value for a total of 21 percent lumbar spine impairment.

Residual Functional Capacity

The ALJ found that claimant's RFC was medium/heavy. However, because of claimant's restrictions (sitting and standing limits), the ALJ lowered claimant's RFC to medium. We disagree.

Here, claimant could occasionally lift 72 pounds and carry 60 pounds. Frequently, claimant could lift 18 pounds and carry 12 pounds. As such, claimant can do more than light activities (occasionally lift/carry 20 pounds and frequently lift/carry 10 pounds), but not the full range of medium activities (occasionally lift/carry 50 pounds and frequently lift/carry 25 pounds). OAR 436-35-310(3)(f)-(h). Thus, claimant's RFC is medium/light. See OAR 436-35-310(3)(g). However, claimant has "restrictions" from sitting for more than 1/2 hour at a time and standing for more than 1 hour at a time. OAR 436-35-310(3)(l)(A). Therefore, claimant's RFC will be lowered to the next lower classification. OAR 436-35-310(7). Consequently, claimant's RFC is light. Accordingly, since claimant's base functional capacity (BFC) is heavy, his adaptability value is 5. OAR 436-35-310(6).[1]

Assembling the Factors

The factors for age, education, training (SVP) and BFC were uncontested. Assembling the factors, we multiply the age (1), education (0), training factors (1) total (2) and the adaptability value (5) for a product of 10. That product is then added to the impairment value of 21 percent for a total of 31 percent. See OAR 436-35-280. Claimant is entitled to 31 percent unscheduled permanent disability for the compensable injury.

The insurer requested a hearing, seeking a reduction in the Order on Reconsideration award of permanent disability. By this order, we have found that the permanent disability awarded by the Order on Reconsideration should not be disallowed or reduced. Under such circumstances, claimant is entitled to an attorney fee award under ORS 656.382(2) for successfully defending her unscheduled award at hearing.

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 $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearings record), the complexity of the issues, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

ORDER

The ALJ's order dated May 3, 1995 is modified. In lieu of the ALJ's award and in addition to the 23 percent (73.6 degrees) awarded by the Order on Reconsideration, claimant is awarded 8 percent (25.6 degrees) unscheduled permanent disability, giving him a total of 31 percent (99.2 degrees) unscheduled permanent disability for a low back injury. Claimant's attorney is awarded an attorney fee in the amount of 25 percent of the increased compensation awarded by this order (the difference between ALJ's 15 percent award and this 31 percent award), not to exceed $3,800, payable directly to claimant's counsel. Claimant's attorney is also awarded a fee of $1,500 for services at hearing regarding the permanent disability issue, payable by the insurer.

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[1] We have received a memorandum of supplemental authorities from claimant which cites to Carroll v. Boise Cascade Corp., 138 Or App 610 (1996). Because claimant has received an adaptability factor greater than zero, Carroll is inapposite.

In the Matter of the Compensation of
EDWARD H. FOX, SR., Deceased, Claimant
WCB Case No. 94-01956
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Peterson's order that affirmed an Order on Reconsideration that awarded claimant permanent total disability benefits effective June 27, 1992. On review, the issue is permanent total disability.

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

Claimant died on April 22, 1993, from causes unrelated to the compensable injury. Claimant's claim was closed by a Determination Order on June 2, 1993, which awarded 35 percent unscheduled permanent disability. Claimant's surviving spouse requested reconsideration, and a January 28, 1994 Order on Reconsideration found claimant permanently and totally disabled, effective June 27, 1992. The employer requested a hearing, and the ALJ affirmed the Order on Reconsideration.

Because the carrier is seeking to eliminate the Order on Reconsideration's permanent total disability award, it has the burden to prove that claimant was not permanently and totally disabled. Earl D. Lesperance, 45 Van Natta 2133 (1993). The employer raises three arguments in support of its contention that claimant was not permanently and totally disabled prior to his death. The employer first contends that claimant never reached a medically stationary status after his May 29, 1991 compensable injury. On this basis, the employer contends that claimant's disability cannot be considered permanent. Claimant asserts that the employer agreed at hearing that there was no issue regarding claimant's medically stationary date. After reviewing the transcript, it is unclear that the parties agreed that the medically stationary date was not in dispute. Accordingly, we address the merits of that issue.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment, or the passage of time. ORS 656.005(17). Resolution of the medically stationary date is primarily a medical question resolved by competent medical evidence. Harmon v. SAIF, 54 Or App 121 (1981).

The Order on Reconsideration found claimant medically stationary on June 26, 1992. This conclusion was based on a June 26, 1992 chart note of Dr. Balek's which contained the notation "stable status." Dr. Balek, claimant's attending physician, later opined that claimant was medically stationary with regard to his orthopedic and work-related injuries on January 13, 1993. (Ex. 201A). Dr. Balek's November 6, 1992 chart note also states that claimant's closed head injury and multiple orthopedic injuries are "all stable at this time." Dr. Balek's chart notes indicate that claimant's condition was stable on June 26, 1992 and remained stable thereafter.

Dr. Lloyd, claimant's psychologist, noted in a June 24, 1992 report that it was unlikely that any further recovery in claimant's brain condition was expected. Dr. Lloyd also later opined that claimant's condition was stable and not improvable as of April 21, 1993. (Ex. 195B).

Claimant was examined, on behalf of the employer, by Dr. Moulton, a psychiatrist, in June 1992. Dr. Moulton opined that claimant's psychiatric condition was neither fixed nor stable. Dr. Moulton recommended further treatment. (Ex. 140-21).

Dr. Beaty, neuropsychologist, also examined claimant on behalf of the employer in September 1992. Dr. Beaty opined that claimant's brain condition appeared to be fixed and stable from the standpoint of natural recovery, but could probably be improved by focused, process specific cognitive rehabilitation interventions.

Dr. Klecan, psychiatrist, was appointed medical arbiter. Based on a records review, Dr. Klecan concluded that claimant's brain condition was medically stationary in June 1992. Dr. Klecan stated:

"I base my conclusions as to his medically stationary status on the clear documentation in the records that improvement, even dramatic improvement, had been noted in some brain functions during the first year. Then there was a cessation of further improvement. The records document clearly a process of improvement leading up to his stationary status as defined above." (Ex. 202-5).

Dr. Klecan explained that his conclusions were based on his knowledge and understanding of the natural course of recovery from traumatic brain injuries. Dr. Klecan also stated that claimant's course followed the natural course of recovery of other head-injured patients. Dr. Klecan opined that with brain-injured patients, it is medically improbable that there will be functional improvement of any significant degree after one year.

Regarding claimant's physical condition, we find no persuasive reason not to rely on the opinion of claimant's treating physician, Dr. Balek. See Weiland v. SAIF, 64 Or App 810 (1983). Dr. Balek's chart notes indicate that claimant's condition was medically stationary on June 26, 1992. We likewise find no reason not to defer to the opinion of Dr. Lloyd, claimant's treating psychologist, regarding the medically stationary status of claimant's brain injury. Id.

The employer argues that Dr. Lloyd's opinion is inconsistent and that his later statements indicate that claimant was not medically stationary. We disagree. The employer contends that Dr. Lloyd's reports indicate that he expected improvement in claimant's condition and then "abruptly changed course." In fact, Dr. Lloyd's reports show that, after re-evaluating claimant's condition after 8 months of treatment, Dr. Lloyd reached the conclusion that claimant's condition was not continuing to improve significantly. (Ex. 138). We do not consider Dr. Lloyd's conclusion, after re-evaluating claimant's progress, to be an abrupt change from his earlier reports. Instead, we understand that claimant did not improve as much as Dr. Lloyd had hoped.

Moreover, we are not persuaded that Dr. Lloyd's opinions concerning claimant's medically stationary status are inconsistent. In support of its argument, the employer relies on "post-reconsideration order" deposition testimony from Dr. Lloyd. First, the admissibility of this evidence is questionable under amended ORS 656.283(7). Second, we need not resolve that "admissibility" issue because, even if the report was admissible, we are not persuaded by Dr. Lloyd's testimony that he had a reasonable expectation of further material treatment. The employer argues that Dr. Lloyd consider treatment after June 1992 "curative." However, Dr. Lloyd testified that to stop treatment in June 1992 even though the condition appeared to be stabilized would have been ethically unwise and would have reduced any chance of rehabilitation to zero. Dr. Lloyd's statements do not persuade us that he did not believe that claimant's brain condition was stable. Thus, even if Dr. Lloyd's deposition testimony is admissible, it does not alter our conclusion that claimant's brain condition was medically stationary in June 1992.

In view of the fact that Dr. Lloyd was most familiar with claimant's brain condition and had treated him for that condition over a long period of time, we find his opinion regarding whether that condition was medically stationary to be the most persuasive. Dr. Lloyd opined that claimant was medically stationary (further recovery was not expected) in June 1992. (Ex. 138-3). Dr. Lloyd's opinion is supported by that of Dr. Klecan who also believed that claimant's brain condition reached a medically stationary status in June 1992.

Based on the persuasive opinions of Drs. Balek and Lloyd, we conclude that claimant's compensable physical and mental conditions were medically stationary by June 26, 1992. Accordingly, based on the medical evidence, we reject the employer's argument that claimant's condition did not become medically stationary prior to his death.

The employer next argues that the ALJ erred in failing to consider claimant's potential for improvement after a work hardening program or rehabilitation training. The employer argues that claimant's death from noncompensable cancer prevented him from receiving vocational retraining and work hardening that likely would have improved his employability. In support of its argument, the employer relies on Nyre v. F & R Leasing, 106 Or App 74 (1991), and Elder v. Rosboro Lumber Co., 106 Or App 16 (1991).

We find Nyre and Elder distinguishable. In Nyre, the claimant needed retraining but his subsequent, noncompensable cervical condition prevented him from being retrained. The court held that the claimant's noncompensable cervical condition (and its effect on the claimant's ability to be retrained) should be disregarded and the claimant's disability should be evaluated as of the date immediately preceding the date when his noncompensable condition became disabling.

In Elder, as a result of his compensable injury, the claimant had to be retrained in order to obtain gainful employment. The claimant was in the process of retraining when a post-injury, noncompensable seizure rendered him unable to continue. Before that seizure, the claimant's rehabilitation consultant reported that he foresaw no barriers to continued employer after the training program was completed. On Board review, we assumed that, but for the intervening noncompensable disability, the claimant would have completed the rehabilitation program and would have been employable. The court affirmed, holding that to find the claimant permanently and totally disabled because his noncompensable disability prevented his retraining would conflict with the rule that noncompensable post-injury disabilities may not be considered in determining whether a claimant is permanently and totally disabled.

Unlike in Nyre or Elder, there is no evidence in this case that vocational retraining (or work hardening) would have rendered claimant employable.[1] In fact, claimant had not begun a training or work hardening program at the time he was diagnosed with his cancer and no such programs had yet been planned for claimant. The best that can be established on this record is that there might have been a possibility that retraining or work hardening could have improved claimant's chances of becoming employable. Based on this record, we are not persuaded that claimant would have become employable but for his noncompensable cancer condition. Accordingly, we decline to eliminate claimant's permanent total disability award based on a speculative future change in employment status. Gettman v. SAIF, 289 Or 609 (1980).

Finally, the employer contends that the ALJ erroneously interpreted the evidence as showing that claimant was totally incapacitated from performing any gainful employment. The employer argues that a preponderance of the evidence establishes that claimant was employable. We disagree.

Before we can address the employer's argument, it is necessary to address an evidentiary question raised by the 1995 amendments to the workers' compensation law. We note that the record contains "post-reconsideration" evidence. Subsequent to the date of the ALJ's order, the legislature enacted Senate Bill 369 which amended ORS 656.283(7). Or Laws 1995, ch 332, § 34 (SB 369, § 34). That statute now provides, in part:

> "Evidence on an issue regarding a notice of closure or determination order that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing, and issues that were not raised by a party to the reconsideration may not be raised at hearing unless the issue arises out of the reconsideration order itself."

The amendments to ORS 656.283(7) apply retroactively unless there is a specific exception stated in Senate Bill 369. Because there is no specific exception, the amendment would appear to be applicable to this claim. However, we need not resolve the issue of whether amended ORS 656.283(7) applies to this claim. This is because, whether we confine our review to the "reconsideration record" or consider the entire record as the ALJ did, we would still conclude that claimant was permanently and totally disabled as of June 1992. See Duane B. Onstott, 47 Van Natta 1429 (1995) (Board did not resolve the question of the applicability of amended ORS 656.283(7) where the result would be the same whether review was limited to "reconsideration record," or whether entire record was considered).

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[1] The only vocational evidence in the record establishes that vocational rehabilitation would have been unsuccessful. (Tr. 134, 221). The admissibility of this evidence is questionable, however, because it was not submitted at the reconsideration proceeding. See amended ORS 656.283(7). The record at the time of reconsideration contains no evidence that vocational retraining or work hardening would have been successful. Given this lack of vocational evidence that rehabilitation/retraining efforts would have been successful prior to the onset of claimant's noncompensable cancer, we conclude that the employer has failed to establish that claimant was not permanently and totally disabled regardless of whether or not the "post-reconsideration" evidence is considered. In light of such circumstances, we decline to resolve the "evidentiary" issue.

At the time of the reconsideration proceeding, the record contained medical opinions from Drs. Balek and Lloyd that claimant was permanently and totally disabled. After discussing claimant's disabilities due to his brain and physical injuries, Dr. Lloyd opined that it was likely that claimant would have been unable to be successful in the competitive labor market during the remainder of his working years. Dr. Lloyd believed that claimant would have been on significant disability throughout the rest of his life.

Dr. Balek opined that claimant was permanently and totally disabled from the time of the compensable injury to the time of his death. Dr. Balek further opined that if claimant had not had lung cancer, he would have continued to be permanently and totally disabled.

The reconsideration record also contained a vocational report from Ms. Nelson, rehabilitation consultant, which concluded that claimant's compensable injuries had rendered him unemployable.

Finally, the reconsideration record contained the report of Dr. Klecan, medical arbiter. Dr. Klecan opined that, if not for his cancer, claimant would have been able to return to some type of work but only in a structured situation with close supervision. Dr. Klecan felt that it was improbable that claimant would have been able to earn anything but a minimum wage, and that only in a supervised situation.

The employer relies on Dr. Klecan's opinion to argue that claimant was employable. To the extent that Dr. Klecan's opinion supports a conclusion that claimant is employable, we do not find his opinion to be as persuasive as the opinions of Drs. Balek and Lloyd. Because claimant had already died from noncompensable cancer at the time of the medical arbiter examination, Dr. Klecan was only able to perform a records review. By contrast, Dr. Balek and Dr. Lloyd had treated claimant over an extended period of time for his compensable condition. Under these circumstances, because of their familiarity with both claimant's physical and mental conditions, we defer to the opinions of claimant's treating physicians, Drs. Balek and Lloyd. Both of these physicians opined that claimant was permanently and totally disabled as the result of his compensable injury. The only vocational evidence in the record also supports the conclusion that claimant was permanently and totally disabled. Accordingly, based on the "reconsideration record," we find that the preponderance of the evidence establishes that claimant was permanently and totally disabled.

Even if we consider the "post-reconsideration" record evidence, we still conclude that claimant was permanently and totally disabled. Subsequent to the reconsideration order, Drs. Balek and Lloyd were deposed. At their depositions, both physicians indicated that they still believed that claimant was permanently and totally disabled. The "post-reconsideration" record also contains a report from Dr. Lezak, who is a professor of neurology and psychiatry. Dr. Lezak opined that claimant was unemployable as a result of the residuals from his May 29, 1991 compensable injury.

In addition to the documentary evidence discussed above, the record contains testimony of Dr. Klecan, as well as vocational testimony from Ms. Nelson and Mr. Hughes, a vocational rehabilitation consultant. Mr. Hughes and Ms. Nelson testified that claimant was not employable. Dr. Klecan testified that claimant was employable. However, as the ALJ noted, in rendering his opinion, Dr. Klecan considered only claimant's brain condition and did not consider claimant's disability due to his physical condition and was not familiar with claimant's physical status. Under such circumstances, we do not find Dr. Klecan's testimony, assuming that it is admissible, to be persuasive. After reviewing the "post-reconsideration" evidence, we are persuaded that the preponderance of the evidence supports a conclusion that claimant was permanently and totally disabled.

Based on this record, without considering the subsequent disability caused by his noncompensable cancer, we conclude that claimant was not able to perform a gainful or suitable occupation. We reach the same conclusion whether the "reconsideration record" alone is considered or whether the entire record, including "post-reconsideration" evidence is considered. Under such circumstances, we affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $3,200, 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 attorney's statement of services), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated February 13, 1995 is affirmed. For services on review, claimant's attorney is awarded $3,200, payable by the self-insured employer.

February 22, 1996 Cite as 48 Van Natta 420 (1996)

In the Matter of the Compensation of
DEBRA S. HARRISON, Claimant
WCB Case No. 95-03373
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Baker's order that dismissed as premature her hearing request which raised issues of: (1) the self-insured employer's alleged "de facto" denial of "a probable flexor tendon rupture and acute neuropraxia;" and (2) penalties and attorney fees for allegedly unreasonable claims processing. In addition, with its respondent's brief, the employer submits additional evidence. We treat this submission as a motion for remand. On review, the issues are dismissal, remand, "de facto" denial, penalties, and attorney fees. We vacate the dismissal order, deny remand, find there was no "de facto" denial, and decline to assess penalties and attorney fees.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Dismissal

The ALJ concluded that, under amended ORS 656.262(6)(d), the employer had 30 days from receipt of written communication from claimant requesting revision of a Notice of Acceptance to make such revision or make other written clarification in response to claimant's request before claimant may have a hearing on the alleged "de facto" denial. Because the hearing was held less than 30 days after the effective date of the new law, the ALJ concluded that a hearing was premature on the issues of the alleged "de facto" denial and penalties and attorney fees on the allegedly unreasonable "de facto" denial. Therefore, the ALJ dismissed claimant's hearing request on those issues. At hearing and on review, claimant argues that she complied with the requirements of amended ORS 656.262(6)(d) through her written hearing request. We agree with claimant.

After claimant filed her hearing request and before the date of hearing, the legislature enacted Senate Bill 369 which, inter alia, amended ORS 656.262(6)(d). Or Laws 1995, ch 332, § 28(6)(d) (SB 369, § 28(6)(d)). Amended ORS 656.262(6)(d) prohibits a worker from alleging a "de facto" denial at any hearing or other proceeding on the claim if the worker did not provide a written objection to the carrier's notice of acceptance.

As a preliminary matter, we find that amended ORS 656.262(6)(d) applies retroactively to claimant's claim. In this regard, the legislature explicitly stated its intent that the Act "is intended to be fully retroactive unless a specific exception is stated[.]" SB 369, § 66(1). None of the exceptions listed in section 66 of SB 369 apply to the current matter. Therefore, we conclude that amended ORS 656.262(6)(d) applies retroactively to claimant's claim. See Guillermo Rivera, 47 Van Natta 1723 (1995) (applying amended ORS 656.262(6)(d) retroactively to the claimant's claim).

Subsequent to the ALJ's order, in Guillermo Rivera, supra, we addressed the issue of whether a written request for hearing can serve as a written communication objecting to a carrier's notice of acceptance. There, two days before hearing, the claimant filed an additional written request for hearing alleging a "de facto" of a cervical strain. Shortly before hearing, the self-insured employer accepted the cervical strain. We found that the claimant's additional request for hearing constituted "communication in writing" to the employer of claimant's objections to the notice of acceptance pursuant to amended ORS 656.262(6)(d). The employer had 30 days to respond to the claimant's written communication concerning the notice of acceptance. Since the employer accepted the cervical strain before the hearing and effectively revised the notice of acceptance to include that injury, we concluded that the provisions of amended ORS 656.262(6)(d) were satisfied. Id. at 47 Van Natta 1724.

In reaching that conclusion, we noted that, had the employer not accepted the cervical strain on the date of hearing (two days after the claimant's "written communication"), the employer could have challenged the claimant's cervical "de facto" denial allegation as premature. In making this notation, we reasoned that, pursuant to amended ORS 656.262(6)(d), a claimant's failure to first provide written communication to the carrier to allow it 30 days within which to respond precludes the claimant from alleging a "de facto denial" at any hearing or other proceeding. Id. at 47 Van Natta 1724 n1.

Here, claimant's written March 17, 1995 hearing request alleging a "de facto" denial of a "probable flexor tendon rupture and acute neuropraxia" constitutes "communication in writing" to the employer of claimant's objections to the notice of acceptance under amended ORS 656.262(6)(d). The March 17, 1995 hearing request was a written communication that effectively challenged the scope of the notice of acceptance with regard to the "probable flexor tendon rupture and acute neuropraxia." The employer had 30 days to respond to claimant's written communication concerning the notice of acceptance. The employer did not respond within 30 days. However, on April 24, 1995, the employer responded to the issues raised in claimant's hearing request by issuing a general denial of "all other issues claimant maintains; penalties and attorney fees." On the basis of the lapse of more than 30 days and the employer's ultimate response, we conclude that the provisions of amended ORS 656.262(6)(d) were satisfied. Therefore, claimant's hearing request was not premature and the ALJ had jurisdiction over claimant's claim.

Remand

With its respondent's brief, the employer submits copies of: (1) a July 6, 1995 "post-order" letter from claimant's attorney to the employer's claims processing agent objecting to the omission from the Notice of Acceptance of the condition of "probable partial flexor tendon rupture and acute neuropraxia;" and (2) an August 2, 1995 "post-order" letter from the employer's claims processing agent responding that this diagnosis is considered a different diagnosis for the same injury and is accepted as well. We treat these submissions as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985).

We may remand a case to the ALJ should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Assuming for the sake of argument that this evidence was not obtainable with due diligence at the time of hearing, we would still deny the employer's motion for remand because the submitted evidence is not likely to affect the outcome of the case. That is, for the reasons discussed below, even considering this evidence, we find that the employer did not "de facto" deny a "probable partial flexor tendon rupture and acute neuropraxia" condition.

In addition, to the extent that the employer's submissions could be considered a request that we take administrative notice of this correspondence, we deny that request. The correspondence submitted by the employer does not meet the standard of being facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Mark A. Crawford, 46 Van Natta 725, 727 (1994). Therefore, we do not take administrative notice of this correspondence.

"De Facto" Denial

Whether an acceptance occurs is a question of fact to be decided based on all the evidence. SAIF v. Tull, 113 Or App 449, 454 (1992). On October 18, 1994, claimant injured her left wrist while trying to install a plexiglass strip on a display at work. On October 19, 1994, claimant sought treatment with Dr. Price, her family physician, who noted swelling and pain over the left volar wrist with numbness in the index, long, and ring fingers. (Ex. 1). Dr. Price diagnosed a probable partial flexor tendon rupture and acute neuropraxia. Id. He referred claimant to Dr. Lawton, orthopedist, who became claimant's attending physician. (Exs. 1, 2).

On October 19, 1994, Dr. Lawton examined claimant and provided the following initial diagnosis: "[claimant] may have subluxed a tendon or bone but without obvious tendinous disruption. Ligamentous injury is likely and could prolong the recovery period." (Ex. 2, 2A). On January 23, 1995, the employer accepted the claim for "subplexed [sic] tendon without obvious tendinitis [sic] disruption." (Ex. 11).

On October 26, 1994, Dr. Lawton examined claimant and noted "some areas of numbness involving her thumb and also tenderness along the volar aspect as before." (Ex. 7A). He also found that claimant had "a positive Tinels along the dorsal aspect of her thumb, probably has a neuropraxia type blow injury to the branches of the radial sensory branch." Id. On November 9, 1994, Dr. Lawton examined claimant and noted that claimant "likely has a nueropraxy [sic] type injury to the sensory branch." Id.

On December 19, 1994, Dr. Lawton examined claimant and issued a report to the employer's claims examiner summarizing his treatment. (Ex. 8A). He noted that at the time of claimant's initial visit, he and Dr. Price felt that claimant "likely strained a tendon or ligament with secondary inflammation in addition to neuropraxia injury to her superficial radial nerve." (Ex. 8A-1). Following examination, Dr. Lawton noted that the "initial tendon and ligamentous injury has healed without residuals" and the "nerve injury is also healing and likely will continue on to complete and full recovery." (Ex. 8A-2).

By letter dated March 29, 1995, Dr. Lawton informed claimant's attorney that claimant's treatment was limited to her left wrist injury, which was felt to be a strained "tendon or ligament about the wrist and also an injury to the superficial radial nerve." (Ex. 18).

Here, claimant has been given different diagnoses for her left wrist condition. However, there is no medical evidence that claimant has received treatment for a condition different from the one accepted by the employer. While Dr. Lawton's initial diagnosis was a subluxed tendon or bone without obvious tendinous disruption, there is no evidence that claimant sustained separate injuries to the wrist or that there were separate conditions resulting from her compensable injury. Therefore, we find that claimant's left wrist condition is the same condition that it has been since the original injury, even though different diagnoses/medical terminology has been employed. Consequently, we conclude that the employer did not "de facto" deny claimant's "probable partial flexor tendon rupture and acute neuropraxia" condition. See Karen S. Boling, 46 Van Natta 1522 (1994) (where different diagnoses/medical terminology employed, but the claimant's current condition was the same condition that it had been since the original injury, no "de facto" denial found); Leslie C. Muto, 46 Van Natta 1685 (1994) (holding the same); Warren R. Friend, 46 Van Natta 1520 (1994) (where diagnoses were used interchangeably, but the medical evidence established that the claimant had but one condition, no "de facto" denial found).

Penalties and Attorney Fees

Because we find no "de facto" denial and there is no evidence of amounts due or unreasonable resistance to the payment of compensation, claimant is not entitled to penalties or attorney fees. See ORS 656.262(10), renumbered 656.262(11), 656.382(1).

ORDER

The ALJ's order dated August 9, 1995 is vacated in part and affirmed in part. That portion of the order that dismissed claimant's hearing request regarding the alleged "de facto" denial, penalty, and

attorney fee issues is vacated. The hearing request is reinstated. Claimant's request for penalties and attorney fees regarding the employer's allegedly unreasonable claims processing is denied. The remainder of the ALJ's order is affirmed.

February 22, 1996 Cite as 48 Van Natta 423 (1996)

In the Matter of the Compensation of
WILLIAM E. HAYS, Claimant
WCB Case No. 95-02924
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that dismissed claimant's hearing request on the ground that the Hearings Division lacked jurisdiction over this dispute, which involved a managed care organization's (MCO's) disapproval of proposed medical services. On review, the issues are jurisdiction and, alternatively, medical services.

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

The ALJ concluded that, under amended ORS 656.260(6), (14) and (15), the Director of the Department of Consumer and Business Services has exclusive over this MCO dispute. We agree. See Ronald R. Streit, Sr., 47 Van Natta 1577 (1995) (amended ORS 656.260(6) vests in Director exclusive jurisdiction over MCO disputes).

Claimant raises several statutory and constitutional arguments on review. First, he asserts that the ALJ erred by failing to address his claim for SAIF's "de facto" denial of his claim. Because we lack jurisdiction over this claim under amended ORS 656.260, we have no authority to address that assertion. Claimant's recourse is to present the "de facto" denial issue to the Director.[1]

In a related vein, claimant asserts that, because SAIF conceded the compensability of his claim before hearing, he is entitled to an attorney fee under ORS 656.386(1), as well as a penalty under ORS 656.262(11) or a penalty-related attorney fee under ORS 656.382(1) for SAIF's unreasonable failure to accept the claim earlier. Because we lack jurisdiction over this matter, we also lack jurisdiction over the attorney fee and penalty issues. See Or Laws 1995, ch 332, § 42d(5) (neither ALJ nor Board may award penalties or attorney fees for matters arising under the Director's review jurisdiction); Thomas L. Abel, 47 Van Natta 1571 (1995). Accordingly, we do not address them.

Next, claimant asserts that amended ORS 656.327(2) violates his due process rights. That statute does not apply to this MCO dispute. Amended ORS 656.327(1)(a) (indicating that amended ORS 656.327 applies to medical treatment disputes not subject to ORS 656.260).[2] Assuming that claimant

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[1] There was no dispute regarding the compensability of claimant's underlying claim. (See Tr. 20). Therefore, assuming that this was a "245" medical services dispute, jurisdiction would still rest with the Director. Amended ORS 656.245(6); see Richard Wheeler, 47 Van Natta 2011 (1995) (Board retained jurisdiction over dispute involving compensability of condition on which medical services claim was based).

[2] Amended ORS 656.327(1)(a) provides:

"If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment, not subject to ORS 656.260, that the injured worker has received, will receive or is proposed to receive, is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties." (Emphasis added).

meant that amended ORS 656.260 violates his due process rights, that argument fails. The gist of claimant's argument is that the procedure afforded by the amended statute will violate his due process rights. Because claimant has yet to avail himself of that process, he has yet to be denied anything. Under the circumstances, claimant's due process arguments are premature, and we will not consider them. Jim M. Greene, 47 Van Natta 2245 (1995)).[3]

Last, claimant asserts that amended ORS 656.386(1), one of the attorney fee statutes, violates the Contract Clause of Article I, section 21, of the Oregon Constitution. Because we lack jurisdiction over any attorney fee issues that arise from this MCO dispute, we also lack jurisdiction over any constitutional challenge regarding those issues. In any event, because amended ORS 656.386(1) has yet to be applied to this case, claimant's constitutional challenge to that statute is premature. Jim M. Greene, supra. Therefore, we do not consider it.

ORDER

The ALJ's order dated July 7, 1995 is affirmed.

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[3] Alternatively, to the extent that claimant's argument may be construed as asserting that the retroactive application of amended ORS 656.260 presently violates his due process rights, we reject it. See Liberty Northwest Ins. Corp. v. Yon, 137 Or App 413 (1995) (in rejecting due process argument, court held that amendments to ORS 656.245, 656.327 and 656.704 eliminated claimant's choice of having medical services dispute resolved by Board, but did not deny him an opportunity to have his claim reviewed).

February 22, 1996 Cite as 48 Van Natta 424 (1996)

In the Matter of the Compensation of
DONALD P. JAMES, Claimant
WCB Case Nos. 95-02921 & 94-09030
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Robert Yanity (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Balasubramani's order that: (1) found that claimant's chiropractor's report constituted an aggravation claim for a low back condition; (2) set aside SAIF's denial of the aggravation claim; (3) awarded interim compensation; and (4) assessed penalties for allegedly unreasonable claims processing. On review, the issues are aggravation claim, aggravation, medical services, interim compensation, and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. We do not adopt his Findings of Ultimate Fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation claim

The ALJ relied on ORS 656.005(12)(b)(B) and concluded that a report from Dr. Hewitt, claimant's treating chiropractor, constituted a claim for an aggravation. However, on June 7, 1995, the legislature enacted SB 369, which amended ORS 656.005(12)(b)(B) . Additionally, we subsequently issued our decision in Manuel Altamirano, 47 Van Natta 1499 (1995). In Altamirano, we found no relevant exceptions to the amendment, and therefore, we concluded that Section 1 of SB 369 applied retroactively. See Volk v. America West Airlines, 135 Or App 565 (1995). Consistent with our reasoning in Altamirano, supra, we retroactively apply the amended statute in this case.

ORS 656.005(12)(b)(B) has been amended to provide that a chiropractor may be an attending physician for a period of 30 days from the date of first visit on the initial claim or for 12 visits, whichever occurs first. In light of the amendment, we concluded in Altamirano that, because of the amended language of the statute which now expressly pertains to an initial claim (rather than an aggravation or own motion claim), a chiropractor did not qualify as an attending physician who could authorize time loss on an aggravation claim.

Amended ORS 656.273(3) now provides, in part, that a "claim for aggravation must be accompanied by the attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury." We conclude that, consistent with our reasoning in Altamirano, a chiropractor cannot qualify as an attending physician for purposes of authorizing time loss on an aggravation claim. Likewise, we hold that a chiropractor does not qualify as an attending physician for purposes of providing a report to support an aggravation claim.

Accordingly, because a chiropractor cannot qualify as an attending physician on an aggravation claim, we conclude that Dr. Hewitt's report cannot constitute a claim for aggravation. Therefore, because claimant's aggravation claim was not accompanied by an attending physician's report, it is not a claim for aggravation pursuant to amended ORS 656.273(3). Consequently, we reverse the ALJ's finding that Dr. Hewitt's report was a claim for an aggravation.

In reaching our conclusion, we acknowledge our decision in Rick A. Webb, 47 Van Natta 1550 (1995), which declined to retroactively apply amended ORS 656.273(3). In Webb, we concluded that it would be absurd to require the claimant to comply with the portion of the statute which prescribed a form and format for an aggravation claim that was not in existence at the time of the claimant's aggravation claim. However, we distinguish Webb from the present case.

Noting that the insurer in Webb had previously not disputed the validity of its notice of an aggravation claim, we rejected the insurer's contention that the claimant's aggravation claim was not compensable because claimant did not provide written notice of his aggravation claim in the "post-claim" format prescribed by the Director. Rick A. Webb, supra. Here, in contrast, SAIF has challenged the validity of claimant's aggravation claim from the outset. More importantly, instead of an after-the-fact "Director's form" challenge, SAIF's statutory argument is the authority of the physician advancing the aggravation claim. Therefore, we find Webb distinguishable.[1]

Aggravation/Interim compensation

In light of our conclusion that no aggravation claim was made in this case, it follows that claimant has not established a compensable aggravation. Similarly, because no aggravation has been established, there is no entitlement to interim compensation.[2] Accordingly, we reverse the ALJ's order on the issues of aggravation and interim compensation.

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[1] Claimant has raised several constitutional challenges to the retroactive application of the statute. First, claimant contends that he is required to seek a remedy under the Act, as there is no longer a civil remedy available. Amended ORS 656.018. However, in order to show that he has been deprived of a remedy in violation of the Constitution, claimant must first demonstrate that he has been injured by operation of the amended statute. See McKinney v. Watson, 74 Or 220, 223 (1915); Jim M. Greene, 47 Van Natta 2245 (1995). In other words, claimant must obtain a legal ruling that, under amended ORS 656.018, he is prohibited from bringing a civil action. Because claimant has not done so, we conclude that his constitutional challenge on that basis must fail.

Additionally, claimant argues that he has a due process right to a jury trial, and the amendments to the Act have deprived him of that constitutional right. However, claimant did have a hearing and does have a right to litigate this matter. See Liberty Northwest Insurance Corp. v. Yon, 137 Or App 413 (1995). Accordingly, we are not persuaded that claimant has been deprived of due process.

[2] Alternatively, we conclude that even if an aggravation claim had been made, because time loss cannot be authorized by a chiropractor, claimant has not established an entitlement to interim compensation. Altamirano, supra.

Medical services

In the event that a compensable aggravation was not established, claimant alternatively sought payment of his medical bills pursuant to ORS 656.245. Here, because the parties' dispute concerns whether medical treatment for claimant's current condition is causally related to his compensable injury, the dispute necessarily involves compensability of the condition on which the medical treatment is based. Consequently, we retain jurisdiction to consider the parties' dispute. ORS 656.245(6); Richard L. Wheeler, 47 Van Natta 2011 (1995).

Relying on Dr. Hewitt's opinion, the ALJ found that claimant had established causation. We adopt the ALJ's reasoning and conclusions, with respect to the issue of causation. Accordingly, we set aside SAIF's denial of claimant's medical services claim.

Penalties

The ALJ assessed a penalty for SAIF's unreasonable failure to timely process his aggravation claim and pay interim compensation benefits. In light of our conclusion that no aggravation claim was made and no interim compensation benefits were due, we reverse the ALJ's penalty award on that basis. However, we find that a penalty is appropriate for SAIF's failure to timely process medical bills. That penalty shall be 25 percent of the unpaid bills due and payable as of April 14, 1995, the date of SAIF's response to claimant's hearing request wherein it contested that he was not entitled to medical services. The penalty for this untimely claim processing shall be equally shared by claimant and his attorney.

Here, SAIF had notice of the claim by October 11, 1994. (Exs. 70, 71). Accordingly, SAIF had 90 days within which to accept or deny the claim. However, SAIF did not act on the claim. Moreover, on April 14, 1995, SAIF responded to claimant's request for hearing by stating that "claimant has not incurred an aggravation; is not entitled to time loss nor medical services." Additionally, at hearing, SAIF took the position that there was no aggravation claim and claimant was not entitled to medical services. (Tr. 8). Consequently, because SAIF did not deny claimant's claim until more than 90 days from the time it had notice of the claim, its denial was untimely. Accordingly, a penalty is assessed for SAIF's unreasonable processing of claimant's medical bills. ORS 656.262(11). That penalty is based on the unpaid medical bills due on April 14, 1995, when SAIF finally responded to the medical services claim.

Attorney fees

The ALJ awarded an assessed attorney fee for claimant's counsel's services at hearing. Although we have reversed the ALJ's holding on the aggravation issue, claimant has prevailed on the alternative issue of medical services. Accordingly, we affirm the ALJ's attorney fee award.

Claimant is also entitled to an attorney fee for services on review concerning the issue of medical services. 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 medical services issue is $900, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 8, 1995 is reversed in part and affirmed in part. Those portions of the ALJ's order which set aside the SAIF Corporation's denial of an aggravation claim and awarded interim compensation are reversed. SAIF's aggravation denial is reinstated and upheld. SAIF's denial of claimant's medical services is set aside and the medical services claim is remanded to SAIF for processing according to law. That portion of the ALJ's order which assessed a penalty against SAIF for an allegedly unreasonable failure to process claimant's aggravation claim and interim compensation benefits is reversed. A penalty is assessed against SAIF for its unreasonable processing of claimant's medical bills. The penalty is based on 25 percent of the amounts of the unpaid medical services bills "then due" at the time of SAIF's April 14, 1995 response to claimant's hearing request, with one-half of the penalty awarded to claimant and one-half of the penalty awarded to claimant's counsel in lieu of an attorney fee. The ALJ's attorney fee award is affirmed. For services on review concerning the medical services issue, claimant is awarded an assessed attorney fee of $900, to be paid directly to claimant's counsel by SAIF. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
RICHARD LA FRANCE, Claimant
WCB Case No. 92-13528
ORDER ON REVIEW
Dye & Malagon Associates, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that dismissed for lack of jurisdiction claimant's requests for hearing from: (1) an April 11, 1994 Determination Order, which was issued following completion of an authorized training program (ATP); and (2) an October 14, 1992 Order on Reconsideration, which was issued prior to the ATP. In addition, claimant requests that, if we find the Hearings Division has jurisdiction, we remand the claim to the ALJ for determination of the extent of unscheduled permanent disability. On review, the issues are jurisdiction, remand, and extent of unscheduled permanent disability. We deny the motion to remand, affirm in part, and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. At the February 16, 1995 hearing, claimant's attorney stated that he would be relying on the documentary record, without the presentation of any testimony. (Tr. 5). The insurer's attorney stated that he took the same position. (Tr. 6).

On May 14, 1993, ALJ Black issued an Order Deferring Hearing. This deferral order provided that claimant's hearing request from the "pre-ATP" Order on Reconsideration was deferred and a hearing date would be assigned when the claim was re-closed following the ATP. It directed the Department or the insurer to notify the Hearings Division when the claim was re-closed.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts. On January 11, 1991, claimant compensably injured his back. On February 18, 1992, the claim was first closed by a Determination Order which awarded 32 percent unscheduled permanent disability. Reconsideration was requested and, on October 14, 1992, an Order on Reconsideration issued which increased claimant's unscheduled permanent disability award to 36 percent. Claimant requested a hearing on that Order on Reconsideration. Subsequently, both parties requested that the hearing be deferred pending the conclusion of claimant's ATP. On May 14, 1993, a prior ALJ issued an order deferring that hearing.

From March 1, 1993 through December 12, 1993, claimant participated in an ATP. Following the conclusion of the ATP, a Determination Order issued on April 11, 1994, which reduced the unscheduled permanent disability award to 18 percent. On September 29, 1994, claimant sought reconsideration. On December 21, 1994, the Department issued an Order Denying Reconsideration, finding that, pursuant to Weyerhaeuser Co. v. Purdy, 130 Or App 322 (1994), the Department did not have jurisdiction to reconsider the "post-ATP" Determination Order. On December 22, 1994, claimant requested a hearing challenging, *inter alia*, the December 21, 1994 Order Denying Reconsideration.

Jurisdiction Regarding the "Post-ATP" Determination Order

Relying on former ORS 656.268(8) and (9), the ALJ found that claimant was not required to request reconsideration of a "post-ATP" Determination Order but, instead, had 180 days from the date the "post-ATP" Determination Order was mailed within which to timely request a hearing on that order. Because more than 180 days had lapsed between the issuance of the April 11, 1994 "post-ATP" Determination Order and the time of claimant's December 22, 1994 request for hearing on the Order Denying Reconsideration, the ALJ concluded the Hearings Division did not have jurisdiction over the "post-ATP" Determination Order. We agree. Weyerhaeuser Co. v. Purdy, supra.

Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.268(8) and (9). Or Laws 1995, ch 332, § 30 (SB 369, § 30). These amendments, in part: (1) created a new ORS 656.268(8); (2) renumbered former ORS 656.268(8) as amended ORS 656.268(9), both deleting and adding provisions to that renumbered subsection; and (3) deleted former ORS 656.268(9). Amended ORS 656.268(8) provides that "[n]o hearing shall be held on any issue that was not raised and preserved before the department at reconsideration. However, issues arising out of the reconsideration order may be addressed and resolved at hearing." SB 369, § 30(8).

Amended ORS 656.268(9) provides for the processing of a claim during a worker's participation in an ATP and for redetermination of the claim after the worker ceases to be enrolled and actively engaged in the ATP. This subsection adds some provisions under which a redetermination may be made where a worker is not medically stationary or where the worker has not returned to work. However, we need not address those provisions because there is no dispute that claimant remained medically stationary during and after the ATP and that he was employed after completion of the ATP. In regard to the present case, the relevant provision added by amended ORS 656.268(9) is as follows: "[t]he redetermination or notice of closure is appealed in the same manner as are other determination orders or notices of closure under this section." SB 369, § 30(9).

Finally, the legislature deleted former ORS 656.268(9), which provided that "[t]he Department of Consumer and Business Services shall mail a copy of the determination to all interested parties. Any such party may request a hearing under ORS 656.283 on the determination within 180 days after copies of the determination are mailed."

Our first task is to determine which, if any, of these amendments apply to the present case. The court has held that the provisions of SB 369 apply retroactively to all pending cases, unless specifically excepted by section 66. Volk v. America West Airlines, 135 Or App 565 (1995). Here, the only relevant exception is provided by section 66(4), which provides, in part, that the amendments to ORS 656.268(9) by section 30 of the Act "shall apply only to claims that become medically stationary on or after the effective date of this Act." SB 369, § 66(4). The Act became effective upon its passage on June 7, 1995. SB 369, § 69. Claimant became medically stationary on December 16, 1991, several years before the effective date of Senate Bill 369. Therefore, the amendments to ORS 656.268(9) do not apply retroactively to claimant's claim.

Claimant argues that section 66(4) is confusing as to whether it denies retroactive application of the deletion of former ORS 656.268(9) or retroactive application of the amendments to renumbered ORS 656.268(9), which include the deletion and addition of several provisions, including addition of the provision that appeal is in the same manner as other determination orders or notices of closure. We find that, by its terms, subsection 66(4) applies to all of the amendments to ORS 656.268(9), both those deleting former ORS 656.268(9) and those renumbering and changing the language in amended ORS 656.268(9). To hold otherwise would fail to give full effect to the legislative intent expressed in subsection 66(4).

Accordingly, we find that former ORS 656.268(8) and (9) apply to the current claim. Prior to Senate Bill 369, these were the statutes that governed the processing of a worker's claim during and after the period the worker was "enrolled and actively engaged in" an ATP. Furthermore, in Weyerhaeuser Co. v. Purdy, supra, the court interpreted those statutes. In Purdy, the court held that a worker's enrollment in an ATP "triggers an entirely separate review process from what is described in [former] ORS 656.268(5), which was unaffected by the 1990 amendments to the workers' compensation statutes." Id. at 130 Or App 325-26.[1] Thus, the court concluded that the claimant's timely request for a hearing on a "post-ATP" Determination Order, without first following the reconsideration process, properly brought her claim within the jurisdiction of the Hearings Division and the Board.

Claimant argues that the holding in Purdy should be limited to the fact situation where a worker timely requests a hearing on a "post-ATP" determination order but does not request a reconsideration. However, neither the terms of former ORS 656.268(8) and (9) nor the holding in Purdy support such a limitation. Former ORS 656.268(9) specifically states that a party requesting a hearing on a "post-ATP"

[1] The 1990 amendments to former ORS 656.268(5) to which the court referred created the reconsideration process.

determination order "may request a hearing under ORS 656.283 on the determination within 180 days after copies of the determination are mailed." No other statutory means of requesting a hearing on a "post-ATP" determination order is provided. In addition, as quoted above, the court in Purdy recognized that enrollment in an ATP created a review process that was separate from the reconsideration process. This separate process required the worker to request a hearing within 180 days from the mailing of the "post-ATP" determination order. Former ORS 656.268(8) and (9); Weyerhaeuser Co. v. Purdy, supra. Accordingly, we do not agree with the limitations claimant attempts to impose on the application of the holding in Purdy.

Claimant also argues that, even if amended ORS 656.268(9) does not retroactively apply to this case, "it nevertheless manifests the legislative intent that was inherent in former subsection (8) -- specifically, that an appeal of a [post-ATP] Determination Order is no different than an appeal of any other determination order." (Appellant's Brief, page 3-4). Claimant asserts that amended ORS 656.268(9) simply "clarifies," rather than "changes," the process for perfecting review. Thus, claimant's argues, whatever the Purdy court said to the contrary was not intended by the legislature.

Claimant's arguments disregard the fact that the legislature significantly changed the language regarding the manner in which to request review of a "post-ATP" determination order by both deleting former ORS 656.268(9) and adding new language to amended ORS 656.268(9). In addition, the legislature specifically expressed its intent that the changes to ORS 656.268(9) not be applied retroactively. SB 369, § 66(4). From this, it follows that the legislature recognized that it was changing, not merely clarifying former ORS 656.268(8) and (9).

Finally, claimant notes that amended ORS 656.268(8) is to be applied retroactively. (SB 369, § 66). Therefore, claimant argues, application of amended ORS 656.268(8) "compels the conclusion that a request for reconsideration operates to preserve claimant's right to review." (Appellant's Reply Brief, page 2). We disagree with claimant's argument for the following reasons.

Senate Bill 369, subsection 66(6) provides that "[t]he amendments to statutes by this Act and new sections added to ORS chapter 656 by this Act do not extend or shorten the procedural time limitations with regard to any action on a claim taken prior to the effective date of this Act." Pursuant to former OR 656.268(8) and (9), which we have found applicable to this case, claimant had 180 days from the mailing date of the "post-ATP" Determination Order within which to timely request a hearing. Claimant failed to meet that deadline. Pursuant to SB 369, § 66(6), amended ORS 656.268(8) cannot serve to extend that procedural time limitation. See Motel 6 v. McMasters, 135 Or App 583 (1995) (procedural time limit involved; therefore, pursuant to SB 369, § 66(6), old law applies). Consequently, we conclude that former ORS 656.268(8) and (9) apply to this case.

Here, claimant did not request a hearing on the April 11, 1994 "post-ATP" Determination Order until December 22, 1994. Thus, claimant did not request a hearing within 180 days following the issuance of the "post-ATP" order. Therefore, we agree with the ALJ that the Hearings Division does not have jurisdiction over the "post-ATP" Determination Order. Accordingly, the April 11, 1994 "post-ATP" Determination Order has become final by operation of law.

Jurisdiction Regarding the October 14, 1992 Order on Reconsideration

The ALJ found that litigation regarding the October 14, 1992 Order on Reconsideration remained before the Hearings Division by virtue of the Deferral Order. However, the ALJ concluded that, given the mandatory nature of the redetermination following completion of an ATP, the October 14, 1992 Order on Reconsideration "is no longer viable following the issuance of the post-ATP determination, but is subsumed by the later order." (Opinion and Order, page 4). Given that, the ALJ concluded that the Deferral Order did not create jurisdiction in the Hearings Division where none otherwise existed. While we find that the Hearings Division retains jurisdiction over the October 14, 1992 Order on Reconsideration, we agree with the ALJ regarding the ultimate effect of the subsequent "post-ATP" Determination Order.

Regarding the jurisdiction issue, we find David E. Sakrisson, 45 Van Natta 1069 (1993), on point. In Sakrisson, the claimant's claim was initially closed by an April 18, 1989 Determination Order. The claimant requested a hearing regarding that award, seeking an increased permanent disability award. Before a hearing was held, the insurer reopened the claimant's claim for vocational training. The

claimant's request for hearing was deferred pending completion of the ATP. Following completion of the ATP, the claimant's claim was reclosed by a June 6, 1991 Determination Order. The claimant did not appeal the June 6, 1991 Determination Order and it became final by operation of law.

We found that OAR 438-006-0105(1) provides that a hearing may be deferred if the primary issue is unscheduled permanent disability and the claimant is entitled to temporary disability compensation under an ATP. Id. Because the claimant's claim was reopened for an ATP and the claimant's hearing request was deferred by an ALJ's order indicating that a hearing date would be assigned when the claim was closed, we concluded that the deferral order preserved the claimant's hearing request on the April 18, 1989 Determination Order.

In reaching this conclusion, we distinguished those cases where the parties and ALJs attempted to preserve issues for later litigation and, in doing so, the ALJs dismissed the claimants' hearing requests. In those cases, the claimants were required to reraise the "preserved" issues within the time limits set out by ORS 656.319. In contrast, the claimant's hearing request in Sakrisson was never dismissed but was expressly deferred for future resolution, as permitted by OAR 438-006-0105(1). In addition, we relied on the court's holding in Minor v. Delta Truck Lines, 43 Or App 29 (1979), rev den 288 Or 253 (1980), that the Board is precluded from denying a hearing regarding the adequacy of a Determination Order award of permanent disability pending completion of a rehabilitation program. 45 Van Natta at 1070. Thus, we concluded that the claimant's failure to appeal the "post-ATP" Determination Order did not affect his right to a hearing on the "pre-ATP" Determination Order.

Here, too, claimant's hearing request regarding the October 14, 1992 "pre-ATP" Order on Reconsideration was not dismissed. Instead, it was deferred pending completion of the ATP, an action expressly permitted by OAR 438-06-105(1). In addition, as in Sakrisson, the ALJ's deferral order stated that a hearing would be rescheduled when the claim was closed. Therefore, even if claimant's failure to request a hearing within 180 days from the mailing date of the "post-ATP" Determination Order prevented the Hearings Division from having jurisdiction over that Determination Order, we conclude that any such failure does not affect his right to a hearing on the October 14, 1992 Order on Reconsideration. Although claimant's hearing was deferred during an ATP, he preserved an appeal from the October 14, 1992 Order on Reconsideration and has a right to a hearing on that order. Minor v. Delta Truck Lines, supra; David E. Sakrisson, supra. Therefore, we find that the Hearings Division had jurisdiction over the issue of extent of disability regarding the October 14, 1992 "pre-ATP" Order on Reconsideration.

Remand

Claimant requests that, if we find that the Hearings Division has jurisdiction over the extent issue, we remand the case to the ALJ for hearing on the extent of unscheduled permanent disability. We may remand a case to the ALJ should we find that the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand, it must be clearly shown that material evidence was not obtainable with due diligence at the time of the hearing. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, although the ALJ ultimately dismissed claimant's hearing requests for lack of jurisdiction, the hearing was convened and documentary exhibits were received into evidence. In addition, both claimant and the insurer stated that they would rely on the documentary record, without presenting any testimonial evidence. (Tr. 5, 6). Under these circumstances, we conclude that the record has not been improperly, incompletely or otherwise insufficiently developed and deny claimant's motion. Therefore, we deny the motion for remand.

Unscheduled Permanent Disability

As the ALJ found, redetermination of extent of disability is mandatory when a worker ceases to be enrolled and actively engaged in the training program, provided that the worker is medically stationary. ORS 656.268(9);[2] Watkins v. Fred Meyer, Inc., 79 Or App 521 (1986) (interpreting former

[2] ORS 656.268(9) was amended to include the possibility of redetermining disability after cessation of participation in a training program "if the worker's accepted injury is no longer the major contributing cause of the worker's combined or consequential condition or conditions pursuant to ORS 656.005(7)." However, this amendment does not apply under the facts of the current case.

ORS 656.268(5), an earlier version of the statute that contained the same relevant language as ORS 656.268(9) regarding the mandatory nature of the redetermination); Hanna v. SAIF, 65 Or App 649 (1983) (same). This redetermination is made without regard to previous awards. Watkins v. Fred Meyer Inc., supra. Moreover, the worker need not show a worsening in his condition to be entitled to this redetermination. Hanna v. SAIF, supra. Furthermore, this mandatory redetermination can result in a reduction of the worker's extent of disability, as determined prior to the training program. SAIF v. Sweeney, 115 Or App 506 (1992), on recon 121 Or App 142 (1993).

Under this statutory scheme and the facts of the present case, although we retain jurisdiction of the October 14, 1992 Order on Reconsideration via the Deferral Order, as explained above, the "post-ATP" Determination Order remains the final determination of claimant's disability to date. In other words, the "post-ATP" Determination Order stands and claimant's total unscheduled permanent disability award to date is 18 percent. Thus, claimant is not entitled to additional permanent disability regarding his appeal of the "pre-ATP" Order on Reconsideration (which had previously awarded claimant 36 percent unscheduled permanent disability).

ORDER

The ALJ's order dated May 11, 1995 is reversed in part and affirmed in part. That portion of the order that found that the Hearings Division did not have jurisdiction over the October 14, 1992 Order on Reconsideration is reversed. Claimant's hearing request of the October 14, 1992 Order on Reconsideration is reinstated. Claimant is not entitled to additional unscheduled permanent disability. The remainder of the order is affirmed.

February 22, 1996 Cite as 48 Van Natta 431 (1996)

In the Matter of the Compensation of
REX T. MIELKE, Claimant
WCB Case No. 95-02141
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Gunn and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Davis' order which directed it to calculate the rate of claimant's temporary total disability (TTD) benefits based on the parties' intent at the time of hire for claimant's position at the time of his injury. On review, the issue is rate of temporary disability.

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

Claimant sustained a compensable injury on May 27, 1994. On May 2, 1994, less than four weeks prior to his injury, he began working for the employer in an eight-hour per day dock worker position, paid at the rate of $11.85 per hour. Prior to May 2, 1994, claimant worked for this employer in a four-hour, casual labor, on-call position at a lower hourly rate.

The ALJ found that claimant's TTD should be calculated under former OAR 436-60-025(5)(a), which provided that when a worker has been employed less than four weeks, the parties' intent at the time of hire established the wage for purposes of calculating the TTD rate. Reasoning that claimant began a "new" job with the employer on May 2, 1994, the ALJ concluded that the parties' intent at the time of hire for the new position determined the TTD rate, since claimant had been employed in that position for less than four weeks. We agree.

In claimant's part-time casual laborer position, he worked on-call and was not allowed to work more than four hours per shift. His duties were limited, he was not permitted to use equipment, he had no benefits or union representation, and he was not permitted to work overtime. By contrast, as an eight-hour dock worker, he could run equipment and was required to obtain a commercial driver's

license. Claimant had health benefits, was eligible to work overtime, was represented by the union, and was eligible to accrue time toward the "seniority board" which would eventually entitle him to holiday, vacation and sick pay.

Under such circumstances, we find that claimant's work duties and his employment relationship changed significantly when claimant was hired in the eight-hour dock worker position, such that he was hired in a "new" position at that time. See Khampeng Thammasouk, 45 Van Natta 487 (1993) (claimant, a student, began a "new" job when he renewed his employment relationship each summer). Therefore, since claimant had worked in his new position less than four weeks when he was injured, the TTD rate is properly calculated based on the parties' intent at the time of hire.

Since we have not disallowed or reduced the compensation awarded to claimant by the ALJ, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 8, 1995 is affirmed. Claimant's attorney is awarded $800 for services on Board review, to be paid by the insurer.

February 22, 1996 Cite as 48 Van Natta 432 (1996)

In the Matter of the Compensation of
EDUARDO O'CAMPO, Claimant
WCB Case No. 94-12988
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Employers Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Daughtry's order which: (1) found that, pursuant to ORS 656.325(5)(c), the insurer properly terminated claimant's temporary total disability (TTD) benefits, and (2) declined to assess a penalty for allegedly unreasonable claim processing. On review, the issues are TTD and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

On May 20, 1994, claimant injured his low back. Claimant initially treated with Dr. Castillo, D.O. (Exs. 2, 3, 4). Dr. Castillo signed an 827 form on May 25, 1994, announcing that claimant's attending physician was Dr. Castillo. On June 8, 1994, Dr. Castillo released claimant to modified work. (Ex. 4A). Claimant remained on modified work until June 28, 1994, when Dr. Castillo released him from work.

On July 8, 1994, claimant was examined by Dr. Moen, orthopedic surgeon. (Ex. 4E). Claimant also continued to see Dr. Castillo, who released claimant from work on July 21, 1994 and August 10, 1994. (Exs. 5A, 7A). Although Dr. Moen did not submit a "Change of Physician" (829) form, the insurer began to direct all correspondence to Dr. Moen.

On August 2, 1994, the insurer wrote to Dr. Moen, stating that "[the insurer] would like to work with [Dr. Moen] in finding modified work for [claimant]." (Ex. 8). The letter also contained a statement of authorization for a modified job, which Dr. Moen signed on August 16, 1994. The insurer accepted claimant's claim for a lumbar strain on August 22, 1994.

Dr. Castillo continued to authorized time loss on September 9, 1994, November 10, 1994, and January 17, 1995. (Exs. 10A, 13, 13A). The insurer paid time loss only through August 5, 1994. (Ex. 10). Dr. Castillo did not release claimant to regular or modified employment.

On September 30, 1994, the employer sent claimant a letter. Because it had not received documentation from claimant concerning whether he was authorized to work in the United States, the employer announced that it was terminating claimant's employment. (Ex. 12).

The ALJ concluded that the insurer properly terminated claimant's TTD benefits pursuant to amended ORS 656.325(5)(c). Finding that, with the acquiescence of Dr. Castillo, Dr. Moen performed the functions of an attending physician, the ALJ reasoned that Dr. Moen was claimant's attending physician. We do not agree.

Amended ORS 656.325 (5)(c) provides:

> "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."

In applying the statute, we first determine whether claimant's "attending physician" approved claimant for modified work. Whether a doctor qualifies an as attending physician is a question of fact. See Paula J. Gilman, 44 Van Natta 2539 (1992). In this regard, OAR 436-10-060(1) provides:

> "A newly selected attending physician or a referral physician who becomes primarily responsible for the worker's care, shall notify the insurer not later than 5 days after the date of change or first treatment, using Form 829 (Change of Attending Physician). This form should only be completed and submitted when the previous attending physician is no longer going to be primarily responsible for the worker's care."

Here, for whatever reason, the insurer began to direct its correspondence, and questions concerning claimant's condition, to Dr. Moen. Nevertheless, the record contains no evidence that claimant wished to change attending physicians, nor is there a Form 829 indicating a change of physician. See Trevor E. Shaw, 46 Van Natta 1821 (1994) (record did not support a change of attending physician when the claimant self-referred to a physician, whom claimant saw only one time, and who did not sign a "Change of Physician" form). Moreover, following his visits to Dr. Moen, claimant continued to see Dr. Castillo, who continued to authorize time loss at least through January 17, 1995. (See Exs. 11A, 13, 13A).

Accordingly, absent any persuasive evidence to the contrary, we conclude that claimant had not changed attending physicians to Dr. Moen. Thus, because Dr. Castillo did not approve employment in a modified job, the insurer was not authorized to terminate claimant's TTD benefits on August 5, 1994. See ORS 656.325(5)(c). Consequently, claimant is entitled to have his TTD payments reinstated. Therefore, we reverse the ALJ's order regarding TTD, and remand the claim to the insurer for further processing according to law.[1]

Penalty

A penalty may be assessed when a carrier "unreasonably delays or unreasonably refuses to pay compensation." Amended ORS 656.262(11)(a). The standard for determining unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt about its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

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[1] The ALJ did not address claimant's constitutional challenge to ORS 656.325(5)(c), and claimant continued to raise the argument on review. However, because we have found that Dr. Moen was not claimant's attending physician, ORS 656.325(5)(c) does not apply. Consequently, we need not address claimant's constitutional argument.

Here, subsequent to claimant's referral to Dr. Moen, the insurer began treating Dr. Moen as claimant's treating physician, even though the record contained no notice to the insurer, either from claimant, Dr. Castillo, or Dr. Moen, that claimant wished to change attending physicians. Furthermore, there is no evidence that the insurer sought clarification from either physician or from claimant as to the identity of claimant's attending physician. Instead, the insurer submitted a modified work release to Dr. Moen, and relied on Dr. Moen's release to a modified job in order to cease claimant's TTD benefits after August 5, 1994, allegedly pursuant to ORS 656.325(5)(c).

In light of the circumstances existing at the time of its termination of temporary disability, we are not persuaded that the insurer had a legitimate doubt regarding its continuing liability to pay these benefits. We reach such a conclusion because there was no correspondence in the insurer's possession at the time of its termination which expressly indicated that claimant had changed his attending physician from Dr. Castillo to Dr. Moen. Therefore, we conclude that the insurer improperly terminated claimant's TTD benefits. Accordingly, claimant is awarded a penalty equal to 25 percent of the TTD benefits due as a result of this order, from the date of the insurer's termination until the date of hearing. Amended ORS 656.262(11). Claimant's attorney shall receive one-half of this penalty in lieu of an attorney fee. Amended ORS 656.262(11)(a).

ORDER

The ALJ's order dated June 8, 1995, as amended August 10, 1995, is reversed. The insurer is directed to pay temporary disability benefits beginning from the effective date of its termination of such benefits until termination is authorized by law. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800, payable directly to claimant's attorney. Claimant is also awarded a penalty equal to 25 percent of the temporary disability benefits due as a result of this order, payable from the effective date of the insurer's termination of temporary disability through the date of hearing, to be equally divided between claimant and his attorney.

February 22, 1996 Cite as 48 Van Natta 434 (1996)

In the Matter of the Compensation of
JOHN L. PARTIBLE, Claimant
WCB Case No. 95-03334
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Schultz's order which held that: (1) claimant's request for treatment constituted a palliative care issue which would fall under the Director's jurisdiction; and (2) by entering into a Claim Disposition Agreement (CDA), claimant had waived his right to make a claim for a thoracic spine condition. On review, the issues are jurisdiction, the effect of a CDA, and medical services. We reverse in part and vacate in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. We do not adopt his Findings of Ultimate Fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction

The ALJ reasoned that, because the insurer denied compensability of claimant's medical services on the ground that the thoracic condition was not related to the compensable condition, it appeared that the Hearings Division would have jurisdiction over this matter. For the following reasons, we conclude that the Hearings Division and the Board have jurisdiction over the issue of causation.

In Walter L. Keeney, 47 Van Natta 1387 (1995), we concluded that no exception existed to the application of the new law, SB 369, and the relevant statutory amendments. Accordingly, we retroactively applied the law and concluded that the Director has exclusive jurisdiction over ORS 656.273(1) medical services disputes. See also Newell v. SAIF, 136 Or App 280 (1995). However, in Richard L. Wheeler, 47 Van Natta 2011 (1995), we found that we retained jurisdiction to determine whether a claimant's current condition is causally related to the compensable injury. We concluded that, inasmuch as such a dispute necessarily involves the compensability of the condition on which the medical treatment is based, the insurer's formal denial pertained to the "compensability of the underlying claim," and, therefore, we retained jurisdiction pursuant to amended ORS 656.245(6). Finally, we noted that once the causation issue was resolved, we did not have authority to address the propriety of proposed treatment for the disputed condition. Wheeler, supra.

Here, following receipt of bills from Dr. Mantell, claimant's chiropractor, the insurer returned two bills stating that they were being returned as "they are not related to the accepted condition under (claimant's) workers' compensation claim." (Ex. 15). At hearing, the insurer relied on Exhibit 15 in support of its position. Consequently, although the insurer stated that compensability was not at issue, such a statement is not consistent with its reliance on Exhibit 15, which denies that the medical treatment is causally related to the compensable condition. Therefore, the Hearings Division and the Board have jurisdiction to decide the issue of causation.

Effect of the CDA

The ALJ also held that, because claimant entered into a CDA which settled his accepted cervical strain and a herniated disc at C6-7, claimant could not make a claim for a thoracic spine condition. The ALJ concluded that claimant's remedy was to request clarification of the Notice of Acceptance to include the thoracic spine, which he had failed to do prior to entering into the settlement. We disagree.

In Jeffrey B. Trevitts, 46 Van Natta 1767 (1994), Aff'd Trevitts v. Hoffman-Marmolejo, 138 Or App 455 (1996), we concluded that a claimant was attempting to obtain nonmedical benefits for a condition that arose from the underlying accepted condition. Consequently, because the CDA entered into by the parties had provided for a full release of benefits under the accepted injury, we concluded that all of the claimant's nonmedical service rights related to the entire claim had been settled by the CDA.

In Christopher J. Kaufman, 47 Van Natta 433 (1995), however, we found that because the claimant was bringing a claim for a new injury which was contended to be separate and distinct from the accepted injury, the CDA did not and could not have resolved compensability disputes. Accordingly, we concluded that resolution of the matter involved the claimant's right to benefits under his prior accepted claim (which were limited to medical services as a result of the CDA), versus his right to benefits under a "new" injury claim, which would include all benefits under Chapter 656.

In the present case, claimant is not contending that his thoracic condition is a new injury which is separate and distinct from the accepted injury. Rather, claimant argues that "the condition in question is the direct result of (the) original injury." Claimant's brief at pg. 7. Therefore, because claimant is seeking benefits under his prior accepted claim, and since he has released all non-medical benefits pursuant to the CDA, his benefits are limited to medical services.

In light of our decision that claimant may seek medical services for his thoracic condition, we reverse that portion of the ALJ's order which found that the CDA precluded claimant from making such a claim.

Medical Services

Claimant contends that his current thoracic condition is related to his compensable 1993 injury. In order to establish the compensability of his current condition, claimant must establish either that his condition and need for treatment was directly caused by the industrial accident (in which case, the material contributing cause standard applies) or that the current condition arose as a consequence of the compensable injury, which is the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411, 414 (1992).

For the following reasons, we conclude that either under a standard of major or material contributing cause, claimant has proven that his current thoracic condition is related to the compensable injury.

Dr. Jura, claimant's treating doctor, referred claimant to Dr. Mantell for chiropractic treatment. On June 11, 1995, Dr. Jura reported that claimant's thoracic complaints which he first noted in June or July of 1993 were related to the compensable injury. Dr. Jura stated that claimant had complaints "inferior to the cervical spine," and his diagnostic impression on claimant's first visit "included thoracic strain as well as cervical strain." (Ex. 17).

There is no medical opinion in the record which contradicts Dr. Jura's report relating claimant's thoracic strain to the compensable injury. Consequently, we conclude that claimant has established that his medical service claim for his thoracic condition is causally related to his compensable injury.

Finally, the remaining issue to be decided is whether claimant's chiropractic treatment constitutes palliative care. Because jurisdiction over this matter rests with the Director, rather than the Hearings Division, we vacate the portion of the ALJ's order that purported to decide the issue of palliative care. Thomas L. Abel, 47 Van Natta 1511 (1995).

Claimant is entitled to an assessed attorney fee for prevailing over the insuer's denial of medical services. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review concerning the causation/medical services issue is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of the hearings 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.

ORDER

The ALJ's order dated June 23, 1995 is reversed in part and vacated in part. That portion of the ALJ's order that found that claimant was precluded from bringing a medical services claim for his thoracic condition is reversed. The insurer's denial of medical service, insofar as it denies causation, is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review concerning the issue of causation, claimant's counsel is awarded an assessed attorney fee of $1,500, to be paid by the insurer. That portion of the ALJ's order that purported to address the issue of palliative care is vacated.

February 22, 1996 Cite as 48 Van Natta 436 (1996)

In the Matter of the Compensation of
JULIE M. RUSSO, Claimant
WCB Case No. 94-15322
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Cobb & Woodworth, Defense Attorneys
Robert J. Yanity (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that declined to reclassify claimant's injury claim as disabling. On review, the issue is claim reclassification. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was not temporarily disabled because she did not miss more than three days from work and that she had not suffered any permanent impairment as a result of her compensable left eye injury. The ALJ concluded that claimant had no disability due and, therefore, her claim was nondisabling. We agree.

Relying on Sharman R. Crowell, 46 Van Natta 1728 (1994), claimant contends that she was partially disabled, as evidenced by her medical restrictions[1], from performing "any kind of work."

Subsequent to the ALJ's order, in Karren S. Maldonado, 47 Van Natta 1535 (1995), we held that the unambiguous language of amended ORS 656.005(7)(c)[2] overruled our holding in Sharman R. Crowell, supra. In particular, we stated that "it is not enough that a claimant be limited to modified work; there also must be entitlement to temporary benefits or a reasonable expectation of permanent disability." Maldonado, supra.

Here, even assuming for the sake of argument that claimant's medical restrictions constituted a release to modified work, claimant has nonetheless failed to establish that she is entitled to temporary disability.

Amended ORS 656.210(3) provides:

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

Claimant was injured on Thursday, December 9, 1993, approximately one hour before the end of the work day. She sought treatment at the emergency room that day. The emergency room doctor, Dr. Dugoni, took claimant off work until December 11, 1993 and advised claimant to follow-up with Dr. Chestler. (Ex. 1). Claimant missed work on December 10, 1993. (Tr. 9; ex. 12). Dr. Chestler saw claimant on December 10, 1993 and released claimant to regular work that day. (Ex. 1A). Saturday and Sunday were claimant's regularly scheduled days off. Claimant returned to work on Monday, December 13, 1993, but missed three hours of work. (Exs. 6, 12).

Based on the above, we find that claimant did not miss three days of work. Claimant, therefore, is not entitled to temporary disability benefits.[3] Amended ORS 656.210(3); OAR 436-30-020(2); see also Timothy A. Bostick, 46 Van Natta 942 (1994) (claim nondisabling where the claimant missed three days of work, but where disability did not continue for a period of 14 days), aff'd Bostick v. Ron Rust Drywall, 138 Or App 552 (1996).

Because no temporary disability benefits are due and payable, claimant's claim is not disabling unless there is proof of a reasonable expectation of permanent disability. Although claimant concedes that this alternative theory was not raised at hearing, she requests remand for the taking of additional evidence of whether there is a reasonable expectation of permanent disability.

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[1] Claimant worked as an administrative assistant. After she injured her eye, the emergency room doctor instructed claimant to wear an eye patch for 24 hours and not to drive a motor vehicle or operate machinery.

[2] Amended ORS 656.005(7)(c) now defines a disabling injury as "an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury." Or Law 1995, ch 332 §1 (SB 369, §1). The statute applies retroactively. Karren S. Maldonado, supra n. 1; see Volk v. America West Airlines, 135 Or App 565 (1995).

[3] Our conclusion regarding claimant's entitlement to temporary disability would be unaffected regardless of whether the Crowell analysis or the current version of ORS 656.005(7)(c) was applied. Because claimant was neither temporarily nor permanent disabled, she did not bring herself within the terms of the statute. In addition, the requirement that a worker be temporarily disabled and/or entitled to permanent disability to warrant claim reclassification was in effect at the time of hearing. Because claimant could have, but did not raise her equal protection arguments at hearing, we do not consider them on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991).

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing. Compton v. Weyerhaeuser Co., 301 Or 641 (1986).

In Clifford E. Clark, 47 Van Natta 2310 (1995), the claimant requested remand contending that the law at the time of hearing did not require evidence of the potential for permanent disability to establish that the claim was disabling. In denying the motion to remand, we determined that this was not the situation where the hearing record contained evidence that would satisfy the old law but not the new law. Instead, we found that there was no evidence that would meet the standard which existed at the time of hearing. Since the circumstances/situation did not arise where the hearing record contained evidence that would satisfy the old law but not the new law, we denied the motion to remand. Furthermore, because amended ORS 656.005(7) and the law in effect at the time of hearing required the same type of evidence, we found that such evidence was obtainable with due diligence.

Here, claimant's condition was medically stationary on December 10, 1993 and she has not sought treatment since that date. At the time of hearing, claimant was aware that proving an entitlement to an award of permanent disability was a means of reclassifying her claim as disabling.[4] OAR 436-30-045(7). She, however, chose not to present evidence on this question. Given claimant's explanation for her failure to obtain the evidence which she now seeks, we find that she has not established due diligence. Thus, like Clark, the lack of evidence is the result of a lack of due diligence rather than a change in the legal standard. See also, Diane E. Sullivan, 43 Van Natta 2791 (1991) (inadequate case preparation is insufficient to merit remand). Consequently, we deny the motion to remand.

On December 9, 1993, Dr. Dugoni reported that claimant was able to return to work with no restrictions, other than to wear an eye patch for 24 hours. (Ex. 1-5). Dr. Chestler declared claimant medically stationary on December 10, 1993 and released her to regular work without restrictions. (Ex. 1A).

Under the circumstances, we conclude that the medical evidence fails to establish that claimant's left eye injury has resulted in permanent impairment. If there is no measurable impairment, no award of permanent impairment shall be allowed. OAR 436-35-270. Claimant's testimony that her pain affected her ability to work is insufficient to establish impairment under the standards. OAR 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991). Thus, we conclude that, under the standards, claimant will not be entitled to a permanent disability award and that there is no reasonable expectation that permanent disability will result from the injury. Claimant, therefore, is not entitled to reclassification of her claim. Accordingly, claimant's claim shall remain classified as "nondisabling."

ORDER

The ALJ's order dated April 10, 1995 is affirmed.

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[4] Amended ORS 656.005(7)(c) requires claimant to prove a reasonable expectation that permanent disability will result from the injury. Claimant argues that the law at the time of hearing required proving that there was a "substantial likelihood" that she would be entitled to a permanent disability award. Claimant, thus, contends that, because the "substantial likelihood" standard is a higher standard, she should be allowed to present evidence under the lesser "reasonable expectation" standard in the amended statute. However, because claimant was medically stationary, the substantial likelihood standard under the Director's rule which existed at the time of the hearing is inapplicable. Rather, claimant would have had to show that she would be entitled to a permanent disability award under the standards. OAR 436-60-045(7)(b). Therefore, if claimant is not entitled to permanent disability under the standards, there can be no reasonable expectation that permanent disability will result from the injury for purposes of the then-applicable Director's rule.

In the Matter of the Compensation of
BECKY M. STILES, Claimant
WCB Case Nos. 95-06738 & 95-05062
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that: (1) set aside SAIF's disclaimers and denial of claimant's left wrist condition; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) disclaimer and denial of the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the first finding of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Concluding that claimant first sought treatment for her left carpal tunnel syndrome (CTS) in December 1994, while SAIF was on the risk, the ALJ assigned responsibility for the claim to SAIF. SAIF asserts that, because claimant first sought treatment for left CTS in January 1994, when Liberty was on the risk, Liberty is responsible for the claim. We agree.

Claimant worked for Liberty's insured from July 1993 through September 19, 1994, and for SAIF's insured from September 22, 1994 forward.

On January 7, 1994, claimant consulted Dr. Buchanan, treating physician, for bilateral wrist problems. Buchanan reported that claimant had "develop[ed] some problems of carpal tunnel symptoms to the left wrist and hand," and that she had had surgery for right CTS. (Ex. 3-7; emphasis added). Buchanan prescribed Ibuprofen and Mellaril. (Id.) Claimant returned to Buchanan in February 1994 for continued left wrist symptoms. (Id.) In March 1994, Dr. Buchanan suggested that claimant might be developing left wrist tendinitis. (Id. at 9).

On December 9, 1994, claimant returned to Dr. Buchanan, who diagnosed "flare-up of both wrists," and prescribed a night splint and medication. (Ex. 4-1). Buchanan thereafter diagnosed probable CTS. (Id. at 2, -3). The diagnosis was confirmed by electrodiagnostic studies. (Ex. 6).

In February 1995, claimant consulted Dr. Filarski. Filarski noted that claimant initially had left wrist symptoms in February 1994, but that claimant did "not recognize having overt symptoms of CTS at that time but rather this only beginning in 1/95." (Ex. 9-2).

Dr. Jewell examined claimant on SAIF's behalf. Jewell reported that claimant first sought medical care for her left wrist in January 1995. (Exs. 14-2, -3, 16-1).

In May 1995, Dr. Buchanan reported that claimant began to complain of left wrist and arm problems on December 9, 1994. (Ex. 17A-1). Buchanan later reported that the major cause of claimant's exacerbated left wrist symptoms was her work with SAIF's insured, and that the "very minimal" left wrist symptoms of which claimant complained in January and February 1994 did not constitute left CTS. Rather, in view of the minimal nature of the 1994 symptoms and the prompt resolution of those symptoms without further testing, Buchanan believed that claimant's 1994 symptoms were "easily compatible with a mild strain or tendinitis," not left CTS. (Ex. 21-1).

Thereafter, Dr. Filarski noted that claimant's left wrist condition was not definitively diagnosed as CTS until January 1995. (Ex. 22-2).

The last injurious exposure rule provides that where, as here, a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). If a claimant receives treatment for a compensable condition before experiencing time loss due to the condition, the date the claimant first received treatment related to the compensable condition is determinative for the purpose of assigning initial responsibility for the claim, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994). The dispositive date is the date that the claimant first sought treatment for symptoms, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

On this record, we find that claimant first sought treatment for left CTS in January 1994. On January 7, 1994, Dr. Buchanan examined claimant to evaluate her wrist symptoms; Buchanan reported that claimant had developed left "carpal tunnel symptoms," and prescribed medication. (Ex. 3-7). That consultation was the triggering event for the onset of disability. See Norman L. Selthon, 45 Van Natta 2358, 2359 (1993) (examination to evaluate claimant's condition was triggering event for the onset of disability).

We are not persuaded by Dr. Buchanan's 1995 reports stating that claimant first sought care for left CTS in December 1994 and that claimant's January 1994 left wrist symptoms were a manifestation of a mild strain or tendinitis. Those reports amount to a post hoc revision of the plain language of Dr. Buchanan's January 1994 report. Moreover, Buchanan's 1995 analysis focused on the cause of claimant's left CTS. Because the issue here is responsibility, not compensability, that analysis is entitled to less weight.

Finally, we do not rely on Dr. Filarski's reports regarding the onset of claimant's left CTS. Filarski's initial report restates claimant's belief regarding the onset of her left CTS. Because this is a medically complex case, we do not rely on lay opinions, or medical reports based on such opinions, to establish the onset of disability. Therefore, we discount Filarski's initial report. We also discount Dr. Filarski's later report stating that claimant's left CTS was not definitely diagnosed until January 1995. The dispositive date is the date claimant first sought treatment for left CTS symptoms, even if that condition was not diagnosed until later. SAIF v. Kelly, 130 Or App at 188.

Here, we rely on a plain reading of Dr. Buchanan's January 7, 1994 report to conclude that claimant first sought treatment for left CTS symptoms in January 1994, when Liberty was on the risk. That conclusion finds support in Dr. Jewell's opinions to the same effect.

Having concluded that claimant first sought treatment for left CTS when Liberty was on the risk, we will initially assign responsibility to Liberty. Liberty can shift responsibility to SAIF, the later carrier, by showing that the later employer actually contributed to a worsening of claimant's left CTS. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992).

Liberty asserts that a July 1995 report from Dr. Filarski establishes that claimant's work for SAIF's insured independently worsened her left CTS. We disagree.

The report on which Liberty relies is a concurrence letter that its counsel authored. In the letter, counsel asked, assuming claimant had worked for SAIF's insured from September 1994 through at least March 1995 and performed fairly intensive hand work and that her prior work made some contribution to her left CTS, "was claimant's work at [SAIF's insured] the major cause of a pathological worsening of the carpal tunnel disease?" (Ex. 23). Dr. Filarski responded, without any explanation, "Yes." Counsel also stated, "If your response to the question above was 'yes' please describe the pathology that was caused by claimant's work with [SAIF's insured] and offer any analysis you think appropriate." (Id.) Filarski responded, "Carpal canal inflammation with median nerve compression." (Id.)

Dr. Filarski's report is insufficient to establish that claimant's work for SAIF's insured contributed independently to the cause or worsening of the left CTS. Although Filarski agrees that that work caused a pathological worsening of claimant's left CTS, Filarski offers no explanation for that

agreement. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (rejecting conclusory medical opinion). His identification of a specific pathological process, and his assumptions regarding claimant's work activities, do not provide a sufficient explanation regarding why Filarski believes that claimant's work for SAIF's insured, as compared to her earlier employment, pathologically worsened the left CTS. For these reasons, we conclude that Dr. Filarski's report fails to establish that claimant's work for SAIF's insured contributed independently to the cause or worsening of her left CTS. Because Liberty has failed to establish that claimant's work activities with SAIF's insured actually contributed to a worsening of claimant's left CTS, Liberty remains responsible for that condition.

ORDER

The ALJ's order dated August 21, 1995 is reversed. Liberty Northwest's Insurance Corporation's disclaimer and denial is set aside and the claim is remanded to Liberty for processing according to law. Liberty is responsible for the ALJ's attorney fee award. SAIF's disclaimers and denial are reinstated and upheld in their entirety.

February 22, 1996 Cite as 48 Van Natta 441 (1996)

In the Matter of the Compensation of
DANELL L. SWEISBERGER, Claimant
WCB Case No. 93-07843
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) declined to award an assessed attorney fee under ORS 656.382(1) for the insurer's allegedly unreasonable delay in determining claimant's eligibility for vocational assistance; (2) affirmed a Director's order finding that claimant is not eligible for vocational assistance; and (3) directed claimant's attorney to recover the "out-of-compensation" attorney fee arising out of an increased temporary total disability award from claimant. On review, the issues are jurisdiction and vocational assistance, penalties and attorney fees. We vacate in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

At hearing before ALJ Herman, claimant sought: (1) a penalty for the insurer's allegedly unreasonable delay in determining her eligibility for vocational assistance for the period of March 10, 1992 through December 9, 1992; (2) an assessed attorney fee in connection with a July 9, 1993 Director's Order which directed the insurer to implement an on-the-job evaluation of claimant; and (3) review of a November 29, 1994 Director's Order which found that she was no longer eligible for vocational assistance.

At the same hearing, the parties also stipulated to correct an error in claimant's October 25, 1994 "post-training program" Determination Order, which awarded claimant temporary total disability compensation through September 24, 1993 rather than September 24, 1994, and claimant sought an approved attorney fee based on the increased time loss award.

The ALJ declined to award a penalty for the insurer's allegedly unreasonable delay in providing vocational assistance to claimant, but awarded an assessed fee under ORS 656.382(1) in the amount of $1,000 based upon the insurer's unreasonable resistance to implementing an authorized training program for claimant following the Director's July 9, 1993 Order.

The ALJ also affirmed the Director's November 29, 1994 Order terminating claimant's vocational assistance, modified the October 25, 1994 Determination Order to award additional temporary disability for the period of September 13, 1993 through September 24, 1994, and awarded claimant's counsel an "out-of-compensation" attorney fee based upon the increased temporary disability award. Relying on the insurer's representation that the additional temporary disability award had been paid, the ALJ directed claimant's attorney to recover his "out-of-compensation" attorney fee from claimant in the manner prescribed in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1016 (1994), aff'd, Volk v. America West Airlines, 135 Or App 565 (1995).

On review, claimant challenges three aspects of the ALJ's order. Claimant contends that she is entitled to a penalty-related attorney fee for the insurer's allegedly unreasonable delay in determining her eligibility for vocational assistance. Claimant also argues that, notwithstanding the SB 369 amendments to ORS 656.283(2), the Board retains jurisdiction to resolve this vocational assistance dispute, and that she is entitled to job placement assistance. Finally, claimant contends that Jane A. Volk, supra, was improperly decided and that her attorney is entitled to be paid the approved fee directly from the insurer.

Jurisdiction and Vocational Assistance

ORS 656.283(2)(c) was amended by Or Laws 1995, ch 332, § 34(2) (SB 369, § 34(2)), and now provides, among other things, that when the Director issues an order regarding vocational assistance after administrative review of the matter, "the order shall be subject to review only by the director." (Emphasis added). We held in Ross M. Enyart, 47 Van Natta 1540 (1995), that the legislature expressly intended that this provision apply retroactively and that the Director now has exclusive jurisdiction over all vocational assistance disputes, including those presently pending before the Board. See also Robert B. Enders, 47 Van Natta 1651 (1995).

Because neither the Hearings Division nor the Board has jurisdiction to review the Director's order terminating claimant's entitlement to vocational services, we vacate that portion of the ALJ's order that affirmed the Director's November 29, 1994 order.

On review, claimant challenges the retroactive application of amended ORS 656.283(2) on several grounds. First, claimant argues that retroactive application of the amended statute will lead to an absurd or unjust result because the Act does not extend the procedural time limit in which he may seek a contested case hearing before the Director. Claimant also contends that retroactive application of the new law violates Article I, Section 10 of the Oregon Constitution, because it deprives him of any remedy at all. We reject both of these arguments.

We held in Ross M. Enyart, supra, that because the legislature has explicitly authorized the Director to address vocational assistance disputes, the question of whether a request for Director review is timely rests with the Director and not this forum. In this regard, we note that on August 18, 1995, the Director adopted temporary OAR 436-01-015 which pertains to hearing requests filed with the Director which were previously filed with the Board or Hearings Division under former law. In light of such circumstances, we conclude that retroactive application of amended ORS 656.283(2) will not lead to injustice or deprive claimant of a forum to resolve the vocational assistance dispute. See also Liberty Northwest Ins. Corp. v. Yon, 137 Or App 413 (1995) (retroactive application of ORS 656.245, 656.327 and 656.704 does not violate due process; new law eliminated the claimant's choice to have medical services dispute resolved by Board, but did not deny him opportunity to have claim reviewed); Kathleen M. Butler 47 Van Natta 2202 (1995) (no constitutional impediment to the retroactive application of ORS 656.260(6), which gives the Director exclusive jurisdiction over managed care organization disputes).

Claimant also contends that even if none of the exceptions to retroactive application set forth in section 66 of SB 369 are applicable, amended ORS 656.283(2)(c) creates its own specific exception where it states that "[w]hen the director issues an order after review under paragraph (b) of this subsection, the order shall be subject to review only by the director." Claimant argues that because the Director's jurisdiction extends only to orders issued "under paragraph (b)" of amended 656.283(2), a paragraph that did not exist prior to the enactment of SB 369, the legislature intended that the Hearings Division and Board retain jurisdiction to resolve vocational assistance disputes litigated under the predecessor statute. We disagree.

While we acknowledge that the Director's orders in this case were issued pursuant to former ORS 656.283 and not under paragraph (b) of amended ORS 656.283(2), we do not construe the text of amended 656.283(2)(c) as creating a "specific exception" to the Director's exclusive jurisdiction over vocational services disputes in those cases where the Director's administrative order predated the enactment of SB 369. On the contrary, we conclude, given the text and context of the amended statute, that the Director's exclusive jurisdiction over vocational assistance matters extends to review of administrative orders issued under the predecessor statute as well as orders issued under paragraph (b) of the amended statute.[1] See Ross M. Enyart, supra; Robert B. Enders, supra.

Both the former and amended vocational assistance statutes provide for limited review of administrative orders issued by the Director. Under the old law, a party dissatisfied with an administrative order was entitled to request a hearing before the Hearings Division. Former ORS 656.283(3). Under the new law, a dissatisfied party is entitled to a contested case hearing before the Director. Amended ORS 656.283(2)(c). We construe the subsection (2)(c) of the amended statute to divest the Board and Hearings Division of jurisdiction to review vocational assistance administrative orders issued by the Director in all pending and future cases, without exception.

Penalties and Assessed Attorney Fees

Because we lack jurisdiction over vocational assistance matters, we also lack the authority to consider penalty or attorney fee requests arising out of the insurer's processing of a vocational assistance claim. See Donald D. Paul, 47 Van Natta 1946 (1995); see also SB 369, § 42(d)(5). Accordingly, we vacate that portion of the ALJ's order which awarded an assessed attorney fee under ORS 656.382(1) based on the insurer's allegedly unreasonable resistance to providing appropriate vocational services. We also do not consider claimant's request for a penalty-related attorney fee based on the insurer's allegedly unreasonable delay in determining her eligibility for vocational assistance, and dismiss claimant's hearing request insofar as it pertains to these penalty and attorney fee issues.

"Out-of-Compensation" Attorney Fee

We adopt and affirm that portion of the ALJ's order directing claimant's counsel to recover the "out-of-compensation" attorney fee from claimant in the manner prescribed by Jane A. Volk, supra.

ORDER

The ALJ's order dated June 6, 1995 is vacated in part and affirmed in part. Those portions of the order that awarded an assessed attorney fee of $1,000 pursuant to ORS 656.382(1) and affirmed the Director's November 29, 1994 vocational assistance order are vacated. Claimant's hearing request is dismissed insofar as it pertains to vocational assistance matters and related penalties and attorney fees. The remainder of the order is affirmed.

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[1] For example, the first sentence of amended ORS 656.283(2)(c) provides: "Director approval of an agreement resolving a vocational assistance matter shall be subject to reconsideration by the director under limitations prescribed by the director, but shall not be subject to review by any other forum." This language supports our determination that the legislature intended, without exception, to divest the Board and Hearings Division of jurisdiction over all vocational assistance matters.

In the Matter of the Compensation of
ELSA S. WONG, Claimant
WCB Case Nos. 95-03769 & 94-14073
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Mills' order which: (1) set aside its alleged "back-up" denials of claimant's injury/occupational disease claim for a left upper extremity condition; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are the propriety of the employer's denials 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

In May 1994, claimant developed right arm and shoulder pain while operating a 10-key pad as a "proof operator." The employer's previous processing agent, Sedgwick James, accepted the claim in July 1994 for right biceps tendonitis based on the diagnosis provided by claimant's then-attending physician, Dr. Minz. (Ex. 16).

On her return to regular work in July 1994, claimant began experiencing left upper extremity pain, prompting her to file a claim on July 20, 1994 for her left finger and wrist complaints. Claimant began treating with Dr. Takacs, who diagnosed fibrositis and poor job satisfaction. (Ex.21). Dr. Takacs noted that psychological and social factors were playing a role in claimant's complaints.

Claimant's physical condition was eventually evaluated by examining physicians, Drs. Fuller and Reimer, in August 1994. (Ex. 30). They reported diffuse complaints in claimant' wrists, shoulders and elbows. Noting some non-organic findings on examination, the panel diagnosed subjective non-verifiable pain due to psychosocial factors. When claimant returned to Dr. Takacs, she diagnosed somatic preoccupation. (Ex. 31).

On September 21, 1994, Sedgwick James sent claimant a denial letter. In the letter, Sedgwick James acknowledged receipt of a claim for "left fingers, wrist and hand strain." However, Sedgwick James wrote that the medical evidence indicated that there was no new injury, but rather a "continuation" of the accepted May 1994 right biceps tendonitis claim. Stating that it was denying claimant's "claim," Sedgwick James advised claimant that all benefits relating to the claim would be processed off the May 1994 claim. (Ex. 37).

Claimant eventually ceased treatment with Dr. Takacs and sought care from Dr. Brower, who also referred claimant to Dr. Layman for an evaluation of claimant's symptomatology. Medical evidence from Drs. Brower and Layman indicated that claimant's condition was primarily subjective, although both suspected that an "overuse" syndrome might be present. (Exs. 42, 48).

On January 1, 1995, a new processing agent, Helmsman Northwest, began administering the employer's workers' compensation claims. On January 25, 1995, the new processor issued a partial denial of a "consequential condition," consisting of claimant's "left shoulder, left wrist, left fingers, and left hand," on the ground that neither claimant's compensable May 1994 injury nor her work activities were the major contributing cause of her need for treatment or disability. (Ex. 52). That same day, Helmsman denied the compensability of those same body parts on the ground that they did not arise out of and in the course of her employment. (Ex. 53).

Claimant requested a hearing appealing both of Helmsman's January 25, 1995 denials. Claimant also sought penalties and attorney fees, alleging that both denials were unreasonable "back-up" denials.

The ALJ found that the employer had accepted the conditions listed in its September 21, 1994 denial letter and set aside the employer's January 25, 1995 denials as invalid "back-up" denials because they were not based on "later obtained evidence" that those conditions were not compensable. See CNA Insurance Companies v. Magnuson, 119 Or App 282 (1993). Moreover, the ALJ concluded that the January 1995 denials were unreasonably issued. The ALJ, thus, assessed a 25 percent penalty on all compensation made payable by his order.

On review, the employer contends the ALJ erred in: (1) determining that the employer's September 21, 1995 denial was also an acceptance of the left upper extremity condition listed in the letter; (2) concluding that the January 1995 denials were invalid "back-up" denials ; and (3), assuming that the denials were invalid, finding that the denials were not based on "later obtained evidence." We disagree.

We adopt and affirm the ALJ's reasoning that the employer had accepted claimant's left upper extremity condition listed in the September 21, 1994 letter as a "continuation" of the compensable May 1994 injury. Although the meaning of the September 21, 1994 letter is not free from doubt, we construe any ambiguity against the employer, whose processing agent drafted the document. Cf. Nationwide Mut. Ins. Co. v. Williams, 55 Or App 442, 446, rev den 292 Or 825 (1982) (construe ambiguous terms in the insurance contract against the drafter); see also Tattoo v. Barrett Business Service, 118 Or App 348, 351 (1993) (employers are bound by the express language of their denials). We, therefore, agree that the denials issued on January 25, 1995 constituted "back-up" denials of the condition accepted in September 1994 letter. Moreover, we concur with the ALJ's analysis that the January 1995 denials were invalid "back-up" denials under ORS 656.262(6)(a) because they were not based on "later obtained evidence."[1] CNA Insurance Companies v. Magnuson, supra.

However, we take issue with one aspect of the ALJ's order. One body part listed in the January 25, 1995 denials was not mentioned in the employer's September 21, 1994 letter, which we have determined to be an acceptance of the condition listed therein. That body part is claimant's left shoulder. Inasmuch as this body part was never accepted by the employer in its September 21, 1994 letter, the January 25, 1995 denials were valid with respect to that component of claimant's left upper extremity condition. Moreover, because the record does not establish that claimant's left shoulder complaints are related in material or major part to her compensable right biceps tendonitis claim or to her work activities, we do not find this component of claimant's left upper extremity condition to be compensable. Accordingly, we uphold the employer's denials to the extent that they deny the compensability of claimant's left shoulder complaints.

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 concerning the "back-up" denial issue is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

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[1] The employer argues that, even if the September 21, 1994 denial was an acceptance of a consequential condition related to the compensable May 1994 claim, the January 25, 1995 denial of a consequential condition should be upheld pursuant to ORS 656.262(6)(c). That provision allows an employer to deny a consequential condition if the otherwise compensable injury "ceases" to be the major contributing cause of the consequential condition. We disagree with the employer that this provision is applicable. Assuming but not deciding that claimant's left upper extremity condition is a "consequential condition," for ORS 656.262(6)(c) to apply, the compensable injury must "cease" to be the major contributing cause of claimant's consequential condition. The word "cease" implies that there must be a change in claimant's condition or a change of circumstances such that the compensable injury is no longer the major contributing cause of claimant's condition. Here, the dispute is not about a change in condition or circumstances. Rather, the employer contends that claimant's left upper extremity condition has never been compensable. Inasmuch as that is a basis for a "back-up" denial under ORS 656.262(6)(a), rather than a "ceases" denial under ORS 656.262(6)(c), we do not find the latter statutory provision to be applicable.

ORDER

The ALJ's order dated July 19, 1995 is affirmed in part and reversed in part. That portion of the ALJ's order which set aside the employer's denial of the left shoulder component of claimant's left upper extremity condition is reversed. The employer's denials are reinstated and upheld to the extent that they deny compensability of the left shoulder component of claimant's left upper extremity condition. The remainder of the ALJ's order is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1,000, payable by the employer.

February 23, 1996 Cite as 48 Van Natta 446 (1996)

In the Matter of the Compensation of
ROBERT A. McMAINS, Claimant
WCB Case No. 95-04456
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our February 12, 1996 Order on Review that reversed that portion of an Administrative Law Judge's (ALJ's) order which assessed SAIF a penalty for unreasonable delay in the payment of compensation.

On reconsideration, SAIF contends that the ALJ incorrectly assessed a penalty for allegedly miscalculating claimant's rate of temporary disability benefits. Specifically, SAIF asserts that it correctly calculated claimant's temporary disability based on his weekly earnings for the 52 weeks prior to his injury. OAR 436-60-025(5)(a). In his reply brief claimant conceded that the ALJ erred in assessing SAIF a penalty for allegedly miscalculating claimant's temporary disability.

After considering SAIF's request, and in light of claimant's concession, we modify our prior order. In other words, we reverse that portion of the ALJ's order which assessed SAIF a penalty for allegedly miscalculating claimant's temporary disability.

Accordingly, on reconsideration, as modified herein, we republish our February 12, 1996 order, effective this date. 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
RUBEN JUAREZ, Claimant
WCB Case No. 94-10688
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that upheld the SAIF Corporation's denial of claimant's current low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

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

Claimant compensably injured his low back in October 1986 while moving heavy boxes. He was declared medically stationary as of December 6, 1988, and awarded 38 percent unscheduled permanent disability. His unscheduled permanent disability award was subsequently increased to 58 percent by a stipulated order entered June 13, 1989.

Claimant continued to obtain treatment for low back pain through March 1991. In April 1992, SAIF rescinded its approval of palliative care (medication) because claimant was not working. Claimant did not appeal this denial, and did not seek further treatment for his low back until May 1994.

On May 4, 1994, claimant went to the emergency room complaining of an acute onset of back pain while walking in his yard. Although he had been employed in some light duty jobs during 1993 and 1994, claimant was not working at the time of this onset of pain. Claimant saw Dr. Stearns, who diagnosed an "acute lumbar strain with a history of chronic back pain."

SAIF denied the compensability of claimant's current low back condition and medical treatment, contending that his October 1986 injury was not the major contributing cause of his current need for treatment.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to establish that his compensable injury was the major contributing cause of his current condition. The ALJ relied on the opinion of Dr. Stearns (the only physician to address the causation of claimant's current condition), who reported that claimant's current low back problems related more to his recent activities than to his 1986 injury, although that injury was a contributing factor.

On review, claimant argues that the ALJ applied the wrong legal standard. Specifically, claimant contends that the proper test is the material cause standard set forth in amended ORS 656.245(1)(a) because this claim involves only the compensability of medical treatments rendered since May of 1994.[1] Claimant further contends that Dr. Stearns' opinion establishes that his accepted 1986 injury is a material contributing factor to his current need for treatment.

SAIF responds that claimant should be precluded from reframing the case as merely a medical services dispute where he argued the compensability of his current condition at hearing and did not assert application of amended ORS 656.245(1)(a) and the material cause standard until his reply closing argument.[2] SAIF also argues that even if claimant had properly raised the medical services issue, the

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[1] We retain jurisdiction under amended ORS 656.245(6) to determine whether medical treatment for claimant's current condition is causally related to his compensable injury. See Richard L. Wheeler, 47 Van Natta 2011 (1995).

[2] Claimant's request for hearing listed the issues as "compensability," "penalty" and "attorney fees" and omitted any reference to medical services.

ALJ properly applied the major cause standard under amended ORS 656.245(1) because claimant is seeking compensation for a consequential condition of his compensable injury.[3]

Putting aside the question of whether claimant may "reframe" the nature of the compensability dispute on review,[4] we agree with SAIF that the ALJ properly applied the major contributing cause standard in this case. Under amended ORS 656.245(1), we apply the material cause standard when a claimant seeks continued treatment for the same injury or condition accepted by the carrier. See, e.g., Beck v. James River Corp., 124 Or App 484 (1993). When the treatment is directed to a new injury or a condition different from an already accepted claim, however, we must make an initial determination of the compensability of that underlying condition under ORS 656.005(7)(a). Id; Robert F. Shelton, 48 Van Natta 133 (1996); David L. Dodson, 47 Van Natta 1523 (1995). When that new or different condition is a consequential or combined condition (see ORS 656.005(7)(a)(A) and (B)), the claimant must establish that the need for treatment is caused in major part by the original accepted injury. Amended ORS 656.245(1); Shelton, supra; Dodson, supra.

In this case, the record fails to establish that claimant's medical treatments in May of 1994 were directed to the same injury or condition accepted by SAIF in 1986. According to Dr. Stearns, the only physician to address the nature and cause of claimant's current condition, claimant sustained an acute lumbar strain in 1994. That acute condition came about as a result of claimant's 1986 compensable injury, degenerative changes in his back subsequent to that injury, and his current activities. (Exs. 23, 27-23). Based on this assessment, we find that claimant sought treatment in May of 1994 for a condition different from the low back injury accepted by SAIF in 1986. We further find that ORS 656.005(7)(a)(A) is applicable because claimant's current condition results from a number of factors and not directly from claimant's 1986 accident. Since the record does not support a finding that claimant's medical treatments subsequent to May 4, 1994 were directed to a condition caused in major part by his accepted 1986 injury, we uphold SAIF's denial. See ORS 656.005 (7)(a)(A); amended ORS 656.245 (1).

ORDER

The ALJ's order dated July 28, 1995 is affirmed.

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[3] Amended ORS 656.245(1)(a) provides: "For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of recovery requires, subject to the limitations in section 3 of this 1995 Act, including such medical services as may be required after a determination of permanent disability. In addition, for consequential and combined conditions described in ORS 656.005(7), the insurer or self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury." (emphasis added).

[4] SAIF is correct that we will generally not consider an issue raised for the first time during closing argument. Larry L. Schutte, 45 Van Natta 2085 (1993); Leslie Thomas, 44 Van Natta 200 (1992). Assuming (without deciding), however, that claimant's position is merely a different theory of compensability, rather than a separate issue, we find no prejudice to SAIF by considering this late-raised argument on review, particularly because we are persuaded by the record that the ALJ applied the proper legal standard in any event.

February 15, 1996 Cite as 48 Van Natta 448 (1996)

In the Matter of the Compensation of
BILL L. MARTIN, Claimant
Own Motion No. 94-0615M
THIRD OWN MOTION ORDER ON RECONSIDERATION
Bruce D. Smith, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our December 28, 1994 Own Motion Order, as reconsidered on January 20, 1995 (postponing) and January 11, 1996, in which we declined to reopen his 1989 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery or hospitalization.

On January 29, 1996, we abated our order, and allowed the SAIF Corporation 14 days in which to file a response to the motion. We have received SAIF's response, and proceed with the reconsideration.

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

As noted in our prior order, we find that claimant's compensable condition has worsened requiring surgery.

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

SAIF contends that claimant was not in the work force at the time of the current disability. Claimant has not worked since 1991, although he attested in his affidavit that he received unemployment compensation until early 1992. Claimant also stated (but submitted no corroborating evidence) that he looked for work until mid-1993. From mid-1993 until his compensable injury worsened requiring surgery, claimant contends that he was willing to work, but unable to work due to the compensable injury.

In our prior order, we concluded that, although claimant has established his willingness to work, he has not established that he has been unable to work due to the compensable injury. In his January 23, 1996 Motion for Reconsideration, claimant contends that:

> "There is nothing in the record to suggest that [claimant's] back condition or any other noncompensable condition had prevented him from working before his right shoulder injury at Elcor Door. On this record, it is reasonable to conclude that the claimant's compensable right shoulder rotator cuff tear has made it futile for him to seek work."

We disagree.

In our prior order, we noted that the record established that claimant had sustained several noncompensable injuries over the years. In claimant's January 11, 1995 sworn statement, he stated that: "I believe that disclosure of my physical disabilities (I have injuries to my knees and back, in addition to the compensable injury) probably played a part in my being unable to obtain employment." Further, in a December 1, 1994 Independent Medical Examination (IME), Dr. Donahoo, examining claimant at SAIF's request, noted that:

> "For the past 1-1/2 years, [claimant] has been using his cane due to the chronic right knee problem,, and has been seeing a general practitioner in Grants Pass, Dr. Abdul Nur, for his knee...
>
> "The [claimant] presents with a cane today, he is in the midst of a Social Security disability hearing/appeal, and has had multiple injuries in the past, having been off work for over two years with his back ..."

Finally, in his May 12, 1994 medical report, Dr. Appleby, claimant's treating physician, noted three problems for which claimant sought medical treatment: (1) residual right shoulder rotator cuff tear (which was ultimately found compensable); (2) residual left shoulder subacromial pain; and (3) residual right elbow lateral epicondylitis. Claimant's left shoulder and right elbow are not compensable conditions.

Although claimant contends that only his compensable right shoulder injury has made it futile for him to seek work, the record does not support that contention. Here, claimant acknowledges that his noncompensable injuries have "played a part in my being unable to obtain employment." In addition, he was still using a cane for his noncompensable right knee condition in December 1994, and apparently had been using the cane for over one year. Thus, although we agree that his compensable right shoulder condition has contributed, in part, to his inability to work, we are not persuaded that claimant has been unable to work due to the compensable injury since 1993.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our December 28, 1994 order, as reconsidered on January 20, 1995 and January 11, 1996, in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

February 15, 1996 Cite as 48 Van Natta 450 (1996)

In the Matter of the Compensation of
PATRICIA VOGT, Claimant
Own Motion No. 96-0017M
OWN MOTION ORDER OF DISMISSAL
Peter E. Baer, Claimant Attorney
VavRosky, et al, Defense Attorney

Claimant has requested that the Board exercise its own motion authority pursuant to ORS 656.278 and find her current condition compensable to her 1987 injury claim. In the alternative, claimant requests that "the case be reopened for further testimony." The Board finds that it lacks jurisdiction to grant claimant's requests.

FINDINGS OF FACT

Claimant filed an industrial injury claim allegedly on July 16, 1987, while working for the self-insured employer, Multnomah County School District. The employer denied the claim. Claimant requested a hearing with the Hearings Division on that denial. On April 3, 1989, Administrative Law Judge (ALJ) Mulder issued an opinion and order in which he found that claimant had not incurred a compensable injury. Claimant requested Board review of the April 3, 1989 Opinion and Order, and, on May 24, 1990, the Board affirmed the ALJ's order. On February 26, 1992, the Court of Appeals affirmed the Board order without opinion. See Vogt v. Multnomah County School District No. 1, 111 Or App 666, rev den 313 Or 355(1992).

On December 27, 1995, claimant requested Director review of her claim, citing that the request was concerning "ORS 656.278 Board's own motion to reopen case for perjury testimony & need for surgery at C6-7."

On January 8, 1996, claimant directed a letter to the Workers' Compensation Board "Office of Hearings and Appeals." Claimant requested that the Board reopen claimant's claim under its own motion authority, or, in the alternative, reopen the record for admission of further testimony. The Board forwarded the request to the employer for consideration, and to the Hearings Division.

In a January 19, 1996 letter to Virgil Osborn, Special Assistant Attorney General at the Workers' Compensation Division, the employer requested clarification with respect to claimant's request for contested case review.

In a January 23, 1996 letter, Mr. Osborn returned claimant's request for Director review, stating that "the Director does not deal with compensability issues, and as such, all those matters must be taken care of at the Board. To the extent this matter has been litigated to finality it appears further action is inappropriate, but that issue is for the Board to decide."

CONCLUSIONS OF LAW

The Board may, upon its own motion, modify, change or terminate former findings, orders or awards if in its opinion such action is justified. ORS 656.278(1). This authority extends to those accepted claims for which claimant's aggravation rights have expired under ORS 656.273. In addition, this authority is limited to those cases in which there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. The Board is not authorized to modify, change or terminate former findings or orders that a claimant incurred no injury or incurred a noncompensable injury. Amended ORS 656,278(6)(a).

As noted above, the Board's own motion authority extends only to cases in which there is a claim for worsening of an accepted injury, where claimant's aggravation rights have expired. Here, claimant's claim was initially denied. Although claimant appealed that denial, subsequent litigation has failed to set aside the employer's denial of her claim. The results of the litigation are final. Therefore, claimant has failed to perfect a compensable injury claim under workers' compensation law, as the claim remains denied. Were we to grant claimant's request to find her claim compensable, we would be modifying, changing, or terminating a former finding or order that claimant incurred no injury or incurred a noncompensable injury. Such an action would exceed our statutory authority. See amended ORS 656.278 (6)(a).

Thus, under ORS 656.278, we have no authority to grant any request pertaining to claimant's alleged 1987 injury claim. See ORS 656.278(1), (6)(a); Robert S. Neeland, 40 Van Natta 52 (1988); Arlene T. Fulkerson, 41 Van Natta 55 (1989).

Accordingly, we lack jurisdiction to consider claimant's request to reopen her 1987 claim for the payment of temporary disability compensation or to reopen the claim for admission of further testimony.

IT IS SO ORDERED.

February 23, 1996 Cite as 48 Van Natta 451 (1996)

In the Matter of the Compensation of
SYBIL A. ROANE, Claimant
WCB Case No. 95-03786
ORDER OF DISMISSAL
Malagon, Moore, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

The self-insured employer requested review of Administrative Law Judge (ALJ) Michael Johnson's order that awarded a $1,500 carrier-paid attorney fee under amended ORS 656.386(1). The parties have submitted a proposed "Stipulation and Order of Settlement," which is designed to resolve all issues raised or raisable between them, in lieu of the ALJ's order.

Pursuant to the stipulation, the parties agree that claimant shall receive $500 (less a $125 attorney fee). We interpret the agreement as a modification of the ALJ's attorney fee award from $1,500 to $125.[1] The stipulation further provides that the ALJ's order shall be "set aside" and "annulled." Finally, the parties agree that the request for Board review shall be dismissed.

We have approved the parties' stipulation, thereby fully and finally resolving this dispute, in lieu of the ALJ's order. Accordingly, this matter is dismissed.

IT IS SO ORDERED.

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[1] Inasmuch as the $375 payment to claimant is neither temporary or permanent disability compensation, it constitutes a gratuitous benefit in excess of the employer's statutory claim processing obligations. As such, it is a voluntary payment, which does not require our approval. See ORS 656.018(5). Nevertheless, to the extent that the parties agree that claimant's attorney shall receive $125 (rather than the $1,500 granted by the ALJ's order), such a stipulation represents a modification of the ALJ's order and does require our approval.

In the Matter of the Compensation of
ROCK A. DAVIS, Claimant
WCB Case No. C600315
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Malagon, et al, Claimant Attorneys
Employer Defense Counsel, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

On February 2, 1996, 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 the compensable injury. We approve the proposed disposition.

First, we note that, in response to our request, the parties submitted an addendum providing that each party waives the 30-day "cooling off" period. See ORS 656.236(1)(b); Jerry Nash, 47 Van Natta 1095 (1995). Moreover, the agreement provides the following:

> "Pursuant to ORS 236 [sic], in consideration of the payment of $3,755.48 by the insurer/employer, claimant releases his right to the following workers' compensation benefits: temporary disability, permanent disability, vocational rehabilitation, survivor's benefits, aggravation rights per ORS 656.278, and Own Motion rights per ORS 656.278. The insurer's/employer's obligation to provide these benefits is also released. Claimant agrees that [the insurer] may recover overpayments in the total sum of $116.38 out of this settlement sum, thereby leaving a total amount due to claimant of $3,639.10, before payment of attorney fees." (Emphasis added.)

Where an overpayment apparently has been made pursuant to claims processing obligations, that overpayment cannot qualify as "proceeds" of the parties' CDA. E.g., Ronald Smith, 47 Van Natta 38 (1995). Therefore, in this case, claimant's agreement to allow the insurer to recover its overpayment cannot be included in the consideration for the CDA.

The CDA otherwise provides as follows: $3,263.55 due to claimant and $375.55 due to claimant's attorney, totaling $3,639.10. Thus, based on this information and the previous discussion concerning the $116.38 overpayment, we interpret the CDA as providing that the total amount of the consideration is $3,639.10 (not $3,755.48 as listed in the disposition). No part of the stated overpayment is included in this figure.

Accordingly, we conclude that, as interpreted in this order, the CDA in this case is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. ORS 656.236(1); OAR 438-009-0020(1). Therefore, the parties' claim disposition agreement, as clarified, is approved. An attorney fee of $375.55, payable to claimant's counsel, also is approved.

IT IS SO ORDERED.

In the Matter of the Compensation of
KAREN HUDSON, Claimant
WCB Case No. 94-13996
SECOND ORDER DENYING RECONSIDERATION
Craine & Love, Claimant Attorneys
Schwabe, et al, Defense Attorneys
Anthony A. Allen, Attorney

Claimant requests reconsideration of our January 19, 1996 order.[1] In that order, we reversed an Administrative Law Judge's (ALJ's) order that had set aside the self insured employer's denial of claimant's injury claim for stress-related physical symptoms.

Claimant has petitioned the Court of Appeals for judicial review of our order. ORS 656.295(8). In addition, the 30 day period within which to withdraw and reconsider our order has expired. SAIF v. Fisher, 100 Or App 288 (1990). Thus, jurisdiction over this matter currently rests with the court. ORS 656.295(8); 656.298(1).

Nevertheless, at any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). However, this authority is rarely exercised. Ronald D. Chaffee, 39 Van Natta 1135 (1987). For the reasons which follow, we deny claimant's motion for reconsideration.

Claimant argues that we erroneously interpreted ORS 656.295(5) to require that evidence proffered post-hearing must be unobtainable at the time of hearing. We need not address that assertion because, even assuming that the "unobtainable" standard is not applicable to the Board's remand analysis under ORS 656.295(5), we conclude that the record was not "improperly, incompletely or otherwise insufficiently developed." In this regard, claimant has acknowledged that she could have pursued an occupational disease theory at hearing and chose not to do so. The choice not to pursue an occupational disease claim is claimant's to make. Although claimant now wishes to reconsider that decision as a result of the statutory changes, we do not find that claimant's tactical decision not to pursue her occupational disease claim constitutes a compelling reason to remand. Nothing prevented claimant from prosecuting her occupational disease claim at hearing. To the contrary, claimant expressly and unambiguously chose to withdraw that claim. Under these circumstances, we do not find the record incompletely or insufficiently developed and we find no compelling reason for remand.

This case is analogous to Clifford E. Clark, 47 Van Natta 2310 (1995). There, the claimant sought remand to introduce evidence concerning the potential for permanent disability in order to establish that his claim was disabling under amended ORS 656.005(7)(c). Under the law in effect at the time of hearing, a disabling claim could be established with evidence that a worker was released to modified work. The claimant chose this theory at the hearing. A disabling claim could also be established with evidence that a permanent disability award was likely. When the amended law foreclosed the claimant's argument under the "modified work" approach, he sought remand for further development of the "permanent disability" approach. Because a disabling claim could be established with evidence that a permanent disability award was likely under both the old and new law, we declined to remand.

In both Clark and the present case, amendments to the law foreclosed one avenue of establishing an entitlement to compensation, but other routes existed both at the time of hearing and after the statutory amendments. Those other avenues were not pursued for voluntary tactical reasons, but they were available both before and after the changes in the law. Given the availability of those other routes of establishing an entitlement to compensation and the voluntary choice not to pursue them, we do not find remand to be appropriate.

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[1] The motion is neither accompanied by an "association of counsel" or executed attorney retainer agreement documenting that the attorney who submitted the motion is now representing claimant's interests. In light of such circumstances, we are not inclined to consider the motion. Nevertheless, since the motion has been submitted on claimant's behalf and because we are not altering the ultimate conclusion reached in our prior decision, we have addressed the contentions presented in the motion.

Claimant next contends that her right to a remedy guaranteed by Article I, section 10, of the Oregon Constitution and her right to due process under the Fourteenth Amendment of the United States Constitution have been infringed by the retroactive application of amended ORS 656.802. We disagree.

As previously discussed, claimant had the option of pursuing her claim under either an injury or an occupational disease theory. Claimant elected, for strategical reasons, to pursue an injury claim and withdrew her occupational disease claim. She now wishes to re-assert an occupational disease claim and introduce evidence concerning that claim. Yet, claimant could have asserted an occupational disease claim and introduced evidence supporting that claim at hearing.

The denial of her request for remand is not an infringement of her right to a remedy or her right to challenge the employer's denial. Rather, claimant's choice to assert a claim for a stress-related physical condition under an injury theory and not to assert her claim under an occupational disease theory has resulted in her inability to obtain compensation. It is true that the standards for establishing a compensable injury/occupational disease claim for a stress-related condition have become more rigid under the 1995 amendments. Nevertheless, tougher standards for establishing a compensable claim do not necessarily equate with an infringement of the right to seek compensation or a denial of due process. Claimant has availed herself of her right to seek benefits under the Workers' Compensation Act. Unfortunately for claimant, under the applicable statutory standards, her claim does not satisfy the prerequisites for receiving compensation under the Act.

Accordingly, claimant's motion for reconsideration is denied. The issuance of this order neither "stays" our previous order nor extends the time for seeking review. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

February 23, 1996 Cite as 48 Van Natta 454 (1996)

In the Matter of the Compensation of
RONALD R. ZIMBELMAN, Deceased, Claimant
WCB Case Nos. 93-02973 & 93-02972
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

On January 25, 1996, we issued an Order on Remand which upheld the self-insured employer's denial of the deceased worker's myocardial infarction Asserting that legal and medical causation has been established, the decedent's widow seeks reconsideration of our decision and a finding that her deceased husband's claim is compensable.[1]

In order to further consider this matter, we withdraw our January 25, 1996 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

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[1] Since it is unclear whether a copy of claimant's submission has been provided to the other parties, copies of the motion have been included with the parties' attorneys' copies of this order.

In the Matter of the Compensation of
WILLIAM F. MACKEY, Claimant
WCB Case No. 93-03321
ORDER ON REMAND
Nancy F. A. Chapman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Mackey, 136 Or App 540 (1995). The court reversed and remanded our prior order for reconsideration in light of the Senate Bill 369. (SB 369).

In our prior order, we concluded that: (1) claimant's attorney was not entitled to an assessed fee pursuant to former ORS 656.386(1) for services rendered in obtaining the pre-hearing rescission of the SAIF Corporation's disclaimer of responsibility; (2) claimant's attorney was not entitled to an assessed fee pursuant to former ORS 656.382(1) for SAIF's unreasonable disclaimer of responsibility; and (3) claimant was entitled to a penalty pursuant to former ORS 656.262(10) for SAIF's unreasonable disclaimer of responsibility, with the penalty to be split equally between claimant and his attorney, in lieu of an attorney fee. William F. Mackey, 46 Van Natta 1431 (1994). On reconsideration, we withdraw our prior order and issue the following order.

FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) findings of fact with the exception of the first and second ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

Applicability of SB 369

In the absence of a specific exception, the changes to the Workers' Compensation Law made by SB 369 apply to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act (June 7, 1995). Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 569 (1995). Here, our prior order was appealed and the case has been remanded to us from the court. Because our order has not become final, SB 369 is applicable. Furthermore, there are no specific exceptions to retroactive application of the amendments to former ORS 656.262(10), 656.382(1), and 656.386(1), the statutes that are applicable to the attorney fee and penalty issues before us. Or Laws 1995, ch 332, § 66 (SB 369, § 66). Therefore, the amendments to those statutes apply to the present case.[1] SB 369, § 28, 42b, 43.

Attorney Fee for Rescission of the Disclaimer of Responsibility

We adhere to and republish the conclusions and reasoning contained in our July 5, 1994 order, with the following supplementation.

In our prior order, we concluded that claimant's attorney is not entitled to an assessed fee pursuant to former ORS 656.386(1). In reaching this conclusion, we applied Gamble v. Nelson International, 124 Or App 90 (1993), in which the court determined that a disclaimer of responsibility is not a denial, reasoning that a disclaimer serves only to notify the claimant that his or her claim may be compensable against another employer or insurer. Consequently, the court determined that the disclaimer neither triggered the provisions regarding a request for hearing under former ORS 656.319 nor provided a basis for an attorney fee award under former ORS 656.386(1) because the disclaimer did not create an issue concerning the compensability of the claim.

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[1] We note that former ORS 656.308(2), the statute that set forth the procedures regarding issuance of a disclaimer of responsibility, was repealed by section 37 of SB 369. However, because former ORS 656.308(2) involves procedural time limits, section 66 of SB 369 provides a specific exception to the retroactive application of the amendments to former ORS 656.308(2). Therefore, former ORS 656.308(2) applies to the present case. Motel 6 v. McMasters, 135 Or App 583 (1995) (retroactivity exception for procedural time limits applies to responsibility disclaimer/denial requirements of amended ORS 656.308(2); thus, the former law applies). That said, application of the former ORS 656.308(2) does not affect our decision regarding the attorney fee and penalty issues under the facts of this case.

Because we found that, under the facts of this case, SAIF's disclaimer was not a denial and did not create an issue concerning the compensability of claimant's low back claim, we determined that claimant's attorney was not entitled to an assessed attorney fee under former ORS 656.386(1).

SB 369 amended ORS 656.386(1) to provide, in part, that a reasonable attorney fee shall be allowed where an attorney is instrumental in obtaining a rescission of a denial in a denied claim prior to a decision by the ALJ. SB 369, § 43(1). In addition, amended ORS 656.386(1) defined "denied claim" as "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." Id.

Application of amended ORS 656.386(1) does not change the result in this case. Because we find that SAIF's disclaimer was not a denial and did not create an issue concerning the compensability of claimant's low back condition, it follows that claimant is not entitled to an assessed attorney fee under amended ORS 656.386(1), which requires those elements.

Attorney Fee for an Unreasonable Disclaimer of Responsibility

The ALJ determined that SAIF acted unreasonably in issuing the disclaimer of responsibility. However, because there were no amounts "then due" at the time of hearing upon which to base a penalty under former ORS 656.262(10), the ALJ awarded an assessed attorney fee pursuant to former ORS 656.382(1) for SAIF's unreasonable conduct. We need not address whether SAIF's issuance of the disclaimer of responsibility was unreasonable because, even if SAIF acted unreasonably in issuing the disclaimer, based on the following reasoning, we find that claimant is entitled to neither a penalty nor an attorney fee for SAIF's conduct.[2]

In 1979, claimant sustained a compensable injury with a prior employer which primarily injured his left elbow. (Exs. 1, 2, 3, 4). Subsequently, claimant became self-employed as a roofing contractor and purchased workers' compensation coverage through SAIF. Thereafter, claimant had a long history of work-related low back injuries, which were accepted by SAIF. (Exs. 7, 8, 13, 13A, 14B, 16, 23, 24). On January 21, 1993, claimant sustained another work-related low back injury while lifting a ladder. (Exs. 29A, 30). On March 2, 1993, SAIF issued a disclaimer of responsibility indicating that the 1979 injury may be responsible for claimant's current low back condition. (Ex. 34).

On March 30, 1993, less than 90 days after the employer had notice or knowledge of the claim, SAIF accepted the claim as a nondisabling lumbar strain. (Exs. 30, 40). Prior to the date of acceptance, claimant made no claim for any compensation other than medical services. (Exs. 42, 43A, 54). As for the medical services, the first medical bill was received by SAIF on March 8, 1993, and paid within 30 days. (Exs. 53-1, 54). All subsequent medical bills were also paid within 30 days. Id.

A penalty is assessable when a carrier unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim. Former ORS 656.262(10) (renumbered ORS 656.262(11)).[3] In determining whether a carrier's conduct is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of its conduct. Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988).

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[2] On remand, claimant asserts that the only issue before us on remand is the effect of Senate Bill 369 on our prior decision in this case. Claimant's assertion, however, is based on the incorrect assumption that our previous order is the "law of the case." Inasmuch as the court has reversed our previous order and remanded for reconsideration, our previous order is a nullity. See Dung T. Nguyen, 44 Van Natta 477 (1992) (order on remand reached different conclusions than order on review); Nancy C. Evenhus, 42 Van Natta 2625 (1990) (since court had remanded for the Board to review remaining issues raised by the denial, no finding within an order had yet become final in the matter).

[3] The only change made by SB 369 to former ORS 656.262(10) was to renumber the statute as ORS 656.262(11). SB 369, § 28(11). This renumbering was effective June 7, 1995. SB 369, § 28, 66. Accordingly, we apply the new number in this case.

Even if we found SAIF's disclaimer of responsibility was unreasonable, no penalty or attorney fee is due under the facts of this case. In other words, even if SAIF's action in issuing the disclaimer of responsibility was unreasonable under the facts of this case, that action did not result in any unreasonable delay in accepting or denying the claim, or unreasonable delay/refusal to pay compensation. In this regard, SAIF had 90 days from the date the employer had notice or knowledge of the claim within which to accept or deny the claim. ORS 656.262(6). SAIF accepted the claim within 90 days. (Exs. 30, 40). Therefore, because SAIF timely accepted the claim, it stands to reason that it did not unreasonably delay acceptance of the claim.

Furthermore, the only compensation claimant claimed prior to acceptance was for medical services. However, pending acceptance or denial of a claim, compensation does not include medical benefit costs. ORS 656.262(6). In any event, SAIF paid all medical bills within 30 days of receipt. (Exs. 53-1, 54). The Director's rules allow a carrier 45 days from receipt to timely pay medical bills. OAR 436-10-100(9). Therefore, even if we were to consider the medical bills received prior to acceptance, we would find that SAIF did not unreasonably delay or unreasonably refuse to pay compensation.[4] Accordingly, by the terms of ORS 656.262(11)(a), claimant is not entitled to a penalty.

In addition, unless specifically authorized by statute, attorney fees cannot be awarded. Forney v. Western States Plywood, 297 Or 628 (1984). ORS 656.382(1)[5] authorizes an attorney fee when a carrier unreasonably resists the payment of compensation. Here, even if we find that SAIF acted unreasonably in issuing the disclaimer of responsibility, this conduct did not result in the resistance of any payment of compensation. As explained above, claimant's claim was timely accepted and all benefits were timely paid. We, therefore, have no authority to award an attorney fee under this section. Forney v. Western States Plywood, supra; Ugo E. Brabo, 47 Van Natta 1936 (1995).

Accordingly, on reconsideration of our prior order, the ALJ's order dated September 27, 1993 is reversed. The assessed attorney fee awards are reversed.

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[4] In our prior order, we relied on Conagra, Inc. v. Jeffries, 118 Or App 373 (1993), in determining that claimant was entitled to a penalty pursuant to former ORS 656.262(10). On reconsideration, we find Jeffries distinguishable. In Jeffries, the carrier unreasonably denied the claim and subsequently accepted the claim by stipulation following a hearing. The court determined that, although a carrier is not required to pay medical benefits before or after it denies a claim, once the denial is determined to be improper, "any benefits that become due as a result of the setting aside of the denial are considered to be due as of the date the denial is set aside." Id. at 376. The court concluded the claimant was entitled to a penalty based on the amounts due as of the date of the stipulation, the date the denial was set aside.

Here, we have determined that SAIF's responsibility disclaimer was not a denial. In addition, unlike the carrier in Jeffries, SAIF timely accepted the claim and timely paid all benefits. Thus, here, there was no unreasonable delay in acceptance of the claim or payment of compensation upon which to base a penalty under ORS 656.262(11)(a).

[5] We note that SB 369 made minor amendments to ORS 656.382(1). However, those amendments are not relevant to the issue before us and do not affect the result in this case.

February 27, 1996 Cite as 48 Van Natta 457 (1996)

In the Matter of the Compensation of
RAY A. NARDO, Claimant
WCB Case No. 94-12243
CORRECTED ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Dennis L. Ulsted (Saif), Defense Attorney

On February 15, 1996, the Board modified an Administrative Law Judge's (ALJ's) order by reducing claimant's unscheduled permanent disability award for a right shoulder injury from 17 percent (54.4 degrees) to 12 percent (38.4 degrees). It has come to our attention that the Board's order contains a clerical error. Specifically, in the first sentence of footnote 2, on page 3 of the order, the second reference to "Dr. Fry's" measurements should be changed to "Dr. Filarski's." In addition, the reference in the second sentence of that footnote should also be changed from "Dr. Fry's" to "Dr. Filarski's."

In other words, the aforementioned footnote should read as follows: "As supporting evidence of different testing methods, SAIF points to Dr. Fry's measurement of abduction in claimant's uninjured left shoulder (150 degrees), which was 30 degrees less than Dr. Filarski's abduction measurement in the same shoulder (180 degrees). (Exs. 12-2, 16-3). However, Dr. Filarski's abduction finding correlates to no impairment rating under the standards. OAR 436-35-330(5). Therefore, we find the different abduction measurements to be of little significance; it is certainly insufficient evidence that Dr. Fry used incorrect ROM testing methods."

Accordingly, the Board's February 15, 1996 order is withdrawn. As corrected herein, the February 15, 1996 order is republished in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

February 27, 1996 Cite as 48 Van Natta 458 (1996)

In the Matter of the Compensation of
JOE R. RAY, Claimant
WCB Case No. 95-02305
ORDER ON RECONSIDERATION
Coons, Cole & Cary, Claimant Attorneys
Roberts, et al, Defense Attorneys

Claimant has requested reconsideration of the Board's February 15, 1996 Order on Review. Although claimant "neither requests nor expects the Board to reconsider its final decision reflected in the order," he requests reconsideration to allow the Board the opportunity to correct scrivener's errors and omit what claimant considers "surplusage" in the order.[1] After conducting our reconsideration, we make the following corrections to the Board's prior order. These changes are as follows.

We replace the first sentence of the second paragraph on page two with the following, "Dr. Stanford, orthopedist, examined claimant at the request of the insurer."

We add "(emphasis added)" to the quoted language from Virlena Crosley which begins on page 6 and ends on page 7.

Claimant's remaining requests do not merit further discussion.

Accordingly, subject to the aforementioned corrections, the Board's February 15, 1996 order shall remain unchanged.[2] The parties' rights of appeal shall continue to run from the date of the Board's February 15, 1996 order.

IT IS SO ORDERED.

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[1] Claimant also refers to concessions made at the oral argument. In response to such comments, copies of the transcript of the oral argument have been included with the parties' counsels' copies of this order.

[2] Chair Hall and Member Gunn join this order for the purpose of making the aforementioned corrections. However, Chair Hall and Member Gunn continue to adhere to their separate concurring/dissenting opinions as set forth in the Board's February 15, 1996 order.

In the Matter of the Compensation of
GARY G. BRITTON, Claimant
WCB Case Nos. 95-04539 & 95-02235
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Lundeen, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's left carpal tunnel syndrome; and (2) upheld the SAIF Corporation's denial of the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of finding number 16 on page 4.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted 1984 claim with Liberty for bilateral carpal tunnel syndrome (CTS). In 1990, claimant underwent surgery for the right CTS. Claimant also has an accepted 1992 claim with SAIF for injuries related to a motor vehicle accident.

In November 1992, claimant sought treatment for increased left CTS symptoms. Finding that the treating physician did not provide a persuasive opinion, the ALJ concluded that responsibility for claimant's left CTS remained with Liberty. Liberty challenges the ALJ's decision, asserting that the most reliable medical opinion proves that the 1992 accident was the major contributing cause of a worsening of the left CTS and, thus, responsibility for the condition should shift to SAIF. We agree.

The responsible carrier remains responsible for a compensable injury unless the worker sustains a "new compensable injury involving the same condition." ORS 656.308(1). "The standards for determining the compensability of a combined condition under ORS 656.005(7) shall also be used to determine the occurrence of a new compensable injury or disease[.]" Id. Thus, we analyze whether claimant has sustained a "new compensable injury" for which SAIF is responsible.

According to Dr. Jewell, claimant's treating hand surgeon, claimant's motor vehicle accident pathologically worsened claimant's preexisting left CTS, resulting in his current need for treatment and disability. (Exs. 28, 32B, 36). Dr. Jewell's opinion is opposed by Dr. Donahoo, examining orthopedic surgeon, and Dr. Button, record reviewing hand surgeon. Dr. Donahoo found no evidence of a worsening or change in the underlying pathology of the left CTS and concluded that claimant was experiencing only ongoing symptomatology. (Ex. 30-13, -14). Dr. Donahoo considered the major contributing cause of the development and/or worsening of the left CTS to be the December 1984 work activities with Liberty's insured. (Ex. 33-5).

Dr. Button agreed that claimant's left CTS had not objectively worsened and found no evidence of carpal tunnel symptomatology following the 1992 motor vehicle accident. (Ex. 35-2). Dr. Button also concluded that claimant's treatment was in major part due to the preexisting left CTS. (Id. at 3).

There is no dispute that claimant's left CTS preexisted the 1992 compensable motor vehicle accident. Liberty's theory is that the motor vehicle accident combined with the left CTS, resulting in claimant's need for treatment. Under such a theory, in order for responsibility to shift to SAIF, Liberty must show that the 1992 motor vehicle accident is the major contributing cause of the need for treatment. ORS 656.308(1); ORS 656.005(7)(a)(B).

The ALJ in part discounted Dr. Jewell's opinion because the ALJ considered Dr. Jewell to be an "advocate" for Liberty when Dr. Jewell referred to himself as "the expert for Liberty" and refused SAIF's request to provide an opinion except through deposition. (Ex. 34). We find such evidence insufficient to show that Dr. Jewell was an "advocate" for Liberty. There is no evidence or even suggestion that Dr. Jewell would profit in any way if Liberty successfully shifted responsibility to SAIF. Rather, Dr. Jewell's

self-characterization merely recognized that his opinion was favorable to Liberty; that is not enough to qualify an expert as an "advocate." Compare Mike Sepull, 42 Van Natta 470 (1990) (treating physician with "significant financial interest" in the claim found to be an advocate for claimant and, thus, did not provide a reliable opinion).

We find no persuasive reasons not to defer to Dr. Jewell as the treating physician. Dr. Jewell has treated claimant since April 1987 and performed the right CTS surgery. Dr. Jewell continued to treat claimant after the 1992 motor vehicle accident. In view of this extensive contact with claimant both before and after the 1993 motor vehicle accident, we find Dr. Jewell to be in a better position to evaluate causation than Dr. Donahoo, who examined claimant one time, and Dr. Burton, who reviewed only the medical records. Furthermore, although Dr. Jewell's reports did not expressly describe the chronology of claimant's symptoms following the accident, because he reviewed Drs. Donahoo's and Burton's reports (which did contain such history), Dr. Jewell relied on an accurate history. Dr. Jewell provided persuasive reasoning supporting his opinion, explaining that either the trauma of the accident or the musculosketal pain disorder that resulted from the accident caused the left CTS to pathologically worsen. (Ex. 36-1).

Finally, by stating that the motor vehicle accident pathologically worsened the left CTS, we conclude that Dr. Jewell showed that the compensable 1992 injury is the major contributing cause of the need for treatment. Thus, responsibility for claimant's condition shifts from Liberty to SAIF. ORS 656.308(1); 656.005(7)(a)(B).

Although not contested on Board review, the ALJ's order also addressed the compensability of claimant's condition. Under such circumstances, claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the potential compensability issue. Paul R. Huddleston, 48 Van Natta 4 (1996). 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 August 14, 1995 is reversed in part and affirmed in part. Liberty's denial is reinstated and upheld. SAIF's denial is set aside and the claim is remanded to SAIF for processing according to law. SAIF is responsible for the ALJ's attorney fee award. For services on review, claimant's attorney is awarded $1,000, payable by SAIF. The remainder of the order is affirmed.

February 27, 1996 Cite as 48 Van Natta 460 (1996)

In the Matter of the Compensation of
BRIAN L. SCHMITT, Claimant
WCB Case No. 94-10599
ORDER DENYING RECONSIDERATION
Black, et al, Claimant Attorneys
Cowling, et al, Defense Attorneys

The insurer requests reconsideration of that portion of our February 13, 1996 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that set aside a September 30, 1991 Notice of Closure and a December 31, 1991 Order on Reconsideration as premature. Contending that the surgery proposed by Dr. Appleby, claimant's attending surgeon, is not expected to materially improve the function of claimant's compensable wrist condition but, rather, simply to reduce claimant's pain, the insurer continues to assert that claimant's condition was medically stationary at claim closure.

After considering the insurer's motion, we have nothing further to add to our previous order. Accordingly, the insurer's motion for reconsideration is denied. The parties' rights of appeal shall continue to run from the date of our February 13, 1996 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
GLORIA J. FLUKER, Claimant
Own Motion No. 94-0510M
OWN MOTION ORDER DENYING RECONSIDERATION
Welch, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

On February 23, 1996, the Board received claimant's February 15, 1996 letter in which she requests "future reconsideration of the denial motion for temporary disability compensation for my compensable neck, low back and right knee injury dated 11-3-94." We treat claimant's letter as claimant's pro se request for reconsideration of our January 23, 1996 Own Motion Order, in which we declined to authorize the payment of temporary disability compensation pursuant to the parties' July 24, 1995 Stipulation and Disputed Claim Settlement Agreement. We decline to reconsider our order based on the following reasoning.

The SAIF Corporation issued a denial of the compensability of claimant's current L4-5 disc herniation and ensuing surgery on November 3, 1994. Claimant appealed the denial to the Hearings Division. (WCB Case No. 94-14172). On July 24, 1995, Administrative Law Judge (ALJ) Neal approved the parties Stipulation and Disputed Claim Settlement Agreement. Pursuant to that agreement, claimant withdrew her request for hearing in the matter, and the parties agreed that the request for hearing "be dismissed with prejudice and that payment shall be accepted in full settlement of all issues raised or raisable."

A stipulation is a negotiated, signed agreement, based on a weighing of choices and the exercise of judgment as to the most beneficial outcome for each party. See Melvin D. Manire, 47 Van Natta 1108 (1995); Fimbres v. Gibbons Supply Co., 122 Or App 467, 471 (1993). Once approved by the ALJ, it has the finality and effect of a judgment. Id.

Here, claimant's July 24, 1995 agreement specifically stated that, should the ALJ approve the agreement, SAIF's denial, as supplemented by the contentions of SAIF in the agreement, will remain in full force and effect. In addition, the agreement stated that "[c]laimant shall have no further entitlement to compensation or any other legal right related to the denied treatment or condition(s)."

Here, claimant seeks the following relief:

> "Should I experience a flair up of increase [sic] pain and in need of medical attention, I think it only fair that Safe [sic] authorize a medical evaluation, treatment if deemed necessary and compensation should I have to be off the job for a period of time."

Our decision with respect to our January 23, 1996 order remains unchanged, as we are without authority to circumvent a compensability issue regarding a current condition denial to which the parties have previously stipulated.

However, should claimant experience a worsening of her compensable condition which requires hospitalization or inpatient or outpatient surgery, she may again request that her 1983 claim be reopened for the payment of temporary disability compensation at that time.

Accordingly, claimant's current request for relief is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
LOUISE T. HAMBY, Claimant
WCB Case No. 95-00821
ORDER ON REVIEW
Daniel M. Spencer, Claimant Attorney
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that upheld the SAIF Corporation's denial of claimant's right ankle injury claim. On review, the issue is compensability.

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

Subsequent to the filing of Board briefs in this case, SAIF submitted a Memorandum of Additional Authority advising the Board of a recent court case pertaining to the issue of course and scope of employment. Villafuerte v. Unger Farms, 136 Or App 487 (1995). It is permissible for any party to provide supplemental authorities to assist the Board in its review of a case. However, further argument will not be considered. See Betty L. Juneau, 38 Van Natta 553, 556 (1986). Accordingly, we allow SAIF's submission, but consider it only to the extent that it advises us of recent developments in the law. See Dale A. Pritchett, 44 Van Natta 2134 (1992); Debra A. West, 43 Van Natta 2299 (1991).

On review, claimant argues that the ALJ erred in relying on Cope v. West American Insurance Company, 309 Or 232 (1990). Claimant contends that "Cope is old law, worthy of a decent burial." (Claimant's Reply Brief, page 1). We disagree that the Workers' Compensation law recited in Cope is no longer valid.

In Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994), the Court explained the significance of its prior decision in Cope; specifically, the Court addressed the following passage:

> "[W]hen an employee traveling to or from work sustains an injury on or near the employer's premises, there is a 'sufficient work relationship' between the injury and the employment only if the employer exercises some 'control' over the place where the injury is sustained. Whether the requisite control is evinced by increased, employer-created risks, or by the employer's property rights to the area where the injury is sustained, is immaterial. Some form of employer control of the area demonstrates the work-connection necessary to make the injury compensable." Cope v. West American Ins. Co., supra, 309 Or at 239 (citations omitted).

In Norpac, the Court explained that the issue in Cope was whether summary judgment was appropriate; the Court was not requested to apply the "parking lot" exception to the "coming and going" rule to determine the compensability of the claimant's injury. Norpac Foods, Inc. v. Gilmore, supra, 318 Or at 368. Therefore, the Court found the quoted passage in Cope dictum. However, the Court also found that the quoted passage only dealt with "how much employer control is necessary for the 'parking lot rule' to become operative." Id. The Court concluded that, because Cope "did not address the question of how the 'parking lot rule' operates in determining compensability," Cope was not to be interpreted to mean that every injury occurring in an employer-controlled parking lot was per se compensable. Id. Instead, the Court concluded that "[t]he 'parking lot rule' establishes only that the time, place, and circumstances of the injury are sufficiently work-related to justify compensability. * * * A claimant must also establish a causal connection between the injury and the employment. . . ." Id.

Thus, the Norpac Court did not hold that the above-quoted statement of law in Cope was invalid, only that it was limited to explaining the amount of employer control necessary to make the "parking lot" exception to the "going and coming" rule operative. Here, the ALJ found that claimant failed to prove that the employer had the requisite control over the icy public roadway where claimant fell on her way to work to make the "parking lot rule" operative. Contrary to claimant's argument, the ALJ did not find that an injury occurring outside of the employer's leased parking lot was per se not compensable.

Finally, contrary to claimant's argument, we do not find that the ALJ placed undue emphasis on Cope. Instead, the ALJ relied on a number of relevant cases, including Cope, in explaining that claimant failed to prove that her fall on an icy public roadway on the way to work was outside of the "going and coming" rule. We agree with the ALJ's reasoning and conclusions.

ORDER

The ALJ's order dated May 5, 1995 is affirmed.

February 28, 1996 Cite as 48 Van Natta 463 (1996)

In the Matter of the Compensation of
VICKI D. POLLOCK, Claimant
WCB Case No. 94-10269
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order that upheld the self-insured employer's denial of her aggravation claim for right shoulder bursitis. On review, the issues are waiver and, alternatively, aggravation.

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

By Stipulation and Order approved July 26, 1994,[1] the parties resolved two separate injury claims and an aggravation claim involving claimant's neck and shoulders. Pursuant to the stipulation, the employer rescinded its earlier denials and accepted nondisabling injuries to claimant's neck, left shoulder and arm and right shoulder. Claimant agreed that "all her requests for hearing, and all issues that have been or could be raised at this time are deemed settled by this agreement." (Ex. 26A).

The ALJ found, based on Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994), that claimant was barred from asserting the compensability of her right shoulder aggravation claim because the issue could have been negotiated before approval of the parties' July 26, 1994 stipulation. The ALJ reasoned that since claimant's physician had diagnosed the reexacerbation of her right shoulder bursitis on June 29, 1994 and had taken claimant off of work between June 29, 1994 and July 6, 1994, the aggravation claim was an issue that could have been raised and negotiated as part of the parties' stipulation.

Claimant argues on review that since there is no evidence in the record establishing that the employer "received" claimant's June 29, 1994 aggravation claim prior to the parties' July 26, 1994 stipulation, the aggravation claim was not a raisable issue at that time.[2] We disagree.

Claimant's argument is premised on the erroneous assumption that an issue is not ripe or raisable by a party unless or until the adverse party is shown to be on notice that the potential issue exists. Such a requirement has not been imposed in construing the preclusive effect of a stipulation.

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[1] Claimant signed the stipulation on July 19, 1994, and her attorney signed it on July 22, 1994.

[2] Claimant also argues that because the aggravation claim had yet to be denied at the time the stipulation was approved, "claimant could not have forced employer to litigate the merits of the June 29, 1994 aggravation claim." While it is true that "litigation" of the claim before the Hearings Division would not have been possible at the time of the parties' stipulation, "litigation" is not the proper test. Indeed, in Good Samaritan Hospital v. Stoddard, supra, the court expressly found that a denial is not required for an issue to be raisable. "The correct inquiry is whether claimant's condition and its compensability may have been negotiated before approval of the settlement." 126 Or App at 73. In this case, since claimant's right shoulder bursitis reexacerbation had been diagnosed and related to her prior on-the-job injuries before the parties' stipulation was signed and approved, the aggravation issue was ripe for negotiation and could have been raised.

Indeed, in Daniel R. Loynes, 47 Van Natta 1075, 1076 (1995), we held that the parties' stipulation, which settled all issues then "raised or raisable," barred the claimant from subsequently litigating his entitlement to temporary total disability benefits because the "claimant was on notice that there was a potential dispute" well before the settlement agreement was approved.

In Daniel R. Loynes, the claimant compensably injured his ribs, shoulder and low back in a May 1993 accident. The carrier accepted the rib and shoulder conditions, but did not address the low back condition. In June of 1993, the claimant's physician released him to modified work, and the employer sent a written offer of modified employment. The physician then withdrew the first work release and released the claimant to modified work as of July 5, 1993. The employer did not issue another written offer of modified employment. The claimant returned to work, and the carrier paid temporary partial disability from July 5 through July 29, 1993. The claimant subsequently filed a hearing request challenging the carrier's "de facto" denial of his low back condition. The parties resolved this hearing request by stipulation in February 1994, wherein the carrier agreed to accept the condition and pay an attorney fee. The claimant then filed another hearing request, asserting entitlement to temporary total disability benefits based on the carrier's failure to issue a second offer of employment and payment of only temporary partial disability during July 1993. Although we made no finding regarding the carrier's notice of the temporary total disability dispute, we held the issue was raisable at the time of the parties' stipulation because the claimant was aware of the problem.

Accordingly, in this case, because it is claimant who now seeks to litigate the issue, it is immaterial, for purposes of our analysis, whether the employer had actually "received" notice of the claim prior to approval of the stipulation. Considering the undisputed evidence that claimant was aware of a potential dispute concerning her June 29, 1994 aggravation claim, the compensability of the aggravation claim was an issue that "could have been raised" by claimant before approval of the parties' stipulation. Good Samaritan Hospital v. Stoddard, supra.

ORDER

The ALJ's order dated May 18, 1995 is affirmed.

Board Chair Hall specially concurring.

While I am bound by Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994), to conclude that claimant's aggravation claim is barred because the issue relates to claimant's compensable injury and could have been raised before the parties' stipulation was approved, I write separately to state that, had I been deciding this case on an empty slate, I would conclude otherwise.

The subject matter of the parties' July 26, 1994 stipulation was the compensability of claimant's injuries. Because the aggravation of claimant's injuries was not "at issue" or contemplated by the parties' agreement, I would not consider claimant's June 29, 1994 aggravation claim to be an issue that was raised or raisable because it falls outside the subject matter of the parties' negotiations. I realize, however, that my interpretation of "what could have been negotiated before approval of the settlement" is narrower than that taken by the court in Stoddard.

In the Matter of the Compensation of
RICHARD UHING, Claimant
Own Motion No. 94-0078M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Benjamin W. Ross, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's November 27, 1995 Notice of Closure, as amended on November 29, 1995, which closed his claim with an award of temporary disability compensation from May 30, 1995 through November 14, 1995. SAIF declared claimant medically stationary as of November 2, 1995. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the November 27, 1995 Notice of Closure, as amended on November 29, 1995, 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.

In response to the Board's request to submit evidence used in closing the claim, SAIF submitted a November 14, 1995 medical report in which Dr. Wong, claimant's then-treating physician, opined that claimant's compensable medical condition was medically stationary, but that his psychological condition was not medically stationary. SAIF also submitted a November 22, 1995 letter, in which Dr. Fleming, claimant's then-treating psychologist, opined that claimant was medically stationary with respect to his psychological condition on November 2, 1995.

Claimant's proposed surgery was approved by the Director in 1994. Claimant postponed surgery pending results of more conservative treatment. Prior to undergoing surgery, claimant underwent pain management at a pain center. At the time SAIF closed his claim, claimant's surgery was still pending. We do not find any evidence that claimant "refused" surgery, but, rather, it appears that claimant opted for other treatment prior to undergoing surgery.

In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered so long as it addresses claimant's condition at the time of closure, not subsequent changes in claimant's condition. Scheuning v. J.R. Simplot & Co., 84 Or App 622 (1987).

Subsequent to SAIF's closure of his claim, claimant changed his primary care physician. Dr. Noyes, claimant's new treating physician, referred claimant to Dr. Grewe for a neurosurgical consultation. In a January 2, 1996 medical report, Dr. Grewe opined that:

> "Radiographically, [claimant] has foraminal stenosis suggested on the left at L5-S1, as well as moderately severe degenerative change. [Claimant] feels he has exhausted conservative management and after a long discussion desires to proceed with the previously proposed fusion procedure."

On January 2, 1996, Dr. Grewe requested authorization to perform that procedure.

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). However, we can give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Because the proposed surgery was still pending, we find reason to examine why Dr. Wong opined that claimant was medically stationary in November 1995.

In those cases where a claimant's medically stationary status is contingent upon undergoing a recommended surgery, we have held that a claim is not prematurely closed if the claimant refuses the

surgery. E.g. Karen T. Mariels, 43 Van Natta 2452 (1992); Stephen L. Gilcher, 43 Van Natta 319, 320 (1991). However, in those cases where surgery was postponed, but the record establishes that the surgery is reasonable and necessary and expected to materially improve claimant's compensable condition, we have found that the carrier erred in closing the claim prior to surgery. See Bill H. Davis, 47 Van Natta 219 (1995); Jerry Simmons, 47 Van Natta 2423 (1995). If there is a reasonable expectation of improvement with surgery, the criteria for being declared "medically stationary" have not been met. ORS 656.005(17).

Based on the record, we find that Dr. Wong's November 15, 1995 report (the only report from claimant's former treating physician in the record) lacks reasoning to support his opinion. That report does not specify why he considered claimant to be medically stationary on that date. Rather, the report advises that "[t]he MRI shows disc degeneration at L3-4, L4-5, and L5-S1," and discusses claimant's depression.

On the other hand, Dr. Grewe performed a "complex" neurosurgical evaluation on January 2, 1996. In rendering his opinion, Dr. Grewe utilized the November 1, 1995 lumbar MRI scan, which, he opined, demonstrated moderately severe degenerative changes at L5-S1, and revealed that the left L5 foramina "is stenosed somewhat" (an interpretation of the MRI which is notably similar to that of Dr. Wong on November 14, 1995). Here, Dr. Grewe considered and compared pre-closure medical reports prior to recommending that claimant undergo the proposed surgery. Inasmuch as the record does not establish that claimant's condition worsened subsequent to claim closure, we are persuaded that claimant's condition on January 2, 1996 remained essentially the same as it was at claim closure. See Scheuning v. J.R. Simplot & Co., supra. We find that Dr. Grewe's recommendation and opinion are well-reasoned, while Dr. Wong offers no reasoning as to why he opined that claimant was medically stationary. Weiland v. SAIF, supra; Somers v. SAIF, supra.

On this record, we conclude that claimant has carried his burden of proving that he was not medically stationary when his claim was closed.

Accordingly, we set aside SAIF's November 27, 1995 Notice of Closure, as amended on November 29, 1995, as premature. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

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

IT IS SO ORDERED.

February 29, 1996 Cite as 48 Van Natta 466 (1996)

In the Matter of the Compensation of
KENNETH C. FELTON, Claimant
Own Motion No. 96-0005M
OWN MOTION ORDER OF ABATEMENT
EBI Companies, Insurance Carrier

Claimant requests reconsideration of our January 31, 1996 Own Motion Order, in which we declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force when his condition worsened requiring surgery.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The insurer is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
FLOYD D. GATCHELL, Claimant
WCB Case No. 95-03978
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Merrily McCabe (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order which declined to set aside a Disputed Claim Settlement (DCS). On review, the issue is the validity of the DCS.

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

Claimant sustained an injury on August 9, 1993 to his neck and left shoulder, for which he filed a workers' compensation claim. The SAIF Corporation denied the claim on June 2, 1994, which prompted claimant to request a hearing contesting the denial.

Claimant, who was represented by counsel, settled the claim by way of a DCS. Prior to signing the DCS, claimant assumed that his private health carrier would not seek reimbursement of the medical bills that it had already paid.

Of the total DCS proceeds of $8,000, approximately $4,400 were allocated to claimant, $2,000 to claimant's attorney and the remainder to claimant's medical providers. These providers were specifically listed in the DCS, as was the manner and the amounts in which each was to be reimbursed. There is no evidence that SAIF failed to comply with its obligations under the DCS.

Following ALJ approval of the DCS, claimant's private health carrier sought a refund of payments it had made from at least two of claimant's medical providers. One provider returned $2,582.15 and another medical provider returned an unspecified sum to the private health carrier. Both medical providers, who did not contact claimant prior to returning payments to the health carrier, have now requested payment from claimant for the now-outstanding bills. Claimant requested a hearing seeking to set aside the DCS because of the unforeseen actions of his private health carrier and the medical providers.

The ALJ refused to set aside the DCS. The ALJ reasoned that this was not an extreme situation which would justify setting it aside. We agree with the ALJ.

ORS 656.289(4) authorizes settlement of a claim when there is a bona fide dispute as to compensability. Roberts v. Willamette Industries, 82 Or App 188, rev den 302 Or 461 (1986). Settlements are to be encouraged within the limits of the statute; once approved, they should be set aside only if they clearly violate the statute. Kasper v. SAIF, 93 Or App 246, 250 (1988). In determining whether a settlement violates the statute, we exercise de novo review authority. See, e.g., Daryl G. Richmond, 38 Van Natta 220 (1986) (on reconsideration), aff'd Richmond v. SAIF, 85 Or App 444 (1987); Roberts v. Willamette Industries, supra. We regard setting aside an approved settlement to be an extraordinary remedy to be granted sparingly in the most extreme circumstances. E.g., Pruitt Watson, 45 Van Natta 1633, 1634, on recon 45 Van Natta 2227 (1993).

In this case, the unexpected actions of the private health carrier and claimant's medical providers after the DCS was executed do not justify the extraordinary remedy of setting aside the DCS. In Mary Lou Claypool, the Board concluded that, whether viewed as an agency order or a contract, the grounds for setting aside a DCS were substantially the same, that is, mistake, inadvertence, surprise, excusable neglect, fraud, misrepresentation or other misconduct of an adverse party. 34 Van Natta 943, 946 (1982). We agree with the ALJ's analysis that claimant has proven none of the above factors that would justify setting aside the DCS.[1]

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[1] Claimant encloses on review a copy of his argument presented to the ALJ, which included the contention that the DCS ought to be set aside because of "mistake." Claimant asserted that he was under the "mistaken belief" that he would receive a certain sum of money as a result of the DCS and was "surprised" when the private health carrier requested a refund of the money it had paid claimant's medical providers. While claimant may not have anticipated the actions of the private insurance carrier when he agreed to the DCS, or that the medical providers would return the money they had received, we are not persuaded, nor does claimant cite any authority, that this is the kind of "mistake" or "surprise" that would justify setting aside a DCS. Moreover, claimant has received the sum of money that was specified in the DCS. The fact that medical service providers are now trying to obtain reimbursement from claimant does not necessarily mean that those efforts will be successful.

On review, claimant reiterates his understanding that he was supposed to receive the sum of $4,400.16 after payment of medical expenses and his concern that this will not occur if he is required to make the payments his medical providers have demanded. Claimant asserts that the DCS ought to be set aside because the parties did not have a "meeting of the minds" with respect to the essence of the contract: the net amount of the settlement. We disagree.

The terms of the DCS essentially provided that SAIF's denial would be upheld, claimant would receive from SAIF the sum of $4,400.16, his attorney would receive $2,000, and the remainder of the $8,000 in settlement proceeds would be distributed to medical providers in the manner set forth in the agreement. Claimant does not contend that the agreement as summarized above does not represent what he and SAIF agreed to. Moreover, there is no contention, or evidence, that SAIF did not fully comply with its obligations under the terms of the DCS. Claimant received exactly what was intended under the terms of the DCS. Under these circumstances, we are unable to conclude that SAIF and claimant did not have a "meeting of the minds" as to the terms and conditions of their agreement.[2]

Granted, as a result of the actions of third parties subsequent to execution of the agreement, claimant's right to receive the full benefit of the DCS proceeds has apparently been challenged.[3] However, this is a matter outside the purview of this forum.[4] Our review is limited to determining whether the requisite circumstances necessary to set aside a previously approved DCS exist. Absent a showing of extreme circumstances, we decline to apply the extraordinary remedy of setting aside a DCS drafted and approved in accordance with all applicable statutory and administrative requirements.

ORDER

The ALJ's order dated September 27, 1995 is affirmed.

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[2] ORS 656.313(4)(c) provides that, in cases where a claim is resolved by DCS, the insurer shall reimburse, out of the settlement proceeds, medical providers for billings received on or before the date on which settlement terms were agreed. See also OAR 438-009-0010(2)(g)(h). However, this section only applies to billings that were not otherwise partially or fully reimbursed. In this case, billings were either covered in the DCS or they were "reimbursed" by the private health insurance carrier. Although medical service providers have now returned money that they received from the private health insurance carrier, this does not invalidate the DCS, where there is no contention that the insurer or claimant failed to comply with ORS 656.313(4)(c).

[3] It is by no means certain that claimant will not receive the net settlement amount he desires. Although claimant avers in his brief that he did not receive the net settlement amount, his stipulated testimony does not indicate that he has made payment to the medical providers as they have requested. Moreover, even if claimant has made payment to them, as noted by the ALJ, claimant may have a civil remedy against the private health insurance carrier to recoup such a payment.

[4] By reason of the parties' DCS, claimant's neck and left shoulder conditions are not compensable by operation of law. This would presumably obligate claimant's private insurance carrier to provide medical services benefits for these noncompensable conditions. However, this is not the appropriate forum for resolution of any private contractual/benefit dispute between claimant and his private insurance carrier.

In the Matter of the Compensation of
DAVID GRENBEMER, Claimant
Own Motion No. 94-0544M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our January 31, 1996 Own Motion Order Reviewing Carrier Closure, in which we affirmed the SAIF Corporation's closure of his claim. We are forwarding claimant's request and attached evidence to the SAIF Corporation. The parties are advised to copy all parties with information pursuant to OAR 438-012-0016.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. SAIF is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
HELEN K. LARA, Claimant
WCB Case No. 93-12770
ORDER ON REMAND
Cheek & Tiscornia, Claimant Attorneys
Paul L. Roess, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. By order dated October 25, 1995, the court reversed and remanded our prior order, Helen K. Lara, 46 Van Natta 2443 (1994), for reconsideration in light of Senate Bill 369. (SB 369). In our prior order, we affirmed the Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's aggravation claim for a low back condition.

In response to claimant's request, a supplemental briefing schedule was implemented. In her supplemental brief, claimant requests remand to the ALJ for further development of the record. We proceed with our reconsideration. On reconsideration, we withdraw our prior order and issue the following order.

FINDINGS OF FACT

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

On October 26, 1992, claimant compensably injured her low back. On May 17, 1993, this claim was closed by a Determination Order that awarded 23 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the loss of use or function of the left leg. (Ex. 13). This Determination Order was not appealed. At the time of the May 17, 1993 award, claimant had low back pain with occasional shooting pain and numbness in the left leg with prolonged sitting. She also had the following lumbar ranges of motion: 25 degrees of flexion; 5 degrees of extension; and 15 degrees of bilateral lateral flexion. (Exs. 10, 11, 12). Despite the back pain, claimant was able to continue working for the employer in a light duty job as an asphalt loader.

Subsequent to the May 17, 1993 award, claimant's back pain gradually worsened and, by late June 1993, she was no longer able to perform her light duty job. On July 1, 1993, she returned to Dr. Cummings, attending physician, who released her from work pending an evaluation by Dr. Misko. (Ex. 16). On July 19, 1993, Dr. Misko examined claimant and estimated her lumbar flexion as about 30 degrees. (Ex. 19). Dr. Misko diagnosed facet syndrome L5-S1, left, and recommended a facet injection.

On August 16, 1993, Drs. Dinneen, orthopedist, and Barth, neurologist, examined claimant on behalf of the insurer. (Ex. 20). They measured 10 degrees of flexion, 4 degrees of extension, and 8 degrees of right lateral flexion. (Ex. 20-2). Drs. Dinneen and Barth noted that the ranges of motion were valid, but they could not attribute the loss of range of motion to the compensable injury. They also stated that, because claimant did not need surgery, her condition was medically stationary. (Ex. 20-3).

Dr. Cummings concurred with Drs. Dinneen's and Barth's opinion. (Ex. 21). Dr. Misko concurred only with Drs. Dinneen's and Barth's findings and diagnosis, not their opinion that claimant's condition had not worsened. (Exs. 22, 26). Based on the decreased ranges of motion measured by Drs. Dinneen and Barth, Dr. Misko opined that claimant's compensable condition had worsened since the May 1993 Determination Order and that the worsening was more than a waxing and waning of claimant's condition. (Ex. 26, 27-16, -17).

On December 14, 1993, claimant underwent a facet injection performed by Dr. Misko. (Ex. 24). Claimant's symptoms subsequently improved. On February 7, 1994, Dr. Misko released claimant for regular work without restrictions.

CONCLUSIONS OF LAW AND OPINION

Remand

Claimant requests remand to the ALJ for further development of the record regarding whether her worsened condition following the May 1993 Determination Order represents more than a waxing and waning of her condition contemplated by that award. Based on the following reasoning, we decline to remand this case to the ALJ.

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). To warrant remand, there must be good cause or a compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Claimant cites no evidence that she wishes to submit regarding the waxing and waning issue; she merely asserts that she needs to inquire of her attending physician as to his opinion regarding the extent of waxing and waning anticipated at the time of the May 1993 Determination Order. Claimant makes this assertion based on her belief that only an attending physician at claim closure may determine the extent of anticipated waxing and waning of a worker's condition. However, as we explain below in the "aggravation" section, this underlying belief is not supported by the statutory scheme. Because the record is fully developed regarding the waxing and waning issue, and no explicit opinion from the attending physician is required regarding that issue, we conclude that claimant's unspecified evidence is not reasonably likely to affect the outcome of the case.[1] Therefore, we find no compelling basis to remand the case to the ALJ for further development of the record regarding the waxing and waning issue. Accordingly, we decline to remand this case to the ALJ.

Applicability of SB 369

In the absence of a specific exception, the changes to the Workers' Compensation Law made by SB 369 apply to cases in which a final order has not issued or for which the time to appeal has not expired on the effective date of the Act (June 7, 1995). Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 569 (1995). Here, our prior order was appealed and the case has been remanded to us from the court. Because our order has not become final, SB 369 is applicable. Furthermore, there are no specific exceptions to retroactive application of the amendments to former ORS 656.273 and the addition of 656.214(7), the statutes that are applicable to the aggravation issue before us. Or Laws 1995, ch 332, § 66 (SB 369, § 66); See Helen M. Callander, 47 Van Natta 1626 (1995). Therefore, the changes made to those statutes apply to the present case.

Aggravation

To establish a compensable aggravation, claimant must prove that her compensable condition worsened since the last award of compensation and that the worsening was causally related to the compensable condition. ORS 656.273(1). Thus, an aggravation has two components: causation and worsening. We adopt the ALJ's reasoning and conclusions that claimant has established the "causation" component of her aggravation claim. In other words, relying on the persuasive opinion of Dr. Misko, consulting and treating neurosurgeon, we find that claimant suffered a tear of the fibrous capsule surrounding the L5-S1 facet at the time of the compensable injury and that tear, not claimant's preexisting disc disease, was the major contributing cause of claimant's worsened symptoms and need for treatment. In addition, based on the following reasoning, we conclude that claimant has also established the "worsening" component of the aggravation claim.

The "worsening" component of an aggravation claim must be established by medical evidence supported by objective findings. ORS 656.273(1). Furthermore, where permanent disability has been previously awarded, as in this case, claimant must establish that the worsening is more than waxing and waning of symptoms contemplated by the previous award. ORS 656.273(8).

In addition, subsequent to our prior order, the 1995 Legislature added ORS 656.214(7) and amended ORS 656.273(1). SB 369 §§ 17, 31. Specifically, ORS 656.273(1) was amended to provide, in relevant part, that "[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." SB 369, § 31 (emphasis added). ORS 656.214(7) provides that "all permanent disability contemplates future waxing and waning of symptoms of the condition. The results of waxing and waning may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability, or inpatient hospitalization."

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[1] Because we decide the remand issue based on this factor, we need not determine whether the other two factors apply.

In Carmen C. Neill, 47 Van Natta 2371 (1995), we examined the interrelationship between amended ORS 656.273(1) and 656.214(7) and determined that an "actual worsening" under amended ORS 656.273(1) is established by: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the condition greater than that anticipated by the prior award of permanent disability.

Here, the worsening is established by medical evidence supported by objective findings. In this regard, during their August 1993 examination, Drs. Dinneen and Barth measured substantially decreased range of motion over that measured at the time of the May 1993 Determination Order, the last arrangement of compensation. (Exs. 10, 11, 12, 13, 20). Although Drs. Dinneen and Barth acknowledged claimant's reduced range of motion and the validity of that measurement, they stated that the reduction was not related to the compensable injury. However, they did not explain this statement. As noted above, we adopt the ALJ's reasoning and conclusions regarding causation, including the ALJ's conclusion that Drs. Dinneen's and Barth's conclusory causation opinion is not persuasive.[2] On the other hand, Dr. Misko concurred with the findings in Drs. Dinneen's and Barth's August 1993 examination and persuasively explained that these reduced range of motion findings were caused by the compensable injury.[3] (Exs. 26, 27-9, 27-16). Thus, we find that claimant's worsening, as evidenced by her reduced range of motion, is established by medical evidence supported by objective findings. ORS 656.005(19); 656.273(1).

However, there is no evidence that claimant sustained a pathological worsening of her underlying compensable condition. Therefore, the question is whether claimant's symptomatic worsening, which resulted in marked decreased range of motion, represents a worsened condition within the meaning of ORS 656.273 and 656.214(7). In other words, was claimant's symptomatic worsening of the compensable condition greater than that anticipated by the prior award of permanent disability? Carmen C. Neill, supra. Based on the following reasoning, we answer this question in the affirmative.

Dr. Misko opined that claimant's symptomatic worsening, which included marked decrease in lumbar range of motion, was caused by the compensable injury. (Exs. 26, 27-16, -17, -18, -19). In addition, Dr. Misko opined that the symptomatic worsening and worsened findings between the April 1993 and August 1993 examinations constituted a worsening of claimant's condition and not simply a waxing and waning of that condition. (Ex. 27-17). Dr. Misko examined and treated claimant and reviewed her medical records, including records generated both before and after the May 1993 award. (Exs. 25, 26, 27-15). On this basis, we find that Dr. Misko had a complete and accurate history of claimant's condition both before and after the May 1993 award. In addition, we find Dr. Misko's opinion well-reasoned. Based on Dr. Misko's persuasive opinion, we find that claimant has established that her symptomatic worsening is greater than that contemplated by the May 1993 Determination Order.[4] See Somers v. SAIF, 77 Or App 259 (1986).

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[2] Because Drs. Dinneen's and Barth's conclusory causation opinion is unpersuasive, it follows that Dr. Cummings' concurrence with that opinion is also unpersuasive.

[3] In his July 19, 1993 examination, Dr. Misko noted that claimant "can flex about 30 [degrees]." (Ex. 19). In his deposition, Dr. Misko acknowledged that this showed a greater range of motion than the 25 degrees of flexion measured by the examining panel in April 1993 [the report upon which the May 1993 Determination Order was based]. (Ex. 27-13). However, Dr. Misko explained that his measurement was an estimate, whereas the April 1993 examination was more accurate, being based on two inclinometer measurements. Id. Moreover, Dr. Misko explained that he based his opinion regarding the marked decreased range of motion on a comparison of the April 1993 examination and Drs. Dinneen's and Barth's August 1993 examination, both of which were done with double inclinometers. (Ex. 27-14, -16). Based on this explanation, we find Dr. Misko's opinion regarding claimant's decreased range of motion persuasive.

[4] In reaching this decision, we note some of the legislative history we relied on in Carmen C. Neill, supra. In discussing ORS 656.214(7), Representative Mannix stated, in part, that:

> "[a]t some point somebody's symptoms will have increased so much that the doctor's going to come to the conclusion that there is actually a worsening of the condition. Let the doctor say so. But let's not say that there are any other assumptions that somehow meant to having just the waxing and waning of symptoms reported that meant you have an aggravation. Ask the doctor the question about the aggravation." Id. at 2376 (citing Minutes of the House Committee on Labor, Tape 42A, March 3, 1995).

In reaching this conclusion, we acknowledge that, in our prior order, we declined to consider the opinion of Dr. Malos, consulting physician, in determining whether the May 1993 Determination Order contemplated future waxing and waning of symptoms of claimant's low back condition. In reaching that decision, we reasoned that, pursuant to former ORS 656.245(3)(b)(B) (renumbered ORS 656.245(2)(b)(B)),[5] only the attending physician at claim closure may make impairment findings in evaluating a worker's disability. No other medical experts' impairment findings may be considered, unless the attending physician ratifies those findings. Therefore, we concluded that, under ORS 656.273(8), only findings from, or ratified by, a worker's attending physician at claim closure regarding waxing and waning of symptoms of a ratable condition may be considered in determining whether such waxing and waning was contemplated by the prior permanent disability award. Because Dr. Malos was not claimant's attending physician and Dr. Cummings, who was claimant's attending physician at claim closure, did not concur with Dr. Malos' anticipation of waxing and waning of symptoms of claimant's accepted low back condition, we found that we could not consider Dr. Malos' opinion regarding the waxing and waning issue. Furthermore, because there was no other persuasive evidence that waxing and waning of symptoms was contemplated by the Determination Order, we concluded that ORS 656.273(8) did not apply to this claim. Helen K. Lara, supra.

However, the enactment of ORS 656.214(7) overrules this reasoning. Pursuant to ORS 656.214(7), all permanent disability contemplates future waxing and waning of symptoms of the condition. Therefore, the fact that only an attending physician at claim closure may make impairment findings is no longer relevant to the issue of whether a prior award contemplated waxing and waning of symptoms. That issue is decided by ORS 656.214(7) without reference to any medical evidence. Id.

In addition, there is no statutory limitation on the medical evidence that may be used to establish whether a worsening is more than the waxing and waning of symptoms of the condition contemplated by the prior permanent disability award. In this regard, the limitations on who may rate impairment at claim closure necessarily do not apply to this issue because the evaluation of a current worsening regarding an as yet unreopened claim has nothing to do with rating the claim at closure. ORS 656.245(2)(b)(B). Because there is no statutory limitation on the medical evidence regarding this issue, we find that the usual methods of determining the persuasiveness of such medical evidence apply, e.g. whether the medical expert has a complete and accurate history and presents a well reasoned opinion. Somers v. SAIF, supra. As discussed above, Dr. Misko's opinion meets that standard.

Thus, claimant has established all of the elements of a compensable aggravation claim. Accordingly, we set aside the insurer's September 14, 1993 denial of claimant's aggravation claim.

Attorney Fees

Claimant has finally prevailed after remand with respect to her low back aggravation claim. Under such circumstances, ORS 656.388(1) provides for an attorney fee award for claimant's counsel's services before every prior forum. At hearing, the ALJ awarded claimant's counsel an assessed fee of $2,300 for prevailing over the insurer's denial of claimant's aggravation claim. ORS 656.386(1). On review, we awarded a $1,000 carrier-paid attorney fee. ORS 656.382(2). We reinstate those awards. Inasmuch as, following remand, we have not disallowed or reduced the compensation awarded by the ALJ, claimant's counsel is also entitled to an assessed attorney fee under ORS 656.382(2) for services before the Court of Appeals and before the Board on remand.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services before the Court of Appeals and before the Board on remand is $2,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Here, the scenario presented by Representative Mannix occurred. Dr. Misko opined that claimant's symptoms increased to the point that there was an actual worsening of the condition. In addition, Dr. Misko was asked whether this represented a worsening of the condition or simply a waxing and waning. Dr. Misko responded that it was a worsening of the condition. Therefore, the elements of an "actual worsening" pursuant to ORS 656.273(1) are met.

[5] This renumbering was effective June 7, 1995. SB 369, §§ 25, 66. Accordingly, we apply the new number in this case.

Accordingly, on reconsideration, the ALJ's order dated May 27, 1994 is affirmed. For services before the court and before the Board on remand, claimant's counsel is awarded $2,500, to be paid by the insurer. This attorney fee is in addition to the $3,300 granted by the ALJ's order and our prior order.

IT IS SO ORDERED.

February 29, 1996 Cite as 48 Van Natta 473 (1996)

In the Matter of the Compensation of
MARY J. McKENZIE, Claimant
WCB Case Nos. 94-15132 & 94-15131
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Scott Terrall & Associates, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Davis' order that: (1) directed it to pay an earlier ALJ's temporary disability award for the period beginning September 7, 1994; and (2) assessed a penalty of 25 percent of all temporary disability accrued and due since that date. On review, the issues are claim processing and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We offer the following summary of relevant facts.

ALJ Thye previously ordered payment of temporary disability benefits under this claim, commencing September 7, 1994 (the date of his order). (Ex 58). On review, the Board held, inter alia, that the employer was obligated to pay temporary disability benefits from November 17, 1992 until such benefits could be lawfully terminated.[1] (See Ex. 62). The employer paid no temporary disability compensation after ALJ Thye's order.

Claimant requested a hearing, seeking enforcement of ALJ Thye's order. The ALJ directed the employer to pay temporary disability compensation "from the date of [ALJ] Thye's Opinion and Order of September 7, 1994. . . .until such time as the employer/processing agent is entitled pursuant to law to terminate such benefits." (O&O p. 5).

The employer requested review, arguing that it is not required to pay temporary disability benefits beginning on September 7, 1994, because claimant's attending physician authorized no time loss for September 7, 1994 or any period thereafter.[2] We disagree.

The employer's obligation to pay temporary disability was created by ALJ Thye's order directing it to pay such benefits on September 7, 1994. Notwithstanding appeals, ALJ Thye's order was effective and enforceable when issued.[3] See Anthony N. Bard, 47 Van Natta 2016, 2017 (1995). Consequently, we conclude, as did the ALJ, that the employer should have begun paying temporary disability benefits on September 7, 1994.

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[1] Our June 22, 1995 Order on Review, as amended August 16, 1995, is pending before the Court of Appeals.

[2] See 656.262(4)(f); see also ORS 656.268(3); former ORS 656.245(3)(b)(B).

[3] In effect, the employer asks us to ignore (or effectively reverse) ALJ Thye's order and our Order on Review affirming ALJ Thye's order. We decline to countenance a collateral attack on a previous order that issued in a separate hearing. See Elmer F. Knauss, 47 Van Natta 826, on recon, 47 Van Natta 1064 (1995) (An order may be given precedential effect even though adjudication is not final due to an appeal).

In addition, considering the unambiguous order directing the employer to pay temporary disability compensation, the employer's contention that claimant is not entitled to such compensation does not persuade us that the employer had a legitimate doubt regarding its duty to comply with the order. See Imre Kamasz, 47 Van Natta 332, 334 (1995); Karen S. McKillop, 44 Van Natta 2473, 2474 (1992) ("The employer's apparent belief that the award of interim compensation was made in error may be grounds for an appeal in the first proceeding. It is not, however, a legitimate basis for the failure to comply with the order."). Accordingly, we agree with the ALJ that a penalty is warranted. See Glen D. Roles, on remand, 45 Van Natta 282, 284-85 (1993) (We decline to provide sanctuary for conduct which essentially defies the clear directive of a ALJ's order).

Inasmuch as claimant did not timely submit an appellate brief, no attorney fee pursuant to ORS 656.382(2) shall be awarded for services on review. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The ALJ's order dated August 18, 1995 is affirmed.

February 29, 1996 Cite as 48 Van Natta 474 (1996)

In the Matter of the Compensation of
BRADLEY S. PARKER, Claimant
WCB Case No. 94-07649
ORDER DENYING RECONSIDERATION
Rasmussen, et al, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

On January 24, 1996, the Board affirmed an Administrative Law Judge (ALJ's) order that: (1) directed the insurer to pay temporary total disability benefits (TTD) between June 7, 1994 and July 28, 1994; and (2) assessed a 25 percent penalty for the insurer's allegedly unreasonable claims processing. Claimant, pro se, has submitted two letters asking us to "amend" the previous order to award TTD beginning June 7, 1993, rather than June 7, 1994 as found in the order.[1] Inasmuch as the Board's order has become final, we are without authority to consider claimant's request.

A Board order is final unless within 30 days after the date of mailing of copies of such order, one of the parties appeals to the Court of Appeals for judicial review. ORS 656.295(8). 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 the Board's January 24, 1996 order was February 23, 1996. Claimant's February 24, 1996 request was received by the Board on February 26, 1996. Thus, before claimant requested modification of the Board's order, the 30-day period of ORS 656.295(8) had expired. Inasmuch as the Board's January 24, 1996 order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its mailing to the parties, we are without authority to alter the Board's prior decision. See ORS 656.295(8); International Paper Co. v. Wright, supra; Fischer v. SAIF, supra; Donald J. Bidney, 47 Van Natta 1097 (1995). Consequently, claimant's motion for reconsideration is denied.[2]

IT IS SO ORDERED.

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[1] Since it is unclear whether copies of claimant's motions have been provided to the insurer, copies have been included with the insurer's counsel's copy of this order.

[2] Although we are without authority to modify the Board's prior decision, we note that, had we been so authorized, we would not have altered the order. Claimant is essentially seeking TTD for a period which preceded June 7, 1994 (the date of the appealed prior ALJ's order which had set aside the insurer's "back-up" denial). Yet, as explained in the Board's previous order, ORS 656.313(1)(a)(A) required the insurer to only pay TTD commencing with the prior ALJ's June 7, 1994 order. In other words, pending its appeal of the prior ALJ's June 7, 1994 order, the insurer was not obligated to pay any TTD due prior to the June 7, 1994 order. Since our decision was confined to the issue of what TTD was due claimant pending the insurer's appeal of the prior ALJ's June 7, 1994 order, we were necessarily required to limit our award to TTD commencing June 7, 1994.

In the Matter of the Compensation of
CONRID J. PAXTON, Claimant
WCB Case Nos. 95-00537, 94-13809 & 94-10357
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
William J. Blitz, Defense Attorney
James B. Northrop (Saif), Defense Attorney
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation, on behalf of Sun Studs (SAIF/Sun Studs), requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's hearing loss claim; (2) upheld SAIF's denial, on behalf of Woolley Enterprises (SAIF/Woolley), of the same condition; and (3) upheld RLC Industries' (RLC's) denial of the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

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

Claimant was employed by Sun Studs from October 1991 to present, not October 1990 to present. (See Opinion and Order at 1).

CONCLUSIONS OF LAW AND OPINION

The ALJ held that SAIF/Sun Studs was responsible for claimant's hearing loss claim. We disagree.

Claimant was employed as a heavy equipment maintenance worker by Woolley Enterprises from 1977 to January 1981; by RLC from January 1981 to October 1991; and by Sun Studs from October 1991 forward. He has marked work-related hearing loss. At hearing, the issues were compensability and responsibility for that condition. On review, the only issue is which, of the three carriers, is responsible for that condition.

No one has accepted the hearing loss claim; accordingly, we apply the last injurious exposure rule. That rule provides that when, as here, a worker proves that an occupational disease was caused by work conditions that existed when more than one carrier was on the risk, the last employment providing potentially causal conditions is deemed responsible for the disease. Boise Cascade Corp. v. Starbuck, 296 Or 238 (1984). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). If a worker has not experienced time loss due to the compensable condition, the "onset of disability" occurs when the worker first receives treatment for the compensable condition, unless the subsequent employment contributes independently to the cause or worsening of the condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Here, claimant has not experienced time loss due to his hearing loss condition. Because he first received treatment for that condition when SAIF/Sun Studs was on the risk, we initially assign responsibility to SAIF/Sun Studs. Timm v. Maley, supra, 125 Or App at 401.

SAIF/Sun Studs can shift responsibility to a prior carrier by showing that claimant's work exposure while a prior carrier was on the risk was the sole cause of claimant's hearing loss condition, or that it was impossible for conditions while SAIF/Sun Studs was on the risk to have caused that condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985). SAIF/Sun Studs has met its burden.

Dr. Ediger, audiologist, originally concluded that claimant had ear canal collapse and that his left ear hearing loss was due to recreational gun noise. (Ex. 5-6). Ediger subsequently concluded that, based on a comparison of hearing tests from 1981 to the present, the major contributing cause of

claimant's hearing loss was pre-1981 excessive noise exposure. (Ex. 6; see Ex. 5-4). Thereafter, in response to RLC's queries, Dr. Ediger agreed that, if claimant's hearing loss was work-related, it was due to all of his employments, including that at RLC. (Ex. 8-2). In response to queries by SAIF/Sun Studs, Dr. Ediger opined that claimant's hearing loss was caused, in major part, by pre-1981 or 1982 excessive noise exposure. (Ex. 9-1, -2). Finally, Ediger concluded that claimant's hearing loss could not have been caused by his work exposure at Sun Studs, but was solely due to factors other than that employment. (Ex. 11).

Dr. Scott, otolaryngologist, concluded that, based on a June 4, 1981 hearing test, and claimant's relatively unchanged hearing loss thereafter, his hearing loss occurred before 1981. (Ex. 7-3). Similarly, Dr. Hodgson, otologist and neuro-otologist, determined that, based on the June 4, 1981 hearing test, and the fact that claimant has experienced no increase in hearing loss due to occupational noise exposure after 1981, the major portion of claimant's hearing loss is due entirely to occupational noise exposure prior to June 4, 1981. (See Ex. 10A-5).[1]

On this record, we find that the sole cause of claimant's hearing loss was his work exposure before June 4, 1981. In making that finding, we rely on Drs. Scott's and Hodgson's reports to that effect; because they are inconsistent, we do not rely on Dr. Ediger's reports. Consequently, responsibility shifts from SAIF/Sun Studs.

The remaining question concerns which carrier, between RLC and SAIF/Woolley, is responsible for claimant's hearing loss claim. As the last employer of the two, RLC is responsible unless, as stated above, it shows that claimant's work exposure while SAIF/Woolley was on the risk was the sole cause of claimant's hearing loss condition, or that it was impossible for conditions while RLC was on the risk to have caused that condition. See FMC Corp. v. Liberty Mutual Ins. Co., supra, 70 Or App at 374.

RLC has not met that burden. It was on the risk from January 1981 until October 1991. Because the preponderance of the medical evidence establishes that claimant's employment prior to June 4, 1981 caused his hearing loss, and because RLC was on the risk for six months of that time (from January to June 1981), RLC has failed to meet its burden under the sole cause or impossibility tests. Consequently, RLC remains responsible for claimant's hearing loss.

In sum, we conclude that RLC is responsible for claimant's hearing loss claim. Consequently, we reverse the ALJ's decision assigning responsibility to SAIF/Sun Studs.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $500, payable by SAIF/Sun Studs, the carrier that requested Board review. Cigna Insurance Companies v. Crawford & Company, 104 Or App 329, 331 (1990). In reaching that conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated July 21, 1995 is reversed. The SAIF Corporation's denial on behalf of Sun Studs is reinstated and upheld. RLC Industries' denial is set aside and the hearing loss claim is remanded to RLC for processing according to law. The ALJ's assessed fee award of $2,500 shall be paid by RLC, rather than SAIF/Sun Studs. For services on Board review, claimant's attorney is awarded an assessed fee of $500, payable by SAIF/Sun Studs. The remainder of the ALJ's order is affirmed.

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[1] Dr. Hiatt performed a records review, concluding, in a "check-the-box" concurrence report, that claimant's hearing had deteriorated between 1982 and 1994 and that his work activity before May 12, 1982 caused that deterioration. (Ex. 12). Because Hiatt's report is virtually unexplained, we do not rely on it.

In the Matter of the Compensation of
MICHAEL D. QUINTON, Claimant
WCB Case No. 94-13396
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Robert J. Yanity (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order which: (1) upheld the SAIF Corporation's denial of claimant's low back injury claim; and (2) declined to award penalties or attorney fees for SAIF's allegedly unreasonable claim processing. After briefing was completed, the employer submitted a statement from claimant's wife. We treat such a submission as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand, subjectivity, compensability, penalties and attorney fees.

We deny the employer's motion for remand and adopt and affirm the ALJ's order with the following supplementation.

Remand

The employer submitted a statement from claimant's wife in which she alleges that claimant was not injured on the job in Colorado. As previously noted, we generally treat such submissions as a motion for remand. See Judy A. Britton, supra.

We may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. See ORS 656.295(5). To warrant remand, the moving party must show good cause or a compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). A compelling basis exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Inasmuch as we agree with the ALJ that SAIF's denial was proper, the statement submitted is unlikely to affect the outcome of the case (see discussion of issues below). Accordingly, we find no good cause or compelling basis to remand. We, thus, deny the employer's motion for remand.

Subjectivity

In July 1994, the employer abruptly abandoned its logging activities in Oregon and moved most of its operation to Colorado. (Tr. 35, 51). The ALJ upheld SAIF's denial of claimant's alleged August 29, 1994 low back injury incurred while working in Colorado. The ALJ reasoned that claimant, a logger, was not a subject worker at the time of injury, because claimant did not have a reasonable expectation of continuing an employment relationship in Oregon after completion of work in Colorado. Therefore, the ALJ determined that claimant was not a worker who had temporarily left the state incidental to his employment and that he was not entitled to workers' compensation benefits in Oregon.

In order to receive Oregon workers' compensation benefits for an injury sustained in another jurisdiction, a worker must be employed in Oregon and become injured while temporarily out of state incidental to Oregon employment. ORS 656.126(1).[1] In construing ORS 656.126(1), Oregon courts have applied a "permanent employment relation test," wherein all circumstances are relevant, including the intent of the employer, the understanding of the employee, the location of the employer and its facilities, the circumstances surrounding claimant's work assignment, the state laws and regulations to which the employer is otherwise subject, and the residence of the employees. Northwest Greentree, Inc. v. Cervantes-Ochoa, 113 Or App 186, 189-90 (1992) (citations omitted).

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[1] ORS 656.126(1) provides:

"If a worker employed in this state and subject to this chapter temporarily leaves the state incidental to that employment and receives an accidental injury arising out of and in the course of employment, the worker, or beneficiaries of the worker if the injury results in death, is entitled to the benefits of this chapter as though the worker were injured within this state."

Under the test, the key inquiry is the extent to which claimant's work outside the state is temporary. Power Master Inc. v. Blanchard, 103 Or App 467, 471 (1990); Hobson v. Oregon Dressing, Inc., 87 Or App 397, 400, rev den 304 Or 437 (1987); Phelan v. H.S.C. Logging, Inc., 84 Or App 632, 635, rev den 303 Or 590 (1987). The out-of-state work must be incidental to work performed in Oregon for an Oregon employer and there must be proof of an established employment relationship between the worker and this employer in Oregon before the out of state injury occurs. Steven A. Dancer, 40 Van Natta 1750 (1988); aff'd mem 99 Or App 488 (1989). In addition, the worker must have a reasonable expectation of returning to work for the employer in Oregon. Roy L. Center, 44 Van Natta 365, 367 (1992); Lyle E. Estes, 43 Van Natta 62, 63 (1991) .

There is no dispute that claimant and the employer had an established employment relationship in Oregon before the out-of-state injury allegedly occurred. Claimant asserts that the ALJ erred in concluding that claimant did not have a reasonable expectation of returning to work for the employer in Oregon.

Claimant cites portions of his testimony which he asserts establishes that his work in Colorado was temporary and that he reasonably expected to return to Oregon to work for his employer. These include his testimony that the employer's operation in Colorado was temporary, that he maintained an Oregon residence throughout his employment in Colorado, that he intended to return to work in Oregon, and that the employer's equipment was sent back and forth between Oregon and Colorado. Claimant also cites the memorandum of a conversation between SAIF's claims specialist and the employer's bookkeeper, in which it is recorded that the employer intended to return to Oregon upon completion of the Colorado job and that claimant was employed only temporarily in Colorado. (Ex. 1-YB). Finally, claimant argues that the employer's renewal of its insurance policy with SAIF in July 1994 also evidences the employer intent to remain in Oregon and demonstrates that claimant's expectation of returning to the state was reasonable. We disagree.

First, there is no evidence in the record that explains why the employer renewed its policy with SAIF. Under these circumstances, we refuse to speculate about the employer's intentions based on its renewal of its SAIF insurance policy. Second, there is no explanation in the memorandum of the conversation between SAIF's claims specialist and the employer's bookkeeper of the basis on which the bookkeeper concluded that the employer intended to return to Oregon. Finally, while claimant may have anticipated returning to Oregon to work for his employer, claimant's own testimony demonstrates that this expectation was not reasonable.

Claimant testified that he anticipated working again in Oregon, provided that "timber, you know, came back, this was our base." (Tr. 49). However, there is no evidence that reliance on this contingency was reasonable. Claimant, himself, testified that the employer moved to Colorado because work in Oregon was "dying out." (Tr. 51). Claimant also conceded that job prospects in Oregon looked "pretty grim" and that there was no work to come back to in Oregon. (Tr. 58, 59). Claimant only knew of one employee, a log truck driver, who remained in Oregon to work after operations were moved to Colorado. (Trs. 71). All other employees were moved out of Oregon. Claimant explained that, while initially paychecks for work performed in Colorado were issued through an Oregon bank, paychecks were subsequently drawn on a Colorado bank. (Tr. 52-3). Finally, claimant testified that the last paper work he received from the employer came from New Mexico. (Tr. 52). As far as claimant knew, the employer had completely ceased operations in Oregon on January 1, 1995. (Tr. 54).

In light of this testimony, we agree with the ALJ that claimant did not have a reasonable expectation of returning to work in Oregon, even though he may have believed that the possibility still existed. Roy L. Center; Lyle E. Estes, supra.[2] The record establishes that, when the employer

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[2] In reaching this conclusion, we distinguish Todd E. Moe, Dec'd, 46 Van Natta 1752 (1994). There, we held that the employer was a subject Oregon employer and that the decedent was a subject Oregon employee at the time he sustained his fatal injury in Montana. We reasoned that, since the record established that the employer intended to return to Oregon after temporarily conducting logging operations in Montana, the decedent had a reasonable expectation of returning to work in Oregon when he was fatally injured.

In contrast to the decedent in Moe, claimant in this case did not have a reasonable expectation of returning to Oregon in light of his testimony concerning the state of the timber industry in Oregon, the employer's abrupt departure from Oregon, and the cessation of the employer's operations in Oregon. In contrast to Moe, where the facts did not indicate that the employer had

abandoned its Oregon logging activities in July 1994, there was no Oregon employment to which claimant could return. Therefore, we agree with the ALJ's determination that, when claimant was allegedly injured, he was not temporarily employed in Colorado incidental to Oregon employment.

Estoppel

Claimant also contends that SAIF is estopped from denying coverage of claimant's Colorado injury. According to claimant's testimony, his supervisor, Mr. Adams, assured him, both prior to the move to Colorado and during operations in Colorado, that SAIF would cover any on-the-job injuries. (Trs. 37, 41). Claimant also testified that an unidentified representative from SAIF assured him after his injury that SAIF would take care of his injury. (Tr. 68). Claimant, citing Paulson v. Western Life Insurance Co., 292 Or 38 (1981), asserts that he relied to his detriment on the representations of his employer, whom he asserts was SAIF's agent, and of SAIF. We do not find claimant's estoppel argument persuasive.

We turn first to claimant's contention that SAIF should be estopped from denying coverage based on representations made by his supervisor. In Paulson, one issue was whether, in a group-health insurance context, the employer-policyholder, in the administration of the insurance policy, was the agent of the insurer, of the insured worker, or the agent of neither. The Court wrote that:

> "when the plan is exclusively administered by the insurer, as a matter of law no agency relationship exists between the insurer and the employer. But if the employer performs all of the administration of the policy, an agency relationship exists between the insurer and the employer, as a matter of law. Between these two extremes, as the division of functions becomes less separate, or to put it another way, as the employer assumes responsibility for more administrative or sales functions which are customarily performed by an insurer, a question of fact will arise as to the agency relationship between the insurer and the employer." 292 Or at 44.

While Paulson stands for the proposition that, under certain circumstances, an employer could become an agent of the insurer, we are not persuaded that this principle is applicable here. First, this is not a dispute concerning group-health insurance. More importantly, there is no evidence in the record concerning the extent to which, if any, the employer assumed responsibility for administrative or sales functions with respect to its insurance policy. On this record, we are unable to conclude that an agency relationship existed between the employer and SAIF. Thus, we conclude that claimant's supervisor's alleged statements did not estop SAIF from denying coverage of claimant's injury in Colorado, even assuming that claimant relied on these representations in deciding to move to Colorado.

We are also not persuaded that the doctrine of estoppel applies with respect to the alleged representation by SAIF after claimant was injured that "everything would be taken care of." In order to prove an estoppel, there must be evidence "from which the trier of fact could find that (1) a false representation (albeit an innocent one) was made (2) by someone having knowledge of the facts to (3) one who was ignorant of the truth, (4) that the statement was made with the intention that it be acted upon by the plaintiff and (5) that plaintiff acted upon it." Collver v. Salem Ins. Agency, Inc., 132 Or App 52, 62 (1994) (citing Paulson v. Western Life Insurance Co., supra).

In this case, claimant had already been injured when he was purportedly assured by SAIF that his injury would be covered. Thus, claimant could not have acted in reliance on any statement by SAIF. We, therefore, find that claimant has failed to prove an estoppel.

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permanently moved to Montana, the record here compels a different conclusion. It is true that, as in Moe, the employer in this case paid its Oregon workers' compensation insurance premiums. Unlike Moe, however, the employer, here, did not testify regarding its expectations. Based on claimant's testimony which indicates that the employer completely ceased any business activities in Oregon by January 1, 1995, and, indeed, had maintained a very minimal level of business activity in the state prior to that time, we are not persuaded that the employer intended to return to Oregon after completion of work in Colorado. Moreover, even if the employer did intend to resume Oregon operations, we would still conclude that, given claimant's testimony, any expectation that claimant could resume an employment relationship with this employer in Oregon was not reasonable.

Penalties and Attorney Fees

Claimant also alleges that SAIF's denial was unreasonable and that penalties and/or attorney fees should be awarded for this, as well as SAIF's failure to timely provide discovery of the memorandum of conversation between SAIF's claims specialist and the employer's bookkeeper. We disagree.

Given our resolution of this claim, we find that SAIF did not unreasonably deny claimant's claim. Moreover, we agree with SAIF that, even if it did not timely provide discovery to claimant, claimant is not entitled to a penalty. As a result of our order, there are no "amounts due" on which to base a penalty under ORS 656.262(11). In addition, there is no basis for an attorney fee pursuant ORS 656.382(1). Because there is no evidence that any compensation was due at the time of the allegedly unreasonable conduct, there can be no unreasonable resistance to the payment of compensation. SAIF v. Condon, 119 Or App 194, 196, rev den 317 Or 163 (1993); Bruce Hardee, 46 Van Natta 2261, 2263 (1994).

ORDER

The ALJ's order dated March 27, 1995 is affirmed.

February 29, 1996 Cite as 48 Van Natta 480 (1996)

In the Matter of the Compensation of
JERRY R. VORCE, Claimant
WCB Case No. 95-02938
ORDER ON REVIEW
Huffman, Zenger & Rich, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The noncomplying employer (NCE), R & L Peterson Mfg., requests review of Administrative Law Judge (ALJ) Neal's order that upheld the SAIF Corporation's acceptance of claimant's left hand injury and psychological condition. The NCE contends that claimant was not a subject worker at the time of his injury. On review, the issue is subjectivity. We affirm.

FINDINGS OF FACT

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

Claimant began working on the shingle saw at Mr. Peterson's mill approximately three weeks prior to his injury on December 3, 1993. (Tr. 163; Ex. 6-2). At that time, claimant discussed purchasing the saw from Mr. Peterson for $1, but claimant indicated he was not sure he wanted to, and the deal never materialized. (Tr. 163, 172, 185; Ex. 6-3). Nevertheless, claimant agreed to try operating the shingle saw, although he had no experience or training on that equipment. (Tr. 186; Ex. 6-2). During the time he worked as a shingle sawyer, claimant did not have his own labels for the shingles he produced, but instead used Mr. Peterson's labels. (Tr. 44, 57-58). He did not purchase his own liability insurance, nor did he register or file taxes as a business entity. (Tr. 166, 177; Ex. 6-3).

Claimant believed that Mr. Peterson had the authority to monitor the quality and quantity of his work, as well as the right to fire claimant, at the time he worked as a shingle sawyer. (Tr. 176). Claimant also believed that Mr. Peterson had the authority to set the hours of his work. (Tr. 178-79). Claimant considered Mr. Peterson to be his boss, with the authority to hire and fire. (Ex. 6-3; see also Tr. 167-68, 179).

CONCLUSIONS OF LAW AND OPINION

In order to determine whether a person is a "subject worker" under the Workers' Compensation Law, the first inquiry is whether a person is a "worker." S-W Floor Cover Shop v. Natl. Council on Comp. Ins., 318 Or 614, 630 (1994). The next inquiry is whether the "worker" is a "nonsubject" worker pursuant to one of the exceptions under ORS 656.027. Id.; amended ORS 656.005(28). On review, the NCE concedes that if claimant was a worker at the time of his injury, he was not a nonsubject worker.

(Appellant's Brief at 3). Accordingly, the dispute in this case concerns whether claimant was a "worker."

Amended ORS 656.005(30)[1] defines a "worker" as "any person . . . who engages to furnish services for a remuneration, subject to the direction and control of an employer[.]" Whether one is a "worker" incorporates the judicially created "right to control" test. S-W Floor Cover Shop, supra. The principal factors in the traditional "right to control" test are: "(1) direct evidence of the right to, or the exercise of, control; (2) the method of payment; (3) the furnishing of equipment; and (4) the right to fire." Castle Homes, Inc. v. Whaite, 95 Or App 269, 272 (1989) (citation omitted).

If application of the "right to control" test is inconclusive in determining whether one is a worker, it is appropriate to apply the "relative nature of the work" test. Kaiel v. Cultural Homestay Institute, 129 Or App 471, 477 (1994); Daniel C. Greer, 47 Van Natta 48, 49 (1995). The factors that are considered under the "relative nature of the work" test include: (1) the character of the claimant's work; i.e., how skilled it is, how much of a separate calling it is and the extent to which it may be expected to carry its own accident burden; and (2) the relationship of claimant's work to the employer's business; i.e., how much it is a part of the employer's regular work, whether it is continuous or intermittent and whether the duration is sufficient to amount to the hiring of continuing services, as distinguished from contracting for completion of a particular job. Woody v. Waibel, 276 Or 189, 195 (1976); Daniel C. Greer, supra, 47 Van Natta at 49-50.

Applying the right to control test, we conclude that claimant was a worker, based on the following reasoning.

Claimant testified that he was paid on a piecework basis, based on the number of squares of shingles he produced each week. Mr. Peterson agreed that he paid claimant a certain amount per square of shingles, but he characterized this payment as a draw against claimant's share of profits. (Tr. 38-39, 55, 79-80, 82). We find claimant's testimony more persuasive regarding the method of payment.

The NCE's characterization of the method of payment derives from the terms of an alleged contract between claimant and Mr. Peterson, whereby claimant was to buy the shingle saw, operate it as an independent contractor, and realize 30 percent of the profits from Mr. Peterson's sale of the shingles. (Tr. 34-39, 79). We agree with the ALJ's determination that such a contract did not exist. The alleged contract was not in writing. (Tr. 36). Claimant was not aware of an alleged contract prior to hearing, and even Mr. Peterson admitted that he had not discussed some of the terms of the contract with claimant. (Tr. 63, 67, 69-70, 80, 163-64). Therefore, we conclude that there was no oral contract between claimant and Mr. Peterson concerning the sale of equipment and establishing an independent contractor relationship.

Claimant's description of the method of payment is also consistent with Mr. Peterson's prior method of paying sawyers. (Tr. 120-21, 125, 133-34). Accordingly, we conclude that claimant was paid by the piece of work produced. When payment is by quantity, the method of payment factor in the "right to control" test is largely neutral. Henn v. SAIF, 60 Or App 587, 592 (1982).

Turning to the other factors in the "right to control" test, we again find claimant's testimony more persuasive. Claimant testified that he considered Mr. Peterson to be his boss. He believed Mr. Peterson had the authority to monitor the quality and quantity of his work, as well as to set the hours of his work. Claimant believed Mr. Peterson could fire him. Mr. Peterson's contrary testimony is premised on the existence of a contract between himself and claimant, which we have found did not exist. Accordingly, we rely on claimant's more persuasive testimony and conclude that the NCE had the right to control claimant's work, as well as the right to fire claimant.

Regarding the final factor, we find that the NCE furnished claimant's equipment. Claimant testified that he discussed buying the shingle saw from Mr. Peterson for $1, but that the deal never materialized. Mr. Peterson, on the other hand, testified to a complicated contractual arrangement whereby claimant was allegedly buying the saw and operating it independently. As discussed above, we find that the alleged contract did not exist. Therefore, we find claimant's testimony more persuasive and conclude that claimant was not buying the saw from Mr. Peterson at the time of his injury. Accordingly, we conclude that the NCE furnished claimant's equipment.

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[1] Prior to the amendments of SB 369, effective June 7, 1995, this provision was numbered ORS 656.005(28). SB 369 renumbered the provision, but did not change the language. Or Laws 1995, ch 332, § 1(30) (SB 369, § 1).

Considering all the "right to control" factors, we find that the evidence establishes that claimant was subject to the direction and control of the NCE. Accordingly, we find that claimant was a worker under the "right to control" test.

Since we have found claimant to be a worker under the "right to control" test, we need not inquire further. However, were we to find the evidence under the "right to control" test inconclusive, we would apply the "relative nature of the work" test to determine the relationship between claimant and the NCE. Kaiel, supra; Daniel C. Greer, supra. Under that test, we would also conclude that claimant was a worker.

Claimant was unskilled in operating the shingle saw when he undertook to operate that equipment. According to claimant, Mr. Peterson approached him about operating the shingle saw when the former sawyer left. (Tr. 163). Previously claimant had been a packer and bolt cutter at Mr. Peterson's mill. (Tr. 159-60). Claimant did not carry his own insurance, nor would we find it reasonable for someone who made as little as claimant (approximately $150 per week as a sawyer) to carry his own accident burden. (Tr. 51; Ex. 6-2).

In addition, claimant's work sawing shingles was an integral part of Mr. Peterson's business of producing and selling shakes and shingles. (Tr. 126-27). As Mr. Grebenc, the former shingle sawyer, testified, it would not make sense for Mr. Peterson to have a sawyer working independently, buying logs and selling the finished product independent of Mr. Peterson. (Tr. 129). Furthermore, claimant appeared to have been hired to work on a continuous basis, rather than for completion of a particular job. Accordingly, considering the character of claimant's work and the relationship of claimant's work to the employer's business, we would find claimant to be a worker.

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 438-15-010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $300, payable by the SAIF Corporation on behalf of the NCE. 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 June 12, 1995 order, as amended June 14, 1995 and June 20, 1995, is affirmed. Claimant's attorney is entitled to $300 for his services on Board review, to be paid by the SAIF Corporation on behalf of the NCE.

February 29, 1996 Cite as 48 Van Natta 482 (1996)

In the Matter of the Compensation of
KIM D. WOOD, Claimant
WCB Case Nos. 92-16294 & 92-11017
ORDER ON REMAND
Galton, Scott & Colett, Claimant Attorneys
Frank J. Susak, Defense Attorney
Schwabe, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Bills Kwik Market v. Wood, 135 Or App 692 (1995). In accordance with the court's order, this case has been remanded to us for reconsideration in light of Senate Bill 369.

In our prior order, we reversed those portions of the ALJ's order which: (1) upheld Grocers Insurance's (Grocers') denial of claimant's aggravation claim for a left knee condition; and (2) awarded claimant interim compensation from May 21, 1992 through May 31, 1992. In addition, we affirmed those portions of the ALJ's order that: (1) declined to assess a penalty or related attorney fee for Grocers' allegedly unreasonable aggravation denial; (2) declined to award claimant an assessed attorney fee for prevailing against Grocers' alleged "de facto" denials of her left patellar conditions; (3) declined to assess a penalty or related attorney fee for Grocers' allegedly unreasonable failure to pay interim compensation; and (4) declined to assess a penalty or related attorney fee for Consolidated Freightways'

allegedly unreasonable claims processing. Kim D. Wood, 46 Van Natta 1827 (1994). On reconsideration, we withdraw our prior order and issue the following order.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the second paragraph on page 5 of the order and briefly summarize the relevant facts.

In April 1988, claimant sought treatment for left knee symptoms from Dr. Tesar, M.D. Dr. Tesar diagnosed a left knee medical meniscus tear and recommended surgery. In May 1988, Dr. Tesar arthroscopically removed a loose body and shaved the medial femoral condyle. Claimant's post-operative diagnosis was a chondral defect in the medial femoral condyle, as well as a loose body in the left knee.

In July 1989, claimant slipped and fell on the anterior aspect of her left knee while working for Grocer's insured. She sought treatment from Dr. Keizer, M.D., who diagnosed a possible torn meniscus and a derangement on the inferior surface of the left patella. Dr. Keizer performed an arthroscopy in which he found and shaved a dime-size defect in the area over claimant's left medial femoral condyle. Claimant continued to experience left knee symptoms and in October 1989, Dr. Keizer performed a left patellar lateral retinacular release. Grocers' paid for this surgery and the resultant temporary disability benefits.

Following the July 1989 incident, claimant filed an 801 form alleging that she had sustained a work-related injury to her left knee. By letter dated August 28, 1989, Grocers' accepted a "left knee strain." Claimant's claim was closed by a January 30, 1990 Notice of Closure which award temporary disability benefits only. A March 21, 1990 Determination Order modified the Notice of Closure to include a 5 percent award of scheduled permanent disability for loss of the left leg (knee). By stipulation dated June 4, 1990, claimant's award of scheduled permanent disability was increased to 15 percent.

Claimant returned to work at Grocers' insured, but continued to experience left knee symptoms. In an October 2, 1990 letter, Dr. Keizer reported that claimant was unable to perform her work duties due to residual chondromalacia of the left patellofemoral joint. In December 1990, claimant began working for Consolidated Freightways as a file clerk.

In February 1992, claimant began experiencing increased symptoms in her left knee. She sought treatment from Dr. Grossenbacher, M.D., who diagnosed left patellar instability and chondrolmalacia. As a result of her ongoing symptoms, Dr. Grossenbacher performed arthroscopic surgery with patellar medial facet shaving and medial femoral condyle shaving in June 1992. Thereafter, both Grocers' and Consolidated Freightways denied claimant's left knee condition both on compensability and responsibility grounds.

CONCLUSIONS OF LAW AND OPINION

Scope of Acceptance/Aggravation

Claimant asserts that the ALJ erred in upholding Grocers' denials of her aggravation claim for a left knee condition. Specifically, claimant contends that Grocers' accepted her entire left knee condition as it existed in 1989, including conditions that were caused by the noncompensable 1988 left knee injury and preexisted the 1989 accepted left knee injury. We disagree.[1]

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[1] On remand, claimant asserts that the only issue is the affect of Senate Bill 369 on our prior decision in this case. Claimant's assertion, however, is based on the incorrect assumption that our previous order is the "law of the case." Inasmuch as this matter was remanded to us for reconsideration, our previous order is a nullity. See Dung T. Nguyen, 44 Van Natta 477 (1992) (order on remand reached different conclusions than order on review); Nancy C. Evenhus, 42 Van Natta 2625 (1990) (since court had remanded for the Board to review remaining issues raised by the denial, no finding within an order had yet become final in the matter).

Acceptance of a claim encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49 (1987). Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449 (1992). "Merely paying or providing compensation shall not be considered as an acceptance of a claim or an admission of liability." ORS 656.262(10) (formerly ORS 656.262(9)).

Here, the only condition that Grocers' specifically accepted in writing was a "left knee strain." (Ex. 9). Inasmuch as there is a specific acceptance, we need not look to the contemporaneous medical evidence to determine what condition was accepted by Grocers'. See Cecilia A. Wahl, 44 Van Natta 2505 (1992) (When the acceptance does not identify the specific condition, we look to the contemporaneous medical records to determine what condition was accepted). Moreover, the fact that no physician had diagnosed a knee strain at the time of acceptance neither changes the condition specifically accepted by Grocers'[2] nor does it make Grocers' liable for conditions that it had not specifically accepted in writing. See Johnson v. Spectra Physics, supra. Similarly, the fact that Grocers' paid disability compensation and medical services expenses does not make Grocers' liable for condition's other than those specifically accepted in writing. ORS 656.262(10).

Under these circumstances, we conclude that the only condition accepted by Grocers' was a left knee strain. We now turn to the merits of claimant's aggravation claim.

Claimant's current left knee condition involves patellofemoral instability with chrondromalacia of the medial femoral condyle and degenerative arthritic changes in the medial compartment. None of these conditions have been accepted by Grocers'. Moreover, the medical opinions are in agreement that claimant's medial femoral condyle condition preexisted her compensable injury and contributes to her current left knee condition. (Exs. 50, 51, 54, 56, 60, 61, 63, 65, 66). Consequently amended ORS 656.005(7)(a)(B) is applicable. See Gloria T. Olson, 47 Van Natta 2348 (1995). Thus, it is claimant's burden to establish that the July 11, 1989 injury is the major contributing cause of her current left knee condition.

Dr. Grossenbacher, one of the claimant's treating surgeons, initially concluded that claimant's 1992 knee problems were related to her 1989 work injury. (Ex. 38-2). Subsequently, Grossenbacher opined that claimant's current left knee problems stemmed from her 1988 noncompensable injury to the medial femoral condyle. (See Ex. 57). Dr. McNeil, examining physician, concluded that claimant's current left knee problems were directly related to her 1988 medial femoral condyle. (Ex. 58).

Thereafter, Dr. Grossenbacher stated that claimant's primary problem related to her degenerative medial femoral condyle condition, which had been first documented in 1988. (Ex. 61). In a final concurrence letter, Grossenbacher agreed that the major contributing cause of claimant's current condition was the degenerative changes in her medial femoral condyle. (Ex. 65). There are no contrary medical opinions.

In light of the opinions of Drs. Grossenbacher and McNeil which indicate that claimant's preexisting condition is the major, if not direct, cause of her current condition, claimant has failed to establish that her current left knee condition is compensable. Consequently, Grocers' denial must be upheld.

Penalty and Related Attorney Fee for Grocers' Allegedly Unreasonable Denial

We adhere to and republish the conclusions and reasoning contained in our September 8, 1994 order.

Assessed Attorney Fee for Prevailing against Grocers' Alleged "De Facto" Denials of Claimant's Left Patellar Conditions

We adhere to and republish the conclusions and reasoning contained in our September 8, 1994 order.

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[2] We note that in an August 12, 1992 report, Dr. Perry, who performed an insurer-arranged medical examination, opined that claimant's July 1989 compensable injury likely represented a knee sprain/strain superimposed as an aggravation upon claimant's preexisting left knee condition. (Ex. 50-5). Consequently, contrary to the dissent's contention, it would appear that a condition exists corresponding with Grocers' prior claim acceptance.

Interim Compensation

We adhere to and republish the conclusions and reasoning contained in our September 8, 1994 order.

Unreasonable Claims Processing -- Consolidated Freightways

We adhere to and republish the conclusions and reasoning contained in our September 8, 1994 order.

ORDER

The ALJ's order dated May 4, 1993 is reversed in part and affirmed in part. That portion of the ALJ's order that awarded claimant interim compensation from May 21, 1992 through May 31, 1992, and assessed a penalty based on those amounts is reversed. The remainder of the order is affirmed.

Chair Hall concurring in part and dissenting in part.

I agree with the majority's disposition of the interim compensation, penalty, and attorney fee issues. However, the majority also concludes that claimant's current left knee condition was not encompassed within Grocers' initial acceptance. Because I believe our initial decision on this issue was legally and factually correct, I dissent.[1]

The majority relies on Johnson v. Spectra Physics, 303 Or 49 (1987) to support its conclusion that the condition accepted by Grocers' was a "left knee strain." I find the majority's reliance misplaced. Johnson involved a "back up" denial and in that context, the Supreme Court held that the acceptance of a claim only encompasses those conditions specifically and officially accepted in writing. Johnson, supra at 55-56. There, the insurer had accepted in writing fewer than all of the claimant's conditions. The court concluded that, because the insurer had taken no action regarding one of the claimant's conditions, the insurer had not accepted that condition. Id.

The Supreme Court has recognized and discussed its limited holding in Johnson. In SAIF v. Allen, 320 Or 192 (1994), the Court indicated that Johnson concerned the requirements for an acceptance to trigger a "back-up" denial and not the requirements for a denial of a claim for compensation. Id. at 215.

In contrast to Johnson, the present case does not involve a "back up" denial. Moreover, Grocers' acceptance identified a condition that not only did not exist, it was never even diagnosed and claimant never sought treatment for it. For these reasons, Johnson is distinguishable.

Although it is undisputed that Grocers' accepted claimant's 1989 knee injury claim, the effect of the majority's decision is to render that acceptance a nullity and leave this claimant, some five years after the original "accepted" injury, with no "accepted" claim at all. Since no "strain" was ever claimed or diagnosed, the majority's conclusion that Grocers' accepted a "strain" condition makes no sense. I would continue to adhere to the original decision in this case and find, based on SAIF v. Tull, supra and Georgia-Pacific v. Piwowar, 305 Or 494 (1988), that consistent with its actions in handling this case, Grocers acceptance encompassed all of the conditions that caused claimant's symptoms and need for treatment following her 1989 compensable injury, including the preexisting medial femoral condyle condition. See Janet L. Lundsten, 46 Van Natta 1747 (1994).

In answer to the court's remand of this case for reconsideration in light of Senate Bill 369, it is concluded that determining "the scope of acceptance" is still an issue of fact, and that SAIF v. Tull supra and Piwowar, supra remain the law.

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[1] I note that the present majority opinion is, in essence, Member Haynes' dissent in the Board's initial order. The initial majority opinion was issued by myself and former Member Westerband. The facts have not changed.

In the Matter of the Compensation of
MORRIS B. GROVER, Claimant
Own Motion No. 96-0046M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al, Claimant Attorneys
EBI Companies, Insurance Carrier

Claimant requests reconsideration of our February 6, 1996 Own Motion Order in which we declined to reopen his 1979 claim for the payment of temporary disability compensation because he failed to establish he was in the work force at the time of his current disability.

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

On December 26, 1995, Dr. Dunn, claimant's treating physician, recommended a revision of claimant's fractured patellar component. Thus, we conclude that claimant's compensable condition has worsened requiring surgery.

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

The insurer initially contended that claimant was retired, and thus, was not in the work force at the time of current disability. Claimant contends that he qualifies for temporary disability compensation because he was declared permanently and totally disabled due to a subsequent work injury.

In a February 22, 1996 letter, the insurer informed the Board that:

> "[The insurer] is rescinding the carrier's Own Motion recommendation dated January 19, 1996 regarding [claimant] as this was issued in error. I refer you to the June 26, 1986 Opinion and Order in which [claimant] was declared permanently and totally disabled."

We treat the insurer's letter as a concurrence with claimant's position that he remains in the work force, unable to work due to his permanent total disability.

On this record, we conclude that claimant has established that he remained in the work force at the time of current disability.

Parenthetically, because claimant is receiving permanent total disability benefits on a subsequent injury claim, he contends that he is "entitled to receive compensation from both employers." Claimant is not entitled to receive more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Therefore, if concurrent temporary disability compensation is due claimant as a result of this order, the insurer may petition the Workers' Compensation Division for a pro rata distribution of payments. OAR 436-60-020(8) and (9).

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL A. BEALL, Claimant
WCB Case No. 94-01552
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Lindsay, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) upheld the insurer's denial of claimant's left shoulder injury claim; and (2) declined to assess 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.

Claimant requested a hearing from the insurer's denial of his left shoulder joint injury. At hearing, the insurer "denied there was an injury at work that caused the shoulder strain." Based on the credible persuasive testimony of the insurer's two witnesses, the ALJ concluded that, more likely than not, claimant's injury could not have happened as he described. Finding the medical evidence based upon claimant's unreliable history of his injury not persuasive, the ALJ concluded claimant had failed to prove the compensability of his claim.

On review, claimant contends that "this case is supposed to be about claimant's left shoulder injury. The mechanics of the accident itself was not among claimant's Specification of Issues." Claimant therefore requests that, if the Board finds the accident details are dispositive but inconclusive, the case be remanded to the ALJ so that the record may be sufficiently developed. See ORS 656.295(5).

To the extent claimant suggests that considering whether his injury occurred as he alleged was beyond the scope of the ALJ's review, we disagree. Inasmuch as claimant raised the issue of the compensability of his left shoulder condition, he necessarily has the burden to prove that the injury is compensable. See ORS 656.266. ORS 656.005(7)(a) defines "compensable injury" as, in part, "an accidental injury . . . arising out of and in the course of employment requiring medical services or resulting in disability or death." The "in the course of" portion of the definition encompasses the concept of legal causation, considering time, place and circumstances. Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994).

When parties litigate an issue by implicit agreement, that issue properly is considered by the ALJ even though it was not a ground relied upon by the insurer in its denial. Judith M. Morley, 46 Van Natta 882, on recon 46 Van Natta 983 (1994). See also Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for the ALJ and Board not to decide that issue). Conversely, when the claimant objects to the insurer's oral amendment to its denial, we consider it error for the ALJ to consider the amended denial. Dolph M. Wiedenmann, 46 Van Natta 1584 (1994).

Here, the issue was framed at hearing as the insurer's denial of claimant's left shoulder condition. During opening statements, the insurer stated that "we denied there was an injury at work that caused the shoulder strain, and we'll have evidence to support that position by way of two witnesses." (Tr. 15). There was no objection or response from claimant's attorney regarding the insurer's opening statement. Assuming, without deciding, that the issue at hearing did not pertain to whether the accident occurred as claimant alleged, evidence was presented without objection on that issue. Because the parties tried the issue of whether claimant's injury occurred in the course of his employment by implicit agreement (that is, without objection), we conclude that the issue was properly before the ALJ. Judith M. Morley, supra; Weyerhaeuser Co. v. Bryant, supra.

We next consider whether the record regarding the details of the accident is completely and sufficiently developed. We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate on a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, claimant testified as to the manner of his injury and had the opportunity to call witnesses to support his theory of injury. Likewise, the insurer called two witnesses who testified that the accident could not have occurred as claimant described. Under these circumstances, we find that the record regarding whether claimant's left shoulder injury arose out of and in the course of his employment is completely and sufficiently developed. Moreover, claimant does not indicate what additional evidence could be presented concerning the mechanism of the accident. Thus, we find there is no compelling reason to remand this matter to the ALJ for further evidence taking.

ORDER

The ALJ's order dated April 28, 1995 is affirmed.

March 4, 1996 Cite as 48 Van Natta 488 (1996)

In the Matter of the Compensation of
WAYNE L. DUVAL, Claimant
WCB Case No. 93-06091
ORDER ON REMAND
Coons, Cole & Cary, Claimant Attorneys
Roberts, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Cabex Mills, Inc. v. Duval, 137 Or App 525 (1995). In our prior order, we held that the insurer was barred by claim preclusion from denying that claimant's left knee degenerative arthritis was part of his 1977 accepted left knee injury claim and, therefore, that his current left knee condition was compensable. Wayne L. Duval, 46 Van Natta 2423 (1994). The court has remanded the case for reconsideration in light of the intervening amendments to the Workers' Compensation Act.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, as supplemented in our prior order.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant originally injured his left knee at work in March 1977. He described a twisting left knee injury on an "801" form. (Ex. 2). In April 1977, Dr. Schachner, treating physician, diagnosed a torn meniscus and, during a June 6, 1977 surgery, discovered degenerative arthritis. (Exs. 1, 3). On a June 9, 1977 "802" form, the insurer indicated that it had accepted the left knee claim. (Ex. 3A). The insurer did not learn of the degenerative arthritis until sometime thereafter.[1]

Prior to claim acceptance, Dr. Schachner indicated that claimant's symptoms were due to the torn meniscus. (See Ex. 1). Thereafter, Schachner saw claimant for complaints related to the underlying arthritis. (Ex. 7-1). In a November 1977 closing report, Dr. Schachner concluded that claimant's meniscal symptoms had resolved and that any residual symptoms were related to the underlying arthritis. (Id.) A January 1978 Determination Order awarded claimant 15 percent permanent disability for loss of left leg. No one appealed that order.

Claimant did not seek treatment for his left knee again until early 1993, at which time Dr. Carter recommended a total knee arthroplasty for advanced degenerative arthritis. The insurer denied the claim on the ground that there was insufficient evidence that the current condition and need for treatment were related to the 1977 injury.

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[1] The record does not establish when the insurer received Dr. Schachner's operative report. The report indicates, however, that it was not transcribed until June 8, 1977. (Ex. 3). In the absence of any indication to the contrary, we find that the insurer did not receive the report until after it issued the "802" form, which indicated that it had already accepted the injury claim.

Claimant requested a hearing. The ALJ rejected claimant's argument that, by failing to contest the 1978 Determination Order, the insurer had accepted the degenerative arthritis. The ALJ then concluded that claimant had failed to establish the compensability of his current left knee condition under ORS 656.005(7)(a)(B).

Claimant requested Board review. On review, we concluded that, under Messmer v. Deluxe Cabinet Works, 130 Or App 254, rev den 320 Or 507 (1995), the insurer was barred by claim preclusion from denying that claimant's degenerative arthritis was part of his 1977 claim. That conclusion was based on the insurer's failure to challenge the 1978 Determination Order. Accordingly, we reversed the ALJ's conclusion the claimant's current left knee condition was not compensable. Wayne L. Duval, supra, 46 Van Natta at 2425.

The insurer sought judicial review by the Court of Appeals. Meanwhile, the Legislature amended the Workers' Compensation Act. Or Laws 1995, chapter 332 (SB 369). The court has remanded for our reconsideration in light of the amendments.

Messmer v. Deluxe Cabinet Works, supra, held that claim preclusion bars a carrier from denying that a noncompensable condition that served as a basis of a final permanent disability award is part of the claimant's compensable claim. That case has been legislatively overruled. Amended ORS 656.262(10) (formerly ORS 656.262(9));[2] see Craig L. Hiatt, supra, 47 Van Natta at 2288 n 1 (referring to legislative history indicating that legislature intended to overrule Messmer). Now, a carrier may contest the compensability of a condition rated by a closure order so long as the carrier has not formally accepted that condition. Id. at 2289.

Our first inquiry, then, is whether the insurer has formally accepted claimant's degenerative condition. It has not.

Whether an acceptance occurs is a question of fact. SAIF v. Tull, 113 Or App 449, 452 (1992). A claim acceptance encompasses only those conditions specifically or officially accepted in writing. Johnson v. Spectra Physics, 303 Or 49, 55-56 (1987).

Here, the only written evidence specifically regarding the 1977 acceptance is a June 9, 1977 "802" Insurer's Report of Occupational Injury or Disease, indicating that the insurer had accepted claimant's March 1977 injury claim. For these purposes, that report does not constitute an acceptance of any condition. See EBI Ins. Co. v. CNA Insurance, 95 Or App 448, 450 (1989) ("1502" form, an insurer's report, does not constitute notice that a claim has been accepted or denied). Even if it did, it does not identify the specific condition that the insurer accepted. Therefore, we look to the contemporaneous medical records to determine what the insurer accepted. William T. Smith, 46 Van Natta 2169, 2170 (1994).

Dr. Schachner diagnosed a torn meniscus in April 1977, and degenerative arthritis on June 6, 1977. (Exs. 1, 3). The insurer, however, was not apprised of the degenerative condition until after it had issued the "802" form on June 9, 1977, which indicated that it had already accepted the injury claim.[3] On those facts, we find that there were no contemporaneous medical reports of degenerative arthritis at the time of the insurer's acceptance, and, therefore, that the insurer's acceptance did not include degenerative arthritis. Instead, we find that the insurer accepted a torn meniscus. William T. Smith, supra, 46 Van Natta at 2170.

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[2] As amended, ORS 656.262(10) provides:

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

Because there has been no final order or decision regarding this case, amended ORS 656.262(10) applies retroactively to it. SB 369, § 66(5)(a); Craig L. Hiatt, supra, 47 Van Natta at 2288.

[3] See note 1, supra.

Claimant asserts that, because the insurer's acceptance did not specify what it had accepted, under Georgia-Pacific v. Piwowar, 305 Or 494 (1988), the insurer accepted any cause of his left knee symptoms, including degenerative arthritis. We disagree. Piwowar holds that, if a carrier accepts a claim for symptoms, that acceptance encompasses the causes of the symptoms. Id. at 501-02. Here, we have held that, although the insurer accepted the claim without specificity or limitation, in view of the contemporaneous medical records, the acceptance was limited to a torn meniscus, which is a specific condition, not merely a set of symptoms. Therefore, because the insurer did not accept a claim for symptoms, Piwowar is inapposite.[4]

The remaining issue concerns the compensability of claimant's current left knee condition. The record establishes that claimant's degenerative knee condition preexisted his 1977 injury (Exs. 7-1, 11-6, 14), and that claimant's current condition is the result of a combination of that injury and the degenerative condition. (See, e.g., Ex. 11-6). Therefore, the current condition is compensable, if at all, under amended ORS 656.005(7)(a)(B).[5] Under that statute, claimant must prove that the 1977 injury is the major contributing cause of his current disability or need for treatment. Both the treating and examining physicians have concluded that claimant's degenerative arthritis, and not his 1977 injury, is the major cause of his current left knee condition. (Exs. 11-6, 13, 14). That disproves, rather than proves, the compensability of this claim under amended ORS 656.005(7)(a)(B). Consequently, we agree with the ALJ's decision to uphold the insurer's denial.

Accordingly, on reconsideration of our November 30, 1994 order, we affirm the ALJ's order dated March 11, 1994.

IT IS SO ORDERED.

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[4] In referring to claimant's twisting knee injury, the worker's portion of the "801" form described how claimant's knee injury occurred; it did not identify the precise nature of the injury. Therefore, we conclude that the insurer did not accept a "twisted left knee," which arguably may have implicated the Piwowar analysis. See Barbara Simmons, 46 Van Natta 1428 (1994) (Board rejected argument that carrier had accepted "hurt back", because "801" form on which argument was based described how claimant injured her back, not the nature of her injury). In any event, even if claimant had filed a claim for, and the insurer had accepted a twisted knee injury, the contemporaneous medical records refute any assertion that the acceptance included degenerative arthritis.

[5] In his brief on review, claimant asserts that this case is governed by the material contributing cause standard, because it applied at the time of the processing of his 1977 claim. We disagree, because amended ORS 656.005(7)(a)(B), which requires proof under the major contributing cause standard, applies retroactively to this case. Elmer Hitchcock, 47 Van Natta 2146, 2147 (1995).

In the Matter of the Compensation of
DANNY R. FULLER, Claimant
WCB Case No. 93-12935
ORDER OF ABATEMENT
Schneider, Hooton, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On February 2, 1996, the Board reversed an Administrative Law Judge's (ALJ's) order which: (1) set aside its denial of claimant's aggravation/current condition claim for an upper neck condition; (2) set aside its partial denial of claimant's right shoulder impingement syndrome; and (3) assessed a penalty for an allegedly unreasonable denial. Contending that the Board's order contains several clerical, factual, and legal errors, claimant seeks reconsideration of the decision.

In order to further consider claimant's motion, the Board's February 2, 1996 order is abated. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, the Board will proceed with its reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES HARDIN, Claimant
WCB Case No. 95-00357
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's current neck condition. In its brief, SAIF contends that the ALJ abused her discretion in: (1) allowing claimant to offer only a part of Exhibit 22; and (2) denying SAIF's motion to leave the record open to obtain a deposition of one of SAIF's medical experts. SAIF requests that this matter be remanded to the ALJ with instructions to reopen the record to receive the deposition. On review, the issues are evidence, continuance, remand, and compensability. We deny the motion for remand and, on the merits, affirm.

FINDINGS OF FACT

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

Claimant compensably injured his neck in 1991 as a result of a beam falling on his head. In early 1993, claimant developed neck stiffness and pain with headaches that progressively worsened. On September 20, 1994, he awoke with severe neck and shoulder pain, for which he sought medical treatment. He was diagnosed with, inter alia, a disc abnormality at C4-5 for which surgery was requested. Dr. Dickerman examined claimant for SAIF in November 1994. On January 6, 1995, SAIF denied the claim.

On January 12, 1995, claimant filed a hearing request on the aggravation denial. On January 19, 1995, the parties were notified that a hearing was scheduled for March 29, 1995. At SAIF's request, claimant was examined by Drs. Strum and White, who issued a report on March 6, 1995. (Ex. 22). In that report, Dr. White concluded that claimant's 1991 injury was the major contributing cause of his current neck condition. However, Dr. Strum agreed with Dr. Dickerman's report concluding that the major contributing cause of claimant's current neck condition was claimant's preexisting degenerative condition, although Dr. Strum also said he would change his position if a myelogram C/T revealed a "soft disc herniation" at C4-5. Claimant's counsel received a copy of this report on March 16, 1995. Id. This report was submitted to the ALJ by claimant's counsel by letter of March 28, 1995.

SAIF's counsel did not object to the admissibility of the exhibit, which was admitted in its entirety as Exhibit 22. (O&O at 1). However, SAIF's counsel requested that the record be left open so that SAIF could depose Dr. Strum. (Tr. 2). Claimant's counsel objected. (Tr. 3). The hearing was closed on August 1, 1995. No deposition of Dr. Strum appears in the record.

CONCLUSIONS OF LAW AND OPINION

Evidence

On review, SAIF first contends that the ALJ abused her discretion in allowing claimant to offer only a part of Exhibit 22. We disagree.

An ALJ is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure, and may conduct a hearing in any matter that will achieve substantial justice. ORS 656.283(7). The ALJ is given broad discretion on determinations concerning the admissibility of evidence. See, e.g., Brown v. SAIF, 51 Or App 389, 394 (1991) (the ALJ's decision to admit or exclude evidence is limited only by the consideration that the hearing as a whole achieve substantial justice).

Here, SAIF contends that the ALJ erred in bifurcating Exhibit 22 and allowing claimant the right to offer only the opinion of Dr. White with respect to causation. However, the ALJ also allowed SAIF an opportunity to offer Dr. Strum's opinion. Consequently, the whole of Exhibit 22 was entered into evidence and is part of the record before us. SAIF was not deprived of substantial justice and we find no abuse of discretion.

Continuance

SAIF next asserts that the ALJ abused her discretion in denying its motion to leave the record open to obtain a deposition of Dr. Strum, one of its medical experts. Again, we disagree.

OAR 438-006-0091 provides:

"The parties shall be prepared to present all of their evidence at the scheduled hearing. Continuances are disfavored. The ALJ may continue a hearing for further proceedings:

"*****

"(2) Upon a showing of due diligence if a party seeks further opportunity to cross-examine on documentary medical evidence."

Because the language of the continuance rule is permissive, we review the ALJ's ruling for abuse of discretion. See Georgia-Pacific v. Kight, 126 Or App 244, 246 (1994).

The record shows that SAIF scheduled an examination by Drs. White and Strum 23 days before the scheduled hearing. SAIF received Dr. Strum's report 16 days before the March 29, 1995 scheduled hearing. During this 16-day period, there is no indication SAIF made any arrangements to depose Dr. Strum or to obtain any clarifying opinion. Moreover, SAIF's delay is unexplained. In light of this, we cannot find that it was an abuse of discretion for the ALJ to deny a continuance of the hearing for SAIF to obtain Dr. Strum's deposition.

Remand

For the aforementioned reasons, we find no good cause or other compelling basis for remanding this case to the ALJ. See Kienow's Food Stores v. Lyster, 79 Or App 416, 420 (1986). SAIF's motion for remand is denied.

Compensability

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

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

ORDER

The ALJ's order dated August 31, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the SAIF Corporation.

In the Matter of the Compensation of
JAMES D. JANSEN, Claimant
WCB Case No. 95-03627
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Bailey & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Mongrain's order which found that claimant's right hip/groin claim should be classified as disabling. On review, the issue is claim classification.

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

Relying on amended ORS 656.210, the ALJ found that claimant's claim was disabling. In so doing, the ALJ determined that claimant lost wages because his compensable injury precluded him from working "relief" work at a higher wage.

On review, the insurer contends that claimant did not lose any wages as a result of his injury. Therefore, according to the insurer, claimant was not entitled to temporary disability and thus, his claim should be classified as nondisabling.

To classify a claim as disabling, there must also be an entitlement to temporary disability benefits or a reasonable expectation of permanent disability. ORS 656.005(7)(c); Karren S. Maldonado, 47 Van Natta 1535 (1995). Generally, a claimant is entitled to temporary disability compensation if he or she has sustained wage loss as a result of the compensable injury. See RSG Forest Products v. Jensen, 127 Or App 247, 250-51 (1994). TTD benefits are based on the wage paid at the time of injury. ORS 656.210; Coombe v. SAIF, 111 Or App 71, 75 (1992).

Amended ORS 656.212(2), which is applicable to this case,[1] now provides that TPD is to be calculated based on the loss reflected in a comparison of claimant's wages at modified employment with his at-injury wages. Thus, where a claimant's wages at modified employment are less that his at-injury wages, the calculation of claimant's TPD rate may not result in zero.

Claimant testified that he worked for his employer as a plugger, but was also called upon to be a relief worker as a puller on the round table. He sustained a compensable injury while working as a puller on the round table. (Tr. 5). Claimant testified that his wages as a "puller" were about 70 to 80 cents an hour more that his wages as a plugger. Id. During the time that claimant was released to modified work he received the wage he was paid as a plugger. (Tr. 7).

Here, we find that claimant was entitled to temporary disability benefits and therefore, his claim should be classified as disabling. ORS 656.005(7)(c). At the time of his injury, claimant's wage was based on his job as a puller on the round table. Claimant's uncontested testimony was that his wage as a "puller" was about 70 to 80 cents more per hour than his wage as a plugger. Temporary disability benefits are to be calculated based on the wage claimant was receiving at the time of injury. See ORS 656.210(2)(a)(A). Claimant's modified work wage was less than his at injury wage. Such a reduction would indicate that claimant was entitled to temporary disability benefits. ORS 656.212(2). Accordingly, we conclude that claimant's injury was disabling. ORS 656.005(7)(c).

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

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[1] See Volk v. America West Airlines, 135 Or App 565 (1995) (Generally, the amendments to the Workers' Compensation Law made by Senate Bill 369 apply to cases currently pending before the Board, absent a specific exception to the retroactive application of the law). See also Walter L. Keeney, 47 Van Natta 1387 (1995). No specific exception applies in this case. Cf. Motel 6 v. McMasters, 135 Or App 583 (1995).

ORDER

The ALJ's order dated July 18, 1995 is affirmed. For services on review claimant's attorney is awarded $500, payable by the insurer.

March 4, 1996 Cite as 48 Van Natta 494 (1996)

In the Matter of the Compensation of
ROBERT J. KEALER, Claimant
WCB Case No. 94-10014
ORDER ON REVIEW
Johnson, Cram & Associates, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order which upheld the insurer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability.

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

Relying on the opinion of Dr. Radecki, the ALJ determined that claimant's employment activities were not the cause of his CTS. In so doing, the ALJ declined to rely on the medical opinions of Drs. Ferguson and LaFrance.

On review, claimant contends that the ALJ erred by relying on the opinion of Dr. Radecki. Specifically, claimant asserts that Dr. Radecki's opinion relied on an inaccurate history. We need not consider this assertion, as we do not find expert medical evidence in the record to support claimant's claim.

Claimant has asserted that his CTS condition is compensable as a occupational disease. ORS 656.802. Accordingly, claimant bears the burden to prove that his work activity for the insurer's insured was the major contributing cause of his CTS. See ORS 656.266; ORS 656.802(2)(a).

In resolving complex medical causation issues, such as those presented here, we rely on medical opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986). In addition, we generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find persuasive reasons not to rely on the medical opinion of claimant's attending physician, Dr. Ferguson.

In January 1994, Dr. Ferguson, treating physician, opined that claimant's work was the "significant initiating factor" for claimant's CTS. (Ex. 13-2). On June 28, 1994, Dr. Ferguson concurred with the report of Dr. Radecki which stated that claimant's CTS was an idiopathic process due to such factors as claimant's age, weight and diabetes. (Exs. 25, 28).

On November 14, 1994, Dr. Ferguson authored a letter to claimant's attorney stating that claimant's work was a material contributing factor in the development of his CTS. (Ex. 32-3). On November 16, 1994, Dr. Ferguson, in a letter written by claimant's attorney, agreed that the major contributing cause of claimant's CTS was his work activities. (Ex. 32-2).

Dr. LaFrance stated that the etiology of claimant's CTS "most likely reflects the alteration in [claimant's] work patterns." (Ex. 8-2). Dr. LaFrance opined that claimant's work for the lumber company " appeared to have been the basis of the presentation of this process." Id.

In April 1994, Dr. Radecki, who examined claimant on behalf of the insurer, opined that claimant had a preexisting median nerve problem which was made symptomatic by his work as a "sticker." (Ex. 25-3). Dr. Radecki detailed claimant's wrist movements while claimant demonstrated his work activities. (Ex. 25-1). According to Dr. Radecki, claimant's CTS was an idiopathic process due to such factors as claimant's age, weight and diabetes.

We decline to rely on Dr. Ferguson's opinion because it has changed without adequate explanation. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (court discounts medical report based on unexplained change of opinion). For instance, Dr. Ferguson concurred with Dr. Radecki that claimant's CTS was idiopathic, then stated that claimant's work was a material contributing cause of his CTS, and then changed his opinion again stating that claimant's work was the major contributing cause of his CTS. Because Dr. Ferguson's opinion changes without adequate explanation, we afford it little persuasive weight. See Moe v. Ceiling Systems, supra.

Additionally, we decline to find Dr. LaFrance's report dispositive because of its conclusory nature. See Somers v. SAIF, supra. For instance, although Dr. LaFrance's opinion tends to support compensability, he offers little explanation for his findings. As such, there is no persuasive medical opinion which adequately supports a major causation standard of proof. Therefore, we conclude that claimant has failed to meet his burden of proof. ORS 656.266.

ORDER

The ALJ's order dated June 12, 1995 is affirmed.

In the Matter of the Compensation of
MARVIN L. MILLER, Claimant
WCB Case No. 93-10357
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Hall and Christian.

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

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

Claimant suffered a mild stroke on May 25, 1993, while driving his vehicle in the course of his work. The ALJ analyzed the claim as an accidental injury and concluded that claimant's work-related stress was the preeminent causative factor in the occurrence of his stroke.

The insurer argues that the claim should be analyzed as an occupational disease, not an injury. We disagree.

In Cleon K. Sinsel, 48 Van Natta 2 (1996), the claimant sought compensation for chest pain he experienced while working. On remand from the Court of Appeals, the claimant argued that amended ORS 656.802(1)(b) did not apply to his claim because the medical evidence showed that he was under "physical stress" rather than "mental stress." Under amended ORS 656.802(1)(b), a "'mental disorder' includes any physical disorder caused or worsened by mental stress." Based on the claimant's physician's report that the claimant's chest pain "was on the basis of stress, and lack of adequate rest" and that the claimant had been "very busy with forest fires and has been stressed out and not getting enough sleep," we concluded that fatigue from physical exertion caused the claimant's episode of chest pain. Since "mental stress" was not implicated in causing the claimant's chest pain, we declined to analyze the claim as a mental disorder under amended ORS 656.802(1)(b).

In this case, Dr. Mahoney, claimant's treating physician, reported that claimant's stroke was caused by the stress that claimant experienced in his job setting. (Ex. 7). Dr. Mahoney explained:

> "This patient has had a very high level of stress in his workplace. As you know, this patient had worked very long hours. It was common for him to work from 2 or 3 a.m. until 8 or 9 p.m. at night. He was also having to drive long distances in the course of his work."

"* * * * *

"The stress related to this patient's work is of a very unusual level. I am not aware of ever taking care of a patient who toiled at his job for the hours that this patient does. The demands to perform the long hours of work and the long hours of driving created an unusually high level of stress that was the chief contributing factor in this patient developing a stroke." (Ex. 18).

In a deposition, Dr. Mahoney reiterated that claimant worked long hours, traveled long distances and got very little sleep. (Exs. 23-18, 23-21, 23-22).

Because Dr. Mahoney referred to claimant's "stress" in conjunction with claimant's long hours at work, long hours driving and lack of sleep, we find that the most reasonable interpretation of Dr. Mahoney's opinion is that claimant's stroke was caused by physical stress or fatigue, rather than psychological or mental stress. Dr. Mahoney did not mention a psychological component or problem in discussing the cause of claimant's stress or his stroke. As in Cleon K. Sinsel, supra, we are not prepared to interpret a reference to "stress" as an indication that claimant's stroke was attributable to psychological or mental causes. Under these circumstances, we conclude that amended ORS 656.802(1)(b) does not apply to this claim.

After reviewing the record, we agree with the ALJ that this matter should be analyzed as an injury, rather than an occupational disease. Claimant's stroke was a sudden event, not an ongoing condition or state of the body or mind. See Mathel v. Josephine County, 319 Or 235 (1994). Claimant's stroke was unexpected; he testified that he had never experienced similar symptoms before. (Tr. 20). See Valtinson v. SAIF, 56 Or App 184 (1982). Therefore, notwithstanding that claimant's stroke was precipitated by job stress, we analyze the claim as one for an accidental injury. See Florence Andrews, 46 Van Natta 1922 (1994) (analyzing the claimant's stress-related stroke as an "injury").

The ALJ found that claimant had "predisposing risk factors" for a stroke, including high blood pressure and high cholesterol. Also, claimant had smoked earlier in his life and had arteriosclerotic cerebral vascular disease. Although the ALJ applied a material contributing cause standard, we conclude that, even under the major contributing cause standard, claimant's stroke claim is compensable.

Subsequent to the ALJ's order, the Legislature amended ORS 656.005(7)(a)(B) and added a definition for the term "preexisting condition." ORS 656.005(24). We find that claimant's high blood pressure, high cholesterol, previous smoking and arteriosclerotic cerebral vascular disease were "preexisting conditions."

Although Drs. Mahoney and Connor disagreed about the degree to which some of the preexisting conditions caused claimant's stroke, their opinions indicate that claimant's "underlying" and "predisposing" risk factors combined with the May 25, 1993 work incident to cause or prolong disability or a need for treatment. Therefore, we analyze the claim under the major contributing cause standard of amended ORS 656.005(7)(a)(B).

The insurer contends that the ALJ erred by relying on Dr. Mahoney's opinion because it is based on inaccurate understanding about claimant's work stress. The insurer argues that the opinion of Dr. Connor is more persuasive. We disagree.

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, there are no persuasive reasons not to defer to Dr. Mahoney's opinion that claimant's work-related stress was the major contributing cause of his stroke. Contrary to the insurer's contentions, we are not persuaded that Dr. Mahoney had an inaccurate understanding about claimant's work-related stress. Based on Dr. Mahoney's opinion, we agree with the ALJ that claimant has established the compensability of his stroke.

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

ORDER

The ALJ's order dated May 5, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

March 4, 1996 Cite as 48 Van Natta 497 (1996)

In the Matter of the Compensation of
DARAL T. MORROW, Claimant
WCB Case No. 95-04882
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) awarded temporary disability; and (2) assessed a penalty for allegedly unreasonable claim processing. In his respondent's brief, claimant challenges that portion of the ALJ's order that declined to award a separate attorney fee under ORS 656.382(1). On review, the issues are temporary disability, penalties, and attorney fees.

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

First, we briefly summarize the relevant facts. Claimant sustained a low back injury on June 13, 1994 while employed by Barrett Business Services (BBS), whose claims processor is Sedgwick James & Co. (Sedgwick). By an order dated March 17, 1995, ALJ Stephen Brown found claimant's condition compensable and BBS/Sedgwick responsible. On October 18, 1995, we affirmed ALJ Brown's order on review.

Claimant obtained treatment for his low back condition from Dr. Belza, neurologist, on June 13, 1994. Dr. Belza authorized claimant to be off work "for the next week." (Ex. 33). Claimant did not return to Dr. Belza, but instead next treated with Dr. Shames at the Siskiyou Community Health Clinic. (Ex. 35). Claimant did not further seek treatment for his low back condition.

On March 28, 1995, following ALJ Stephen Brown's March 17, 1995 order, Dr. Shames signed and completed a supplemental medical report (Form 828) for Sedgwick, indicating that claimant was not released for work, and that he had "no idea" whether claimant was medically stationary. (Ex. 47). Claimant has not worked since his June 13, 1994 injury. (Tr. 14).

Claimant again sought treatment at the Siskiyou Community Health Clinic on April 11, 1995, when he was seen by Dr. Shames' associate, Dr. Nordal. On April 11, 1995, Dr. Nordal indicated that claimant should not return to work until he was evaluated at the Pacific Spine and Pain Clinic in Ashland. (Ex. 51). On April 29, 1995, Dr. Nordal clarified that the recommended treatment was specifically for claimant's low back pain. (Id.).

On June 13, 1995, Dr. Shames indicated that claimant had only been seen in his clinic in June 1994 and April 1995 for the June 1994 injury, and that claimant had not been evaluated at the Pacific Spine and Pain Clinic as recommended by Dr. Nordal. For these reasons, Dr. Shames concluded that it was too difficult to authorize a release from work as a result of the June 1994 injury. (Ex. 54).

Applying ORS 656.262(4), as amended by Senate Bill 369, effective June 7, 1995, the ALJ found that claimant was entitled to temporary disability compensation for the period March 17, 1995 until June 13, 1995. We agree, and we supplement and modify the ALJ's reasoning as follows.

Amended ORS 656.262(4) prescribes the conditions under which temporary disability is payable. That statute provides, in relevant part:

> "(a) The first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation.

"* * * * *

"(f) Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance." (Emphasis supplied to identify language added by SB 369).

Since there is no relevant specific exception to the general retroactive application of ORS 656.262(4), we agree with the ALJ that amended ORS 656.262(4) applies to this case. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995).

Claimant requested an expedited hearing regarding the employer's failure to pay temporary disability compensation pursuant to ALJ Brown's March 17, 1995 order. In the case before us, we consider only claimant's eligibility for temporary disability for the period beginning March 17, 1995 (the date of the appealed ALJ's order). Amended ORS 656.313(1)(a),[1] Eulalio M. Garcia, 47 Van Natta 991 (1995) (temporary disability awarded for periods prior to ALJ's order is stayed pending appeal under ORS 656.313(1), but temporary disability benefits which accrue from the date of the order appealed cannot be stayed pending appeal).

Amended ORS 656.262(4)(a) provides that temporary disability compensation shall be paid within 14 days after the employer has notice or knowledge of the claim, "if the attending physician authorizes the payment of temporary disability compensation." According to the plain language of the statute, two events are necessary in order to trigger the payment of temporary disability compensation: (1) the employer's notice or knowledge of a claim; and (2) the attending physician's authorization of the payment of temporary disability.

Here, there is no dispute that the employer had notice or knowledge of the claim. In addition, we find that the attending physician authorized the payment of temporary disability compensation, retroactive to March 17, 1995, based on the following reasoning.

On March 28, 1995, Dr. Shames responded to Sedgwick's request for a supplemental medical report (Form 828) indicating that claimant was last seen on June 27, 1994, that he was not released to work, and that he (Dr. Shames) had no idea whether claimant was medically stationary. (Ex. 47). We interpret this document as indicating that Dr. Shames, claimant's attending physician for his low back condition,[2] authorized temporary disability from the date of claimant's last treatment, June 27, 1994. Accordingly, we conclude, based on Dr. Shames' March 28, 1995 report, that claimant's attending physician authorized the payment of temporary disability compensation.[3]

Amended ORS 656.262(4)(f) provides that no authorization of temporary disability compensation shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to issuance of the authorization. Here, Dr. Shames' authorization of temporary disability issued March 28, 1995, the date he signed the report authorizing temporary disability. Since we interpret Dr. Shames' report as indicating that claimant had not been released to work since his last treatment in June 1994, we find that Dr. Shames authorized retroactive temporary disability. However, pursuant to amended ORS 656.262(4)(f), retroactive authorization of temporary disability is effective for no more than 14 days prior to the date of issuance of the authorization. Accordingly, we conclude that Dr. Shames' authorization of temporary disability is retroactive only to March 14, 1995.

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[1] Senate Bill 369 amended ORS 656.313(1), but not in any manner significant to this case.

[2] We agree with the ALJ's finding that Dr. Shames and Dr. Nordal of the Siskiyou Community Health Center were claimant's attending physicians for his low back condition. (Opinion and Order at 5-6). The employer does not argue on review that either Dr. Shames or Dr. Nordal was not claimant's attending physician.

[3] We further find that Dr. Shames' authorization was confirmed by Dr. Nordal's authorization on April 11, 1995, as clarified April 29, 1995. (Ex. 51). However, since we have found that Dr. Shames authorized temporary disability by his March 28, 1995 report, we do not find that Dr. Nordal's April 11, 1995 prescription is the initial authorization that triggered Sedgwick's duty to pay temporary disability.

In this case, however, the dispute concerns only claimant's entitlement to temporary disability beginning March 17, 1995 (the date of ALJ Brown's appealed order). Since we have found that Dr. Shames authorized temporary disability retroactive to at least March 17, 1995, we agree with the ALJ that claimant is entitled to temporary disability compensation beginning March 17, 1995.

Temporary disability compensation shall continue until one of the events identified in amended ORS 656.268(3)[4] occurs. As relevant here, amended ORS 656.268(3)(d) provides that "[a]ny other event that causes temporary disability benefits to be lawfully suspended, withheld or terminated under ORS 656.262(4) or other provisions of this chapter" qualifies as such an event. As relevant to this case, amended ORS 656.262(4)(f) provides that "[t]emporary disability is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability. . . ."

Here, by letter dated June 13, 1995, Dr. Shames advised that it was too difficult to authorize a release from work due to the June 1994 incident. (Ex. 54-2). Based on this comment, we conclude that Dr. Shames "ceased" to authorize temporary disability effective June 13, 1995. Accordingly, we agree with the ALJ that claimant is entitled to temporary disability compensation for the period March 17, 1995 through June 13, 1995.

Penalties/Attorney Fees

We adopt and affirm the ALJ's order assessing a penalty under amended ORS 656.262(11) for Sedgwick's unreasonable claim processing. However, we modify the ALJ's order by finding, consistent with our reasoning above, that Sedgwick's duty to pay temporary disability arose when it received Dr. Shames' March 28, 1995 report authorizing temporary disability. (Ex. 47). Since we have found that the authorization was retroactive for 14 days, we agree with the ALJ that the penalty should be assessed on the full period of time loss awarded in the ALJ's order, March 17, 1995 through June 13, 1995.

Claimant contends on review that he is entitled to an additional penalty-related attorney fee under ORS 656.382(1), arguing that Sedgwick's failure to comply with ALJ Brown's order is a separate and distinct processing infraction from its failure to pay claimant's compensation. We disagree.

Under former ORS 656.262(10),[5] claimant was not entitled to an attorney fee under ORS 656.382(1) on the same factual basis asserted in support of a penalty/attorney fee under ORS 656.262(10). Martinez v. Dallas Nursing Home, 114 Or App 453 (1992). In Martinez, the Board had found that the carrier's refusal to pay medical bills found compensable under an unappealed Board order was the same factual basis for which a penalty had been assessed under ORS 656.262(10). Here, the ALJ assessed a penalty under amended ORS 656.262(11) for Sedgwick's failure to pay temporary disability compensation pursuant to the former ALJ's order. This is the same factual basis on which claimant asserts he is entitled to an attorney fee under ORS 656.382(1) (i.e., the employer's failure to pay temporary disability under ALJ Brown's order). Accordingly, claimant is not entitled to an attorney fee under ORS 656.382(1).

Since we have not disallowed or reduced the compensation awarded to claimant, claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the temporary disability issue is $1,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant is not entitled to an attorney fee for his counsel's services on review regarding the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986). Likewise, claimant is not entitled to an attorney fee for his counsel's unsuccessful efforts in seeking an attorney fee award under ORS 656.382(1).

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[4] We apply ORS 656.268(3), as amended by Senate Bill 369, effective June 7, 1995, since no specific exception to the general retroactive application of the statute applies in this case. SB 369, § 66; Volk, supra.

[5] ORS 656.262(10) was not amended by Senate Bill 369, but the section was renumbered ORS 656.262(11).

ORDER

The ALJ's order dated June 29, 1995 is affirmed. Claimant's attorney is awarded $1,000 for services on review, to be paid by the self-insured employer.

March 4, 1996 Cite as 48 Van Natta 500 (1996)

In the Matter of the Compensation of
GUADALUPE VALADEZ, Claimant
WCB Case No. 95-07414
ORDER ON REVIEW
Samuel A. Ramirez, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that dismissed claimant's hearing request. 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.

On May 24, 1995, claimant signed a retainer agreement employing his then- attorney of record to represent him in connection with his workers' compensation claim. On June 28, 1995, claimant, through his then attorney of record, requested a hearing regarding the insurer's May 5, 1995 denial and raising the issue of compensability. A hearing was eventually scheduled for October 3, 1995. (WCB Case No. 95-07414).

On July 20, 1995, claimant's then-attorney of record submitted a "Notice of Dismissal," announcing that claimant was withdrawing his hearing request. Specifically, this notice stated: "[c]omes now Claimant, by and through his attorney, . . . and requests dismissal of the Request for Hearing filed on June 28, 1995 raising the issue(s) of compensability from the May 5, 1995 denial letter." On August 1, 1995, the ALJ dismissed claimant's hearing request.

On August 30, 1995, the Board received a request for review of the ALJ's dismissal order from claimant's current attorney. By letter dated October 2, 1995, claimant's current attorney stated that there had been a misunderstanding between claimant and his former attorney and that claimant still requests a hearing. Claimant's current attorney stated that "[c]laimant did not want to withdraw his request for a hearing, but his attorney withdrew as counsel, not the request for a hearing."

Notwithstanding claimant's current attorney's assertions that claimant's former attorney did not withdraw claimant's request for hearing, the record establishes that claimant's former attorney did just that in his "Notice of Dismissal." In addition, claimant's hearing request was dismissed in response to his then-attorney's express withdrawal of the request. Claimant does not dispute that his then-attorney had authority to act on his behalf or that the ALJ dismissed the hearing request in response to his then-attorney's withdrawal of the hearing request. William A. Martin, 46 Van Natta 1704 (1994); Verita A. Ware, 44 Van Natta 464 (1992). Under these circumstances, we find no reason to alter the ALJ's dismissal order.

In addition, to the extent that claimant's current attorney's assertions might be considered a request for remand for hearing regarding the propriety of the ALJ's dismissal, we deny that request. We may remand to the ALJ should we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5).

In previous cases regarding the issue of whether a hearing request should have been dismissed, we have remanded the matter to the ALJ with instructions to conduct further proceedings to determine whether the dismissal was justified. Tamara Riddle, 41 Van Natta 971 (1989); Robert J. Buckley, 41 Van Natta 1761 (1989); Donald R. Roth, 42 Van Natta 1091 (1990). Those cases have involved situations where the ALJ has dismissed a claimant's request for hearing and the record does not contain any motions, correspondence, records of telephonic conversations, testimony, or other exhibits concerning the dismissal of the claimant's hearing request.

Here, in contrast to Riddle and its progeny, the record contains a motion from claimant's then-attorney withdrawing claimant's hearing request. Therefore, we do not find the record insufficiently developed regarding the issue of the propriety of the ALJ's dismissal. Accordingly, to the extent that claimant requests remand, we deny that request. William A. Martin, supra.

ORDER

The ALJ's order dated August 1, 1995 is affirmed.

March 4, 1996 Cite as 48 Van Natta 501 (1996)

In the Matter of the Compensation of
GERALD A. ZELLER, Claimant
WCB Case No. 95-08331
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Gunn and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Howell's order that: (1) awarded temporary disability benefits from April 13, 1995 through May 18, 1995; and (2) assessed a penalty for allegedly unreasonable claim processing. On review, the issues are temporary disability, penalties and attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the exception of the first sentence of the third paragraph on page 1. In addition, we briefly summarize and supplement the pertinent findings.

On April 1, 1995, claimant compensably injured his left knee at a North Carolina job site. Although his left knee symptoms increased, he continued working through April 7, 1995, when he quit his job. Claimant did not inform the employer that he quit his job because of his knee. Claimant flew back to Oregon on April 8, 1995 and filed an injury claim with the employer on April 10, 1995.

On April 12, 1995, claimant sought medical treatment from Dr. Miller, his family doctor, who released him to "regular" work but restricted him from bending his knee. (Ex. 4). The family doctor also referred him to an orthopedist, Dr. Stanley, who began treating him on April 13, 1995. (Exs. 4B and 5). Dr. Stanley diagnosed a torn medial meniscus, noting that claimant would like to get it treated because "he is between jobs and he needs to be able to bend his knee." Dr. Stanley planned to perform an arthroscopy in the near future. (Ex. 5).

Because claimant had left its employ, the employer did not offer claimant either regular or modified work. Claimant did not return to work. On May 18, 1995, Dr. Stanley authorized modified work as of April 13, 1995. The insurer paid temporary total disability beginning on May 19, 1995, the date of claimant's left knee arthroscopic surgery. On June 30, 1995, the insurer accepted claimant's claim as a disabling left knee meniscus tear.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant was entitled to temporary disability compensation from April 13, 1995 through May 18, 1995. The insurer asserts that, because claimant quit his employment for reasons unrelated to his injury, he did not "leave work" due to his injury and is, therefore, not entitled to temporary disability benefits until May 19, 1995, the date of surgery. We disagree.

The issue is whether claimant was entitled to temporary disability benefits on an open claim between April 13, 1995 (the date claimant was released to modified work) and May 19, 1995 (the date the employer began temporary total disability payments). Generally, a claimant is entitled to temporary disability compensation if he or she has sustained wage loss as a result of the compensable injury. See RSG Forest Products v. Jensen, 127 Or App 247, 250-51 (1994) (worker is entitled to interim compensation if he has suffered loss of earnings as a result of a work injury).

We adopt and affirm that portion of the ALJ's order finding that claimant had left work at the employer due to the compensable injury. Furthermore, Dr. Snyder imposed work restrictions on claimant due to his compensable left knee injury as of April 13, 1995. Therefore, claimant lost wages due to the work injury during the period from April 13, 1995 and May 18, 1995. Consequently, claimant "left work" by experiencing a loss of earnings as the result of the work restrictions placed on him by Dr. Snyder. However, we modify the ALJ's award of temporary disability compensation for the following reason.

A claimant's entitlement to temporary disability for all periods of time during an open claim is contingent upon authorization of temporary disability by the attending physician. ORS 656.262(4)(f) 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."

On May 18, 1995, attending physician Snyder released claimant to modified work from April 13 through May 18, 1995, due to his compensable left knee condition. The insurer, however, did not receive notice sufficient to require it to begin paying temporary disability benefits prior to the date of Dr. Snyder's release. Thus, inasmuch as Dr. Snyder indicated on May 18, 1995 that claimant was disabled, claimant's entitlement to temporary disability benefits began on May 4, 1995, 14 days prior to May 18, 1995, the date Dr. Snyder authorized the payment of benefits. ORS 656.262(4)(f); Delores L. Holmes, 47 Van Natta 2359 (1995). Consequently, we conclude that claimant is entitled to temporary disability compensation from May 4, 1995 through May 18, 1995.[1]

Penalty and Attorney Fees

We adopt the ALJ's reasoning regarding the insurer's failure to make temporary disability payments, noting that by May 22, 1995, the insurer had notice that claimant had left work due to his injury (as a result of its receipt of Dr. Snyder's restrictions from regular work). We affirm the ALJ's assessment of a 15 percent penalty, but modify the dates upon which it is based to May 4, 1995 through May 18, 1995. This penalty is to be shared equally by claimant and his attorney. ORS 656.262(11)(a).

ORDER

The ALJ's order dated September 25, 1995 is modified. In lieu of the temporary disability compensation awarded by the ALJ, claimant is awarded temporary disability compensation from May 4, 1995 through May 18, 1995. Claimant's "out-of-compensation" attorney fee, as awarded by the ALJ, is modified accordingly. Likewise, the ALJ's 15 percent penalty assessment is modified to be based on any temporary disability compensation due and payable by this order, to be shared equally by claimant and his counsel.

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[1] Because claimant's interim compensation is based on a release to modified work, his disability was partial. Thus, he is entitled to temporary partial disability benefits during the period in question. ORS 656.212; David L. Gooding, 47 Van Natta 1468 (1995). Under ORS 656.212, claimant's temporary disability compensation through May 18, 1995, is calculated based on a comparison of claimant's wages at modified employment and his at-injury wages. We have determined herein that claimant is entitled to temporary partial disability from May 4, 1995, through May 18, 1995. It is up to the insurer to determine the correct rate of temporary partial disability under ORS 656.212. It is possible that the rate of temporary partial disability may be zero under that statute. In any event, if claimant disagrees with the insurer's processing of his claim, claimant may request a hearing challenging the employer's conduct.

In the Matter of the Compensation of
RONALD R. NEWELL, Claimant
WCB Case No. 95-04988
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order which upheld the SAIF Corporation's denial of his occupational disease claim for a mental stress condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for findings number 5 and 6. We add the following supplementation.

Claimant was treated with medication for depression in 1991. (Ex. 1-1).

In September 1993, a large metal bar fell off a rack and struck claimant on the head. Following that injury, claimant complained of depression that occurred simultaneously with headaches in the top part of his head. (Ex. 1-2). Dr. Johnson recommended a CT scan because of neuropsychiatric symptoms following the head injury. There is no evidence that claimant obtained a CT scan.

In November 1994, Dr. Holloway treated claimant for depression and insomnia.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks compensation for a stress-related depressive episode that he contends arose from his work conditions. In order to establish compensability of a stress-related mental disorder, the worker must prove that employment conditions were the major contributing cause of the mental disorder and establish its existence with medical evidence supported by objective findings. The mental disorder must be one that is recognized in the medical or psychological community. The employment conditions producing the mental disorder must exist in a real and objective sense. In addition, they must be conditions other than those generally inherent in every working situation, or reasonable disciplinary, corrective or job performance actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles. Finally, there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. Amended ORS 656.802(2) & (3).

Claimant works as a mechanic. It is his job to maintain vehicles that transport tree planters to and from tree planting work in the woods. In addition to keeping the vehicles running, claimant is required to make repairs to windows, doors and various interior parts of the vehicles. It is not disputed that the employees do not take good care of the interior or the engines of the employer's vehicles.

Additionally, various employees, other than claimant, use the employer's tools and they often disappear from the shop. Many of the employees exhibit no concern for the employer's property. Claimant is responsible for shopping to replace the missing tools and equipment, at the owner's expense.

On January 25, 1995, claimant had a sudden onset of depression while shopping for parts for the employer's business. Claimant contends that his work conditions are the primary stressors causing his psychological condition, and that they are conditions other than those generally inherent in every working situation. See ORS 656.802(3)(b).

The ALJ concluded that the conditions were generally inherent in every working situation. Alternatively, the ALJ concluded that claimant had failed to prove medical causation of his psychological claim. For the following reasons, we agree that claimant has failed to prove that his work activities were the major contributing cause of his psychological condition.

Dr. Telew, psychiatrist, examined claimant for SAIF on March 30, 1995. (Ex. 7). Claimant described a "vague" history of depression, giving the doctor no specific details. Dr. Telew also obtained a history of "chaos and turmoil" in claimant's workplace, and noted the frustration and futility claimant had in getting his work done. (Ex. 7-1, 2). Dr. Telew also noted that claimant had been off work for 13 years after a 1978 back injury.

Dr. Telew diagnosed a major depressive episode of mild severity. He concluded that there was no direct causal relationship to claimant's work. (Ex. 7-4).

Claimant relies on the opinion of Dr. Holloway, attending physician, who treated claimant for depression in November 1994, and after his January 1995 episode. (Exs. 1-4, 3-1). Dr. Holloway opined that the conditions that produced claimant's mental disorder are "multi-factorial." (Ex. 9-1). He cited claimant's underlying personality as that of a loner and one who is compulsive, and who does not like "his order and place in the world disrupted." (Id).

Dr. Holloway further noted that "outside environmental factors" could lead to claimant's episode. He cited work conditions requiring sharing of tools, and the work quality of others that was not up to claimant's standards. Dr. Holloway concluded that "the major contributing cause which set off this depressive episode" was claimant's work conditions. (Ex. 9-1) (Emphasis added).

We are not persuaded that Dr. Holloway's conclusion is sufficient to meet claimant's burden of proving that work activities are the major contributing cause of his psychological condition. To begin, we find his opinion contradictory in that he attributed the depressive episode to many factors, including both work conditions, and claimant's underlying personality.

Further, although the medical evidence shows that claimant has a preexisting depression condition, and a head injury with associated headaches and depression, it does not appear that Dr. Holloway evaluated claimant's previous medical history prior to providing an opinion concerning causation of claimant's psychological condition. Moreover, in opining that claimant's work activities were the major contributing cause of "this depressive episode," Dr. Holloway appears to be identifying the "precipitating cause," rather than the major contributing cause. See Dietz v. Ramuda, 130 Or App 397 (1994)(an event that precipitates symptoms of a preexisting condition is not necessarily the major contributing cause of those symptoms). Accordingly, we conclude that claimant has failed to meet his burden of proving that his work activities were the major contributing cause of his January 1995 episode of depression, and we affirm the ALJ's order.

ORDER

The ALJ's order dated August 21, 1995 is affirmed.

In the Matter of the Complying Status of
TRISHA CLARKE & TOM BOSWELL, NCE
WCB Case No. 94-15497
ORDER OF DISMISSAL
Willner & Heiling, Attorneys

Claimant requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) declined to award claimant an attorney fee based on the noncomplying employer's (NCE's) unsuccessful appeal of the Department's NCE order; and (2) declined to award a penalty under ORS 656.382(3) for the NCE's allegedly frivolous appeal. On review, the issues are penalties and attorney fees. We dismiss for lack of jurisdiction.

FINDINGS OF FACT

On September 17, 1994, claimant filed a claim for compensation with the Department of Consumer and Business Services.

On November 16, 1994, the Department issued a Proposed and Final Order finding the employer to be noncomplying and assessing a civil penalty. The claim was referred to the SAIF Corporation for processing.

On December 8, 1994, the NCE requested a hearing regarding the Department's Order. The ALJ's order contained a statement explaining the parties' rights of appeal, providing that the proper appellate forum was the Court of Appeals.

A hearing was held on March 16, 1995. Neither the NCE nor counsel for the NCE appeared.

The ALJ affirmed the Department's order in its entirety and declined to award penalties or attorney fees.

Claimant requested Board review.

FINDING OF ULTIMATE FACT

No matter concerning a claim was contested with the NCE's appeal of the Department's order.

CONCLUSIONS OF LAW AND OPINION

An alleged noncomplying employer may contest the Department's order of noncompliance by filing a request for hearing with the Department pursuant to ORS 656.740. The ALJ's order is deemed to be a final order of the Director. ORS 656.740(1), (3). Jurisdiction for review of the ALJ's order is as provided in ORS 656.740(4).

We lack appellate jurisdiction to review an ALJ's order addressing the issue of noncompliance in cases where the proceeding was not consolidated with a matter concerning a claim or where the employer contested only the Director's noncompliance order. ORS 656.740(4)(c); Ferland v. McMurty Video Productions, 116 Or App 405 (1992), Spencer House Moving, NCE, 44 Van Natta 2522 (1992), aff'd Miller v. Spencer, 123 Or App 635 (1993). However, when an order declaring a person to be noncomplying is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review of the ALJ's order shall be as provided for a matter concerning a claim. ORS 656.740(4)(c). Matters concerning a claim under ORS 656.001 to 656.794 are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. ORS 656.704(3).

When the issue at hearing regarding the Department's NCE order is whether the claimant was a subject worker and whether the employer was a subject employer, appellate jurisdiction lies with the Court of Appeals under ORS 656.740(4). Spencer House Moving, NCE, supra, 44 Van Natta at 2523. Appellate jurisdiction rests with the court even if the ALJ's order awards an assessed attorney fee. See Ace Tree Company, 46 Van Natta 1067, 1068 (1994) (Although the ALJ may have been incorrect in awarding an attorney fee, jurisdiction to correct any such error is with the Court of Appeals, not the Board); Kyoto Restaurant, 46 Van Natta 1009 (1994) (The claimant's request for Board review of a stipulation (between the Department and the NCE) affirming an NCE order was dismissed; claimant's request for an assessed attorney fee rested with the Court of Appeals).

Here, the NCE requested a hearing regarding the Department's NCE order. As the ALJ noted, neither the NCE nor SAIF challenged the compensability of claimant's claim. Thus, no request for hearing raised a matter concerning a claim and the ALJ's order dismissing the NCE's hearing request did not result from a hearing in which the issue of noncompliance was consolidated with a matter concerning a claim.[1] See ORS 656.740(3)(c). Since the ALJ's dismissal order solely pertained to the NCE's appeal from the Director's noncompliance order, we lack appellate review authority. ORS 656.740(4)(c); Ferland v. McMurty Video Productions, supra. Such review authority, including claimant's request for penalties and attorney fees, rests with the Court of Appeals. See Ace Tree Company, supra; Kyoto Restaurant, supra.

Consequently, the ALJ's order constitutes a final order of the Department and must be appealed directly to the Court of Appeals. ORS 656.740(1), (3); Ferland, supra; Spencer House Moving, supra; Ace Tree Company, supra.

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] In Hayes v. SAIF, 132 Or App 455 (1995), the NCE requested a hearing on the Department's noncomplying employer order (which found the NCE to be a subject/noncomplying employer and claimants to be subject workers) and on SAIF's acceptance of the claims. At the hearing, the NCE stipulated that SAIF's acceptances would stand if the NCE order was upheld. When the ALJ affirmed the NCE order and SAIF's claim acceptances, the NCE requested Board review. We dismissed, reasoning that appellate review jurisdiction rested directly with the Court of Appeals because the NCE's stipulation limited the issue to whether the NCE was a subject employer. The NCE appealed our order, contending that he was entitled to Board review because, at the hearing, he had contested SAIF's claim acceptance, as well as the Department's NCE order. The court agreed, holding that the Board had jurisdiction to review the Department's order. In reaching its conclusion, the court reasoned that the claimants' rights to compensation remained "directly in issue" as described in ORS 656.704(3) and 656.740(3)(c) because whether the claimants were "casual workers" under ORS 656.027(3) affected not only the NCE's status as a subject employer, but the claimants' status as subject workers.

Here, as in Hayes, the NCE order pertained to the NCE's status as a subject employer and claimant's status as a subject worker. However, unlike Hayes, no request for hearing challenged SAIF's acceptance of the claim. Under such circumstances, the NCE's appeal of the Department's order was not contested at the same hearing as a matter concerning a claim. Thus, appellate review authority rests directly with the court under ORS 656.740(4). Such a conclusion is in accordance with the Spencer House Moving and Ferland holdings, which were neither expressly, nor implicitly disavowed in Hayes.

Board Chair Hall dissenting.

Despite the plethora of cases cited by the majority, I submit that there is much confusion in this area of law. With no disrespect intended toward precedent, I further submit that this unfortunate situation results from careless wordplay and misinterpretation of ORS 656.740, especially subsection (4)(c), and 656.704(3). This issue warrants our taking the time to reexamine the law.

Under ORS 656.740, hearings and review of noncompliance and civil penalty cases are conducted under ORS 183.310 to 183.550, the Administrative Procedures Act (APA). ORS 656.740(1) provides: "A person may contest a proposed order of the director declaring that person to be a noncomplying employer, or a proposed assessment of civil penalty, by filing with the department * * * a written request for hearing. . . ."

To begin, ORS 656.740 addresses "noncompliance." This section does not encompass "subjectivity" of either the employer or the employee. Indeed, establishment of subjectivity is a prerequisite to the application of ORS 656.740, as ORS 656.005(18) defines a "noncomplying employer" as a "* * * subject employer who has failed to comply with ORS 656.017." Noncompliance is an issue of insurance coverage, not an issue of subjectivity. Consequently, in examining ORS 656.740 and the hearings/appeal procedure provided, we should not lose sight of the fact that the procedure is only for dealing with the issue of compliance (insurance coverage) and civil penalties arising therefrom. It is error to decide other issues, claims, or matters in the process for resolving compliance.

The limited nature of ORS 656.740 is apparent from subsection (4)(c), which provides:

> "When an order declaring a person to be a noncomplying employer is contested at the same hearing as a matter concerning a claim pursuant to ORS 656.283 and 656.704, the review thereof shall be as provided for a matter concerning a claim." (Emphasis added).

Because ORS 656.740, the enabling statute for noncompliance (coverage) hearings, refers only to NCE orders and civil penalties, it is clear that an "APA type" proceeding is required only when compliance and civil penalties are the sole issues. If a matter concerning a claim is involved, the case is litigated under ORS Chapter 656 and the APA is not implicated. Thus, there are occasions when the limited compliance issue may be afforded the broader appeal procedures, but the reverse is not true. That is, ORS 656.740 does not allow matters concerning claims to be decided within the more limited procedures of the APA.

This "exclusive" reading of ORS 656.740 is entirely consistent with ORS 656.283 and 656.704, which address "matters concerning claims." ORS 656.283 (1) provides that "any party or the director may at any time request a hearing on any question concerning a claim." ORS 656.704 provides in pertinent part:

> "* * * *
>
> "(3) For the purpose of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue." (Emphasis added).

Confusion over these separate proceedings appears to flow from the use of terminology, in past cases, involving "status" and "subjectivity" versus "noncompliance." Compliance disputes are easily recognized: They concern only whether the employer had coverage pursuant to ORS 656.017. When the sole issue is whether the employer had coverage, the "worker's right to receive compensation" is not at issue. By statute, the SAIF Corporation steps into the shoes of a noncomplying employer and provides benefits. See ORS 656.054. Noncompliance, by itself, does not put a claimant's compensation at issue.

"Subjectivity" issues, on the other hand, involve the "status" of the worker and/or the employer. Addressing subjectivity requires defining the status of the worker and/or the employer or identifying the worker's activity at the time of injury. See ORS 656.027; Bisbey v. Thedford, 68 Or App 200 (1984) (Where claimant's employment status was determinative, jurisdiction rested with the Board). All subjectivity cases necessarily, and "directly," involve the worker's right to receive compensation. The very entitlement to benefits depends upon the status of an employer and employee being "subject" to the Workers' Compensation Act. When the putative employer's defense to the charge that it failed to comply with the coverage requirements of the Act involves the "status" (i.e., "subjectivity") of the employer and/or the employee, the claimant's right to receive compensation is always at issue.

A problem has been created. The error begins when "subjectivity" becomes an issue (a defense to the lack of coverage) in the NCE setting. What began as a pure question of coverage/compliance becomes complicated when the Director mistakenly addresses subjectivity. (The Director lacks jurisdiction to address subjectivity, even in the context of an NCE hearing, under ORS 656.283 and 656.704.) (See discussion, supra). This "original error" is compounded when reviewing bodies persist in ignoring the fact "a matter concerning a claim" is at issue when subjectivity (claimant's and/or the employer's status) is decided along with the insurance coverage question.

In Ferland v. McMurtry Video Productions, 116 Or App 405 (1992), the claimant was injured while working for an NCE. The Department issued a proposed order finding the employer noncomplying and the employer requested a hearing before a Division referee. The referee issued an order finding that the claimant was a subject worker and the employer was noncomplying. The Board dismissed the request for review for lack of jurisdiction. In affirming the Board's dismissal, the court indicated that the hearing concerned "only the status of the employer," citing ORS 656.740(4)(c). 116 Or App at 407. But what is meant by "status?" The employer's noncompliance (failure to meet coverage requirements) or the employer and/or the employee's subjectivity?

In Spencer House Moving, 44 Van Natta 2522 (1992), aff'd Miller v. Spencer, 123 Or App 635 (1993), rev den 318 Or 326 (1994), the Board noted that the sole issue at hearing was the employer's "status". The employer objected to the Department's finding that it was noncomplying and its finding that claimant was a subject worker. Nonetheless, the Board found no matter concerning a claim at issue. The court affirmed cryptically, per curiam, citing Ferland v. McMurtry Video Productions, supra.

In contrast, the recent decision in Hayes v. SAIF, 132 Or App 455 (1995), sheds light on this issue. In Hayes, the employer requested a hearing objecting to SAIF's acceptance of the claimants' claim on its behalf. At the commencement of the hearing, the parties agreed that, if the claimants were subject workers, the proposed order of noncompliance and SAIF's acceptance were proper. In other words, the claimants' "status" was determinative in the NCE context. The referee affirmed the Director's order which found the employer noncomplying and awarded fees to each of claimants' attorneys. The Board dismissed the employer's appeal for lack of jurisdiction, based on a finding that the NCE order was not contested at the same hearing as a matter concerning a claim.

The Hayes court reversed the Board's order and remanded the case to us, instructing that we do have jurisdiction. The court held:

> "Despite the stipulation, claimants' rights to receive compensation remained 'directly in issue,' because whether claimants were 'casual workers' within the meaning of ORS 656.027(3) affected not only Hayes' status as a subject employer, but also claimants' status as subject workers. It follows that the Board had jurisdiction to review the order." 132 Or App at 460 (emphasis added).

In Hayes, the court has recognized the point being made in this dissent: Subjectivity goes to the very heart of "a matter concerning a claim" over which the Board has review authority. Thus, when the "subjectivity status" of the employer or employee is called into question, the Board has jurisdiction. We should choose our terms carefully because, if the "noncompliance status" of the employer is the sole issue, the Board does not have review authority.[1]

Under the majority's decision, the claim is dismissed for lack of jurisdiction because "compensability" of the claim was not challenged. According to the majority, no "matter concerning a claim" is at issue even when subjectivity is at issue. By reading the statute to foreclose jurisdiction in this case, the Board perpetuates the confusion outlined above. Because I believe it is never too late to revisit issues of law and precedent, I respectfully dissent.

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[1] Otherwise, we take the erroneous position that "a matter concerning a claim" is only at issue when acceptance/compensability of the claim is at issue.

March 6, 1996 Cite as 48 Van Natta 508 (1996)

In the Matter of the Compensation of
ANNETTE E. FARNSWORTH, Claimant
WCB Case No. 94-14877
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Claimant requests reconsideration of our February 13, 1996 order that affirmed an Administrative Law Judge's order that: (1) found that the self-insured employer did not issue a "back-up" denial; (2) upheld the employer's denial of claimant's right shoulder condition; and (3) declined to assess a penalty for the employer's allegedly unreasonable claim processing. Claimant contends that, because the employer authorized a right shoulder surgery, the Board should issue an order requiring the employer to pay for the surgery and assessing a penalty for its allegedly unreasonable failure to pay for the procedure.

After considering claimant's request and reviewing the record, we decline to address the issues that claimant has raised on reconsideration. We base this conclusion on the following reasoning.

On review, the issues were limited to "back-up" denial, compensability and penalties for the employer's late denial. Now, claimant asserts that, because the employer authorized a right shoulder surgery, the employer is estopped to deny it; further, claimant asserts that the employer's failure to pay for the surgery warrants a penalty. Claimant raised those issues for the first time on reconsideration. Therefore, we will not consider them. E.g., Robert K. Warren, 47 Van Natta 1471, 1473 n 4 (1995); see Vogel v. Liberty Northwest Ins. Corp., 132 Or App 7, 13 (1994) (Board has discretion not to address issue raised for first time on reconsideration).

In reaching this conclusion, we note claimant's argument that "[a]ffirming part of the denial, compensability of the right shoulder condition, does not mean that the entire denial should be affirmed." (Claimant's Motion to Abate and Reconsider at 4). We reject that argument because the ALJ upheld the denial without qualification. (Opinion and Order at 6). Therefore, if claimant disagreed with that portion of the decision that pertained to the denial of her surgery, she could have raised that argument, and the related penalty argument, on review. Because she did not do that, we will not consider those arguments now. E.g., Robert K. Warren, 47 Van Natta at 1473 n 4.

Accordingly, our February 13, 1996 order is withdrawn. On reconsideration, as supplemented here, we republish our February 13, 1996 order in its entirety. The parties' appeal rights shall run from the date of this order.

IT IS SO ORDERED.

March 6, 1996 Cite as 48 Van Natta 509 (1996)

In the Matter of the Compensation of
JON O. NORSTADT, Claimant
WCB Case Nos. 94-10782, 94-10781, 94-10773, 94-10774 & 94-05124
ORDER OF ABATEMENT
Coons, Cole & Cary, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Lundeen, et al, Defense Attorneys
Kevin L. Mannix, P.C., Defense Attorneys
Cowling, Heysell, et al, Defense Attorneys

Claimant requests reconsideration of our February 7, 1996 Order on Review that: (1) upheld the denials and disclaimers of claimant's occupational disease claim for bilateral hearing loss issued by Murphy Plywood Company/Liberty Northwest Insurance Corporation (Liberty), Parkway Ford/Liberty, Able Temporary/ Health Future Enterprises, Inc., Douglas County Forest Products/Liberty, and Huffman and Wright Logging/Liberty; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claims processing.

In order to further consider this matter, we withdraw our February 7, 1996 Order on Review. The carriers are granted an opportunity to respond. To be considered, each carrier's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
KEITH THOMAS, Claimant
WCB Case Nos. 95-02928 & 94-15031
ORDER ON REVIEW
Heiling, Dodge & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its disclaimers and denial of responsibility for claimant's current low back condition; (2) upheld Albertson's Inc.'s (Albertson's) disclaimers and denial of responsibility for the same condition; and (3) assessed a penalty against SAIF for its allegedly unreasonable claim processing. Albertson's cross-requests review of that portion of the ALJ's order that assessed a penalty against it for its allegedly unreasonable claim processing. On review, the issues are responsibility and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of facts.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We adopt and affirm the ALJ's reasoning and conclusion regarding this issue, with the following supplementation.

Albertson's asserts that, based on a Claim Disposition Agreement (CDA) that disposed of claimant's 1989 low back strain claim with it, claimant was precluded from filing a 1994 low back strain claim against it. We need not address that issue because, for the reasons stated in the ALJ's order, as supplemented below, we agree that Albertson's is not responsible for claimant's current low back strain.

Claimant sustained a compensable low back strain in 1989 while working for Albertson's. Claimant was also diagnosed with degenerative disc disease. The back strain claim was eventually resolved by a CDA. Claimant had intermittent low back problems thereafter. From approximately October 1992 to August 1994, however, claimant was relatively pain-free and sought no treatment for back complaints.

On August 18, 1994, claimant injured his low back while he was working for SAIF's insured. The truck he was driving got stuck on some rocks. In the process of pushing claimant's vehicle off the rocks, another driver struck claimant's truck hard, jarring claimant and causing him significant low back pain. (E.g., Exs. 100, 104-2). Claimant began treating with Dr. Holman, D.C., on August 24, 1994 for his low back complaints. (Ex. 90-1).

In November 1994, Drs. Watson and Martens examined claimant on SAIF's behalf. By that time, claimant's low back condition had returned to a "pre-traumatic level." (Ex. 104-2). Watson and Martens diagnosed a history of chronic back strain phenomena since 1989, and most recently in 1994, as well as degenerative disc disease. (Id. at 6). They concluded that "[t]here was no question that the pre-existing back condition, coupled with the most recent incident, 'caused the resultant disability and need for treatment.'" (Id. at 7). They also concluded that "[t]he major contributing cause of the need for treatment is no doubt related to the degenerative disc disease * * *", and that claimant's "need for recent treatment does not constitute a new, separate and/or 'major' injury." (Id.)

Thereafter, Dr. Holman concluded that claimant's preexisting back condition combined with the August 1994 incident to cause the resultant disability and need for treatment. (Ex. 108-1). In reaching that conclusion, Holman noted that claimant's preexisting injuries had been basically "stable" or "dormant" during the two years preceding the August 1994 incident. (Id.) Holman stated that claimant's preexisting back condition was "the major contributing cause for the weakening of his spinal column however as mentioned this was at a stationary level and appeared to be dormant at this level until this incident occurred." (Id.) Finally, Holman concluded that the major contributing cause of claimant's current need for treatment was the August 17, 1994 incident. (Id.)

Because claimant's current low back strain claim involves the "same condition" as that which Albertson's has already accepted, ORS 656.308(1) applies. Amended ORS 656.308(1) provides:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all future compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. The standards for determining the compensability of a combined condition under ORS 656.005 (7) shall also be used to determine the occurrence of a new compensable injury or disease under this section." Or Laws 1995, ch 332, § 37. (Emphasis added).

The emphasized language, added in June 1995, codifies SAIF v. Drews, 318 Or 1 (1993), which held that the major contributing cause standard in ORS 656.005(7)(a)(B) applies to shifting of responsibility among employers under ORS 656.308(1). Under either the former or present versions of ORS 656.308(1), then, claimant sustained a "new compensable injury" if the August 1994 incident was the major contributing cause of his current disability or need for treatment.

When the medical evidence is divided, we tend to give greater weight to the reports of the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find no persuasive reason not to give greater weight to the reports of Dr. Holman, treating chiropractor. He concluded that the major contributing cause of claimant's current need for treatment was the August 17, 1994 work incident. In view of claimant's lack of low back problems during the two years before the August 1994 work injury, we find Holman's report sufficient to establish that claimant sustained a "new compensable injury" in August 1994.

In reaching that conclusion, we acknowledge Dr. Holman's statement that claimant's preexisting back condition was the major contributing cause of his weakened spinal column. Because that conclusion addresses the general condition of claimant's spine, we do not find it in conflict with Holman's final conclusion that claimant's August 1994 work incident was the major contributing cause claimant's current disability and need for treatment. Therefore, notwithstanding Dr. Holman's "weakened spinal column" conclusion, we continue to find his report sufficient to establish that claimant sustained a "new compensable injury" in August 1994.

In contrast, we find persuasive reasons not to rely on the reports of Drs. Watson and Martens. They saw claimant only once, at which time claimant's back had already returned to a "pre-traumatic level." More important, however, Watson's and Marten's conclusions regarding the cause of claimant's current disability and need for treatment, and the character of claimant's current injury, are conclusory. Consequently, we discount their report.

In sum, the preponderance of the evidence establishes that claimant sustained a "new compensable injury" to his low back in August 1994. Therefore, SAIF, the carrier on the risk when claimant sustained that injury, is responsible for processing that claim as a new injury claim. Amended ORS 656.308(1). For these additional reasons, we affirm the ALJ's decision assigning responsibility to SAIF.

Penalties -- SAIF

Concluding that there was no evidence that claimant's low back condition was not work related, the ALJ assessed a 25 percent penalty against SAIF for its unreasonable claim processing. SAIF asserts that, at the time of its denial, there existed a legitimate doubt regarding the compensability of claimant's claim. Therefore, it asserts, its denial was not unreasonable. We agree.

If a carrier "unreasonably delays or refuses to pay compensation," it shall be liable for a penalty of up to 25 percent of the amounts then due. ORS 656.262(11)(a). Unreasonable resistance to payment of compensation exists when, from a legal standpoint, the carrier had no legitimate doubt about its liability at the time of resistance. E.g., International Paper Co. v. Huntley, 106 Or App 107 (1991).

Here, Drs. Watson's and Marten's report opposing compensability issued before SAIF denied the compensability of claimant's claim. (Exs. 104, 105). That report concludes that the major cause of claimant's low back strain is preexisting degenerative disc disease. (Ex. 104-7). Dr. Holman's report specifically supporting compensability did not issue until after SAIF denied the claim. (Ex. 105, 108).

On this record, we find that, at the time of SAIF's denial, there existed a legitimate doubt regarding its liability for the claim. Consequently, SAIF's denial was not unreasonable and there exists no basis for assessing a penalty under ORS 656.262(11)(a). Accordingly, we reverse the ALJ's penalty assessment against SAIF.

Penalty -- Albertson's

Applying reasoning similar to that stated above, the ALJ assessed a penalty against Albertson's for its unreasonable claim processing. ORS 656.262(11)(a). Albertson's argues that it should not be subject to a penalty, because claimant was not entitled to file a claim against it. Alternatively, it argues that, because a legitimate doubt exists regarding its liability for the claim, its conduct was not unreasonable. Because we agree with the latter argument, we need not address the former argument.

Here, as did SAIF, Albertson's denied the compensability of claimant's current low back after Drs. Watson and Martens issued their report opposing compensability. (Exs. 104, 109). That report is sufficient to create a legitimate doubt about Albertson's liability for the claim. Therefore, Albertson's denial was not unreasonable. Consequently, there exists no basis for assessing a penalty against it under ORS 656.262(11)(a). Accordingly, we reverse the ALJ's penalty assessment against Albertson's.[1]

Because claimant's respondent's brief was untimely, we do not award an attorney fee for services on review. Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The ALJ's order dated July 7, 1995 is affirmed in part and reversed in part. That portion of the ALJ's order assessing penalties against the SAIF Corporation and Albertson's Inc. is reversed. The remainder of the ALJ's order is affirmed.

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[1] The ALJ also determined that there was no justification for SAIF's and Albertson's failure to comply with ORS 656.307 and OAR 436-60-180. We understand the ALJ to have concluded that, because claimant's claim was clearly compensable, SAIF and Albertson's should have requested a paying agent and processed the claim under ORS 656.307. Because we have found that there existed a legitimate doubt regarding the compensability of claimant's claim at the time of each carrier's denial, we reject the ALJ's reasoning under that statute.

In the Matter of the Compensation of
JOHN E. BAFFORD, Claimant
WCB Case No. 95-07349
ORDER OF DISMISSAL
Myrick, Seagraves, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Claimant, pro se, has requested review of Administrative Law Judge (ALJ) Nichols' December 13, 1995 order. The self-insured employer has filed a motion to dismiss claimant's request for Board review, contending that claimant neglected to provide notice of his appeal to all parties to the proceeding within 30 days of the ALJ's order. See ORS 656.289(3); 656.295(2). Because the record does not establish that the other parties timely received notice of claimant's request, we dismiss.

FINDINGS OF FACT

On December 13, 1995, ALJ Nichols issued an Opinion and Order which upheld the employer's denial of claimant's occupational disease claim for a left leg deep vein thrombophlebitis condition. Parties to that order were claimant, claimant's attorney, the employer, its claim processor, 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 after the mailing date of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On January 11, 1996, the Board received claimant's request for Board review. Claimant's letter, which was hand-delivered to the Board's Medford office, expressed disagreement with the ALJ's decision and stated that he was lodging "a formal appeal on my denial for my Workers' Comp." Claimant's request did not indicate that copies had been provided to the other parties.

On January 22, 1996, the Board mailed a computer-generated letter to the parties, acknowledging claimant's request for Board review of ALJ Nichols' December 13, 1995 order. Receipt of this acknowledgment constitutes 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 App 47, 51 (1985); Argonaut Insurance v. King, supra. All parties to the ALJ's order must be served or receive notice, even if the appealing party makes no claim as to the excluded party. Kelsey v. Drushella-Klohk NCE, 128 Or App 53, 57 (1994); Mosley v. Sacred Heart Hospital, supra.

Here, the 30th day after the ALJ's December 13, 1995 order was January 12, 1996. Therefore, January 12, 1996 was the final day to perfect a timely appeal of the ALJ's order. Claimant's undated request for review was hand-delivered with the Board on January 11, 1996. Inasmuch as the request was received by a permanent office of the Board prior to expiration of the aforementioned 30-day statutory period, it was timely filed. See ORS 656.289(3); ORS 656.295(2); OAR 438-005-0046(1)(b).

However, the record fails to establish that the other parties to the proceeding before the ALJ were either provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Rather, the record indicates that the employer's first notice occurred when it received a copy of the Board's January 22, 1996 letter acknowledging claimant's request for Board review. Since January 22, 1996 is more than 30 days after the ALJ's December 13, 1995 order, such notice would be untimely.

Under such circumstances, we conclude that notice of claimant's request was not provided to the other parties within 30 days of the ALJ's December 13, 1995 order.[1] Consequently, we lack jurisdiction to review the ALJ's order. See ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has apparently requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the 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] In the event that claimant can establish that he provided notice of his request for Board review to the employer or its attorney within 30 days of the ALJ's December 13, 1995 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. Since our authority to reconsider this order expires within 30 days after the date of this order, claimant must file his written submission as soon as possible.

In the Matter of the Compensation of
JIMMY WIMER, Claimant
WCB Case No. 95-04408
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our February 6, 1996 Order on Review that affirmed the Administrative Law Judge's (ALJ) order which upheld the insurer's denial of claimant's right shoulder injury claim. Claimant requests that we clarify our order to find whether claimant's decision to stay the night after completion of his continuing education class took him out of the course and scope of his employment.

We continue to find that claimant was engaged in strictly a personal activity at the time of his injury. Thus, assuming, without deciding, that claimant was a traveling employee, we have concluded that claimant was on a distinct departure on a personal mission at the time of his injury. In reaching that conclusion, we adopted the ALJ's finding that the "employer was not aware that claimant was planning on spending Friday night [September 16, 1994] in Portland." Moreover, the business purpose of claimant's trip ended after completion of claimant's continuing education class at 11:35 a.m. The employer would not have paid for lodging on Friday night since claimant's class lasted only a half day. Finally, claimant was not acting according to any employer directive at the time of the motor vehicle accident.

Accordingly, we withdraw our February 6, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our February 6, 1996 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
MICHELLE L. ANDREASEN, Claimant
WCB Case No. 95-04171
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Breathouwer, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order which: (1) set aside its "back-up" denial of claimant's low back injury claim; (2) found that claimant was entitled to temporary partial disability benefits; and (3) assessed penalties or attorney fees for the employer's allegedly unreasonable termination of temporary disability benefits. On review, the issues are compensability, penalties and attorney fees.

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

The ALJ determined that the employer's "back-up" denial of claimant's low back claim was improper. In setting aside the employer's "back-up" denial, the ALJ found that the medical opinion of Dr. Duff was not "later obtained evidence."

On review, the employer contends that the reports of Drs. Duff and Adamcak were obtained subsequent to its acceptance and therefore, constitute "later obtained evidence." As such, according to the employer, the "later obtained evidence" supports the noncompensability of claimant's low back condition. Therefore, the employer asserts that its "back-up" denial should be reinstated and upheld.

We need not decide in this case whether Drs. Duff and Adamcak's reports constitutes "later obtained evidence" for purposes of ORS 656.262(6) because even if it does, we would find that the employer has failed to sustain its burden of proof on the issue of compensability.

On January 27, 1994, claimant was asked by her employer to demonstrate how to "kick out" a school bus window in order to exit the bus in an emergency. Claimant unsuccessfully attempted to "kick out" the bus window approximately ten times. (Tr. 21). Claimant testified that she had "tightness" in her low back immediately after the demonstration. (Tr. 20).

On February 9, 1994, Dr. Snow, treating physician, diagnosed right knee strain, an injury which he felt was "very consistent" with sustaining a kicking blow to an immovable force (i.e. claimant's work incident). (Ex. 1-2). Additionally, Dr. Snow diagnosed right lumbosacral/S1 strain, which he reported as also "stemming" from claimant's work incident. Dr. Snow relied on a history that claimant's primary complaint after the work incident involved her right low back and hip.

In February 1995, Dr. Duff performed an employer-arranged medical examination, and opined that there was no "conclusive connection at all between [claimant's] present symptoms and any incident in January 27, 1994." (Ex. 9-4). Dr. Snow concurred with Dr. Duff's medical report in a letter sent by the employer's attorney. (Ex. 10).

Absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). When the medical evidence is divided, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

Here, we find no persuasive reason not to defer to the opinion of Dr. Snow, treating physician. Dr. Snow's opinion was based on an accurate history and was well reasoned. For instance, Dr. Snow addressed the mechanism of claimant's work incident and determined that her injury was "very consistent" with her failed attempts to kick out the bus window. Dr. Snow was also aware that claimant's had low back complaints after trying to kick out the bus window.

In contrast, we decline to rely on Dr. Duff's opinion because it was based on an incomplete history. Dr. Duff's opinion was based on a history that claimant did not experience any immediate low

back symptoms after the January 1994 work incident. However, claimant's credible testimony and Dr. Snow's report establish that claimant had low back complaints after trying to kick out the bus window.[1] As such, Dr. Duff's opinion was based on an inaccurate history and is therefore afforded little persuasive weight. See Miller v. Granite Construction Co., 28 Or App 473, 476 (1977) (medical opinion that is not based on a complete and accurate history is less persuasive).

Finally, Dr. Snow's concurrence with Dr. Duff's opinion does not undermine Dr. Snow's initial opinion. In other words, because Dr. Snow was subsequently asked to give his opinion based on an inaccurate version of events, we rely on Dr. Snow's initial opinion which was based on an accurate history.

Consequently, we find that the employer has not established by a preponderance of the evidence that claimant's low back condition is not compensable. Amended ORS 656.262(6)(a). We therefore affirm the ALJ's ultimate conclusion that the employer's "back-up" denial must be set aside.

Temporary Disability

The ALJ found that claimant was entitled to temporary disability. In so doing, the ALJ determined that claimant was not offered modified work by the employer.

On review, the employer contends that the termination of temporary disability was appropriate in light of claimant allegedly removing herself voluntarily from the work force. Therefore, the employer argues, it could not offer claimant modified work.

Generally, a claimant is entitled to temporary disability compensation if he or she has sustained wage loss as a result of his compensable injury. See RSG Forest Products v. Jensen, 127 Or App 247, 250-51 (1994) (worker is entitled to interim compensation if he has suffered loss of earnings as a result of a work injury).

Here, it is not necessary to resolve whether the employer may have offered claimant modified work in order to determine whether claimant is entitled to temporary disability benefits after she left her employment. First, we note that claimant's claim remained open because the employer's Notice of Closure was set aside by the Order on Reconsideration. Consequently, this claim concerns entitlement to procedural, rather than substantive, temporary disability. See David P. Becknell, 47 Van Natta 610, 611 n.2 (1995). Second, claimant was released only to modified work at the time she left employment. She was unable to return to her regular work duties. Therefore, because her disability was partial, she was entitled, at least theoretically, to temporary partial disability benefits (TPD). ORS 656.212. Accordingly, we affirm the ALJ's decision and direct the insurer to calculate claimant's TPD under the statute.

Penalties and Attorney Fees

We adopt and affirm the ALJ's conclusions and reasoning in regard to assessing the employer penalties and attorney fees.

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

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[1] The ALJ found that claimant's testimony was credible as to demeanor and substance. Since the ALJ's credibility finding was based in part upon the observation of claimant's demeanor, we defer to that determination. See International Paper Co. v. McElroy, 101 Or App 61 (1990). 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). After our de novo review of the record, we agree with the ALJ that claimant was a credible witness.

Finally, we note that claimant's attorney is not entitled to a fee for services regarding the penalty and attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated August 7, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the employer.

March 8, 1996 Cite as 48 Van Natta 517 (1996)

In the Matter of the Compensation of
AURORA M. AREVALO, Claimant
WCB Case No. 95-05919
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the self-insured employer's denial of her aggravation claim for a low back injury. On review, the issue is aggravation.

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

Subsequent to the ALJ's order, we issued our decision in Carmen C. Neill, 47 Van Natta 2371 (1995). In Neill, we found that amended ORS 656.273(1) retroactively applied to cases in which the time to appeal the Board's decision has not expired, or if appealed, has not finally be resolved on appeal. See Newell v. SAIF, 136 Or App 280 (1995). Under amended ORS 656.273(1), a claimant must now show that she sustained "an actual worsening of the compensable condition" in order to prove an aggravation. An "actual worsening" may be proven by establishing either: (1) a pathological worsening of the underlying condition; or (2) a symptomatic worsening of the compensable condition that is greater than anticipated by the prior award of permanent disability. Neill, supra.[1]

Here, in 1993, as a result of her compensable low back injury, claimant received an award of 31 percent unscheduled permanent disability, as well as 2 percent scheduled permanent disability award for the right hip. The only medical evidence which supports claimant's aggravation claim comes from Dr. Collada, her treating physician. Dr. Collada reported that in September 1994, claimant experienced a "significant flare-up of symptoms." (Ex. 62). However, outside of scarring from claimant's prior injury, Dr. Collada reported no new objective findings. (Ex. 62). Moreover, Medical Consultants' Northwest, which examined claimant at the request of the insurer, opined that claimant's current symptoms were not supported by objective findings. (Ex. 59).

As noted above, a symptomatic worsening can establish an aggravation, provided that the worsening is greater than contemplated by the prior award of permanent disability. See Carmen C. Neill, supra. Thus, assuming *arguendo* that we find Dr. Collada's opinion persuasive, it only establishes that claimant sustained a symptomatic worsening. Where, as here, a claimant has received a prior award of permanent disability, amended ORS 656.214(7) is applicable. That statute provides that "all permanent disability contemplates future waxing and waning of symptoms of the condition. The results of waxing and waning may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability or inpatient hospitalization."

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[1] In determining what constitutes an "actual worsening," we relied on the legislature history concerning amended ORS 656.273(1), as well as the history behind the addition of ORS 656.214(7) which provides that "all permanent disability contemplates futher waxing and waning of symptoms. The results of the waxing and waning may include, but are not limited to, loss of earning capacity, periods of temporary total or temporary partial disability, or inpatient hospitalization." Neill, supra.

Here, claimant has received a prior award of 31 percent unscheduled permanent disability, as well as 2 percent scheduled permanent disability for the right hip. Therefore, under amended ORS 656.214(7), claimant has the burden of showing that her symptomatic worsening was greater than anticipated by the prior award of permanent disability. See ORS 656.266. The fact that claimant may have incurred a temporary loss of earning capacity does not establish that her symptomatic worsening was greater than anticipated. See Paul Bilecki, 48 Van Natta 97 (1996). Here, there is no evidence which establishes that claimant's symptomatic worsening is greater than contemplated by her prior award.[2] Accordingly, we agree with the ALJ that claimant has not proven an aggravation.

ORDER

The ALJ's order dated August 30, 1995 is affirmed.

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[2] In Carmen C. Neill, supra, we remanded the case to the ALJ for the submission of further evidence regarding whether the claimant had sustained an "actual worsening. We did so because the new law went into effect after the record concerning the aggravation had been developed and because the claimant had not received a prior award of permanent disability. In this case, the hearing took place after the new law went into effect and therefore, the parties had the opportunity to generate medical evidence concerning whether claimant has sustained an "actual worsening." Consequently, unlike Carmen C. Neill, supra, we see no compelling reason to remand.

Board Chair Hall specially concurring.

I agree that on this record, claimant has not established an "actual worsening." I write only to respond to an argument raised in the employer's brief.

The employer asserts because claimant failed to prove a permanent decrease in the range of motion in her low back, she failed to prove an aggravation. (Respondent's Brief at p. 2). Under the former version of ORS 656.273(1) a permanent worsening was not required to establish an aggravation. See Smith v. SAIF, 302 Or 396, 399 (1986). This is also true under the amended version of that statute as evidenced by Representative Mannix's comments. He stated:

> "Well, to be frank about it, the attending physician will tend to err on the side of caution and say well looking at this and evaluating this condition, yeah it's worse. Is it temporarily or permanently worse? That doesn't matter. If it's a worsened condition you'll get an aggravation." (Emphasis supplied)

(Minutes of the Senate Labor and Government Operations Committee, Tape 49A, February 17, 1995). Thus, contrary to the employer's contention, it is not incumbent upon an injured worker to establish that a compensable condition has permanently worsened in order to prove an aggravation.

In the Matter of the Compensation of
DOROTHY E. BRUCE, Claimant
WCB Case No. 95-02277
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) awarded temporary disability from May 8, 1993, through July 11, 1993; and (2) assessed a penalty for allegedly unreasonable claim processing. Claimant cross-requests review of that portion of the order that declined to assess a penalty for the insurer's alleged untimely payment of permanent partial disability awarded by a Determination Order. On review, the issues are temporary disability compensation and penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Temporary Partial Disability Benefits

We adopt the ALJ's conclusions and reasoning with the following supplementation.

The insurer asserts that claimant is not entitled to additional temporary disability benefits on the basis that Dr. Kopp's authorization was retroactive. We disagree.

Inasmuch as claimant's claim has been closed, the issue is claimant's substantive right to temporary disability benefits. A claimant's substantive entitlement to temporary disability benefits is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992). Thus, if a claimant leaves work as a result of her compensable injury, she is entitled to temporary disability benefits. See Tom D. Husted, 44 Van Natta 510 (1992). Unlike a claimant's procedural entitlement to temporary disability benefits during an open claim, substantive entitlement to such benefits is not contingent upon authorization of time loss by the attending physician. Esther C. Albertson, 44 Van Natta 521, aff'd Albertson v. Astoria Seafood Corporation, 116 Or App 241 (1992).

Here, claimant was initially injured in May 1991, but continued to work. The employer took her off work due to her injury on May 7, 1993 and did not allow her to return to work until her condition resolved. (Exs. 2 and 3). Subsequently, on July 12, 1993, Dr. Kopp released claimant to light duty work. However, the employer did not have any light duty jobs and would not allow claimant to return to work until she had been released to regular duty. (Exs. 3, 4-3 and 6). Based on the record as a whole, we conclude that claimant has established that she was disabled as of May 8, 1993. Accordingly, we affirm the ALJ's opinion that claimant is entitled to temporary partial disability benefits as of that date.

Penalty - Failure to Pay Temporary Disability

The insurer contends that no penalties should be assessed, as there was no compensation "then due" upon which to base a penalty. We disagree. The June 13, 1993 Determination Order awarded temporary partial disability from May 8, 1993 through July 11, 1993. The insurer was required to pay these temporary disability benefits within 30 days of the date of the determination order. ORS 656.313; OAR 436-60-150(6); Sisters of Providence v. East, 122 Or App 366 (1993) (an insurer cannot stay payment of temporary disability benefits pending an order on reconsideration). As of the May 17, 1995 hearing, the insurer had not paid the aforementioned temporary partial disability benefits. The insurer offered no explanation for its failure to pay the temporary disability benefits awarded by the Determination Order. Consequently, we find the insurer's failure to pay unreasonable and affirm the ALJ's penalty assessment. Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

Penalty - Late Payment of Scheduled Permanent Disability

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

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 concerning this issue is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that no attorney fee is available for that portion of claimant's brief devoted to the penalty issues. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated June 16, 1995 is affirmed. Claimant's counsel is awarded a reasonable attorney fee of $1,500, to be paid by the insurer.

In the Matter of the Compensation of
DAN D. CONE, Claimant
Own Motion No. 94-0006M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Terry & Wren, Claimant Attorneys
Kevin Mannix, Defense Attorney

Claimant requests review of the self-insured employer's December 27, 1995 Notice of Closure which closed his claim with an award of temporary disability compensation from January 3, 1994 through August 28, 1994. The employer declared claimant medically stationary as of August 29, 1994.

ISSUES

Claimant requests review of the employer's closure of his claim, contending that: (1) he was not medically stationary on August 29, 1994 and that the employer's closure of his claim was premature; (2) he is entitled to additional temporary disability compensation; and (3) the employer's December 27, 1995 Notice of Closure does not reflect the appropriate temporary disability compensation rate.

FINDINGS OF FACT

Claimant sustained a compensable injury to his back in 1985. His aggravation rights in that claim expired on June 5, 1990. Claimant's claim was reopened pursuant to the Board's Own Motion authority on December 11, 1995 to provide temporary disability compensation for claimant's compensable injury beginning the date he underwent surgery for the compensable condition. Claimant underwent that surgery on January 3, 1994.

On August 29, 1994, Dr. Weiss, consulting physician, opined that "[claimant's condition] has not changed for greater than six months and therefore would be considered stable and ratable for purposes of impairment determination."

In a September 1, 1994 chart note, Dr. Djernes, consulting physician, recommended claimant undergo a functional capacity assessment. Dr. Djernes opined that claimant's physicians "have not gotten real far with [claimant's] medical management." Dr. Djernes recommended that claimant participate in the "WorkFit" program.

On October 4, 1994, Dr. Henbest, claimant's treating physician, reviewed claimant's MRI of the cervical spine, and opined that:

> "At this point, from a surgical standpoint [claimant] is stable and he is starting into a WorkFit Program. I completely concur with this, and at the end of that we should be able to determine what he can and cannot do in work."

In an "Initial WorkFit Staffing Report for Week 1 - October 7, 1994," Dr. Weiss identified the program as "three weeks of work hardening." In that report, Dr. Weiss noted that:

"The [claimant] will continue working toward a minimum of 10% gains per week in all functional activities. With regard to vocational issues, the [claimant] is working with Stephen Abelsohn who has submitted 3 job analyses including a possible mechanizing position at White Satin."

In an October 10, 1994 telephone call report, Dr. Henbest stated that:

> "Stephen Abelsohn was contacted by phone today, October 7, 1994, in regards to [claimant]. It appears that [claimant] is going through the work hardening program or WorkFit Program.
>
> "I have deferred any decisions as to [claimant's] condition and future job to Dr. Weiss' evaluation."

On November 2, 1994, the employer's claims administrator wrote to Dr. Henbest. In that letter, the claims administrator acknowledged claimant's participation in the WorkFit program and Dr. Henbest's desire to wait for the completion of the program before rendering an opinion with respect to Dr. Weiss' closing evaluation. Because he was advised that the program was completed at that time, the claims administrator requested that Dr. Henbest submit his opinion as to his concurrence with Dr. Weiss' closing report.

On November 8, 1994, the employer's claims administrator again wrote to Dr. Henbest, acknowledging that he had received a call from Mr. Abelsohn, claimant's vocational counselor, in which it was purported by Mr. Abelsohn that Dr. Henbest believed that claimant may not have reached maximum medical improvement. In that letter, the claims administrator advised that, based on Mr. Abelsohn's report that Dr. Henbest wished to re-evaluate claimant's medical condition sometime during February of 1995, under those circumstances, the employer would not attempt to close claimant's claim until at least February 1995.

In a November 10, 1994 letter, Dr. Henbest wrote:

> "I have received [the claims administrator's] letter of inquiry dated November 2, 1994 on [claimant]. In that you ask as to whether or not I concur with Dr. Weiss' comments, and the answer is yes."

The employer closed claimant's claim on December 27, 1995, and declared claimant medically stationary as of August 29, 1994.

CONCLUSIONS OF LAW

Premature 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 December 27, 1995 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 August 29, 1994, Dr. Weiss opined that claimant's compensable medical condition had not improved "for greater than six months and therefore would be considered stable." On October 6, 1994, Dr. Henbest opined that "from a surgical standpoint [claimant] is stable." However, Dr. Henbest noted that, after completion of the WorkFit program, he would reevaluate claimant "to determine what he can and cannot do in work." On November 10, 1994, Dr. Henbest opined that he concurred with Dr. Weiss' comments in his August 29, 1994 closing evaluation. These opinions are unrebutted. Thus, the medical record establishes that claimant's compensable condition was medically stationary on August 29, 1994.

Claimant contends that involvement in the WorkFit program during September and October 1994 established that he was not yet medically stationary on August 29, 1994. However, the record establishes (and the physicians concur) that the WorkFit program is a work hardening program designed to increase a worker's functional capacities (rather than to improve a medical condition). Although the program included physical therapy, we find that this kind of medical treatment is considered ongoing, maintenance care. David L. Grenbemer, 48 Van Natta 195 (1996). Indeed, when Dr. Djernes recommended the functional capacity assessment and the WorkFit program, he opined that claimant needed "medical management" rather than medical treatment. In any case, we have found that the provision of ongoing care would not necessarily establish that a claimant was not medically stationary. Maarefi v. SAIF, 69 Or App 527, 531 (1984).

Here, claimant apparently did not wish to return to work in any job other than that of welder (his job-at-injury). However, Dr. Weiss recommended that claimant not be returned to his former welding position, as welding entailed putting the body in awkward positions for long periods of time, and these activities did not fall within claimant's physical capacities/restrictions. The WorkFit program was intended to increase claimant's strength and allow him to return to appropriate work. In accordance with this goal, his vocational counselor recommended 3 jobs for which claimant was suited (none of which was a welder), and claimant accepted one of those positions with the employer-at-injury. Thus, we are not persuaded that the WorkFit program affected claimant's compensable medical condition, other than to increase claimant's strength to perform the type of work he wished to perform. Because his condition had not improved in six months prior to the program, we would not expect it to materially improve subsequent to participation in a physical management program, nor do we find evidence that this was the case. ORS 656.005(17).

Claimant also contends that, because he was not released to work on August 29, 1994, that he was not medically stationary on that date. We disagree. Although a claimant cannot be declared medically stationary (unless a physician so opines) simply because he is released to work, the proposition does not apply in reverse. ORS 656.268(4)(a). In other words, if a worker is released to work, this does not mean that the worker's condition will not improve with time or further medical treatment. On the other hand, when a physician declares a worker "medically stationary," the physician has determined that the worker's compensable condition will not improve with further medical treatment or the passage of time. ORS 656.005(17). Thus, a physician's opinion that a claimant is medically stationary is more persuasive than a work release, or the lack thereof.

Finally, claimant contends that "the employer should be estopped from arguing that medically stationary date (August 29, 1994), as Mr. Marsh (the claims administrator) expressly stated the employer would not close the claim until Dr. Henbest reevaluated the claimant." We do not find claimant's argument regarding "estoppel" persuasive. The doctrine of equitable estoppel is only intended to protect those who materially change their positions in reliance on another's acts or representations. See Meier & Frank Co. v. Smith-Sanders, 115 Or App 159 (1992); Audrey L. Sanders, 46 Van Natta 1190 (1994).

Here, based on remarks made in a November 8, 1994 letter, claimant contends that the claims administrator expressly stated that the employer would not close the claim until Dr. Henbest reevaluated claimant. Claimant contends that, because of this statement, claimant reasonably relied on the letter, not requesting a further medical report from Dr. Henbest at the critical time. We conclude that the claims administrator's actions were in keeping with his commitment to claimant as expressed in his November 8, 1994 letter. In that letter, the claims administrator stated that the employer "will not attempt to close [claimant's] claim until [Dr. Henbest has] had a chance to examine [claimant] in February [1995]."[1] The employer did not close the claim until December 27, 1995, well after the date it had pledged to hold the claim open. We are not persuaded that claimant was prevented from requesting further medical reports "at the critical time," as the claim was not closed until some ten months later. Even assuming that claimant is correct, we are not persuaded that claimant materially changed his position in reliance on the claims administrator's actions. See id.

In sum, the record persuades us that claimant has not established that he was not medically stationary on December 27, 1995, when his claim was closed.[2] Therefore, we conclude that the employer's closure was proper.

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[1] Claimant is apparently confusing the terms "medically stationary" and "claim closure" with respect to their relevancy here. Claimant argues that the employer should be "estopped" from arguing that he was medically stationary on August 29, 1994 because the employer promised not to "close" the claim until February 1995. In this context, the employer promised to defer closing the claim (the mailing or "notice" of the Notice of Closure) until February 1995. The employer did not defer its declaration of claimant's medically stationary status to that date.

[2] Claimant contends that his claim was prematurely closed. However, as previously noted, the propriety of the closure is determined by whether claimant was medically stationary on the date the claim was closed, that is, on December 27, 1995. Claimant has submitted no evidence to support any contention that he was not medically stationary on that date. Berliner v. Weyerhaeuser Corp, supra; Sullivan v. Argonaut Ins. Co., supra; Alvarez v. GAB Business Services, supra.

Temporary Disability Benefits

Claimant contends that he is entitled to additional temporary disability compensation beyond August 28, 1994. A claimant's procedural entitlement to temporary disability benefits is for all periods during an open claim. OAR 436-30-036(1). The employer closed claimant's claim on December 27, 1995, prior to any appeal from claimant, and terminated claimant's right to procedural benefits. A claimant's substantive entitlement to temporary disability benefits is determined on claim closure and is proven by a preponderance of the evidence in the entire record showing that the claimant was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; Lebanon Plywood v. Seiber, 113 Or App 651, 654 (1992).

Here, claimant's substantive entitlement to temporary disability benefits ended on his medically stationary date. Claimant was awarded temporary disability compensation from January 3, 1994 until the medically stationary date. Inasmuch as claimant has not established that he was not medically stationary on August 29, 1994, we are not authorized to impose a procedural "overpayment" by awarding temporary disability benefits beyond the date that claimant is substantively entitled to such benefits, i.e. the medically stationary date. Id.

Calculation of Temporary Disability Benefits

Claimant also contends that the employer improperly calculated his temporary disability benefits. The employer's response indicates that claimant's appropriate TTD rate was based on claimant's wage at the time of his June 5, 1985 injury. Claimant argues that his wage records for the 12-month period preceding his January 1994 disability would show higher actual weekly income, thus entitling him to a higher TTD rate. Pursuant to ORS 656.202(2)[3], a worker's rate of temporary disability compensation shall be based on the wage of the worker at the time of injury. Thus, although claimant has submitted his pay records from January 2, 1994 through November 6, 1994, we do not find that claimant has established that his temporary disability rate was incorrect.

ORDER

The employer's December 25, 1995 Notice of Closure is affirmed.

IT IS SO ORDERED.

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[3] ORS 656.202(2) provides that: "Except as otherwise provided by law, payment of benefits for injuries or deaths under this chapter shall be continued as authorized, and in the amounts provided for, by the law in force at the time the injury giving rise to the right to compensation occurred." (Emphasis added).

In the Matter of the Compensation of
MERRIANN DECENSO, Claimant
WCB Case No. 94-15186
ORDER ON REVIEW
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the SAIF Corporation's denial of her occupational disease claim for a mental disorder condition; (2) declined to award a penalty for SAIF's allegedly unreasonable denial; and (3) declined to award a penalty for SAIF's alleged discovery violation. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ concluded that some of the stressors cited by claimant were employment conditions that were generally inherent in every working situation. The ALJ further concluded that claimant had not proven that she suffered from a mental disorder which is generally recognized in the medical or psychological community. Amended ORS 656.802(3). For the following reasons, we conclude that claimant has failed to prove her case.

The ALJ essentially found that many of the incidents cited by claimant had not occurred.[1] After reviewing the record, we agree with the ALJ's assessment of the incidents listed by claimant. Consequently, we are not persuaded that all of the employment conditions listed by claimant existed in a real and objective sense. ORS 656.802(3)(a).

Additionally, as noted by the ALJ, Dr. Halter, claimant's treating psychologist, reviewed claimant's records at the request of claimant's counsel and relied on a history which included the aforementioned events. (Ex. 115). Therefore, like the ALJ, we reject Dr. Halter's opinion, as we find that it is not based on a complete and accurate history. See Miller v. Granite Construction, 28 Or App 473 (1977).

Finally, the remaining medical opinion was provided by Dr. Wittkopp, who examined claimant on behalf of SAIF. The ALJ discounted Dr. Wittkopp's opinion, as the ALJ did not accept Dr. Wittkopp's diagnosis of an "epileptic personality." However, we need not discuss whether Dr. Wittkopp's opinion satisfies the statutory requirement of a mental disorder which is generally recognized in the medical or psychological community, as Dr. Wittkopp's opinion does not support compensability. Specifically, Dr. Wittkopp opined that the major contributing cause of claimant's current mental condition was her preexisting personality disorder. (Ex. 117).

Under the circumstances, we conclude that claimant has failed to prove by clear and convincing evidence that her mental disorder arose out of and in the course of employment. ORS 656.802(3)(d). As all elements of the statute must be satisfied in order for claimant to prevail, and claimant has not proven those required elements, we adopt the ALJ's conclusion on the issue of compensability. ORS 656.802(3).

Penalty/unreasonable denial

Because we have found that claimant's claim is not compensable, we conclude that SAIF's denial was not unreasonable.

Penalty/discovery violation

At hearing, claimant requested a penalty based upon SAIF's alleged discovery violations. However, even if the record did establish a discovery violation, the underlying claim is not compensable. Therefore, there has been no unreasonable resistance to the payment of compensation. James G. Harris, 47 Van Natta 2367 (1995). Under such circumstances, claimant is not entitled to a penalty pursuant to ORS 656.262(11). Boehr v. Mid Willamette Valley Food, 109 Or App 292 (1991); Randall v. Liberty Northwest Insurance Corp., 107 Or App 599 (1991).

ORDER

The ALJ's order dated October 24, 1995 is affirmed.

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[1] For example, claimant contended that she had been "set up" at work and sexually harassed by a coworker. Claimant also asserted that there was a concerted effort at work to get rid of her. However, the ALJ did not find any evidence to support these contentions.

In the Matter of the Compensation of
JANICE K. OTT-PETTRY, Claimant
WCB Case No. 95-02528
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that reclassified claimant's bilateral wrist claim as disabling. On review, the issue is claim classification. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted bilateral wrist claim. A February 17, 1995 Determination Order found that the claim properly was classified as nondisabling. Claimant requested a hearing, alleging that the claim should be reclassified as disabling.

The ALJ, citing to Sharman R. Crowell, 46 Van Natta 1728 (1994), found the claim disabling because claimant was restricted to, and remained on, modified duty. Although acknowledging the enactment of amended ORS 656.005(7)(c), the ALJ did not find the statute to be "determinative" "[f]or the reasons stated in Crowell (that this is a question of classification, not entitlement) and because claimant's entitlement to a permanent disability award is far from a close question."

On review, the employer asserts that, under amended ORS 656.005(7)(c), the claim should be classified as nondisabling because temporary disability benefits were not due and payable and claimant failed to prove a reasonable expectation of permanent disability. We agree.

Amended ORS 656.005(7)(c) now defines a "disabling compensable injury" as an "injury which entitles the worker to compensation for disability or death" and is "not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury." Pursuant to the statute, in order for a claim to be disabling, there must be entitlement to temporary disability benefits or a reasonable expectation of permanent disability. Karren S. Maldonado, 47 Van Natta 1535 (1995).

As the ALJ found, although on modified employment, claimant was not entitled to, and did not receive, temporary disability benefits. At the time claimant was declared medically stationary, her treating physician indicated no permanent impairment. (Ex. 28). Nothing in the record shows any expectation of permanent disability. Under these circumstances, the claim properly is classified as nondisabling. ORS 656.005(7)(c).

Claimant contends that the amended statute is invalid in that it violates Article I, section 20 of the Oregon Constitution and the Fourteenth Amendment of the United States Constitution. Specifically, claimant asserts that, because the amended statute distinguishes between workers who do and do not receive temporary disability, the legislature has "deferred to the unbounded, arbitrary and capricious decision of the employer" whether the worker will be offered a modified job and, thus, prevented from establishing a disabling claim.

We are not persuaded by claimant's argument. First, temporary disability benefits are "due and payable" for workers who are entitled to temporary total disability; the decision whether a worker is temporarily totally disabled is for the physician, not the employer. Furthermore, the statute also defines a claim as disabling if there is "a reasonable expectation of permanent disability." Again, this determination solely is for the physician. Consequently, we disagree with claimant that the legislature has conferred any authority to the employer for deciding if a claim is disabling in the context of entitlement to temporary total disability or evidence of a reasonable expectation of permanent disability.

It is conceivable that the employer could prevent entitlement to temporary partial disability by offering modified employment at wages the same or greater than the "at-injury" wage. According to claimant, this possibility shows that the statute impermissibly divides workers into two classes: those who have disabling claims because the employer did not offer modified employment and those who have nondisabling claims because the employer offered modified employment at an "at-injury" wage.

Article I, section 20, provides that "[n]o law shall be passed granting to any citizen or class of citizens privileges, or immunities, which, upon the same terms, shall not equally belong to all citizens." The first inquiry is whether there exists a "class" that is cognizable under Article I, section 20. In evaluating that issue, "we must first determine whether the class "'is created by the challenged law itself' or 'by virtue of characteristics * * * apart from the law in question.'" Sealey v. Hicks, 309 Or 387, 397 (1990) (quoting State v. Clark, 291 Or 231, 240 (1981)). "Those characteristics said to exist apart from the law itself include 'antecedent personal or social characteristics or societal status * * *.'" Ag West Supply v. Hall, 126 Or App 475, 478 (1994) (quoting Hale v. Port of Portland, 308 Or 508, 525 (1989)). Only classes based on those characteristics are considered classes for purposes of Article I, section 20; groups created by virtue of a challenged statute are not considered to be classes for the purposes of Article I, section 20. Hicks, supra, 309 Or at 397.

As explained above, claimant's challenge to ORS 656.005(7)(c) is based on classes created wholly by the statute and not on antecedent personal or social characteristics or societal status. Therefore, the classification claimant challenges does not involve a "class" for Article I, section 20, purposes. Ag West Supply v. Hall, supra, 126 Or App at 478. Accordingly, we reject her "equal protection" arguments. See Kathleen A. Wilfong, 48 Van Natta 165, 166-67 (1996).

Claimant alternatively argues that, if the Board nevertheless applies the new law, the case should be remanded. According to claimant, if she had not relied upon Crowell, pursuant to the administrative rules in effect at the time of hearing, she could prove her claim disabling only with evidence of an actual entitlement to permanent disability. OAR 436-30-045(5)(b). Because the amended statute requires a "reasonable likelihood of permanent disability," claimant asserts that the claim should be remanded in order to provide her with an opportunity to comply with the "reduced burden of proof."

In order to merit remand for additional evidence, such evidence could not have been obtainable at the time of hearing. Compton v. Weyerhaueser Co., 301 Or 641 (1986). As claimant acknowledges, at hearing she could have relied upon the standards provided in the administrative rules to classify the claim as disabling. As claimant also concedes, this approach likely would have produced evidence sufficient to satisfy the amended statute. The fact that claimant chose not to submit such evidence (because she relied on Crowell) does not mean that any additional evidence she could now submit was not obtainable at the time of hearing. See Clifford E. Clark, 47 Van Natta 2310 (1995) (Board denied motion to remand for additional evidence regarding claim classification because, inasmuch as the administrative rules provided that a disabling claim could be established with evidence of a likelihood of permanent disability, the additional evidence was not unobtainable). Thus, we deny the motion to remand.

ORDER

The ALJ's order dated June 9, 1995 is reversed. The Order on Reconsideration is affirmed. The ALJ's attorney fee award is reversed.

March 8, 1996 Cite as 48 Van Natta 526 (1996)

In the Matter of the Compensation of
JERRY S. QUILLEN, Claimant
WCB Case No. 95-01255
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Claimant requested reconsideration of our January 30, 1996 Order on Review that affirmed an Administrative Judge's (ALJ's) order which affirmed an Order on Reconsideration awarding 15 percent (48 degrees) unscheduled permanent disability for a back condition. Claimant contends that the court's recent decision in Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996) requires a conclusion that he is entitled to additional unscheduled permanent disability.

In order to consider this matter, we abated our January 30, 1996 order. Having received the self-insured employer's response to claimant's motion, we proceed with our reconsideration and replace our order with the following order.

On reconsideration, the self-insured employer agrees that Carroll v. Boise Cascade Corporation, supra, governs the extent of claimant's unscheduled permanent partial disability. The employer does not contest the ALJ's findings and conclusions regarding claimant's impairment and disability. Accordingly, we adopt and republish those findings and conclusions, except for the "Findings of Ultimate Fact" and the last two paragraphs of the "Conclusions of Law and Reasoning." We reach the following additional conclusions.

The ALJ found that claimant was not entitled to an adaptability value under OAR 436-35-310(6) because claimant had returned to his regular work. However, since the ALJ's order, the Court of Appeals determined that a former Director's rule, which also gave a zero adaptability value in certain circumstances, was invalid because it was inconsistent with ORS 656.726(3)(f)(A). Carroll v. Boise Cascade Corporation, supra. In Joe R. Ray, 48 Van Natta 325 (1996), we held the rule applicable in the present case is similarly invalid. Accordingly, that rule may not be used in determining the extent of claimant's unscheduled permanent disability. Instead, because the societal factors must be considered under the standards, we assign claimant an adaptability factor of 1, as in Joe R. Ray, supra.

The factors are assembled as follows: The total value of claimant's age, education and skills is (4) is multiplied by the adaptability value of (1) for a total of 4. OAR 436-35-280(6). When this value is added to the value for impairment (15), the result is 19. OAR 436-35-280(7). Therefore, claimant's unscheduled permanent disability is 19 percent.

Accordingly, the ALJ's order dated June 5, 1995 is modified. In addition to the Order on Reconsideration award of 15 percent (48 degrees) unscheduled permanent disability, claimant is awarded 4 percent (12.8 degrees) unscheduled permanent disability, for a total unscheduled permanent disability award of 19 percent (60.8 degrees). Claimant's counsel is awarded an out-of-compensation fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney. The parties' appeal rights shall begin to run from the date of this order.

IT IS SO ORDERED.

March 8, 1996 Cite as 48 Van Natta 527 (1996)

In the Matter of the Compensation of
STEPHEN A. VINZANT, Claimant
WCB Case Nos. 95-01153 & 94-06432
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys
Bailey & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Kemper Insurance Company (Kemper) requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its denial of claimant's current low back condition; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty) denial of claimant's claim for the same condition. In its brief, Kemper also contends that the ALJ erred in denying its motion to dismiss. On review, the issues are motion to dismiss, compensability and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back in 1979 while employed by Kemper's insured, Stone Forest Industries. In 1988, claimant underwent low back surgery for a disc herniation at L4. The disc herniation was causally related to the 1979 compensable injury. After 1988, claimant continued to

experience periodic low back pain, but did not seek medical treatment until 1992. In September 1992, claimant sought treatment for "a resurgence of his previous work injury." Thereafter, claimant did not seek treatment for his low back again until January 1994.

In 1992, claimant began working for Liberty's insured, Cascade Wood Products. On January 22, 1994, claimant sought treatment for lower back pain which developed acutely after an uneventful work day and after sleeping on the floor the previous night. Claimant was treated by Dr. Peterson. Claimant filed claims for his current low back condition with Kemper and Liberty. Both insurers issued denials of claimant's current low back condition and disclaimers of responsibility. Each insurer named the other as potentially responsible for claimant's condition. Claimant requested a hearing on the denials.

The ALJ found that claimant's current low back condition was materially related to claimant's 1979 injury at Kemper's insured. Finding that claimant had not sustained a new compensable injury or disease at Liberty's insured, the ALJ found Kemper responsible for claimant's low back condition and set aside its denial.

On review, Kemper asserts that no medical evidence causally relates claimant's low back condition to his 1979 compensable injury at Kemper's insured. Liberty likewise asserts that the medical evidence does not implicate claimant's work at its insured as a causal factor in claimant's current low back condition. Claimant contends that the medical evidence should be read as relating claimant's recent back problems to his 1979 injury or his most recent industrial exposure.

The medical evidence concerning the cause of claimant's current low back condition comes from Dr. Peterson.[1] Dr. Peterson diagnosed claimant's condition as a strain, but could not relate claimant's current problems to the 1979 compensable injury. Instead, Dr. Peterson indicated that "it would appear that it was some more recent strain probably related to his current work activities." Dr. Peterson also expressed agreement with the statement that claimant's symptoms were a new and separate injury from the 1979 injury and that the major contributing cause of the low back problems was "a new and separate injury that occurred while at home or with the most recent employment exposure." (Ex. 79-2). Dr. Peterson later concluded that claimant's diagnosis was a strain without relationship to work activities. (Ex. 90). At his deposition, Dr. Peterson acknowledged that, based on claimant's history to him, he could not relate claimant's strain to his work activities for Liberty's insured. (Ex. 91-13). Although Dr. Peterson suspected a herniated disc, this diagnosis was never confirmed. (Ex. 91-14). Dr. Peterson acknowledged that he could not implicate claimant's work activities or any injury directly as causes of claimant's condition. (Ex. 91-15).

Based on the medical evidence from Dr. Peterson, we are unable to conclude that either the 1979 compensable injury or claimant's more recent work activities at Liberty's insured are a material or the major contributing cause of claimant's current low back condition. Under such circumstances, claimant has failed to establish compensability of his current low back condition. Because claimant's current condition is not compensable, we do not address responsibility. Moreover, in light of our resolution of this case, we find it unnecessary to rule on Kemper's motion for dismissal.

ORDER

The ALJ's order dated June 20, 1995 is reversed in part and affirmed in part. Kemper's denials are reinstated and upheld. The ALJ's award of a $2,800 attorney fee payable by Kemper is also reversed. The remainder of the ALJ's order is affirmed.

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[1] Dr. Jonasson also gives an opinion concerning claimant's low back condition. However, his opinions primarily pertain to claimant's claim for a new injury at Liberty's insured occurring in August 1994. The parties agreed to litigate that claim at a later time. (Tr. 3-4). In any case, Dr. Jonasson did not relate claimant's low back condition to the 1979 compensable injury at Kemper's insured.

In the Matter of the Compensation of
ERNEST L. CHAVEZ, Claimant
WCB Case No. 95-07552
ORDER ON REVIEW (REMANDING)
Benjamin W. Ross, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members en banc.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that dismissed his hearing request concerning Fred Meyer's compensability and responsibility denial of claimant's claim for a right shoulder strain and back condition. In its respondent's brief, Fred Meyer seeks the assessment of a sanction against claimant's counsel for a frivolous appeal under ORS 656.390. On review, the issues are the propriety of the ALJ's dismissal under ORS 656.308(2)(c) and sanctions under ORS 656.390. We vacate the ALJ's order, deny the sanction request and remand.

The following procedural history appears from the parties' allegations and briefs on review and documents submitted to the ALJ.

On August 26, 1994, claimant compensably injured his right shoulder while working for Liberty Northwest's insured. Liberty accepted a right shoulder strain on October 11, 1994.

Prior to claim acceptance, claimant was placed on a 30-day suspension at work. During the suspension, claimant went to work for Fred Meyer, Inc., as a temporary replacement for striking workers. Claimant was employed by Fred Meyer for 4 days, from September 16, 1994 to September 24, 1994. Thereafter, the medical records indicate that claimant was subsequently employed by North American Van Lines.

On December 7, 1994, claimant sought treatment from Dr. Hosko for recurrence of right shoulder pain. Dr. Hosko diagnosed thoracic strain/sprain. On December 16, 1994, claimant changed attending physicians to Dr. Andrews, who diagnosed parathoracic muscle strain and right anterior chest pain/costochondritis. On December 22, 1994, Dr. Andrews also diagnosed lumbar strain. Dr. Andrews diagnosed a right shoulder strain on January 23, 1995.

Liberty issued a disclaimer of responsibility for claimant's right shoulder strain claim. Liberty notified claimant that his current problem could be the result of an injury sustained while working at Fred Meyer.

Fred Meyer issued a disclaimer of responsibility and denial of compensability and responsibility in response to claimant's claim "for a condition diagnosed as Right Shoulder Strain for injury date of 10-1-94." Claimant filed a request for hearing regarding Fred Meyer's denial.[1]

Fred Meyer filed a motion for dismissal pursuant to ORS 656.308(2)(c), on the ground that the record did not contain substantial evidence to support a finding of responsibility against it. Liberty objected to dismissal, contending that the record contained some evidence that Fred Meyer was responsible for a worsening of claimant's condition. Liberty relied on a medical report that stated that claimant had worked for Fred Meyer during the strike and got worse and also had low back pain.

The ALJ reviewed the evidence submitted and found that the record clearly established that claimant did not sustain a new injury or increased symptoms during his short tenure with Fred Meyer. Rather, the ALJ found that claimant's symptoms increased during his subsequent employment with a moving company. The ALJ dismissed claimant's hearing request, reasoning that the record did not contain substantial evidence to support a finding of compensability or responsibility against Fred Meyer. Claimant requests Board review of the ALJ's order of dismissal.

Fred Meyer argues that, since claimant did not respond to its motion to dismiss, all issues raised by claimant are raised for the first time on review and should not be addressed. We disagree.

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[1] We note that none of the carriers requested the designation of a paying agent under ORS 656.307.

Claimant asserts that he did not file a separate response to Fred Meyer's motion because he agreed with Liberty's objection to the motion for dismissal. Since Liberty objected to dismissal of Fred Meyer because the record contained some evidence that Fred Meyer was responsible for a worsening of claimant's condition, that issue is not raised for the first time on review.

Furthermore, there is no evidence in the record that claimant agreed with Fred Meyer's motion to dismiss or that he waived his right to argue that Fred Meyer should not be dismissed from the case. See Wright Schuchart Harbor v. Johnson, 133 Or App 680, 685-86 (1995) (waiver must be plainly and unequivocally manifested, either in terms or conduct that clearly indicates the intent to renounce a known privilege or power). Since claimant has timely requested review of the ALJ's order, and because the request contests findings and conclusions contained in that decision, we are authorized to consider claimant's arguments. Cf. Marie E. Kendall, 47 Van Natta 335 (1995) (although the carrier did not file a respondent's brief, it was not precluded from requesting reconsideration of the Board's order). Moreover, since the ALJ dismissed claimant's request for hearing pursuant to ORS 656.308(2)(c), our review of the ALJ's order necessarily involves the interpretation and application of that statute.

The ALJ found that there was no substantial evidence in the record that the claim was compensable as to Fred Meyer. Claimant argues that the ALJ had no authority to dismiss Fred Meyer because it issued a compensability denial. Fred Meyer responds that ORS 656.308 provides the authority for the ALJ's dismissal. We disagree.

ORS 656.308(2)(c) provides, in part:

> "Upon written notice by an insurer or self-insured employer filed not more than 28 days or less than 14 days before the hearing, the Administrative Law Judge shall dismiss the party from the proceeding if the record does not contain substantial evidence to support a finding of responsibility against that party." (Emphasis added).

In interpreting ORS 656.308(2)(c), we begin with an examination of the text and context of the statute. PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). In examining the text and context, we apply relevant rules of statutory construction, such as the rule that words of common meaning are generally assumed to have that common meaning. We also consider, as part of the statute's context, other provisions of the same statute and other related statutes. Id. at 611.

By its terms, ORS 656.308(2)(c) relates only to responsibility. Specifically, it allows dismissal of a party if there is no substantial evidence to support a finding of responsibility. Since the text of ORS 656.308(2)(c) does not refer to findings of compensability or compensability denials, we conclude that the dismissal procedures apply only to responsibility issues.

The context of ORS 656.308(2)(c) reinforces the clear language of the statute because the other sections of ORS 656.308(2) also focus on responsibility issues. ORS 656.308(2)(a) refers to procedures involving responsibility denials and provides that a carrier who disputes responsibility shall so indicate in or as part of a denial. The denial must advise the worker to file separate, timely claims against other potentially responsible carriers. Such denials are final unless the worker files a timely request for hearing pursuant to ORS 656.319. Subsection 2(a) also provides that all such hearing requests shall be consolidated.

ORS 656.308(2)(b), which pertains to joinder issues, provides that no carrier will be joined to any hearing unless the worker has filed a written claim against it or the carrier has consented to issuance of a ".307" order. Subsection 2(b) also provides that a carrier may contend that another carrier is responsible regardless of whether claimant has filed a claim against the other carrier.

Finally, ORS 656.308(2)(d) provides for an attorney fee for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. See Paul R. Huddleston, 48 Van Natta 4 (1996) (distinguishing between a "compensability denial" attorney fee under ORS 656.386(1) and a "responsibility denial" attorney fee under ORS 656.308(2)(d)).

Neither the text nor context of ORS 656.308(2)(c) supports Fred Meyer's contention that the ALJ had authority to dismiss claimant's hearing request concerning Fred Meyer's compensability denial.[2]

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[2] Since the intent of the legislature is clear from the text and context of the statute, further inquiry is unnecessary. PGE v. Bureau of Labor and Industries, supra, 317 Or at 611.

There is no reference in ORS 656.308 or elsewhere in ORS chapter 656 to a procedure for dismissing a hearing request on the basis that the record does not contain substantial evidence to support a finding of compensability. In order to interpret ORS 656.308 in such a manner, we would be required to read into the statute words that are not there. We are prohibited from doing so. See ORS 174.010 (in interpreting a statute, we are "not to insert what has been omitted").

We conclude that the ALJ had no statutory authority to dismiss claimant's hearing request on the basis that the record did not contain substantial evidence to support a finding of compensability regarding his claim with Fred Meyer. Cf. Joel C. Guzek, 47 Van Natta 1589 (1995) (the ALJ had no statutory or administrative authority to dismiss the claimant's hearing requests because he could not adequately state a "justiciable controversy").

We may remand a case to the ALJ for further evidence taking, correction or other necessary action if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5). Remand is appropriate upon a showing of good cause or some other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986).

Here, Fred Meyer denied compensability on May 25, 1995 and there is no evidence that it later conceded compensability. No hearing was convened and the parties did not have an opportunity to litigate the compensability of claimant's current condition claim. Compensability must be proved as a threshold to responsibility. See Joyce A. Crump, 47 Van Natta 466 (1995). In particular, a worker must first show that the claim, whether accidental injury or occupational disease, is causally related to work activities. See ORS 656.005(7)(a); ORS 656.802. Unless a carrier concedes compensability, a claimant has the burden of proving that an injury or occupational disease is compensable.[3] See ORS 656.266.

Accordingly, we vacate the ALJ's order and remand this case to ALJ Poland for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

In light of our disposition, we reject Fred Meyer's contention that we should assess a sanction against claimant's counsel for a frivolous appeal under ORS 656.390. Since we are remanding, we do not address claimant's other contentions on review.

IT IS SO ORDERED.

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[3] If Fred Meyer had conceded that claimant's condition was compensable, it would have been appropriate for the ALJ to consider whether Fred Meyer should be dismissed from the proceeding pursuant to ORS 656.308(2)(c). See Castle & Cooke v. Alcantar, 112 Or App 392, 395 (1992) (concession of compensability does not operate to waive an employer's right to argue that the disability is not related to a work exposure in its employment).

March 12, 1995 Cite as 48 Van Natta 531 (1996)

In the Matter of the Compensation of
BRADLEY S. PARKER, Claimant
WCB Case No. 94-07649
SECOND ORDER DENYING RECONSIDERATION
Rasmussen, et al, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

Pursuant to our February 29, 1996 order, we denied claimant's motion for reconsideration of our January 24, 1996 order which had affirmed an Administrative Law Judge (ALJ's) order that: (1) directed the insurer to pay temporary total disability benefits (TTD) between June 7, 1994 and July 28, 1994; and (2) assessed a 25 percent penalty for the insurer's allegedly unreasonable claims processing. In reaching our conclusion, we reasoned that, since the 30-day statutory appeal period had expired, we lacked authority to reconsider our decision. Submitting a copy of its February 16, 1996 petition for judicial review, the insurer requests that we modify our February 29, 1996 order to clarify that our January 24, 1996 order was appealed. Based on the insurer's appeal, claimant (through his new attorney) asks that we address the "typographical error" in our January 24, 1996 order.

Although the insurer's petition includes a certificate stating that a copy of the petition was mailed to the Board on February 16, 1996, our first notice of the appeal occurred on March 6, 1996 when we received the insurer's request for reconsideration which included a copy of the petition. In any event, it is not our task to determine whether the insurer's petition for judicial review was timely and properly perfected.[1] Moreover, even if our January 24, 1996 order was timely appealed, we would continue to deny claimant's motion for reconsideration. We base this conclusion on the following reasoning.

At any time subsequent to the filing of a petition for judicial review and prior to the date set for hearing, we may withdraw an appealed order for purposes of reconsideration. ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). However, this authority is rarely exercised. Ronald D. Chaffee, 39 Van Natta 1135 (1987).

Here, claimant asked us to "amend" our January 24, 1996 order to award TTD beginning June 7, 1993, rather than June 7, 1994 as found in the order. Nevertheless, as explained in footnote 2 of our February 29, 1996 order, our review authority was confined to the issue of claimant's entitlement to TTD beginning June 7, 1994 (the date of an appealed prior ALJ's order). In other words, our TTD award was not a "typographical error" as claimant suggests.

Accordingly, as modified and supplemented herein, we adhere to our February 29, 1996 order denying claimant's motion for reconsideration. The issuance of this order neither "stays" our previous order nor extends the time for seeking review. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656 (1985).

IT IS SO ORDERED.

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[1] In other words, we shall forward the appellate record to the court in accordance with ORS 656.298(5).

In the Matter of the Compensation of
LANA L. RUNKEL, Claimant
WCB Case No. 93-14247
ORDER ON REVIEW (REMANDING)
William H. Skalak, Claimant Attorney
Jerome P. Larkin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Herman's order which: (1) upheld the SAIF Corporation's denial of her aggravation claim for a psychological condition; (2) declined to award interim compensation from June 29, 1993 to August 20, 1993; and (3) declined to award penalties or attorney fees for SAIF's allegedly unreasonable claim processing. In its brief, SAIF contends that the ALJ erred in setting aside its denial of claimant's current psychological condition. On review, the issues are aggravation, compensability, interim compensation, penalties and attorney fees. We affirm in part, reverse in part and vacate in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, but offer the following brief summary of the factual background of this claim.

On December 16, 1986, claimant strained her low back while performing her employment duties. SAIF accepted the claim as a "back strain." (Ex. 3).

In 1987, claimant began experiencing speech difficulties that prompted a referral to a speech pathologist, who diagnosed "spastic dysphonia, probably emotional." (Ex. 5). A psychiatrist, Dr. Klein, evaluated claimant's psychological status and then referred claimant to a psychologist, Dr. Yospe, for treatment of the spastic dysphonia disorder. (Ex. 6C-2, 14).

In October 1987, an examining psychiatrist, Dr. Friedman, diagnosed major depression, the major contributing cause of which was claimant's compensable 1986 injury. (Ex. 6C-4). In January 1989, another examining psychiatrist, Dr. Glass, disagreed with the diagnosis of depression and instead diagnosed psychological factors affecting claimant's pain behavior and a passive-aggressive, passive-dependent personality disorder with hysterical and histrionic features. (Ex. 11-6). A psychologist, Dr. Davies, later agreed with Dr. Glass' diagnosis. (Ex.21-3). Another psychiatrist, Dr. Turco, also opined in October 1989 that claimant suffered from a passive-aggressive and passive-dependent personality disorder with hysterical and histrionic features. (Ex. 25-3). Noting that claimant was quite fixed in her role as an invalid, Dr. Turco wrote that claimant would not return to work. Dr. Klein, who was claimant's attending psychiatrist, substantially agreed with Dr. Turco's report. (Ex. 26).

The claim was initially closed on January 25, 1990, by a Determination Order that awarded 42 percent unscheduled permanent disability for claimant's low back.

Claimant briefly returned to work in October 1990 as a candy maker, but, within two weeks, was again disabled when she experienced low back and right leg pain. She has not worked since that time. Claimant was examined by another psychiatrist, Dr. Bellville, in December 1990. Dr. Bellville essentially agreed with Dr. Glass' assessment of claimant's psychological condition. (Ex. 36-9).

Claimant underwent multiple cervical surgeries in January, February and May 1991. In April 1991, Dr. Parvaresh, a psychiatrist, declared claimant medically stationary from a psychological standpoint. In August 1991, Dr. Klein opined that there was no need for further psychological care beyond periodic status checks and as-needed visits for flare-ups. (Ex. 44).

In conjunction with an October 11, 1991 request for claim closure, SAIF listed the compensable conditions as "low back strain, psych." (Ex. 45A). A Determination Order was issued on November 18, 1991, but did not award additional permanent disability, even though both claimant's low back and psychological conditions were considered. (Ex. 46).

Claimant requested reconsideration, resulting in the appointment of medical arbiters for both the low back and psychological conditions. (Ex. 57). A July 29, 1992 Order on Reconsideration affirmed the Determination Order. (Ex. 58). Claimant's psychological condition was evaluated as an accepted condition, but no permanent disability was awarded for this condition on the ground that claimant's psychological condition had not permanently worsened.

In the spring and summer of 1993, claimant was involved in vocational rehabilitation efforts. On June 17, 1993, SAIF sent claimant a letter informing her that it would no longer pay the medical bills from Dr. Butler (her attending orthopedist) and Dr. Klein, because they were not members of the managed care organization with whom SAIF had entered into an agreement. (Ex. 66A).

Emotionally distraught by the contents of SAIF's letter, claimant unsuccessfully attempted to drive her car off the road. (Ex. 67). Claimant was given a psychiatric admission to a hospital, where she was treated by a psychiatrist, Dr. Fairley. (Ex. 67). According to chart notes from a hospital social worker, a SAIF claims adjuster stated that SAIF would assume liability for payment of claimant's hospital expenses. (Ex. 67-31).

After claimant was discharged from the hospital, SAIF issued a denial of aggravation and of claimant's current psychological condition on the ground that any worsening of claimant's psychological condition was the result of a preexisting condition. (Ex. 77). Claimant requested a hearing contesting the denial and alleging entitlement to interim compensation from June 29, 1993 to August 20, 1993, the date of SAIF's denial, as well as penalties and attorney fees for failure to pay interim compensation.

CONCLUSIONS OF LAW AND OPINION

Interim Compensation

The ALJ noted that claimant was not working at the time of aggravation claim, which was based on her June 1993 hospitalization. The ALJ reasoned that, although claimant had participated in vocational rehabilitation, this participation was motivated by a desire to maintain her benefits and not to return to work. Thus, the ALJ declined to award interim compensation, finding that claimant had withdrawn from the work force at the time of her June 1993 aggravation. See Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989).

Claimant cites the ALJ's finding that due to her personality disorder and resulting commitment to invalid status, claimant was not motivated to return to work nor deemed capable of cooperating with vocational rehabilitation efforts. Claimant contends that the ALJ erred in using a compensable aspect of her psychological disorder to deny her interim compensation benefits. We agree.

For reasons discussed below, we agree that claimant's personality disorder is a compensable component of this claim. In order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) although not employed at the time, is willing to work and is making reasonable efforts to obtain employment or (3) willing to work, although not employed at the time and not making reasonable efforts to obtain employment because of a work-related injury, where such efforts would be futile. Dawkins v. Pacific Motor Trucking, supra, 308 Or at 258 (citations omitted).

We agree with claimant that, at the very least, she has satisfied the third prong of the Dawkins criteria. Even assuming that claimant was not making reasonable efforts to find employment, such efforts would have been futile given her compensable personality disorder, which the ALJ found, and we concur, is responsible for her lack of motivation and unwillingness to work. Accordingly, we find that claimant was in the work force at the time of her aggravation claim in June 1993. She is, therefore, entitled to interim compensation from June 29, 1993 to August 20, 1993. Claimant's counsel is awarded an attorney fee equal to 25 percent of the increased compensation resulting from this order, not to exceed $3,800, payable directly to claimant's attorney

Penalties and Attorney Fees

Claimant contends that, if we find that she is entitled to interim compensation, SAIF acted unreasonably in refusing to pay her interim compensation. We disagree.

The ALJ refused to assess penalties or attorney fees for SAIF's failure to pay interim compensation based on a finding that claimant was not entitled to interim temporary disability. Although we have found that claimant was entitled to interim compensation, we nonetheless conclude that SAIF's claim processing was not unreasonable.

Considering that claimant last worked in October 1990, and the medical evidence that claimant has become entrenched in her invalid status, we find that SAIF legitimately questioned its liability for interim compensation. Therefore, we do not find SAIF's refusal to pay interim compensation in June 1993 to have been unreasonable. Because we find that SAIF had a "legitimate doubt" regarding its liability for interim compensation, see Brown v. Argonaut Insurance Company, 93 Or App 588 (1988), we affirm the ALJ's decision not to assess a penalty or attorney fee.

Scope of Acceptance

In determining whether claimant had established a compensable aggravation claim for her psychological condition, the ALJ identified the threshold issue as whether or not SAIF had accepted a psychological component to her compensable 1986 low back injury claim, and, if so, what condition or conditions were accepted. Although SAIF had not issued a formal, written acceptance of any psychological condition, the ALJ reasoned that it had accepted a psychological claim through its conduct.

The ALJ noted that SAIF had paid for psychological care since 1987 and had actively managed the psychological aspect of claimant's compensable claim. Moreover, the ALJ observed that, when SAIF closed the claim in October 1991, the claim summary form had listed the accepted conditions as including "psych." In addition, the ALJ noted that a medical arbiter had been appointed to evaluate claimant's psychological condition and that numerous medical evaluations had been scheduled to evaluate claimant's psychological condition. The ALJ concluded that, based on the totality of the evidence, SAIF had assumed liability for claimant's psychological condition by actively processing the claim for seven years.

After concluding that SAIF had accepted claimant's psychological claim, the ALJ determined that SAIF's acceptance was very broad, inasmuch as it had made no attempt to limit or confine its acceptance to a specific diagnosis or disease process. Accordingly, the ALJ interpreted SAIF's acceptance as encompassing all possible causes of claimant's psychological condition, including chronic depression, psychological factors affecting a physical condition and a mixed personality disorder.

On review, SAIF contends that it did not accept claimant's personality disorder. We disagree.

SAIF broadly described the accepted psychological condition as "psych" without attempting to further define or limit its acceptance. Under these circumstances, we agree with the ALJ that SAIF's acceptance should be broadly construed to encompass all causes of her psychological condition, including claimant's personality disorder. See Janet L. Lundsten, 46 Van Natta 1747, 1750 (1994) (when carrier's partial denial identified the accepted condition as "a work-related injury to [claimant's] low back," acceptance construed to include L5-S1 disc condition). Accordingly, we agree with the ALJ that claimant's personality disorder is among the accepted psychological conditions.

Aggravation

Having determined claimant's compensable psychological conditions, the ALJ then addressed the issue of whether claimant proved that she sustained a compensable aggravation claim. The ALJ first determined that claimant had satisfied the causation element of her aggravation claim, reasoning that, inasmuch as claimant's psychological condition, including personality disorder, had been accepted, the compensable 1986 injury was causally related to claimant's current psychological condition. Although finding that a preponderance of the medical evidence established that claimant's psychological condition had worsened when claimant became actively suicidal and required hospitalization, the ALJ nonetheless upheld SAIF's aggravation denial because claimant's had failed to prove that her worsened condition resulted in diminished earning capacity.

On review, SAIF contends that, under ORS 656.005(7)(a)(A), claimant failed to prove that her worsened psychological condition is a compensable consequential condition because the major contributing cause of her psychological condition is her anxiety regarding claim processing and vocational issues. SAIF also contends that claimant's current psychological condition is not compensable under ORS 656.005(7)(a)(B) because claimant's preexisting personality disorder is the major contributing cause of her need for treatment in June 1993. We disagree.

First, we find that ORS 656.005(7)(a)(B) is not applicable. Because claimant's personality disorder, which preexisted the compensable 1986 injury, is itself a compensable condition, it does not constitute a preexisting condition for the purposes of ORS 656.005(7)(a)(B). Ronald L. Ledbetter, 47 Van Natta 1461, 1462 (1995). Because there is no evidence that the compensable personality disorder combined with any other preexisting condition, neither the current nor former version of ORS 656.005(7)(a)(B) applies to this case. See Joyce E. Soper, 46 Van Natta 740 (1994) (Former ORS 656.005(7)(a)(B) not applicable where the claimant's preexisting degenerative arthritis condition was ordered accepted by a prior litigation order).

We also conclude that ORS 656.005(7)(a)(A) is not applicable. We agree with the ALJ's reasoning that claimant's need for psychological care in June 1993 was a result of her accepted personality disorder rather than SAIF's claim processing actions.[1] Given that the personality disorder is compensable, ORS 656.005(7)(a)(A) would not apply because the alleged consequential condition has already been accepted. We, therefore, agree with the ALJ that claimant's current psychological condition is compensable and that claimant has satisfied the causation element of ORS 656.273.

The ALJ found that, while the medical evidence did not specifically address the issue of a "worsening," claimant's accepted psychological condition had worsened based on the fact that she had become suicidal and required hospitalization.

Since the ALJ's order, the legislature amended ORS 656.273(1) to require that a "worsened condition" be established by medical evidence of an "actual worsening." Or Laws 1992, ch. 332, § 31. We have previously examined the issue of what constitutes an "actual worsening" for the purposes of ORS 656.273(1). See Carmen C. Neill, 47 Van Natta 2371 (1995). Based on our examination of the

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[1] In Roseburg Forest Products v. Zimbelman, 136 Or App 75, 80 n.2 (1995), the court stated that a claimant's reaction to claims processing is not caused by a compensable injury, but rather is caused by the process by which the claimant is compensated for the injury. The court reasoned that, because those causes are collateral to the injury, they cannot be considered as caused by the compensable injury. Zimbelman is not applicable here, inasmuch as we agree with the ALJ that claimant's need for psychological treatment is a result of her accepted personality disorder rather than SAIF's claim processing actions.

legislative history, we reached the following conclusions with regard to what constitutes an "actual worsening" under amended ORS 656.273(1). A pathological worsening of the underlying condition is sufficient to establish an actual worsening. In addition, a symptomatic worsening of the condition, that is greater than anticipated by the prior award of permanent disability, is also sufficient to establish an actual worsening.

We may remand a case that 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, 420 (1986). A compelling basis for remand exists when the record is devoid of evidence regarding a legal standard that goes into effect while Board review of a case is pending. Carmen C. Neill, supra.

Here, after issuance of the ALJ's order, amended ORS 656.273(1)'s "actual worsening" standard went into effect. Claimant has not received a prior award of permanent disability for her psychological condition. Moreover, the record is devoid of medical evidence regarding whether claimant sustained an "actual worsening" in June 1993.[2] In light of the fact that claimant has not received a prior award of permanent disability and since the record was developed/closed prior to the effective date of amended ORS 656.273(1), we consider the record regarding whether claimant's compensable psychological condition has "actual[ly] worsen[ed]" to be incompletely and insufficiently developed to determine the compensability of claimant's aggravation claim.[3] Carmen C. Neill, supra.

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

ORDER

The ALJ's order dated January 19, 1995 is affirmed in part, reversed in part and vacated in part. We affirm those portions which determined that SAIF had accepted claimant's psychological condition, including her personality disorder, set aside SAIF's denial of claimant's current psychological condition, and declined to award penalties and attorney fees. For services on review regarding the compensability of claimant's current psychological condition, claimant's counsel is awarded an assessed attorney fee of $750, payable by SAIF.

We reverse that portion which declined to award claimant interim compensation. Claimant is awarded interim compensation from June 29, 1993 to August 20, 1993. Claimant's counsel is awarded an attorney fee equal to 25 percent of the increased compensation resulting from this order, not to exceed $3,800, payable directly to claimant's attorney. We vacate that portion of the ALJ's order which upheld SAIF's aggravation denial and remand this matter to ALJ Herman for further proceedings in which each party will be permitted to present evidence regarding the compensability of claimant's June 1993 aggravation claim. Those proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order regarding the aggravation issue.

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[2] As the ALJ noted, there is no medical evidence that specifically addresses the issue of a "worsening." Dr. Fairley described claimant as "markedly depressed" at the time of her hospitalization (Ex. 69-2) and another psychiatrist, Dr. Spangler, diagnosed severe, recurrent major depression. (Ex. 81). However, there is no medical evidence pertaining to whether claimant, who had a long history of psychological problems prior to her suicide attempt, experienced an "actual worsening" of her conditon. In light of this, we are unwilling to infer a pathological worsening from claimant's suicide attempt and subsequent hospitalization.

[3] In view of this conclusion, we do not address the diminished earning capacity issue. See Helen Callander, supra.

In the Matter of the Compensation of
LARRY L. LYMAN, Claimant
WCB Case No. 95-05766
ORDER ON REVIEW (REMANDING)
David C. Force, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that dismissed, without a hearing, claimant's request for hearing from the SAIF Corporation's denial of his aggravation claim. On review, claimant seeks reversal of the ALJ's dismissal order and remand for a hearing on the merits of his claim. We vacate the ALJ's order and remand.

FINDINGS OF FACT

Claimant has an accepted low back claim that was closed in 1986 and reclosed in 1989. On May 10, 1995, claimant filed a hearing request on an aggravation claim. A hearing was scheduled for July 26, 1995. Prior to hearing, SAIF moved to dismiss the request for hearing. Submitting its proposed exhibits, SAIF contended that, inasmuch as claimant did not file an aggravation claim prior to the expiration of his aggravation rights, the Hearings Division lacked jurisdiction over the dispute. Contending that there were material issues of fact to be addressed at hearing, claimant argued that SAIF's motion for dismissal should be denied.

The ALJ admitted the documents submitted by SAIF for the purpose of considering its motion. The ALJ dismissed claimant's request for hearing for lack of jurisdiction. The ALJ adopted SAIF's argument that claimant did not file an aggravation claim prior to the expiration of his aggravation rights. The ALJ did not convene a hearing, take any testimony, or permit claimant to submit exhibits or to cross-examine the medical experts. Claimant filed a motion for reconsideration, arguing that he should be permitted to present evidence at hearing that his condition worsened prior to the expiration of his aggravation rights. Again adopting SAIF's arguments, the ALJ denied claimant's motion. This appeal by claimant followed.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that an ALJ should not dismiss a request for hearing based on a factual conclusion without convening a hearing at which the parties present evidence to support their respective factual contentions. For the following reasons, we agree.

The Hearings Division has jurisdiction over all matters concerning a claim. ORS 656.283(1). Here, SAIF denied claimant's aggravation claim on the grounds that claimant did not file the claim prior to the expiration of his aggravation rights. Claimant requested a hearing on that denial, which is a "matter concerning a claim." Accordingly, the ALJ had jurisdiction over claimant's hearing request. See Ana R. Sanchez, 45 Van Natta 753 (1993) ("Back-up" denial on the basis that the claimant was not a subject worker was a "matter concerning a claim"; ALJ had jurisdiction over hearing request).

Like the ALJ in Sanchez, the ALJ in this case could have upheld or set aside SAIF's denial. However, it was not appropriate to reach the merits of the denial and dismiss the hearing request for lack of jurisdiction, without considering the entire record before making a decision on the merits. As exemplified by Sanchez, disputes involving "matters concerning a claim" must be decided on the basis of a sufficiently developed hearing record. See also Nancy L. Cook, 45 Van Natta 977 (1993) (The ALJ's role is to evaluate the entire record and produce an order containing an organized set of facts and conclusions of law with an explanation why the facts supported by the evidence lead to a conclusion). In light of the Sanchez and Cook rationale, the ALJ erred in deciding the aggravation issue without first conducting a hearing. Thus, we reinstate claimant's hearing request.

Should we determine that a case has been improperly, incompletely or otherwise insufficiently developed, we may remand to the ALJ for further evidence taking, correction, or other necessary action. See ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); see Homer Betancourt, 46 Van Natta 2399 (1994) (Compelling reason for remand found where the claimant's request for hearing was dismissed, over the claimant's objection and without convening a hearing or taking any evidence, based on the employer's contention that the Hearing's Division lacked jurisdiction over the claimant's aggravation claim).

Because the ALJ dismissed claimant's request for hearing (over claimant's objection) without taking any testimony or permitting claimant to submit any documentary evidence, we conclude that the record has been incompletely developed. Because we find this a compelling reason for remand, and to assure that the parties will be afforded substantial justice, see ORS 656.283(7), we remand this matter to ALJ Mongrain to conduct a hearing.[1]

Accordingly, we vacate the ALJ's order and remand to ALJ Mongrain for further proceedings consistent with this order to be conducted in any manner that the ALJ determines will achieve substantial justice to all the parties. Thereafter, the ALJ will issue a final, appealable order.

In reaching this conclusion, we are mindful that ORS 656.273(4)(a)[2] provides that a "claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268." Furthermore, we note that for aggravation claims filed after the five-year period has expired, ORS 656.278(1)(a)[3] confers "exclusive jurisdiction on the Board." Mary K. Karppien, 46 Van Natta 678 (1994) (citing Miltenberger v. Howard's Plumbing, 93 Or App 475, 477 (1988)). By this order, we do not decide whether claimant filed an aggravation claim prior to the expiration of his aggravation rights. Rather, in remanding this case to the ALJ for resolution, the parties should be prepared to address the effect these points and authorities have on the issues presented.

ORDER

The ALJ's order dated July 13, 1995 is vacated. Claimant's request for hearing is reinstated. This matter is remanded to ALJ Mongrain for further proceedings consistent with this order.

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[1] We have faced a similar problem in recent cases. See, e.g., Homer Betancourt, supra; Kathleen F. Gonzalez, 46 Van Natta 2288 (1994). We recognize the worthy goal of expeditiously resolving disputes. Had claimant agreed to resolving the procedural/jurisdictional issue prior to the commencement of the evidentiary hearing, remand would likely not have been necessary. However, when a motion to dismiss is contested, as here, it is frequently more expeditious to develop a record before granting the motion to dismiss, thereby eliminating the need to remand if a party requests Board review.

[2] Although the Legislature amended parts of ORS 656.273, this subsection was not amended. See Or Laws 1995, ch 332, § 31 (SB 369, § 31).

[3] Although the Legislature also amended parts of ORS 656.278, other than editing changes, this subsection was not amended. See Or Laws 1995, ch 332, § 33 (SB 369, § 33).

In the Matter of the Compensation of
LAURA MADEROS, Claimant
WCB Case No. 94-14383
ORDER ON REVIEW (REMANDING)
Welch, Bruun & Green, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Christian and Gunn.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order which set aside its denial of claimant's injury claim for right shoulder conditions. Claimant cross-requests review of that portion of the ALJ's order which upheld the employer's denial of claimant's aggravation claim. On review, the issues are compensability and aggravation. We affirm in part and reverse in part with respect to compensability and vacate and remand with respect to aggravation.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant, a food server, lifted a bucket of ice with her right arm when she felt a sudden onset of pain in the right side of her neck and shoulder. Claimant came under the care of an osteopath, Dr. Connor, who diagnosed a cervical-dorsal strain. The claim was accepted for that condition.

Claimant was off work for three weeks, during which time she wore a sling on her right arm for the first week. Dr. Connor declared claimant medically stationary as of August 13, 1993 without permanent impairment. (Ex. 7). The claim was closed by Notice of Closure on November 24, 1993. Claimant was given an award of temporary disability only.

After claim closure, claimant continued to experience symptoms in the right shoulder and received occasional treatment from Dr. Connor and his partner, Dr. Pentecost. In April 1994, Dr. Pentecost referred claimant to Dr. Kaesche, an orthopedist, for evaluation of persistent pain in the right AC joint. (Ex. 10). Dr. Kaesche diagnosed post-traumatic calcification of the right acromioclavicular (AC) joint. Dr. Kaesche recommended resection of the distal clavicle and removal of the meniscus.

Subsequently, on May 10, 1994, another osteopath, Dr. Heusch, evaluated claimant's right shoulder condition at the request of Dr. Pentecost. Dr. Heusch diagnosed adhesive capsulitis superimposed on a functional component. (Ex. 12-3). Shortly after this examination, Dr. Kaesche became claimant's attending physician.

Claimant was evaluated by examining physicians Drs. Dinneen and Platt, who opined that claimant's compensable injury was not the major contributing cause of a right shoulder and neck strain. Thereafter, the employer issued a denial of aggravation on June 14, 1994. The listed basis was that claimant's neck and upper back condition had not worsened since claim closure in November 1993. (Ex. 15). On November 17, 1994, the employer denied the compensability of claimant's diagnosed right AC joint calcification and right shoulder adhesive capsulitis on the ground that they were not causally related to the August 6, 1993 injury. (Ex. 23).

The ALJ upheld the employer's June 4, 1994 aggravation denial, reasoning that there was insufficient medical evidence that claimant's accepted cervical-dorsal strain had worsened. The ALJ, however, set aside the employer's November 17, 1994 denial of claimant's right AC joint calcification and adhesive capsulitis, concluding that the preponderance of the evidence established that the "sole cause" of those conditions was the August 6, 1993 compensable injury.

On review, the employer contends that the ALJ misinterpreted the medical evidence, which it asserts is insufficient to establish that claimant's right shoulder conditions are compensably related to the August 6, 1993 injury. Claimant argues that, while the ALJ properly set aside the employer's denial of her right shoulder conditions, the ALJ should have also set aside the employer's aggravation denial. Claimant reasons that, if her right shoulder conditions are compensable, then the aggravation denial should also be set aside.

Right Shoulder Adhesive Capsulitis

The employer does not delineate the precise legal standard to be applied in determining the compensability of this condition. On the other hand, claimant contends that a material causation standard is appropriate.

In determining the compensability of a claim, it is the Board's task to identify and apply the appropriate legal standard . See Hewlettt-Packard Co. v. Renalds, 132 Or App 288 (1995); Daniel S. Field, 47 Van Natta 1457 (1995). In this case, Dr. Connor diagnosed adhesive capsulitis as "secondary" to a right shoulder strain. (Ex. 25). Dr. Pentecost opined that wearing a sling "could have caused" this condition. In light of this medical evidence, it appears that claimant's right shoulder adhesive capsulitis is compensable, if at all, as an indirect consequence of claimant's compensable injury, as opposed to a direct result of the August 6, 1993 accident. Therefore, the major contributing cause standard should apply. ORS 656.005(7)(a)(A); see Albany General Hospital v. Gasperino, 113 Or App 411 (1992). However, we need not resolve this issue, for we conclude that claimant's adhesive capsulitis is compensable under either a material or major causation standard.

Dr. Connor, claimant's initial attending physician, stated that claimant's capsulitis was secondary to a right shoulder strain and that claimant's present need for treatment was related primarily to her accepted claim. (Ex. 25). We generally defer to the medical opinion of an attending physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). We find no such reasons in this case. Accordingly, we agree with claimant that Dr. Connor's opinion is persuasive regarding the etiology of claimant's adhesive capsulitis condition.

Dr. Pentecost, who has also been an attending physician, opined that wearing a sling "could have caused" claimant's adhesive capsulitis. (Ex. 30). Inasmuch as Dr. Pentecost expresses his opinion in terms of medical possibility rather than medical probability, we find that this opinion to be of limited value in resolving the causation issue. Gormley v. SAIF, 52 Or App 1055 (1981).

Drs. Dinneen and Platt provided the only other opinions addressing the causation of claimant's capsulitis condition. Dr. Dinneen, in a September 27, 1994 letter with which Dr. Platt concurred, expressly ruled out a causal connection between the capsulitis condition and claimant's injury, emphasizing that such a condition is generally a response subsequent to enforced immobilization of the shoulder. (Exs. 20, 22). As previously noted, however, claimant did wear a sling for a week after her compensable injury in August 1993. Since Drs. Dinneen's and Platt's opinions identify enforced immobilization as a cause of adhesive capsulitis, and because claimant's right shoulder was placed in a sling for a week after her compensable injury, we conclude that, if anything, Dr. Dinneen's and Dr. Platt's medical opinions assist claimant in satisfying her burden of proving medical causation.

In conclusion, we find that the medical evidence establishes that claimant's adhesive capsulitis is compensable under either a material or major causation standard. Accordingly, we affirm the ALJ's conclusion that this condition is compensable. However, for the following reasons, we disagree with the ALJ's analysis regarding claimant's AC Joint calcification.

AC Joint Calcification

Claimant contends that the appropriate legal standard for determining compensability of this condition is material contributing cause. Dr. Kaesche and Dr. Pentecost both relate claimant's AC joint calcification to the trauma claimant sustained on August 6, 1993. (Exs. 17, 30). Inasmuch as the medical evidence relating this condition to the August 6, 1993 injury does so on the basis that the AC joint calcification is connected to the traumatic accident rather than claimant's cervical and dorsal spine injury, we agree with claimant that a material causation standard is applicable. Albany General Hospital v. Gasperino, supra. Nevertheless, we do not find the above medical evidence relating claimant's condition to the August 6, 1993 accident to be persuasive.

On June 17, 1994, Dr. Kaesche opined that, based on claimant's history of having twisted her shoulder when the August 6, 1993 incident occurred, there was a "correlation" between the calcification and the injury event. (Ex. 17). However, Dr. Kaesche does not explain how twisting claimant's shoulder caused calcification in the AC joint. Moreover, Dr. Kaesche does not address in any of his reports the medical evidence, particularly from Dr. Heusch, which suggested that the calcification in claimant's right shoulder was probably preexisting, and that there was insufficient time between the injury event and the November 1993 x-ray which detected the calcification to draw a causal connection between claimant's injury and her AC joint calcification.

Even the medical opinion of Dr. Pentecost, the other physician on whom claimant relies, questions how "such seemingly minor trauma" could have caused calcification of the right AC joint. (Ex. 30). Although Dr. Pentecost concluded that "in all medical probability" the calcification in claimant's right AC joint was caused by the August 6, 1993 trauma, his opinion was based entirely on the lack of prior x-rays or prior history of trauma. Given that Dr. Pentecost questions his own conclusion, as well as the fact that his opinion lacks any explanation of how the trauma to claimant's shoulder caused her AC joint calcification, we do not find his opinion to be persuasive.

Instead, we rely on the medical opinions of Dr. Dinneen and, especially, Dr. Heusch. Dr. Heusch opined in a September 28, 1994 report that claimant's right AC joint calcification "most likely" preexisted the August 6, 1993 injury. Dr. Heusch explained that, if the calcification was causally related to the August 1993 trauma, it was not likely that the calcification would have developed in such close proximity and time with the industrial injury. (Ex. 21). Dr. Heusch concluded that the calcification of the right AC joint and associated pain and tenderness "would most likely be a separate and distinct problem from the [August 6, 1993] industrial injury." Id.

Dr. Dinneen's opinion supports that of Dr. Heusch. Dr. Dinneen also noted that there was insufficient time between the August 1993 incident and the detection of the calcification to establish that this condition was due to the compensable incident. (Ex. 28). Inasmuch as Dr. Heusch's and Dr. Dinneens' opinions are well reasoned and explained, we find them more persuasive than those of Dr. Kaesche and Dr. Pentecost. Somers v. SAIF, supra.

Accordingly, we conclude that claimant has failed to sustain her burden of proving that the August 6, 1993 accident is a material contributing cause of her right AC joint calcification. Therefore, we reinstate the employer's denial of this condition.

The ALJ awarded a $2,500 attorney fee for claimant's counsel's efforts in setting aside the employer's denial of claimant's shoulder conditions. However, as a result of our order, the employer's denial has been partially reinstated. Thus, it is necessary to modify the ALJ's attorney fee award. After considering the factors in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the adhesive capsulitis compensability issue is $1,250, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Aggravation

The ALJ upheld the employer's denial of claimant's aggravation claim, reasoning that there was insufficient evidence that claimant's accepted cervical-dorsal strain had worsened. On review, claimant does not contest that finding. Instead, claimant asserts that the ALJ should have considered her right shoulder condition and concluded that she had established a compensable aggravation claim.

We have determined that the ALJ properly set aside the employer's denial of claimant's right shoulder adhesive capsulitis condition. Inasmuch as this condition is compensable, we must determine whether it has compensably worsened.

Subsequent to the ALJ's order, the 1995 Legislature amended ORS 656.273(1) to read in part: "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by evidence of an actual worsening of the compensable condition supported by objective findings." Or Laws 1995, ch 332, § 31 (SB 369, § 31) (emphasis added). Amended ORS 656.273(1) applies retroactively to cases in litigation. Carmen C. Neill, 47 Van Natta 2371 (1995). Although the 1995 amendments do not define the term "actual worsening," we have determined that a pathological worsening or a symptomatic worsening that is greater than anticipated by a prior award of permanent disability is sufficient to establish an "actual worsening." Id.

We may remand a case for further evidence taking if we find 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, supra, 79 Or App at 420. A compelling basis for remand exists when the record is devoid of evidence regarding a legal standard that goes into effect while Board review of a case is pending. See, e.g., Troy Shoopman, 46 Van Natta 21, 22 (1994) (case remanded to ALJ because record devoid of evidence regarding legal standard recently announced by Supreme Court); see also Betty S. Tee, 45 Van Natta 289 (1993) (Board remanded matter to ALJ in light of Supreme Court's intervening definition of relevant statutory term); cf. Rosalie S. Drews, 46 Van Natta 408, recon den 46 Van Natta 708 (1994) (Board declined to remand case to ALJ for additional evidence under Supreme Court's recent interpretation of statute, when record was sufficiently developed to analyze issue under that interpretation).

Here, while Board review of this matter was pending, the "actual worsening" standard of amended ORS 656.273(1) went into effect. The record contains an opinion by Dr. Connor that claimant's right shoulder condition had worsened based on Dr. Pentecost's March 30, 1994 chart note documenting reduced range of motion. (Ex. 25-1). However, the record is insufficiently developed to assist us in determining whether claimant sustained an "actual worsening" of her compensable adhesive capsulitis condition (for which she has not previously received a permanent disability award) as defined in Neill.

Under the circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant sustained a compensable aggravation. See Carmen C. Neill, supra (remanding for submission of additional evidence regarding an "actual worsening" where the claimant had not received a prior award of permanent disability and where the parties lacked an opportunity to develop record regarding appropriate legal standard). Moreover, because amended ORS 656.273(1) went into effect after this record was developed/closed and while Board review of this matter was pending, we find that there is a compelling reason to remand for the submission of additional evidence regarding whether claimant sustained an "actual worsening" with respect to her adhesive capsulitis condition.

Accordingly, the ALJ's April 7, 1995 order is affirmed in part, reversed in part, modified in part, and vacated in part. That portion which set aside the employer's denial of claimant's AC joint calcification condition is reversed. The employer's denial of that condition is reinstated and upheld. The ALJ's attorney fee award is modified. In lieu of the ALJ's award, claimant is awarded an attorney fee of $1,250.

That portion of the ALJ's order upholding the employer's aggravation denial is vacated. This matter is remanded to ALJ Peterson for further proceedings regarding the compensability of claimant's aggravation claim. Those proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice Thereafter, the ALJ shall issue a final, appealable order on the aggravation issue. The remainder of the ALJ's order is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DARLYNDA J. McLAIN, Claimant
WCB Case No. 94-14022
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that upheld the insurer's denial of claimant's claim for a neck injury. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We summarize the ALJ's findings of fact. Claimant is a district sales manager for a newspaper company. Her job consists of supervising 60 newspaper carriers, including recruiting and motivating carriers and recording and handling complaints. Claimant works approximately half of the time in the office and half of the time in the field. She uses her own car to pick up and deliver supplies and to take carriers around neighborhoods to solicit subscriptions. She claims and is paid mileage for work done off the premises. She manages her own work schedule. Her hours vary and she is paid a salary with no overtime.

Once a year, the newspaper sponsors an awards banquet to honor the top three route carriers. The district sales manager is invited if one of the manager's carriers is to be honored. The manager is expected, but not required, to attend.

On February 4, 1995, claimant left work in Salem to go to her home in Monmouth, Oregon to get ready for the carrier awards banquet which was to be at 6:00 PM in a restaurant in Salem, Oregon. Claimant arrived home, got ready and then set off with her husband for the banquet. After stopping at a service station, claimant and her husband were involved in an automobile accident as they were driving to the awards banquet. Claimant was injured in the accident. After attending to the details of the accident, claimant and her husband attended the banquet and then joined some other employees after the banquet for a social night out.

Claimant has never received mileage reimbursement for her trips from her home in Monmouth to her work in Salem, including the trip to and from the banquet on February 4, 1994.

Traveling Employee

On review, claimant first argues that the injuries she sustained on the way to the banquet are compensable under the traveling employee rule. Based on the following reasoning, we conclude that claimant was not a traveling employee when her injuries occurred.

For an injury to be compensable under workers' compensation law, it must "arise[e] out of and in the course of employment." ORS 656.005(7)(a). The requirement that the injury occur "in the course of employment" concerns the time, place and circumstances of the injury. Norpac Foods, Inc., v. Gilmore, 318 Or 363 (1993). The requirement that the injury "arise out of" the employment tests the causal connection between the injury and the employment. Id. As a general rule, injuries sustained while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210 (1987). However, where travel is a necessary part of employment, risks incident to travel are covered by the workers' compensation law even though the employee may not be working at the time of the injury. Proctor v. SAIF, 123 Or App 326, 329 (1993). In Savin Corp. v. McBride, 134 Or App 321, 324 (1995), the court quoted Professor Larson's explanation of the rule:

> "Employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Thus, injuries arising out of the necessity of sleeping in hotels or eating in restaurants away from home are usually held compensable." 1A Larson, Workmen's Compensation Law § 25.00, 5-275 (1990).

Here, we agree that when claimant worked in the field, away from the employer's premises as part of her district sales manager duties, she was a "traveling employee." In other words, while in the field, claimant's work entailed travel away from the employer's premises. However, claimant's injuries did not occur while she was performing her work duties for the employer in the field. Rather, claimant was injured on her way to the awards banquet sponsored by her employer. Thus, we do not believe that claimant was a "traveling employee" when her injury occurred. Were we to conclude otherwise, it could be argued that claimant maintained her traveling employee status 24 hours a day, even though only a portion of her work day was spent traveling. Instead, because claimant was going from her home to the carrier awards banquet, we believe that the "going and coming" rule is applicable.

Special Errand Exception

Claimant next argues that she falls within the "special errand" exception to the "going and coming" rule. We adopt the ALJ's discussion of the "special errand" exception to the "going and coming" rule with the following supplementation.

Under the "going and coming" rule, injuries sustained by employees when "going to and coming" from work are generally not considered to arise out of and occur in the course of employment. Philpott v. SIAC, 234 Or 37 (1963). One of the exceptions to this rule is the "special errand" exception. Larson states the special errand exception as follows:

> "When an employee, having identifiable time and space limits on his employment, makes an off-premises journey which would normally not be covered under the usual going and coming rule, the journey may be brought within the course of employment by the fact that the trouble and time of making the journey, or the special inconvenience, hazard, or urgency of making it in the particular circumstances, is itself sufficiently substantial to be viewed as an integral part of the service itself." 1 Larson, Workmen's Compensation Law 4-204, § 16.11 (1995).

In Hickey v. Union Pacific Railroad Co., 104 Or App 724 (1990), the court discussed the "special errand" exception to the "going and coming rule." In Hickey, the deceased worker, a warehouse foreman, worked his regular hours on the date of his accident (7:30 a.m. to 5:00 p.m.). He was supposed to have loaded a truck that had to leave at 4:00 the next morning. However, the truck arrived late and was not ready to be loaded until 5 or 5:30 p.m. The decedent left work and went to a church meeting that he and his wife had planned to attend. He made a special trip to work at 11 p.m. to load the truck. On his way home from loading the truck, his motorcycle collided with a train and he was killed.

The court held that the decedent's activities came within the "special errand" exception to the "going and coming" rule because of the added hazard of the trip, the deviation from normal working hours, the lack of advance notice and primary benefit to employer. Specifically, the court found that the trip home from work created a risk of injury which was substantially increased over the risks decedent normally bore going to and from work during his regular hours. The Hickey court emphasized that the decedent's trip occurred during the only hours during which a train would pass over the crossing.

Here, by contrast, claimant has not shown that her trip from her home to the banquet resulted in substantially increased risk over her usual trips to work. Moreover, claimant could have stayed in Salem and was not required to return home before the banquet.

Another factor discussed in Hickey was the deviation from normal working hours. Here, as pointed out by the ALJ, because claimant's work hours varied, she has not established that her injury (which occurred at 5:40 p.m.) occurred during a deviation from her usual hours.

The Hickey court also cited lack of advance notice as a factor to be considered in determining whether the "special errand" exception applies. Here, the record establishes that claimant had advance notice of the banquet.

The last factor considered by the Hickey court was the primary benefit to the employer. Although claimant's employer likely benefited from her attendance at the banquet, this fact alone does not persuade us that claimant's trip from home came within the "special errand" exception. Claimant's normal trips to and from work also benefited her employer, but normal commuting does not qualify under the "special errand" exception. Based on the facts of this case, we are not persuaded that claimant's trip to the banquet comes within the "special errand" exception to the going and coming rule. Accordingly, we affirm the ALJ's decision.

In light of our resolution of the course and scope issue, we do not address the insurer's argument that ORS 656.005(7)(b)(B) bars compensability of claimant's claim.

ORDER

The ALJ's order dated March 27, 1995 is affirmed.

March 13, 1996 Cite as 48 Van Natta 544 (1996)

In the Matter of the Compensation of
RONALD R. ZIMBELMAN, Deceased, Claimant
WCB Case Nos. 93-02973 & 93-02972
SECOND ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

The widow of the deceased worker (hereafter, claimant), requests reconsideration of our January 25, 1996 Order on Remand which held that the decedent's emotional condition was not a compensable consequence of his carpal tunnel and cervical condition claims. On February 23, 1996, we withdrew our January 25, 1996 order for purposes of reconsideration. Having received the insurer's response, we proceed with our reconsideration.

Claimant contends that the decedent's heart attack was caused by stress related to his carpal tunnel and cervical condition claims. In medically complex cases such as this, expert medical testimony is necessary to establish medical causation. Uris v. Compensation Dept, 247 Or 420 (1967).

In our prior order, we found the opinions of the physicians who supported compensability of claimant's emotional condition, Drs. Grossman and Teal, unpersuasive since they related decedent's emotional distress partly or completely to the self-insured employer's processing of his claim. Yet, as we concluded in our previous decision, events pertaining to claims processing cannot be considered to be caused by the injury. See Baar v. Fairview Training Center, 139 Or App 196 (1996).

Because there is no persuasive medical evidence that the compensable carpal tunnel and cervical claims are the major contributing cause of decedent's emotional condition, claimant has not established compensability of the emotional condition (or the resulting heart attack). Accordingly, for these reasons, we adhere to our prior decision that decedent's emotional condition is not compensable.

On reconsideration, as supplemented herein, we republish our January 26, 1996 order in its entirety. The parties rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

March 14, 1996 Cite as 48 Van Natta 545 (1996)

In the Matter of the Compensation of
JON A. GRIFFIN, Claimant
WCB Case No. 95-04596
ORDER ON REVIEW
Benjamin W. Ross, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Schultz's order which declined to remand his claim to the Director for promulgation of a temporary rule regarding his forearm condition. On review, the issue is remand. We deny the request for remand and affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of finding number 3.

CONCLUSIONS OF LAW AND OPINION

On December 13, 1993, claimant sustained a compensable left arm injury. The SAIF Corporation accepted a disabling left forearm strain.

On April 27, 1994, claimant underwent wrist surgery to release the first and second dorsal wrist compartments. (Ex. 6). In September 1994, Dr. VanAllen, treating surgeon, stated that claimant did not have any permanent forearm or wrist impairment due to his December 1993 injury. (Ex. 10). Dr. VanAllen did not perform a closing examination.

On September 28, 1994, claimant's claim was closed by Notice of Closure (NOC) that awarded no permanent disability benefits. (Ex. 11). On March 8, 1995, claimant requested reconsideration of the NOC, disagreeing with the rating of impairment, and requesting a temporary rule to address permanent disability related to his surgical procedure. (Ex. 14-2). Claimant did not disagree with the impairment findings, and did not request a medical arbiter examination.

On April 6, 1995, an Order on Reconsideration issued. (Ex. 16). The order stated that, because Dr. VanAllen did not perform a closing examination pursuant to OAR 436-30-015(2)(c)[1], claim closure was premature. Therefore, the NOC was rescinded, and claimant's claim was returned to open status. (Ex. 16-4). Furthermore, because the claim was determined to be prematurely closed, claimant's request for promulgation of a temporary rule was considered moot. (Id.)

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[1] OAR 436-30-015 sets out carriers' responsibilities with regard to claim closure. OAR 436-30-015(1) provides instructions for closure by NOC, whereas OAR 436-30-015(2) refers to closure by the Department. Here, the Appellate Unit erroneously applied the rules for closure by the Department, rather than rules for closure by NOC. In doing so, because the record contained no closing medical examination (See OAR 436-30-015(2)(c)), the reconsideration order found that claim closure was premature.

The ALJ addressed the premature closure issue, setting aside the Order on Reconsideration, and reinstating SAIF's NOC. The ALJ concluded, however, that the Hearings Division did not have jurisdiction to remand the claim to the Director. Claimant now seeks remand to the Director for adoption of a temporary rule to award scheduled permanent disability for his surgery because the Director's disability rating standard "does not address surgical procedures other than bone involvement." (Ex. 14-2). We decline to grant claimant's request.

Under ORS 656.726(3)(f)(C), the Director shall stay further proceedings and shall adopt temporary rules when "it is found that the worker's disability is not addressed by the standards adopted pursuant to this paragraph." The Board has authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability. Gallino v. Courtesy Pontiac-Buick-GMC, supra. Claimant has the burden of proving that his disability is not addressed by the standards. See ORS 656.266; Valorie L. Leslie, 46 Van Natta 1919 (1994); Susan D. Wells, 46 Van Natta 1127 (1994).

Here, the record contains no evidence that claimant has a disability related to his December 1993 compensable injury. On September 2, 1994, Dr. VanAllen stated that claimant did not have permanent impairment related to his injury. Thus, notwithstanding claimant's argument that any surgical procedure produces some degree of disability, the medical evidence in this record supports a conclusion that claimant has not suffered permanent impairment due to his compensable injury. Such evidence is required to establish entitlement to an award of permanent disability. OAR 436-35-007(1). Accordingly, because there is no disability to be addressed under the existing standards, we need not remand to the Director to adopt a temporary rule. See Susan D. Wells, supra.

ORDER

The ALJ's order dated July 20, 1995 is affirmed.

March 14, 1996 Cite as 48 Van Natta 546 (1996)

In the Matter of the Compensation of
MICHAEL L. HARMON, Claimant
WCB Case No. 95-02506
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Davis' order which: (1) declined to direct the insurer to provide to claimant in the context of third-party litigation its estimate of future claim expenses; and (2) declined to award penalties or attorney fees for the insurer's allegedly unreasonable failure to provide this information. On review, the issues are claim processing, penalties and attorney fees. We vacate the ALJ's order and dismiss claimant's request for hearing for lack of jurisdiction.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and offer the following brief summary of the background of this dispute.

Claimant sustained a compensable injury when he fell while performing his employment duties. The insurer accepted the claim and provided workers' compensation benefits. Claimant's attorney filed a lawsuit seeking recovery of damages from allegedly negligent third parties.

While the workers' compensation claim was open, claimant's attorney wrote the insurer, requesting the insurer's "final lien amount." The insurer advised claimant's counsel that the lien was over $174,000 for temporary disability and medical costs, but that the lien was not final inasmuch as claimant was not medically stationary. Claimant's counsel then wrote the insurer and requested an estimate of future expenses so that he could make a settlement "demand." The insurer refused to reveal its reserves and recommended that counsel make his own independent evaluation of the claim.

Subsequently, more letters were exchanged between the insurer, its counsel and claimant's attorney. There was no change in the insurer's position. It maintained that revealing the amount of its reserves would result in disclosure of information that would place the insurer at a disadvantage when dealing with the workers' compensation claim. Claimant then requested a hearing seeking an order requiring the insurer to provide claimant with full information regarding the amount of its statutory lien pursuant to ORS 656.593(1)(c), as well as penalties and attorney fees for the insurer's allegedly unreasonable failure to provide the information requested.

CONCLUSIONS OF LAW AND OPINION

At the hearing, the insurer sought dismissal of claimant's hearing request on the ground that the Board, rather than the Hearings Division, had jurisdiction over the third-party lien issue and that the Director had jurisdiction over the penalty issue. The ALJ disagreed, reasoning that claimant's hearing request was a request for an order requiring the insurer to produce discoverable information and was, therefore, a "controversy" concerning a claim over which the Hearings Division had jurisdiction.

Having resolved the jurisdictional issue, the ALJ then addressed claimant's request for the insurer's estimate of future claim costs. Concluding that claimant's request was not germane to any pending controversy, the ALJ determined that the discovery dispute was premature. The ALJ acknowledged that the insurer would at some point have to reveal the amount of its lien. However, the ALJ was not persuaded that it was then required to do so. Finally, the ALJ declined to award a penalty or attorney fee, reasoning that there was no evidence that the insurer had resisted the payment of compensation or unreasonably delayed acceptance or denial of a claim.

On review, claimant contends that he is entitled to documents showing the amount of the third-party lien, asserting that there is no case law, statute, or administrative rule that prohibits such disclosure. The insurer responds that it is only obligated to disclose its lien when a final settlement has been concluded between claimant and any third party or after the workers' compensation claim has been closed. For the following reasons, we conclude that neither the Board nor the Hearings Division has jurisdiction over this matter.

An ALJ has jurisdiction only over matters concerning a claim. ORS 656.283(1); ORS 656.708. Matters concerning a claim are those matters in which "a worker's right to receive compensation, or the amount thereof, are directly at issue." ORS 656.704(3); see EBI Companies v. Kemper Group Insurance, 92 Or App 319 (1988) (issue of whether the responsible party in a .307 dispute must reimburse the designated paying agent is not a "matter concerning a claim."); Lloyd v. Employee Benefits Ins. Co., 96 Or App 591 (1989) (issue of penalties for workers' compensation carrier's late reimbursement of medical bills to private health carrier is also not a "matter concerning a claim.").

Our authority in matters concerning settlement of a third-party action is defined by statute. Donald W. Yedloutschnig, 43 Van Natta 615, 616 (1991) (citing SAIF v. Wright, 102 Or 598 (1990)). This jurisdiction over third-party matters is limited. Generally, we are authorized to order written approval of the settlement by the paying agency and, if the settlement is approved, we are authorized to determine a "just and proper" distribution of settlement proceeds. ORS 656.587, ORS 656.593(3); Id.

In this case, the ALJ concluded that the Hearings Division had jurisdiction to consider the lien issue, reasoning that claimant was requesting discovery in the context of an open claim. In Lawrence A. Durette, 42 Van Natta 413 (1990), we noted that failure to timely comply with a request for documents can be an unreasonable resistance to the payment of compensation under ORS 656.382(1). Therefore, a request for hearing on an issue of discovery placed the claimant's right to receive compensation directly at issue and, thus, was a matter concerning a claim. Id.

Here, claimant is seeking information regarding the amount of the insurer's anticipated future expenses in the context of negotiation of a third party settlement. This is in contrast to the usual case in which discovery is either not provided or not provided timely. In such instances, a claimant's entitlement to compensation can be affected by a carrier's failure to comply with discovery procedures because his or her counsel's ability to adequately represent the claimant is hindered.

However, in this case, any monies that claimant will receive from the third party are not "compensation" as defined in ORS 656.005(8), which limits "compensation" to benefits provided for a compensable injury by an insurer or self-insured employer. Inasmuch as third party settlement proceeds are not provided by an insurer or self-insured employer, they do not constitute "compensation."

Therefore, claimant's entitlement to "compensation" is not affected by the insurer's unwillingness to disclose the amount of its lien.[1]

Moreover, settlement of the third-party suit does not deprive claimant of any benefits to which he is currently entitled or will be in the future. The insurer, through its lien, is only reimbursed for benefits that it has provided to claimant or will reasonably be expected to provide in the future, as well as other "costs" of the claim. ORS 656.593(1)(c). Settlement of a third-party lawsuit does not alter the amount of compensation to which claimant is otherwise entitled for his compensable injury.

Thus, claimant's right to receive compensation, or the amount thereof, is not directly at issue with respect to negotiation of a third party settlement. Because of this, the insurer's failure to provide information regarding its anticipated future claim costs to claimant's counsel is not "a matter concerning a claim" over which the Hearings Division or the Board has jurisdiction.[2]

Accordingly, we hold that the Hearings Division lacked authority to address claimant's request for relief. We, therefore, vacate the ALJ's order.

ORDER

The ALJ's order dated June 16, 1995 is vacated. Claimant's request for hearing is dismissed.

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[1] We recognize that, in Howard v. Liberty Northwest Ins., 94 Or App 283, 287 (1988), the court held that the Board had jurisdiction to enforce a Disputed Claim Settlement, even though the proceeds of the settlement were not "compensation." The court reasoned that, because the agreement resolved a dispute involving a worker's right to receive compensation, which was resolved, as it must have been, within the workers' compensation system by an agreement which the Board had jurisdiction to approve or disapprove, the Board had jurisdiction to supervise its enforcement. Id. We find Howard distinguishable because the third-party settlement in this case does not involve resolution of a dispute concerning claimant's right to receive compensation. Claimant has an accepted claim. His right to receive compensation for his compensable injury is unaffected by any third-party settlement.

[2] Even assuming we had jurisdiction over this dispute, we are inclined to agree with the ALJ that the insurer is not statutorily obligated to disclose information regarding its future lien. After claimant reaches a settlement agreement with the third party, the offer is then referred to the insurer for approval. ORS 656.587. If the settlement is approved, the insurer would be entitled to a "just and proper" share of the proceeds. ORS 656.593(3). At that point, it would be appropriate for the insurer to substantiate the present value of its reasonably anticipated future claim expenses in support of its claim for a "just and proper" share. See ORS 656.593(1)(c). We acknowledge that it is not unusual for a carrier to provide an estimate of future claim costs prior to settlement of a third-party lawsuit. See generally Estate of Troy Vance v. Williams, 84 Or App 616 (1987); Brian McKinney, 45 Van Natta 1064 (1993). However, there is no statutory requirement that it provide an estimate of future claim costs or reveal "reserve" information prior to settlement of the third-party lawsuit. But see Denton v. EBI Companies, 67 Or App 339, 347 (1984) (a claimant's attorney, in negotiating a third-party settlement, is "vitally interested" in the amount of lien the carrier will claim).

In the Matter of the Compensation of
DEBRA A. KAHN, Claimant
WCB Case Nos. 94-14085 & 94-11801
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Holtan's order which: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for her left shoulder condition and fibromyalgia syndrome; (2) upheld Liberty Northwest Insurance Corporation's denial for the same condition; and (3) declined to award interim compensation. With her brief, claimant submits several articles regarding fibromyalgia syndrome. We treat claimant's additional submissions, that were not admitted into evidence at the hearing, as a motion for remand. See Judy A. Britton, 37 Van Natta 1262 (1985). On review, the issues are remand, compensability and interim compensation.

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

Remand

Claimant has included with her brief several articles concerning fibromyalgia syndrome which were not admitted into evidence at the hearing. Since our review is limited to the record developed before the ALJ, we treat claimant's submission as a motion for remand. See Judy A. Britton, supra.

We may remand a case to the ALJ, if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); Bailey v. SAIF, 296 Or 41, 45 n.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986); Metro Machinery Rigging v. Tallent, 94 Or App 245, 249 (1988).

Here, claimant has offered no reasons why the information on fibromyalgia was unobtainable with due diligence at the May 24, 1995 hearing. Furthermore, the proffered evidence will not likely affect the outcome of the case. Therefore, we deny claimant's request for remand.

Compensability

We adopt the ALJ's reasoning in regard to the compensability of claimant's left shoulder condition and fibromyalgia syndrome.

Interim Compensation

Finding that the work releases of Drs. Baker and Marjanovic failed to relate claimant's inability to perform her regular work to a job-related injury, the ALJ declined to award claimant interim compensation. On review, claimant asserts that she is entitled to interim compensation because amended ORS 656.262 should not be applied retroactively to her claim. We adopt the ALJ's conclusions with the following supplementation.

In order to qualify for interim compensation, a claimant must establish that he or she left work as a result of an injury or suffered a loss of earnings as a result of an injury. RSG Forest Products v. Jensen, 127 Or App 247 (1994). ORS 656.262(4)(a), which governs entitlement to interim compensation, was amended by the 1995 legislature. Or Laws 1995, ch 332, § 28. Amended ORS 656.262(4)(a) provides that: "[t]he first installment of temporary disability compensation shall be paid no later than the 14th day after the subject employer has notice or knowledge of the claim, if the attending physician authorizes the payment of temporary disability compensation."

Here, we find that under either the former or amended versions of ORS 656.262(4)(a), claimant would not be entitled to interim compensation because she has failed to prove that she lost time from work as a result of a job-related injury. Dr. Baker took claimant off work from June 23, 1994 to August 9, 1994. (Ex. 79). On August 17, 1994, Dr. Marjanovic authored a work release stating, "No work" from August 5, 1994 to September 30, 1994. (Ex. 84). Neither physician attributed claimant's work release to her employment.

Assuming without deciding that Drs. Baker and Marjanovic work releases authorized the payment of temporary disability compensation, claimant has failed to prove that she lost time from work as a result of a job-related injury or occupational disease. See RSG Forest Products v. Jensen, supra. Consequently, under either version of the statute, claimant would not be entitled to interim compensation. Accordingly, we find that claimant has not proven an entitlement to interim compensation.

ORDER

The ALJ's order dated August 15, 1994 is affirmed.

In the Matter of the Compensation of
ILENE A. MAYFIELD, Claimant
WCB Case No. 95-04524
ORDER ON REVIEW
Stebbins & Coffey, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that awarded claimant 35 percent (112 degrees) unscheduled permanent disability for a low back condition, whereas an Order on Reconsideration had granted no permanent disability. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order with the following changes and supplementation. In the second finding on page 1, we change "(Ex.13)" to "(Ex. 10)." In addition, we change the ALJ's reference from "fish weigher" on pages 1 and 3 to "fish packer."

SAIF contends that claimant is not entitled to an award for chronic loss of use of her low back. In order to be entitled to an unscheduled chronic condition impairment award, a preponderance of medical opinion must establish that the worker is unable to repetitively use a body area due to a chronic and permanent medical condition. OAR 436-35-320(5). This rule requires medical evidence of, at least, a partial loss of ability to repetitively use the body part. See Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995); Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993).

SAIF argues that Dr. Smith's reports are insufficient to establish a chronic condition award. SAIF asserts that a physician's statements that the worker should avoid repetitive activities in order to prevent reinjury are insufficient.

Contrary to SAIF's assertion, Dr. Smith's statements concerning the repetitive use of claimant's back were not merely limitations imposed to avoid reinjury. Dr. Smith was asked to comment on claimant's functional capacity due to the March 18, 1994 injury. Dr. Smith reported that claimant "does well as long as she avoids exacerbating activities such as excessive standing or walking or bending." (Ex. 15). Dr. Smith explained:

> "4. I do not feel [claimant] has limitation in the repetitive use of her back providing she stays within the limits of her residual functional capacity.
>
> "5. Regarding her residual functional capacity, she is able to lift and carry 20 lbs. on a frequent basis. Her consecutive sitting is limited to about 1 hour, consecutive standing to 1/2 hour and walking to about 10 minutes because of back pain. She is permanently precluded from activities including frequent stooping * * *. However, she does have difficulty getting from a crouched or kneeling position back into an upright position." (Id.; emphasis added).

Since Dr. Smith did not attribute claimant's back findings to causes other than the compensable low back injury, we construe the findings as showing that claimant's chronic loss of use of her low back was due to her compensable injury. See Kim E. Danboise, 47 Van Natta 2163, on recon 47 Van Natta 2281 (1995). We agree with the ALJ that claimant is entitled to an award for chronic loss of use of her low back.

Alternatively, SAIF argues that, if claimant has permanent impairment, the value for the adaptability factor should be zero and claimant should be awarded 5 percent unscheduled permanent partial disability. Relying on William L. Knox, 45 Van Natta 854 (1993), SAIF asserts that the Board should consider the record as a whole, including the job duties and the physical demands of the relevant job, in determining which DOT job title is most appropriate. SAIF contends that the ALJ erred by finding that "fish packer" (DOT #920.687-086) was the most appropriate DOT job title. SAIF asserts that "tallier" (DOT #221.587-030) and "grader" (DOT #529.687-098) more accurately reflect claimant's at-injury job.

Claimant acknowledges that both the DOT classification for "fish packer" and "tallier" describe portions of her job. However, she asserts that OAR 436-35-310(4)(a) requires application of the highest strength for a combination of Dictionary of Occupational Titles (DOT) codes, which is "heavy."

We find that SAIF's reliance on William L. Knox, supra, is misplaced. In Knox, we applied the standards that became effective April 1, 1991. In that case, we found it reasonable to consider both the claimant's job duties and the physical demands of his job in determining a proper DOT to be assigned to his job.

Here, because the claim closed with an October 12, 1994 Notice of Closure, the applicable standards for determining claimant's entitlement to unscheduled permanent disability are contained in WCD Admin. Order 93-056. Former OAR 436-35-310(4)(a) provides that a claimant's base functional capacity (BFC) is the highest strength category assigned in the DOT for the most physically demanding job she has successfully performed in the five years before determination. Former OAR 436-35-310(4)(a) also provides that, when a combination of DOT codes most accurately describes a worker's duties, the highest strength for the combination of codes shall apply.

Claimant's "801" and "827" forms described her job as "fish pan weigher." (Exs. 2, 4). In the "Information for Vocational Eligibility Evaluation" form, claimant described her job as "fillet pan weigher" and described her duties as "weigh fish, operate computer, pack fish and whatever else needs to be done." (Ex. 7). She described the equipment used as "fillet belts, elec. switches, fillet pans, computer, scales and etc." (Id.)

After reviewing the record, we are persuaded that a combination of DOT codes most accurately describes claimant's duties. We agree with claimant that her job involved elements of both "fish packer" (DOT #920.687-086) and "tallier" (DOT #221.587-030). DOT #920.687-086 assigns a strength category of "heavy" and DOT #221.587-030 assigns a strength category of "light." Under former 436-35-310(4)(a), since a combination of DOT codes most accurately describes claimant's duties, the highest strength for the combination of codes shall apply. Therefore, we agree with the ALJ that claimant's job established her strength category as heavy. Accordingly, we affirm the ALJ's award of 35 percent unscheduled permanent disability.

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

ORDER

The ALJ's order dated July 28, 1995 is affirmed. For services on review, claimant is awarded $1,000, payable by SAIF.

March 14, 1996 Cite as 48 Van Natta 551 (1996)

In the Matter of the Compensation of
CHRISTI McCORKLE, Claimant
Own Motion No. 95-0353M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Pozzi, et al, Claimant Attorneys

Claimant requests review of the self-insured employer's November 28, 1995 Notice of Closure which closed her claim with an award of temporary disability compensation from June 27, 1995 through November 6, 1995. The employer declared claimant medically stationary as of November 6, 1995. Claimant contends that she is entitled to additional benefits as she was not medically stationary when her claim was closed.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that 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 November 28, 1995 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's

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

The employer submitted medical reports which it considered in closing claimant's claim. In a September 12, 1995 medical report, Dr. Carpenter, claimant's treating physician, noted that claimant was still experiencing pain and swelling in her knee. He opined that claimant was progressing satisfactorily, however, degenerative changes were occurring. Dr. Carpenter noted that claimant's work restrictions would remain the same.

In a November 6, 1995 medical report, Dr. Carpenter again noted that claimant had continued weakness of the right knee and had difficulty negotiating stairs, and because of chondromalacia and degenerative changes of the right knee, Dr. Carpenter opined that claimant would eventually require total joint replacement. In addition, Dr. Carpenter stated that:

> "On examination, there is no effusion of the right knee. There is a well-healed incision. There is medial joint line tenderness. There is no medial or lateral laxity of the knee. The anterior cruciate ligament is intact. Hypertension produces discomfort. Flexion of the knee is possible to 125 degrees. McMurray testing reveals crepitus and discomfort, both on internal and external rotation of the knee."

Finally, Dr. Carpenter noted that claimant would remain limited in her general work abilities.

On December 4, 1995, Dr. Carpenter reiterated that "degenerative changes [are] occurring [in the right knee] which are slow to improve." In that report, Dr. Carpenter stated that:

> "I am still resisting replacement arthroplasty on the right knee. [Claimant] is getting somewhat anxious and she is specifically asking for replacement arthroplasty. I told her that it would be appropriate at this time to obtain second opinions, such as Dr. Stahaly or Zirkle in the Tri-Cities relative to replacement arthroplasty.
>
> "It is my impression that she is medically stationary, but that she will require replacement joint arthroplasty in the future. It would be a matter of timing. We will see her back on a prn basis."

Dr. Carpenter's September 12, 1995 and November 6, 1995 records establish that degenerative changes were occurring in claimant's right knee, and that her work restrictions remained the same. Those reports do not indicate that claimant was medically stationary on either of those dates. Indeed, Dr. Carpenter's notations in his November 6, 1995 report that there was medial joint line tenderness, that hypertension produced discomfort, and that testing revealed crepitus and discomfort, persuade us that claimant was not yet medically stationary on that date. Finally, Dr. Carpenter continues to opine that claimant has degenerative changes in her knee that will require further surgery in the future.[1] On this record, we are unable to conclude that Dr. Carpenter opined claimant to be medically stationary on November 6, 1995.

Based on the medical record submitted to us by the employer, we are persuaded that claimant was not medically stationary on November 28, 1995, when the employer closed her claim.

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

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

IT IS SO ORDERED.

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[1] However, we are not persuaded that claimant's medically stationary status was contingent upon undergoing the proposed surgery. See Bill H. Davis, 47 Van Natta 219 (1995) (claim was prematurely closed because the claimant's surgery was delayed). Here, the record does not establish that any physician recommended that claimant undergo surgery at closure. On the contrary, Dr. Carpenter stated that he was "resisting" further surgery at that time, while acknowledging that "at some point" claimant will require the total joint arthroplasty.

In the Matter of the Compensation of
SANDRA MILES, Claimant
WCB Case No. 95-03845
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Michael V. Johnson's order that directed it to reopen claimant's claim and process her fibromyalgia condition to closure. Claimant cross-requests review of that portion of the order that declined to assess a penalty for the insurer's allegedly unreasonable processing of her fibromyalgia claim. On review, the issues are claim preclusion, claims processing and penalties. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and summarize the pertinent facts as follows:

On December 28, 1992, claimant slipped and fell at work and sustained a low back and right ankle injury. These conditions were accepted by the insurer on February 2, 1993. On March 16, 1993, claimant was diagnosed with fibromyalgia.

Claimant's low back and right ankle claims were closed by a May 10, 1993 Notice of Closure declaring claimant medically stationary as of April 1, 1993 and awarding no permanent disability. Claimant requested reconsideration. A July 30, 1993 Order on Reconsideration awarded claimant 24 percent permanent partial disability for her low back and right ankle. The insurer requested a hearing challenging the reconsideration order.

On October 12, 1993, the insurer issued a partial denial of claimant's fibromyalgia condition. Claimant requested a hearing on this denial, which was consolidated with the insurer's hearing request.

Following a hearing on the consolidated issues, ALJ (then Referee) Daughtry reduced claimant's award of permanent partial disability for her low back and right ankle injuries to zero, and found the fibromyalgia condition compensable. (Ex. 25). This order was affirmed by the Board on October 28, 1994.

The insurer accepted the fibromyalgia condition, but did not reopen claimant's claim. Claimant requested a hearing raising, among other things, aggravation and time loss.

CONCLUSIONS OF LAW AND OPINION

Claim Preclusion and Claim Processing

Finding that claimant was not precluded from challenging the insurer's processing of her fibromyalgia claim, the ALJ directed the insurer to "reopen" the claim and process the fibromyalgia condition to closure.

On review, the insurer argues that pursuant to the "claim preclusion" rule of res judicata,[1] claimant is barred from litigating certain issues related to her fibromyalgia condition because she had the opportunity to litigate these issues in the prior hearing before ALJ Daughtry and failed to do so. Specifically, the insurer argues that because claimant did not challenge the medically stationary date set forth in the Notice of Closure and Order on Reconsideration, she cannot now seek to have the claim "reopened" to pay additional time loss relating to her fibromyalgia condition in the absence of proving an aggravation of her condition. We agree.

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[1] Unlike issue preclusion, claim preclusion does not require that an issue actually be litigated. Rather, the claim preclusion doctrine applies when there is an opportunity to litigate an issue before a final determination of the proceeding. Drews v. EBI Companies, 310 Or 134, 140 (1990); Popoff v. J.J. Newberrys, 117 Or App 242 (1992).

We start with the premise that a claimant may only receive additional time loss following claim closure upon proof of either premature closure or aggravation. See, e.g., Roy A. McFerran, 34 Van Natta 621 aff mem, 60 Or App 786 (1982); Susan Bechtal, 35 Van Natta 267 (1983). We reject claimant's contention that her consequential fibromyalgia condition should be processed separately from her low back and right ankle strains because it was diagnosed after these two conditions were accepted. All three of these compensable conditions arose out of the same industrial injury, and should therefore be processed to closure together. See Rogers v. Tri-Met, 75 Or App 470 (1985) (a claimant must be medically stationary from all compensable conditions before the claim is properly closed); see also Cheryl A. Trask, 47 Van Natta 322 (1995) (same). This is true even though one of the conditions is consequential to the initial injury or disease. E.g., Kociemba v. SAIF, 63 Or App 557 (1983).

If, at the time the of the consolidated hearing before ALJ Daughtry, claimant was not medically stationary (i.e., because of continuing problems with her consequential fibromyalgia condition) she should have objected to the closure of her claim.[2] We recognized in Rex A. Howard, 46 Van Natta 1265 (1994), that "[f]inality attaches to uncontested closure orders, barring future litigation of any issue determined by the order."[3] Because claimant did not contest her medically stationary status during the prior proceeding before ALJ Daughtry and did not request that the Notice of Closure and Order on Reconsideration be set aside as premature, she cannot now argue that she is entitled to additional time loss in the absence of evidence showing that her condition has worsened since claim closure.

Because there is no evidence in the record establishing that claimant's condition has, in fact, worsened, she cannot prove the existence of an aggravation claim. We therefore reverse that portion of ALJ Johnson's order directing the insurer to "reopen" the claim and process the fibromyalgia condition to closure.

Penalty

Because we find, on this record, that the insurer had no obligation to "reopen" claimant's claim, no penalties for alleged unreasonable claim processing are warranted.

ORDER

The ALJ's order dated June 20, 1995 is affirmed in part and reversed in part. That part of the order that directed the insurer to process claimant's fibromyalgia condition to closure is reversed. That part of the order that awarded an attorney fee to be paid out of any temporary disability compensation is also reversed. The remainder of the order is affirmed.

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[2] Claimant did raise "premature closure" in her request for reconsideration, but did not do so at the hearing before ALJ Daughtry. There, claimant did not object to the April 1, 1993 medically stationary date or request that the Order on Reconsideration be set aside because it failed to include any evaluation of her fibromyalgia condition.

[3] In Rex A. Howard, we held that the claimant, who did not directly challenge a 1987 Determination Order, could not collaterally attack the validity of that order at a later proceeding. We found that the medically stationary status and aggravation date determined by the 1987 Determination Order were final for purposes of res judicata, and claimant could not subsequently assert that this order was an invalid closure of his claim.

Board Chair Hall specially concurring.

While I am bound by the principle of stare decisis to conclude that claimant may not collaterally attack the closure of her claim in this case, I write separately to address my concerns about the application of the doctrine of "claim preclusion" under these circumstances.

As I explained in my dissenting opinion in Rex A. Howard, 46 Van Natta 1265 (1994) (Board member Hall, dissenting), I believe that an order which closes a claim may be rendered null and void as a matter of law by a subsequent order finding additional non-medically stationary conditions compensable. This is so because, as the majority notes, a claimant must be medically stationary from all compensable conditions, even consequential conditions, before a claim is properly closed. Rogers v. Tri-Met, 75 Or App 470 (1985); Kociemba v. SAIF, 63 Or App 557 (1983).

Accordingly, if I were deciding this case on a clean slate, I would conclude that ALJ Daughtry's order directing the insurer to accept claimant's consequential fibromyalgia condition rendered the prior Notice of Closure and that part of the Order on Reconsideration approving the closure of claimant's claim void ab initio. Having determined that the closure of her claim was void (and therefore her claim remained in open status), I would further find the issue is preserved and that claimant is not precluded from litigating her medically stationary date or her entitlement to temporary disability benefits arising out of her accepted fibromyalgia condition. As I explained in my dissenting opinion in Rex A. Howard, it is not clear to me how an order which is rendered void ab initio can be collaterally attacked when it no longer exists.

March 14, 1996 Cite as 48 Van Natta 555 (1996)

In the Matter of the Compensation of
HELEN TURNER, Claimant
WCB Case Nos. 94-11658, 94-11657 & 94-08918
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

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

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

Claimant quit her job at the employer on March (not May) 25, 1994. She initially mentioned an on-the-job fall to Dr. Kelber (not Dr. Buza) on May 20, 1994, who referred her to Dr. Buza for neurosurgical consultation.

We briefly summarize the relevant facts. In September 1993, claimant sought treatment for left foot weakness and pain. She also reported chronic low back pain. Dr. Stigler found spinal stenosis and disc protrusions at L4-5 and L5-S1. He attributed claimant's left foot condition, inter alia, to a left S1 radiculopathy. (Exs. 7 through 10).

Sometime in early 1994, claimant experienced a fall down some stairs at work. There is no evidence that she lost time from work or sought medical treatment for her injuries. She did not file a claim at that time.

On May 20, 1994, claimant sought treatment from Dr. Kelber, her family physician, for ongoing back pain, which she attributed to a falling incident at work. Kelber referred her to Dr. Buza, neurologist, for an evaluation of back and leg pain of several years' duration. Dr. Buza reported increased right leg involvement and recommended conservative treatment, although the possibility of decompression surgery was discussed. (Exs. 3-5, and 15 through 19).

In November 1994, claimant sought treatment from Dr. Brett, neurologist. Claimant reported falling down stairs while carrying heavy equipment at work in January 1994, which worsened her low back and left leg pain. Dr. Brett noted marked spinal stenosis, increased disc protrusion, advanced facet osteoarthritis and marked degenerative changes at L4-5 and L5-S1. Dr. Brett performed a decompressive laminectomy bilaterally at L4-5 for spinal stenosis and a keyhole laminectomy left at L5-S1. Diskectomies were not required. (Exs. 36 through 40).

It is claimant's burden to prove the compensability of her claim by a preponderance of the evidence. ORS 656.266. When a preexisting disease or condition combines with a compensable injury to cause or prolong disability or the need for treatment, the combined condition is compensable only if the compensable injury is the major contributing cause of the combined condition. ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, rev den 318 Or 27 (1993).

Here, we find that claimant had a preexisting condition which combined with her early 1994 compensable injury to cause or prolong her disability or need for treatment. Dr. Buza opined that a trauma such as her fall could increase claimant's symptoms. (Ex. 27). Dr. Brett opined that claimant's fall combined with her spinal stenosis to result in her need for surgery. (Exs. 36 and 42).

Drs. Buza and Brett both offered opinions regarding the cause of claimant's condition. We conclude that claimant has failed to carry her burden of proof.

Dr. Buza opined that the major cause of claimant's current complaints is lumbar stenosis. He based his opinion on the vagueness of claimant's report of the mechanism of the falling injury and the fact that she had been treated for her foot symptoms prior to the fall. He opined that the lumbar stenosis was not trauma related, although, as noted above, he stated that trauma could increase claimant's symptoms. (Ex. 27).

Dr. Brett opined that it was medically probable that claimant's fall at work precipitated worsening cauda equina compression, by pathologically worsening her L4-5 disc, which increased her bilateral radicular leg pain, resulting in increased spinal stenosis at L4-5 and her need for surgery. (Ex. 42). Dr. Brett does not indicate that the injury was more than a "precipitating cause" of a worsened disc, which then had an effect on claimant's spinal stenosis. Moreover, he does not discuss the relative contribution of her preexisting degenerative condition to her current condition. We conclude that Dr. Brett's opinion is insufficient to establish that claimant's injury was the major contributing cause of her current condition. Dietz v. Ramuda 130 Or App 397, 401, rev allowed 320 Or 492 (1994) (although a work event that is the precipitating cause of a disease or injury may be the major contributing cause, the proper application of ORS 656.005(7)(a)(B) requires an evaluation of the relative contribution of each cause, including the precipitating cause, to establish which is the primary cause). Accordingly, we conclude that claimant failed to carry her burden of proof.

ORDER

The ALJ's order dated June 2, 1995 is affirmed.

March 15, 1996 Cite as 48 Van Natta 556 (1996)

In the Matter of the Compensation of
RODRICK L. COTNER, Claimant
WCB Case No. 95-07862
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that awarded an 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," but not his "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded claimant's counsel an attorney fee pursuant to ORS 656.386(1) for overturning an alleged "de facto" denial of an L1-2 herniated disc condition. On review, the insurer contends that both amended ORS 656.262(6)(d) and amended ORS 656.386(1) preclude an attorney fee award. We agree.

Before we proceed with our analysis, it is necessary to briefly summarize the factual background of this claim. Claimant filed a workers' compensation claim for an alleged low back injury occurring on or about July 7, 1992. The insurer denied the claim on November 6, 1992. A prior ALJ, however, found the claim compensable in an August 23, 1994 Opinion and Order. The Board affirmed that order on April 12, 1995.

The insurer issued a Notice of Claim Acceptance dated May 24, 1995, in which it accepted a "low back strain." Dissatisfied with the scope of the insurer's claim acceptance, claimant's counsel wrote the insurer on May 31, 1995, demanding that it accept a "transthoracic anterior lumbar diskectomy at L1-2 with interbody fusion." In a June 29, 1995 response, the insurer notified claimant's counsel that it was amending its acceptance notice to include an L1-2 disc herniation.

On July 5, 1995, claimant requested a hearing, alleging a "de facto" denial. Claimant also asserted entitlement to penalties and attorney fees based on the insurer's allegedly unreasonable failure to issue a timely acceptance notice within 30 days of the Board's April 12, 1995 Order on Review.

At the hearing, claimant contended that the insurer "de facto" denied the L1-2 disc herniation when it issued its May 24, 1995 acceptance of only his low back strain. Claimant further argued that the insurer's modification of its acceptance to include the disc herniation entitled him to an assessed fee pursuant to ORS 656.386(1).

The ALJ agreed, reasoning that amended ORS 656.262(6)(d) was inapplicable because the insurer accepted claimant's low back claim by litigation order.[1] Based on his review of the prior ALJ's order, the ALJ determined that claimant's disc herniation was a compensable component of the claim. When the insurer failed to accept that condition, the ALJ concluded that claimant could request a hearing raising "de facto" denial. According to the ALJ, claimant's counsel secured an assessed attorney fee pursuant to amended ORS 656.386(1) by obtaining the amended acceptance without an ALJ's intervention.

We disagree with the reasoning that amended ORS 656.262(6)(d) does not apply to acceptances issued pursuant to litigation orders. The "litigation order" distinction overlooks the fact that amended ORS 656.262(6)(d) expressly applies to objections to a "notice of acceptance." There is no exception for those issued as a result of a litigation order.

Here, the Board's prior order affirmed the previous ALJ's order that found claimant's low back claim compensable and remanded the claim for "acceptance." In response to the Board's order, the insurer issued a "Notice of Acceptance," accepting a low back strain. When claimant disagreed with the scope of the insurer's acceptance and requested that his disc herniation be specifically accepted, the insurer amended its acceptance notice within 30 days of claimant's request. The insurer's amendment was timely under the provisions of amended ORS 656.262(6)(d). The insurer, thus, satisfied the requirements of the statute.

We now turn to the issue of whether claimant's counsel is entitled to an assessed attorney fee under amended ORS 656.386(1). For the following reasons, we find that he is not.

Under amended ORS 656.386(1), an attorney fee is awarded "in cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge." We must, however, determine whether claimant's disc herniation was a "denied claim." Amended ORS 656.386(1) defines a "denied claim" as:

> "[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. A denied claim shall not be presumed or implied from an insurer's or self-insured employer's failure to pay compensation for a previously accepted injury or condition in a timely fashion."

In Elizabeth A. O'Brien, 47 Van Natta 2152 (1995), we held that the claimant was entitled to a carrier-paid attorney fee under amended ORS 656.386(1) when she established that a disputed cervical disc herniation was compensable. A prior litigation order had set aside a denial of the claimant's cervical condition. Thereafter, the claimant objected to the carrier's notice of acceptance of disk bulges, contending that her disc herniations had previously been found compensable. When the carrier declined to amend its acceptance, the claimant requested a hearing.

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[1] Amended ORS 656.262(6)(d) provides that, if an injured worker believes that a condition has been incorrectly omitted from a "notice of acceptance," the worker must first communicate his or her objections to the carrier. The carrier then has 30 days to revise the acceptance or to make other written clarification in response. A worker who fails to comply with these requirements may not allege a "de facto" denial based on the carrier's acceptance. The worker may object to the notice of acceptance at any time.

Determining that the prior order had directed the carrier to accept the disc herniations, we concluded that the carrier was precluded from contesting the compensability of the herniations. Moreover, in light of the carrier's refusal to pay compensation for the claimant's disc herniations based on the express ground that the herniations were not compensable, we reasoned that her disc herniations constituted a "denied claim" under amended ORS 656.386(1). We cited Guillermo Rivera, 47 Van Natta 1723 (1995).

In Rivera, we also concluded that the claimant's cervical condition constituted a "denied claim" pursuant to amended ORS 656.386(1). In reaching this conclusion, we cited the employer's acknowledgment that it questioned the causation of the claimant's cervical condition, as well as its concession that a fee for a cervical "de facto" denial was appropriate.

In contrast to O'Brien and Rivera, we conclude that there was no "denied claim" within the meaning of amended ORS 656.386(1) in this case. The insurer did not decline to amend its notice of acceptance in response to claimant's objection. Quite the contrary, the insurer amended its notice of acceptance to include claimant's disc herniation within the time frame required by amended ORS 656.262(6)(d). The insurer also did not question causation either when it accepted claimant's disc herniation or at hearing. Finally, the insurer never conceded that a "386(1)" fee was appropriate.

In light of such conduct, we conclude that the insurer did not refuse to pay compensation for claimant's disc herniation on the express ground that this condition was not compensable or otherwise did not give rise to entitlement to any compensation.[2] Because there was no "denied claim" within the meaning of amended ORS 656.386(1), we reverse the ALJ's award of an assessed fee pursuant to that statute.[3]

ORDER

The ALJ's order dated October 18, 1995, is reversed in part and affirmed in part. That portion that awarded an assessed attorney fee under ORS 656.386(1) is reversed. The remainder of the ALJ's order is affirmed.

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[2] The parties refer us to Judy A. Danielson, 47 Van Natta 1556 (1995), and Wesley R. Craddock, 46 Van Natta 713 (1994). Both cases are inapposite because they did not apply amended ORS 656.262(6)(d) or amended 656.386(1).

[3] Had we determined that amended ORS 656.262(6)(d) did not apply to acceptance notices issued pursuant to litigation orders, this would not have changed the result. In order to receive an attorney fee under amended ORS 656.386(1), there must have been a "denied claim." Given our finding that there was no "denied claim" in this case, claimant's counsel still would not have been entitled to a fee under that statute even if, as the ALJ determined, claimant could allege a "de facto" denial without complying with the notice requirements of amended ORS 656.262(6)(d).

In the Matter of the Compensation of
TIVIS E. HAY, Claimant
WCB Case Nos. 92-13904, 92-11494 & 92-09270
ORDER ON REMAND
Stebbins & Coffey, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Judy C. Lucas (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. In our prior order, Tivis E. Hay, 46 Van Natta 1002 (1994), we held that Liberty Northwest Insurance Corporation (rather than the SAIF Corporation either under a prior accepted claim or a new claim) was responsible for a new occupational disease claim for claimant's low back condition. Pursuant to its September 6, 1995 order, the court has remanded this matter for reconsideration in light of amended ORS Chapter 656.

FINDINGS OF FACT

We republish the "Findings of Fact" from our prior order.

CONCLUSIONS OF LAW AND OPINION

Claimant, a log scaler, sustained a compensable low back injury in 1984, while SAIF was on the risk. The claim was closed in May 1984. In 1986, claimant sought further medical treatment for low back symptoms. Claimant's onset of additional symptoms occurred shortly after his job duties were changed to include extensive driving on logging roads. In 1987, claimant was examined by Dr. Schachner, who noted lumbosacral degenerative disc disease on claimant's spinal x-ray.

In June 1991, while Liberty was on the risk, claimant compensably injured his left leg and right shoulder. Liberty accepted a claim for contusion/abrasion left leg/right shoulder.

Subsequent to the 1991 injury, claimant began to experience low back pain. In January 1992, claimant consulted his treating physician, Dr. Gurney, who obtained an MRI that revealed extensive degenerative changes at L5-S1. (Ex. 9). SAIF denied responsibility under its accepted 1984 injury claim, and denied compensability and responsibility of a new occupational disease claim. Liberty denied responsibility of claimant's current condition as related to his accepted 1991 claim, and denied compensability and responsibility of a new occupational disease claim.

The ALJ concluded that claimant had established a new occupational disease for his current low back condition following the closure of his 1984 injury claim. Therefore, applying the "last injurious exposure rule," the ALJ concluded that, because claimant first sought treatment for his current condition when Liberty was on the risk, Liberty was responsible for claimant's new occupational disease.

In our prior order, we affirmed the ALJ's order. In doing so, we determined that claimant's current low back condition was the same condition as that which SAIF accepted in 1984. Tivis E. Hay, supra; see Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993); former ORS 656.308. Accordingly, relying on Dr. Gurney's opinion, we found that SAIF had proven that claimant's work activities subsequent to closure of its 1984 claim were the major contributing cause of his current condition. Accordingly, we held that SAIF had established a "new occupational disease" after the closure of the 1984 claim. See former ORS 656.308(1), former ORS 656.802; Tivis E. Hay, supra (citing Steven K. Bailey, 45 Van Natta 2114, 2116 (1993)).

After concluding that claimant had sustained a "new occupational disease," we then were required to determine whether SAIF, which had provided coverage for the employer between 1984 and 1991, or Liberty, which provided coverage after 1991, was responsible for the new claim. Applying the last injurious exposure rule, we found that the "onset of disability," that is, when claimant first sought treatment for his current condition, was January 1992, while Liberty was on the risk. Tivis E. Hay, supra. Consequently, we initially assigned responsibility for claimant's occupational disease to Liberty. See Boise Cascade Corp. v. Starbuck, 296 Or 238, (1984). Furthermore, because Liberty could not show that claimant's work exposure while SAIF was on the risk was the sole cause of claimant's current low back condition, or that it was impossible for conditions while Liberty was on the risk to have caused that condition, we concluded that responsibility for claimant's "new occupational disease" remained with Liberty. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985).

Liberty petitioned the court for judicial review of our prior order. As previously noted, citing the 1995 statutory amendments, the court has remanded for reconsideration.

Subsequent to our prior order, the legislature amended ORS 656.308. Those amendments apply retroactively to this case. See SB 369, § 37; Volk v. America West Airlines, 135 Or App 565 (1995). Amended ORS 656.308(1) provides in part: "The standards for determining the compensability of a combined condition under ORS 656.005(7) shall also be used to determine the occurrence of a new compensable injury or disease under this section."

Accordingly, applying ORS 656.005(7)(a)(B) in the context of amended ORS 656.308 (1), an employer with an accepted injury or occupational disease remains responsible for future medical services and disability related to the compensable condition subject to the following exception. Specifically, responsibility can shift to a subsequent employer if the claimant sustains a new compensable injury involving the same condition, and the employer with the accepted injury establishes that the subsequent

injury or work conditions combined with the preexisting condition (accepted injury),[1] and that the subsequent injury or work conditions are the major contributing cause of the combined condition. See amended ORS 656.308(1); see also Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314 (1993)(ORS 656.308 encompasses occupational diseases).

Here, based on the reasoning expressed in our prior order, we conclude that claimant's current back condition is the same condition for which SAIF has an accepted claim. Tivis E. Hay, supra; see ORS 656.308(1). Furthermore, pursuant to amended ORS 656.005(24), because SAIF's 1984 accepted injury constitutes an "injury that precedes the onset of an initial claim for an occupational disease," we conclude that SAIF's accepted low back injury constitutes a "preexisting condition" for purposes of determining compensability under ORS 656.308(1). Finally, we apply ORS 656.005(7)(a)(B) to determine whether claimant's current condition combined with his preexisting condition to cause or prolong disability or need for treatment. See ORS 656.308(1).

The salient issue is whether claimant's current condition constitutes a "new occupational disease." In 1995, the Legislature also amended ORS 656.802, adding subsection (2)(b), which states: "If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease."

Dr. Gurney, treating physician, opined that the cause of the symptoms for which claimant sought treatment in 1992 was "his accumulative injuries that occurred in 1984 and his being jossled [sic] around in the pickup during his work related activities and also his June 1991 injury." (Ex. 14A). We interpret this description of the cause of claimant's condition to mean that Dr. Gurney concluded that claimant's current condition was a combination of all his injuries and work exposures with the employer. (Ex. 15-1). Accordingly, relying on Dr. Gurney's opinion, we conclude that claimant's current condition combined with his preexisting condition, including the previous accepted injury.

This occupational disease claim is based on a worsening of claimant's preexisting low back condition. Therefore, in order to establish a new occupational disease, SAIF must prove that claimant's employment conditions subsequent to the 1984 closure of his accepted claim were the major contributing cause of the combined condition and pathological worsening of his low back condition. ORS 656.802(2)(b); see Dan D. Cone, 47 Van Natta 2220, 2221 n 1 (1995).

In Cone, we applied the "responsibility" principles of ORS 656.308(1) in the same-employer context. Furthermore, relying on amended ORS 656.802(2)(b), we determined that, in order to prove a "new occupational disease," the claimant must establish that a "series of traumatic events or occurrences" subsequent to his prior nondisabling injury caused a worsening of his condition. Moreover, because the claimant's occupational disease claim was based on a worsening of a "preexisting disease" as defined in ORS 656.005(24) (i.e.; a worsening of his prior accepted injury caused by his subsequent work activities), we concluded that he must establish that these "post-injury" employment conditions were the major contributing cause of "the combined condition and pathological worsening of the disease." In other words, we reasoned that it was not sufficient to show that "post-injury" work conditions were the major contributing cause of only the worsening of the preexisting disease.

We apply the same reasoning in this case. For the reasons stated in our prior order, we continue to rely on Dr. Gurney's opinion. After conducting our review under the amended statutes, however, we conclude that SAIF has failed to meet its burden of proving that a new compensable low back occupational disease arose after SAIF's 1984 claim was closed. We base this conclusion on the following reasoning.

Dr. Gurney initially opined that claimant's 1991 injury caused his previously asymptomatic back condition to become symptomatic. (Ex. 10). He further stated that claimant's preexisting degenerative joint disease and his 1991 injury were contributing causes of the condition, but he could not determine which was the major cause. Dr. Gurney's subsequent chart notes and reports referred to claimant's current "symptoms," and current "low back pain." (Exs. 11, 14A).

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[1] "Preexisting condition" is defined, in part, as: "[A]ny 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 * * *." Amended ORS 656.005(24) (emphasis added).

On September 8, 1992, Dr. Gurney agreed that the cumulative effects of claimant's injuries, and his work exposure with the employer, were the major contributing cause of claimant's current low back condition and need for medical services. (Ex. 15). Nevertheless, Dr. Gurney did not address the issue of a pathological worsening of the disease, and the record contains no persuasive evidence of a pathological worsening. Under such circumstances, we are unable to find that claimant's "post-1984" employment exposure was the major contributing cause of the combined condition and pathological worsening of claimant's preexisting disease. Thus, SAIF has failed to establish that claimant suffered a new occupational disease claim. ORS 656.802; Dan D. Cone, supra.

Because SAIF has failed to prove that claimant sustained a new occupational disease involving his low back condition following closure of its 1984 injury, we conclude that SAIF, under its 1984 claim, remains responsible for claimant's current low back condition. See ORS 656.308(1); ORS 656.802(2)(b). Consequently, in lieu of our prior order, we reverse the ALJ's decision that placed responsibility for claimant's low back condition on Liberty.

Finally, claimant is entitled to an attorney fee for services at hearing, on Board review, before the court and before the Board on remand. ORS 656.388(1). Because no party has challenged the ALJ's $2,800 attorney fee at hearing, and the Board's $1,000 award on review, we will adhere to those awards, except that SAIF is now responsible for those fees. Furthermore, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services before the Court of Appeals and before the Board on remand is $2,500, payable by SAIF under its 1984 claim. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate briefs), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, the ALJ's order dated May 27, 1993 is reversed. The SAIF Corporation's denial of claimant's low back condition under its 1984 claim is set aside, and the claim is remanded to SAIF for processing in accordance with law. Liberty Northwest Insurance Corporation's denial is reinstated and upheld. SAIF is responsible for the attorney fee awards granted by the ALJ's order and our prior order. For services before the court and before the Board on remand, claimant's counsel is awarded $2,500, to be paid by SAIF.

IT IS SO ORDERED.

March 15, 1996 Cite as 48 Van Natta 561 (1996)

In the Matter of the Compensation of
MELVIN L. SHROY, Claimant
WCB Case Nos. 93-07329 & 93-02639
ORDER ON REMAND
Robert G. Dolton, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Safeway Stores, Inc. v. Shroy, 136 Or App 612 (1995). In our prior order, we: (1) reversed that portion of the Administrative Law Judge's (ALJ) order that upheld the self-insured employer's denial of claimant's aggravation claim for a low back condition; and (2) affirmed that portion of the ALJ's order that reversed an Order on Reconsideration which awarded 5 percent scheduled permanent disability for the left foot. Melvin L. Shroy, 46 Van Natta 1599 (1994). The court has reversed our prior order and remanded for an application of amended ORS 656.273(3). On reconsideration, we withdraw our prior order and issue the following order.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the ALJ's order with one exception. The ALJ found that "The cause of claimant's decreased sensation on the medial aspect of the left foot is related to claimant's August 17, 1990 injury, not his April 17, 1992 injury." (O & O at p. 3). The date "August 17, 1990" should read "April 17, 1990."

CONCLUSIONS OF LAW AND OPINION

Aggravation

The ALJ concluded that claimant had not perfected an aggravation claim under former ORS 656.273(3). We agree that claimant has not perfected an aggravation claim, but do so based on the following reasoning.

Subsequent to the ALJ's order, the legislature amended ORS 656.273(3) in Senate Bill 369. Except as otherwise provided, Senate Bill 369 applies to matters for which the time to appeal the ALJ's decision has not expired or, if appealed, has not been finally resolved on appeal. Newell v. SAIF, 136 Or App 280, 282 (1995); Volk v. America West Airlines, 115 Or App 565, 572-73 (1995).

Amended ORS 656.273(3) now provides, in part, that a "claim for aggravation must be accompanied by the attending physician's report establishing by written medical evidence supported by objective findings that the claimant has suffered a worsened condition attributable to the compensable injury." We have previously held that this portion of amended ORS 656.273(3) is retroactively applicable and must be complied with in order to perfect an aggravation claim. See Donald P. James, 48 Van Natta 424 (1996); Ilene M. Herget, 47 Van Natta 2285, 2286 n. 2 (1995).

In Donald P. James, supra, the claimant's aggravation claim was based on a report from his treating chiropractor. Inasmuch as a chiropractor is ineligible to serve as an attending physician on an aggravation claim under amended ORS 656.005(12)(a)(B), we held that the treating chiropractor's report was not sufficient to establish an aggravation claim under amended ORS 656.273(3). In reaching this conclusion, we distinguished our holding in Rick A. Webb, 47 Van Natta 1550 (1995) (Portion of amended ORS 656.273(3) which prescribes a Director's form and format for an aggravation claim that was not in existence at the at the time the aggravation claim was filed is not retroactively applicable) on the basis that the carrier had challenged the validity of claimant's aggravation claim from the outset and that the challenge was not based on the "Director's form", but rather on the authority of the physician advancing the claim.

Here, claimant's aggravation claim is based on a report from Dr. Snodgrass, a neurologist who performed a medical arbiter examination on behalf of the Appellate Unit of the Workers' Compensation Division. Dr. Snodgrass is not claimant's attending physician. Moreover, the employer in this case, as in Donald P. James, has challenged the validity of claimant's aggravation claim from the outset on the basis that Dr. Snodgrass is not authorized to advance the aggravation claim. Accordingly, because Dr. Snodgrass is not claimant's attending physician, we conclude that his report cannot constitute a claim for aggravation. Inasmuch as claimant's aggravation claim was not accompanied by an attending physician report, it is not a claim for aggravation under amended ORS 656.273(3). Donald P. James, supra.[1] Consequently, we affirm the ALJ's finding that claimant has not perfected an aggravation claim.

Extent of Scheduled Permanent Disability

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

Accordingly, on reconsideration of our August 5, 1994 order, we affirm the ALJ's order dated October 13, 1993.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we do not find Dr. McNeill's April 8, 1993 report (Exhibit 44) to be sufficient to perfect an aggravation claim under amended ORS 656.273(3). While Dr. McNeill is claimant's attending physician, his report does not establish that claimant suffered a "worsened condition" as required by statute. Although the report relates the numbness in claimant's left foot to his compensable injury, it does not address whether this represents a worsening of claimant's compensable condition. In this regard, Dr. McNeill reported that claimant had experienced similar symptoms following the May 1990 compensable injury. (Ex. 44).

In the Matter of the Compensation of
DONALD P. JAMES, Claimant
WCB Case Nos. 95-06521 & 95-06280
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Lundeen, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Peterson's order which: (1) set aside its denial of responsibility for claimant's current low back condition; (2) upheld Liberty Northwest Insurance Corporation's "de facto" denial of the same condition; and (3) awarded a $3,000 carrier-paid attorney fee to be paid by SAIF. Claimant cross-requests review of that portion of the ALJ's order that declined to assess a penalty against Liberty Northwest for its allegedly unreasonable claim processing. On review, the issues are responsibility, penalties and attorney fees. We reverse in part, affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's "findings of fact" with the exception of his finding that claimant filed an aggravation claim against SAIF and Liberty.

CONCLUSIONS OF LAW AND OPINION

Responsibility

Setting aside SAIF's "aggravation" denial, the ALJ found SAIF responsible for claimant's low back strain arising out of an incident on January 26, 1995, when claimant experienced severe low back pain while doing some lifting for SAIF's insured. On review, SAIF contends that the ALJ erred in finding that claimant suffered an aggravation of his previously accepted claim of March 10, 1994. It asserts that claimant never raised the issue of aggravation and that, therefore, the issue was not properly before the ALJ. We agree.

Claimant initially injured his low back on August 18, 1993, while employed by Liberty's insured. Liberty accepted the claim as an "acute lumbosacral strain." Claimant received a total of 9 percent unscheduled permanent disability for this injury.

On March 10, 1994, claimant sustained another injury, this time while employed by SAIF's insured. SAIF accepted a nondisabling lumbar strain. (Ex. 25).

In October 1994, claimant filed aggravation claims for his low back condition (diagnosed as lumbosacral strain) against both SAIF and Liberty Northwest. By Opinion and Order of June 8, 1995, a prior ALJ found that claimant had proven a compensable aggravation claim against SAIF. The Board, however, has now reversed that decision, finding that, although SAIF is responsible for claimant's low back condition, no proper aggravation claim was filed. Donald P. James, 48 Van Natta 424 (1996).

In the meantime, claimant experienced a sudden onset of severe back pain on January 26, 1995, while working for SAIF's insured. A low back strain was again diagnosed. (Ex.1). On February 21, 1995, SAIF wrote claimant to advise him that he should file a claim with Liberty. (Ex. 11). On February 24, 1995, claimant wrote Liberty, informing it that a "claim" was being made under the August 1993 date of injury. (Ex. 12). Liberty received the letter on February 27, 1995. (Tr. 22).

Liberty did not respond to claimant's February 24, 1995 letter and never accepted or denied claimant's "claim." SAIF issued a denial of responsibility on May 10, 1995. SAIF requested designation of a paying agent under ORS 656.307, but the Department denied the request on June 23, 1995, on the mistaken ground that the prior ALJ's June 8, 1995 order had resolved the responsibility issue.

Claimant filed a request for hearing on May 30, 1995. His request raised the issues of compensability, responsibility, penalties and attorney fees.

The ALJ concluded that a preponderance of the evidence established that claimant sustained an "aggravation" of his preexisting low back condition in January 1995. The ALJ concluded that, because the prior ALJ's June 8, 1995 order determined that SAIF was responsible for claimant's preexisting low back condition, SAIF was now responsible for an "aggravation" in January 1995. Thus, the ALJ set aside SAIF's denial of the "aggravation" claim and upheld Liberty's "de facto" denial of responsibility.

Although the ALJ interpreted claimant's January 1995 exacerbation as an "aggravation claim," we agree with SAIF that claimant did not raise the issue of aggravation. We reach that conclusion for the following reasons.

The ALJ's scope of review is limited to issues raised by the parties. Jeffrey D. Ward, 45 Van Natta 1513, 1514 (1993); Alden D. Muller, 43 Van Natta 1246 (1991) (Board vacated the portion of the ALJ's order that addressed an issue not raised by the parties). Here, claimant's hearing request did not raise aggravation as an issue; rather, only compensability, responsibility, penalties and attorney fees were raised. Moreover, at the hearing, the issues were listed as compensability, responsibility and penalties. (Tr. 27). Claimant's counsel described the January 1995 claim as the "1995 condition claim" and the issue as the compensability of the "1995 condition." (Trs. 3, 6). Almost the entire hearing was devoted to discussion of the issues. Only one question was asked of claimant by his counsel: whether his medical bills had been paid. (Tr. 28). Claimant's counsel solicited no testimony or medical reports regarding whether claimant suffered an aggravation of his prior compensable injuries.[1]

Finally, SAIF's counsel specifically noted there was no aggravation claim with respect to SAIF's March 1994 injury. (Tr. 14). SAIF's counsel stated: "He's [claimant's counsel] basically saying that we don't have everybody here because there's not really an aggravation claim against the March 1994 SAIF injury, and that's sort of what's missing." (Tr. 14). Claimant's counsel did not disagree with SAIF's counsel's assessment and never used the words "aggravation claim" in describing the claim at hearing.

Based on our review of the record, we find that the issue of aggravation was not raised. Accordingly, we reverse that portion of the ALJ's decision which construed the January 1995 claim as an "aggravation claim."

Although we agree with SAIF that claimant did not raise aggravation as an issue, we nevertheless conclude that it is responsible for claimant's current low back condition. We base this conclusion on the following reasoning.

ORS 656.308(1) provides, in part: "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer."

Claimant has experienced a series of low back strains, beginning with the 1993 Liberty injury. Dr. Rabie, claimant's attending physician, agreed that claimant has a chronic low back strain condition. (Ex. 28). In light of this opinion, we conclude that claimant's injuries involve the "same condition." We, therefore, find that ORS 656.308(1) applies.

In March 1994, claimant sustained a "new compensable injury" under ORS 656.308(1) when he sustained a lumbar strain while working for SAIF's insured. Because claimant's current low back condition (low back strain) involves the "same condition" as involved in the March 1994 claim, SAIF is responsible for all further compensable medical services pertaining to claimant's low back condition under ORS 656.308(1). Smurfit Newsprint v. DeRosset, 118 Or App 371, 372 (1993).

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[1] We acknowledge that SAIF solicited a medical report from two examining physicians, Drs. Duff and Wilson, in which they were asked to comment on whether the January 1995 claim was an "aggravation" of any prior claims. The physicians, however, were unable to respond to the question because they were unaware of the January 1995 claim. (Ex. 21-8). Inasmuch as there is nothing to indicate that the inquiry in SAIF's "IME" report was anything other than precautionary, we conclude that this medical report was insufficient to establish that claimant raised "aggravation" as an issue pursuant to his hearing request from SAIF's denial.

Moreover, even if claimant's current low back condition did not involve the "same condition," but only the same body part, we would still find SAIF responsible under the analysis of Industrial Indemnity Co. v. Kearns, 70 Or App 583 (1984). See Raymond H. Timmel, 47 Van Natta 31 (1995) (where the claimant has several accepted claims for injuries involving the same body part but not the same condition, Kearns remains valid law, notwithstanding the enactment of former ORS 656.308(1)).[2] Under Kearns, SAIF would be presumptively responsible for claimant's condition unless the medical evidence established that claimant's March 1994 industrial injury did not independently contribute to a worsening of his low back condition. Kearns, supra, 70 Or App at 587.

Here, there is no evidence that would rebut the "Kearns" presumption that claimant's March 1994 injury independently contributed to a worsening of claimant's low back condition.[3] Thus, even if Kearns were applicable to this case, we would still conclude that SAIF remains responsible for claimant's low back condition arising from the January 1995 exacerbation.

Penalties and Attorney Fees

The ALJ found Liberty's failure to accept or deny claimant's claim within 90 days of its February 27, 1995 notice of a claim unreasonable. However, the ALJ declined to assess a penalty because, having determined that SAIF was responsible for claimant's low back condition, there were no "amounts due" from Liberty on which to base a penalty. Claimant contends that a penalty should have been assessed. We agree.

We concur with the ALJ's reasoning that Liberty's claim processing (its failure to accept or deny claimant's claim) was unreasonable.[4] In SAIF v. Whitney, 130 Or App 429 (1994), the court upheld the assessment of penalties against two insurers, although only one was substantively liable for the claim. We, therefore, conclude that a penalty for unreasonable conduct may be assessed against Liberty even though no amounts are due under the claim against it. SAIF v. Whitney, supra. Accordingly, inasmuch as Liberty's failure to accept or deny the claim was unreasonable, we conclude that a penalty of 25 percent of amounts due claimant (from SAIF) is appropriate. This penalty shall be paid by Liberty and will be based on the compensation payable by SAIF as a result of the ALJ's order (as of the date of hearing). Larry S. Karnoski, 46 Van Natta 2526 (1994).

Finally, the ALJ awarded an assessed attorney fee of $3,000, payable by SAIF, for claimant's counsel's efforts in setting aside SAIF's denial of responsibility. SAIF argues that claimant should receive no more than an attorney fee of $1,000 pursuant to ORS 656.308(2)(d). Claimant responds that his counsel is entitled to the attorney fee awarded under ORS 656.386(1) and/or ORS 656.308(2)(d). We agree with SAIF.

We first address the applicability of ORS 656.386(1). SAIF did not contend at hearing that claimant's claim was not compensable or that claimant was not entitled to compensation. (Tr. 7). In its May 22, 1995 denial letter, SAIF included "notice of hearing" provisions and stated that its letter was a "denial of your claim for benefits." (Ex. 22). However, SAIF's denial also included a caption stating that it was a "DENIAL OF RESPONSIBILITY" and expressly notified claimant that SAIF had requested designation of a paying agent under ORS 656.307. Although it did not contain a specific concession of compensability, the denial stated that SAIF "disclaim[ed] responsibility for your condition(s) diagnosed as low back strain."

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[2] Effective June 7, 1995, Senate Bill 369 amended ORS 656.308(1) to provide that the standards for determining the compensability of a combined condition under ORS 656.005(7) shall be used to determine the occurrence of a new compensable injury or disease under ORS 656.308(1). Inasmuch as we apply the Kearns presumption only when ORS 656.308(1) is not applicable (in cases not involving the "same condition"), the amendment to that statute does not affect our analysis in Timmel.

[3] Dr. Rabie agreed that the major contributing cause of claimant's disability and need for treatment was his preexisting low back strain condition, which would include SAIF's accepted March 1994 low back strain injury. (Ex. 28).

[4] It is true that we have agreed that Liberty was relieved of further liability for claimant's low back condition because of ORS 656.308. However, that statute does not excuse Liberty's failure to respond to an explicit claim submitted by claimant's counsel in February 1995. Moreover, the Department's belief that the prior hearing had resolved this responsibility dispute does not justify Liberty's failure to process the claim. Liberty knew or should have known that there were separate responsibility disputes, inasmuch as claimant's counsel attached a copy of SAIF's February 21, 1995 letter which contained a January 1995 date of injury. (Ex. 12).

In Ray L. Bennett, 47 Van Natta 866 (1995), one of the carriers had issued a denial that stated, in part: "After review of the investigation material available, it appears that your condition is compensable; however, responsibility may rest with one of the employers identified above. Therefore, this letter represents a denial of responsibility for your current condition." In addition, the carrier's denial indicated that a paying agent had been requested.

Relying on James D. Lollar, 47 Van Natta 740 (1995), and James McGougan, 46 Van Natta 1639 (1994), we concluded that the carrier's denial in Bennett did not raise an issue of compensability. We found that the carrier's responsibility denial clearly and unambiguously conceded that the claim was compensable and indicated that responsibility was the only issue. Although the carrier's denial contained "notice of hearing" provisions and stated that it was a denial of the claim for benefits, we did not construe the denial to extend to compensability, given the express language conceding compensability and denying only responsibility.

We reach a similar conclusion in this case. In its May 22, 1995 denial letter, SAIF stated that its denial was one of responsibility and notified claimant that it would be requesting the designation of a paying agent pursuant to ORS 656.307. Notwithstanding the lack of a specific concession of compensability and the inclusion of "notice of hearing" provisions, we do not construe SAIF's denial to extend to compensability, considering the express language in its caption denying responsibility only, as well as SAIF's request for designation of a paying agent. See Ray L. Bennett, supra; James D. Lollar, supra; James McGougan, supra.

In summary, we conclude that the responsibility denial issued by SAIF did not raise an issue of compensability. Furthermore, we find that SAIF did not refuse to pay compensation on the express ground that claimant's low back condition was not compensable. See amended ORS 656.386(1). We also find that SAIF did not refuse to pay on the express ground that the claim did not "give rise to an entitlement to any compensation." See id. Accordingly, claimant's claim for benefits with SAIF does not constitute a "denied claim" pursuant to amended ORS 656.386(1). We, thus, conclude that SAIF is not responsible for an attorney fee pursuant to ORS 656.386(1) because there was no "denied claim."

With respect to Liberty, it never denied claimant's claim, but it failed to concede compensability. Thus, through its inaction, Liberty left claimant's compensation potentially at risk and prevented issuance of a ".307 order."

The issue here is whether, with respect to Liberty, claimant has prevailed against a "denied claim" within the meaning of ORS 656.386(1). That statute defines a "denied claim" as "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."

At the hearing, Liberty moved to dismiss claimant's hearing request on the ground that there was no evidence that it was the responsible carrier. (Tr. 14). However, we are unwilling to equate this motion, or Liberty's failure to respond to claimant's claim, to a denial of the compensability of claimant's current low back condition on the "express ground" that claimant's current low back condition was not compensable or otherwise did not give rise to an entitlement to compensation. In other words, inasmuch as ORS 656.386(1) now requires an express basis for a refusal to pay compensation, we do not interpret a carrier's failure to concede compensability as providing an "express ground" for refusing to pay compensation.[5] While such conduct may be considered unreasonable claim processing (supporting imposition of a penalty or attorney fee when such issues are properly raised), it does not equate to the "express ground" that ORS 656.386(1) requires for a "denied claim." Therefore, we decline to award claimant's counsel an assessed attorney fee under ORS 656.386(1), payable by Liberty.

We now address the applicability of ORS 656.308(2)(d). ORS 656.308(2)(d) states:

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[5] Used as an adjective, "express" is defined in Webster's II New Riverside University Dictionary (1984) as "firmly and explicitly stated."

"Notwithstanding ORS 656.382(2), 656.386 and 656.388, a reasonable attorney fee shall be awarded to the injured worker for the appearance and active and meaningful participation by an attorney in finally prevailing against a responsibility denial. Such a fee shall not exceed $1,000 absent a showing of extraordinary circumstances."

Notwithstanding ORS 656.386(1) (that entitles claimant to an attorney fee for prevailing over a compensability denial), and ORS 656.382(2) (that provides for an attorney fee for successfully defending against a carrier's request for hearing/review), ORS 656.308(2)(d) limits claimant to a maximum $1,000 attorney fee for "finally prevailing against a responsibility denial," absent a showing of extraordinary circumstances.

This case involved a standard responsibility issue. The hearing lasted for one hour and a half. There was only one witness, claimant. The hearing transcript numbered 29 pages. Further, the record consisted of 30 exhibits, none of which were apparently procured by claimant's counsel. Claimant's counsel asked one question at hearing. Finally, there were no depositions. Claimant filed a 7-page respondent's/cross-appellant's brief which addressed the responsibility issue. Claimant also filed a 2-page "cross-reply." Claimant advocated a "responsibility" decision that was ultimately successful, but a significant portion of his briefs concerned the penalty and attorney fee issues, not the responsibility issue. Based on this record, we conclude that there were no "extraordinary circumstances" to justify a greater fee than the statutory maximum. Cf. Julie M. Baldie, 47 Van Natta 2249 (1995) (no "extraordinary circumstances" found to justify fee greater than statutory maximum).

Accordingly, for services concerning the responsibility issue, in lieu of the ALJ's $3,000 attorney fee award, we conclude that claimant is entitled to a $1,000 attorney fee, payable by SAIF. Finally, we note that this attorney fee award is for services regarding the responsibility issue both at hearing and on review. Tammy Locke, 48 Van Natta 250 (1996) (in light of the statutory context provided by amended ORS 656.386(1) and 656.388(1), legislature intended, in cases in which a claimant finally prevails against a responsibility denial, to authorize a maximum cumulative attorney fee of $1,000 for services at all levels of litigation, except in cases involving extraordinary circumstances).

ORDER

The ALJ's order dated September 5, 1995 is affirmed in part, reversed in part and modified in part. That portion which refused to award a penalty is reversed. Claimant is awarded a 25 percent penalty based on all compensation due from SAIF as a result of this order (as of the date of hearing), payable by Liberty, to be shared equally by claimant and his attorney. That portion of the ALJ's order which awarded an assessed attorney fee of $3,000 is modified. In lieu of the ALJ's award, claimant's counsel is awarded an assessed attorney fee of $1,000, payable by SAIF. The remainder of the ALJ's order is affirmed.

Board Chair Hall specially concurring.

I have previously expressed my view that a carrier, in a responsibility denial, must very clearly concede compensability in order to avoid liability for an assessed fee under ORS 656.386(1). See James D. Lollar, 47 Van Natta 740 (1995) (Member Hall dissenting). Here, I agree with the lead opinion that, given its language, SAIF's denial contained an express concession of compensability.

In the Matter of the Compensation of
NADEZHDA SMIRNOVA, Claimant
WCB Case No. 95-03513
ORDER ON REVIEW
Thomas A. Coleman, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that increased claimant's unscheduled permanent disability award for a left shoulder condition from 7 percent (22.4 degrees), as awarded by an Order on Reconsideration, to 22 percent (70.4 degrees). On review, the issue is the extent of unscheduled permanent disability.

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

The ALJ declined to rely on the impairment findings of claimant's attending physician, Dr. Mortimer-Lamb, and instead relied on the findings of the medical arbiter, Dr. Dinneen. For the following reasons, we agree with the ALJ's decision to defer to the impairment findings of Dr. Dinneen.

Although Dr. Mortimer-Lamb believed that claimant embellished her symptoms, Dr. Dinneen did not note any exaggeration or embellishment during his examination. In addition, Dr. Dinneen indicated that claimant's range of motion findings were valid. Furthermore, a psychiatric evaluation of claimant, performed on behalf of the insurer, concluded that claimant was not suffering from any psychiatric disorder. The psychiatric evaluation did not mention exaggeration of physical symptoms or secondary gain. Finally, Dr. Dinneen's examination of claimant was performed closest in time to the date of the Order on Reconsideration.

Notwithstanding Dr. Mortimer-Lamb's concerns that claimant embellished and exaggerated her symptoms, we are persuaded that claimant had the impairment found by Dr. Dinneen. Under such circumstances, we affirm the ALJ's order.

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

ORDER

The ALJ's order dated June 9, 1995 is affirmed. For services on review, claimant's attorney is awarded $750, payable by the insurer.

In the Matter of the Compensation of
GERALD E. SMITH, Claimant
WCB Case No. 95-01361
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
David O. Horne, Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that upheld the insurer's denial of claimant's claim for a September 26, 1994 back strain injury. The insurer requests review of that portion of the ALJ's order that set aside its denial of claimant's claim for an October 17, 1994 back strain injury. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's "Opinion and Conclusion," except for the first two sentences and the second paragraph, with the following supplementation.

The ALJ found that the October 17, 1994 ladder injury did not happen, based on a conclusion that claimant's account of the incident was not credible. Claimant initially reported that the ladder he was on wobbled or shifted, causing him to strain his back when he reached for support from the ceiling above him. Later, claimant contended that the ladder broke. Based on this variation, the ALJ found claimant's reporting inconsistent. The ALJ also found that claimant's history that the ladder broke was inconsistent with expert evidence that the ladder had been deliberately damaged. We disagree.

We note at the outset that the expert evidence indicating that the ladder was deliberately damaged is not probative. Even accepting that the ladder was deliberately damaged, that fact does not implicate claimant any more than anyone else who had access to the ladder. Similarly, we find that claimant's opinion about the status of the ladder (i.e., whether it wobbled before or after it broke) at the time of the injury is not probative.

In sum, we do not find claimant's reporting regarding the ladder to be meaningfully inconsistent. Instead, we find that claimant's history regarding the October 17, 1994 back strain has been consistent over time and consistent medically with the strain injury suffered. Consequently, we conclude that claimant has carried his burden. See Barnett v. SAIF, 122 Or App 279 (1993).

Claimant's attorney is entitled to an assessed fee for services at hearing and on review regarding the October 17, 1994 injury. 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 concerning the October 17, 1994 injury is $1,500 payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review regarding the insurer's appeal of that portion of the ALJ's order regarding September 26, 1994 injury. 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 September 16, 1994 injury is $500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 1, 1995 is reversed in part and affirmed in part. That portion of the order that upheld the insurer's denial of claimant's claim for an October 17, 1994 back strain injury is reversed. The denial is set aside and the claim is remanded to the insurer for processing according to law. The remainder of the order is affirmed. For services at hearing and on review regarding the claim for an October 17, 1994 injury, claimant is awarded a $1,500 attorney fee, payable by the insurer. For services on review regarding the insurer's appeal, claimant is awarded a $500 attorney fee, payable by the insurer.

March 19, 1996 Cite as 48 Van Natta 570 (1996)

In the Matter of the Compensation of
DIANE J. ELLIS, Claimant
WCB Case No. 94-12014
ORDER ON REVIEW
Schneider & Hooton, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

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

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

On review, claimant argues that the opinions of Dr. Pelmas, treating surgeon, and Dr. Karty, treating D.O., meet claimant's burden of proving that her work activities are the major contributing cause of her right knee medial meniscus tear. (Exs. 33, 34). Specifically, claimant challenges the ALJ's characterization of these opinions as conclusory "check-the-box" concurrences to letters sent by claimant's attorney. Citing Marta I. Gomez, 46 Van Natta 1654 (1994), claimant argues that these opinions are well-reasoned and meet her burden of proof. We disagree that the opinions of Drs. Pelmas and Karty meet the standard articulated in Gomez.

In Gomez, supra, we explained that, although former OAR 438-07-005(4) expresses the Board's preference for the use of written interrogatories and/or depositions to avoid unnecessary costs and delays in procuring medical expert testimony, that preference does not relieve the Board of its obligation to evaluate the sufficiency and persuasiveness of medical evidence submitted as interrogatories or depositions. We reasoned that, "[w]hether referred to as a 'check-the-box' report or a 'concurrence', the persuasiveness of a medical expert's response depends on the explanation that corresponds to the expert's opinion." Id. We concluded that we would continue to give the most weight to opinions that are well-reasoned and based on complete information and the least weight to conclusory, poorly analyzed opinions. Id.

For the reasons cited by the ALJ, we find the opinions of Drs. Pelmas and Karty unpersuasive. With the exception of claimant's attorney's recitation of claimant's medical and work history, Dr. Pelmas provides no explanation or analysis for her opinion regarding the casual relationship between claimant's right knee condition and her work activities.

ORDER

The ALJ's order dated June 26, 1995 is affirmed.

In the Matter of the Compensation of
JOHN E. FARNES, Claimant
WCB Case No. 93-10384
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's back injury claim; and (2) assessed a penalty for an allegedly unreasonable denial. On review, the issues are compensability and penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that an injurious event at work caused claimant's subsequent disability and need for medical treatment for his back. We disagree.

To prove entitlement to benefits for a compensable injury, claimant must establish, inter alia, that the claimed work incident was a material contributing cause of his back condition or his need for treatment for his back. See ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992). "Material contributing cause" means a substantial cause (but not necessarily the sole cause or even the most significant cause). See Van Blokland v. Oregon Health Sciences University, 87 Or App 694, 698 (1987).

Claimant contends that he strained his back at work on June 8, 1993 while tightening headbolts on a "D8 Cat" with a torque wrench. (Ex. 83). The incident was not witnessed.

We note that, despite accepting claimant's testimony, the ALJ made no express credibility findings based upon claimant's demeanor. Accordingly, we are in as good a position as the ALJ to determine whether claimant is credible, based on an objective evaluation of the substance of claimant's testimony and other inconsistencies in the record. Coastal Farm Supply v. Hultberg, 84 Or App 282, 285 (1987). We proceed with that evaluation.

Claimant has historical and present somatic preoccupation and functional[1] problems manifest as back pain complaints. (Exs. 72-2, 80-5, 89-6, 90-4, 94, 98, 102-31). He admitted to a co-worker that he had faked a prior work injury and testified at this hearing that he had misrepresented facts to another agency regarding work assignments. (Tr. 61, 123-125, 127-130; see Exs. 36, 104). Dr. Verzoza, treating physician, suspected that claimant "is trying to get out of his work with injury" and "that he is using some of this for secondary gain."[2] (Ex. 103-17-20; see Ex. 88-2).

We also note that claimant testified that he was unable to "bend over and use wrenches" between June 14, 1993 and October 1993. (Tr. 69-70). However, a two hour July 3, 1993 surveillance videotape reveals claimant bending under the hood of a car and using tools from a bent back position for considerable periods of time. (Exs. 105, 106).

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[1] "Functional disease" refers to "symptoms or complaints that cannot be supported by objective findings." (Ex. 102-30).

[2] Although Dr. Verzoza believed that claimant did have a "valid injury," she explained: "My feeling is there are a lot of other factors in here. First of all I think he was using his pain to be disabled so that he could get a lighter type of work, or some other kind of job, or maybe go to another employer, so that--because there is also a lot of animosity with the employer." (Ex. 103-18, see Exs. 103-21; 103-47). She observed that claimant is not "motivated at all to go back to work." (Ex. 103-30, see Ex. 103-36-37).

We acknowledge that claimant reported the alleged injury promptly and sought treatment for it equally promptly. We further acknowledge that Dr. Verzoza recorded that claimant had findings consistent with a back strain injury on the day of the alleged work incident. However, considering claimant's prevarication under oath at this hearing, his prior misrepresentations, and his functional and somatic problems, we are not persuaded that claimant injured his back on June 8, 1993 as he claims he did.[3]

Finally, because we have found that the claim is not compensable, there are no "amounts then due" upon which to base a penalty. Accordingly, the ALJ's order is reversed.

ORDER

The ALJ's order dated March 22,1995 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's penalty and attorney fee awards are reversed.

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[3] We further acknowledge the employer's contention that claimant should be subject to the "major contributing cause" standard imposed by ORS 656.005(7)(a)(B). However, we need not determine whether claimant is subject to that standard because the result would be the same.

Board Member Gunn dissenting.

For the following reasons, I disagree with the majority's conclusion that claimant has not proven a compensable injury. The majority concedes that claimant promptly reported and sought treatment for an injury. Moreover, the majority agrees that Dr. Verzoza recorded findings consistent with a back strain injury on the day claimant alleges he was injured. Consequently, the majority's reason for finding this claim not compensable is that claimant has admitted to some prior misconduct.

Here, the employer's theory is that claimant either "staged or faked" an injury. The employer suggests that there is "much evidence" in the record to establish a motive for claimant's faking an injury, such as claimant's prior poor performance and problems with his supervisor. However, although the employer poses an interesting theory, it provides no evidence to back it up. In this case, claimant has proven what is required of him by law.

In dissenting from the majority's decision, I note that, if this were a morality play, rather than a workers' compensation case, claimant would probably lose. However, claimant has proven his case under the statute. Specifically, I would respectfully direct the majority's attention to the report of Dr. Verzoza, who candidly acknowledged and discussed claimant's problems, yet concluded that he did have a work-related injury on this occasion. Based on that opinion, the decision of the ALJ should be affirmed.

In the Matter of the Compensation of
KENNETH E. SMITH, Claimant
WCB Case No. 94-14649
ORDER ON REVIEW
Dale L. Smith, Claimant Attorney
Steven T. Maher (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except we correct the last finding of fact to read: "Claimant's work activity was the major contributing cause of his need to seek treatment and disability."

CONCLUSIONS OF LAW AND OPINION

Finding that a November 1994 work injury was the major contributing cause of claimant's disability and need for treatment, the ALJ set aside the insurer's denial of claimant's low back injury claim. On review, the insurer contends that there is no evidence that claimant fell and injured his low back in the course of his employment with its insured. Moreover, the insurer argues that, even assuming the alleged event occurred, claimant has failed to demonstrate objective findings of injury and failed to establish compensability of his low back condition and need for treatment by the requisite major contributing cause standard.

We adopt the ALJ's reasoning and conclusion that, in November 1994, claimant fell at work, and that this incident caused claimant to seek medical treatment and to lose time from work. In this regard, the ALJ found claimant to be a credible and forthright witness. We defer to the ALJ 's demeanor-based credibility finding. See International Paper Co. v. McElroy, 101 Or App 61 (1990). The question remains, however, whether the work incident resulted in a compensable injury to claimant's low back. For the following reasons, we agree claimant has proved the compensability of his low back injury.

Relying on ORS 656.005(19), the insurer first argues that there are insufficient objective findings to support claimant's claim. That statute provides:

> "'Objective findings' in support of medical evidence are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable." Or Laws 1995, ch 332, § 1 (SB 369, § 1).

We analyzed ORS 656.005(19) in Jairo Garcia, 48 Van Natta 235 (1996). There, after considering legislative history, we found legislative intent to overrule our order in Suzanne Robertson, 43 Van Natta 1505, 1507 (1991), which held that, under former ORS 656.005(19), the claimant could satisfy the statute with medical evidence determining that the claimant suffers from a disability or a physical condition that requires medical services. That determination could be based on purely objective factors, as set out in former ORS 656.005(19), or on the worker's description of the pain he was experiencing, as long as the physician indicated that the worker in fact experienced symptoms and did not merely recite the worker's complaints of pain. Id. See also Georgia-Pacific Corp. v. Ferrer, 114 Or App 471 (1992) (worker established compensable injury supported by objective findings when physicians diagnosed the worker with a cervical dorsal sprain based on their objective evaluations of pain complaints and muscular responses during physical examinations).

Here, we agree with the insurer that Dr. Brown, who initially treated claimant, indicated that claimant had no objective findings of a low back injury. Specifically, Dr. Brown found "no ecchymosis, abrasion or swelling * * *, no definite tenderness" and stated that claimant exhibited "normal gait, is able to walk on heels and toes, perform unassisted painless full deep knee bends, sit without evidence of discomfort, assume supine position without difficulty and arise to sitting position likewise without difficulty or obvious discomfort." (Ex. 4-1). A subsequent x-ray also revealed no abnormalities. (Id.)

Dr. Achari treated claimant a short time later. Dr. Achari found limited movement of the lumbar spine and limited straight leg raising, and diagnosed a lumbosacral strain. (Ex. 6-3). Examining neurologist Dr. Isaacs recorded similar limitations, including restricted straight leg raising, and concurred with Dr. Achari's diagnosis. (Ex. 9A-10).

We conclude that the limited range of motion findings reported by Drs. Achari and Isaacs are "verifiable indications of injury" and "measurable." See Jairo Garcia, supra. Furthermore, we agree with, and adopt the ALJ's reasoning and conclusion, that the more thorough examinations by Dr. Achari and Dr. Isaacs entitle their opinions to greater weight than that of Dr. Brown. Consequently, we conclude that claimant satisfied ORS 656.005(19).

We now turn to the insurer's contention that claimant did not establish that the work injury was the major contributing cause of his low back disability and need for treatment. The parties do not dispute that claimant has preexisting conditions or that claimant's treatment was directed to a combined

condition. Therefore, claimant must establish the compensability of the lumbar injury claim by the "major contributing cause" standard applicable to "combined" conditions under ORS 656.005(7)(a)(B).[1] Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), mod 120 Or App 590, 594, rev den 318 Or 27 (1993). The relative contribution of each cause of claimant's condition, including the precipitating cause, must be evaluated to establish which is the primary cause. See Dietz v. Ramuda, 130 Or App 397, 401-02 (1994), rev allowed 320 Or 492 (1995).

Given the multiple potential causes for claimant's lumbar condition, we find that the application of the "major contributing cause" standard to the facts of this case presents a complex medical question which must be resolved on the basis of expert medical evidence. See Uris v. Compensation Dept., 247 Or 420, 426 (1967); Barnett v. SAIF, 122 Or App 281 (1993). The medical evidence in this case is divided between Drs. Issacs and Achari, who support compensability, and Dr. Brown, who does not. After evaluating the opposing medical opinions, we are more persuaded by that of Dr. Isaacs.

On November 4, 1994 (after a fall at work the previous day), claimant sought treatment from Dr. Brown for low back pain. At hearing, Dr. Brown testified that, because claimant had no "injury," the major contributing cause of his disability and need for treatment was the preexisting degenerative condition. As we have found herein, claimant sustained an injury on November 3, 1994. Inasmuch as Dr. Brown failed to consider the contribution of claimant's work injury to the combined low back condition, we accord his opinion little weight. See Dietz v. Ramuda, supra; Somers v. SAIF, 77 Or App 259 (1986).

When his low back pain did not subside, on November 8, 1994, claimant sought treatment from Dr. Achari. Dr. Achari diagnosed and treated claimant for a lumbosacral strain. Dr. Achari opined, without explanation, that although claimant has preexisting lumbar degenerative disc disease, the "reason for his medical care was due to the injury he sustained on 11-3-94." While we do not accord Dr. Achari's unexplained opinion much weight, see Allie v. SAIF, 79 Or App 284, 288 (1986), we find it supports Dr. Isaacs' well-reasoned opinion.

At the insurer's request, Dr. Isaacs examined claimant on February 7, 1995. Dr. Isaacs performed a thorough examination, reviewed claimant's records and imaging studies and prepared a thorough and comprehensive report. Dr. Isaacs concluded that claimant's preexisting conditions, along with the work injury, combined to cause claimant's disability and need for treatment. Dr. Isaacs explained that none of the preexisting conditions was the major cause of the disability or need for treatment. Rather, he explained, the November 1994 fall resulted in claimant's pain, disability and need for treatment. We find Dr. Isaacs' opinion persuasive.

Accordingly, claimant established that the November 1994 fall was the major contributing cause of his disability and need for treatment in November 1994. See ORS 656.005(7)(a)(B); Tektronix, Inc. v. Nazari, supra. We therefore affirm the ALJ's order setting aside the insurer's denial, insofar as it pertained to claimant's injury claim.

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

ORDER

The ALJ's order dated March 21, 1995 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

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[1] After the ALJ's order issued, the legislature amended ORS 656.005(7)(a)(B). Or Laws 1995, ch 332, § 1. Both amended and former ORS 656.005(7)(a)(B) contain the "major contributing cause" standard of compensability. Consequently, the outcome in this case is the same under either version.

In the Matter of the Compensation of
LEWIS H. TITUS, Claimant
WCB Case Nos. 94-09737 & 94-07998 & 94-06921
ORDER ON REVIEW
Brothers, et al, Claimant Attorneys
Bonnie Laux (Saif), Defense Attorney
David Horne, Defense Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer (Willamette Industries, Inc.) requests review of those portions of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its denial of claimant's low back condition; and (2) upheld the SAIF Corporation's and Employers Insurance of Wausau's denials of the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. Claimant suffered a compensable low back injury in March 1980, while working for Pope & Talbot, SAIF's insured. The claim was closed without an award of permanent disability. Between 1980 and 1987, claimant had occasional intermittent minor symptoms that did not require medical attention.

In March 1987, claimant underwent a preemployment physical examination for Willamette Industries, Inc. (Willamette). The examiner reported that claimant had a history of back strain in 1979, but had experienced no recurrence since that time.

Claimant sustained a second compensable low back injury on February 15, 1989, while working for Willamette. A lumbar CT scan showed a mild central disk protrusion at L5-S1. (Ex. 18). The claim was closed without a permanent disability award. Claimant testified that, after the 1989 injury, he had symptoms most of the time, although the level of symptoms varied. (Tr. 16).

In February 1992, claimant began working for Pacific Gas and Transmission, Wausau's insured, as a mechanic's apprentice. Claimant's job was not physically demanding.

Claimant's current low back condition arose in early 1994, when he suffered an exacerbation of low back pain. On January 25, 1994, Dr. Boggess reported that claimant had low back pain with radicular discomfort into the right buttocks. (Ex. 25). An MRI scan showed a large disc rupture at L5-S1. (Exs. 27, 28). On February 16, 1994, Dr. Kendrick performed a microlumbar discectomy at L5-S1.

At hearing, the parties stipulated that claimant's herniated disc condition was compensable. The ALJ applied ORS 656.308(1) and found that Willamette was responsible for claimant's condition since it was the employer with the last accepted claim.

Willamette argues that claimant's current herniated disc condition is not the "same condition" which it accepted in 1989. Therefore, according to Willamette, ORS 656.308 does not apply to this case. Instead, Willamette asserts that the case should be analyzed under the last injurious exposure rule.

ORS 656.308(1) provides, in part: "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition."[1] To establish a new injury, claimant's employment activity in early 1994 must have been the major contributing cause of claimant's disability or need for medical treatment. ORS 656.308(1); SAIF v. Drews, 318 Or 1 (1993). However, ORS 656.308 applies only if claimant's current condition is the "same condition" as that previously accepted by SAIF in 1980 or by Willamette in 1989. Smurfit Newsprint v. DeRosset, 118 Or App 371-72, on remand Armand J. DeRosset, 45 Van Natta 1058 (1993).

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[1] We note that ORS 656.308(1) was amended by the 1995 Legislature. Or Laws 1995, ch 332, § 37 (SB 369, § 37). However, the amended version of the statute would not change our analysis or result in this case.

In 1980, Dr. Golden diagnosed an acute lumbosacral strain. Although Dr. Golden initially thought there could have been a disc herniation, he subsequently reported that a lumbar myelogram was "completely normal." (Exs. 7, 8). Claimant's 1989 injury involved a mild central disk protrusion at L5-S1, although Dr. Kendrick testified that there was no evidence from the 1989 CT scan that claimant had a herniated or ruptured disk. (Exs. 18, 48-9). In 1994, however, claimant sustained a large disc rupture at L5-S1. (Ex. 27). Since the 1980 and the 1989 injuries did not involve a herniated disc, they did not involve the same condition that claimant suffered from in 1994. Therefore, ORS 656.308(1) does not apply.

Because ORS 656.308(1) is not applicable, we would ordinarily turn to the "last injury" rule to determine responsibility. See Donald M. Hughes, 46 Van Natta 2281 (1994). However, where actual causation with respect to a specific identifiable employer is established, it is unnecessary to rely on judicially created rules of assignment pertaining to successive or concurrent employments to determine responsibility. See Runft v. SAIF, 303 Or 493, 502 (1987); Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-45 (1984); Eva R. Billings, 45 Van Natta 2142 (1993).

Here, claimant argues that he has established medical causation and responsibility with Willamette. Based on a review of the medical evidence, we conclude that application of the "last injury" rule is unnecessary because we are persuaded that the 1989 injury is the major contributing cause of claimant's herniated disc condition.

Dr. Kendrick treated claimant for the 1989 injury and also treated claimant in early 1994 for recurrent radicular back pain. On February 4, 1994, Dr. Kendrick commented on claimant's 1989 industrial injury and reported that claimant had "original improvement with episodic problems ever since and now simply the same symptoms (only at a greater level) confirmed with a disc rupture." (Ex. 28). Dr. Kendrick believed that claimant's symptoms were related to the industrial injury. (Id.)

In a June 19, 1994 report, Dr. Kendrick agreed with a report from Drs. Bald and Bobker, which said that claimant's current condition dated back to his original injury in 1980. (Exs. 33, 39). Drs. Bald and Bobker concluded that the major contributing cause of claimant's current condition was the 1980 injury with SAIF's insured. (Ex. 33). After reviewing the report from Drs. Bald and Bobker, Dr. Kendrick reported that the 1980 injury "set the stage which gradually developed over a period of time into the frank rupture." (Ex. 39). Dr. Kendrick believed that the 1989 injury was a "relatively minor episode" and was a lesser contribution. (Id.)

On November 3, 1994, Dr. Kendrick reviewed his records and talked to claimant in detail about his history. (Ex. 47). Claimant told Dr. Kendrick that he had very infrequent problems from 1980 until 1989. However, after the 1989 injury, claimant had problems on "a very more often-than-not basis from 1989 until the time of his surgery." (Id.) Claimant told Dr. Kendrick that his symptoms from 1989 until 1994 were identical, changing only in matter of degree. Dr. Kendrick explained:

> "Based on that history, it would seem reasonable to me that he had perhaps, but not definitely, some injury to his 5-1 disc in 1980 and that he pretty clearly had injury to his 5-1 disc in 1989, at least to a high degree of medical probability. It was the gradual worsening of that, attributable to that injury of 1989, which lead (sic) to his surgery in 1994." (Id.)

In a deposition, Dr. Kendrick adhered to that opinion. (Ex. 48-18). Dr. Kendrick was asked about his earlier opinion on June 19, 1994, in which he had commented that the 1989 episode was a relatively minor episode. Dr. Kendrick testified that he had had a lengthy conversation with claimant to clarify some of his history. (Ex. 48-19). Dr. Kendrick explained that claimant's history after the 1980 and the 1989 injuries was crucial:

> "And the history as obtained, partly from the record, partly from the patient, seemed to be consistent to me with the fact that he was having initial problems after the 1980 injuries, that they gradually settled down or settled down at some point; and then when he recovered from that injury, that he went a number of years with very little problems with his low back prior to the 1989 injury.

> "And it was really that fact coupled with the fact that the patient was very clear in giving me the history that following 1989 he, as he put it had, quote, nothing but trouble, closed quotes, with repetitive episodes five or six times a year, significant problems with his back and so forth. Putting those two facts together allowed me to change my opinion." (Exs. 48-19, 48-20).

Dr. White agreed that claimant's 1989 injury should bear the responsibility for claimant's current condition and need for treatment and he believed that claimant had suffered a disc herniation in 1989. (Ex. 45).

On the other hand, Dr. Golden, who treated claimant for the 1980 injury, reported that neither the 1980 nor the 1989 injury was the major contributing cause of claimant's current condition. (Exs. 44, 46). Dr. Golden believed that "some other much later incident" was more causally related. (Ex. 44). According to Dr. Golden, since the studies in 1989 did not show a herniation, that information "minimized any connection" between the 1989 injury and the 1994 disc condition. (Ex. 46).

We are not persuaded by Dr. Golden's opinion since he did not describe the later incident that caused claimant's herniated disc, nor did he discuss whether it was work-related. Furthermore, Dr. Golden did not discuss the effect of the mild central disk protrusion at L5-S1 in 1989. Although Dr. Kendrick agreed that the 1989 CT scan did not show a herniated or ruptured disk, the 1989 CT scan did show that claimant had a mild central disk protrusion at L5-S1. (Exs. 18, 48-9).

Drs. Arbeene and Wilson concluded that claimant's disc herniation resulted from the natural progression of degenerative disc disease. (Ex. 41). However, the other physicians found no evidence of preexisting degenerative disc disease. Dr. Golden, who treated claimant's 1980 back injury, reported that there was no evidence of significant disk disease in 1980. (Ex. 44). Dr. Kendrick testified that there was very little or no significant degenerative disk disease in 1989. (Exs. 48-10, 48-11). In addition, Drs. Bald and Bobker were not able to identify any preexisting degenerative problem that was progressive in nature. (Ex. 33). In light of these contradictory opinions, particularly those of claimant's treating physicians, we are not persuaded that claimant's current condition was caused by degenerative disc disease.

Drs. Bald and Bobker reported that claimant's current condition dated back to his original injury in 1980. (Ex. 33). They acknowledged that the 1989 injury and the disc protrusion might have contributed to his symptoms, but they concluded that the major contributing cause of claimant's current condition was the 1980 injury. (Id.)

Generally, we tend to give greater weight to the claimant's treating physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Here, there are no persuasive reasons not to defer to Dr. Kendrick's revised opinion and deposition testimony. Dr. Kendrick's understanding of claimant's history was consistent with claimant's testimony at hearing. Furthermore, Dr. Kendrick provided a reasonable explanation for his change of opinion. Since Dr. Kendrick treated claimant in 1989 and 1994 and performed low back surgery on claimant in 1994, Dr. Kendrick had a better opportunity to evaluate claimant's condition than the other physicians who had only examined claimant on a very limited basis. We are persuaded by Dr. Kendrick's reports, as supported by that of Dr. White, that claimant's 1989 injury at Willamette was the major contributing cause of his current herniated disc condition. Consequently, we conclude the ALJ properly assigned responsibility for claimant's current condition to Willamette.

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

ORDER

The ALJ's order dated August 10, 1995 is affirmed. For services on review, claimant's counsel is awarded $1,000, payable by Willamette Industries, Inc.

In the Matter of the Compensation of
STEVEN D. WINDSOR, Claimant
WCB Case Nos. 95-03437 & 95-03436
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) upheld the SAIF Corporation's denial, on behalf of C.K. Claggett Contractor, Inc., of claimant's cervical condition; and (2) found that claimant did not timely appeal SAIF's denial, on behalf of Clackamas Community College, for a thoracic condition. Claimant also asserts that SAIF, on behalf of Clackamas Community College, "de facto" denied the cervical condition. On review, the issues are timeliness and compensability.

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

On review, claimant objects to the ALJ's conclusion that he did not timely appeal from SAIF's December 5, 1994 denial, issued on behalf of Clackamas Community College. Claimant further contends that, even if he is prohibited from challenging that denial, he may litigate whether SAIF, on behalf of Clackamas Community College, is liable for the cervical condition on the theory that SAIF "de facto" denied the condition.

As indicated above, we agree with and adopt the ALJ's analysis and conclusion regarding the timeliness issue. Moreover, even assuming that claimant is correct concerning a "de facto" denial, there is no evidence that the injury at Clackamas Community College caused the cervical condition. Thus, we conclude that, on the merits, claimant could not prevail on the theory of a "de facto" denial.

Claimant personally submitted various documents to the Board, including claimant's responses to comments by SAIF's attorney during closing argument, post-hearing correspondence to and from SAIF, and claimant's comments concerning a medical report admitted at hearing. Claimant seeks remand of the case to the ALJ for review of the briefs and additional materials submitted on review. In addition, claimant, through his attorney, submitted an additional post-hearing report from his former treating orthopedic surgeon, Dr. Mandiberg.

Because we lack authority to consider evidence that is not part of the record developed at hearing, we treat claimant's submission of additional documentary evidence as a motion to remand to the ALJ for admission of the documents. Under ORS 656.295(5), the Board may remand to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. Bailey v. SAIF, 296 Or 41, 45 n 3 (1985). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

We find that some of the documents submitted by claimant, such as copies of medical publications and pre-hearing medical records, existed at the time of the hearing. Thus, the documents were obtainable at the time of hearing or admitted into the record. Hence, we find no compelling reason to remand for admission of these documents.

The post-hearing reports consist of a September 8, 1995 letter from a SAIF claims adjuster to the Department; a September 14, 1995 Corrected Notice of Acceptance from SAIF; a December 7, 1995 Order of Dismissal; and a January 11, 1996 medical report from Dr. Mandiberg. None of the documents contain information concerning the central issues in this case--the timeliness of claimant's request for hearing concerning the thoracic condition and the compensability of claimant's cervical condition. To the contrary, Dr. Mandiberg's report reiterates his opinion that the cervical condition was caused by a nonwork-related motor vehicle accident.

Consequently, we conclude that admission of the documents would not change our conclusions that claimant did not timely request a hearing from the denial of the thoracic condition nor proved the compensability of his cervical condition. Thus, admission of the materials would not affect the outcome of the case and there also is no compelling reason to remand for admission of this evidence.

ORDER

The ALJ's order dated August 2, 1995 is affirmed.

March 20, 1996 Cite as 48 Van Natta 579 (1996)

In the Matter of the Compensation of
SYLVIA ARANDA, Claimant
WCB Case No. 94-03093
ORDER ON REVIEW
James L. Francesconi, Claimant Attorney
Carrol J. Smith (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Crumme's order which awarded temporary partial disability (TPD). On review, the issue is temporary disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings with the following corrections.

Following claimant's September 1989 compensable low back condition, claimant returned to work on June 24, 1991 for four hours a day. After three days, claimant was taken off work for a week. She returned to work sorting fruit and performing clean-up duties. Claimant continued to work until she was laid off in September 1991.

CONCLUSIONS OF LAW AND OPINION

Claimant's accepted cervical claim was closed by a September 13, 1994 Determination Order (DO), which awarded TPD from October 18, 1991 through April 13, 1994 and awarded 5 percent unscheduled permanent disability. A November 15, 1994 Order on Reconsideration modified the DO to award no temporary disability. Claimant requested a hearing seeking TPD from October 18, 1991 through March 2, 1994.

The ALJ found that claimant had returned to full-time work on July 22, 1991. The ALJ further found that claimant was partially disabled, due to her accepted cervical condition, based on Dr. Nash's August 27, 1991 release and had remained partially disabled through February 1994. Reasoning that claimant was entitled to temporary disability only for a two year period, under ORS 656.212, the ALJ awarded TPD from October 18, 1991[1] through October 17, 1993.

Since the claim is closed, the issue is claimant's substantive entitlement to temporary disability. Therefore, claimant must show, based on a preponderance of the evidence, that she was at least partially disabled due to the compensable cervical condition. See SAIF v. Taylor, 126 Or App 658 (1994).

Claimant contends that as a result of her cervical condition she was released to modified work, and therefore, is entitled to TPD. We agree.

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[1] SAIF issued a formal acceptance of the cervical claim as an occupational disease and indicated the date of injury as October 18, 1991.

On May 6, 1991, Dr. Nash, claimant's then treating physician, declared claimant's low back condition medically stationary. He released claimant to light-sedentary work for four hours a day for four weeks, then to full-time. Claimant was also restricted from standing more than 30 minutes, lifting over 15 pounds, lifting from the floor, climbing, and repetitive crawling.

Claimant returned to work on June 24, 1991 for four hours a day. After three days, claimant was taken off work for a week. She returned to work, four hours a day, sorting fruit at a conveyor belt and also performing clean-up duties. On July 19, 1991, Dr. Berkeley examined claimant for complaints of low backache, interscapular pain, bilateral leg pain, neck pain, and right arm pain. He noted that claimant had been working for the past three weeks, four hours a day. Dr. Berkeley recommended that claimant avoid production line work.

Based on the above, we find that claimant was performing work four hours a day at the time she sought treatment, on July 19, 1991, for her cervical condition. We find Dr. Berkeley's restriction to avoid production line work was the first medical verification of claimant's inability to work due to the cervical condition. See ORS 656.210(2)(b)(B).

Claimant's inability to perform the production line work establishes that claimant was, at least partially, disabled due to her cervical condition. Moreover, Dr. Nash, on August 27, 1991, released claimant to light work with lifting restrictions of no more than 12 pounds and extended the four hours per day limitation another six to eight weeks. Because claimant was restricted and returned to modified work, although at her at-injury wage, she was temporarily and partially disabled as of July 19, 1991.[2] However, since claimant seeks TPD beginning October 18, 1991, we will not address her entitlement to TPD prior to that date. Claimant is only entitled to TPD for a period of two years under amended ORS 656.212(2). Claimant, therefore, is entitled to TPD from October 18, 1991 through October 17, 1993.[3] However, we note that claimant's rate may well be zero once her TPD is calculated under amended ORS 656.212(2). See also Lonnie L. Dysinger, 47 Van Natta 2282 (1995) (amended ORS 656.212 overruled the court's holding in Stone v. Whittier Wood Products, 124 Or App 117 (1993)).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $900, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 8, 1995 is affirmed. For services on Board review, claimant's attorney is awarded a $900 attorney fee, payable by the SAIF Corporation.

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[2] Claimant's temporary disability benefits for her cervical claim are based on her wage at the time there was medical verification of inability to work. ORS 656.210(2)(b)(B); John McConnell, 45 Van Natta 1197 (1993) (for a worker who incurs an occupational disease, TTD benefits are based on the wage of the worker at the time of medically verified disability). As discussed above, Dr. Berkeley's July 19, 1991 release to work was medical verification of claimant's disability. At the time, claimant's wage was $5.20 per hour.

[3] In reaching this conclusion, we do not address the issue of claimant's entitlement to temporary disability benefits that may arise from her pending aggravation claim for the low back condition.

In the Matter of the Compensation of
WILLIAM B. FORD, Claimant
WCB Case Nos. 95-00726 & 95-00663
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the insurer's denial of claimant's cervical and thoracic injury claim. On review, the issue is whether claimant's motor vehicle accident arose out of and occurred in the course of his employment. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant is employed as a service technician for the insured's soft drink bottling company. Claimant spends a significant portion of his time in the field, servicing the employer's customers. When he is dispatched to a customer's location to deliver product or to install or repair the company's equipment, claimant drives a company van. Claimant is sometimes dispatched directly from his home to a customer's location. Some days, claimant works at a customer's location without ever going into the employer's plant. Claimant is sometimes assigned to call on customers after leaving the plant while enroute home.

Due to a shortage of parking space inside its locked premises, the employer encourages the service technicians to drive the company vans home at night and back to work in the morning. Service technicians are forbidden to use the vans for any personal use. The employer pays all expenses associated with the use of the company vans by the service technicians. Vans not taken home by the service technicians generally have to be parked on the street, where several have been vandalized. The company disciplines employees for unsafe conduct while in a company vehicle which results in a motor vehicle accident (MVA), even where the employee is commuting to work and has not yet checked in at the company's premises to begin the work day or where the employee has left work for the day and is enroute home.[1]

On October 21, 1994, claimant left his home in the company van at about 6:30 A.M.. On the way to the employer's plant, another car hit claimant's van from behind, injuring claimant. The ALJ found that, at the time of the accident, claimant was simply driving himself to work and was not particularly "subject" to any employer regulations. The ALJ further found that the employer's "interest" in claimant's conduct while driving a company vehicle was insufficient to bring his injury within an exception to the "going and coming" rule. Reasoning that his activity at the time of the MVA did not arise out of and in the course of claimant's employment, the ALJ upheld the insurer's denial.

Claimant argues that because the employer furnished the vehicle, encouraged claimant to drive its van going and coming to work (thereby deriving the benefit of having the van off the streets), and exercised control over claimant while he drove its van, claimant was within the course and scope of his employment when he was injured. We agree.

In First Interstate Bank of Oregon v. Clark, 133 Or App 712, rev den 321 Or 429 (1995), the court reiterated that the legal framework for determining whether an injury "arose out of" and "in the course of " employment included two prongs: (1) whether the injury occurred in the course of employment (considering time, place and circumstances); and (2) whether a causal connection existed between the injury and the employment. Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994).

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[1] In 1992, claimant was suspended from work for a week without pay after he was found to be at fault in an accident in a company van while returning home.

Generally, injuries sustained while going to or coming from work are not compensable. SAIF v. Reel, 303 Or 210 (1987). However, where travel is a necessary incident of the employment, risks incidental to travel are covered by workers' compensation law even though the employee may not be working at the time of injury. Proctor v. SAIF, 123 Or App 326, 329 (1993); see SAIF v. Reel, supra at 216 ("[W]hen the travel is essentially part of the employment, the risk remains an incident to the employment even though the employee may not actually be working at the time of the injury").

In this case, claimant spends a major portion of his work time "in the field"; i.e., at locations other than the employer's bottling plant. He is regularly dispatched to customers' locations to deliver product or to install or repair the company's equipment. The employer provided claimant with a company van, which it encouraged claimant to drive home at night and back to work in the morning. Thus, because travel was a necessary incident of claimant's employment, we conclude that claimant was a "traveling employee" at the time of his injury. See Elva McBride, 46 Van Natta 282 (1994), aff'd Savin Corp. v. McBride, 134 Or App 321 (1995); PP&L v. Jacobson, 121 Or App 260 (1993) (Where claimant's job necessitated travel on a daily basis, claimant was a "traveling employee").

Even if claimant were not a traveling employee, the employer maintained control over claimant while he drove its van and derived a benefit from having its van parked off the streets, We would find these circumstances sufficient to bring claimant (while going to and from work) within the course and scope of his employment.

Considering claimant's status as a traveling employee and the employer's course of conduct in providing vans (for claimant and the other service technicians), we conclude that claimant's injury is compensable. See ORS 656.005(7)(a). Accordingly, we reverse the ALJ's decision and set aside the insurer's denial of claimant's cervical and thoracic injury claim.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review in prevailing over the insurer's denial. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $4,000, 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 and statement of services), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel may go uncompensated.

ORDER

The ALJ's order dated May 16, 1995 is reversed. The insurer's denial is set aside and the claim is remanded for processing according to law. For services at hearing and on review, claimant is awarded a $4,000 attorney fee, payable by the insurer.

March 20, 1996 Cite as 48 Van Natta 582 (1996)

In the Matter of the Compensation of
DONALD P. JAMES, Claimant
WCB Case Nos. 95-02921 & 94-09030
ORDER OF ABATEMENT
Patrick K. Mackin, Claimant Attorney
Robert Yanity (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

The SAIF Corporation requests reconsideration of that portion of our February 22, 1996 Order on Review which: (1) held that we had jurisdiction to consider the parties' medical services dispute; and (2) set aside SAIF's denial of claimant's medical services claim. Specifically, SAIF contends that, pursuant to amended ORS 656.245(1), the Director has sole jurisdiction over this matter, and alternatively, even if the Board does have jurisdiction, claimant has not established an entitlement to medical services.

In order to further consider this matter and to give claimant an opportunity to respond, we withdraw our February 22, 1996 order. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM A. KENDALL, Claimant
WCB Case No. 95-06557
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that affirmed an Order on Reconsideration that awarded no permanent disability. On review, the issues are unscheduled and scheduled permanent disability.

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

Before conducting a reevaluation of the extent of a claimant's permanent disability following closure of an aggravation claim, the claimant must establish a permanent worsening of his compensable condition since the last award or arrangement of compensation. Stepp v. SAIF, 304 Or 375 (1987); OAR 436-35-005(9) and OAR 436-35-007(5). A worker has permanently worsened when the loss of use or function for scheduled claims is greater than previously awarded.

Here, claimant's compensable neck injury claim was closed by an April 13, 1994 Notice of Closure (NOC) that awarded 12 percent unscheduled permanent disability and no scheduled permanent disability. Claimant requested reconsideration and, prior to reconsideration, he experienced an aggravation of his neck condition that resulted in a second surgery. An Order on Reconsideration issued December 8, 1994, which affirmed the April 13, 1994 NOC in all respects.

On January 3, 1995, a NOC issued closing the claim after the aggravation. The NOC found that claimant's loss of earning capacity had not increased since the last closure, and, therefore, extent of disability was not redetermined. Claimant requested reconsideration and an arbiter panel was appointed. A May 17, 1995 Order on Reconsideration increased claimant's total award to 17 percent unscheduled permanent disability; a May 26, 1995 Amended Order on Reconsideration then set aside the increase and affirmed the January 3, 1995 NOC in all respects. Claimant requested a hearing raising the issues of unscheduled and scheduled permanent disability.

In concluding that claimant was not entitled to a reevaluation of the extent of his permanent disability following the closure of his aggravation claim, the ALJ only addressed claimant's request for an award of unscheduled permanent disability. On review, claimant contends that he is entitled to an award of scheduled permanent disability based on a chronic condition that limits repetitive activity of his upper extremities. The SAIF Corporation makes two assertions: that claimant has not established that he has a chronic condition in either arm that would warrant an award; and, alternatively, that there is no medical evidence that claimant suffers a chronic condition of his arms due to the compensable cervical condition.

To be entitled to permanent disability compensation for a scheduled chronic condition impairment, there must be medical evidence of at least a partial loss of ability to repetitively use the body part. Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995); Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993).

Here, we find no persuasive medical evidence of a partial loss of claimant's ability to repetitively use both arms. The arbiters noted that, prior to his surgeries, claimant had "significant right arm pain and numbness and tingling in his second through fifth digits." (Ex. 15-2). They continued, "[Claimant] now basically only has some wrist pain when he uses the arm to much (sic)." Id. They also stated that "[Claimant] is mildly limited in his ability to repetitively use his upper extremities. His job has been so modified." (Ex. 15-5). The arbiters identified no condition affecting claimant's arms and gave no explanation as to why claimant was to limit the use of both arms, particularly when symptoms had appeared in only one arm prior to the neck surgery.

Moreover, there is no other medical report in the record regarding any bilateral arm complaints. The medical evidence supports no more than an inference that the limitation may prevent an increase in symptoms. Thus, claimant has failed to establish that he has suffered a partial loss of ability to use both arms. See James R. Dryden, 47 Van Natta 1328 (1995) (statement that repetitive use of the upper extremities would exacerbate bilateral arm conditions does not establish a partial loss of ability to repetitively use the left arm); David A. Kamp, 46 Van Natta 389, 390 (1994) (limitations imposed to avoid reinjury insufficient to establish a chronic condition); Rae Holzapfel, 45 Van Natta 1748, 1749 (1993) (recommendation that the claimant avoid repetitive strenuous work with her hands in order to prevent an increase in symptoms insufficient to establish a permanent and chronic impairment of the wrists).

Because claimant has not established that he is entitled to a scheduled permanent disability award for his arms following closure of his aggravation claim, he has not established a permanent worsening of his compensable condition and, hence, is not entitled to a reevaluation of the extent of his permanent disability award. Since claimant has not established a partial loss of his ability to repetitively use both arms, we need not address SAIF's alternative argument.

ORDER

The ALJ's order dated September 12, 1995 is affirmed.

March 20, 1996 Cite as 48 Van Natta 584 (1996)

In the Matter of the Compensation of
DEANNA L. KLOCK, Claimant
WCB Case No. 95-04841
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order which reduced claimant's unscheduled permanent disability award for a low back condition from 5 percent (16 degrees), as granted by an Order on Reconsideration, to zero. On review, the issue is extent of unscheduled permanent disability.

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

The ALJ determined that claimant was not entitled to any values for age, education and adaptability because she had been released to and had returned to her regular work. The ALJ made that determination based on ALJ Baker's prior factual finding that claimant had been released to and had returned to her regular work. Because that factual finding had been necessary to a determination in the prior case, before ALJ Baker, the ALJ in this proceeding concluded that claimant was precluded from relitigating that issue in the present case.

Claimant requested review of ALJ Baker's order. On review, we reversed ALJ Baker's order, finding that claimant's then-attending physician, Dr. Scoltock, had not released her to regular work as of January 4, 1994. Deanna L. Klock, 47 Van Natta 2229 (1995). However, our finding on review that claimant was not released to regular work does not affect the outcome in this case.

The ALJ here found, and we agree, that the preponderance of medical evidence fails to establish that claimant has any permanent impairment as a result of the accepted injury. Since claimant has failed to establish any impairment, she is not entitled to an unscheduled permanent disability award. ORS 656.726(3)(f)(A); OAR 436-35-270(2), 436-35-280(1) (WCD Admin. Order 93-056).

ORDER

The ALJ's order dated July 24, 1995 is affirmed.

In the Matter of the Compensation of
GEORGE A. McGEE, Claimant
WCB Case No. 94-12504
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order which upheld the insurer's denial of claimant's injury claims for a right wrist sprain and low back condition. On review, the issue is compensability.

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

In upholding the insurer's denial, the ALJ determined that the medical evidence failed to prove that claimant sustained an injury to either his wrist or back. On review, claimant contends that medical and lay evidence persuasively establish that his wrist and back problems were the result of an industrial accident. Because the preponderance of the persuasive medical evidence (regardless of whether there were objective findings in the record) supports a finding that claimant did not sustain a compensable injury, we disagree.

Claimant asserts that his injuries are directly related to a work accident. Under such an injury theory, claimant must establish, by medical evidence supported by objective findings, that his work activities were a material contributing cause of his disability or need for medical treatment. ORS 656.005(7)(a). See Albany General Hospital v. Gasperino, 113 Or App 670 (1992); Mark N. Wiedle, 43 Van Natta 855 (1991).

The question presented is a medical one. Accordingly, claimant's lay testimony is "probative but not dispositive." See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980). The resolution of the issue largely turns on an analysis of the medical evidence. Uris v. Compensation Department, 247 Or 240, 426 (1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). We generally defer to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). Finally, we rely on those expert medical opinions which are well-reasoned and based on accurate and complete histories. See Somers v. SAIF, 77 Or App 259 (1986).

Here, we find no persuasive reasons to discount the opinion of claimant's treating physician, Dr. Bald. Concurring with the insurer, Dr. Bald agreed that his diagnosis of claimant's wrist sprain and mid-lumbar strain were made on the basis of claimant's subjective complaints. Questioning the severity of claimant's condition, Dr. Bald conducted a "reliability" test to determine the extent or existence of an actual injury. Claimant failed this test. As such, Dr. Bald agreed with the insurer that he could not rely on claimant's subjective complaints as an accurate indicator of the existence of an injury to claimant's wrist and back. In light of such circumstances, we conclude that Dr. Bald was unable to relate claimant's symptoms to his work activities.

Additionally, we find Dr. Goluban's opinion persuasive. Dr. Goluban, an emergency room physician (who examined claimant shortly after the alleged accident) was unable to verify within reasonable medical probability that claimant actually sustained an injury to his wrist. Consequently, the persuasive opinions of Drs. Bald and Goluban support a finding that claimant did not sustain a compensable injury to his wrist or back.

Conversely, we decline to rely on the opinions of Drs. Stein, emergency room physician, and the medical examiners. First, we find the medical opinion of Dr. Stein inconsistent and conclusory and therefore, not persuasive. Dr. Stein agreed that there were no objective signs of injury to claimant's wrist. Further, Dr. Stein agreed that he questioned the severity/existence of claimant's wrist and back injuries. However, without explanation, Dr. Stein agreed that claimant actually sustained an injury to his wrist and back. We find Dr. Stein's opinion unpersuasive because he failed to explain why he questioned the severity/existence of claimant's injuries in one instance and then (within medical probability) agreed that claimant actually sustained an injury to his wrist and back. See Moe v. Ceiling Systems, supra.

In conclusion, finding no persuasive reason against deferring to the attending physician's opinion, we rely on the conclusions reached by Dr. Bald (as supported by Dr. Goluban). See Weiland v. SAIF, supra. Accordingly, we conclude that claimant has failed to prove that his work accident was a materially contributing cause of his right wrist and back condition. Consequently, the insurer's denial is upheld.

ORDER

The ALJ's order dated May 3, 1995 is affirmed.

March 20, 1996 Cite as 48 Van Natta 586 (1996)

In the Matter of the Compensation of
MARTIN MENDOZA, Claimant
WCB Case No. 95-05181
ORDER ON REVIEW
Max Rae, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that: (1) upheld the insurer's denial of claimant's low back injury claim; and (2) declined to assess a penalty and attorney fee for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant lifted and carried heavy rolls of upholstery material at work on December 22, 1994; he felt no pain at that time. The next day, claimant experienced low back pain and was unable to bend over. Claimant returned to work on December 27, 1994. Thereafter, claimant continued to experience low back pain.

Claimant first sought treatment on December 28, 1994. Claimant began treating with chiropractic physician Webb on January 17, 1995. On February 7, 1995, claimant changed attending physicians to D. Mitchell, M.D. Dr. Mitchell diagnosed lumbar strain, and referred claimant back to Dr. Webb for continued chiropractic care.

Dr. Webb diagnosed right sacroiliac sprain with subluxation complex and lumbalgia. Based on the mechanism of claimant's injury, Dr. Webb concluded that "[t]he December 22, 1994 injury is the major contributing cause of [claimant]'s need for treatment." (Ex. 9).

Finding that Dr. Webb neither identified a specific injurious event on December 22, 1994 nor explained how claimant's condition on December 23, 1994 was related to work activity on December 22, 1994, the ALJ found unpersuasive the doctor's opinion that claimant's need for treatment is due in major part to the December 22, 1994 "injury." We disagree.

An injury need not be instantaneous. LP Company v. Disdero Structural, 118 Or App 36 (1993). Rather, a condition which develops over a brief period of time may be an "injury." See Valtinson v. SAIF, 56 Or App 184, 187 (1982). Therefore, unlike the ALJ, we are not troubled by Dr. Webb attributing claimant's low back condition to a work injury, absent a discrete injurious event.

On this record, we find Dr. Webb's opinion sufficient to establish a material connection between claimant's low back condition and his work activity on December 22, 1994. See ORS 656.005(7); Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992).

In any event, even if Dr. Webb's opinion were insufficient to satisfy claimant's burden of proof, we would continue to find the claim compensable. Where a case is not complex, expert medical evidence is not required. See Uris v. Compensation Department, 247 Or 420, 424 (1967); Barnett v. SAIF, 122 Or App 279, 283 (1993). Again, unlike the ALJ, we are not convinced that this case involves a complicated medical question which requires expert medical opinion.

In Barnett, the court enumerated relevant factors for determining whether expert testimony of causation is required: (1) whether the situation is complicated; (2) whether symptoms appear immediately; (3) whether the worker previously was free from disability of the kind involved; and (5) whether there was any expert testimony that the alleged precipitating event could not have been the cause of the injury.

Here, the circumstances are straightforward and uncomplicated. Claimant performed intensive physical work for the employer on December 22, 1994. Claimant then began experiencing low back pain within one day. Claimant promptly sought medical attention for his symptoms and promptly filed a claim with the employer. The record indicates that claimant has no preexisting condition, and there is no expert medical evidence that the alleged work events could not have been the cause of the injury. Because the circumstances of claimant's injury do not raise any of the factors requiring expert medical evidence as enumerated in Barnett, we also conclude that expert medical evidence regarding the cause of claimant's back strain is not required.

Consequently, on this basis as well (i.e., claimant's testimony), we would find that claimant has established a material connection between his condition and his work activity. Therefore, we set aside the insurer's denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review for prevailing over the insurer's denial is $3,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to this case (as represented by the record and claimant's appellate brief), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

Penalty

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

ORDER

The ALJ's order dated July 24, 1995 is affirmed in part and reversed in part. That portion of the order which upheld the insurer's denial of claimant's low back condition is reversed. The insurer's denial is set aside, and the claim is remanded to the insurer for processing in accordance with the law. For services at hearing and on review, claimant's attorney is awarded $3,000, payable by the insurer. The remainder of the order is affirmed.

March 20, 1996 Cite as 48 Van Natta 587 (1996)

In the Matter of the Compensation of
ROBERT A. McMAINS, Claimant
WCB Case No. 95-04456
SECOND ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Pursuant to our February 23, 1996 Order on Reconsideration, we reversed a penalty assessed by the Administrative Law Judge (ALJ) for miscalculation of claimant's temporary disability (TTD). We took this action in response to the SAIF Corporation's motion for reconsideration of our February 12, 1996 Order on Review. In reaching our conclusion, we noted that claimant had conceded that the ALJ's penalty assessment was erroneous.

SAIF now seeks further reconsideration of our decision. Noting that the ALJ also directed it to recalculate claimant's TTD, SAIF asks that we set aside that portion of the ALJ's order.

After considering SAIF's request and in light of claimant's prior concession on this TTD "recalculation" issue, we grant the motion for reconsideration. Therefore, we reverse that portion of the ALJ's order which directed SAIF to recalculate claimant's TTD.

Accordingly, our prior orders are withdrawn. On reconsideration, as supplemented and modified herein, we adhere to and republish our prior orders. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

March 20, 1996 Cite as 48 Van Natta 588 (1996)

In the Matter of the Compensation of
RICHARD W. NELSON, Claimant
WCB Case No. 95-06454
ORDER ON REVIEW
Reeves, Kahn & Eder, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Martha Brown's order that upheld the insurer's denial of claimant's bilateral carpal tunnel condition. On review, the issue is compensability.

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

On review, relying on Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994), claimant argues that he may establish compensability of his bilateral carpal tunnel condition using the "last injurious exposure rule." In Bennett, the claimant had filed occupational disease claims for hearing loss against two employers and later entered into a Disputed Claim Settlement (DCS) with the first employer. The court held that if a claimant can show that employment conditions, which may include conditions to which the claimant was exposed at the first employer, were the major contributing cause of the occupational disease, the claimant may rely on the last injurious exposure rule to prove the compensability of the claim against a later employer by showing that employment conditions there could have caused the condition. Id. at 78; Lola M. Springer, 46 Van Natta 1672, 1673 (1994).

We find that claimant has correctly summarized the holding in Bennett.[1] However, we agree with the ALJ that the medical evidence does not meet claimant's burden of proving a compensable occupational disease claim regarding his bilateral carpal tunnel disease condition. We rely on medical opinions that are well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986). Furthermore, we tend to give greater weight to the conclusions of claimant's treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983).

Here, the medical record regarding the cause of claimant's bilateral carpal tunnel condition consists of medical opinions from three physicians: Dr. Wells, treating orthopedist, Dr. Denker, former treating physician, and Dr. Radecki, examining physician. (Exs. 52, 53, 54). Both Drs. Wells and Radecki examined claimant one time and Dr. Denker examined claimant twice. (Exs. 46, 50, 52-2, 53).

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[1] At hearing, the parties agreed that only compensability, and not responsibility, was at issue. (Tr. 5). On review, the insurer objects to claimant's use of the last injurious exposure rule as a means of proving compensability where responsibility is not at issue. We need not address this objection because, even assuming the last injurious exposure rule applies in this case as a rule of proof, the only evidence that would support compensability under that rule is not persuasive, as explained above and in the ALJ's order.

Dr. Radecki opined that the major contributing cause was either idiopathic or familial, noting that claimant's mother had undergone carpal tunnel release. (Ex. 53-7). Dr. Radecki also noted other factors which indicated nonwork causes of claimant's condition, including past intravenous drug use, increased evidence of carpal tunnel syndrome in the nondominant hand, and lack of improvement after being away from work for several months. Dr. Denker concurred with Dr. Radecki's opinion. (Ex. 54).

Only Dr. Wells' opinion supports compensability. However, Dr. Wells' opinion is a check-the-box opinion without any explanation. Claimant argues that the "mere fact that Dr. Wells' causation opinion is in a check-the-box format does not mean automatic unreliability." (Appellant Brief, page 7). We agree. However, the problem with Dr. Wells' opinion is not the format, but the fact that it contains no explanation, it is simply a conclusory statement. Marta I. Gomez, 46 Van Natta 1654 (1994) (persuasiveness of expert opinion depends on the persuasiveness of the foundation on which the opinion is based; least weight given to conclusory, poorly analyzed opinions, citing Moe v. Ceiling Systems, 44 Or App 429, 433 (1980)). Therefore, we agree with the ALJ that Dr. Wells' opinion is not persuasive.

Finally, claimant argues that Dr. Radecki's opinion is unpersuasive. In support of this argument, claimant relies on several cases in which Dr. Radecki's opinion has been found unpersuasive in comparison to other medical opinions in those cases. However, as the insurer points out, the court has held that "the contribution of one expert's opinion to the preponderance of evidence in one case has no bearing on the relative weight of the same expert's opinion in another case with a different mix of medical opinions." Giesbrecht v. SAIF, 58 Or App 218 (1982). Therefore, the cases cited by claimant are not relevant to the persuasiveness of Dr. Radecki's opinion in this case. In any event, we have found that Dr. Wells' opinion, the only opinion that supports compensability, is not persuasive. Thus, even if we were to find Dr. Radecki's opinion unpersuasive, which we do not, claimant has failed to meet his burden of proof.

ORDER

The ALJ's order dated September 15, 1995 is affirmed.

March 20, 1996 Cite as 48 Van Natta 589 (1996)

In the Matter of the Compensation of
KENNETH D. PARSONS, Claimant
WCB Case No. 95-07142
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's right carpal tunnel syndrome (CTS) claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the employer as a business administrator since July 1991. His job duties require repetitive use of a 10-key and a computer with mouse. In January 1995, claimant developed symptoms, including pain, numbness in the medial fingers of the right hand, and paresthesia in the distal arm. Claimant sought treatment in February 1995 with Dr. Harvey, who diagnosed right carpal tunnel syndrome. Nerve conduction studies demonstrated focal compressive neuropathy in the carpal tunnel bilaterally.

Claimant had similar right hand symptoms in 1989 and 1990 while working as an accountant. At that time, claimant's weight was 337 pounds. At the time of his 1995 examinations, claimant's weight ranged from 380 to 400 pounds.

The ALJ discounted the opinions of Dr. Button and Dr. Tesar as internally inconsistent. Deferring to the opinion of the treating physician, Dr. Harvey, the ALJ concluded that claimant's repetitive work activities were the major contributing cause of claimant's current CTS. We disagree with the ALJ's interpretation of the medical evidence.

Dr. Button examined claimant on April 19, 1995. Dr. Button noted diminished sensation over the median nerve distribution, which lent correlation to the nerve conduction studies. Dr. Button opined that claimant's CTS was idiopathic, but that claimant's morbid obesity was the major contributing cause of his CTS, with work activities also being a factor. Dr. Button explained that increased body mass resulted in increase hydrostatic pressure in the distal extremities. Dr. Button explained that pressure increases with inactive use (such as while sleeping) of the pumping mechanism of using the flexor tendons, which pass through the carpal tunnel. The pumping mechanism reduces the pressure to relieve the paresthesia. Dr. Button discounted claimant's work activities because computer entry is anatomically performed by the intrinsic muscle tendons, which lie beyond the carpal tunnel.

Contrary to the ALJ's finding that Dr. Button's analysis was equivocal and unconvincing, we find Dr. Button's opinion well-reasoned and explained. Dr. Button persuasively explained how claimant's morbid obesity, rather than the work activities, was the major cause of the CTS.

Dr. Tesar, orthopedic surgeon, concurred with Dr. Button. Dr. Tesar also examined claimant on May 25, 1995. At the time of Dr. Tesar's examination, claimant's CTS symptoms had resolved, but he had numbness on the dorsal and palmar aspects of the right ring and small fingers. Dr. Tesar reported that claimant's present sensory complaints were indicative of an ulnar compressive neuropathy of the elbow. However, based on the nerve conduction studies and claimant's history, Dr. Tesar diagnosed claimant's condition as symptomatic CTS on the right. Dr. Tesar opined that claimant's work activities were a factor, but the idiopathic nature of CTS and claimant's morbid obesity were the major contributing cause of the CTS. Dr. Tesar explained that claimant's bilateral electrical abnormalities incriminated the idiopathic nature of CTS.

Along with his check-the-box concurrence with Dr. Button's report, Dr. Tesar explained his concurrence as well as his own examination findings in his May 1995 report. Thus, although Dr. Button had noted CTS symptoms of diminished sensation over the median nerve distribution, at the time of Dr. Tesar's examination, those symptoms had resolved. Rather, claimant presented with symptoms consistent with an early cubital tunnel syndrome. Therefore, any inconsistencies (noted by the ALJ) were explained in Dr. Tesar's examination report. See Linda M. Thomas, 47 Van Natta 75, 76 (1995) (given the nature of the check-the-box concurrence with another doctor's report, it was reasonable for the doctor to explain his opinion in a separate letter). Like Dr. Button, Dr. Tesar persuasively explained his reasoning and opinion.

Dr. Harvey initially opined that claimant's work activities and his obesity both contributed to his CTS, and that there was no way to accurately determine the major contributing cause. In response to inquiries from claimant's attorney, Dr. Harvey subsequently opined that claimant's obesity was a major contributing factor to his CTS, but secondary to work activities. Within the same concurrence letter, Dr. Harvey opined that, to a reasonable degree of medical probability, claimant's work activities were 51 percent of the cause and his obesity was 49 percent of the cause of his CTS. Dr. Harvey further disagreed with Dr. Button that claimant's condition was due to his weight or due to idiopathic factors.

We find Dr. Harvey's subsequent opinion internally inconsistent. First, Dr. Harvey opines that claimant's obesity was the major cause, with work activities a material cause, of his CTS. Dr. Harvey, then, without, explanation reverses his opinion. Because he fails to explain these inconsistencies, we find his opinion unpersuasive. See Kelso v. City of Salem, 87 Or App 630 (1987). Furthermore, Dr. Harvey does not explain the basis for his disagreement with Dr. Button. See ESCO Corporation v. Manley, 83 Or App 406, 409 (1987) (medical opinion discounted where doctor failed to explain dispute with another doctor's conclusion regarding causation).

Consequently, based upon the persuasive opinions of Drs. Button and Tesar, we conclude that claimant has failed to establish that his work activities were the major contributing cause of, or worsening of, his right CTS.

ORDER

The ALJ's order dated October 6, 1995 is reversed. The SAIF Corporation's June 2, 1995 denial is reinstated and upheld. The ALJ's $3,000 assessed attorney fee is also reversed.

March 22, 1996 Cite as 48 Van Natta 591 (1996)

In the Matter of the Compensation of
TIMOTHY BLOEMENDAAL, Claimant
WCB Case No. 95-06519
ORDER ON REVIEW
Myrick, Seagraves, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) found that claimant's claim was timely filed; and (2) set aside SAIF's denial of claimant's low back injury claim. On review, the issues are timeliness of claim filing and compensability. We affirm.

FINDINGS OF FACT

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

Claimant was employed as an auto detailer. On or about December 9, 1993, claimant lifted a seat from a van and strained his back. He told a co-worker about the incident. The co-worker noted that he was in pain. Claimant did not report the incident to his supervisor. On December 13, 1993, claimant sought treatment for low back pain from Dr. Sinclair, who diagnosed "possible slipped disc, possible muscle pull." (Ex. 1). On December 23, 1993, claimant provided a short term disability claim form to Dr. Sinclair, indicating that the injury occurred on December 10, 1993 at 7:30 pm and that the injury was caused when he was bending over at home. (Ex. 2). Claimant returned to modified work on December 28, 1993. (Ex. 2).

Within a day or so of returning to work, claimant spoke to three co-workers regarding his injury and reported the incident to Mr. Able, his immediate supervisor. (Tr. 59, 96, 98). Mr. Able talked with the three co-workers. (Tr. 59, 60). None had witnessed the injury, so, in conformity with the employer's practice, Mr. Able suggested that claimant file his claim with his short term disability carrier, which claimant did. (Ex. 2, Tr. 60).

Claimant again sought treatment for his low back in March 1995. (Ex. 1). On April 20, 1995, claimant filed a Form 801 with the employer, stating that he injured his low back on December 9, 1993, when he bent over and lifted a seat out of a van. (Exs. 3 and 5). On April 21, 1995, claimant reported to Dr. Sinclair that, in December 1993, he had been lifting a back seat from a minivan at work and developed low back pain, which had never gone away. (Ex. 1-5). On April 25, 1995, Dr. Sinclair filed a Form 827 with SAIF, attributing the onset of claimant's low back condition to the alleged December 1993 lifting incident. (Ex. 4). On May 19, 1995, SAIF denied the claim on the basis that there was insufficient evidence that claimant's low back sprain was the result of a compensable work-related injury or disease and that claimant's notice of injury was untimely. (Ex. 8).

CONCLUSIONS OF LAW AND OPINION

Timely Filing

Under former ORS 656.265[1], an injured worker must give written notice of the accident to the employer not later than 30 days after the accident. Failure to give notice bars a claim unless the employer had actual knowledge of the injury or had not been prejudiced by failure to receive the notice.

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[1] The ALJ correctly concluded that amended ORS 656.265 does not apply here. See Or Laws 1995, ch 332, § 66(2) (Senate Bill § 66(2)).

The ALJ concluded that the employer had knowledge of claimant's injury, based on the testimony of Mr. Able, claimant's immediate supervisor. SAIF contends that Mr. Able's testimony should be given little weight because he is biased as a result of his leaving work and filing his own workers' compensation claim against the employer, in which he names Mr. Jones, the general manager, as the source of his stress claim.

When credibility findings have been based on witness' demeanor, we defer to the credibility findings of the ALJ. International Paper Co. v. McElroy, 101 Or App 61 (1990); Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987). However, when the ALJ's credibility findings are based on the substance of the witness' testimony, rather than the witness' demeanor, we are equally capable of assessing credibility. Hultberg, at 285.

Here, we defer to the ALJ's demeanor-based credibility findings regarding Mr. Jones and Mr. Able. Moreover, although the credibility of a witness may be attacked by evidence that the witness engaged in conduct or made statements showing bias or interest, see e.g., James v. General Motors of Canada, Ltd., 101 Or App 138, 141 (1990), there is no evidence that Mr. Able is hostile toward the employer or is motivated to prove Mr. Jones a liar. Absent some confirming evidence that Mr. Able is hostile or so motivated, we are unwilling to presume that he is, or that the circumstances of his filing a workers' compensation claim make him more likely to lie. In addition, we agree with the ALJ's assessment of Mr. Able's testimony: Mr. Able's answers at hearing were straightforward and direct, with no evidence of dissembling, even when damaging to himself. Consequently, after our de novo review of the record, including Mr. Able's credible testimony, we agree with the ALJ's finding that claimant timely reported the incident to his supervisor. (Tr. 59-62; 68-72; 74).

When an individual in a supervisory position has knowledge of a worker's injury, that knowledge may be imputed to the employer. Colvin v. Industrial Indemnity, 301 Or 743, 747 (1986). Moreover, if the employer has knowledge of the injury, claimant's claim is not barred even if the employer was prejudiced by the late filing of the claim. Argonaut Ins. Co. v. Mock, 95 Or App 1, 5-6, rev den 308 Or 79 (1989). Consequently, because the employer had knowledge of the worker's injury, claimant's failure to timely give written notice does not bar his claim. See former ORS 656.265(4)(a).

Compensability

SAIF asserts that claimant has failed to establish that his unwitnessed injury is compensable. We disagree.

It is claimant's burden to establish by a preponderance of the evidence that the alleged injury happened as described. ORS 656.266; Hutcheson v. Weyerhaeuser, 288 Or 51 (1979). Claimant asserts that his back symptoms arose on December 9, 1993, after lifting a van seat at work. Claimant further asserts that his back symptoms increased after sitting through a meeting at work and worsened after he bent over at home, to the point that he sought medical treatment. (Tr. 114).

Although nothing in the contemporary medical records corroborates claimant's version of events (Exs. 1 and 2), and the incident itself was unwitnessed, claimant's supervisor admits that a co-worker verified that claimant had told him about the incident at the time it occurred and noted that claimant was in pain at the time. (Tr. 71). This admission, compounded by claimant's fear of filing a workers' compensation claim (Tr. 86, 114) and the employer's recommendation that he not do so, is sufficient to establish, by a preponderance of the evidence, that the alleged injury happened as described.

Moreover, on December 13, 1993, claimant sought treatment from Dr. Sinclair for back pain that began four days earlier. (Ex. 1). Dr. Sinclair found bilateral positive straight leg raising in the low and upper back, which he diagnosed as a muscle strain, or possible disc, and which he attributed to claimant's work. (Exs. 1, 9).

Based on the aforementioned medical and lay evidence, we consequently conclude that claimant's injury is compensable. ORS 656.005(7)(a). Accordingly, we affirm the ALJ's decision to set aside SAIF's denial.

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

ORDER

The ALJ's order dated September 22, 1995 is affirmed. For services on review, claimant's counsel is awarded a reasonable attorney fee of $1,500, to be paid by the SAIF Corporation.

March 22, 1996 Cite as 48 Van Natta 593 (1996)

In the Matter of the Compensation of
SENETRA SMITH-WAMPLER, Claimant
WCB Case No. 93-15113
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order that: (1) declined to dismiss claimant's request for hearing; and (2) set aside its partial denial of claimant's current left shoulder condition. On review, the issues are dismissal and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Dismissal

We adopt the conclusions and reasoning as set forth in the "Motion to Dismiss" portion of the ALJ's order with the following supplementation.

The employer asserts that the ALJ lacked jurisdiction over this matter because claimant moved for dismissal. We disagree.

While we acknowledge that claimant did move for dismissal, her argument illustrates that she was asserting that the employer was precluded from issuing its denial. Thus, we agree with the ALJ that claimant was, in actuality, seeking "dismissal" of the employer's denial. In any event, the ALJ retained jurisdiction over this matter unless and until claimant's hearing request was dismissed via ALJ order. See, e.g., Mary J. McFadden, 44 Van Natta 2414 (1992). Although claimant's request may have initiated the dismissal process, it is the dismissal order which terminates the Hearings Division's jurisdiction. Id. Since the ALJ did not dismiss claimant's hearing request, the ALJ retained authority to address the propriety of the employer's denial.

Compensability

We adopt the conclusions and reasoning as set forth in the ALJ's order with the following supplementation.

Contrary to the employer's contention, the prior ALJ's order determined that as of October 12, 1993 (the date of the prior ALJ's order), claimant's left shoulder condition was compensably related to the 1991 accepted injury with the employer and not to the prior 1987 injury accepted by SAIF. That determination was essential to the ALJ's judgment, as well as to the subsequent Board order. See Senetra Smith-Wampler, 46 Van Natta 1661 (1994). Consequently, the employer is precluded from denying claimant's condition before that date. See Fimbres v. Gibbons Supply Co., 122 Or App 467 (1993).

The employer is not precluded from denying claimant's condition after the date of the prior hearing. However, like the ALJ, we find no persuasive evidence that claimant's left shoulder injury has combined with a preexisting mental condition or any other preexisting condition after the date of the prior ALJ's order. Inasmuch as there is no "combination," ORS 656.005(7)(a)(B) does not apply to this matter. See Ronald L. Ledbetter, 47 Van Natta 1461 (1995). Since claimant's compensable left shoulder condition remains a material contributing cause of her current left shoulder condition, we hold that the condition is compensable. ORS 656.005(7)(a), 656.245(1)(a).

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

ORDER

The ALJ's order dated August 18, 1995, as amended August 21, 1995, is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $750, payable by the self-insured employer.

March 22, 1996 Cite as 48 Van Natta 594 (1996)

In the Matter of the Compensation of
REX T. MIELKE, Claimant
WCB Case No. 95-02141
ORDER ON RECONSIDERATION
Richard A. Sly, Claimant Attorney
Lundeen, et al, Defense Attorneys

The insurer requests reconsideration of our February 22, 1996 Order on Review. Specifically, the insurer contends that, in determining the proper rate of temporary disability, we did not consider that claimant worked varying hours both as an on-call, four-hour-per-day worker and as an eight-hour-per-day worker.

We withdraw our February 22, 1996 order for reconsideration. After reviewing the insurer's motion and memorandum in support, we continue to adhere to the findings, reasoning and conclusions reached in our prior order.

Specifically, we note that we did consider that claimant worked varying hours in both positions. However, our original order was based on the finding that claimant began a new position with the employer on May 2, 1994, and that he had been employed in that position less than four weeks at the time of his injury on May 27, 1994. In making those findings, we considered not only the number and variability of the hours worked in each position, but also several other factors bearing on the nature of claimant's work duties and his employment relationship. Since we found that claimant had worked in his new position less than four weeks at the time of his injury, we concluded that the temporary disability rate was properly calculated based on the parties' intent at the time of hire. Former OAR 436-60-025(5)(a).[1] We continue to adhere to this conclusion.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 22, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Former OAR 436-60-025(5)(a) provided, in relevant part: "For workers employed less than four weeks. . . the insurer shall use the intent at time of hire[.]"

In the Matter of the Compensation of
ROBERT A. WENTZ, Claimant
WCB Case No. 95-05278
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Gunn and Neidig.

Claimant requests review of Administrative Law Judge (ALJ) McCullough's order that upheld the SAIF Corporation's denial of claimant's aggravation claim for a back condition. In his brief, claimant contends that this case should be remanded to the ALJ. On review, the issues are remand and aggravation.

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

On review, claimant asserts that there is an absence of evidence contemplating a waxing and waning of claimant's symptoms following initial claim closure, when claimant was awarded permanent disability. Claimant further argues that, because the law was amended to now provide a presumption that all permanent disability awards contemplate future waxing and waning of symptoms of the condition,[1] and because the claim was closed before this amendment, we should remand the claim for "an opportunity to present evidence on this issue of whether waxing and waning was a consideration at the time of the PPD award."

Under ORS 656.295(5), we may remand a case to the ALJ for further evidence taking if we find that the case has been improperly, incompletely or otherwise insufficiently developed. Bailey v. SAIF, 296 Or 41, 45 n 3 (1983). In order to satisfy this standard, a compelling reason must be shown for remanding. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of the case; and (3) is reasonably likely to affect the outcome. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

The amendment to ORS 656.214(7) became effective on June 7, 1995 and retroactively applies. Or Laws 1995, ch 332, §§ 17, 66(1). The hearing in this case convened on July 12, 1995. The ALJ's order issued on August 3, 1995. Thus, the amended law was in effect at the time of the hearing. Consequently, claimant had an opportunity at hearing to submit the evidence he now considers necessary to satisfy ORS 656.214(7).

Claimant does not assert that any evidence not admitted at hearing was unobtainable at that time. Moreover, the state of the law was the same at hearing as it is now on review. Thus, we find no compelling reason to remand and we deny claimant's motion.[2]

ORDER

The ALJ's order dated August 3, 1995 is affirmed.

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[1] ORS 656.214(7) provides that all "permanent disability contemplates future waxing and waning of the symptoms of the condition."

[2] We distinguish this case from Carmen C. Neill, 47 Van Natta 2371 (1995), where we remanded to the ALJ for the submission of further evidence regarding whether the claimant had sustained an "actual worsening" under ORS 656.273(1). We did so because the new law went into effect after the record concerning the aggravation had been developed/closed and because the claimant had not received a prior award of permanent disability.

As explained above, in this case, the hearing took place after the new law went into effect and, therefore, the parties had the opportunity to generate medical evidence concerning whether claimant's prior permanent disability award contemplated future waxing and waning of symptoms. Consequently, unlike Carmen C. Neill, supra, there is no compelling reason to remand.

In the Matter of the Compensation of
CLANCY WHITTEN, Claimant
Own Motion No. 94-0518M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
Liberty Northwest, Insurance Carrier

Claimant requests reconsideration of our January 12, 1996 Own Motion Order Reviewing Carrier Closure which: (1) affirmed the insurer's December 14, 1995 Corrected Notice of Closure; and (2) allowed claimant's attorney an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded by the insurer, not to exceed $1,050 under OAR 438-015-0010(4) and OAR 438-015-0080. Concerning payment of the attorney fee, we further directed that, in the event the insurer had paid to claimant the full amount of additional compensation awarded by the order, claimant's attorney could seek recovery of the fee in the manner prescribed in Jane A. Volk, 46 Van Natta 681 (1994), on recon 46 Van Natta 1017 (1994); aff'd Volk v. America West Airlines, 135 Or App 565 (1995).

Claimant seeks reconsideration, contending that our directive regarding payment of the attorney fee is inconsistent with the court's holding in SAIF v. O'Neal, 134 Or App 338 (1995). On January 29, 1996, we withdrew our prior order for reconsideration. After conducting further consideration of this matter, we issue the following order.

On November 28, 1995, the Board received claimant's request for review of the insurer's September 29, 1995 Notice of Closure of his claim. That closure awarded claimant temporary disability compensation from August 18, 1994 through September 21, 1995, and declared claimant medically stationary on September 22, 1995. That request, which was accompanied by an executed retainer agreement, further indicated that a copy of the submission had been provided to the insurer. Through his attorney-of-record, claimant requested additional temporary disability compensation, contending that he was not medically stationary when his claim was closed.

On December 4, 1995, the Board sent a letter acknowledging the request for review of the Own Motion Closure to both the insurer and to claimant's attorney. Pursuant to that letter, the insurer was granted an opportunity to respond to claimant's request.

On December 14, 1995, the insurer responded to the Board's acknowledgment letter. Announcing that it had "reviewed [claimant's] claim and the documentation supplied by his counsel," the insurer enclosed a December 14, 1995 Corrected Notice of Closure in this claim. In accordance with that corrected notice, the insurer had paid claimant temporary disability compensation from August 18, 1994 through November 27, 1995, and declared claimant medically stationary on November 27, 1995.

On December 18, 1995, the Board acknowledged receipt of the insurer's corrected notice and sought the parties' respective positions regarding its effect on claimant's pending request for review. On December 22, 1995, the insurer advised the Board that:

> "It is the position of [the insurer] that the additional information provided in the November 27, 1995 report from Dr. Golden changed the benefits allowed to [claimant]. After receiving that information, the corrected Own Motion Notice of Closure was issued and the adjustment in benefits was paid to [claimant]."

On January 2, 1996, claimant's attorney notified the Board that:

> "Claimant agrees that 11/27/95 is the appropriate medically stationary date. If additional benefits are due pursuant to the newly issued Notice of Closure, Claimant's attorney is entitled to a 25% attorney fee up to $1,050. Claimant requests that the Board issue an order to that effect."

On January 12, 1996, we issued our order affirming the insurer's December 14, 1995 Corrected Notice of Closure, and approved an out-of-compensation attorney fee in the amount of 25 percent of the increased temporary disability compensation awarded by our order. Our order further directed claimant's attorney to seek recovery of the attorney fee pursuant to Volk, in the event the insurer had already paid claimant the additional compensation.

On reconsideration, claimant's attorney contends that the insurer paid the additional temporary disability compensation awarded from September 22, 1995 through November 27, 1995, directly to claimant, and that the insurer did not issue a separate check to claimant's attorney representing 25 percent of the additional benefits awarded by our January 12, 1996 order. Claimant's attorney further requests that the Board "order [the insurer] to pay an attorney fee of $1,050 to this office and to declare an overpayment against Claimant's future benefits."

In support of his assertion, claimant relies on the reasoning expressed by the court in SAIF v. O'Neal, supra. In O'Neal, the court affirmed the Board's orders in Nancy E. O'Neal, 45 Van Natta 1490, on recon 45 Van Natta 1743, on recon 45 Van Natta 2081 (1993), which had directed a carrier to pay an "out-of-compensation" attorney fee to the claimant's counsel even though the "increased" compensation had previously been paid to the claimant. In doing so, the court recognized that former ORS 656.386(2) specified that the "out-of-compensation" attorney fee must be paid from the claimant's compensation. SAIF v. O'Neal, supra, 134 Or App at 343. Nevertheless, the court reasoned that, when the carrier's unnecessary and unilateral action makes the additional award necessary, the statute should not be read to preclude the Board from ordering the carrier to pay the fees directly to the attorney. Consequently, under the "unique circumstances" presented in O'Neal, the court held that it was permissible for the Board to require the carrier to pay the claimant's attorney directly and to recover that amount from the claimant's future compensation.

Prior to the court's opinion in O'Neal, we issued our decision in Jane A. Volk, supra. There, we declined to order a carrier to pay an "out-of-compensation" fee directly to the claimant's counsel because the "increased" compensation had already been properly paid to the claimant pursuant to an appealed closure order. Instead, we ruled that the claimant's counsel should seek payment of the fee from the claimant directly or indirectly by means of a "lien recovery" procedure. In doing so, we distinguished our O'Neal holding. Whereas the "increased" compensation in O'Neal had been unilaterally paid to the claimant by the carrier subsequent to the filing of a hearing request designed to obtain that very increase, we reasoned that the "increased" compensation awarded in Volk had already been properly paid by the carrier pursuant to a prior, appealed closure order. In reaching this conclusion, we described the O'Neal rationale as standing for the proposition that, when a carrier neglects to follow the basic course of conduct of communicating through a claimant's legal representative and pays disputed compensation directly to a claimant without accounting for that claimant's attorney's rightful share, the Board is permitted to direct that carrier to pay that fee to the claimant's attorney. Jane A. Volk, supra, 46 Van Natta at 686.

While the claimant's appeal of our decision in Jane A. Volk, supra, was pending judicial review, the 1995 legislature amended ORS 656.386(2). The former version had provided that: "In all other cases attorney fees shall continue to be paid from the claimant's award of compensation except as otherwise provided in ORS 656.382." The amended version of the statute now states that: "In all other cases, attorney fees shall be paid from the increase in the claimant's compensation, if any, except as otherwise expressly provided in this chapter."

Based on this statutory change, the Volk court rejected the claimant's challenge to our refusal to direct the carrier to pay the attorney fee to the claimant's counsel. The court reasoned that the "amended language makes it clear that it is not permissible to require that 'out-of-compensation' attorney fees be paid from any other source than the claimant's compensation, unless the statutes expressly provide otherwise." Volk v. America West Airlines, supra, 135 Or App at 573.

Considering amended ORS 656.386(2) and the Volk decision, it is appropriate to reexamine our holding in O'Neal. After conducting that reexamination, we hold that the O'Neal rationale remains viable.

As with its current version, former ORS 656.386(2) mandates that "out-of-compensation" attorney fees must be paid from a claimant's compensation. Our decision in O'Neal did not hold otherwise. In fact, as recognized by the O'Neal court, the statute should not be read to preclude the Board from ordering the carrier to pay the fees directly to the attorney when the carrier's unnecessary and unilateral action makes the additional award necessary. SAIF v. O'Neal, supra, 134 Or App at 343.

In other words, the O'Neal rationale does not support the proposition that the Board is authorized to award a "carrier-paid" attorney fee when "increased" compensation has already been paid to the claimant. Rather, consistent with ORS 656.386(2), the O'Neal holding recognizes that the claimant's counsel's fee is payable from the claimant's compensation. However, in those unique circumstances, where the carrier neglects to provide for payment of that fee to the claimant's attorney when that attorney has taken all appropriate measures designed to secure payment of that fee, the O'Neal principle supports the Board's authority to require the carrier to pay that fee to the claimant's counsel and to recover that payment against the claimant's future compensation awards.

Inasmuch as the current version of ORS 656.386(2) continues to mandate the payment of "out-of-compensation" attorney fees directly from a claimant's compensation and since the court has previously determined that the O'Neal rationale does not conflict with statutory requirement, we hold that the O'Neal principle has not been eliminated by the amendments to ORS 656.386(2).[1]

Accordingly, on reconsideration, we direct the insurer to pay to claimant's counsel the attorney fee granted in our January 12, 1996 order. The insurer is also authorized to offset this payment against claimant's future temporary disability compensation in the manner prescribed in ORS 656.268(15)(a). Except as supplemented and modified herein, we republish our January 12, 1996 order. 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 recognize that amended ORS 656.386(2) modified some of the language of the former version of that statute, such as by adding the word "expressly." Not all changes in statutory language are material, however. Carroll v. Boise Cascade, 138 Or App 610 (1996). Because both versions of ORS 656.386(2) require payment of "out-of-compensation" attorney fees directly from a claimant's compensation, and because the O'Neal court approved a limited exception to that requirement under unique circumstances such as these, we conclude that the amendments to ORS 656.386(2) have not affected the O'Neal rationale. We would also add that our review of the legislative history pertaining to the amendments to ORS 656.386 has not revealed any intent to overrule O'Neal.

In the Matter of the Compensation of
CONRID J. PAXTON, Claimant
WCB Case Nos. 95-00537, 94-13809 & 94-10357
ORDER OF ABATEMENT
Aller & Morrison, Claimant Attorneys
William J. Blitz, Defense Attorney
James B. Northrop (Saif), Defense Attorney
Cowling, Heysell, et al, Defense Attorneys

The SAIF Corporation, on behalf of Sun Studs (SAIF/Sun Studs), RLC Industries (RLC), and claimant request reconsideration of our February 29, 1996 order that reversed an Administrative Law Judge's order that: (1) set aside SAIF/Sun Studs' denial of claimant's hearing loss claim; (2) upheld SAIF's denial, on behalf of Woolley Enterprises, of the same condition; (3) upheld RLC's denial of the same condition; and (4) awarded claimant a $500 carrier-paid attorney fee payable by SAIF/Sun Studs.

To allow sufficient time to consider the requests, we withdraw our February 29, 1996 order. The parties are granted an opportunity to respond to each others' arguments. To be considered, those responses must be submitted within 14 days of the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MONTY L. WALL, Claimant
WCB Case Nos. 95-00999, 95-00460 & 94-08742
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Yturri, Rose, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation requests review of that portion of Administrative Law Judge (ALJ) Mills' order which set aside its denial of claimant's right hip condition. Claimant cross-requests review of that portion of the ALJ's order which upheld Safeco's compensability denial of his psychological condition. On review, the issues are compensability and responsibility. We affirm.

FINDINGS OF FACT

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

The first sentence of the third paragraph on page 3 of the Opinion and Order should read: "On May 17, 1993, claimant injured his big toe on his right foot when he dropped a large piece of metal on it while working as a mechanic for Phillips Long Ford." (not Harvey Zoon Logging).

CONCLUSIONS OF LAW AND OPINION

Compensability/Psychological Condition

The ALJ determined that the opinions of Dr. Kaesche, claimant's treating orthopedist, Dr. Rice, claimant's treating psychiatrist, and Dr. Smith, an examining psychiatrist, failed to establish that claimant's work injury at Safeco's insured, Phillips Long Ford, was the major contributing cause of his psychological condition under either ORS 656.005(7)(a)(A) or (B). We agree.

On review, claimant urges us to rely on the opinion of Dr. Starr, claimant's treating psychologist. (Ex. 103). We recognize that Dr. Starr opined that the major cause of claimant's depression was his response to his foot injury at work. (Id.). However, we find Dr. Starr's opinion relatively conclusory and not fully explained. For example, he does not explain what role claimant's response to claim processing issues played in his depression, as distinguished from his response to the pain and disability of the injury itself, considering that Dr. Starr noted during treatment that bad news concerning processing of his claim affected claimant's mood. (Ex. 64-8). See Baar v. Fairview Training Center, 139 Or App 196 (1996); Roseburg Forest Products v. Zimbelman, 136 Or App 75, 79 n2 (1995) (emotional reaction to pain and disability caused by work injury may be compensable as consequential condition, but reaction to claims processing is not considered to be caused by compensable injury). However, in his opinion, Dr. Starr simply stated that claimant's "response" to his work injury was the major cause of his depression. Under such circumstances, we do not find that Dr. Starr's opinion outweighs the contrary opinions of Drs. Rice, Kaesche and Smith.

Responsibility/Hip Condition

The ALJ found that claimant's right knee and right hip conditions were compensable and that Liberty was responsible for those conditions. Liberty appealed only the ALJ's determination regarding the right hip condition.

We adopt and affirm that portion of the ALJ's order that found claimant's right hip condition compensable against Liberty, with the following supplementation.

Since claimant's right hip condition was not an accepted condition,[1] and since compensability was not conceded (Safeco contested compensability), claimant must first establish compensability of his right hip condition. Joyce A. Crump, 47 Van Natta 466 (1995).

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[1] Claimant had an accepted right knee injury claim with Liberty, arising out of a 1991 work injury. (Exs. 7, 13, 15). Claimant settled this claim by a claim disposition agreement (CDA) in September 1992, whereby he retained only his rights to medical benefits for the accepted condition. (Ex. 15).

Claimant experienced right hip pain while he was treating for his 1991 right knee injury, but there is no evidence that a right hip condition was diagnosed or treated at that time. (See Exs. 5-4, 9). In May 1993, claimant sustained an injury to his right great toe while working for Safeco's insured. In July 1993, Dr. Kopp, claimant's treating physician at that time, noted that claimant complained of right hip pain. (Ex. 19-3). Dr. Kopp diagnosed a right hip sprain/strain, which he attributed to claimant's right toe pain. (Exs. 19-3, 23).

Dr. Kaesche, an orthopedist who examined claimant, noted that claimant had right hip pain, which claimant believed was precipitated by his May 1993 toe injury due to altering his gait as a result of that injury. (Ex. 48-7). Dr. German, claimant's subsequent treating physician, concurred with Dr. Kaesche's report. (Ex. 50). Dr. Petterson, another treating physician, thought that claimant's altered gait resulted in right hip pain. (Ex. 118B).

While the above-cited medical reports suggest a relationship between claimant's right hip condition and his 1993 toe injury, none of these physicians clearly expressed a definite opinion regarding causation. However, Dr. Laycoe, an orthopedist who examined claimant at Safeco's request, did express a clear and definite opinion regarding the cause of claimant's right hip condition. He opined that claimant's preexisting knee condition "clearly" was the major contributing cause of his right hip symptoms. (Ex. 122-2). He further opined that the right toe injury, which resulted in claimant favoring his right foot, "certainly" was not the major contributing cause of his right hip pain. Dr. Laycoe also explained the basis for his opinions. (Id.).

We find Dr. Laycoe's opinion persuasive and sufficient to establish compensability of the right hip condition. Based on Dr. Laycoe's opinion, the right hip condition is most appropriately analyzed as a consequential condition resulting from the accepted right knee condition. ORS 656.005(7)(a)(A). Again relying on Dr. Laycoe's opinion, we find that the right hip condition was caused in major part by the accepted right knee condition and, therefore, is compensable as a consequential condition resulting from the right knee condition. Accordingly, we agree with the ALJ's determination that the right hip condition is compensable.

Liberty contends that, if the right hip condition is compensable, Safeco is responsible based on application of the last injurious exposure rule. We disagree.

When actual causation with respect to a specific employer is proven, it is not necessary to rely on judicially created rules for assigning responsibility between successive employers. Boise Cascade Corp. v. Starbuck, 296 Or 238, 244-45 (1984); Eva R. Billings, 45 Van Natta 2142, 2143 (1993). Here, actual causation has been proven against Liberty. Therefore, it is not necessary to rely on the last injurious exposure rule for assigning responsibility.

Liberty further contends that, even if it is initially responsible for the right hip condition, responsibility should shift to Safeco because the toe injury at Safeco's insured independently caused or worsened claimant's right hip condition. After our review of the record, we find no persuasive medical opinion to support Liberty's position.

Finally, Liberty contends that, because Safeco's disclaimer was untimely, it (Safeco) cannot shift responsibility for claimant's right hip condition back to Liberty. While Safeco may be barred from shifting responsibility, nothing prevents claimant from establishing a claim against Liberty. We have previously held that a carrier's failure to comply with the disclaimer notice of former ORS 656.308(2) precluded that carrier from attempting to shift responsibility for the claim to another carrier. Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994). However, we concluded in Hamrick that the carrier's violation did not preclude the claimant from pursuing the compensability of her claim against the other carrier. See also Jon F. Wilson, 45 Van Natta 2362 (1993).

Here, claimant made a claim against Liberty for his right hip condition. At hearing, claimant did not move to dismiss Liberty. Compare Donald A. James, 46 Van Natta 1898 (1994) (claimant moved for dismissal of all carriers except one). Therefore, we find that claimant continued to pursue his claim against Liberty.

Assuming, without deciding, that Safeco did not timely disclaim under former ORS 656.308(2), its alleged violation does not preclude claimant from pursuing his claim against Liberty. Even if Safeco cannot shift responsibility, its alleged violation does not preclude claimant from pursuing his claim against Liberty. Penny L. Hamrick, supra. Therefore, since we find that claimant is still pursuing his claim against Liberty, any alleged failure by Safeco to issue a timely disclaimer of responsibility is of no consequence in this case.

Accordingly, we agree with the ALJ's determination that claimant's right hip condition is compensable and that Liberty is responsible for that condition.

Since claimant did not submit an appellate brief regarding the right hip condition, claimant is not entitled to an attorney fee pursuant to ORS 656.382(2). See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The ALJ's order dated June 2, 1995 is affirmed.

March 26, 1996 Cite as 48 Van Natta 601 (1996)

In the Matter of the Compensation of
GARY G. BRITTON, Claimant
WCB Case Nos. 95-04539 & 95-02235
ORDER ON RECONSIDERATION
Starr & Vinson, Claimant Attorneys
Lundeen, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our February 28, 1996 Order on Review that found SAIF, rather than Liberty Northwest Insurance Corporation, responsible for claimant's left carpal tunnel syndrome and further found SAIF liable for attorney fees assessed at hearing and on review. SAIF asserts that, because it did not deny compensability, it is not liable for the attorney fee assessed at hearing. SAIF also contends that it is not liable for the assessed attorney fee on review because it did not request review of the ALJ's order. Liberty has responded, contending that SAIF is responsible for claimant's attorney fee awards.

We disagree with SAIF that only Liberty denied compensability. In its denial, SAIF found that claimant's compensable injury with SAIF was "not the major contributing cause of the development or worsening of your condition diagnosed as bilateral carpal tunnel syndrome" and informed claimant that "THIS IS A DENIAL OF YOUR CLAIM FOR BENEFITS." (Ex. 32-1). At hearing, SAIF's attorney stated that SAIF had "issued a partial denial and we are denying responsibility as well as compensability." (Tr. 2). Thus, because SAIF denied compensability, and claimant "finally prevailed" over such denial on review, SAIF is liable for the assessed attorney fee awarded at hearing. ORS 656.386(1).

As SAIF points out, however, Liberty requested Board review. Consequently, we agree with SAIF that Liberty, rather than SAIF, is liable for the $1,000 assessed attorney fee awarded on review. ORS 656.382(2); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990); Dolly S. Mack, 46 Van Natta 1991, 1993 (1995).

Accordingly, we withdraw our February 28, 1996 order. On reconsideration, as supplemented and modified herein, we adhere to and republish our February 28, 1996 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
GRACE E. CASSIDY, Claimant
WCB Case No. 93-14898
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

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

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. We do not adopt her Findings of Ultimate Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant seeks compensation for a psychological condition which allegedly arose from her detention and arrest for shoplifting while performing her work activities as a secret shopper. Relying on ORS 43.130 and the doctrine of issue preclusion, the ALJ gave preclusive effect to a municipal court jury verdict regarding claimant's conviction on the shoplifting offense. On review, claimant contends that issue preclusion should not be applied as the ALJ declined to give any effect to a decision of the Employment Appeals Board, which found that claimant did not shoplift.

For the following reasons, we conclude that, even if the criminal court conviction was not given preclusive effect, (i.e., if we agreed that claimant did not shoplift), claimant would not prevail on the merits of her case.

Here, it is undisputed that claimant has a preexisting psychological condition. (Exs. 34, 36). Consequently, to establish compensability, claimant must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b).

Claimant's counselor, Ms. Kellow, MSW, reported that claimant had previously been treated for panic attacks. Following the work incident, Ms. Kellow again treated claimant for a panic attack. Ms. Kellow diagnosed claimant's condition as "panic disorder with agoraphobia," "post traumatic stress disorder, acute and delayed," and "major depression, single episode, moderate." Ms. Kellow listed claimant's psychosocial stressors as: "traumatic incident at work, husband's life-threatening drinking, separation and filing for divorce, memories of childhood incest." (Ex. 36-3). Dr. Brandt, claimant's family physician, agreed with the findings set forth in Ms. Kellow's report. (Ex. 37).

Dr. Turco, psychiatrist, examined claimant on behalf of the employer. Dr. Turco reviewed Ms. Kellow's records and reported that claimant had a significant psychiatric condition long before the work incident of November 1993. Dr. Turco diagnosed claimant's current condition as "hysterical personality traits," with a history of some chronic anxiety related to personal problems. (Ex. 34-8, 39).

After considering the medical evidence in this case, we conclude that claimant has failed to prove that the November 1993 work incident is the major contributing cause of the worsening of her preexisting psychological condition. Specifically, Dr. Turco has not found a psychological condition related to work. Moreover, although Ms. Kellow listed the work incident as a stressor, she has not provided an opinion that the incident was the major contributing cause of claimant's condition or a worsening of her preexisting condition. See e.g. Stacy v. SAIF, 131 Or App 610 (1994)(Because a determination of major contributing cause requires the assessment of the relative contribution of different causes, see Dietz v. Ramuda, 130 Or App 397 (1994), it is necessary to consider the effect of all possible causes of a condition, including assessing the contribution of an underlying preexisting condition). Finally, Dr. Brandt, claimant's family physician, agreed with Kellow's findings.

Under the circumstances, we conclude that claimant has not proven the compensability of her claim. ORS 656.802; 656.266. Therefore, the employer's denial must be upheld.

ORDER

The ALJ's order dated September 11, 1995 is affirmed.

March 27, 1996 Cite as 48 Van Natta 603 (1996)

In the Matter of the Compensation of
KENNETH P. McCORMICK, Claimant
WCB Case Nos. 95-01711 & 94-13457
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of claimant's aggravation claim for a low back injury. In its brief, the insurer contends that claimant's aggravation claim is barred by the terms of the parties' Stipulation. On review, the issues are claim preclusion and, if the claim is not precluded, aggravation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claim Preclusion

Claimant experienced a compensable low back injury in April 1993. His claim was closed by a December 21, 1993 Notice of Closure that awarded 19 percent unscheduled permanent disability. A July 6, 1994 Order on Reconsideration increased the permanent disability award to 22 percent. Claimant requested a hearing. On September 16, 1994, while the request for hearing was pending, claimant sought treatment for increased low back symptoms. A claim for aggravation was filed. On October 31, 1994, the parties entered into a stipulation in which they agreed to settle all issues raised or which could have been raised through the date of approval of the stipulation. (Ex. 39). On the same date, the insurer denied claimant's aggravation claim. (Ex. 40).

The ALJ concluded that, because the October 31, 1994 stipulation was signed before the aggravation denial issued and clearly addressed claim closure issues from the 1993 claim closure, the aggravation issue was not precluded by the "boiler-plate" language of the stipulation. The insurer contends that, because claimant could have raised the issue of aggravation at the time of the stipulation, his aggravation claim is barred. We agree.

In Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994), the court reversed a Board order which held that a claimant's wrist nerve condition was not barred by a previous stipulation unless the claimant "intended to waive that right when she signed the stipulation." The court disagreed with our analysis. Instead, relying on Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993), the court explained that, where neither party argues that the language of the settlement is ambiguous, its interpretation is as a matter of law. Thus, the court continued, the "correct inquiry is whether claimant's condition and its compensability could have been negotiated before approval of the settlement." 126 Or App at 73. The court reasoned that, because the claimant's nerve condition had been diagnosed prior to the date the parties entered into the stipulation agreement (in which the parties agreed that the claimant's accepted wrist claim would remain closed), the claimant's nerve condition was an issue that could have been raised before that date. Id. Therefore, the court concluded, the claimant's wrist condition claim was barred by the settlement agreement.

Claimant contends that the settlement did not include all future aggravations, reasoning that, had that been the case, the parties would have entered into a Claims Disposition Agreement rather than

a stipulated settlement. The insurer, however, does not contend that all future aggravation claims are barred, but only the claim that arose prior to the October 31, 1994 stipulation. Moreover, neither party argues that the stipulation is ambiguous. Thus, the question is whether claimant's aggravation claim could have been negotiated before approval of the settlement. The answer is "yes." Consequently, claimant's aggravation claim is barred by the terms of the stipulation.

As noted above, claimant sought treatment for increased low back symptoms and an aggravation claim for his low back injury was filed prior to the October 31, 1994 Stipulation. At the time of the stipulation, therefore, the aggravation issue was pending and could have been negotiated before approval of the settlement. When the parties entered into the stipulation, they agreed to "settle all issues raised or raisable." After approving the stipulation, the ALJ ordered that claimant's request for hearing be "dismissed with prejudice as to all issues raised or which could have been raised through date of approval of the stipulation." (Emphasis added).

Therefore, because claimant had been treated for a worsened low back condition and an aggravation claim had been filed prior to the date the parties entered into the stipulation, claimant's aggravation claim was an issue that could have been raised before the date the stipulation was approved. Under these circumstances, we find that claimant did not preserve the issue of aggravation. Consequently, claimant's aggravation claim for his worsened low back condition is barred by the stipulation. Stoddard, supra; Seney, supra; Jean K. Elliot-Moman, 47 Van Natta 1100 (1995) (when an issue is pending between the parties, a stipulation in which the parties agree to settle "all issues raised or raisable" at the time of the stipulation includes the parties' rights and obligations regarding the pending issue).

Because we have found that claimant's aggravation claim is barred by the terms of the stipulation,[1] we need not address the merits of the claim.

ORDER

The ALJ's order dated July 12, 1995 is affirmed.

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[1] We note that the stipulation also bars the insurer from taking further action on this aggravation claim. Because the aggravation claim was settled by the stipulation, the denial is, in effect, moot.

March 26, 1996 Cite as 48 Van Natta 604 (1996)

In the Matter of the Compensation of
MARLENE J. ANDRE, Claimant
Own Motion No. 95-0458M
OWN MOTION ORDER OF ABATEMENT
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our February 21, 1996 Own Motion Order, in which we declined to reopen her claim for the payment of temporary disability compensation because she failed to establish that she was in the work force when her condition worsened requiring surgery.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. SAIF is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
NAOMI WHITMAN, Claimant
WCB Case No. 95-00647
ORDER ON REVIEW
Vanvoorhees & Larson, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self insured employer requests review of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's upper back and shoulder injury claim. On review, the issue is compensability.

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

The ALJ found that claimant testified credibly to an on-the-job accident which occurred on December 12, 1994. The ALJ applied a material contributing cause standard and concluded that claimant suffered an accidental injury which arose out of and in the course of her employment.

The employer argues that claimant was not a credible witness. According to the employer, the inconsistencies between claimant's testimony and the testimony of other witnesses were significant. The employer also contends that the medical opinion is not persuasive because it was based on an inaccurate history from an unreliable claimant.

Although the ALJ found claimant's testimony credible, he made no express credibility findings based upon claimant's demeanor. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987).

After our de novo review of the record, we agree with the ALJ's analysis and conclusions. We agree with the ALJ that, although there were inconsistencies between claimant's testimony and the testimony of other witnesses, those inconsistencies do not detract from claimant's testimony or the evidence regarding the occurrence of her injury, the prompt reporting of the injury and her receipt of medical services soon after the injury. Inconsistent statements related to collateral matters are not sufficient to defeat claimant's claim where, as here, the record as a whole supports her testimony. See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984), rev den 298 Or 597 (1985).

The employer argues that claimant failed to prove a compensable injury to her mid-back because there were no objective findings of an injury.[1] Amended ORS 656.005(19) provides that "objective findings" in support of medical evidence are:

> "verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

In Jairo J. Garcia, 48 Van Natta 235 (1996), the issue was whether the claimant's subjective pain complaints were sufficient to constitute "objective findings" under amended ORS 656.005(19). Citing Georgia Pacific Corp. v. Ferrer, 114 Or App 471 (1992), and Suzanne Robertson, 43 Van Natta 1505 (1991), we stated that, under former ORS 656.005(19), a worker's description of pain (supported by a physician's indication that the worker was experiencing such symptoms) was sufficient to constitute "objective findings." However, since the 1995 legislature amended the definition of "objective findings," we found it necessary to interpret the amended statutory phrase "verifiable indications of injury or

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[1] We note that, although the employer contends that claimant had a preexisting problem with back pain, there is no medical evidence that claimant's December 12, 1994 injury "combined" with a preexisting back condition. Therefore, amended ORS 656.005(7)(a)(B) does not apply to this claim and claimant need only establish that her work injury was a material contributing cause of her disability and need for treatment. ORS 656.005(7)(a); see Leon M. Haley, 47 Van Natta 2056, on recon 47 Van Natta 2206 (1995).

disease." We found that language ambiguous and turned to the legislative history. After reviewing that history, we concluded that the statutory amendments were clearly intended to overrule the Suzanne Robertson holding. Consequently, we determined that a physician's indication that the worker experiences pain, standing alone, is no longer sufficient to constitute "objective findings."

In Garcia, the claimant's attending physician reported that the claimant had pain, but he characterized the findings of pain as subjective and not objective. The attending physician reported that there were no "objective findings" of injury. We concluded that, in the absence of findings that were "reproducible, measurable or observable," the claimant's injury claim based on his "subjective response" was not compensable because it was not based on "medical evidence supported by objective findings" as required by ORS 656.005(7)(a).

Here, the employer contends that there is no medical evidence supported by objective findings of an injury to claimant's back. We disagree.

Claimant was examined by Dr. Claridge on December 17, 1994, five days after her work injury. Dr. Claridge reported:

> "Exam shows mid T-spine tenderness at the T 6-7-8 area, though no localized area and no significant paraspinous spasm. Some lipoid tissue there. ROM is otherwise okay and no limping." (Ex. 1).

Dr. Claridge prescribed medication, heat and stretching exercises and he took claimant off work for one week.

On December 23, 1994, Dr. Claridge reported that claimant had "tenderness in the right upper paraspinous area that is mild but progressive up to the right trapezius area." (Ex. 1). Claimant's range of motion was "full." Dr. Claridge released claimant from working until December 26, 1994. Dr. Claridge concluded that claimant was medically stationary as of December 30, 1994. (Exs. 1, 10).

On January 20, 1995, Dr. Claridge reported that claimant's "tenderness is localized in the mid T-spine area about T6-7," but he noted that he could not "really localized (sic) it with anymore than trace tenderness today." (Ex. 9). He commented that claimant had paraspinous discomfort. Dr. Claridge also noted that claimant's right trapezius was more tender and there might be a trigger point that could be amenable to a cortisone injection. Dr. Claridge's March 14, 1995 exam did not show any shoulder tenderness or any mid-spinal tenderness or paraspinous tenderness.

The employer relies on Dr. Claridge's comment in a February 23, 1995 report to argue that Dr. Claridge did not believe that claimant's tenderness was an objective finding. On February 23, 1995, Dr. Claridge reported that claimant had incurred a mild thoracic spine sprain on December 12, 1994. He explained that when he saw claimant on January 20, 1995, she had "full range of motion of her shoulder and spine with no sign of atrophy, spasm or objective findings of any significant problem." (Ex. 10). However, Dr. Claridge noted that claimant did have scattered areas of tenderness that were mild.

The employer's reliance on Dr. Claridge's comment in the February 23, 1995 report is misplaced. First, since Dr. Claridge determined that claimant was medically stationary as of December 30, 1994, his findings from the January 20, 1995 exam are not particularly significant in determining whether claimant had objective findings of an injury resulting from the December 12, 1994 accident. In any event, Dr. Claridge's February 23, 1995 report indicates, at most, that claimant had no "objective findings of any significant problem" during the January 20, 1995 examination. Contrary to the employer's assertion, that report does not establish that claimant had no objective findings of an injury.

Based on Dr. Claridge's December 17, 1994 report, we find that claimant had objective findings of a sprain. Under amended ORS 656.005(19), objective findings in support of medical evidence are "verifiable indications of injury" that may include range of motion and palpable muscle spasm. On December 17, 1994, Dr. Claridge found that claimant had mid thoracic spine tenderness at the T 6-7-8 area, but her ROM (range of motion) was "otherwise okay." (Ex. 1). Since claimant's range of motion was "otherwise okay," we infer from Dr. Claridge's statement that claimant's range of motion in her thoracic spine was reduced. Furthermore, Dr. Claridge commented that claimant had "no significant paraspinous spasm." We infer from that statement that claimant did have a paraspinous spasm, albeit insignificant.

Claimant's reduced range of motion in her thoracic spine was "measurable" and the paraspinous spasm was "observable." See Jairo J. Garcia, supra, n. 2 (an example of a "measurable" finding could be reduced range of motion). We conclude that claimant's reduced range of motion and her paraspinous spasm (although insignificant) resulting from the sprain injury constituted "objective findings" under amended ORS 656.005(19). See Rosalie A. Peek, 47 Van Natta 1432 (1995) (bruising and reduced range of motion were verifiable, observable indications of injury); compare Jairo J. Garcia, supra (the claimant's physician indicated only that the claimant had pain and all other findings were normal).

We find that Dr. Claridge's opinion is well-reasoned and based on an accurate history. See Somers v. SAIF, 77 Or App 259 (1986). There are no contrary medical opinions. We agree with the ALJ that Dr. Claridge's opinion is persuasive and sufficient to satisfy claimant's burden of proof.

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

ORDER

The ALJ's order dated April 21, 1995 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $1,000, payable by the employer.

In the Matter of the Compensation of
JAMIL GHORES, Claimant
WCB Case No. 94-00986
ORDER ON REVIEW
Peter O. Hansen, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) affirmed a Determination Order which reversed claimant's permanent total disability (PTD) award as of November 4, 1993; and (2) declined to award penalties for allegedly unreasonable claims processing. On review, the issues are permanent total disability and penalties.

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

At hearing and on review,[1] claimant argues that the insurer must prove that claimant's condition has improved in order to establish that claimant is no longer entitled to PTD benefits. That is not the correct standard. The courts have repeatedly held that, when a carrier seeks to modify or terminate a PTD award, it has the burden to prove that the claimant presently is able to perform a gainful and suitable occupation. Harris v. SAIF, 292 Or 683, 696 (1982); Gettman v. SAIF, 289 Or 609, 614 (1980). This same standard applies even if the claimant's disability or physical condition remains essentially unchanged. Lehman v. SAIF, 107 Or App 207, 211 (1991); Kytola v. Boise Cascade Corp., 78 Or App 108, 112, rev den 301 Or 765 (1986). On this record, we agree with the ALJ's reasoning and conclusions that the insurer has proven that claimant is presently able to perform a gainful and suitable occupation.

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[1] We note that this matter is before the Hearings Division and the Board as the result of a direct appeal from a November 5, 1993 Determination Order issued by the Department in response to the insurer's reexamination of claimant's permanent total disability status pursuant to ORS 656.206(5). As a result, no reconsideration order issued pursuant to ORS 656.268. Therefore, the amendments made by Senate Bill 369 to ORS 656.283(7), which limit the evidence that can be considered at hearing to that submitted at the reconsideration required by ORS 656.268, do not apply. Compare Joe R. Ray, 48 Van Natta 325 (1996) (pursuant to amended ORS 656.283(7), no further evidence of permanent partial disability is admissible after reconsideration required by ORS 656.268).

In addition, on review, claimant argues that the medical evidence does not establish that he can perform medium/heavy work on a sustained basis. However, claimant presents no evidence in support of his argument.

On January 30, 1992, Dr. Snodgrass, neurologist, examined claimant on behalf of the insurer. (Ex. 67). At that time, claimant reported constant pain in his left neck/shoulder area and activities limited to reading, watching television, grocery shopping, and visiting his family. (Ex. 67-2). Dr. Snodgrass concluded that claimant's condition had not changed for the past 10 years and he "would not anticipate any change or return to work from this well-established problem." (Ex. 67-4). However, Dr. Snodgrass changed his opinion after viewing surveillance videos which showed claimant washing a car, changing tires on a car, lifting the hood of a car with his left hand above his head, and unloading household effects from a truck and taking them into a house. These items included a large tool chest on wheels and two large appliances, possibly a refrigerator and washer or a washer and dryer. (Exs. 66a, 66b, 68). After viewing these videos, Dr. Snodgrass concluded that claimant had not been truthful in describing a complete inability to do anything for several years and found claimant capable of medium/heavy work. (Ex. 68-2).

Although claimant argues that Dr. Snodgrass' opinion does not establish that claimant can perform medium/heavy work on a sustained basis, Dr. Snodgrass did not indicate any restrictions regarding claimant's ability to perform this level of work. In addition, after viewing the videos in question, we find that Dr. Snodgrass accurately summarized their content. Furthermore, Dr. Snodgrass' opinion that claimant is capable of medium/heavy work is unrebutted. Although we are not compelled to rely on an unrebutted medical opinion, we find Dr. Snodgrass' opinion persuasive in that it is well-reasoned and based on an accurate history of claimant's abilities. Somers v. SAIF, 77 Or App 259, 263 (1986).

Finally, the employer's vocational expert, Ms. Banks, persuasively opined that claimant is capable of gainful and suitable employment in a hypothetically normal labor market up to a medium work range level. (#3 Tr. 31-32). Ms. Banks' opinion is unrebutted. She listed several medium work range level jobs claimant is capable of performing, including landscaper, carpenter, maintenance worker, warehouse worker, delivery driver, drill press operator, wood working assembly, and janitor. (#3 Tr. 32-33, 37-38). She based her opinion about claimant's employability on Dr. Snodgrass' assessment of claimant's physical capacity, claimant's skills developed in his 20 years as a carpenter, labor market surveys, newspaper ads, and contacts with employers in the Portland area. In addition, she specifically asked employers about the effect of claimant's age and time away from the work force and related the only problem appeared to be in a machine shop setting where claimant would have to remain in an entry level position. (#3 Tr. 38-39). Ms. Banks also found claimant capable of performing several light work range level jobs, including security guard, packager, car wash attendant, furniture assembly, cashier, valet parking, production worker, food preparation. (#3 Tr. 39-40). Based on Ms. Banks' well-reasoned opinion, we find that the insurer has met its burden to prove that claimant presently is able to perform a gainful and suitable occupation.

ORDER

The ALJ's order dated July 12, 1995 is affirmed.

In the Matter of the Compensation of
CYNTHIA A. WATSON, Claimant
WCB Case No. 95-00758
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Christian and Gunn.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's injury claim for neck and facial injuries. On review, the issue is compensability.

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

The employer contends that claimant's injuries, which were incurred while engaged in a snowball fight, did not arise within the course and scope of her employment. Under Oregon law, an active participant in or instigator of horseplay who is injured may not receive compensation unless the employer knew or should have known of and acquiesced in the behavior. See Kammerer v. United Parcel Service, 136 Or App 200 (1995); Stark v. State Industrial Acc. Com., 103 Or 80, 98 (1922).

For the reasons given in the ALJ's order, we agree that the record supports the conclusion that claimant's employer acquiesced in the horseplay which resulted in claimant's injury. Because the employer acquiesced in the horseplay which resulted in claimant's injuries, we conclude that those injuries arose in the course and scope of employment. Kammerer v. United Parcel Service, supra.

On review, the employer raises an issue not raised at hearing or addressed by the ALJ's order. Specifically, the employer contends that claimant's claim is not compensable under ORS 656.005(7)(b)(B), which excludes from compensation an injury incurred while engaging in a recreational activity primarily for the worker's personal pleasure.

At the hearings level, the employer contended that claimant's injuries did not arise out of and in the course of employment because they were the result of horseplay. The employer did not raise ORS 656.005(7)(b)(B) either in its denial or on the record at hearing.

We have consistently held that we will not consider an issue raised for the first time on appeal. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). We acknowledge that the employer's position on review could be characterized as merely a different theory in support of its denial. Nevertheless, because the employer did not make this argument (that claimant's injuries were the result of engaging in a recreational activity primarily for her personal pleasure), we conclude that claimant would be prejudiced if we considered this late-raised theory on review. See Clive G. Osbourne, 47 Van Natta 2291, 2293 (1995).

In Osbourne, the employer argued at hearing that its "back-up" denial was valid under the rule of Bauman v. SAIF, 295 Or 788 (1983). For the first time on Board review, the employer argued that the "back-up" denial should be upheld under ORS 656.262(6), because it was issued as the result of "later obtained evidence" which indicated that the claim was not compensable. We declined to address this new argument on review. We concluded that it would be fundamentally unfair to decide the case on a different basis than that argued at hearing. We find Osbourne to be analogous to the present case where the employer used a "course and scope" defense at hearing and now argues on review that the claim is not compensable under ORS 656.005(7)(b)(B).

This case is also analogous to Joseph D. McRorie, 46 Van Natta 253 (1994). There, the issue at hearing involved the suspension of benefits under ORS 656.325. On Board review, the employer, for the first time, raised the defense that the claimant was not entitled to workers' compensation benefits pursuant to ORS 656.156(1), because his injury resulted from an intentional injury. Finding that it would be fundamentally unfair to permit the employer to raise this defense for the first time on review, we declined to address the employer's "deliberate injury" argument. See also Greg S. Meier, 45 Van Natta 922, on recon 45 Van Natta 1015 (1993).

Here, the employer argued at hearing that claimant's injury did not arise out of and in the course and scope of her employment. On review, the employer for the first time contends that claimant's injuries are not compensable because they were incurred while engaging in an activity primarily for her personal pleasure. There was no opportunity at hearing to litigate the issue or present evidence responding to the new defense. ORS 656.005(7)(b)(B) involves a different standard and necessitates the development of different facts and evidence than does a standard course and scope analysis. Thus, as in Osbourne and McRorie, we conclude that it would be fundamentally unfair to address the employer's defense which was raised for the first time on review. Accordingly, we decline to address the employer's late-raised argument under ORS 656.005(7)(b)(B).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $850, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 26, 1995 is affirmed. For services on review, claimant's attorney is awarded $850, payable by the employer.

In the Matter of the Compensation of
JAY ARANA, Claimant
WCB Case No. 95-04160
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that affirmed an Order on Reconsideration awarding 10 percent (32 degrees) unscheduled permanent disability for a left shoulder condition. On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

Following his injury, claimant was released, and returned, to his regular job as a loader for United Parcel Service. (Exs. 12, 13). That job falls under DOT # 926.687-030 and has an SVP of 3.

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable left shoulder claim. A Determination Order awarded 23 percent unscheduled permanent disability. Claimant requested reconsideration. An Order on Reconsideration reduced the award to 10 percent based on an adaptability value of zero. Claimant requested a hearing.

The ALJ affirmed the Order on Reconsideration, agreeing that adaptability was 0 because claimant returned to regular work. See former OAR 436-35-290(2), 436-35-300(2) (WCD Admin. Order 93-056). Relying on the Board's order in Therese L. Petkovich, 46 Van Natta 1038 (1994), the ALJ rejected claimant's argument that application of the standards assigning no value to adaptability conflicted with England v. Thunderbird, 315 Or 633 (1993).

On review, claimant continues to assert that the standards are inconsistent with ORS

656.726(3)(f)(A)[1] and 656.214(5)[2] because the factors of age and education are not considered if adaptability has no value.

Subsequent to the ALJ's order, the Court of Appeals determined that a former standards giving a zero adaptability value in certain circumstances was inconsistent with ORS 656.214(5) and 656.726(3)(f)(A). Carroll v. Boise Cascade Corp., 138 Or App 610 (1996). The court relied on the Supreme Court's opinion in England v. Thunderbird, supra, which had invalidated a similar rule because it conflicted with a prior version of ORS 656.214.

We recently applied the Carroll decision to former OAR 436-35-280(1) and 436-35-310(2) (WCD Admin. Order 93-056). Joe R. Ray, 48 Van Natta 325 (1996). Under those rules, adaptability is determined by comparing base function capacity (BFC) to the worker's residual functional capacity (RFC) at the time of becoming medically stationary. In Ray, because the claimant's RFC was equal to his BFC, his adaptability factor under the applicable standards was zero. Inasmuch as the adaptability factor was used as a multiplier, the claimant was not allowed a value for age, education, or skills. Under Carroll, we concluded that, therefore, the rule was inconsistent with ORS 656.726(3)(f)(A). Joe R. Ray, supra.

Furthermore, we found that the value for these factors should be added to the value for impairment in determining the unscheduled permanent disability award. Such an analysis essentially resulted in assigning a value of one to the adaptability factor. Joe R. Ray, supra.

This case also comes under the standards set forth in WCD Admin. Order 93-056. As the ALJ found, application of those standards results in a value of 0 for adaptability because claimant returned to regular work. Consequently, based on our reasoning in Joe R. Ray, supra, the rule is inconsistent with ORS 656.726(3)(f)(A) and assign adaptability a value of one and add the value of the remaining factors of age, education and skills to impairment.

There is no dispute that impairment is 10 percent and there is no value for age. Claimant asserts, however, that he proved entitlement to a value of 3 for education. We agree.

Education is determined by the SVP associated with the appropriate DOT code for the job(s) performed by the worker during the five years preceding the time of closure. Former OAR 436-35-300(3), (a). Here, with regard to that time period, the record shows only that claimant worked as a loader for United Parcel Service; such a job falls under DOT # 926.687-030 and has an SVP of 3. Consequently, the value for education is 3.

Thus, the total value for claimant's age and education is 3; that value is multiplied by the adaptability value of 1 for a total of 3. Former OAR 436-35-280(6). When this value is added to the value of 10 percent for impairment, the result is 13. Former OAR 436-35-280(7). Thus, claimant's unscheduled permanent disability is 13 percent.

ORDER

The ALJ's order dated August 9, 1995 is modified. In lieu of the ALJ's award, and in addition to the Order on Reconsideration award of 10 percent (32 degrees) unscheduled permanent disability, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, for a total award of 13 percent (41.6 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the additional compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. In the event, however, that all or any portion of the "increased" unscheduled permanent disability award has already been paid to claimant, claimant's attorney may seek recovery of the fee in accordance with the procedures set forth in Jane A. Volk, 46 Van Natta 681, on recon 46 Van Natta 1017 (1994), aff'd Volk v. America West Airlines, 135 Or App 565 (1995).

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[1] ORS 656.726(3)(f) provides that the "criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job."

[2] ORS 656.214(5) provides, in relevant part:

"In all cases of injury resulting in permanent partial disability * * *, the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f)."

In the Matter of the Compensation of
ORVEL L. CHANEY, Claimant
Own Motion No. 95-0572M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant, pro se, requests reconsideration of our November 29, 1995 Own Motion Order, as reconsidered on January 31, 1996, in which we declined to reopen his 1987 claim for the payment of temporary disability compensation because he failed to establish he was in the work force at the time of his current disability. With his request for reconsideration, claimant submitted additional information regarding the work force issue.

On February 23, 1996, we abated our prior orders to allow SAIF sufficient time to consider claimant's motion for reconsideration. SAIF's response has been received. On reconsideration, we withdraw our prior orders, and issue the following order in place of our prior orders.

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.

As noted in our prior order, claimant underwent a left knee arthroscopy in October of 1995. 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. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

SAIF contends that claimant was not in the work force at the time of disability. Claimant contends that he qualifies for temporary disability compensation because he continued working as a live-in caregiver at the time his compensable condition worsened requiring surgery. Claimant has the burden of proof on this issue and must provide persuasive evidence that he was working at the time of disability.

Here, SAIF contends that claimant was last "gainfully employed" in 1993 because, at the time of disability, he was providing in-home care for his parents. We treat SAIF's contention as an assertion that in-home care does not constitute "gainful employment." In the alternative, SAIF contends that, although claimant provided in-home care for his parents, "there is no medical documentation attached which explains a medical need for [claimant] to provide care for the [parents]."

In support of his contention that claimant remained in the work force at the time of disability, claimant submits a January 5, 1996 signed letter from his mother, in which she stated that:

> "My husband and I are senior citizens, and are very disabled.
>
> "[Claimant] was working at that time at Albany Ore.
>
> "When [claimant] heard we needed live[-]in help desperately, he came to Summit City to care for us, with his wife Debbie.
>
> "We traded suport [sic].
>
> "They did the house work, cooking etc. and received in exchange board and room, from March 15[, 19]95 to Jan. 7[, 19]96. I would say [claimant] was gainfully employed as a live[-]in caretaker, which left him pretty busy when he was able to be on his feet."

Pursuant to ORS 656.005(29), "wages" include the "reasonable value of board, rent, housing, lodging or similar advantage received from the employer[.]" Thus, we conclude that, although claimant was not paid a salary or an hourly wage for in-home care, he did receive "wages" for his work in the form of room and board. See James L. Emerich, 45 Van Natta 1701 (1993); Debbie K. Craft, 47 Van Natta 1346 (1995).

SAIF also argues that claimant requires "medical documentation...which explains a medical need for [claimant] to provide care for the [parents]." We disagree. A claimant might be engaged in other live-in activities (night watchperson, house-sitter, gardener) without verification of its necessity, and still be considered "employed." The dispositive question is whether claimant received remuneration for services as set forth in ORS 656.005(30); it is immaterial whether such services were required.

We hold that wages earned for regular in-home care constitute "earnings," and would establish that a claimant was engaged in regular employment at the time of disability. On this record, we conclude that claimant has established that he was working until the time of his surgery in October 1995.

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

IT IS SO ORDERED.

March 29, 1996 Cite as 48 Van Natta 613 (1996)

In the Matter of the Compensation of
PATRICIA K. STODOLA, Claimant
WCB Case No. 95-03212
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Jame B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Odell's order that: (1) declined to award her temporary total disability benefits; and (2) declined to award penalties and attorney fees for allegedly unreasonable claims processing. On review, the issues are temporary disability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

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

Claimant began working for the employer in 1991. In February 1994, claimant's supervisor gave her a "Notice of Formal Warning" indicating that claimant had 30 days to improve her job performance or be terminated. The disciplinary action was based on complaints of co-workers and clients that claimant was discourteous and antagonistic. Claimant's September 27, 1993 annual evaluation similarly advised claimant of the need for improvement in the area of dealing with people.

Claimant's supervisor began keeping a log of claimant's progress in February 1994. Claimant was making positive strides through June 1994.

On April 15, 1994, claimant compensably injured her low back. She did not seek treatment, and the claim was denied for lack of medical treatment on April 27, 1994. Claimant saw Dr. Stout on May 24, 1994, complaining of pain in the right sacroiliac joint. She was released for regular work, and advised to avoid aggravating maneuvers.

Claimant again injured her back at work on June 7, 1994. She was seen by Dr. Jeffrey and diagnosed with a lumbosacral strain.

On June 8, 1994, claimant met with her supervisor to review and sign a "Return to Satisfactory Status" notice dated April 24, 1994. She was advised that her job performance would continue to be monitored through September 9, 1994, at the request of the employer's Board of Directors.

Claimant was treated by Dr. Ahlen on June 24, 1994. Dr. Ahlen restricted claimant to light work. Claimant provided Dr. Ahlen's written restrictions to her supervisor, and was instructed by the supervisor to limit her work activities accordingly and request assistance from co-workers when necessary. Claimant continued to receive her regular wage.

SAIF accepted claimant's claim for a nondisabling lumbosacral strain on July 6, 1994.

On July 8, 1994, Dr. Ahlen specified that claimant could carry and lift up to 40 pounds, but should avoid twisting and bending. These restrictions were also provided to claimant's supervisor.

Claimant was asked to resign on July 12, 1994. Claimant's supervisor advised claimant that a co-worker had complained of her rudeness on July 8, 1994 and a customer had called with a similar complaint on July 11, 1994. Claimant's requests for reinstatement and/or the opportunity to present her grievance to the employer's Board of Directors were denied.

Dr. Ahlen has continued claimant's work restrictions since July 1994. On October 5, 1994, claimant requested that the Department reclassify her claim as disabling. The claim was so reclassified on December 28, 1994. When SAIF did not pay temporary disability following claimant's employment termination, she requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was not terminated from her employment for reasons related to her compensable injury, and therefore her termination could not be interpreted as a withdrawal of a modified duty position by the employer. In addition, based on OAR 436-60-030(11)(b),[1] the ALJ found that claimant's entitlement to temporary disability benefits ceased upon her termination.

Claimant argues on review that she is entitled to temporary disability benefits from the date of her termination because she continued to suffer disability due to her compensable injury. Claimant also argues that the employer failed to comply with the rule requiring a written offer of modified employment, and therefore SAIF had no authority to terminate her temporary disability benefits. Finally, claimant argues that she was terminated for reasons relating to her compensable injury. We disagree with each contention.

We find this case is governed by Terri Link, 47 Van Natta 1711 (1995). There, as here, the claimant was released for and returned to modified work and did not lose any pay until her termination a few days later. We held that where the claimant was not terminated because of an inability to work due to her compensable injury, she was not entitled to temporary disability benefits on her termination. We explained that, under these circumstances, the pivotal question is not whether the employer complied with ORS 656.268(3), but whether the claimant had established an entitlement to temporary disability benefits in the first instance.

Here, after our review of the record, we find that claimant has not established her entitlement to temporary total disability benefits. Despite her restrictions, claimant was working and receiving her regular wage until her termination on July 12, 1994. The record does not show that claimant left work or that she suffered diminished earning capacity because of her compensable injury. Rather, as the ALJ found, her employment was terminated for reasons unrelated to the compensable injury. The employer, therefore, had no obligation to begin paying temporary disability benefits on claimant's termination.[2]

ORDER

The ALJ's order dated August 16, 1995 is affirmed.

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[1] OAR 436-60-030(11)(b) provides, in pertinent part, that the worker who is discharged for violation of normal employment standards shall be considered the same as the worker who fails to begin employment pursuant to ORS 656.268(3)(c).

[2] Although claimant had been released to modified work before her termination, her temporary partial disability benefits were properly computed at "zero" because her return-to-work wages were the same as her at-injury wages. See, e.g., Nenita Stockie, 48 Van Natta 299 (1996).

Board Member Gunn dissenting.

The majority concludes that claimant was terminated for reasons unrelated to her compensable injury and therefore she did not establish her entitlement to temporary disability benefits. Because, on this record, I am not willing to accept the employer's stated reasons for terminating claimant so shortly after she sustained a compensable injury, I respectfully dissent.

Even more so than the ALJ, I find the timing of claimant's discharge troubling. In fact, I believe that the temporal relationship between claimant's claim and her termination raises a presumption that the two events are causally related. I also believe that, in this case, the timing of claimant's termination constitutes prima facie evidence of a causal relationship sufficient to shift the burden to the employer to prove that the termination was in no way related to claimant's injury.

In evaluating whether the employer has established the lack of a causal relationship, I would apply the "reasonable employer" standard. In my concurring opinion in Daniel A. Jackson, 43 Van Natta 2361 (1991) (Board Member Gunn, specially concurring), I discussed the appellate law and other agency standards for assessing the reasonableness of an employer's conduct in disciplining or terminating an employee. See Brown v. Oregon College of Education, 52 Or App 251 (1981); Oregon School Employees v. Klamath County School District, 9 PECBR 8832 (1986) (Employment Relations Board decision enunciating the "traits possessed by the reasonable employer"). According to these cases, one trait of a "reasonable employer" is that it give an employee who is being dismissed notification of the charges against him or her and at least an informal opportunity to refute the charges to someone authorized to make the final decision. Other traits include being consistent in applying disciplinary sanctions and making a fair and objective investigation before administering discipline. See Daniel A. Jackson, supra.

In this case, I believe the employer failed to meet the "reasonable employer" standard when it terminated claimant on July 12, 1994 because it was not consistent in applying disciplinary sanctions and did not provide claimant with adequate notification of the charges against her. In addition, the employer did not give claimant the opportunity to refute the allegations that led to her termination, as the employer's Board of Directors elected not to entertain her grievance.

In February, 1994, well before her injury, claimant had been given a "formal warning" and advised of her shortcomings. The employer worked with claimant during the next few months to improve her performance and noted no further problems with her performance through June 1994. On June 8, 1994, claimant was advised that she had returned to "satisfactory status" as of mid-April. Then, on July 12, 1994, just days after SAIF accepted her June 7, 1994 claim for a lumbosacral strain, claimant was asked to resign because she was allegedly discourteous to a co-worker on July 8 and a customer on July 11, 1994.

Contrary to the employer's employee manual, claimant was not given notice of disciplinary action before she was discharged. Her earlier warning, in February 1994, should not count since claimant had returned to "satisfactory status" and her job performance had been acceptable for nearly six months. Whereas before her injury claimant was counseled by the employer and given the chance to improve, afterwards she was simply terminated without warning and an opportunity to be heard when others complained of her attitude.

Under these circumstances, I would find that the employer did not act as a "reasonable employer" following claimant's injury claim. I would also find, therefore, that the employer did not prove the lack of a causal relationship between claimant's injury and her termination. Because claimant was terminated for reasons related to her compensable injury, she is entitled to temporary disability benefits from the date of her discharge. Therefore, I respectfully dissent.

In the Matter of the Compensation of
CHARLES TEDROW, Claimant
Own Motion No. 94-0095M
OWN MOTION ORDER
Emmons, et al, Claimant Attorneys
Bailey & Associates, Defense Attorneys

Claimant contends that the insurer has failed to comply with our February 9, 1994 Own Motion Order, and requests that the Board enforce its order by requiring the insurer to pay claimant temporary disability compensation commencing the date of surgery until claimant is medically stationary. In addition, claimant seeks penalties and attorney fees for the insurer's allegedly unreasonable resistance to payment of compensation. On June 1, 1994, in order to consider these issues, the Board implemented a briefing schedule. However, pursuant to the parties' requests for submission of additional information, the matter was subsequently referred to the Hearings Division for findings of fact.

The fact-finding hearing was held before Administrative Law Judge (ALJ) Holtan on October 19-20, 1994. On October 23, 1995, ALJ Holtan issued a recommendation that the Board find that: (1) claimant is entitled to temporary total disability compensation from January 16, 1992 through February 28, 1992; (2) claimant worked four hours per day, for a total of 20 hours per week, from March 1, 1992 through September 18, 1992; (3) claimant worked four hours per day, for a total of 20 hours per week, from September 19, 1992 through March 1, 1993; (4) claimant's attorney receive an approved out-of-compensation attorney fee; and (5) penalties and attorney fees for the insurer's allegedly unreasonable resistance to payment of compensation be disallowed.

Following receipt of ALJ Holtan's recommendation, the Board implemented a briefing schedule to allow the parties an opportunity to respond to the ALJ's recommendation. The parties' responses have been received. We therefore proceed with our review.

ISSUES

1. Entitlement to temporary disability compensation.

2. Penalties and attorney fees for the insurer's allegedly unreasonable delay in payment of compensation.

FINDINGS OF FACT

We adopt the findings of fact set forth in the ALJ's recommendation, with the following supplementation.

On February 9, 1994, we issued our Own Motion Order authorizing the payment of temporary disability compensation for claimant's compensable low back injury. Our order authorized the payment of temporary total disability compensation beginning the date claimant was hospitalized for surgery. In addition, the insurer was ordered to close the claim pursuant to OAR 438-012-0055 when claimant became medically stationary.

On February 21, 1994, the insurer issued its Notice of Closure, which awarded claimant temporary disability compensation from January 16, 1992 through March 1, 1993. Claimant was declared medically stationary on March 1, 1993.

On March 4, 1994, we issued our Own Motion Order on Reconsideration, in which we authorized an approved out-of-compensation attorney fee, in the amount of 25 percent of the increased temporary disability compensation awarded by our February 9, 1994 order.

On May 23, 1994, claimant notified the Board that the insurer had not complied with our February 9, 1994 order "in payment of temporary total disability benefits from the date of surgery until [claimant] is medically stationary." Claimant requested enforcement of our February 9, 1994 Own Motion Order for the payment of temporary disability compensation beginning the date claimant underwent surgery. In addition, claimant requested penalties and attorney fees for alleged unreasonable resistance to pay compensation.

Claimant did not seek review of the insurer's February 21, 1994 Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Compensation

Claimant asserts that he is entitled to further disability benefits pursuant to our February 9, 1994 Own Motion Order and that the insurer improperly withheld those benefits. We disagree.

Our February 9, 1994 order, as reconsidered March 4, 1994, ordered the insurer to pay temporary disability benefits until claim closure pursuant to OAR 438-012-0055. By virtue of our order, claimant's claim was reopened and he became procedurally entitled to temporary disability benefits. However, the insurer closed claimant's claim with a February 21, 1994 Notice of Closure. Since claimant's claim has been closed, his procedural entitlement to temporary disability benefits can no longer be at issue and the Board is without authority to award such benefits. See Lebanon Plywood v. Seiber, 113 Or App 651 (1992); Jo W. Orman, 47 Van Natta 1496 on recon 47 Van Natta 2279 (1995); David A. Tentinger, 45 Van Natta 935 (1993).[1]

The time period for which claimant seeks temporary disability benefits has been substantively determined by the Notice of Closure. If claimant disagreed with the insurer's decisions regarding his substantive entitlement to or the amount of temporary disability compensation, he could have appealed the insurer's February 21, 1994 Notice of Closure. See Thomas L. Abel, 45 Van Natta 1768 (1993). Such an appeal must be made pursuant to OAR 438-012-0060. Under the applicable version of that rule, claimant had 60 days from the mailing date in which to appeal the insurer's Notice of Closure or 180 days if he established good cause for his failure to appeal within the 60-day time limit. See Former OAR 438-12-060. However, claimant did not seek review of the February 21, 1994 Notice of Closure and that closure is now final.[2] Thus, we conclude that we have no authority to award additional temporary disability compensation beyond the amounts already paid by the insurer.

Penalties and Attorney Fees

Claimant contends that he is entitled to penalties and attorney fees for the insurer's allegedly unreasonable failure to pay temporary disability compensation. We disagree.

A carrier's actions are unreasonable if it does not have a legitimate doubt as to its liability. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

At the time claimant filed his own motion request, our administrative rules provided that the first payment of temporary disability benefits must be made within 14 days from the date of an order of the Board reopening the claim. Former OAR 438-12-035(1). Our rules further required that payment of temporary disability benefits be continued "until termination of such benefits is authorized by the terms of ORS 656.268." Former OAR 438-12-035(4).

Here, our February 9, 1994 order obligated the insurer to begin paying temporary disability benefits within 14 days and continue to pay those benefits until termination was authorized under the relevant statutory provisions. The insurer complied with our order by paying claimant benefits pursuant to its February 21, 1994 Notice of Closure. That Notice of Closure also extinguished any further obligation to pay procedural temporary disability benefits. Since the insurer was not obligated to pay further temporary disability benefits following claim closure, it follows that its failure to do so was not unreasonable. Consequently, neither a penalty or related attorney fee is warranted.

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[1] We also note that even if the dispute is characterized as an enforcement proceeding, we still lack authority to award procedural temporary disability as claimant's request does not meet the criteria set forth in Galvin C. Yoakum, 44 Van Natta 2403 on recon 44 Van Natta 2492 (1992). That is, while claimant's request concerns the insurer's "pre-closure" conduct, his request was not filed prior to claim closure and he seeks to obtain a greater temporary disability award than granted by the Notice of Closure. Consequently, we do not have the authority to award further procedural temporary disability benefits under our original order. Yoakum, supra.

[2] To the extent that claimant's position could be interpreted as a disagreement with the rate of temporary disability benefits, his failure to appeal the Notice of Closure would also preclude him from now raising that issue. See Hammon Stage Line v. Stinson, 123 Or App 418 (1993)(the claimant was precluded from contesting rate of temporary disability benefits because the Determination Order that awarded those temporary disability benefits was not appealed and became final).

Finally, claimant's counsel requests an assessed attorney fee for services rendered in this matter. Attorney fees in workers' compensation cases cannot be awarded unless specifically authorized by statute. Forney v. Western States Plywood, 297 Or 628 (1984). Here, claimant does not cite, nor have we found, any statute which would authorize the Board in its own motion authority to award an additional fee to claimant's attorney. Forney v. Western States Plywood, supra; Jerry Simmons, 48 Van Natta 104 (1996). Moreover, claimant has not established entitlement to any further compensation. Therefore, we are unable to grant claimant's request for an assessed attorney fee.

IT IS SO ORDERED.

March 29, 1996 Cite as 48 Van Natta 618 (1996)

In the Matter of the Compensation of
SADIE SYMONDS, Claimant
Own Motion No. 95-0347M
OWN MOTION ORDER OF DISMISSAL
Popick & Merkel, Claimant Attorneys
Bostwick, et al, Defense Attorneys

On July 6, 1995, the Board issued its Own Motion Order, in which we authorized the reopening of claimant's 1978 injury claim for the payment of temporary disability compensation commencing the date claimant was hospitalized or underwent surgery. On July 19, 1995, the self-insured employer issued a Notice of Closure, which closed claimant's claim with an award of temporary disability compensation from November 24, 1993 through December 7, 1993. On March 13, 1996, the Board received a "Stipulation and Order," in which the parties seek Board authorization of additional temporary disability compensation for claimant for the period of December 8, 1993 through December 24, 1993.

In light of such circumstances, the stipulation essentially purports to amend the temporary disability award granted in the employer's July 19, 1995 Notice of Closure. As such, we treat the stipulation as a request for review of the Notice of Closure. Inasmuch as that closure has become final, we are without authority to modify the award granted therein.

A Notice of Closure is final unless the claimant timely files a written request for review of that closure. Here, the employer closed claimant's claim on July 19, 1995. Under former OAR 438-12-060(1), the request for review must be filed with the Board within 60 days after the mailing date of the order, or within 180 days if claimant establishes good cause for failure to file the request within 60 days after the mailing date.

Here, the 60th day following the July 19, 1995 Notice of Closure was September 16, 1995. Further, the 180th day following the July 19, 1995 Notice of Closure was January 14, 1996.[1] Thus, the record neither establishes that claimant requested review of the employer's Notice of Closure of her claim within 60 days after the mailing date of the Notice of Closure, nor that she established, within 180 days after the mailing date, good cause for failure to file the request within 60 days after the mailing date. Id.

Consequently, the record establishes that claimant did not timely request review of the employer's July 19, 1995 Notice of Closure. Because we are without authority to review the employer's July 19, 1995 Notice of Closure, we lack authority to consider an agreement which is designed to modify that final award. Consequently, the request for review of the Notice of Closure is dismissed.

IT IS SO ORDERED.

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[1] We note that the Stipulation and Order was initially directed to the Workers' Compensation Division, rather than to the Board. In addition, the agreement is date stamped "February 15, 1996 Rec'd WCD." However, even if we were to consider the date of the Department's receipt of the agreement, that date also falls beyond the 180 days allowed for timely appeal of the July 19, 1995 Notice of Closure in this claim.

WORKERS' COMPENSATION CASES

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IN THE SUPREME COURT OF THE STATE OF OREGON

Cheryl HUFF, *Respondent on Review,*

v.

GREAT WESTERN SEED CO., a New Jersey Corporation, and Lance Dickey, *Petitioners on Review.*

(CC 930061; CA A80301; SC S41976)

In Banc

On review from the Court of Appeals.*

Argued and submitted September 12, 1995.

Kathy Peck, of Williams, Zografos, Peck & Atwood, Salem, argued the cause for petitioners on review. With her on the briefs was Eli D. Stutsman, Portland.

Mark K. Grider, Salem, argued the cause and filed the brief for respondent on review.

Trent T. Whitford, Salem, filed briefs on behalf of *amicus curiae* Cascade Employers Association.

Corbett Gordon, of Gordon, McKeon & Rives, Portland, filed a brief on behalf of *amicus curiae* Family Restaurants, Inc.; ARG Enterprises, Inc., dba (in Oregon) Stuart Anderson's Restaurants, Stuart Anderson's Black Angus, and Stuart Anderson's Cattle Company; and Community Ambulance.

Francis T. Barnwell and Kenneth E. Bemis, of Bullard, Korshoj, Smith & Jernstedt, Portland, filed a brief on behalf of *amicus curiae* Armstrong World Industries; Food Employers, Inc.; Fred Meyer, Inc.; NIKE, Inc.; Norpac Foods, Inc.; Northwest Packers Industrial Association; Red Lion Inns; Rogue Valley Medical Center; TNT Reddaway Truck Line; and United Grocers, Inc.

322 Or 458> Doris J. Brook, Portland, filed a brief on behalf of *amicus curiae* Oregon Trial Lawyers Association.

GILLETTE, J.

The decision of the Court of Appeals is reversed. The judgment of the circuit court is affirmed.

* Appeal from Linn County Circuit Court, William 0. Lewis, Judge. 131 Or App 459, 885 P2d 723 (1994)

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322 Or 460> We are asked in this case to decide when the statute of limitations begins to run in a particular class of unlawful employment practice actions brought pursuant to ORS 659.121(l). Those actions, designated as "unlawful motive" cases in the employment law field, are cases in which the employer is charged with engaging in a practice that, except for the fact that it is prompted by an unlawful motive, would be lawful. The Court of Appeals concluded that, in such cases, the applicable statute of limitations, ORS 659.121(3)[1] does not begin to run until the plaintiff "ha[s] the requisite knowledge of the employer's discriminatory motive to make him aware that an unlawful practice ha[s] occurred." *Huff v. Great Western Seed Co.,* 131 Or App 459, 464, 885 P2d 723 (1994). On review, we hold that a plaintiff's belated discovery of an employer's unlawful motive does not delay the commencement of the statutory limitations period.

Because this case was decided on a motion to dismiss, we take the facts from plaintiff's complaint. *See Dotson v. Smith,* 307 Or 132, 134, 764 P2d 540 (1988) (stating methodology). In 1991, plaintiff suffered a work-related injury that required her to be absent from work. Later in that year, when plaintiff attempted to return to work, defendants refused to reinstate her. On January 2, 1992, defendants did reinstate plaintiff, but ultimately discharged her one week later, on January 9, 1992. At the time of her discharge, defendants told plaintiff that she was being fired for having a "bad attitude." Two weeks later, however, on January 24, 1992, plaintiff obtained a copy of a memorandum signed by defendant Dickey stating that plaintiff was discharged for "actively promoting and advocating fraudulent injury claims in the category of workman's [sic] compensation against the SAIF Insurance Co."

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[1] ORS 659.121(3) is set out below, 322 Or at 461.

Plaintiff filed the present action on January 20, 1993, alleging that defendants had violated ORS 659.410, 659.415, and 659.420, by refusing to reinstate plaintiff and, later, by firing her for invoking her rights under the workers' compensation statutes.[2] Defendants moved to dismiss the **<322 Or 460/461>** complaint, pursuant to ORCP 21 A(9), on the ground that plaintiff's action had not been commenced within the relevant one-year period of limitation, set out in ORS 659.121(3). That statute provides in part:

> "Where no complaint has been filed pursuant to ORS 659.040(l) or 659.045(l) and except as otherwise provided herein, the civil suit or action shall be commenced within one year of the occurrence of the alleged unlawful employment practice. "

The trial court granted defendants' motion and entered judgment against plaintiff.

On appeal, the Court of Appeals reversed, holding that, because ORS 659.121(3) embraces the so-called "discovery rule,"[3] the limitations period provided therein did not begin to run until plaintiff received Dickey's memorandum, thereby discovering defendants' unlawful motive. In so holding, the court relied on its own opinions in *Kraxberger v. Chevron USA, Inc.*, 118 Or App 686, 848 P2d 1242 (1993), and *Cortez v. State of Oregon,* 121 Or App 602, 855 P2d 1154, *rev den* 318 Or 25 (1993), both of which assume, without analysis, that ORS 659.121(3) incorporates the discovery rule. Defendants now ask this court to examine that assumption and to decide this case on the basis of this court's own analysis of ORS 659.121(3).

322 Or 462> A discovery rule cannot be assumed, but must be found in the statute of limitations itself. Our task, thus, is an interpretive one: We must determine whether the legislature intended to adopt the discovery rule when it enacted ORS 659.121(3).

As always, we begin the process of statutory interpretation with the text and context of the statute. *PGE v. Bureau of Labor and Industries,* 317 Or 606, 610, 859 P2d 1143 (1993). On its face, ORS 659.121(3) conveys a legislative intent that the limitations period commence with the "occurrence" of the unlawful employment practice, but when is that?

The word is not defined in the statute. Neither is it self-defining. Resort to the dictionary, while it suggests a direction, does not resolve the issue, either. The dictionary defines "occurrence" as "something that takes place; *esp:* something that happens unexpectedly and without design[;] * * * the action or process of being met with or coming into view." *Webster's Third New Int'l Dictionary, 1561* (unabridged 1993). The first definition would make the "occurrence" an event that need not have been discovered to have legal effect. The second definition, on the other hand, could be said to lend some comfort to the other view. On its face, therefore, it is not clear which interpretation of ORS 659.121(3) was intended by the legislature. *See PGE,* 317 Or at 611 (stating that standard for resolving statutory interpretation questions based on text and context alone). We therefore turn to legislative history to resolve remaining doubts as to the legislature's intent. Id. at 611-12.

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[2] ORS 659.410(l) provides:

> "It is an unlawful employment practice for an employer to discriminate against a worker with respect to hire or tenure or any term or condition of employment because the worker has applied for benefits or invoked or utilized the procedures provided for in ORS chapter 656 or of ORS 659.400 to 659.460 or has given testimony under the provisions of such sections."

ORS 659.415(l) provides, in part:

> "A worker who has sustained a compensable injury shall be reinstated by the worker's employer to the worker's former position of employment upon demand for such reinstatement, if the position exists and is available and the worker is not disabled from performing the duties of such position."

ORS 659.420(l) provides:

> "A worker who has sustained a compensable injury and is disabled from performing the duties of the worker's former regular employment shall, upon demand, be reemployed by the worker's employer at employment which is available and suitable."

[3] The "discovery rule" is a rule of interpretation of statutes of limitation that has the effect of tolling the commencement of such a statute under certain conditions.

The statute's legislative history shows that the legislative committees charged with initial consideration of the 1977 bill that became ORS 659.121(3 — House Bill (HB) 2223 — contemplated the benefits of incorporating a discovery rule into the limitations period, but ultimately decided against that approach. We set out that history below.

In explaining HB 2223 to the House Labor Committee, Assistant Attorney General Bill Canessa discussed the Attorney General's differences with the Bureau of Labor over the bill. One point of contention was over the incorporation of a discovery rule:

> **322 Or 463>** "There has been much discussion about an opportunity for discovery. A period of time in which it was reasonable for a complainant to discover whether there had been an act of discrimination. If we put in a time of discovery, we run into all sorts of administrative problems in part of the Bureau having to determine whether the complainant did or should have reasonably known that a discriminatory act had taken place. Though trying to allow a little extra time, we opted on one year.'

Minutes, House Labor Committee, HB 2223, Tape 14, Side 1 at 22.5, April 8, 1977. According to Canessa,

> "people simply really don't always know when they were discriminated against. A year helps cover that. Another possibility is to put the knew or should have known kind of language * * * and then, of course, you get a certain amount of litigation about what that means and was the employer prejudiced and that sort of thing. So, but even when you use that kind of language, I think it should be a year."

Id. at 30.3.

Later in the same session, one representative specifically requested that discovery rule language be included in the engrossed bill. The committee's chair rejected that request, but reserved the issue for later discussion:

> "***: Could we also ask to put 'could have reasonably known' in?
>
> "*** : No. I'm not going to put it in there. I've intentionally left that out. And I want the 180 days in just like this. * * * I would like to get that out as soon as possible and get it back to the committee because I want a hearing on it. * * * I want each of the committee members to have a paper that would have the following issues: The first one is the statute of limitation. The bill presently has 180 days. I want to look at the issue of whether it should be one year, and the issue of whether it should take in the concerns as expressed by some of the witnesses that the language should say, 'or should have known of such occurrences' or 'first reasonably became aware of such occurrences.' "

Id. at Side 2 at 7.4. Although there is no usable record of the House Labor Committee session at which that issue probably was discussed, the available record does make it clear that the bill was approved by the committee, and passed by the entire **<322 Or 463/464>** House, *without* the discovery rule language that the committee had discussed.

The measure reached the Senate Judiciary Committee in June of 1977. The record shows that the members of that committee, like the members of the House Labor Committee, were cognizant of the fact that the bill did not provide for a discovery rule. An exchange occurred between Senator Walt Brown, a member of the committee, and Representative Gretchen Kafoury concerning the issue:

> "SEN W. BROWN expressed his concern on HB 2223 to Rep. Kafoury in that it was his feeling that the non-discovery of a sex discrimination for a period of one year will preclude relief.

> "REP. KAFOURY replied that she had worked the past two years with employers trying to explain what the law was regarding affirmative action. She explained she had found that when a complaint is filed so long after the fact * * * it is often a disservice to both the complainant and the employer[.] * * * [S]he felt satisfied the way the language is in HB 2223."

Minutes, Senate Judiciary Committee (June 6, 1977). Ultimately, the bill was endorsed by the Senate Judiciary Committee and, later, passed the Senate, without modifications to the relevant wording.

The foregoing legislative history shows that the legislators who were responsible for the final wording of ORS 659.121(3) generally understood that that subsection did not provide for a delay in the running of the limitations period until a plaintiff's discovery of an employer's discriminatory motive. Given that general understanding, the fact that the bill ultimately was endorsed by both the House and Senate committees without the addition of "discovery rule" wording demonstrates that those committees fully intended to exclude the discovery rule.

Thus, we glean from the legislative history of ORS 659.121(3) support for this answer: ORS 659.121(3) does not incorporate an exception for plaintiffs who fail timely to discover their employers' discriminatory motive. The limitations period provided therein commences with the occurrence of the unlawful conduct or "practice" itself.

322 Or 465> In this case, the unlawful conduct complained of was defendants' allegedly discriminatory discharge of plaintiff. Plaintiff's complaint alleges that that event occurred on January 9, 1992, more than one year before the date on which she filed the present action. Dismissal was appropriate under ORS 659.121(3).[4]

The decision of the Court of Appeals is reversed. The judgment of the circuit court is affirmed.

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[4] Plaintiff relies on *Williams v. Waterway Terminals Co.*, 298 Or 506, 693 P2d 1290 (1985), but that case was not about the discovery rule and has no application here.

Cite as 138 Or App 388 (1996) January 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Theresa J. Lester, Claimant.
LIBERTY NORTHWEST INSURANCE CORPORATION
and Oregon Asphalt Paving, *Petitioners,*
v.
John C. URNESS,
Personal Representative of the Estate of Theresa J. Lester, Deceased, *Respondent.*
(TP-90061; CA A87295)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 21, 1995.
Jerald P. Keene argued the cause and filed the brief for petitioners.
Gene Mechanic argued the cause for respondents. With him on the brief were Goldberg & Mechanic and W. Eugene Hallman.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Affirmed.

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138 Or App 390> Petitioners seek review of a third-party distribution order of the Workers' Compensation Board issued under ORS 656.593(3)[1]. They contend that the Board abused its discretion in determining a "just and proper" distribution of the settlement proceeds because it failed to consider and apply the policies of the Workers' Compensation Law. We affirm.

This case is before us for the third time; the facts are set forth in *Liberty Northwest Ins. Corp. v. Golden,* 116 Or App 64, 840 P2d 1362 (1992), *rev den* 315 Or 442 (1993). Theresa Lester died in a job-related accident while working for Oregon Asphalt Paving. Liberty Northwest accepted the claim by the worker's beneficiaries and paid benefits of $806.84 per month to decedent's husband and $150 per month to each of her two children. ORS 656.204. The personal representative of Lester's estate settled a wrongful death action against a third party for $300,000; Liberty Northwest did not object to the amount of the settlement. With Lester's husband's concurrence, the probate court allocated one-half of the third-party settlement to each of her two children and nothing to her husband.[2]

The Board initially determined that Liberty Northwest's lien applied only to the shares of the settlement that the probate court allocated to each beneficiary. Therefore, it held that it was "just and proper" to limit Liberty Northwest's recovery of actual and future claim costs related to the benefits that Lester's children received, because the probate court did not allocate any of the settlement proceeds to her husband.

On review we reversed, holding that the Board applied the wrong standard when it relied on the probate **<138 Or App 390/391>** court's order apportioning the settlement. We pointed out that the beneficiaries of a wrongful death action under ORS 30.020 are not the same as the beneficiaries under the Workers' Compensation Law. Thus, we said:

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[1] ORS 656.593(3) provides:

"A claimant may settle any third party case with the approval of the paying agency, in which event the paying agency is authorized to accept such a share of the proceeds as may be just and proper and the worker or the beneficiaries of the worker shall receive the amount to which the worker would be entitled for a recovery under subsections (1) and (2) of this section. Any conflict as to what may be a just and proper distribution shall be resolved by the board."

[2] At the time of her death, the decedent and her husband were separated. She had twice filed petitions to dissolve the marriage, the children resided with her, and the husband agreed that "they suffered the most damages by losing their mother."

"The action of the probate court cannot determine the amount available for discharge of the paying agency's lien by allocating settlement proceeds to the beneficiaries designated under the Workers' Compensation Law. " 116 Or App at 68.

On remand the Board, concerned about making distribution decisions on an ad hoc basis, applied the distribution scheme for judgment proceeds under ORS 656.593(l) to determine a "just and proper" distribution of settlement proceeds under ORS 656.593(3). We again reversed, *Urness v. Liberty Northwest Ins.Corp.*, 130 Or App 454, 882 P2d 612 (1994), holding that distributions on an ad hoc basis are exactly what ORS 656.593(3) contemplates. Accordingly, we remanded with directions that the Board exercise its discretion and judge each case on its individual merits in arriving at a just and proper distribution of settlement proceeds.

On remand, the Board returned to its original result. It relied on the testimony of the settling party's attorney that, because of the strained relationship between Lester and her husband, any award of tort damages would have been limited to the loss suffered by her minor children. It therefore concluded that "the settlement proceeds were designed to compensate the decedent's minor children for their losses" and determined that it would be just and proper for Liberty Northwest to recover its actual and future claim costs for the two children, but not its costs for the claim of Lester's surviving spouse.

Petitioners now argue that the Board abused its discretion in determining a just and proper distribution of the settlement proceeds because it failed to consider and apply the policies of the Workers' Compensation Law. They assert that the Board ignored its duty to give effect to the individual policies of the workers' compensation system by using tort principles to determine the just and proper distribution of the settlement proceeds. Rather, petitioners say, the Board should have focused its duty to "reduce the cost to the workers' compensation system as much as possible where **<138 Or App 391/392>** there is an alterative source of recovery for the worker's damages." Liberty's entitlement to the proceeds of the settlement could not exceed what Liberty would be entitled to receive from a judgment in a third-party action under ORS 656.593(l) and (2); it could also be less. *Estate of Troy Vance* v. *Williams*, 84 Or App 616, 620, 734 P2d 1372 (1987). In light of the circumstances that the Board identified, we cannot say that it abused its discretion in determining that it is just and proper for Liberty to receive reimbursement only for its actual and future claim costs for the two children, but not for the surviving spouse.

Affirmed.

Cite as 138 Or App 393 (1996) January 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Roger L. Wolff, Claimant.
SAIF CORPORATION and Nendel's, Management & Supply Co., *Petitioners,*
v.
Roger L. WOLFF, *Respondent.*
(WCB 93-06586; CA A86534)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 30, 1995.
James W. Moller, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
James L. Edmunson and Martin L. Alvey filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Reversed and remanded.

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138 Or App 395> Employer and SAIF seek review of an order of the Workers' Compensation Board, contending that the Board erred in holding that employer is barred from denying that claimant's preexisting knee condition is compensable.

Relying on *Messmer v. Deluxe Cabinet Works,* 130 Or App 254, 881 P2d 180 (1994), *rev den* 320 Or 506 (1995), the Board ordered that employer is precluded from denying the compensability of claimant's left knee osteochondritis dessicans, because, although it had never formally accepted that condition, it did not challenge a 1981 determination order that specifically listed osteochondritis as one of claimant's conditions. In 1995, the legislature amended ORS 656.262. Subsection (10) now provides, in part:

> "Payment of permanent disability benefits pursuant to a determination order, notice of closure, reconsideration order or litigation order shall not preclude an insurer or selfinsured employer from subsequently contesting the compensability of the condition rated therein, unless the condition has been formally accepted."

As we held in *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995), the 1995 amendments to the workers' compensation statutes are applicable to all cases pending in administrative proceedings or on review. Accordingly, we reverse and remand this case to the Board for reconsideration in the light of the amendments.

Reversed and remanded.

Cite as 138 Or App 455 (1996) January 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Jeffrey B. Trevitts, Claimant.

Jeffrey B. TREVITTS, *Petitioner,*
v.
HOFFMAN-MARMOLEJO, a joint venture of Hoffman Construction of Oregon and Marmolejo Contractors, Inc., *Respondent.*
(92-13272; CA A85590)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 30, 1995.

James S. Coon argued the cause for petitioner. With him on the opening brief was Royce, Swanson, Thomas & Coon. With him on the supplemental and answering briefs was Swanson, Thomas & Coon.

Janet M. Schroer argued the cause for respondent. With her on the briefs were Eli D. Stutsman, Brian M. Perko and Hoffman, Hart & Wagner.

Vera Langer and Scheminske, Lyons & Bussman filed an *amicus curiae* brief for Hoffman Construction of Oregon and Continental Loss Adjusting Service.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LEESON, J.

Affirmed.

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138 Or App 457> Claimant seeks review of an order of the Workers' Compensation Board that affirmed the referee's holding that a claim disposition agreement (CDA) entered into pursuant to ORS 656.236[1] barred claimant from recovering all nonmedical benefits on his claim. We review for errors of law and substantial evidence, ORS 656.298(6), ORS 183.482(7), (8), and affirm.

On August 15, 1989, claimant sustained a compensable, disabling low back injury that was accepted on September 14, 1989. After x-rays revealed a lumbar disc protrusion, claimant's attending surgeon, Brett, performed an L4-5 diskectomy on November 29, 1989. In July 1990, an MRI detected a small herniation at the L5-Sl level and showed a distortion of the left Sl nerve root. Brett believed that claimant was suffering a pathological worsening related to the compensable injury. Nonetheless, on September 12, 1990, Brett concluded that claimant was medically stationary with moderate permanent disability, subject to certain restrictions for repetitive lifting, bending, stooping, sitting and standing.

Claimant began to negotiate a settlement with employer and, in February 1991, sent a letter to confirm his offer for an "immediate CDA (no time loss, vocational assistance, permanent disability, etc.)" in exchange for $30,000. In April 1991, the parties agreed to a CDA for $25,000. Claimant's attorney then drafted a notice of rights, signed by employer, that stated:

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[1] ORS 656.236 (1993) provided, in part:

> "(1) The parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the director may prescribe."

That statute has been amended by Oregon Laws 1995, chapter 332, section 24, to read, in part:

> "(1)(a) The parties to a claim, by agreement, may make such disposition of any or all matters regarding a claim, except for medical services, as the parties consider reasonable, subject to such terms and conditions as the Workers' Compensation Board may prescribe. For the purposes of this section, 'matters regarding a claim' includes the disposition of a beneficiary's independent claim for compensation under this chapter. Unless otherwise specified, a disposition resolves all matters and all rights to compensation, attorney fees and penalties potentially arising out of claims, except medical services, regardless of the conditions stated in the agreement."

"In return for the agreed upon amount of money, [claimant] will give up or 'release' [his] right to:

"(1) Claim closure and disability rating
"(2) An award for permanent partial disability
"(3) Monthly payments for permanent total disability
"(4) Vocational assistance
"(5) Future time loss benefits"

The notice further stated that "the only benefit [claimant] will *not* release is [his] right to medical benefits for the accepted condition." (Emphasis in original.) Claimant then sent a letter to employer to confirm continuation of time loss payments until the Board approved the CDA, to state that those payments would not be subject to offset and to affirm that claimant would be withdrawing his request for a hearing on the rating of his disability.

The Board approved the CDA on May 21, 1991. The CDA listed the claim number and the date pertaining to the August 1989 injury claim and provided that:

"The accepted conditions subject to this claim disposition agreement are: lumbar strain/sprain, and L4-5 disk protrusion.

"* * * * *

"The above-captioned claim is in accepted status, and the insurer has paid the claimant all benefits due and payable up to the date this agreement was sent to him.

"Pursuant to ORS 656.236, in consideration of the payment of $25,000.00 by the insurer, claimant releases his right to the following workers' compensation benefits: temporary disability, permanent disability, vocational rehabilitation and survivor's benefits, and all other benefits except for medical services. The insurer's obligation to provide these benefits is also released.

"* * * * *

"Claimant retains his right to medical services for the compensable injury."

On December 4, 1991, employer authorized Brett to perform surgery on claimant at the L5-Sl level, and subsequently paid claimant's medical costs. Employer also paid claimant's medical bills for a subsequent L5-Sl surgery. On August 24, 1992, claimant sought temporary total disability **<138 Or App 458/459>** benefits related to the L5-Sl surgery. Employer refused to pay, on the ground that the CDA had released it from its obligation to pay any benefits on the claim, except medical services. Claimant filed a request for hearing on October 13, 1992.

The referee upheld employer's denial, on the ground that under the CDA claimant had unambiguously "waived and released entitlement to any and all further compensation and benefits, solely excepting medical benefits." The Board, sitting *en banc* with one member dissenting, affirmed the referee's ruling but acknowledged that the CDA was ambiguous.

Claimant assigns error to the Board's ruling that the CDA barred him from recovering "any non-medical compensation for his L5-Sl condition where the [CDA signed by claimant] expressly covered only his lumbar sprain/strain and L4-5 disc protrusion." He argues that the CDA unambiguously covers only those two conditions and that, consequently, he is entitled to judgment as a matter of law. Employer responds that the CDA unambiguously settles the entire claim arising from the August 1989 injury. In the alternative, employer argues that if the CDA is ambiguous, extrinsic evidence in the record supports the Board's conclusion that the settlement bars claimant from recovering nonmedical compensation for the L5-Sl condition.

We interpret the terms of a written agreement to settle a workers' compensation claim using the standard rules of contract construction. *See Good Samaritan Hospital v. Stoddard,* 126 Or App 69, 867 P2d 543, *rev den* 319 Or 572 (1994) (applying law of contracts to workers' compensation settlement agreement). The construction of a contract, including the question of whether it is ambiguous, is a question of law for the court. *Timberline Equipment v. St. Paul Fire & Mar. Ins.*, 281 Or 639, 643, 576 P2d 1244 (1978); *Slocum v. Lang,* 132 Or App 571, 576, 889 P2d 379 (1995). A contract is unambiguous if the language is so clear that it precludes doubt by a reasonable person; it is ambiguous if there is more than one sensible and reasonable interpretation. *P & C Construction Co. v. American Diversified,* 101 Or App 51, 56, 789 P2d 688 (1990). We must pursue the intent of **<138 Or App 459/460>** the parties, if possible. ORS 42.240. If language in the contract is ambiguous, extrinsic evidence is admissible to show what the parties intended, and their intention is a question of fact. ORS 41.740; *Timberline Equipment*, 281 Or at 643; *Paragano v. Gray,* 126 Or App 670, 682, 870 P2d 837 (1994).

The CDA states that the "accepted conditions subject to this [CDA]" are the lumbar sprain/strain and the L4-5 disc protrusion. It does not mention the L5-Sl disc herniation. Nevertheless, it fully releases claimant's rights to all benefits, except for medical services. Moreover, by its terms, the only benefits claimant retains are to "medical services for the compensable injury." The retention clause makes no mention of nonmedical benefits related to the L5-Sl disc herniation and specifically addresses the compensable injury rather than any identified conditions. We agree with the Board that the language of the agreement raises "a question concerning the intention of the parties," and conclude that the CDA is ambiguous.

Accordingly, we turn to the Board's finding that, at the time the CDA was executed, the parties intended that claimant would retain his right only to medical services with respect to the claim. That finding is based on the following evidence. Claimant's February 1991 letter offered "an immediate CDA (no more time loss, vocational assistance, permanent disability, etc.)" and did not indicate an intention to retain any nonmedical benefits for any portion of the claim. The April 1991 notice of rights advised claimant that he was releasing his rights to claim closure and disability rating, permanent partial disability payments, permanent total disability payments, vocational assistance and future time loss benefits. The notice did not state that claimant would retain any nonmedical benefits for any portion of the claim. The April 1991 letter from claimant's attorney suggested that claimant would dismiss his hearing request regarding the disputed calculation of his temporary disability rating in exchange for both the continuation of temporary disability pending Board approval of the CDA and the assurance that those temporary payments would not be offset against the CDA proceeds. Finally, the summary page that was attached to the CDA when it was sent to the Board for approval provides that the CDA was a "full release." Substantial **<138 Or App 460/461>** evidence supports the Board's finding that the parties intended a full release of all benefits, except for medical services, related to the August 15, 1989 injury.

In the light of this disposition, we need not address claimant's other arguments nor employer's cross-assignment of error.

Affirmed.

Cite as 138 Or App 484 (1996) January 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of James W. Jones, Claimant.

SAIF CORPORATION and Willamina Lumber Company, *Petitioners,*
v.
James W. JONES, *Respondent.*
(WCB 93-06575; CA A86428)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 30, 1995.
Julene Quinn argued the cause for petitioners. On the brief were Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and David L. Runner, Assistant Attorney General.
James L. Edmunson filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
PER CURIAM
Reversed and remanded for reconsideration.

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138 Or App 485> SAIF seeks review of an order of the Workers' Compensation Board holding that claimant's preexisting facioscapulo-humeral muscular dystrophy has been made worse by his employment and is therefore compensable.

The Board found that claimant's employment is the major contributing cause of the worsening of his preexisting condition. That finding is supported by substantial evidence. As amended by the legislature in 1995, ORS 656.802(2) provides:

> "If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the *combined condition and pathological worsening of the disease.*" (Emphasis supplied.)

The amendment is applicable to all cases pending on review. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). The Board's opinion does not make a determination as to whether employment conditions were the major contributing cause of claimant's combined condition. Accordingly, the case is remanded for reconsideration.

Reversed and remanded for reconsideration.

Cite as 138 Or App 486 (1996) January 3, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Susan A. Michl, Claimant.

BEVERLY ENTERPRISES and Construction State Service Company, *Petitioners,*
v.
Susan A. MICHL, *Respondent.*
(WCB 93-04959; CA A87433)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 30, 1995.
Jerald P. Keene argued the cause for petitioners. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson.
David C. Force argued the cause and filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
PER CURIAM
Motion for sanctions denied; reversed and remanded for reconsideration.

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138 Or App 486> Employer petitions for review of an order of the Workers' Compensation Board upholding the compensability of claimant's knee condition and related surgery. The primary dispute concerns whether claimant's condition is the result of a combination of a work injury and a preexisting condition.

Resolution of this case involves an interpretation of ORS 656.005(7) (a) (B), which was amended by the legislature in 1995. Or Laws 1995, ch 332. The amendments are applicable to all cases still in administrative proceedings or on review. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). We remand the case to the Board for reconsideration in the light of the amendments. Accordingly, we deny claimant's motion for sanctions made pursuant to ORS 656.390.

Motion for sanctions denied; reversed and remanded for reconsideration.

Cite as 138 Or App 503 (1996) January 17, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Preston E. Jones, Claimant.
Preston E. JONES, *Petitioner,*
v.
QUIMBY TRUCKING and SAIF Corporation, *Respondents.*
(WCB 91-13579; CA A79747)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs December 8, 1995.
James L. Edmunson filed the brief for petitioner.
Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and Steve Cotton, Special Assistant Attorney General, filed the brief for respondents.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DEITS, P. J.
Reversed and remanded to the Workers' Compensation Board with instructions to remand to the Director for reconsideration.

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138 Or App 505> Claimant seeks review of an order of the Workers' Compensation Board denying his request for a hearing on the ground that it lacked jurisdiction to hear the case. We remand for reconsideration by the Director.

Claimant suffered a compensable injury to his back in 1986. In 1991, his attending physician, Dr. Flanagan, asked SAIF to approve palliative care for claimant. SAIF refused to approve the treatment. Flanagan then requested the medical director of the Department of Consumer and Business Services (Department)[1] to approve the treatment. The medical director concluded that the treatment should not be allowed. Claimant then asked the Director of the Department to review the matter. The Director refused to do so on the ground that only the attending physician may request review by the Director. Claimant then requested a hearing before the Board's hearings division. The referee held that the hearings division did not have jurisdiction over noncompensable palliative care disputes and dismissed claimant's request for hearing. The Board affirmed the referee's order.

Claimant seeks review of the Board's order. He first argues that, during the pendency of this petition for judicial review, the pertinent statute was amended to allow a claimant to request the Director to review a dispute involving noncompensable palliative care. ORS 656.245(1)(c)(J). Accordingly, he requests that we remand the case to the Director for reconsideration under the new law.

We agree with claimant's argument, as does SAIF. The new version of the statutes clearly is applicable here. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). Because claimant was not given the procedural protections to which he is now entitled under the amended statutes, we remand the case to the Board to remand to the Director for reconsideration.

Reversed and remanded to the Workers' Compensation Board with instructions to remand to the Director for reconsideration.

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[1] At that time, the agency was known as the Department of Insurance and Finance.

Cite as 138 Or App 552 (1996) January 24, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Timothy A. Bostick, Claimant.
Timothy A. BOSTICK, *Petitioner,*
v.
RON RUST DRYWALL and Liberty Northwest Insurance Corporation, *Respondents.*
(WCB 93-05050; CA A84587)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 30, 1995.
Donald M. Hooton argued the cause for petitioner. With him on the brief was Schneider, Hooton.
David 0. Wilson argued the cause and filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

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138 Or App 554> Claimant seeks review of an order of the Workers' Compensation Board classifying his claim as nondisabling and upholding employer's denial of benefits for temporary total disability. We affirm the Board and write only to explain our understanding of ORS 656.210(3).

On May 8, 1991, which was a Wednesday, claimant fractured his left fifth toe and sustained a cervical strain when a scaffold plank fell and hit him on the head and toe. He went to the emergency room on that day. The emergency room doctor told him that he could return to work on Wednesday, May 15. On Friday, May 10, claimant saw Dr. Eubanks, who released him to modified work on Monday, May 13. Saturdays and Sundays are claimant's regularly scheduled days off. It is not apparent from the record whether Eubanks was aware of that. On May 24, 1991, the insurer accepted a claim for a fractured toe as nondisabling. On August 7, 1992, it accepted a claim for cervical strain as nondisabling. On August 13, 1992, claimant requested reclassification of his claim to disabling.

Although the parties concerned themselves below with procedural issues regarding the reclassification, the only issue on review is whether the claim should be classified as disabling or nondisabling.

ORS 656.005(7)(c)[1] defines a disabling injury as

> "an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury."

OAR 436-30-045(5) also provides that a claim is disabling if temporary disability is due and payable.

ORS 656.210(3) provides:

> "No disability payment is recoverable for temporary total or partial disability suffered during the first three calendar days after the worker leaves work or loses wages as a result of the compensable injury unless the worker is totally disabled **<138 Or App 554/555>** after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. If the worker leaves work or loses wages on the day of the injury due to the injury, the day shall be considered the first day of the three-day period."

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[1] Resolution of this case does not appear to be affected by 1995 amendments to the statutes.

The subsection establishes a three-day waiting period for entitlement to benefits for temporary total disability. A worker is not entitled to begin receiving benefits for temporary disability unless the worker is disabled for more than three calendar days. Additionally, benefits for disability are not due for the first three calendar days of disability unless the worker is disabled for 14 consecutive days or more. Claimant does not argue that he is entitled to be compensated for the first three days of disability. Rather, he contends that his claim should be classified as disabling because he was unable to work on Saturday or Sunday, which were his days off. If his claim is classified as disabling, claimant can be eligible for benefits for permanent partial disability and vocational assistance.

The Board found that claimant was *off work* for three days, from Wednesday through Friday, implicitly finding that he had satisfied the three-day waiting period, but that he had not missed work on Saturday or Sunday. The Board found further that the record does not show whether claimant returned to modified work on Monday, May 13, or whether he continued to miss work for a period totaling 14 days. Those findings are supported by substantial evidence. The Board found, essentially, that claimant's first three days of disability were his only days of time loss and it held, accordingly, that claimant had failed to establish that he was entitled to benefits for temporary total disability. For that reason, the Board classified the claim as nondisabling.

From the parties' perspective, this case turns on the significance of the word "calendar" as used in ORS 656.210(3). Claimant asserts that the legislature's decision to describe the three-day waiting period as calendar days shows an intention that benefits for time loss be paid for calendar days, whether or not those days were also work days. Under claimant's analysis, the Saturday and Sunday preceding his **<138 Or App 555/556>** release for work should be counted in determining the duration of his disability. Employer contends that, although the legislature chose the word "calendar," it could not possibly have intended that compensation be paid for calendar days when those are not also work days and that, because claimant has not shown that Saturdays and Sundays are his work days, he has had no time loss.

We first examine the text and context of the statute. As pertinent, ORS 656.210 provides:

"(1) When the total disability [due to a compensable injury] is only temporary, the worker shall receive during the period of that total disability compensation equal to 66-2/3 percent of wages, but not more than 100 percent of the average weekly wage nor less than the amount of 90 percent of wages a week or the amount of $50 a week, whichever amount is lesser. * * *

"(2)(a) For the purpose of this section, the weekly wage of workers shall be ascertained by multiplying the daily wage the worker was receiving by the number of days per week that the worker was regularly employed.

"(b) For the purpose of this section:

"(A) The benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury.

"(B) The benefits of a worker who incurs an occupational disease shall be based on the wage of the worker at the time there is medical verification that the worker is unable to work because of the disability caused by the occupational disease. If the worker is not working at the time that there is medical verification that the worker is unable to work because of the disability caused by the occupational disease, the benefits shall be based on the wage of the worker at the worker's last regular employment.

"(c) As used in this subsection, 'regularly employed' means actual employment or availability for such employment. For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the Director of the Department of Consumer and Business Services, by rule, may prescribe methods for establishing the worker's weekly wage.

"(3) No disability payment is recoverable for temporary total or partial disability suffered during the first three **<138 Or App 556/557>** calendar days after the worker leaves work or loses wages as a result of the compensable injury unless the worker is totally disabled after the injury and the total disability continues for a period of 14 consecutive days or unless the worker is admitted as an inpatient to a hospital within 14 days of the first onset of total disability. If the worker leaves work or loses wages on the day of injury due to the injury, that day shall be considered the first day of the three-day period."

The first two subsections of the statute are concerned primarily with determining the basic measure of time loss benefits, the weekly wage of the worker. Subsection (3) describes the three-day waiting period, during which no benefits are due unless the worker is disabled for 14 consecutive days or more. The statute unambiguously describes the waiting period as three calendar days. There can be no reasonable dispute that the waiting period itself is to be based on calendar days. If a worker is injured on Friday and remains disabled on Saturday and Sunday, even if those days are not regular work days, the worker has satisfied the three-day waiting period and is entitled to begin receiving benefits on Monday. Additionally, we agree with claimant that ORS 656.210(3) also plausibly suggests that if the worker is disabled for 14 days, then benefits are payable for the first three calendar days of disability, irrespective of whether those days were work days.

However, neither the statute nor the administrative rules expressly address the precise issue about which these parties dispute: whether a worker who remains disabled *subsequent* to the three-day waiting period is entitled to benefits for calendar days of disability that are not also work days. Claimant contends that the use of the word "calendar" in subsection (3) suggests that time loss benefits are paid for calendar days of disability. Admittedly, the legislature's choice of the word "calendar" to describe the waiting period creates some ambiguity. If the statute can be understood to provide that benefits are to be paid for the first three calendar days of disability, why then does it not also mean that all benefits for temporary disability are based on calendar days?

The context of the ORS 656.210(3) suggests that the legislature did not intend to establish that benefits for time loss be paid for calendar days. Under the statute, the weekly benefits of a worker depend on the number of days regularly **<138 Or App 557/558>** worked. For example, subsection (2) provides that the worker's weekly wage is to be calculated based on the daily wage multiplied by the number of days regularly worked. That language suggests, but does not expressly provide, an answer to our dilemma, If weekly benefits are to be calculated based on number of work days, then should they not also be paid just for days lost from work?

To the extent that the statute's text and context leave room for doubt, the legislative history is helpful. Before 1969, the three-day waiting period was described in what is now subsection (3) as "three days." In 1969 the legislature amended ORS 656.210 for the sole purpose of adding the word "calendar" before "days." The testimony of Senator Atiyeh before both the Senate Labor and Industries Committee and the House Labor and Management Committee shows that the term "three days" was being interpreted by the Board as three *work* days and that that interpretation created some inequities among workers who were disabled for fewer than 14 days. Workers who were injured at the beginning of their work week and who were disabled for more than three days could begin collecting benefits on the fourth day of their actual disability if that day also happened to be a work day. Workers who were injured toward the end of their work week and whose first three days of disability fell partly over the weekend effectively had a longer waiting period, because they could not begin receiving benefits until they were disabled for three work days. To correct the inequity in the waiting period, Senator Atiyeh suggested amending the statute to make the waiting period three *calendar* days. Minutes, House Committee on Labor and Management, March 26, 1969; Minutes, Senate Committee on Labor and Industries, April 18, 1969. The amendment was unopposed and was passed by both houses with little discussion. There is no suggestion in the legislative history that the bill was intended to do more than establish that the *waiting period* be based on calendar days rather than work days. There is no indication that the amendment was intended to affect the way that benefits are paid or to require that they be *paid* for calendar days. It is true that in this case, if claimant had been injured on a Monday or Friday instead of a Wednesday, he would have been eligible for two days of disability benefits if he had remained disabled for five days. There is no suggestion in the

legislative history that the **<138 Or App 558/559>** goal of the amendment was to correct that inequity. We conclude that, if a worker is disabled for less than a full work week, the fraction of the worker's weekly wage to which the worker is entitled is to be calculated based only on work days missed.

Our interpretation of the statute is consistent with case law holding that benefits for temporary total disability exist for the purpose of compensating a worker for wages lost because of an inability to work. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 702 P2d 403 (1985); *Stiennon v. SAIF*, 68 Or App 735, 738, 683 P2d 556, *rev den* 298 Or 238 (1984). If the worker fails to show lost time from work as a result of the disability, then the worker has failed to establish entitlement to benefits for time loss. In this case claimant has not shown that his fourth and fifth days of disability were work days; therefore, he has not shown that he lost time from work as a result of his disability in excess of the three-day waiting period. The Board correctly held that he has failed to establish that his claim is disabling.

Claimant did not raise his argument in support of his second assignment of error before the Board and we will not consider it.

Affirmed.

Cite as 138 Or App 560 (1996) January 24, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Michael L. Wofford, Claimant.
ROSEBURG FOREST PRODUCTS, *Petitioner,*
v.
Michael L. WOFFORD, *Respondent.*
(WCB 94-04772; CA A87858)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 13, 1995.
Adam T. Stamper argued the cause for petitioner. With him on the brief was Cowling, Heysell, Plouse, Ingalls & Moore.
G. Duff Bloom argued the cause for respondent. With him on the brief was Coons, Cole, Cary & Wing, P.C.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Reversed and remanded for reconsideration.

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138 Or App 562> Employer seeks review of an order of the Workers' Compensation Board affirming an administrative law judge's order relying on *Williams v. Gates, McDonald & Co.,* 300 Or 278, 709 P2d 712 (1985), to uphold the compensability of medical treatment for a nonwork related preexisting condition as a prelude to treatment of a compensable condition. In 1995, the legislature enacted Oregon Laws 1995, chapter 332, section 3, which is codified at ORS 656.225:

> "In accepted injury or occupational disease claims, disability solely caused by or medical services solely directed to a worker's preexisting condition are not compensable unless:
>
> "(1) In occupational disease or injury claims other than those involving a preexisting mental disorder, work conditions or events constitute the major contributing cause of a pathological worsening of the preexisting condition.
>
> "(2) In occupational disease or injury claims involving preexisting mental disorder, work conditions or events constitute the major contributing cause of an actual worsening of the preexisting condition and not just of its symptoms.
>
> "(3) In medical service claims, the medical service is prescribed to treat a change in the preexisting condition as specified in subsection (1) or (2) of this section, and not merely as an incident to the treatment of a compensable injury or occupational disease."

The statute is applicable here. Or Laws 1995, ch 332, § 66; *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). We reverse and remand the case to the Board for reconsideration in the light of ORS 656.225.

Reversed and remanded for reconsideration.

Cite as 138 Or App 610 (1996) January 24, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Robert J. Carroll, Claimant.

Robert J. CARROLL, *Petitioner,*
v.
BOISE CASCADE CORPORATION, *Respondent.*
(93-09021; CA A84564)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 26, 1995.
John M. Coletti argued the cause for petitioner. With him on the brief was Pozzi, Wilson & Atchison.
John E. Pollino argued the cause for respondent. On the brief were Chess Trethewy and Garrett, Hemann, Robertson, Paulus, Jennings & Comstock, P.C.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Reversed and remanded for reconsideration.

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138 Or App 612> Claimant seeks review of an order of the Workers' Compensation Board that reduced his award of unscheduled permanent partial disability (PPD). He argues that the rule that the Board applied to determine the award is invalid. We agree and reverse and remand for reconsideration.

The facts are undisputed. Claimant compensably injured his back and later was released to his regular work. The Notice of Closure did not award him PPD for the loss of function in his back. An Order on Reconsideration affirmed the Notice of Closure. Claimant requested a hearing. At the hearing, the referee awarded claimant 10 percent unscheduled PPD. The referee did so on the basis of a temporary rule, which provided that unscheduled PPD is to be determined first by assigning certain values to a claimant's age, education, adaptability and impairment and then by applying those values to the following formula: [(Age + Education) x Adaptability] + Impairment = PPD. WCD 3-1993 (Temp.) (June 17, 1993). The temporary rule provided that, when a claimant has returned to regular work, the value assigned to adaptability is a minimum value of 1. Applying that value, and others not in dispute, the referee calculated claimant's award as follows: [(Age + Education {4}) x Adaptability {1}] + Impairment {6} = 10.

Employer sought review by the Board. In the meantime, the temporary rule expired. The Board applied the prior rule, which was identical in all but one relevant respect. It provided that, when a claimant has returned to work, the adaptability factor must be assigned a value of zero. *Former* OAR 436-35-310(2) (1992).[1] Applying that rule, the Board calculated claimant's award as follows: [(Age + Education {4}) x Adaptability {0}] + Impairment {6} = 6. The effect of the Board's decision was to multiply claimant's age and education factors, which were assigned a combined value of 4, by zero, and thus convert their combined value to zero. **<138 Or App 612/613>** The Board accordingly reduced claimant's award of unscheduled PPD to 6 percent.

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[1] *Former* OAR 436-35-310(2) (1992) provided:

> "For workers who at the time of determination have a physician's release to regular work, or have either returned to or have the RFC for regular work or work requiring greater strength than work performed on the date of injury, the value for factor or [sic] adaptability is 0."

The rule has since been amended and renumbered. *See* OAR 436-35-280.

On review, claimant argues that the Board erred in applying *former* OAR 436-35-310(2) (1992), which required the factor of adaptability to be assigned a minimum value of zero if a worker has returned to work. According to claimant, that rule violates ORS 656.214(5) and ORS 656.726(3)(f)(A). ORS 656.214(5) provides, in part, that

> "the criteria for rating of [unscheduled] disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is to be calculated using the standards specified in ORS 656.726(3)(f)."

ORS 656.726(3)(f)(A) provides:

> "The criteria for evaluation of disabilities under ORS 656.214(5) shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job."

Claimant argues that, because the factors of age and education are *multiplied* by the adaptability factor under the current rule, assigning a minimum value of zero to the adaptability factor in any case results in a zero value for those other factors. Thus, he contends, even if the age and education factors otherwise are greater than zero, they are deprived of any effect on the award determination. In other words, impairment is not permitted to be "modified" by the factors of age and education, contrary to the statute. Claimant relies on the Supreme Court's decision in *England v. Thunderbird,* 315 Or 633, 848 P2d 100 (1993), in which the court invalidated an earlier version of the same rule because of its incompatibility with an earlier version of the same statutes.

Employer argues that, although the multiplication of age and education factors by a minimum adaptability factor of zero results in a reduction of the age and adaptability factors to zero as well, the fact remains that impairment still is "modified" by those factors:

> "The modification in this scenario is simply to add zero to the impairment finding — the sum of which will be the impairment.'

138 Or App 614> As for *England,* employer argues that the case is not controlling, because it concerned different rules and different statutes.

The challenged rule describes the formula for the calculation of "earning capacity," an inexact term. Spring*field Education Assn. v. School Dist.,* 290 Or 217, 223, 621 P2d 547 (1980). Accordingly, we review the validity of the rule for consistency with the relevant provisions of the workers' compensation statutes. Id. at 224-28; *SAIF v. Cline,* 135 Or App 155, 158, 897 P2d 1172, *rev den* 321 Or 560 (1995). In so doing, we attempt to discern the intentions of the legislature as to the meaning of those statutes, examining the text in context, including prior judicial construction of the statute. *State v. Guzek,* 322 Or 245, 253-55, 906 P2d 272 (1995). If necessary, we also examine the legislative history and other interpretive aids. *PGE v. Bureau of Labor and Industries,* 317 Or 606, 610-12, 859 P2d 1143 (1993).

The Supreme Court's decision in *England* provides context for our analysis of the parties' arguments. In that case, the court construed the 1987 version of ORS 656.214(5), which provided, in part:

> "In all cases of injury resulting in permanent partial disability * * * the criteria for rating of disability shall be the permanent loss of earning capacity due to the compensable injury. Earning capacity is the ability to obtain and hold gainful employment in the broad field of general occupations, taking into consideration such factors as age, education, impairment and adaptability to perform a given job."

At that time, the Director's rule provided that, in calculating a worker's earning capacity, the factors of age, education and adaptability must be assigned a value of zero if the worker returned to his or her former

employment. *Former OAR* 436-35-290(2) (1988); *former* OAR 436-35-300(2) (1988); *former* OAR 436-35-310(2) (1988). The claimant in *England* had compensably injured her neck but was able to continue working. The Board rated her PPD accordingly, assigning no value to her age, education and adaptability factors. She challenged the validity of the rule, arguing that, by assigning a zero value to her age, education and adaptability factors, the rule failed to "tak[e] into consideration" those factors as ORS 656.214(5) required.

138 Or App 615> The Supreme Court agreed, citing two grounds for its decision. First, it observed that the language of ORS 656.214(5) strongly suggested that the four listed factors must be considered:

> "[T]he legislature chose to list the criteria for determining earning capacity and gainful employment by example, but did not use an exhaustive list of factors, The listing of representative factors was a direction to the agency that, in determining a worker's earning capacity, it consider such factors as age, education, impairment and adaptability, and other factors that affect one's earning capacity in a similar way. *The legislature directed that the four listed factors must be considered,* while allowing that other factors having the same characteristics may be considered as well."

315 Or at 638. (Emphasis supplied; citations omitted.) Second, it noted also that the statutory emphasis on earning *capacity,* as opposed to *earnings,* likewise suggests that merely returning to a former job does not obviate the need to take into account the factors of age, education and adaptability in rating disability:

> "Further, the legislature has chosen permanent loss of *earning capacity,* rather than loss of *earnings,* as the criterion for rating of disability. * * * [P]ost-injury employment may establish *earnings,* but it does not necessarily establish earning *capacity*[.]"

Id. at 639. (Emphasis in original.) The court concluded that assigning a value of zero to the factors of age, education and adaptability, merely because a worker has returned to work, was contrary to the statutory requirements of "taking into consideration" those factors and of establishing the worker's earning capacity. *Id.*

The legislature amended ORS 656.214(5) in 1990.[2] However, in all material respects, the statute remains the same. It still provides that "the criteria for rating of disability shall be the permanent loss of earning capacity." ORS 656.214(5). And it provides that earning capacity is to be calculated by "using the standards specified in ORS 656.726(3)(f)," which provides that earning capacity

> "shall be permanent impairment due to the industrial injury as modified by the factors of age, education and adaptability to perform a given job."

ORS 656.726(3)(f)(A). The only discernible change is that, under the earlier version of the statute, earning capacity was to be calculated "taking into consideration" the factors of age, education and adaptability, while the current version provides that earning capacity is impairment "as modified by" those same factors.

We perceive no significant difference between requiring age, education and adaptability to be "considered" in calculating earning capacity and requiring that the calculation consist of impairment "as modified by" age, education and impairment.[3] The ordinary meaning of the term "modify" does not suggest any

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[2] Or Laws 1990, ch 2, § 7 (Spec Sess). The legislature further amended the relevant statutes in 1995 in Senate Bill 369. Or Laws 1995, ch 332, §§ 17, 55, 55a. Those amendments, however, do not apply to this case. Or Laws 1995, ch 332, § 66(4).

[3] Employer's only argument to the contrary is that, because the legislature changed the language, it must have intended the language to have the effect of changing the law. Not all changes in statutory language, however, are material. *Fifth Avenue Corp. v. Washington Co.,* 282 Or 591,597-98,581 P2d 50 (1978). Moreover, it does not necessarily follow that, merely because the legislature changed the language of the statute, it intended to accomplish what employer suggests.

such difference.[4] Even assuming that a contrary reading is not "wholly implausible," *Owens v. MVD,* 319 Or 259, 268, 875 P2d 463 (1994); *deParrie v. City of Portland,* 138 Or App 105, 112, 906 P2d 844 (1995), the legislative history says nothing to the contrary.[5]

In that light, we consider employer's argument that the assignment of a zero value to the age, education and adaptability factors upon a worker's return to work is consistent with the statute. Employer argues that treating the foregoing factors in that fashion satisfies the statutory requirement that impairment be "modified" by them. We disagree. First, the argument is contrary to the language of the statute. In this case, for example, there is no dispute that the combined values for the factors of age and education are four. Yet, under the current rule, claimant's impairment is **<138 Or App 616/617>** not "modified" in any sense by four. Thus, regardless of whether, in some abstract sense, multiplying a quantity by zero constitutes "modifying" it, in cases such as this, the combined age and education factors are not zero, and as such their values are not factored into the earning capacity equation at all. That result is contrary to the statute.

Next, employer argues that age and education are factored into the earning capacity equation; their values simply are reduced to zero when multiplied by the zero value for adaptability that is required upon a worker's return to work. Even if that were so, however, artificially reducing age, education or adaptability factors because of a worker's return to work is contrary to the statutory requirement that the rating of disability be calculated on the basis of earning *capacity.* As the Supreme Court said in *England,* "post-injury employment may establish earnings, but it does not necessarily establish earning *capacity." England,* 315 Or at 639; *see also Smith v. SAIF,* 302 Or 396, 401-02, 730 P2d 30 (1986) (" 'A [worker's] post-injury earnings is evidence which, depending upon the circumstances of an individual case, may be of great, little, or no importance in determining loss of earning capacity' "). We do not understand how it is any less error to assign artificially a zero value to age, education and employment in this case, because of claimant's return to work, than it was to do the same thing in *England.* As we have noted, both in this case and in *England,* the statutes each identify loss of earning *capacity,* not *earnings,* as the criterion for rating disability.

We conclude that former OAR 436-35-310(2) (1992) conflicts with ORS 656.214(5) and ORS 656.726(3)(f) and is, therefore, invalid.

Reversed and remanded for reconsideration.

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[4] *Webster's Third New International Dictionary* 1452 (1976), defines "modify" as "to make minor changes in the form or structure of" and "to change the form or properties of for a definite purpose."

[5] The only reference to the amendment in the legislative history is a comment by Representative Mannix in a floor debate that "earning capacity will be defined and calculated according to specific standards." Minutes, House Special Session, May 7, 1990, p 31.

Cite as 139 Or App 115 (1996) February 7, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John F. Cassidy, Claimant.

ALBERTSONS, INC., *Petitioner,*
v.
John F. CASSIDY and Fred Meyer, Inc., *Respondents.*
(93-00760, 93-07111, 93-00761, 93-07110; CA A86481)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 8, 1995.
Kenneth L. Kleinsmith argued the cause for petitioner. With him on the brief was Meyers, Radler, Replogle & Bohy.
John Hogan argued the cause for respondent John F. Cassidy. On the brief was Donald M. Hooton.
Priscilla M. Taylor argued the cause and filed the brief for respondent Fred Meyer, Inc.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
HASELTON, J.
Reversed and remanded.

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139 Or App 117> Petitioner Albertsons, Inc., seeks review of an order of the Workers' Compensation Board that determined that Albertsons, and not respondent Fred Meyer, Inc., was responsible for claimant's low back injury. Central to the parties' dispute is the question of whether Albertsons' "backup" denial was effective and, particularly, whether Albertsons proved that the claim was not compensable. ORS 656.262(6).

The pertinent portions of the Board's order stated:

> "ORS 656.262(6) requires that a 'backup' denial be based on 'later obtain[ed] evidence' that a claim is not compensable. In addition, if the claimant requests a hearing on the 'backup' denial, the denying carrier must prove by 'clear and convincing' evidence that 'the claim is not compensable.' ORS 656.262(6). Here, in order to meet that burden, [Albertsons] must prove, by clear and convincing evidence, that the November 29, 1992 injury was not the major contributing cause to claimant's disability or need for treatment.
>
> "Having reviewed the evidence, we conclude that [Albertsons] has failed to prove by clear and convincing evidence that claimant did not sustain a compensable injury on November 29, 1992. Accordingly, we, find it unnecessary to determine whether [Albertsons'] denial is based on 'later obtain(ed] evidence.' " (Citations omitted.)

When the Board issued its order in October 1994, ORS 656.262(6) provided, in part:

> "[I]f the insurer or self-insured employer accepts a claim in good faith but later obtains evidence that the claim is not compensable or evidence that the paying agent is not responsible for the claim, the insurer or self-insured employer, at any time up to two years from the date of claim acceptance, may revoke the claim acceptance and issue a formal notice of claim denial. However, if the worker requests a hearing on such denial, the insurer or self-insured employer must *prove by clear and convincing evidence that the claim is not compensable or that the paying agent is not responsible for the* claim." (Emphasis supplied.)

However, in 1995, ORS 656.262(6)(a) was amended to read, in part:

139 Or App 118> "If the insurer or self-insured employer accepts a claim in good faith, in a case not involving fraud, misrepresentation, or other illegal activity by the worker, and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of initial acceptance. If the worker requests a hearing on such revocation or acceptance and denial, the insurer or self-insured employer must *prove, by a preponderance of the evidence, that the claim is not compensable or that the employer or self-insured employer is not responsible for the* claim." ORS 656.262(6)(a) (emphasis supplied).

Thus, the 1995 amendment modified the evidentiary standard under ORS 656.262(6). That amendment, which is not specifically excepted from the omnibus retroactivity provision of the 1995 workers' compensation legislation, applies to this case. *See generally Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). We reverse and remand for the Board to reconsider the effectiveness of Albertsons' "backup" denial in the light of the amended ORS 656.262(6)(a).

Reversed and remanded.

Cite as 139 Or App 130 (1996) February 7, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Walter C. Windom, Claimant.

Walter C. WINDOM, *Petitioner,*

v.

DODGE LOGGING and SAIF Corporation, *Respondents.*

(WCB 93-05126; CA A85288)

Judicial Review from Workers' Compensation Board.

Submitted on record and briefs January 17, 1996.

Floyd H. Shebley filed the brief for petitioner.

Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and Julene M. Quinn, Special Assistant Attorney General, filed the brief for respondents.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

PER CURIAM

Reversed and remanded for reconsideration.

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139 Or App 131> Petitioner argues that the Workers' Compensation Board erred in holding that he was ineligible for vocational assistance because his claim was in "own motion" status. The statute pertinent to his petition, ORS 656.278, has been amended by Oregon Laws 1995, chapter 332. Because the amended version of the statute is applicable, we reverse and remand for reconsideration in the light of the new law. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995).

Reversed and remanded for reconsideration.

Cite as 139 Or App 154 (1996) February 14, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Therese L. Petkovich, Claimant.

Therese L. PETKOVICH, *Petitioner,*
v.
SAFEWAY STORES, INC., *Respondent.*
(93-07299; CA A84646)

Judicial Review from Workers' Compensation Board.
On petitioner's motion for reconsideration filed September 20, 1995. Decision filed September 13, 1995. 136 Or App 612, 902 P2d 137 (1995).
Linda C. Love and Craine & Love for motion.
Before Warren, Presiding Judge, and Edmonds and
Armstrong, Judges.
PER CURIAM
Reconsideration allowed; opinion modified. Reversed and remanded for reconsideration.

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139 Or App 155> Claimant moves for reconsideration of our decision, *Petkovich v. Safeway Stores, Inc.*, 136 Or App 612, 902 P2d 137 (1995), contending that we erred in determining that 1995 amendments to ORS 656.726(3)(f)(D) apply to her case. We allow the motion, modify our opinion and reverse and remand for reconsideration.

Claimant is correct that the amendments to ORS 656.726(3)(f)(D) do not apply to her case. *See* 1995 Or Laws, ch 332, § 66(4). Thus, we reexamine claimant's argument that the Workers' Compensation Board erred in calculating her permanent partial disability award. In calculating claimant's award, the Board applied OAR 436-35-310(2) (March 13, 1992), which provided that, when a claimant had returned to regular work, the adaptability factor was assigned a value of zero.

Claimant argues that OAR 436-35-310(2) (March 13, 1992) conflicts with ORS 656.726(3)(f)(A) and is invalid. Claimant is correct. *Carroll v. Boise Cascade Corp.*, 138 Or App 610, ___ P2d ___ (1996). Hence the Board erred in calculating claimant's permanent partial disability award.

Reconsideration allowed; opinion modified. Reversed and remanded for reconsideration.

Cite as 139 Or App 165 (1996) February 21, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Kerment C. Verner, DCD, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and Glenbrook Nickel Co., *Petitioners,*
v.
Barcy VERNER, Beneficiary of Kerment C. Verner, Deceased, *Respondent.*
(WCB 93-10270; CA A85511)

On remand from the Oregon Supreme Court, *Liberty Northwest Ins. Corp. v. Verner,* 322 Or 214, 904 P2d 171 (1995).

Judicial Review from Workers' Compensation Board.

Submitted on remand December 12, 1995.

E. Jay Perry argued the cause for petitioners. With him on the brief was Employers Defense Counsel.

James L. Edmunson argued the cause for respondent. With him on the brief was Malagon, Moore, Johnson & Jensen.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

WARREN, P. J.

Reversed and remanded for reconsideration.

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139 Or App 167> Employer seeks review of a decision of the Workers' Compensation Board awarding benefits to claimant, who is decedent's beneficiary. The issue before the Board was whether decedent's working conditions caused his death. In deciding that they did, the referee relied primarily on the opinion of claimant's expert pathologist.[1] When this case was first before us, we held that there was no substantial evidence to support the factual assumptions that underlay the expert's opinion and that that lack of evidence required reversal of the Board's decision. 135 Or App 551, 899 P2d 751 (1995). The Supreme Court granted review, vacated our decision and remanded the case for reconsideration in light of *Garcia v. Boise Cascade Corp.,* 309 Or 292, 787 P2d 884 (1990). *Liberty Northwest Ins. Corp. v. Verner,* 322 Or 214, 904 P2d 171 (1995). On reconsideration we reverse and remand the case to the Board for further consideration.[2]

In *Garcia,* the issue was whether the claimant's work was the cause of his condition. The referee and the Board discounted the evidence of his physician that there was a work connection and held that the injury was not compensable. On judicial review, we held that their reasons for doing so were based on findings that were not supported by substantial evidence in the record. We therefore reversed and remanded for the Board to reconsider the case. *Garcia v. Boise Cascade Corp.,* 94 Or App 362, 76 P2d 1245 (1988). On its review of our decision, the Supreme Court held that we had gone beyond the limits of substantial evidence review in evaluating the physician's testimony. Instead of determining whether the Board's finding was reasonable in light of the evidence in the record as a whole, we had erroneously substituted our own view of the evidence for the Board's. The court therefore remanded the case for us to reconsider under the proper standard.[3]

139 Or App 168> By citing *Garcia* when it remanded this case, the Supreme Court has indicated that it believes that we may have again substituted our own opinion for that of the Board rather than determining whether there is substantial evidence to support the Board's decision. We have therefore reexamined the record

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[1] In its order, the Board adopted the referee's opinion and order on the issues that are relevant on judicial review. We will therefore refer to the orders interchangeably.

[2] Our previous opinion adequately states the facts of this case.

[3] On remand, we affirmed the Board's order. *Garcia v. Boise Cascade Corp., 103* Or App 508, 798 P2d 265 (1990).

and have again concluded that the referee's opinion does not support his decision. However, we also conclude that the absence of substantial evidence to support part of the basis for the expert's opinion requires a remand for further consideration rather than outright reversal.

The only evidence in the record offered to support a finding that the conditions under which decedent worked led to his death is the testimony of claimant's expert. That testimony was that a combination of an unpleasant odor, heavy physical exertion and excessive heat caused decedent to become ill and nauseated, resulting in a loss of fluids, a severe imbalance in his electrolytes, and the collapse of his cardiovascular system. The expert emphasized that his belief that claimant was working in excessive heat was important to his analysis.

In our previous opinion we noted that, although there was testimony that a part of the dryer in which decedent was working had temperatures of 110 to 115 degrees, the only evidence was that the area in which decedent was working had temperatures of 80 to 85 degrees; the expert said that those temperatures were not excessive. We could also have noted that the referee expressly found that decedent worked "inside a dryer with a temperature of 80 to 85 degrees" and that that finding is supported by substantial evidence. We therefore held, first, that the expert's opinion was based on a crucial assumption, that decedent worked in excessive heat, that is not supported by the record.[4] Second, we held that that opinion could not provide substantial evidence to support the Board's decision. 135 Or App at 555. We adhere to our first **<139 Or App 168/169>** holding that one of the expert's basic assumptions is without evidentiary support. We now believe, however, that our second holding may have exceeded our scope of review. Our first holding, thus, requires us to remand to the Board for reconsideration rather than making the final decision on compensability ourselves.

It is the Board's role to find the facts of a case; we are not to substitute our judgment. ORS 183.482(7). The Board must evaluate the evidence and draw appropriate factual conclusions. However, the Board has not explained why it accepted the expert's opinion of the cause of death despite its express finding that decedent worked in temperatures of only 80 to 85 degrees, which, under the evidence, was not excessive heat. The only attempted explanation is the referee's statement that he found the expert's opinion "well-reasoned and based on a correct history." The referee did not, however, explain how he reached that conclusion in light of the facts, which he also found, that showed that decedent did not work in excessive heat.

The problem with the Board's order, thus, is that it does not explain why the remaining findings of the Board, which are supported by evidence, lead it to the conclusion that it reached. *Drew v. PSRB*, 322 Or 491, ___ P2d ___ (1996); *Home Plate, Inc. v. OLCC*, 20 Or App 188, 190, 530 P2d 862 (1975), *quoted in Armstrong v. Asten-Hill Co.*, 90 Or App 200, 205-06, 752 P2d 312 (1988); *see also The Steel Yard, Inc. v. Natl. Council* on Comp. Ins., 127 Or App 267, 271, 873 P2d 332 (1994) (Board must articulate a rational connection between the facts that it finds and the legal conclusions that it draws). If the Board decides to accept the expert's opinion despite the inaccuracy of one of his essential assumptions, it must explain why it does so. The Board's order contains no such explanation and, thus, does not satisfy the substantial reason requirement that it show a rational connection between the specific facts that it found and its ultimate conclusion that the expert's opinion was reliable. On remand, it must reconsider its opinion in order to address the relationship between those facts and its ultimate conclusion on the compensability of the claim.

Reversed and remanded for reconsideration.

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[4] Unlike *Garcia*, the problem in this case is not the evidentiary support for the Board's factual findings that are related to the basis for the expert's opinion; rather, the problem is the Board's failure to explain the relationship between those findings and its evaluation of that opinion.

Cite as 139 Or App 196 (1996) February 21, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Douglas R. Baar, Claimant.

Douglas R. BAAR, *Petitioner,*
v.
FAIRVIEW TRAINING CENTER and SAIF Corporation, *Respondents.*
(WCB 92-13378; CA A84296)

In Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted February 2, 1995; resubmitted in banc February 7, 1996.
James L. Edmunson argued the cause for petitioner. With him on the brief was Malagon, Moore, Johnson & Jensen.
Michael 0. Whitty, Special Assistant Attorney General, argued the cause for petitioners. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
DEITS, J.
Affirmed.

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139 Or App 198> Claimant seeks review of an order of the Workers' Compensation Board that held, *inter alia,* that his hypertension condition was not compensable and that housekeeping services recommended by his treating physician were not reimbursable medical services. We affirm.

In 1986, claimant developed left knee problems after he slipped and fell on some stairs. One year later, in August 1987, claimant began working at Fairview Training Center, where he worked until March 1988. In 1989, a referee determined that claimant's work activities there independently contributed to a worsening of his left knee condition, thus making Fairview and its insurer, SAIF, responsible for claimant's related medical expenses. Claimant underwent surgeries on his left knee in 1988, 1989, 1990 and 1991, and he had extensive physical therapy after each surgery. During those surgeries and subsequent therapy, claimant experienced "severe stress, primarily related to his left knee condition and frustration dealing with various SAIF claims adjusters." In January 1992, claimant suffered a hypertensive crisis during a therapy session. He experienced chest pain, shortness of breath, headaches and dizziness. Before that attack, claimant had not been treated for hypertension. Dr. Francis, an internist and cardiologist, diagnosed claimant with essential hypertension, a condition that has no known etiology. Claimant's hypertension condition worsened to the degree that it required medical treatment. He requested that SAIF process that condition as part of his accepted left knee claim, but SAIF denied the compensability of his hypertension. On October 15, 1992, claimant requested a hearing on SAIF's denial.

In the meantime, claimant, on the recommendation of Dr. Raczka, his treating orthopedist, hired Cissy Cleaning Service to clean his house and bought a pair of Nike orthotic shoes. On August 24, 1992, claimant submitted the charges for the housekeeping service and the shoes to SAIF. After SAIF failed to take action on those claims within 90 days, claimant requested a review by the Director of the Department of Insurance and Finance. On February 17, 1993, the Director issued a final order, which concluded that the shoes were reimbursable medical services but that **<139 Or App 198/199>** the housekeeping services were not. On March 8, 1993, claimant filed a supplemental request for a hearing on the Director's final order.

On June 28, 1993, the referee issued an opinion and order setting aside SAIF's denial of claimant's hypertension condition and reversing the Director's decision regarding housekeeping services. The referee concluded that claimant's hypertension condition was a "consequential condition" under ORS 656.005(7)(a)(A) that was "caused in major part by his compensable left knee injury and its sequelae." With respect to the

housekeeping services, the referee determined that under *Pamela J. Panek,* 44 Van Natta 1645 (1992), those services qualified as medical services under ORS 656.245(l). However, on July 9, 1993, the referee, relying on *Lorenzen v. SAIF,* 79 Or App 751, 719 P2d 1336, *rev den* 301 Or 667 (1986), and *Maxine V. McInnis,* 42 Van Natta 81 (1990), issued an order on reconsideration reversing himself on the issue of housekeeping services and, consequently, affirming the Director's final order.

SAIF sought review by the Workers' Compensation Board of that part of the referee's order setting aside its denial of claimant's hypertension claim. Claimant sought review of that part of the referee's order affirming the Director's conclusion that housekeeping services are not reimbursable medical services. With respect to claimant's hypertension claim, the Board, applying ORS 656.005(7)(a)(A), reversed the referee's order:

> "The Referee found that claimant's hypertension is compensable as it is related to his compensable left knee condition under ORS 656.005(7)(a)(A). We agree that ORS 656.005(7)(a)(A) applies to this claim, because the hypertension condition is only indirectly related to the compensable injury. *See Albany General Hospital v. Gasperino,* 113 Or App 411, 414 (1992).
>
> "The court has specifically held that, under ORS 656.005(7)(a)(A), 'any injury or condition that is not *directly* related to the industrial accident is compensable *only if* the major contributing cause is the compensable injury.' *Hicks v. Spectra Physics,* 117 Or App 293, 297 (1992). * * *
>
> **139 Or App 200>** "A finding of 'major' causation requires that the injury contributes more to the claimed condition than all other causes, explanations, or exposures combined ***.
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> "* * * * *
>
> "Although all physicians indicate that claimant's compensable injury is a contributing factor to his hypertension condition and need for treatment, none of the physicians have stated that the compensable injury is *the* major contributing cause. On this record, claimant has not established that the compensable injury contributed more to his hypertension than any other factor. 'Magic words' are not required to establish compensability of a claim. *McClendon v. Nabisco Brands, Inc.,* 77 Or App 412 (1986). However, considering the non-injury factors and the fact that claimant's hypertension condition preexisted the injury, we do not consider the medical opinions sufficient to satisfy the compensability standard." (Emphasis in original.)

The Board also affirmed the referee's order on reconsideration, holding that housekeeping services are not medical services under ORS 656.245(l):

> "On the merits of the 'medical services' issue, we are bound by *Lorenzen v. SAIF,* 79 Or App 751, 752[, *rev den* 301 Or 667] (1986), which held that compensable medical services include only those 'other related services' which are 'of the same kind or class as those services specifically enumerated in [ORS 656.245(1)].' In this case, housekeeping help was recommended solely because of claimant's inability to perform household chores. Under these circumstances, we cannot say that housekeeping help is of the same kind or class as those services specifically enumerated in the statute. *See* ORS 656.245(l)(c).[1] Accordingly, on this record, we conclude, as did the Referee and the Director, that there is no showing that housekeeping services are reimbursable medical services under ORS 656.245."

On reconsideration, the Board affirmed its decision pertaining to the compensability of claimant's hypertension condition:

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[1] In 1995, the legislature renumbered ORS656.245(l)(c) as ORS656.245(l)(b). For ease of reference, we refer to the statute as renumbered.

> "[A]s noted in our prior order, Dr. Francis states that the compensable injury and *the attendant claims processing* **<139 Or App 200/201>** are the major cause of claimant's hypertension * * *. Dr. Francis did not opine that the compensable injury (without claims processing) was the major contributing cause of claimant's hypertension. Consequently, we continue to adhere to our previous conclusion that claimant has not established that his *compensable* injury is the major contributing cause of his hypertension condition." (Emphasis in original.)

Claimant first assigns error to the Board's application of ORS 656.005(7)(a)(A) to determine the compensability of his hypertension condition. Claimant argues that, because the Board mentioned[2] that his hypertension was a preexisting condition, it should have applied ORS 656.005(7)(a)(B). Claimant asserts that the Board should have determined, under ORS 656.005(7) (a) (B), whether his knee injury "was the major cause of any particular need for treatment or degree of disability" rather than determining, under ORS 656.005(7)(a)(A), "whether the injury was the major cause of the hypertension condition itself." However, we decline to address that argument, because claimant failed to preserve it below. Our review of the record indicates that claimant actually argued to the Board that the referee correctly applied ORS 656.005(7)(a)(A) to his claim:

> "Claimant respectfully requests the Board affirm and adopt the referee's finding of fact and conclusions of law relative to his decision to set aside SAIF's denial of treatment for hypertension. The referee applied the correct test and concluded that all reliable medical evidence supported claimant's position."

Accordingly, we will not address claimant's first assignment of error. ORAP 5.45(2); *see also EBI Ins. Co. v. Chandler,* 112 Or App 275, 828 P2d 1047 (1992).

Claimant next argues that the Board erred in considering the actions of employer and SAIF in processing his knee injury claim as "non-injury" factors for purposes of **<139 Or App 201/202>** determining compensability of his hypertension condition under ORS 656.005(7)(a)(A). In particular, claimant argues that "an employer's or its insurer's delay in providing compensation in an injury claim should be considered part of the direct consequence of the industrial injury itself."

ORS 656.005(7)(a)(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 the following limitations:
>
> "(A) *No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential* condition." (Emphasis supplied.)

As the case was presented by the parties to the Board, claimant's accepted left knee condition is the "compensable injury" and claimant's hypertension condition is "a consequence of a compensable injury." Under the above statute, a consequential condition is compensable only if it was caused in major part by the original compensable injury. Claimant argues, however, that the actions of an employer or its insurer in processing a claim are part of a claimant's original "compensable injury" for purposes of determining whether that compensable injury was the major contributing cause of the consequential condition, here, claimant's hypertension.

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[2] The Board did not expressly find that claimant's hypertension was a preexisting condition. In its findings of fact, the Board adopted the findings of the referee, which included the ambiguous statement "[c]laimant had no prior treatable hypertension." In its conclusions of law, the Board, in the context of discussing whether the compensability standard was met, noted that claimant's hypertension preexisted his knee injury, but it did not analyze the claim as involving a preexisting condition.

Particularly in view of our recent decision in *Roseburg Forest Products v. Zimbelman,* 136 Or App 75, 900 P2d 1089 (1995), we are not persuaded by claimant's argument. In that case, the claimant developed bilateral carpal tunnel syndrome and the employer accepted his claim for that condition. Shortly thereafter, the claimant developed a cervical condition, for which the employer denied compensability. Nonetheless, the claimant underwent surgery, which left him temporarily totally disabled. After the surgery, the claimant became "focused" on his disability and **<139 Or App 202/203>** the denial of his claim. In the two weeks preceding his death, the claimant's emotional and physical condition deteriorated. The claimant became "extremely worried" that he would not receive the amount of compensation to which he thought he was entitled. When he received his compensation check, he believed that it was not sufficient. He became extremely agitated, suffered a myocardial infarction, and died.

The claimant's beneficiary sought compensation for the claimant's myocardial infarction on the ground that it was a "consequential condition" caused by the stress of his compensable injuries. The employer denied the claim, but the referee set aside the denial and the Board affirmed. The Board held:

> " '[C]laimant's myocardial infarction was caused, in major part, by his emotional upset over his inability to work, his pain, and his reaction to the employer's processing of his claim, including the disputed temporary disability check. All of these factors are sequelae of claimant's compensable injuries.' "

On appeal, the claimant's beneficiary argued that the "circumstances surrounding a compensable injury" should be considered part of the compensable injury for purposes of determining compensability of consequential conditions under ORS 656.005(7)(a)(A). *Id.* at 78. We disagreed and reversed the Board. We first concluded that, under the plain language of ORS 656.005(7)(a)(A), emotional stress relating to a compensable injury is not considered part of that compensable injury:

> " 'Compensable injury' is defined by statute as '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 * * *.' ORS 656.005(7)(a). Under that definition, the compensable injury is the medical condition that results from the accidental injury and is not the aftereffects of that condition. *See Albany General Hospital v. Gasperino,* 113 Or App 411, 833 P2d 1292 (1992) * * * . Accordingly, the Board erred in treating claimant's emotional condition as part of the original compensable injuries." *Id.* at 79.

We did hold, however, that, although the claimant's emotional condition could not be considered as part of **<139 Or App 203/204>** the original compensable injury, it could be compensable as a consequential condition, itself, if it were caused in major part by the original compensable injury. We took the analysis one step further and concluded that, if the emotional condition were found to be compensable as a consequence of the original injury, the myocardial infarction could, in turn, be compensable as a consequential condition if caused in major part by the claimant's emotional condition. However, in that discussion, we noted that, to the extent that the claimant's stress was caused by his reaction to the claims process, it could not be considered as being caused by the compensable injury:

> "The Board found that claimant's emotional state was also caused in part by claimant's reaction to the processing of his claim and his belief that the amount of compensation was incorrect. A claimant's reaction to the amount of compensation and to claims processing is not caused by the compensable injury; it is caused instead by the process by which the claimant is compensated for the injury." *Id.* at 79 n 2.

If a claimant's stress pertaining to the claims process cannot be said to be caused by the compensable injury, it necessarily follows that the actions of the employer and its insurer in processing an injury claim are not *part of* the compensable injury. Thus, we conclude that the Board properly considered the actions of employer and its insurer in processing claimant's injury claim as "non-injury" factors for purposes of ORS 656.005(7)(a)(A).

Finally, claimant asserts that the Board erred in concluding that, under ORS 656.245(1)(b), housekeeping services were not reimbursable medical services related to his accepted left knee claim. At the outset, we note that the legislature recently amended ORS 656.327(2) to provide for direct review by the Court of Appeals of orders by the Director of the Department of Consumer and Business Services pertaining to medical services. Or Laws 1995, ch 332, § 41. The amended version of that statute is applicable in this case. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). Generally, it has been our practice to remand all cases in which there has been any change in the pertinent language of the statutes and where there is *any* possibility that the change may alter our analysis of the **<139 Or App 204/205>** case in any way. We have remanded such cases in order to allow the Board to consider the matter in the first instance. However, we have made an exception to that practice when it is certain that the change will not alter our analysis in any way and when remand will serve no purpose.

This case comes within the above exception to the general rule. Here, claimant obtained review of the Director's order by a hearings referee and then by the Board under the law as it existed at that time. Although the amendment to the statute did change the process for review of this type of issue, under the circumstances here, that change will not alter our analysis. The Director has, in fact, already ruled on the issue presented here. Nothing in the statute on which the Director based his decision has been changed by the new law. It would serve no purpose to reverse and remand this issue to the Board with instructions to vacate that portion of its order. Accordingly, we will review the Director's order, pursuant to ORS 183.310 *et seq.,* as if claimant had sought our review directly under the amended version of ORS 656.327(2).

ORS 656.245(1)(b) provides, in part:

> "Compensable medical services shall include medical, surgical, hospital, nursing, ambulances and *other related services,* and drugs, medicine, crutches and prosthetic appliances, braces and supports and where necessary, physical restorative services." (Emphasis supplied.)[3]

In interpreting a statute, our goal is to discern the intent of the legislature, starting first with an examination of the statutory text and its context. *PGE v. Bureau of Labor* and *Industries,* 317 Or 606, 610, 859 P2d 1143 (1993). Neither the text nor its context indicates whether the legislature intended housekeeping services to constitute compensable medical services. The underlying legislative history is equally unrevealing. However, applying the rule of *ejusdem generis,* we conclude that, because housekeeping services are not of the "same kind or class" as those listed in the **<139 Or App 205/206>** statute, the legislature did not intend housekeeping services to be compensable medical services under ORS 656.245(l)(b). *See Lorenzen v. SAIF,* 79 Or App 751, 719 P2d 1336, *rev den* 301 Or 667 (1986)(concluding that child care services are not compensable medical services).

Accordingly, the Board did not err in concluding that housekeeping services are not compensable medical services under ORS 656.245(l)(b).

Affirmed.

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[3] In 1995, the legislature amended ORS 656.245(1), Oregon Laws 1995, chapter 332, but did not change the definition of compensable medical services under ORS 656.245(1)(b).

Cite as 139 Or App 222 (1996) February 21, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Diana JACKSON, *Appellant,*

v.

FRED MEYER, INC., a Delaware corporation, *Respondent.*

(94CV0266; CA A85672)

Appeal from Circuit Court, Coos County.

Robert F. Walberg, Judge.

Argued and submitted December 14, 1995.

Charles Robinowitz argued the cause and filed the briefs for appellant.

Michael T. Stone argued the cause for respondent. With him on the brief were Frank A. Moscato and Moscato, Byerly & Skopil.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

EDMONDS, J.

Affirmed.

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139 Or App 224> Plaintiff appeals from a summary judgment dismissing her personal injury claim against defendant, her former employer. ORCP 47. The trial court held that plaintiff s exclusive remedy was under the Workers' Compensation Act. Plaintiff argues that the Act violates Article I, section 10, of the Oregon Constitution, because it takes away her common law remedy against defendant. We affirm.

Plaintiff filed a workers' compensation claim for a work-related injury that occurred in September 1990. She claimed that the injury "aggravated a pre-existing condition in her right wrist." Defendant accepted the claim, and in June 1991, the Department of Insurance and Finance declared plaintiff medically stationary as of May 29, 1991. However, plaintiff continued to send defendant's insurer medical bills for treatment that occurred after May 29. In response, the insurer sent plaintiff a letter denying compensability for those treatments because her "current need for medical care [was] *unrelated* to [her] original industrial injury." (Emphasis supplied.)

Plaintiff filed a request for hearing with the hearings division, but in February 1994, plaintiff and defendant entered into a "disputed claim settlement" in which plaintiff agreed to dismiss her request for hearing. The summary judgment record contains a letter from plaintiff's attorney to defendant's attorney, which states in part:

> "I want to confirm our telephone conversation of February 2, 1994 in which you told me that [defendant] has agreed to pay $4,000 to [plaintiff] as part of a Disputed Claim Settlement involving the denial of March 17, 1992. This settlement resolves all claims for time loss, medical bills, permanent disability, attorney's fees and all other claims which [plaintiff] could have made relating to the denial of March 17, 1992.
>
> "We also discussed the possibility of settling a potential negligence action by [plaintiff] against [defendant] on the grounds that her claim relating to her right wrist fusion, was not compensable as a workers' compensation claim. We agreed that the Disputed Claim Settlement agreement will not act as a bar to this type of claim, and Fred Meyer **<139 Or App 224/225>** will not assert this agreement as a defense to that type of claim, if [plaintiff] decides to pursue it."

Plaintiff thereafter filed this action against defendant, alleging that defendant's negligence in September 1990 caused her damages.

Defendant moved for summary judgment on plaintiff's claim, arguing that under ORS 656.018 (since amended by Or Laws 1995, ch 332, § 5), her exclusive remedy was under the Workers' Compensation Act. In particular, defendant relied on our holding in *Errand v. Cascade Steel Rolling Mills, Inc.*, 126 Or App 450, 869 P2d 358 (1994), *rev'd* 320 Or 509, 888 P2d 544 (1995), in which we held that the Workers' Compensation Act provides the exclusive remedy against employers for work-related injuries to workers. Plaintiff countered that our decision in *Errand* violated section 10 because under its holding, workers injured by employer negligence

were left without any remedy if their injuries were noncompensable. The trial court disagreed and granted summary judgment against plaintiff.

Sometime after the court granted summary judgment in this case, the Oregon Supreme Court issued its opinion in *Errand v. Cascade Steel Rolling Mills, Inc.*, 320 Or 509, 888 P2d 544 (1995), holding that ORS 656.018(2) did not prohibit a worker from bringing a common law claim of negligence against an employer when a workers' compensation claim had been denied. On appeal in this case, plaintiff initially argued that the trial court erred in granting summary judgment, based on the holding in *Errand.* However, before plaintiff filed her reply brief, the legislature amended ORS 656.018(2), *see* Or Laws 1995, ch 332, § 5, and plaintiff now concedes that the amendment effectively overrules the Supreme Court's holding in *Errand.* Consequently, she contends that the amended statute violates Article I, section 10, which provides that "every man shall have remedy by due course of law for injury done him in his person, property, or reputation."

ORS 656.018(2), as amended, provides:

> "The rights given to a subject worker and the beneficiaries of the subject worker under this chapter for injuries, **<139 Or App 225/226>** diseases, symptom complexes or similar conditions arising out of and in the course of employment are in lieu of any remedies they might otherwise have for such injuries, diseases, symptom complexes or similar conditions against the worker's employer under ORS 654.305 to 654.335 or other laws, common law or statute, except to the extent the worker is expressly given the right under this chapter to bring suit against the employer of the worker for an injury, disease, symptom complex or similar condition."

Plaintiff argues that the statute violates section 10 because, at common law, she was only required to prove that the employer's negligence was a substantial factor in causing her injury; under the Worker's Compensation Act, she is required to prove the employment is *the* major contributing cause of her condition. *See* ORS 656.005(7)(a). Thus, as we understand plaintiff's argument, she asks us to hold that the statute is unconstitutional as to those workers whose injuries are work-related but who cannot show that their injuries were the major contributing cause of their current medical conditions.

Before we undertake the determination of that issue, we must first decide whether plaintiff has presented us with " 'an actual factual setting that makes such a decision necessary.' " *Stevens v. City of Cannon Beach,* 317 Or 131, 147, 854 P2d 449 (1993) (quoting *Hodel v. Virginia Surface Mining & Reclamation Assn., Inc.*, 452 US 264, 294-95, 101 S Ct 2352,69 L Ed 2d 1 (1981)), *cert den* ___ US ___, 114 S Ct 1332, 127 L Ed 2d 679 (1994). As the Oregon Supreme Court stated in *Gortmaker v. Seaton,* 252 Or 440, 450 P2d 547 (1969):

> "It is fundamental to appellate jurisprudence that courts do not sit 'to decide abstract, hypothetical, or contingent questions * * * or to decide any constitutional question in advance of the necessity for its decision.' " *Id.* at 442 (quoting Alabama *State Federation of Labor v. McAdory,* 325 US 450, 461, 65 S Ct 1384, 89 L Ed 1725 (1945)).

In this case, we conclude that plaintiff has not provided us with an actual factual setting that properly **<139 Or App 226/227>** frames the issue of the statute's constitutionality.[1] The summary judgment record shows that plaintiff was not completely deprived of a remedy. Under section 10, the legislature has the authority to limit common law remedies as long as it does not leave the injured party entirely without a remedy. *Hale v. Port of Portland,* 308 Or 508, 523, 783 P2d 506 (1989). Defendant accepted compensability of the original injury that occurred in September 1990, and later paid plaintiff $4,000 to settle the claims made after she was declared medically stationery. As a result, plaintiff does not fall within the class of persons who are denied a remedy because they cannot prove that their work-related injuries are the major contributing cause of their conditions. We therefore decline to consider plaintiff's contention and affirm the trial court for that reason.

Affirmed.

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[1] In *Errand,* the Workers' Compensation Board had held that the plaintiff had not established that his condition was compensable because work was not the major cause of his condition.

Cite as 139 Or App 283 (1996) February 21, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

AETNA CASUALTY & SURETY COMPANY, *Petitioner,*
v.
SUE A. BLANTON, D.C., *Respondent.*
(94-027; CA A85910)

Judicial Review from Department of Consumer and Business Services.
Argued and submitted June 21, 1995.
Vera Langer argued the cause for petitioner. On the brief were Allen W. Lyons and Scheminske & Lyons.
Sue A. Blanton, D.C, waived appearance for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Reversed and remanded.

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139 Or App 285> In this medical services dispute, insurer seeks review of a final order of the director of the Department of Consumer and Business Services requiring reimbursement for chiropractic treatment provided to a workers' compensation claimant. The issue is whether the director lawfully may order reimbursement of chiropractic treatment when the treatment was provided without a written treatment plan approved and signed by the injured worker's treating physician. The director held that, although the applicable administrative rule provides that reimbursement shall not be required in the absence of an approved, written treatment plan, strict compliance is not necessary if the treatment is reasonable. Reviewing for errors of law, ORS 656.327; ORS 183.482(7), we disagree with the director's reading of the rule and reverse.

ORS 656.327(1)(a) provides, in part, that, if an insurer believes that an injured worker is receiving medical treatment that is "in violation of rules regarding the performance of medidal services," the insurer may seek review by the director.[1] Among the rules that have been promulgated regarding the reimbursement of medical services is OAR 436-10-040, which provides, in part:

> "(1)(a) Medical services, including diagnostic services, provided to the injured worker shall not be more than the nature of the compensable injury or the process of recovery requires. *Services which are unnecessary or inappropriate according to accepted professional standards, or to these rules, are not reimbursable[.]*
>
> "* * * * *
>
> "(3)(a) Ancillary services including, but not limited to, physical therapy or occupational therapy *by a medical service provider other than the attending physician shall not be reimbursed unless carried out under a written treat*ment *plan prescribed prior to the commencement of treat*ment and *signed by the attending physician within 7 days of the beginning of treatment.* The treatment plan shall include objectives, modalities, frequency of treatment and **<139 Or App 285/286>** duration. A copy of the signed treatment plan *shall be* provided to the insurer by the attending physician within 14 days of the beginning of treatment. * * *
>
> "(b) Medical services prescribed by an attending physician and provided by a chiropractor, * * * *shall be subject to the treatment plan requirements set forth in subsection (3)(a) of this rule[.]"* (Emphasis supplied.)

In this case, claimant sustained a compensable injury on November 12, 1993. Claimant's chiropractor, Dr. Blanton, was claimant's attending physician at the time of the injury. A month later, however, an internist,

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[1] The legislature amended ORS 656.327(l)(a) effective June 7, 1995. Or Laws 1995, ch 332, § 41. That amendment does not affect the disposition of this case. *See former* ORS 656.327(l)(a).

Dr. Beers, became claimant's attending physician. Beers verbally approved the chiropractor's continued treatment of claimant, and, on January 4, 1994, Blanton began treatments. On January 18, 1994, insurer notified Blanton that, because it had not received a referral and a written treatment plan, the chiropractic treatments to that date would not be reimbursed. Blanton then obtained a referral from Beers and, on January 28, 1994, Blanton prepared a chiropractic treatment plan for Beers's approval. In the meantime, Blanton continued treatments. Beers ultimately signed the plan on February 28, 1994. Blanton then billed insurer for eight treatments from January 4 through March 4, 1994. Insurer disallowed reimbursement for treatments provided before February 28, because Beers had not signed the treatment plan at that point. Blanton requested review of insurer's disallowance.

The Medical Review Unit (MRU) affirmed insurer's denial of reimbursement. Blanton then requested review by the director. The director found that, although OAR 436-10-040(3)(a) permits reimbursement only if there is a prior written treatment plan approved by the treating physician, in this case, treatment is reimbursable, because the rule is merely a "guideline, " because the treatment was "reasonable and necessary" and because

> "Beers' failure to provide a treatment plan consistent with the Director's rules reflects upon the complexity of the system rather [than] the appropriateness of the care."

139 Or App 287> On review, insurer argues that there simply is no exception in the rules for good faith ignorance of the complexities of the workers' compensation system. To the contrary, insurer contends, the rule unequivocally states that reimbursement "shall not" be required without a *prior* written, approved treatment plan signed within seven days of the commencement of treatment. We agree.

We begin with a fundamental principle of administrative law that "[w]hen an agency has the authority to adopt rules and does so, it must follow them." *Albertson's* Inc. *v. Bureau of Labor and Industries*, 128 Or App 97, 101, 874 P2d 1352 (1994). An agency does not have the authority to ignore its own rules. *Id.; Georgia-Pacific Corp. v. Kight,* 126 Or App 244, 246, 868 P2d 36 (1994); *Harsh Investment Corp. v. State Housing Division,* 88 Or App 151, 157, 744 P2d 586 (1987), *rev den* 305 Or 273 (1988).

OAR 436-10-040(l)(a) provides that medical services provided without complying with the requirements of the rule "are not reimbursable." OAR 436-10-040(3)(a) further provides that medical services "shall not be reimbursed unless carried out under a written treatment plan" approved by the treating physician within seven days of the first day of treatment. And OAR 436-10-040(3)(b) specifically provides that reimbursement for chiropractic treatment is "subject to the treatment plan requirements set forth in subsection (3)(a) of this rule." There is nothing equivocal about the foregoing rules. They contain no exceptions for reasonable and necessary treatment or for physicians who are unfamiliar with them. Nor can the rules reasonably be regarded as merely precatory. By their own terms, they are mandatory. They clearly provide that medical services "shall not be reimbursed" unless carried out in accordance with the rules.

We are not exalting form over substance. The rules themselves proclaim that

> "[t]he preparation of a written treatment plan and the supplying of progress notes are integral parts of the fee for the medical service."

OAR 436-10-040(3)(e). Moreover, despite the director's concerns, there is no trap for the unwary. The rules are **<139 Or App 287/288>** clear and straightforward. Although, as the director found, Beers may not have been familiar with them, he should have been. Moreover, there is no suggestion that Blanton was unfamiliar with the rules. Indeed, insurer notified Blanton as early as January 18, 1994, that treatments would not be reimbursed without a written treatment plan approved by the attending physician. Yet, Blanton continued to provide treatments without an approved, written plan.

The director erred in ordering reimbursement of chiropractic treatment.

Reversed and remanded.

Cite as 139 Or App 417 (1996) March 6, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Lela M. Kenfield, Claimant.

Lela M. KENFIELD, *Petitioner,*
v.
HEALTH FUTURE, INC., Insurer, and Merle West Medical Center, Employer, *Respondents.*
(WCB 91-08331; CA A87384)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 29, 1996.
Darris K. Rowell argued the cause and filed the brief for petitioner.
Adam T. Stamper argued the cause for respondents. With him on the brief was Cowling, Heysell, Plouse, Ingalls & Moore.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

---

139 Or App 419> Claimant seeks review of an order of the Workers' Compensation Board, contending that the Board erred in dismissing her request for hearing on the ground that the director of the Department of Consumer and Business Services has exclusive jurisdiction of the dispute. We affirm.

Claimant has an accepted claim for low back strain. The claim was closed in 1987 by a determination order. In October 1990, Dr. Grant began treating claimant for chronic myofascial low back and left leg pain and prescribed physical therapy. Employer denied payment of medical treatment and physical therapy on the ground that they constituted noncompensable palliative care. The administrative law judge found that the sole issue was whether the disputed medical care was curative or palliative, and concluded that the Hearings Division did not have original jurisdiction over the request for hearing. Claimant sought review, and we remanded the case to the Board for reconsideration in the light of our opinion in *Meyers v. Darigold, Inc.,* 123 Or App 217, 861 P2d 352 (1993), *rev den* 320 Or 453 (1994).

In its order on remand, the Board found that claimant had not sought review by the director and that the Board therefore had jurisdiction to consider the dispute as we had interpreted ORS 656.327(l) in *Meyers.* The Board found, further, that the requested treatment was palliative, rather than curative, and that it was not compensable under ORS 656.245(l)(b). The Board held that the director had exclusive jurisdiction regarding any further challenge to the denial of palliative medical services. It declined to consider claimant's constitutional challenge to the statutory scheme denying compensation for palliative care.

The parties have stipulated that the requested treatment is reasonable and necessary to claimant's compensable injury. In her petition for review, claimant does not challenge the Board's finding that her requested treatment is palliative rather than curative. She does not ask the court to evaluate the merits of her constitutional challenge. She contends only that the Board erred in determining that it lacked jurisdiction to determine whether the statutory limitations on compensation for palliative care are constitutional, asserting that she **<139 Or App 419/420>** has a vested right to palliative medical services. We conclude that the Board correctly reasoned that, once it had determined that the requested medical care was palliative, any arguments

related to the compensability of the care, including constitutional challenges to the statute, were to be addressed to the director. *Hathaway v. Health Future Enterprises,* 125 Or App 549, 865 P2d 503, *aff'd* 320 Or 383, 884 P2d 549 (1994).[1]

Affirmed.

---

[1] We note that in 1995 the legislature amended ORS 656.327 and ORS 656.245. The amendments are retroactive and apply to this case. The changes do not affect the outcome of this case, however. As amended, ORS 656.327(l) provides:

> "(a) If an injured worker, an insurer or self-insured employer or the Director of the Department of Consumer and Business Services believes that the medical treatment * * * that the injured worker has received, is receiving, will receive or is proposed to receive is excessive, inappropriate, ineffectual or in violation of rules regarding the performance of medical services, the injured worker, insurer or self-insured employer shall request review of the treatment by the director and so notify the parties.
>
> "(b) Unless the director issues an order finding that no bona fide medical services dispute exists, the director shall review the matter as provided in this section. Appeal of an order finding that no bona fide medical services dispute exists shall be made directly to the Workers' Compensation Board within 30 days after issuance of the order. The board shall set aside or remand the order only if the board finds that the order is not supported by substantial evidence in the record. Substantial evidence exists to support a finding in the order when the record, reviewed as a whole, would permit a reasonable person to make that finding. The decision of the board is not subject to review by any other court or administrative agency.
>
> "(c) The insurer or self-insured employer shall not deny the claim for medical services nor shall the worker request a hearing on any issue that is subject to the jurisdiction of the director under this section until the director issues an order under subsection (2) of this section."

As amended, ORS 656.245(l)(c)(J) provides, in part:

> "Notwithstanding any other provision of this chapter, medical services after the worker's condition is medically stationary are not compensable except for the following:
>
> " * * * * *
>
> "(J) With the approval of the insurer or self-insured employer, palliative care that the worker's attending physician referred to in ORS 656.005(12)(b)(A) prescribes and that is necessary to enable the worker to continue current employment or a vocational training program. If the insurer or self-insured employer does not approve, the attending physician or the worker may request approval from the Director of the Department of Consumer and Business Services for such treatment. The director may order a medical review by a physician or panel of physicians pursuant to ORS 656.327(3) to aid in the review of such treatment. The decision of the director is subject to the contested case and review provisions of ORS 183.310 to 183.550."

Cite as 139 Or App 421 (1996) March 6, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Danny B. Conner, Claimant.
Danny B. CONNER, *Petitioner,*
v.
CONNECTICUT INDEMNITY CO. and The Dalles Disposal Service, Inc., *Respondents.*
(WCB 94-01980; CA A88344)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs January 29, 1996.
James L. Edmunson and Paul K. Hoffman filed the brief for petitioner.
Howard R. Nielsen filed the brief for respondents.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Remanded for reconsideration in light of 1995 amendments to ORS 656.005(7)(a)(B) and the enactment of ORS 656.005(24).

---

139 Or App 423> Claimant seeks review of an order of the Workers' Compensation Board upholding insurer's denial of his degenerative disc disease. We remand the case for reconsideration in the light of recent statutory changes.

The record shows that claimant has a preexisting degenerative disc disease. In January 1993, claimant suffered a lumbar strain as a result of a work-related accident, and he has had constant back pain since that time. He was confined to bed for the first 30 days after the injury and was then treated conservatively with physical therapy and medications. After several months, he was released to light duty work. He became medically stationary on October 28, 1993, but continues to suffer low back pain. All doctors agree that claimant's lumbar strain has resolved but that he remains severely impaired. He has reduced lumbar ranges of motion and an inability to use his back repetitively. Dr. Parsons, a consulting neurosurgeon, said that claimant's primary diagnosis is degenerative disc disease. In his report of November 1, 1993, he said that claimant had sustained a lumbar strain as a result of his injury, that he had become medically stationary, and that he is now experiencing symptoms of the preexisting degenerative condition.

On January 7, 1994, as a result of Parsons' opinion, insurer denied the compensability of and responsibility for claimant's degenerative lumbar disc disease:

> "We have received a report from Dr. Parsons in which he indicates that you have recovered from your industrial strain of January 14, 1993.
>
> "Dr. Parsons also indicated that in addition to the accepted lumbar strain you have degenerative lumbar disc disease, and your current permanent restrictions and impairments are related to this disease process rather than to our [sic] industrial strain.
>
> "Therefore, at this time, we must respectfully deny any compensability or responsibility for your degenerative lumbar disc disease being a result of the industrial injury of January 14, 1993, or arising out of, or in the course and scope of, your employment at The Dallas *[sic]* Disposal.
>
> **139 Or App 424>**"This is a partial denial only and in no way affects the benefits afforded to you for the accepted strain portion of this claim. "

On April 18, 1994, just before the hearing, Parsons authored another report in which he concluded that, although claimant's work injury was the major contributing cause of the onset of the symptoms of his degenerative disc disease, "[i]t cannot be determined whether [claimant] would be experiencing low back pain at this time from his degenerative disc disease even if he had not sustained the injury on January 14, 1993. " Parsons was the only physician to address the issue of major contributing cause.

The administrative law judge found that claimant had established, by a preponderance of the evidence, that the compensable injury "combined with claimant's preexisting degenerative lumbar disc disease and that the resultant condition remains the major contributing cause of his current disability." The Board found that the work injury was the major contributing cause of the onset of symptoms of the degenerative disc disease but that the evidence did not support a finding that the industrial injury continued to be the major contributing cause of the degenerative disc disease being symptomatic after April 18, 1994. The Board held, accordingly, that claimant had carried his burden of proving the compensability of his need for treatment and disability only through April 18, 1994. It set aside the insurer's denial to that extent.

Both parties agree that this case is governed by ORS 656.005(7)(a)(B). We have considered and reject without discussion claimant's contention that the Board incorrectly considered whether claimant's condition after April 18, 1994, is related to his compensable injury. The case must be remanded, however. In 1995, the legislature amended and enacted provisions that potentially affect the Board's determination of the compensability of claimant's degenerative condition. ORS 656.005(7)(a)(B); ORS 656.005(24). The amendments are applicable here. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). We remand the case to the Board for reconsideration of its order in the light of the 1995 legislation.

139 Or App 425> Remanded for reconsideration in the light of 1995 amendments to ORS 656.005(7)(a)(B) and the enactment of ORS 656.005(24).

Cite as 139 Or App 459(1996) March 6, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Christopher J. Kaufman, Claimant.

D & D COMPANY and Farmers Insurance Company, *Petitioners*
v.
Christopher J. KAUFMAN, *Respondent.*
(94-03382; CA A87983)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 29, 1996.
Jerald P. Keene argued the cause for petitioners. With him on the brief was Roberts, Reinisch, MacKenzie, Healey & Wilson, P.C.
Floyd H. Shebley argued the cause and filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Reversed and remanded.

---

139 Or App 461> Employer seeks review of a Workers' Compensation Board order holding that claimant's claim for a middle and low back condition was not barred by a Claim Disposition Agreement (CDA). We reverse.

Claimant, a truck driver, compensably injured his middle and low back on April 3, 1992, in a collision with an automobile. Claimant received time loss benefits for five days and then returned to regular work. The claim was closed on July 16, 1992, with no award for permanent disability.

On August 12, 1992, claimant lifted a water cooler at work and again injured his middle and low back. He was treated by Dr. Long and a nurse practitioner. He started missing work on August 22 because of that injury. On August 31, employer notified claimant and the Department of Business and Consumer Services that, pending an investigation, it was classifying the August 12 claim as an aggravation of the April 3 claim. Without objection from claimant, it reopened the claim using the claim number that had been assigned to the April 3 claim and began paying interim time loss benefits.

On December 22, 1992, claimant signed a CDA that had been drafted by his attorney. It released his rights to permanent disability, vocational rehabilitation, survivor benefits and all other rights except medical services for the April 3, 1992, injury claim. The agreement specified that "[t]his claim has not been closed," and that "[t]he worker has not been able to return to the workforce."

On January 28, 1993, while awaiting approval of the CDA by the Board, employer sent claimant a formal notice of acceptance of the August claim as an aggravation of the April 3 claim. The Board approved the CDA on February 1, 1993, at which time employer discontinued paying time loss benefits.

Claimant continued to receive medical treatment for his back symptoms. In November 1993, he requested that his claim be reopened or, alternatively, that the August 12 injury be processed as a claim for a new injury. Relying on the CDA, employer refused. On March 16, 1994, claimant filed a request for a hearing.

139 Or App 462> The ALJ concluded that claimant's claim was barred by the CDA. The Board reversed, holding that claimant's claim for the August 12 incident involved a new injury, that the CDA did not bar litigation, and that claimant was entitled to a hearing on the issue of a *de facto* denial of his new injury claim.

On review, employer contends that the Board erred, because the CDA barred claimant's request for hearing. Claimant responds that he suffered a new injury to his middle and low back on August 12 and that this new injury was not mentioned in, nor resolved by, the CDA that was executed several weeks before employer formally accepted the August 12 claim as an aggravation claim.

We interpret CDAs using the same rules of construction that apply to contracts. *Trevitts v. Hoffman-Marmolejo,* 138 Or App 455, 459, 909 P2d 187 (1996). We must pursue the intent of the parties if possible. ORS 42.240. Whether a contract is ambiguous is a matter of law. *Timberline Equip. v. St. Paul Fire and Mar. Ins.,* 281 Or 639, 643, 576 P2d 1244 (1978). A contract is not ambiguous if it has only one sensible and reasonable interpretation. P *& C Construction Co. v. American Diversified, 101* Or App 51, 56, 789 P2d 688 (1990).

The question is whether the CDA incorporated and released claimant's rights regarding the August 12 incident. We conclude that it unambiguously did.

The CDA was drafted by claimant's attorney and provides that it is a full release of "all other issues or benefits allowed by law, except for medical services." It states that it covers the April 3, 1992 injury. It also states that " [t]his claim has not been closed" and that "[t]he worker has not been able to return to the workforce." Those two statements unequivocally indicate that the CDA encompasses the August 12 incident. The claim for the April 3 injury was closed on July 16, 1992. It was reopened, under the same claim number, at the request of Dr. Long after the August 12, 1992, incident, and claimant received time loss benefits until the Board approved the CDA. If claimant had intended to release his right to benefits only for the April 3 injury, the CDA would have stated that the claim had been closed. Furthermore, claimant returned to work after the April 3 injury. He was **<139 Or App 462/462>** prevented from returning to the workforce only by the August 12 incident. The statement in the CDA that claimant has been unable to return to the workforce is additional evidence that claimant intended the CDA to encompass the August 12 incident. By the terms of the CDA, the April 3 injury and the incident of August 12 were within its scope. As we observed in *Safeway Stores, Inc. v. Seney,* 124 Or App 450, 454, 863 P2d 528 (1993), claimant may not "escape his bargain" by now recharacterizing the August 12 claim as a claim for a new injury.

The Board erred in holding that the CDA did not bar claimant's "new injury" claim for his middle and low back condition.

Reversed and remanded.

Cite as 139 Or App 507 (1996) March 6, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Zane E. Phillips, Claimant.
Zane E. PHILLIPS, *Petitioner,*
v.
John HAMMOND and SAIF Corporation, *Respondents.*
(94-10158; CA A89161)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 26, 1996.

Meagan A. Flynn argued the cause for petitioner. With her on the brief was Pozzi Wilson Atchison.

Julene M. Quinn, Special Assistant Attorney General, argued the cause for respondents. With her on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

PER CURIAM

Award of permanent partial disability reversed and remanded for reconsideration; otherwise affirmed.

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139 Or App 508> Claimant seeks review of an order of the Workers' Compensation Board in which it determined the amount of his permanent partial disability by applying rules that create a formula for the purpose. Claimant argues that the rules are invalid to the extent that they assign a value of zero to the adaptability factor in the formula when the claimant has returned to the claimant's previous work; as a result they prevent any consideration of the statutory factors of age and education. ORS 656.214. In *Carroll v. Boise Cascade Corp.,* 138 Or App 610, ___ P2d ___ (1996), we held under a different version of the rules that such a provision was invalid. The rules involved in this case are subject to the same defect that we identified in *Carroll* and are invalid for the same reasons. As a consequence, claimant's award must be recalculated.

Claimant's arguments concerning the rate at which he is to receive permanent partial disability are premature, as the Board has not yet determined that he is entitled to any particular rate. *See Hamlin v. Salem Area Transit,* 137 Or App 497, 501, 905 P2d 245 (1995). His remaining arguments do not require discussion.

Award of permanent partial disability reversed and remanded for reconsideration; otherwise affirmed.

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