VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 48

(Pages 715-1340)

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

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

APRIL-JUNE 1996

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

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CITE AS

48 Van Natta ____ (1996)

In the Matter of the Compensation of
LINDA M. LACKEY, Claimant
WCB Case No. 95-05618
ORDER ON REVIEW
Robert E. Nelson, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Galton's order which increased claimant's unscheduled permanent disability from 13 percent (41.6 degrees), as awarded by an Order on Reconsideration, to 18 percent (57.6 degrees). On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the first sentence of the "ultimate findings of fact."

CONCLUSIONS OF LAW AND OPINION

Claimant, a service station attendant/manager, sustained a compensable left shoulder and neck injury on July 29, 1993. The claim was closed by Notice of Closure on November 30, 1994, with an award of temporary, but no permanent, disability. Claimant requested reconsideration and, on March 30, 1995, an Order on Reconsideration was issued. It awarded 13 percent unscheduled permanent disability. Claimant requested a hearing seeking an increased award of permanent disability. SAIF cross-requested a hearing seeking a reduction in claimant's award.

The dispute at hearing concerned two factors in the calculation of claimant's permanent disability: the skills value and permanent impairment. In awarding claimant 13 percent unscheduled permanent disability, the reconsideration order had allocated a value of 3 for claimant's skills factor based on a Specific Vocational Preparation (SVP) value of 3 for the DOT code of 915.467-010 (service station attendant). The reconsideration order also gave claimant a value of 7 for permanent impairment based on reduced range of cervical motion.[1]

The ALJ determined that, in addition to impairment for reduced range of cervical motion, claimant was entitled to a 5 percent rating for a "chronic" condition restricting her from repetitively using her left shoulder. Combining that impairment with claimant's 7 percent impairment for reduced range of cervical motion, the ALJ found that claimant was entitled to a value of 12 for permanent impairment.

The ALJ rejected SAIF's argument that claimant's skills value should be 1 based on an SVP of 7 for the DOT code for service station manager (DOT 185.167-014). The ALJ found that the Order on Reconsideration had properly rated claimant's skills value as 3 based on the job description for service station attendant, which has an SVP of 3. Concluding that the reconsideration order had properly calculated claimant's permanent disability with the exception of permanent impairment for a "chronic" condition, the ALJ increased claimant's permanent disability award by 5 percent to a total unscheduled award of 18 percent.

On review, SAIF contends that the ALJ erred in awarding unscheduled permanent disability for a "chronic" condition, relying on OAR 436-35-320(5)(a).[2] SAIF also asserts that the ALJ should have based claimant's skills value on the DOT code for service station manager. We agree that claimant is not entitled to a "chronic" condition award, but do not accept SAIF's argument regarding the skills value.

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[1] Claimant was given no value for age and formal education and an adaptability factor of two. Neither party disputes those values.

[2] OAR 436-35-320(5)(a) provides in part that: "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."

At the outset, we determine the applicable standards. In analyzing the issues presented in this claim, we apply the disability standards in effect when the claim was closed on November 30, 1994 (WCD Admin. Orders 93-056, 6-1992). See OAR 436-35-003(2). As previously noted, OAR 436-35-320(5)(a) provides that, where the total unscheduled impairment in a "body area" is equal to or in excess of 5 percent, the worker is not entitled to any unscheduled chronic condition impairment. A "body area" is defined as "cervical/upper thoracic spine (T-1 to T-6)/shoulders." OAR 436-35-320(5).

We recently held that the Board and the Hearings Division have no authority to invalidate the 5 percent limitation in OAR 436-35-320(5) and, alternatively, that such limitation was within the Director's statutory rulemaking authority under ORS 656.726(3)(f)(A). Gregory D. Schultz, 47 Van Natta 2265, corrected 47 Van Natta 2297 (1995). Here, inasmuch as claimant's cervical spine and left shoulder are in the same "body area," and because claimant has already received in excess of 5 percent unscheduled permanent impairment in that "body area," we reverse the ALJ's award of additional permanent impairment for a "chronic condition." Gregory D. Schultz, supra. We, therefore, agree with SAIF that claimant's permanent impairment is 7 percent as determined in the reconsideration order.

We now turn to the issue of whether claimant's skills value was correctly calculated. SAIF contends that claimant's SVP should be based on the DOT code for service station attendant. It cites claimant's "work history" provided for her vocational eligibility evaluation which states that she performed managerial functions (Ex. 4A-2), as well as her testimony regarding her managerial duties. SAIF argues that claimant's SVP should be 7, not 3, and that her skills value should, therefore, be 1. OAR 436-35-300(4). We disagree.

Even assuming that service station manager is an appropriate job classification for claimant, OAR 436-35-300(4) requires that, for a worker to qualify for an SVP of 7, he or she must have completed from 2-4 years in the position. See generally Edward F. Ebert, 47 Van Natta 2170 (1995), on recon 48 Van Natta 37 (1996) (OAR 436-35-300(3)(b)(A) sets out a rebuttable presumption that a claimant who works less than the maximum, but more than the minimum, period under OAR 436-35-300(4) has skills needed to qualify for SVP 7). Although claimant testified that she thought she worked as a service station manager for two and one-half years, she conceded that she could not remember. (Tr. 12). Claimant's "work history" confirms that claimant performed her position of "station attendant/manager" from October 1992 to "present." The date of the document, however, is April 8, 1994, which is less than two years from the commencement of her employment as a service station manager. (Ex. 4A-4).

Thus, neither claimant's "work history" nor her testimony establishes that she worked the required amount of time to qualify for an SVP 7. Therefore, we agree with the ALJ that SAIF failed to establish that claimant's SVP value was incorrectly rated in the Order on Reconsideration.[3]

In conclusion, we find that claimant's impairment value should be 7 percent, instead of 12, and that the SVP value contained in the Order on Reconsideration (3) is correct. Since the parties do not dispute the other values contained in the Department's permanent disability calculation, we conclude that claimant's unscheduled permanent disability is 13 percent. Inasmuch as this was the amount of permanent disability awarded by the reconsideration order, that order is reinstated and affirmed.

ORDER

The ALJ's order dated August 23, 1995 is reversed. The Order on Reconsideration is reinstated and affirmed in its entirety.

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[3] Amended ORS 656.283(7) provides 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. In Joe R. Ray, 48 Van Natta 325 (1996), we held that evidence not submitted at reconsideration, and not made part of the reconsideration record, was statutorily inadmissible under amended ORS 656.283(7) at a subsequent hearing regarding extent of permanent disability. Under such circumstances, claimant's testimony likely cannot be considered on review. However, Ray does not change the result in this case because, whether or not we considered claimant's testimony, we would still conclude that SAIF has not established that claimant's SVP was incorrectly rated.

In the Matter of the Compensation of
TRACIE L. MARTIN, Claimant
WCB Case No. 94-12729
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Myzak's order that awarded claimant 14 percent (21 degrees) scheduled permanent disability for the loss of use or function of the left forearm, whereas an Order on Reconsideration had awarded no scheduled permanent disability. On review, the issue is extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

Claimant has an accepted left carpal tunnel claim. On February 2, 1994, Dr. Warren, treating physician, declared claimant medically stationary. He found decreased pinpoint discrimination in all five fingers of claimant's left hand. (Ex. 18-2). He also stated that claimant "is obviously unable to perform repetitive heavy grasping with the left hand and forearm." (Id.) Warren did not state that any of claimant's findings were permanent.

CONCLUSIONS OF LAW AND OPINION

On the basis of Dr. Warren's February 2, 1994 findings, the ALJ found that claimant had established a 9 percent impairment value for loss of sensation in the fingers of her left hand and a 5 percent impairment value for a left hand chronic condition, for a combined impairment value of 14 percent. The employer asserts, among other things, that claimant's impairment value should be zero, because there is no evidence that her findings were permanent. We agree.

To obtain a permanent scheduled disability award, claimant must establish a permanent loss of use or function of a body part due to an industrial injury. ORS 656.214(1)(b); OAR 436-35-010(2). If there is no medical evidence of permanent loss of such use or function, there is no basis for a permanent disability award. E.g., Nancy P. Strande, 46 Van Natta 400 (1994).

Here, Dr. Warren found numbness and tingling in the fingers of claimant's left hand and determined that claimant was "obviously unable to perform repetitive heavy grasping activities with the left hand and forearm." (Ex. 18-2). Warren did not, however, state that those findings were permanent. Because there is no other medical evidence establishing the permanency of claimant's left hand findings, there is no basis for a permanent disability award. Consequently, we reverse the ALJ's scheduled permanent disability award and reinstate the Order on Reconsideration.

ORDER

The ALJ's order dated August 31, 1995 is reversed. The Order on Reconsideration is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that there is no medical evidence of the permanency of claimant's inability to perform repetitive activities with her left hand and forearm. Dr. Warren specifically concluded, without qualification, that claimant was unable to perform such activities. (Ex. 18-2). Warren rendered that conclusion in the course of declaring claimant medically stationary and releasing her to regular work. (Id.)

"'Medically stationary' means that no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). In view of that definition, I would construe Dr. Warren's report to mean that no further material improvement was expected regarding claimant's inability to perform repetitive activities. That is, in my estimation, sufficient to establish the permanency of claimant's inability to use her left hand and forearm repetitively. The majority's conclusion to the contrary is simply too exacting. Therefore, I dissent.

In the Matter of the Compensation of
HERBERT R. PEARSON, Claimant
WCB Case Nos. 94-02837 & 92-05433
ORDER ON REVIEW
Schneider, Hooton, Claimant Attorneys
Williams, Zografos, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) upheld the insurer's denial of claimant's occupational disease claim for his respiratory condition; (2) upheld the insurer's denial of claimant's occupational disease claim for porphyria; and (3) upheld the insurer's denial of claimant's claim for a psychological condition. In addition, claimant objects to the ALJ's exclusion of certain evidence. On review, the issues are compensability and propriety of the ALJ's evidentiary ruling. We affirm.

FINDINGS OF FACT

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

Between May 1992 and November 30, 1993, when claimant retired, his chemical exposures at the plant included ZEP 45 (once), ZEP 50 (twice), ammonia fumes (couple of times), and caustic fumes (about 10-12 times). (TB 28-29, 38).[1] Claimant was wearing a respirator during all these exposures, except the ZEP 45 exposure. (TB 34).

The symptoms claimant associated with his chemical exposures included frequency in the need to urinate, difficulty breathing, stabbing pains in the head, hands, shoulders and hips, sore throat, headache, bleeding from the gums and rectum, and rash on his arms and legs. (TB 52-58; see also TA 155).

CONCLUSIONS OF LAW AND OPINION

Evidence

The ALJ declined to admit an April 27, 1994 front page article from the Tillamook, Oregon newspaper offered by claimant. (Ex. 91A). The article described an accidental ammonia leak at the employer's workplace on April 25, 1994 that was apparently caused by an outside contractor drilling into an active ammonia line. The ALJ also denied claimant's alternative request to reopen the record. Claimant contends that the article should be admitted for the purpose of impeaching the testimony of the employer's expert industrial hygiene witnesses. Alternatively, claimant requests reopening of the record for presentation of impeachment evidence.

ALJs are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure and may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7). We review the ALJ's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

We agree with the ALJ's reasoning that the proffered evidence was not relevant to the resolution of the compensability issues in this case. We add the following to respond to claimant's arguments on review.

We do not find that the proffered evidence is relevant to impeach the testimony of the employer's industrial hygiene expert witnesses. Only one industrial hygienist, Debra Corbin, testified regarding her measurements for exposure to ammonia. She testified that she measured ammonia levels in 1991 in the compressor room, the room in which the ammonia is stored. (TB 111). She explained that her measurements gave her no cause for concern regarding exposure in the compressor room. (TB 112). She did not testify, as claimant asserts, that the ammonia handling system was "impregnable,"

[1] Our references to the hearing transcripts are consistent with the ALJ's designations in his Opinion and Order. That is, "TA" refers to the transcript of the hearing on May 28, 1992, while "TB" refers to the transcript of the hearing on April 25, 1994.

nor did she express an opinion regarding whether or not an accidental ammonia leak could occur. Her measurements and testimony concerned only the ammonia exposure levels in the compressor room in 1991. We conclude that an article describing an accidental ammonia leak in 1994, caused by an outside contractor drilling into an active ammonia line, would not in any material way impeach Ms. Corbin's testimony. Accordingly, we find that the ALJ did not abuse his discretion in excluding the evidence.

Alternatively, claimant contends that the hearing should have been continued for the presentation of rebuttal evidence. The ALJ denied claimant's request to reopen the record.

An ALJ "may continue a hearing ... [u]pon a showing of due diligence if necessary to afford reasonable opportunity for the party bearing the burden of proof to obtain and present final rebuttal evidence ..." OAR 438-006-0091(3). OAR 438-006-0091(3) is couched in permissive language and contemplates that the exercise of authority to continue a hearing rests within the ALJ's discretion. See Ronald D. Hughes, 43 Van Natta 1911, 1912 (1991).

Although we recognize that claimant could not have presented the specific, proffered evidence at hearing, since the ammonia leak apparently took place during the time of the hearing, nothing prevented claimant from preparing and presenting other rebuttal testimony at the hearing. Two expert industrial hygiene witnesses testified on behalf of the employer at the hearing. However, their testimony was substantially based on prior reports and measurements, documents dating from 1986 and 1991. (See Exs. 17A, 21A, 58A). Claimant does not contend that he did not timely receive these documents. Thus, we find that claimant could have prepared and presented rebuttal evidence at the time of the hearing. See Larry E. Fournier, 47 Van Natta 786 (1995). Accordingly, we conclude that the ALJ did not abuse his discretion in declining to continue the hearing.

Finally, even if claimant's evidentiary argument were well-taken, we conclude that the proffered evidence would not affect the outcome of this case. That is, we would still find, for the reasons stated in the ALJ's order and our order on review, that the medical evidence fails to satisfy claimant's burden of proof. Therefore, it is not necessary to determine whether the ALJ erred by excluding the newspaper article. See Jose L. Duran, 47 Van Natta 449 (1995); Larry D. Poor, 46 Van Natta 2451 (1994).

Respiratory Condition

We adopt and affirm those portions of the ALJ's order that found that claimant was precluded from relitigating the compensability of occupational exposures prior to a previous ALJ's November 1990 order, and that claimant failed to establish the compensability of his respiratory condition subsequent to November 1990.

Porphyria Condition

We adopt and affirm that portion of the ALJ's order that upheld the insurer's denial of claimant's occupational disease claim for a porphyria condition, with the following supplementation.

The ALJ determined that claimant failed to prove, by a preponderance of the evidence, that he had a porphyria condition. On that basis, the ALJ upheld the insurer's denial of claimant's occupational disease claim for a porphyria condition. Claimant contends that he is not required to prove a specific diagnosis in order to establish compensability of an occupational disease, but that he need only prove that his condition was caused in major part by occupational exposure.

We agree with claimant that he need not prove a specific diagnosis in order to establish a compensable occupational disease. Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). Claimant must prove, by a preponderance of the evidence, that work conditions were the major contributing cause of his disease, or, if his claim is based on the worsening of a preexisting disease, that work conditions were the major contributing cause of the combined condition and pathological worsening of the disease. Amended ORS 656.802(2)(a), (b).

Claimant relies on the opinion of Dr. Morton to establish compensability of his occupational disease. However, Dr. Morton's opinion is premised on his specific diagnosis of porphyria. In other words, Dr. Morton's opinion rests on the premise that claimant has porphyria, which he opined was caused by chemical exposures in the workplace. Thus, the persuasiveness of Dr. Morton's causation opinion depends on whether or not claimant has porphyria.

After our review of the record, we agree with the ALJ's evaluation of the medical evidence and conclude that the preponderance of the medical evidence fails to establish, within reasonable medical probability, that claimant has porphyria. Accordingly, since Dr. Morton's causation opinion rests on his diagnosis of porphyria, and we are not persuaded that claimant has porphyria, we do not find Dr. Morton's causation opinion persuasive. Therefore, we agree with the ALJ's conclusion that the insurer's denial of claimant's occupational disease claim for porphyria should be upheld.

Psychological Condition

We adopt and affirm that portion of the ALJ's order that upheld the insurer's denial of claimant's claim for a psychological condition, with the following supplementation.

Claimant contends that, although he may not have a psychological disorder, he is nevertheless entitled to medical treatment for the anxiety that has resulted from his respiratory condition and/or his porphyria condition. Claimant's theory appears to be that he has a consequential condition resulting from his respiratory condition and/or porphyria condition, which requires medical services.

For every compensable injury, claimant is entitled to medical services for conditions caused in material part by the injury. ORS 656.245(1)(a). However, the statute further provides that "for consequential. . .conditions described in ORS 656.005(7), the insurer . . . 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). Therefore, in order to obtain medical services for his consequential psychological condition, claimant must establish that his condition was caused in major part by a compensable injury.

Here, we have found neither claimant's respiratory condition nor his porphyria condition to be compensable. Therefore, neither of these conditions can constitute a "compensable injury" which could be the major contributing cause of a compensable consequential condition. Nor does claimant contend that any of his specific, compensable accidental injury exposures is the major contributing cause of his psychological condition. Accordingly, we find that claimant has failed to prove that medical services for a psychological condition would be directed to a medical condition caused in major part by a compensable injury. Amended ORS 656.245(1)(a).

ORDER

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

April 1, 1996 Cite as 48 Van Natta 720 (1996)

In the Matter of the Compensation of
MARCIA P. TREVISAN, Claimant
WCB Case No. 95-00290
ORDER ON REVIEW
Wallace & Klor, Claimant Attorneys
Steve A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that dismissed her request for hearing for lack of jurisdiction. On review, the issue is the preclusive effect of a Disputed Claim Settlement (DCS) on a claim for headaches. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In March 1993, an ALJ approved a Stipulation and Order between claimant and the SAIF Corporation in which SAIF accepted the conditions of cervical stenosis and discectomy at C5-6 and C6-7. In July 1994, another ALJ approved the parties' DCS; the agreement provided that, in exchange for consideration to claimant, SAIF's denial of bilateral temporamandibular joint (TMJ) problems would remain in force. (Ex. 26). The DCS further stated that "payment shall be accepted in full settlement of all issues raised or raisable." (Id.)

SAIF subsequently issued a denial of claimant's "headaches." The ALJ, relying on Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994), and Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993), concluded that claimant's request for hearing from the denial should be dismissed for lack of jurisdiction "because the condition and compensability of the potential claim for headaches was at issue before the approval of the settlement." The ALJ, thus, dismissed claimant's request for hearing.

We agree with the ALJ that Stoddard and Seney are applicable to this case. In Seney, the court considered the effect of a stipulation that "resolve[d] all issues which were raised or could have been raised by either party on or before the date this settlement is approved[.]" During negotiations for the settlement, the claimant suffered an aggravation and sought treatment; the carrier denied the subsequent aggravation claim before approval of the stipulation. Based on such facts, the court found that the claimant's "condition and the compensability of a potential claim were at issue during the negotiations and before approval of the settlement" and, because the stipulation resolved all issues which were raised or could have been raised, claimant was barred from challenging the denial. 124 Or App at 453-54.

Stoddard also involved a stipulation resolving "all issues which were raised or could have been raised on or before the date" of the agreement's approval. Citing to Seney, the court found that the "correct inquiry is whether claimant's condition and its compensability could have been negotiated before approval of the settlement." 126 Or App at 69. Because the claimant's disputed condition had been diagnosed and there had been a request for medical services at the time the settlement was signed, the court held that the nerve condition could have been raised and, therefore, the claim was barred by the settlement agreement. Id. at 73.

Here, as found by the ALJ, prior to entering into the DCS, claimant had sought treatment for her headaches, was diagnosed with migraine headaches, and prescribed medication for the condition. (E.g., Ex. 24). Based on such facts, we find that the compensability of the headache condition could have been raised prior to entering into the DCS. Good Samaritan Hospital v. Stoddard, supra.[1]

Such a conclusion, however, does not result in depriving the Hearings Division of jurisdiction over claimant's request for hearing. Rather, the effect of the DCS only is to preclude claimant from asserting her headache claim. Thus, we modify the ALJ's order only to the extent of reinstating claimant's request for hearing and upholding SAIF's denial.

ORDER

The ALJ's order dated April 28, 1995 is modified. Claimant's request for hearing is reinstated. The SAIF Corporation's denial is upheld.

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[1] In reaching this conclusion, we disagree with the reasoning expressed by the dissenting opinion. First, although Seney and Stoddard involved the interpretation of provisions contained in previously approved stipulations, neither decision suggests that the court's reasoning would have been altered had the prior agreement been a Disputed Claim Settlement (DCS). To the contrary, the primary focus of each decision was the "raised or raisable" provision contained in each agreement. In both decisions, the court ruled that the inclusion of such a provision precluded a party from attempting to litigate an issue which was raised or raisable when the agreement was approved. Since a "raised or raisable" provision was included in the parties' DCS and because claimant's migraine headache condition was an issue that could have been raised when the settlement was approved, the Seney/Stoddard rationale provides that further litigation of the condition is precluded.

Second, even if a "DCS" exception to the Seney/Stoddard rationale exists, the parties' agreement was not limited to a DCS of a disputed bilateral TMJ problem. Rather, in addition to resolving that compensability dispute, the agreement further provided for the dismissal of claimant's hearing request (in which claimant had "raise[d] other issues"), as well as "full settlement of all issues raised or raisable." (Ex. 26-1, 3). In other words, although titled "Disputed Claim Settlement," the parties' agreement was, in effect, both a DCS (of the specific denial) and a stipulation (the dismissal of claimant's hearing request, which included all other issues raised or raisable). Consequently, consistent with the Seney/Stoddard rationale, the parties' agreement precludes the litigation of claimant's migraine headache condition which could have been raised at the time of the previously approved agreement.

Board Chair Hall dissenting.

I disagree with the majority's conclusion that the DCS precludes claimant from challenging SAIF's denial of her headache condition and therefore respectfully dissent.

The holdings in Good Samaritan Hospital v. Stoddard, 126 Or App 69 (1994), and Safeway Stores v. Seney, 124 Or App 450 (1993), are distinguishable. Seney and Stoddard concerned stipulations; such agreements are intended to resolve contested matters arising out of claim closure, as well as "any contested matters not arising out of claim closure," whether or not a hearing has been requested. OAR 438-009-0005(1), (2) (WCB Admin. Order 2-1995). A DCS, on the other hand, may be used to settle only "a bona fide dispute over compensability of a claim." ORS 656.289(4)(a). More specifically, a DCS is a "settlement of a denied or disputed claim." OAR 438-009-0010(1).

These definitions show that the scope of a DCS is narrow in that it applies only to bona fide disputes concerning compensability; stipulations, on the other hand, may resolve any contested matter. In the context of these definitions, the holdings in Seney and Stoddard are logical: because those agreements resolved all "raised or raisable" contested matters, and because the facts in each case showed that a particular matter was contested (or potentially contested) at the time of the agreement, the scope of the stipulations encompassed such issues and precluded further litigation.

Here, unlike Stoddard and Seney, there is insufficient evidence of a "bona fide dispute" concerning claimant's headache condition. First, it is undisputed that the headache condition was not denied until after the parties entered into the DCS. The DCS itself states that "a bona fide dispute exists" between the parties "as to the compensability" of denied conditions; it further provides that, with approval of the DCS, claimant will have no additional entitlement to "compensation or any other legal right related to the" denied condition.

Based on the language of the DCS, I would conclude that, at the time of the agreement, there was only a bona fide dispute concerning the denied TMJ condition. In the absence of a bona fide dispute concerning the compensability of the headache condition, I do not consider this matter to be among the "raised or raisable" issues resolved by the DCS. To do otherwise would be to contravene the legal limitations of a DCS. Thus, claimant is not precluded by the DCS from litigating SAIF's denial of the headache condition.

For these reasons, I dissent.

In the Matter of the Compensation of
MARGARET O. BAIN, Claimant
WCB Case No. 95-05340
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that upheld the self-insured employer's denial of claimant's atrial fibrillation. On review, the issue is 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

Concluding that claimant had failed to establish that her work activities were the major contributing cause of her atrial fibrillation, which was allegedly caused by work-related stress, the ALJ held that claimant had failed to establish a compensable mental disorder under ORS 656.802. Claimant

asserts that the reports of Dr. Johnson, treating physician, are sufficient to establish the compensability of her atrial fibrillation. We disagree.[1]

In March 1995, claimant, a bus driver, had a confrontation with an unpleasant passenger. A day later, claimant developed a rapid heartbeat and other cardiac symptoms. During her ensuing hospitalization, she was diagnosed with atrial fibrillation and fibroid-related iron-deficiency anemia. (Exs. A, 3-7, -8, -9, -11, -12). Claimant filed a claim for the atrial fibrillation, alleging that it was caused by the psychological stress of dealing with the unpleasant passenger. (See Ex. 1).

Amended ORS 656.802(1)(b) provides that, "[a]s used in this chapter, 'mental disorder' includes any physical disorder caused or worsened by mental stress."[2] Claimant asserts that her atrial fibrillation -- a physical disorder -- was caused by her work stress. Therefore, pursuant to amended ORS 656.802(1)(b), we analyze this claim as a mental condition. To prevail under that theory, claimant must establish that her work activities were the major contributing cause of the atrial fibrillation. Amended ORS 656.802(2)(a). Claimant has not met that burden.

Dr. Johnson initially concluded that it was possible that claimant's atrial fibrillation was the result of job-related stress. (Ex. 6-1). In a later opinion, however, Johnson stated that potential causes of atrial fibrillation included stress and anemia. (Ex. 8). Then, without addressing claimant's anemia, Johnson concluded that claimant's "job related stress was clearly related to her stress reaction and this elicited the atrial fibrillation." (Id. at 2).

Dr. Johnson's first report is insufficient to meet claimant's burden of proof, because it is couched in terms of possibility, not probability. See Gormley v. SAIF, 52 Or App 1055, 1060 (1981) (claimant must prove medical causation in terms of probability, not possibility). Johnson's later report is likewise deficient. Although he need not recite the statutory template, see, e.g., Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992) (medical evidence need not consist of a specific incantation or mimic statutory language), he failed to analyze the import, if any, of claimant's anemia, a potential cause of atrial fibrillation. That renders his later report unpersuasive. See Dietz v. Ramuda, 130 Or App 397, 401-02 (1994) (to ascertain major contributing cause under ORS 656.005(7)(a)(B), relative contribution of each cause, including the precipitating cause, must be evaluated). Because there is no other medical evidence of causation, we agree with the ALJ that claimant has failed to establish the compensability of her atrial fibrillation as a mental condition under amended ORS 656.802(1)(b) and (2). Hence, we affirm the ALJ's decision upholding the employer's denial of that condition.

ORDER

The ALJ's order dated October 4, 1995 is affirmed.

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[1] The parties also dispute whether claimant's "stress response" was a mental disorder under amended ORS 656.802(3), and whether her work stress was generally inherent in every working situation. In view of our conclusion that the claim fails under the major contributing cause standard, we do not address those issues.

[2] The parties do not dispute that amended ORS 656.802 applies retroactively to this claim. See Or Laws 1995, ch 332, § 66(5)(a); see also Volk v. America West Airlines, 135 Or App 565, 572-73 (1995) (unless provided otherwise, Senate Bill 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).

In the Matter of the Compensation of
MARVIN CRAFTS, Claimant
Own Motion No. 94-0149M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested review of the SAIF Corporation's November 21, 1995 Notice of Closure which closed his claim with an award of temporary disability compensation from May 27, 1994 through November 2, 1995. SAIF declared claimant medically stationary as of October 21, 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).

In a January 3, 1996 letter, claimant advised the Board that Dr. Carlsen, claimant's treating physician, had ordered a bone scan which was performed on December 21, 1995. Further, claimant requested that SAIF update the Board with "this new information."

In a January 24, 1996 letter, SAIF notified the parties that it was in receipt of further information regarding claimant's condition. In addition, SAIF advised that:

> "By notice of this letter we are rescinding the November 21, 1995 Notice of Closure. It appears that [claimant] is in need of further surgery for his compensable right knee condition."

On January 29, 1996, the Board requested the parties' positions regarding the status of claimant's request for review of the November 21, 1995 closure.

On January 30, 1996, claimant, through his attorney, notified the Board that he agreed that SAIF's rescission of the Notice of Closure was proper. Based on the foregoing evidence and information, we find that the November 21, 1995 Notice of Closure was premature, and that the rescission of the Notice of Closure is proper and acceptable to all parties.

Accordingly, the rescission of SAIF's November 21, 1995 Notice of Closure is hereby acknowledged and approved. When appropriate, the claim shall be closed by SAIF pursuant to OAR 438-012-0055.

Finally, claimant's attorney requests an attorney fee for his services in obtaining the rescission of the November 21, 1995 Notice of Closure. Because 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 increased compensation as a result of the review and our order. Jerry Simmons, 48 Van Natta 104 (1996). Claimant's attorney submitted a retainer agreement with his request for review on behalf of claimant. Inasmuch as SAIF acknowledged that its Notice of Closure was premature after claimant, through his attorney, requested review, we conclude that claimant's attorney was instrumental in obtaining the additional benefits for claimant. Rafael Pineda, 47 Van Natta 1446 (1995). Therefore, we are authorized to award claimant's attorney an approved fee in the amount of 25 percent of the increased temporary disability compensation authorized 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.

In the Matter of the Compensation of
KENNETH C. FELTON, Claimant
Own Motion No. 96-0005M
OWN MOTION ORDER ON RECONSIDERATION
EBI Companies, Insurance Carrier

Claimant requests reconsideration of our January 31, 1996 Own Motion Order in which we declined to reopen his 1973 injury 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. In addition, claimant contends that the insurer "should be responsible for retraining and job placement."

On February 29, 1996, we abated our January 31, 1996 order to allow the insurer sufficient time to respond to claimant's motion. We have received the parties' responses. On reconsideration, we withdraw our prior order and issue the following order in its place.

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

In our prior order, we noted that claimant underwent outpatient arthroscopy and debridement of the lateral knee compartment on December 19, 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).

The insurer 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 was willing to work, but unable to work because of the compensable injury at the time of disability. Claimant has the burden of proof on this issue and must provide persuasive evidence that he was unable to work due to his compensable injury at the time of disability.

The insurer contends that claimant is ineligible for temporary disability compensation because he "has not worked since 1990 and has been on social security disability since that time." A claimant's eligibility for social security benefits indicates that he is disabled from work due to one or a number of medical conditions. However, the provision of social security benefits does not establish that a claimant is disabled from work because of a compensable injury. Therefore, a claimant's entitlement to social security benefits is not persuasive evidence that he is disabled due to the compensable injury unless the claimant can establish the disability as compensable.

The insurer contends that the Board's June 24, 1994 order denying the authorization of temporary disability compensation is proof that he was not in the work force at that time. An own motion order denying temporary disability compensation is issued when a claimant has not established that he was in the work force at the time of the current disability. See Kenneth Felton, 45 Van Natta 542 (1993) citing Konnie Sprueill, 45 Van Natta 541 (1993) (although the claimant was receiving disability compensation for a psychological condition under another claim, he failed to establish that his psychological condition was a compensable component of his right knee injury claim with the insurer, or that the compensable condition (the right knee condition) was responsible for making his work search futile). However, in the event that a claimant was unable to establish that he was in the work force due to a compensable injury at the time of a prior disability, he may successfully establish, through persuasive evidence, that he was in the work force at a later time. See Wausau Insurance Companies v. Morris, 103 Or App 270 (1990); Arthur R. Morris, on remand 42 Van Natta 2820 (1990); Lyle L. Smith, 43 Van Natta 169, 432, 1079 (1991). Here, claimant must carry his burden of proving he was in the work force when his current condition worsened requiring surgery.

Claimant submitted a March 11, 1996 letter from Dr. Cook, claimant's treating physician since 1994, in which Dr. Cook opined that claimant was unable to work since September 12, 1994 through the present time. In that letter, Dr. Cook opined that a "work search would be futile because of claimant's compensable [injury] until [claimant] has recovered from surgery." Because Dr. Cook has been claimant's treating physician since September 1994 and has performed two of claimant's surgeries since that time, his opinion persuades us that claimant was unable to work at the time of his current disability. Kenneth Felton, supra. Further, there is no evidence in the record which contradicts Dr. Cook's opinion.

On February 28, 1996, the Board received claimant's undated letter, in which he stated that "I really want and am willing to go back to the work force, but as you can see this is not possible at this time." Thus, we are persuaded that claimant is willing to work. Based on Dr. Cook's medical opinion, we are persuaded that claimant has established that he was unable to work or to seek work at the time of his current disability.

On this record, we conclude that claimant has established that he was in the work force at the time of his current disability.

Claimant also requests vocational assistance for "retraining and job placement." Under amended ORS 656.278, we are unable to grant claimant's request.[1] Thus, the Board, in its own motion authority, does not have jurisdiction to consider vocational issues.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning December 19, 1995, the date he was hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] Pursuant to Senate Bill 369, amended ORS 656.278(2) now prescribes that: "Benefits under subsection (1) of this section do not include vocational assistance benefits under ORS 656.340." This amendment essentially codified the court's decision in Harsh v. Harshco Corporation, 123 Or App 383 (1993), rev den 318 Or 661 (1994).

In the Matter of the Compensation of
FRANK D. GRAY, Deceased, Claimant
WCB Case No. TP95010
THIRD PARTY DISTRIBUTION ORDER
Pozzi, Wilson, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

The personal representative of the deceased worker's estate ("claimant") has petitioned the Board for resolution of a dispute concerning the "just and proper" distribution of proceeds from a third party settlement. See ORS 656.593(3). Specifically, the dispute involves objections from the paying agency, Georgia-Pacific Corporation, to the proposed allocation of the $750,000 wrongful death settlement: $375,000 to the decedent's widow and $375,000 apportioned equally between the decedent's two adult children. In addition, claimant contends that, in determining Georgia-Pacific's "just and proper" share of the settlement proceeds, the deduction for claimant's attorney fee pursuant to ORS 656.593(1)(a) should be 25 percent of the settlement proceeds ($192,060.46), as provided in claimant's contingent fee agreement, rather than the reduced amount of $100,000 actually charged by claimant's attorney.

We approve the allocation between the decedent's widow and children, and find that a distribution to Georgia-Pacific in the amount of $215,146.51 is "just and proper." In so finding, we conclude that the actual fee charged by claimant's attorney is to be used in calculating Georgia-Pacific's recovery under ORS 656.593(1) and (3).

FINDINGS OF FACT

The decedent was employed by Georgia-Pacific as a pipe fitter. On February 5, 1993, an explosion occurred in Georgia-Pacific's Toledo, Oregon plant, resulting in decedent's death.

As a result of the fatal explosion, decedent's widow, individually and as personal representative of the decedent's estate, and decedent's two adult children, son Frank Gray, Jr. and daughter Heidi Gray, brought wrongful death actions against Quality Tank and Construction Co. and Goslin Birmingham Corporation. Before the case went to trial, the Grays agreed to settle their claims against Quality Tank and Goslin for the sum of $750,000, consisting of a lump sum payment of $450,000 and three annuity contracts with a total present cash value of $300,000 (a $150,000 annuity in favor of decedent's widow and a $75,000 annuity in favor of each child). Georgia-Pacific approved of this settlement.

The personal representative then petitioned the Probate Court for approval of the $750,000 settlement and the distribution of proceeds. On October 17, 1995, the court issued an order authorizing the settlement, including the lump sum payment and three annuity contracts. The court's order also authorized the personal representative to pay $100,000 to claimant's counsel as attorney fees and $4,569.46 for costs incurred in pursuing the claim, to distribute the net settlement funds into a trust account pending determination of workers' compensation liens and to distribute the remaining balance 50 percent to the decedent's widow and 25 percent to each child.

With medical costs, burial expenses and monthly widow's benefits, Georgia-Pacific already paid out more than $50,000 as a result of decedent's death. Given Mrs. Gray's age and life expectancy, Georgia-Pacific will likely pay out more than $500,000 in monthly benefits over decedent's widow's lifetime. Claimant does not dispute the expected amount of Georgia-Pacific's lien.

On January 15, 1996, Georgia-Pacific received $50,000 in partial satisfaction of its lien against the proceeds from the wrongful death action. Unable to resolve their dispute regarding Georgia-Pacific's "just and proper" share of the settlement, claimant referred this matter to the Board for its consideration. See ORS 656.593(3).

CONCLUSIONS OF LAW AND OPINION

Georgia-Pacific does not challenge the amount of the proposed settlement, but instead the proposed 50/25/25 allocation of the settlement proceeds among decedent's widow and two children. Acknowledging that whatever rights it may have to the settlement proceeds attaches only to that portion allocated to decedent's wife,[1] Georgia-Pacific argues, in essence, that the proposed allocation is improper and unreasonable because decedent's wife suffered significantly more of a pecuniary loss as a result of decedent's death than decedent's two adult children.

In Worthen v. Lumberman's Underwriting, 137 Or App 368 (1995), the court held that where, as here, the wrongful death beneficiaries include both workers' compensation claimants and non-claimants, the recovery must first be allocated among the wrongful death beneficiaries pursuant to ORS 30.030. Then, once the workers' compensation beneficiary receives his or her portion of the recovery, ORS 656.593 dictates how much of that beneficiary's share will be distributed to the paying agency.[2]

In this case, pursuant to ORS 30.030, the Probate Court approved the $750,000 wrongful death settlement (including the provisions for payment and the 50/25/25 allocation of proceeds between decedent's widow and children) and directed the payment of $104,569.46 in costs and attorney fees. Although we retain the statutory authority under ORS 656.593(3) to resolve the dispute regarding a "just and proper" distribution of settlement proceeds to workers' compensation lienholder Georgia-Pacific, we

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[1] See Scarino v. SAIF, 91 Or App 350, rev den, 306 Or 660 (1988) (adult children's share of third party settlement proceeds are not subject to paying agency's statutory lien because adult children are not "beneficiaries" under the workers' compensation statutes); Neil C. Duclos, 43 Van Natta 28 (1991).

[2] ORS 30.030 requires that the costs, fees and expenses incurred in pursuing the wrongful death claim be paid first. In Worthen, the costs, fees and expenses incurred exceeded the total recovery and therefore none of the wrongful death beneficiaries received any part of the proceeds. The court held that since the decedent's wife (the only workers' compensation beneficiary of the group) did not receive any share of the recovery, the paying agency's lien on her portion of the recovery was effectively extinguished. 137 Or at 374. See also, Robbie W. Worthen, 48 Van Natta 90 (1996).

are bound by the Probate Court's order insofar as it allocates the amount that each wrongful death beneficiary is to receive. See Worthen v. Lumbermen's Underwriting Alliance, Inc., supra.[3] Therefore, contrary to Georgia-Pacific's contention, we are not in a position to evaluate the respective financial and emotional losses of decedent's widow and children resulting from decedent's death and reallocate the proceeds accordingly.[4]

Having determined that we are bound by the Probate Court's approval of the 50/25/25 allocation, we proceed to a determination of Georgia-Pacific's "just and proper" share of decedent's widow's $375,000 portion. ORS 656.593(3). In this regard, we agree with Georgia-Pacific that the attorney fee to be deducted from the workers' compensation beneficiary's recovery pursuant to ORS 656.593(1)(a) should be decedent's widow's share (one-half) of the actual fees charged ($100,000) rather than the 25 percent contingency fee contemplated by the retainer agreement.[5]

Since ORS 656.593(3) requires that we judge each "just and proper" share case on its own merits, we do not automatically apply the distribution scheme for third party judgments under ORS 656.593(1). See Nancie L. Smith, 47 Van Natta 2309 (1995). Despite the impropriety of arbitrarily applying the ORS 656.593(1) formula by rote, a distribution which mirrors the third party judgment scheme may, in fact, be "just and proper" under the merits of the case. See id.

In this case, we find the following to be a "just and proper" distribution of the workers' compensation beneficiary's share of the settlement proceeds:

$375,000.00	(total recovery allocated to decedent's widow)
-$50,000.00	(less one-half actual $100,000 attorney fee)
- $2,280.23	(less one-half of incurred litigation costs)
$322,719.77	(initial balance of proceeds)
-107,465.68	(less 33 1/3 percent statutory share of the balance to the widow; ORS 656.593(1)(b) and (3))
$215,254.09 [6]	(remaining balance to Georgia-Pacific for satisfaction of its current and future liens for compensation paid)

Claimant's attorney is directed to distribute the proceeds of claimant's share of the third party settlement proceeds in the manner detailed above. Any money already paid to Georgia-Pacific for partial satisfaction of its lien, i.e., the $50,000 paid on January 17, 1996, shall be deducted from the $215,254.09 distribution.

IT IS SO ORDERED.

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[3] See also Worthen v. Lumberman's Underwriting Allowance, Inc., 137 Or App 434 (1995), where the court reversed our decision Robbie W. Worthen, 46 Van Natta 226, rev den, 46 Van Natta 987 (1994).

[4] Even if we had the authority to reallocate the damages among the wrongful death beneficiaries, we would reject Georgia-Pacific's argument that decedent's widow's share of the proceeds should be greater. Neither the wrongful death statutes nor the workers' compensation laws require that we measure a beneficiary's loss or determine a just and proper distribution based primarily on pecuniary loss. See Timothy Mares, 47 Van Natta 1078 (1995) (approving $84,000 wrongful death settlement and allocation of $15,000 to decedent's estranged widow and remainder to decedent's parents); Neil C. Duclos, supra (approving equal distribution of wrongful death settlement proceeds between decedent's widow and adult daughter).

[5] Claimant argues that because her counsel voluntarily reduced his fee for the wrongful death beneficiaries' benefit (and not Georgia-Pacific's benefit) as a result of the limited third party recovery, we should still base the attorney fee deduction on the 25 percent amount set forth in the contingency fee agreement. We reject this contention because the statute and rules provide for payment of costs and attorney fees actually "incurred" up to a certain amount (33-1/3 percent; see ORS 656.593(1)(a) and OAR 438-015-0095), rather than the costs and fees expected or anticipated by the parties. By voluntarily reducing the fee, claimant's attorney left a larger balance from which claimant's 33-1/3 statutory share could be deducted, but Georgia-Pacific's "just and proper" share of the balance was likewise larger.

[6] Since it is undisputed that Georgia-Pacific will likely incur claim costs well in excess of its recovery from the settlement proceeds, we find that is a "just and proper" for Georgia-Pacific to recover the remaining balance of $215,254.09. See, e.g., Santos King, 47 Van Natta 2026 (1995) (remaining settlement balance of $26,000 was a "just and proper" distribution to the paying agency, where undisputed claim costs exceeded $47,000).

In the Matter of the Compensation of
MORRIS B. GROVER, Claimant
Own Motion No. 96-0046M
SECOND OWN MOTION ORDER ON RECONSIDERATION (DISMISSING)
Malagon, et al, Claimant Attorneys
EBI Companies, Insurance Carrier

The insurer requests reconsideration of our February 6, 1996 order, as reconsidered on March 1, 1996. The insurer contends that both it and claimant requested own motion relief in error. With its request for reconsideration, the insurer contends that it is currently paying permanent total disability (PTD) benefits to claimant, and that authorization of temporary disability benefits would "penalize" claimant. After reviewing the record, we dismiss the request for own motion relief.

The insurer initially submitted claimant's request for temporary disability compensation for his compensable 1979 industrial injury. Claimant's aggravation rights on that claim expired on November 16, 1984. The insurer opposed reopening the claim, contending that claimant was retired, and thus, not in the work force at the time of current disability.

On February 5, 1996, the Board issued an Own Motion Order, in which we declined to authorize the payment of temporary disability compensation because claimant had not established that he was in the work force at the time of disability.

On February 13, 1996, claimant requested reconsideration of our order, contending that he was declared permanently and totally disabled relative to another claim with a different insurer (the SAIF Corporation). Claimant requested compensation from both employers/insurers, contending that he was entitled to receive temporary, as well as permanent total, disability on two separate claims.

On March 1, 1996, we issued our Own Motion Order on Reconsideration, in which we concluded that claimant has established that he was in the work force at the time of current disability, and granted authorization of temporary disability compensation under his 1979 injury claim, beginning the date claimant underwent surgery for the compensable condition. In that order we noted that, if claimant is entitled to benefits from more than one claim, he is not entitled to receive more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984).

In a March 12, 1996 letter, the insurer requested that the Board "rescind the insurer's original request for Board's Own Motion Recommendation dated January 19, 1996 in its entirety." Contending that it made the recommendation in error, the insurer advised that it took over the payment of claimant's permanent total disability benefits (from SAIF) effective April 10, 1987, pursuant to an Order on Review issued by the Board. The insurer contended that claimant's monthly PTD benefits are $1,921.48, while his temporary total disability benefits would be $1,918.39, three dollars less than his PTD payment. In that respect, the insurer contended that "to suspend permanent total disability benefits and commence paying temporary disability benefits would penalize [claimant]."

By letter dated March 25, 1996, claimant advised the Board that the insurer had brought to his attention that the insurer was responsible for his PTD payments (rather than SAIF), and that "it would be claimant's position that he is not entitled to both permanent total disability and temporary total disability from the same carrier." We treat claimant's position as a withdrawal of his request for own motion relief under his 1979 claim.

Accordingly, claimant's request for own motion relief is hereby dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY HOFFMAN, Claimant
WCB Case No. 95-07045
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that affirmed an Order on Reconsideration that awarded 25 percent (80 degrees) unscheduled permanent disability for a low back injury. On review, the issue is extent of unscheduled permanent disability.

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

The only issue at hearing and on review is adaptability. Claimant became medically stationary on September 27, 1994, and her claim was closed by Determination Order on October 26, 1994. The standards in effect on the date of the Determination Order control. Former OAR 436-35-003(2). Thus, here, WCD Admin. Order No. 93-056 controls regarding the adaptability issue.

Adaptability is measured by comparing the Base Functional Capacity (BFC) to the worker's maximum Residual Functional Capacity (RFC) at the time of becoming medically stationary. Former OAR 436-35-310(2). Here, there is no dispute that claimant's RFC is sedentary/light. The dispute focuses solely on claimant's BFC. Under the facts of this case, where no second-level physical capacity evaluation was performed prior to the work injury, the BFC is determined by the highest strength category assigned in the DOT for the most physically demanding job the worker successfully performed in the five years prior to determination. Former OAR 436-35-310(4)(a). When a combination of DOT codes most accurately describes a worker's duties, the highest strength for the combination of codes applies. Id. Claimant has the burden of proving the nature and extent of any disability resulting from the compensable injury. ORS 656.266.

Claimant's job at-injury, certified nurse's aide (CNA), was the most physically demanding job claimant successfully performed in the five years prior to determination. (Exs. 1, 4). At hearing and on review, claimant argued that the at-injury job should be classified as an "orderly," which has a strength requirement of heavy. DOT 355.674-018. The ALJ concluded that the DOT that most accurately describes the at-injury job is "nurse assistant," which has a strength requirement of medium. DOT 355.674-014. In reaching this conclusion, the ALJ determined that claimant had not proved that her at-injury job required the lifting that was described in the DOT for the "orderly" job. We agree with the ALJ.

There is very little evidence in the record regarding the duties that claimant performed in the at-injury CNA job. Specifically, the record includes the following information regarding the CNA job. The 801 form describes the work injury as follows: "I was using the SARA lift to raise a resident from seated to standing position and when I was pulling him up, I pulled my right lower back and couldn't stand up." (Ex. 1). Claimant reported to a medical provider and the medical arbiter that the injury occurred while claimant was hooking a patient up to a SARA lift when the patient started to slide and claimant tried to grab him. (Exs. 2, 7-1). Finally, in listing her work history, claimant described her duties as a CNA as "to provide care, personnel [sic] & physical to the elderly," listing the equipment used as: "maxi lift, SARA lift, blood pressure cuff, thermometer, wheelchairs." (Ex. 4-2).

The DOT description for "orderly" includes "lifts patients onto and from bed." DOT 355.674-018. On review, claimant focuses on the term "pulling him up," as used in the 801 form quoted above, to argue that the CNA job necessarily required lifting patients. Therefore, claimant argues, the "orderly" classification most closely fits the requirements of the CNA job. We disagree that, on this record, claimant has established that the "orderly" classification most accurately describes claimant's at-injury work. ORS 656.266; compare William L. Knox, 45 Van Natta 854 (1993) (applying an earlier version of the standards, the Board found it reasonable to consider both the claimant's job duties and the physical demands of the job in determining a proper DOT to be assigned to his job; there, the record was adequate to determine that lifting and handling materials were significant elements of claimant's work,

thereby satisfying a DOT classification with a higher strength rating). Here, the record is simply inadequate to find that claimant's at-injury job duties and physical demands satisfy the DOT criteria for classification as an "orderly."[1]

ORDER

The ALJ's order dated September 25, 1995 is affirmed.

[1] In making this determination, we acknowledge that former OAR 436-35-310(4)(a) 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. Therefore, if claimant had established that a combination of the duties for "orderly" (DOT 355.674-018) and "nurse assistant" (DOT 355.674-014) most accurately described her CNA job, she would have been entitled to a strength value of "heavy," the higher strength value of these two DOT codes. DOT 355.674-018. However, here, claimant failed to prove that either the "orderly" DOT code or a combination of the "orderly" and the "nurse assistant" DOT codes apply to her CNA job. Therefore, under the facts of this case, claimant has failed to establish that her CNA job should be classified as requiring a strength category of "heavy."

April 2, 1996 Cite as 48 Van Natta 731 (1996)

In the Matter of the Compensation of
JOSEPH R. HUFF, Claimant
WCB Case Nos. 93-09144 & 93-08632
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Farmers Insurance (Farmers) requests review of those portions of Administrative Law Judge (ALJ) Baker's order which: (1) set aside its denial of responsibility for claimant's left shoulder injury claim; (2) upheld the responsibility denial of the same condition issued by the SAIF Corporation on behalf of the noncomplying employer; and (3) awarded an assessed attorney fee of $3,800, payable by Farmers. On review, the issues are responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant, a mechanic at the employer's service station, experienced left shoulder symptoms in connection with four work incidents. The first occurred on June 19, 1992, while Farmers was on the risk, when a transmission claimant was installing fell on his left shoulder. Claimant reported the incident to his employer, who advised him to "take it easy." (Tr. 38). Claimant testified that no claim was filed at the time because the employer indicated he would "take care of it." Id. Claimant neither sought medical treatment nor missed time from work.

The next three incidents occurred while the employer was in noncompliance with Oregon workers' compensation law from July 1, 1992 through May 10, 1993. In December 1992, claimant suffered left shoulder symptoms while "fighting" a transmission. In February 1993, the left shoulder symptoms occurred when claimant was pushing or pulling strenuously on a cylinder head with his arms extended. The last incident occurred in April 1993, when claimant was again "fighting" a transmission. All three incidents were reported to the employer. (Tr. 35).

It was not until after the April 1993 incident, however, that claimant sought medical treatment from Dr. Fix, a family practitioner, who diagnosed bicipital tendonitis. (Ex. 3-1). SAIF began insuring the employer on May 11, 1993.

SAIF, on behalf of the insured employer, initially denied compensability on June 3, 1993 (Ex. 26). Both Farmers and SAIF (as statutory processing agent for the employer during its period of noncompliance), issued responsibility denials/disclaimers on August 20, 1993 and September 24, 1993 respectively. (Exs. 46, 52). SAIF's denial letter specifically disclaimed responsibility for an alleged injury to claimant's left shoulder and stated that it had requested designation of a paying agent pursuant to ORS 656.307. No "307" order issued.

On April 4, 1994, SAIF issued another disclaimer of responsibility and claim denial on behalf of the noncomplying employer. This time, SAIF specifically denied a claim for an occupational disease for claimant's left shoulder and stated that it had not requested designation of a paying agent. The denial letter also stated that, "if your claim should be found compensable at a later date," then SAIF also disclaimed responsibility for claimant's condition. (Ex. 63b).

On April 19, 1994, SAIF issued yet another denial and disclaimer of responsibility (this time on behalf of the insured employer) in which it reiterated it was denying claimant's claim for an occupational disease. (Ex. 63c). SAIF once again stated that it was not requesting designation of a paying agent.

At hearing, claimant agreed to dismiss SAIF in its status as guaranty insurer in a written stipulation, which provided an attorney fee for claimant's counsel.[1] Id. The ALJ approved the dismissal of SAIF as guaranty insurer. (Tr. 10). SAIF's counsel for the noncomplying employer conceded that claimant's claim was compensable as an "injury," but continued to assert that claimant had not established a compensable occupational disease. (Tr. 25).

The ALJ determined that the claim should be analyzed as an accidental injury, rather than an occupational disease. The ALJ then found that the initial incident in June 1992, while Farmers was on the risk, was the major contributing cause of claimant's shoulder condition and need for treatment. Thus, the ALJ concluded that Farmers was responsible for claimant's left shoulder condition. The ALJ also awarded an assessed attorney fee of $3,800, payable by Farmers.

On review, Farmers contends that claimant's claim should be analyzed as an occupational disease rather than an accidental injury, and that SAIF waived its right to contest responsibility because it issued an untimely disclaimer. Farmers also asserts that, in any event, the ALJ erred in finding that the June 6, 1992 incident was the major contributing cause of claimant's left shoulder condition. Finally, citing amended ORS 656.308(2)(d), Farmers argues that claimant's attorney fee should be reduced to $1,000.

We turn first to Farmers' initial contention that the ALJ mischaracterized the claim as one for accidental injury. Farmers alleges that claimant's claim should be considered an occupational disease under former ORS 656.802(1)(c) (since renumbered 656.802(1)(a)(C)) because it involved a "series of traumatic events" which culminated in claimant's need for medical treatment. While this claim could be described as a series of traumatic events or occurrences, we nonetheless disagree with Farmers' contention. ORS 656.802(1)(a)(C) provides:

> "As used in this chapter, 'occupational disease' means any disease or infection arising out of and in the course of employment caused by substances or activities to which an employee is not ordinarily subjected or exposed other than during a period of regular actual employment therein, * * * including:
>
> "* * * *
>
> "(c) Any series of traumatic events or occurrences which requires medical services or results in physical disability or death."

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[1] The stipulation is not in the record. However, the Board may take administrative notice of facts "capable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." This has been held to include agency orders and stipulations by the parties. See Groshong v. Montgomery Ward Co., 73 Or App 403 (1985); Mark A. Crawford, 46 Van Natta 725, 727 (1994); Jenetta L. Gans, 41 Van Natta 1791 (1989); Susan K. Teeters, 40 Van Natta 1115 (1988). Thus, we take administrative notice of the parties' April 7, 1995 stipulation.

In Ronald V. Dickson, 42 Van Natta 1102, 1107 (1990), aff'd Dickson v. Carolina Casualty, 108 Or App 499 (1991), we examined legislative history to determine what types of claims the legislature intended to be covered by former ORS 656.802(1)(c). After examining the legislative history regarding paragraph (c) of ORS 656.802(1), we concluded that the phrase "series of traumatic events or occurrences" was intended to cover "overuse" of a body part such as a hip, elbow or wrist. Id.

In subsequent cases, the kinds of claims we have considered to be encompassed by that statute have generally been those involving overuse and repetitive trauma. See e.g. Sylvia Aranda, 45 Van Natta 2433, 2435 (1993) (physical overuse of upper body qualified as a "series of traumatic events"); Susan D. Troxell, 42 Van Natta 1300 (1990) (stretching arm repetitively); Dean A. Mintun, 42 Van Natta 1149 (1990) (repetitive forceful use of the arm and shoulder); Mary L. Goudy, 42 Van Natta 1140 (1990) (repetitive activity of sitting at a desk leaning forward looking through a hand-held scope). Inasmuch as this claim does not concern overuse or repetitive trauma, we are inclined to reject Farmers contention that the traumatic incidents in this case are within the scope of ORS 656.802(1)(a)(C).

Moreover, as the court noted in Crowe v. Jeld-Wen, 77 Or App 81, 85-86 (1985) (citing White v. State Ind. Acc. Com., 227 Or 306 (1961)), "An occupational disease is stealthy and steals upon its victim when he is unaware of its presence and approach. Accordingly, he cannot later tell the day, month or possibly even the year when the insidious disease made its intrusion into his body." In this case, claimant knew precisely when his left shoulder symptoms began: June 19, 1992, when a transmission fell on his shoulder. Claimant had never previously had left shoulder problems and has been plagued ever since. (Tr. 39). In light of this, we conclude that claimant's claim, in which his left shoulder condition developed suddenly and unexpectedly on a specific date, was properly characterized as an accidental injury claim.

In addition, we agree with the ALJ's reasoning and conclusion that the June 1992 incident, while Farmers was on the risk, was the major contributing cause of claimant's left shoulder condition and need for treatment. Accordingly, we affirm the ALJ's finding that Farmers is responsible for claimant's left shoulder condition.

Farmers, however, contends that SAIF should be found responsible because it failed to timely disclaim responsibility for claimant's left shoulder condition as required by former ORS 656.308(2). SAIF does not dispute that it untimely disclaimed responsibility pursuant to former ORS 656.308(2). Instead, it responds that amended ORS 656.308, which eliminated the responsibility disclaimer requirements of former ORS 656.802(2), is retroactively applicable. SAIF further asserts that the ALJ's decision was proper under Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994), even if former ORS 656.802(2) applies.

It is unlikely that the amendments to ORS 656.308(2) are applicable to this claim. Motel 6 v. McMasters, 135 Or App 583 (1995). Nevertheless, even if the disclaimer requirements of the former version of the statute do apply, we agree with SAIF that Hamrick is controlling.

Although a carrier's failure to comply with the disclaimer notice of former ORS 656.308(2) may preclude the carrier from attempting to shift responsibility to another carrier, the carrier's violation does not preclude the claimant from pursuing the claim with another carrier. Penny L. Hamrick, supra; Jon F. Wilson, 45 Van Natta 2362 (1993). In this case, SAIF may be precluded from attempting to shift responsibility to Farmers by its failure to timely disclaim. However, claimant pursued his claim against Farmers. When the ALJ specifically asked claimant's counsel whether claimant was actively pursuing a claim against Farmers, counsel replied "yes." (Tr. 16).

Farmers argues that claimant's counsel's responses to the ALJ's inquiry were a "model of ambivalence and indifference to the continued presence of Farmers in the case." Noting that claimant never argued that Farmers should be assigned liability for the claim, Farmers urges us to adopt a requirement that there be a special effort or preference exhibited by a claimant before there can be a finding that a claimant has "actively pursued" a claim against a carrier.

We decline Farmers' invitation to so hold in this case. Claimant's counsel clearly signaled his intention to pursue a claim against Farmers. Id. Later in the proceedings, claimant's counsel once again reiterated that he was not withdrawing his claim against Farmers. (Tr. 30). Accordingly, the record persuasively establishes that claimant was pursuing a claim against Farmers. Even though SAIF was precluded from pointing to Farmers as the responsible party, given claimant's pursuit of his claim against Farmers, the ALJ did not err in his assignment of responsibility. Penny L. Hamrick, supra.

Finding that claimant's counsel had actively and meaningfully participated in the proceedings, the ALJ awarded an attorney fee of $3,800, payable by Farmers. Farmers asserts that claimant's counsel's fee should be reduced in light of amended ORS 656.308(2)(d), which limits the attorney fee in responsibility proceedings to $1,000. Claimant responds that retroactive application of the statute is unreasonable and contrary to equitable and legal principles and a violation of substantive due process under the United States Constitution. We need not definitively resolve these contentions, for even if the $1,000 attorney fee cap of ORS 656.308(2)(d) applies, we would still affirm the ALJ's attorney fee award. We reach this conclusion for the following reasons.

Farmers never denied compensability of claimant's left shoulder claim. Therefore, it has no liability for an attorney fee under ORS 656.386(1). As statutory processing agent for the noncomplying employer, however, SAIF denied both compensability and responsibility for claimant's left shoulder claim. (Exs. 52, 63b). The fact that SAIF did not contest the compensability of the claim under an injury theory does not eliminate its refusal to concede the compensability of the claim under the occupational disease theory. (Tr. 25). In other words, SAIF continued to deny the compensability of claimant's left shoulder claim. Since claimant has established the compensability of his left shoulder claim, we hold that claimant is entitled to an attorney fee award under ORS 656.386(1), to be paid by the carrier who contested the compensability of the left shoulder claim. Edward J. Demille, 47 Van Natta 91 (1995).

We find further support for our conclusion in the Department's administrative rules. OAR 436-60-180(8) provides that the Compliance Section will not designate a paying agent where there remains an issue of whether the injury is compensable against a subject Oregon employer. OAR 436-60-180(1)(a) defines "compensable injury" as an accidental injury or damage to a prosthetic appliance, or an occupational disease arising out of and in the course of employment with any Oregon employer, and which requires medical services or results in disability or death.

In this case, in response to claimant's left shoulder claim, SAIF not only denied responsibility for an accidental injury, but also denied compensability of an occupational disease. However, the Department's rules do not allow designation of a "paying agent" if there is an issue of compensability against a subject employer. In other words, neither ORS 656.307 nor the Department's rules are focused on theories of compensability; rather, the determinative issue is whether compensability of the claim has been conceded.

Here, SAIF conceded compensabilty of the claim insofar as it pertained to an injury theory. Nevertheless, in light of its refusal to concede compensability of the claim under an occupational disease theory, it cannot be said that SAIF conceded compensability of the claim. Because SAIF denied compensability of the left shoulder claim and because the claim has been found compensable, it is responsible for an attorney fee pursuant to ORS 656.386(1).

Therefore, we conclude that there was an issue of compensability prior to the hearing. Claimant's counsel became entitled to an attorney fee pursuant to ORS 656.386(1) when SAIF conceded compensability. (Tr. 25). We now turn to the issue of whether the ALJ's attorney fee award should be modified. For the following reasons, we conclude that it should not be.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that $2,800 constitutes a reasonable fee for claimant's counsel's pre-hearing services in obtaining SAIF's concession of compensability concerning claimant's current left shoulder condition. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Furthermore, after considering those same factors, we find that a reasonable attorney fee for claimant's counsel's services at hearing regarding the responsibility issue is $1,000, to be paid by Farmers. ORS 656.308(2)(d).[2]

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[2] In Tammy Locke, 48 Van Natta 250 (1996), we held that the attorney fee limitation of $1,000 under ORS 656.308(2)(d) is cumulative and applies to all levels of litigation, except in cases involving "extraordinary circumstances." This case consisted of a two-day hearing, involving approximately 100 pages of transcript. There was one witness besides claimant, but he was not examined by claimant's counsel. The medical record consisted of 66 exhibits, including 2 depositions. Although claimant's counsel also pursued a claim against Farmers, counsel's primary position was that SAIF's denial should be overturned. (Tr. 11). Under these circumstances, we do not find "extraordinary circumstances" to justify a fee greater than the statutory maximum. Cf. Julie M. Baldie, 47 Van Natta 2249 (1995) (no "extraordinary circumstances" shown).

Therefore, based on the aforementioned reasoning, we affirm the amount of the ALJ's attorney fee award, but we hold that $2,800 is payable by SAIF and $1,000 is payable by Farmers. We also note that claimant's brief is entirely devoted to the attorney fee issue. In light of such circumstances, assuming for the sake of argument that we were authorized to award an attorney fee for claimant's counsel's services on review, we would decline to do so. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated April 7, 1995 is affirmed in part and modified in part. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded $2,800, to be paid by SAIF, and $1,000, to be paid by Farmers. The remainder of the ALJ's order is affirmed.

April 2, 1996 Cite as 48 Van Natta 735 (1996)

In the Matter of the Compensation of
GERALD A. ZELLER, Claimant
WCB Case No. 95-08331
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our March 4, 1996 order that modified an Administrative Law Judge's order which had awarded temporary disability benefits from April 13, 1995 through May 18, 1995. Contending that we improperly applied ORS 656.262(4) when it was not raised by the insurer, and that we failed to award an assessed attorney fee for his counsel's services before the Board, claimant seeks reconsideration of our order.

Claimant's arguments are not well taken. Claimant requested a hearing, raising the issue of temporary disability compensation on an open claim. Relying on the opinion of Dr. Stanley, claimant's treating physician, the ALJ concluded that claimant had been temporarily disabled from performing his regular work from April 13, 1995 through May 18, 1995. The insurer requested review, disputing claimant's entitlement to temporary disability benefits prior to May 19, 1995, the date of surgery. Thus, the issue at hearing and on review was entitlement to temporary disability. The issue of entitlement to temporary disability on an open claim necessarily involves satisfaction of the statutory requirement of ORS 656.262. Therefore, it is claimant's burden to prove his entitlement to temporary disability prior to May 19, 1995. ORS 656.266.

Prior to 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 former ORS 656.262(4)(a); Bono v. SAIF, 298 Or 405 (1984), Jones v. Emanuel Hospital, 280 Or 147 (1977). ORS 656.262(4)(a) now 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." (Emphasis added). ORS 656.262(4)(f) further provides in pertinent part that "[n]o authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance."

ORS 656.262(4) applies to all claims or causes of action existing or arising on or after June 7, 1995, the effective date of Senate Bill 369. Volk v. America West Airlines, 135 Or App 565 (1995). Since there is no specific exception to the retroactive application of amended ORS 656.262(4), we must apply the new law.

Consequently, because the attending physician first authorized the payment of temporary disability compensation on May 18, 1995, his authorization was not effective to retroactively authorize the payment of temporary disability more than 14 days prior to that date. Thus, claimant's entitlement to temporary disability benefits began on May 4, 1995. ORS 656.262(4)(a) and (f).

Claimant also asserts that he is entitled to an assessed attorney fee under ORS 656.382(2) because his temporary disability benefits were diminished but not eliminated on review. We disagree.

ORS 656.382(2) authorizes a fee when claimant's right to compensation is at risk of disallowance or reduction and the reviewing authority finds that the compensation should not be disallowed or reduced. See, e.g., Ray Schulten's Ford v. Vijan, 105 Or App 294 (1991). Here, we found that claimant's temporary disability compensation as granted by the ALJ's order should be reduced. The fact that a portion of the ALJ's temporary disability award has been undisturbed does not alter the inescapable conclusion that the ALJ's entire temporary disability award for the disputed period has been reduced. Therefore, claimant is not entitled to an assessed attorney fee under ORS 656.382(2).

Accordingly, as supplemented herein, we republish our March 4, 1996 Order on Review in its entirety, effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 3, 1996 Cite as 48 Van Natta 736 (1996)

In the Matter of the Compensation of
DOUGLAS H. BROOKS, Claimant
WCB Case Nos. 94-15372 & 94-15035
ORDER OF REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
David O. Horne, Defense Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

The SAIF Corporation (on behalf of Vancouver Roofing & Sheet Metal Co.) requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its denial of claimant's "new injury" claim for a low back condition; and (2) upheld Wausau Insurance Companies' (on behalf of Atlas Heating Inc.) denial of an aggravation claim for the same condition. Claimant cross-requests review, arguing that: (1) he is entitled to an assessed attorney fee for obtaining a rescission of Wausau's compensability denial; and (2) the ALJ's attorney fee award of $1,000 for prevailing against SAIF's denial was inadequate. On review, the issues are responsibility and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact on pages 1 and 2, up to the last paragraph on page 2, which begins with the sentence: "Dr. Ordonez filed a report and was deposed concerning the contribution of the two work exposures."

CONCLUSIONS OF LAW AND OPINION

Responsibility

Claimant injured his back on January 7, 1992, while working for Wausau's insured. Claimant was diagnosed with "[s]evere L5 radiculopathy on the left caused by a large disc protrusion and probable extrusion at L4-5 on the left." (Exs. 4, 5). On February 19, 1992, Dr. Ordonez performed a semi-hemilaminectomy and diskectomy at L-4, 5. (Ex. 7). Wausau accepted the claim for L4-5 diskectomy. (Ex. 13). On December 17, 1992, the claim was closed with an award of 9 percent unscheduled permanent disability. (Ex. 24).

Claimant began working for SAIF's insured in July 1994. On October 14, 1994, claimant twisted his back at work, but finished his shift. He began to have leg pain the following day and went to see Dr. Custis on October 17, 1994. Dr. Ordonez subsequently diagnosed recurrent L5 radiculopathy on left caused by L4-5 disc protrusion. (Ex. 31). On November 30, 1994, Dr. Ordonez performed back surgery.

Because claimant's current low back condition claim involves the "same condition" as that which Wausau/Atlas Heating, Inc. accepted in 1992, ORS 656.308(1) applies. Wausau /Atlas remains responsible for further medical services and disability relating to the compensable condition unless it proves that claimant sustained a "new compensable injury" involving the same condition. See ORS 656.308(1); SAIF v. Drews, 318 Or 1 (1993). To establish a new injury under ORS 656.308(1), claimant's

employment activity with SAIF's insured must have been the major contributing cause of claimant's disability or need for medical treatment of the "combined condition."[1]

The ALJ relied on the opinion of Dr. Ordonez and found that claimant had suffered a new injury on October 14, 1994, for which SAIF was responsible.

SAIF argues that the ALJ erred in concluding that claimant suffered a new injury while working for its insured. SAIF asserts that the ALJ misread Dr. Ordonez' opinion. According to SAIF, Dr. Ordonez opined that claimant's 1992 injury with Wausau's insured was the major contributing cause of the combined condition.

In contrast, claimant and Wausau argue that Dr. Ordonez concluded that claimant sustained a new injury in 1994 and claimant's work activities with SAIF's insured were the major contributing cause of the new injury.

When the medical evidence is divided, we tend to give greater weight to claimant's treating physician, absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to Dr. Ordonez' opinion because it is contradictory and confusing.

In a post-hearing deposition, Dr. Ordonez agreed that claimant's October 1994 injury combined with the preexisting low back condition to result in claimant's disability and need for treatment. (Ex. 44-25). Dr. Ordonez was asked to explain the major contributing cause of the "resultant condition":

> "We have an underlying condition, which was the previous ruptured disk and subsequent surgery, weakening the spine at the L4-5 level. We have additional -- and the patient recovered from that and became asymptomatic until he performed a number of maneuvers that caused another fragment of the disk to rupture out. And all of a sudden we have a new fragment causing symptoms.
>
> "Those symptoms required surgery in order to be alleviated. Now, the major contributing cause for the symptoms, for the onset of the symptoms, were the maneuvers of movements he performed in '94. When those symptoms resolved, we have a third -- we have another condition, a new condition, which is the first injury of '92 and the second injury of '94, and the new condition that we have resulted in further disability to Mr. Brooks. And if you ask me which injury is more responsible for the new condition, I will say that the original injury precipitated a disk degenerative and a weak spot at the L4-5 level that predisposed him to further injuries later on, and my assignation for the new condition will be 51 percent or more responsibility to the first injury and 49 or less to the second injury." (Ex. 44-25, 44-26).

One of the problems with Dr. Ordonez' opinion is that his definition of the "new condition" is unclear. On the one hand, Dr. Ordonez testified that claimant developed a "new condition" after his two surgeries. (Ex. 44-26). Dr. Ordonez explained that the "new condition" was a different condition than the condition for which he operated in 1994. (Ex. 44-36). Dr. Ordonez said that in 1994 he operated for recurrent symptoms caused by a recurrent disk. (Id.)

In another part of the deposition, however, Dr. Ordonez indicated that the "new condition" was the underlying degenerative process that combined with claimant's work activities. Dr. Ordonez agreed that the major contributing cause of claimant's symptoms was the work activities in October 1994 and the major contributing cause of the "condition" was the first injury in 1992. (Ex. 44-34). Dr. Ordonez defined the "condition" as an "underlying degenerative process set up as a result of a previous injury and surgery." (Id.) Dr. Ordonez agreed that the condition combined with claimant's work activities in 1994 to create a "new condition." Dr. Ordonez also agreed that the 1992 injury was more significant in causing the "new condition." (Id.)

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[1] The parties do not dispute that claimant had a preexisting low back condition that combined with the October 1994 injury to cause his disability and need for treatment. ORS 656.308(1) now provides 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. See Keith Thomas, 48 Van Natta 510 (1996) (amended ORS 656.308(1) codifies SAIF v. Drews, supra, 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)).

Because Dr. Ordonez' opinion is, at best, confusing, we do not find it persuasive. Similarly, we do not rely on the opinion of Dr. Custis because he testified that he would defer to Dr. Ordonez regarding the causation of claimant's back condition. (Ex. 45-8, 45-9).

SAIF relies on the opinion of Drs. Reimer and Scheinberg, who concluded that claimant's primary problem was a preexisting condition "dating back to his lumbar laminectomy/disectomy of 1992 with progressive hypertrophy, disc space collapse, and bulge of remaining disc material which calcified resulting in the current need for treatment." (Ex. 42A). Drs. Reimer and Scheinberg believed that the major contributing cause of claimant's condition was the progression of changes "which occurred at L4-5 on the left as a result of his 1992 injury which caused massive disc herniation with resulting disc space collapse, changes of stenosis, i.e., degenerative change at that level related to the 1992 process." (Id.)

When the medical evidence is divided, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). We are persuaded by the report from Drs. Reimer and Scheinberg that the major contributing cause of claimant's condition was his 1992 injury with Wausau's insured. Thus, we are unable to find that claimant sustained a "new compensable injury" involving the same condition. Consequently, we conclude that Wausau, under its 1992 claim, remains responsible for claimant's low back condition. See ORS 656.308(1); ORS 656.005(7)(a)(B). Accordingly, we reverse the ALJ's responsibility determination.

Wausau's Alleged Compensability Denial

Claimant argues that the ALJ erred in failing to award an attorney fee against Wausau for obtaining a rescission of Wausau's compensability denial. Wausau contends that the language of its denial was one of responsibility only, not compensability. We disagree.

On December 13, 1994, Wausau advised claimant that it was "unable to accept [his] claim for benefits." (Ex. 38). Wausau explained that it appeared that claimant's current condition and need for treatment was a new injury rather than an aggravation of the January 7, 1992 injury. Wausau advised claimant that SAIF/ Vancouver Roofing and Sheet Metal Company could be responsible for his condition. The letter included "notice of hearing" provisions consistent with a notice of intent to disclaim responsibility that is also a denial of compensation under OAR 438-05-053(4) and stated that "[t]his is a denial of your claim for benefits." (Id.) Wausau's letter also stated that SAIF had requested the designation of a paying agent pursuant to ORS 656.307.

At hearing, claimant asserted that Wausau had denied compensability and responsibility. (Tr. 1, 2). Wausau disagreed with that interpretation, explaining that the only issue was responsibility. (Tr. 2). Wausau's attorney stated that it was not denying compensability. (Id.)

In Linda K. Ennis, 46 Van Natta 1142 (1994), we held that the carrier's "disclaimer of responsibility and claim denial" created an issue of compensability. The carrier's letter did not request the designation of a paying agent and it contained "notice of hearing" provisions consistent with a denial of compensation. The letter also stated that it was a denial of a claim for benefits. See, e.g., Howard L. Rose, 47 Van Natta 345 (1995); Angela M. Stratis, 46 Van Natta 816 (1995).

We find this case to be analogous to Linda K. Ennis, supra. Here, Wausau did not expressly concede the compensability of claimant's aggravation claim. Compare Ray L. Bennett, 47 Van Natta 866 (1995) (the carrier's denial clearly conceded that the claim was compensable and that responsibility was the only issue). Although Wausau mentioned that SAIF had requested a paying agent, Wausau did not state that it was requesting a paying agent. An order designating a paying agent did not issue until May 24, 1995, more than two months after the hearing. (Ex. 46). Furthermore, the disclaimer/denial contained "notice of hearing" provisions consistent with a denial of compensation. Accordingly, we conclude that Wausau's denial was a denial of compensability as well as responsibility.

Attorney Fee under ORS 656.386(1)

Under ORS 656.386(1), a 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 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." ORS 656.386(1).

Here, Wausau's denial said that it was unable to accept claimant's claim for benefits. Furthermore, the denial contested causation in that it stated that claimant's current condition and need for treatment appeared to be a new injury rather than an aggravation of the January 7, 1992 injury. (Ex. 38). Under such circumstances, we conclude that Wausau refused to pay compensation on the express ground that the low back condition was not compensable. See ORS 656.386(1). Therefore, claimant's low back condition constitutes a "denied claim" under ORS 656.386(1).

Accordingly, claimant's attorney is entitled to an assessed fee for obtaining a rescission of Wausau's compensability denial prior to the hearing. 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 hearing level regarding the compensability issue is $1,500, payable by Wausau/Atlas. 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.

Attorney Fee under ORS 656.308(2)(d)

Claimant also contends that the ALJ's attorney fee award of $1,000 was inadequate.[2] Claimant argues that his attorney is entitled to an attorney fee of more than $1,000 because litigation of this case presented extraordinary circumstances.

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 Wausau's responsibility denial and has successfully prevailed over that denial. Claimant's attorney contended at hearing and on review that claimant had sustained a "new injury." Although claimant's argument was not successful, his attorney's participation was "active and meaningful" and, by virtue of his successful hearing request, claimant has finally prevailed against Wausau's responsibility denial. See Paul R. Huddleston, 48 Van Natta 4, on recon 48 Van Natta 203 (1996).

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. 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); Paul R. Huddleston, supra.

The hearing in this case lasted one hour. There were three witnesses, including claimant and two of SAIF's witnesses. The transcript is 50 pages long. The record consists of 47 exhibits, including a 50 minute deposition of Dr. Ordonez and a 15 minute deposition of Dr. Custis, both taken on behalf of SAIF. Claimant's counsel procured two exhibits.

On review, claimant's counsel submitted a 7-page respondent's brief, contending that the ALJ's responsibility determination should be affirmed. We acknowledge that claimant's counsel expended a significant amount of effort in trying to prove that claimant's condition constituted a "new injury" for which SAIF was responsible. Notwithstanding such efforts, we have determined that responsibility for claimant's condition rests with Wausau.

After considering the aforementioned factors, we do not find extraordinary circumstances to warrant an attorney fee in excess of the statutory $1,000 limit. See OAR 438-015-0010(4). However, we change the ALJ's order to reflect that claimant's attorney is awarded a $1,000 fee, payable by Wausau, rather than SAIF.

Attorney Fees on Review

Based on the reasoning previously expressed, we find that claimant is not entitled to an additional attorney fee beyond the $1,000 statutory limit for his counsel's services on review concerning

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[2] In light of our conclusion that Wausau denied compensability as well as responsibility, we do not address claimant's alternative argument that the $1,000 limit under ORS 656.308(2)(d) does not apply because this case should have been prosecuted under ORS 656.307 as a pure responsibility dispute.

the responsibility issue. See Tammy Locke, 48 Van Natta 250 (1996) (concluding 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). Furthermore, claimant is not entitled to an attorney fee for services on review concerning his unsuccessful cross-request regarding the ALJ's $1,000 attorney fee award. Finally, claimant is not entitled to an attorney fee for his counsel's services in securing the attorney fee award for Wausau's "pre-hearing" rescission of its compensability denial. See Amador Mendez, 44 Van Natta 736 (1992).

ORDER

The ALJ's order dated September 29, 1995 is reversed in part and affirmed in part. The SAIF Corporation's denial of responsibility is reinstated and upheld. Wausau's denial is set aside and the claim is remanded to Wausau for processing according to law. The ALJ's $1,000 attorney fee award shall be paid by Wausau. For "pre-hearing" services at hearing regarding the rescission of the compensability portion of Wausau's denial, claimant's attorney is awarded an assessed fee of $1,500, to be paid by Wausau. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JACQUELYN A. DOTSON, Claimant
WCB Case No. 94-04793
ORDER ON REVIEW
Adams, Day, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order which: (1) upheld the insurer's denial of claimant's right shoulder condition; and (2) declined to award attorney fees for the insurer's alleged "de facto" denial of claimant's deltoid strain and chronic neuritis condition. On review, the issues are compensability 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

Compensability

The ALJ found that claimant failed to prove that her right shoulder impingement syndrome was related to her industrial accident. In so doing, the ALJ declined to find persuasive the opinion of Dr. Bert, attending physician, reasoning that it was based on an inaccurate history (that claimant's work accident involved a twisting of her arm).

On review, claimant contends that her work accident did involve a twisting motion of her arm. Therefore, according to claimant, Dr. Bert's opinion should be found persuasive because it was based on an accurate history.

Claimant's injury occurred while she had her right arm extended into a delicatessen display case. Unaware that claimant's arm was inside the "display case" a co-worker attempted to close the display case's sliding door. The door struck claimant's upper arm. As claimant attempted to extract her arm from the case, the door struck her twice more once in the right elbow and once in the lower arm.

Claimant filed an "801" form for injury to her right elbow and upper arm. (Ex. 1). According to an evaluator's worksheet, claimant's accepted condition was post-traumatic inflammation of the right brachialis muscle. (Ex. 21).

On December 20, 1993, Dr. Bert diagnosed claimant's shoulder impingement syndrome and requested authorization to perform decompression surgery. (Exs. 28 44-11). On April 13, 1994, the insurer denied that claimant's current right shoulder condition and need for decompression surgery were compensable conditions. (Ex. 31).

According to claimant, her August 30, 1994, industrial accident was a direct cause of her impingement syndrome. Under such a theory, claimant would need to establish that the industrial accident was a material contributing cause of her disability and need for medical treatment. ORS 656.005(7)(a); Mark N. Wiedle, 43 Van Natta 855 (1991). The insurer asserts that claimant's impingement syndrome was a consequence of her compensable right elbow and upper arm injuries and therefore, claimant's burden would be the major contributing cause standard. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). We need not resolve the parties' dispute as to the burden of proof because even under the higher standard, claimant prevails.

While claimant's right elbow and upper arm injuries were readily attributable to the work incident, the cause of her shoulder impingement syndrome was not. Claimant's impingement syndrome was not diagnosed for over two years after her original accident. (Ex. 30). Therefore, we find that the medical causation question is complex, requiring expert medical opinion for its resolution. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986); Uris v. Compensation Department, 247 Or 420 (1967). 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).

On August 30, 1991, claimant sustained injuries to her right elbow and upper arm. On September 23, 1991, Dr. Bernstein evaluated claimant for her right arm injury. (Ex. 3). Claimant reported to Dr. Bernstein that she had pain in her deltoid muscle and a burning sensation in her web space, radial forearm and deltoid surface. Dr. Bernstein's examination revealed "impressive tenderness over the deltoid surface" and that claimant's entire arm was slightly swollen, reddened and warm to the touch.

Dr. Bert performed a translocation of claimant's ulnar nerve in May 1993. Dr. Bert's preoperative report, noted a history of claimant injuring her right arm in an industrial accident in 1991. (Ex. 24). Dr. Bert did not report any other injuries to claimant's arm after the 1991 work related accident. In December 1993, Dr. Bert requested authorization to perform decompression surgery of claimant's right shoulder. (Ex. 28).

In January 1994, Drs. Kho and Dinneen performed an insurer-arranged medical examination (IME), and stated that they could not relate claimant's need for decompression surgery to her work accident of August 1991. (Ex. 29). The IME physicians relied on a history that the medical records did not document any evidence of right shoulder problems. Id.

In March 1994, Dr. Bert, responding to the insurer, was unable to relate claimant's shoulder problem to her work accident. Dr. Bert stated, "the history of the injury is not completely clear to me as the causation of [claimant's] shoulder problem." (Ex. 30).

In May 1994, Dr. Dinneen stated that there was evidence of claimant having deltoid problems shortly after the August 1991 accident. However, Dr. Dinneen still believed that claimant's impingement syndrome was not related to her August 1991 accident. (Ex. 32). Dr. Kho stated that he agreed with Dr. Dinneen that claimant's August 1991 accident did not cause her need for decompression surgery. (Ex. 33).

In June 1994, Dr. Dinneen, concurring in a letter written by the insurer, stated that it was not medically probable that claimant's work accident caused her impingement syndrome. The basis for his opinion was that there was no evidence of claimant having shoulder problems until six months after the August 1991 accident. (Ex. 35).

On June 28, 1994, Dr. Kho authored a letter summarizing a discussion between himself and the insurer's counsel. (Ex. 34). Dr. Kho stated that the mechanism of claimant's injury could not have caused her shoulder condition. Dr. Kho related claimant shoulder impingement to degenerative/ideopathic factors.

In July 1994, responding to claimant's attorney, Dr. Bert stated that he did not have a history of any other injury or trauma to claimant's arm. Dr. Bert opined that claimant's August 30, 1994 work accident was the major contributing cause of her impingement syndrome. (Ex. 36).

In January 1995, Dr. Bert agreed in a letter (which summarized a conversation between himself and the insurer) that he did not have a clear history as to the development of claimant's shoulder condition and was unsure as to the specific cause of this condition (Ex. 39).

On March 29, 1995, Dr. Bert agreed with claimant's letter which summarized a conversation between himself and claimant's counsel. In the letter, Dr. Bert stated that the major cause of claimant's impingement was her August 1991 industrial accident. He based his changed opinion upon further inquiry into the history of claimant's accident. Specifically, Dr. Bert relied on the fact that claimant's did not sustain any other injury to her shoulder since the August 1991 accident and that claimant had shoulder problems after the work accident (as documented by Dr. Bernstein's medical report of September 1991). (Ex. 43).

On deposition, Dr. Bert stated that the deltoid muscle is part of the shoulder. (Ex. 44-28). Dr. Bert opined that Dr. Bernstein's finding of tenderness and warmth to the touch on claimant's deltoid surface were symptoms consistent with shoulder impingement syndrome. (Tr. 44-21). Dr. Bert concluded that the major contributing cause of claimant's impingement syndrome was her work accident. Dr. Bert based his opinion on the fact that claimant (historically) had no other injury to her shoulder and that Dr. Bernstein's report documented objective findings of impingement syndrome since the August 1991 accident.

Here, we find no persuasive reasons to discount the opinion of claimant's treating physician, Dr. Bert. Weiland v. SAIF, supra. Dr. Bert's opinion was based on Dr. Bernsteins findings of symptoms consistent with impingement syndrome three weeks after the accident and the fact that claimant did not have any other history of injury to her shoulder. In addition, Dr. Bert performed decompression surgery on claimant's shoulder and was in the best position to render an opinion concerning the cause of claimant's impingement syndrome. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). As such, we conclude that Dr. Bert's opinion supports a finding that the major cause of claimant's right shoulder impingement syndrome was the industrial accident of August 30, 1991.

In contrast, we decline to rely of the opinions of Drs. Dinneen and Kho. For instance, Dr. Dinneen's June 1994 opinion is not persuasive because it is based on the fact that claimant did not have shoulder problems for six months after the August 1991 injury. However, the preponderance of the evidence supports a finding that claimant had symptoms consistent with shoulder impingement syndrome after the August 1991 accident. Dr. Bert (based on Dr. Bernstein's report) opined that claimant had symptoms of shoulder impingement syndrome (i.e. tenderness and warmth of the deltoid surface) approximately three weeks after the August 1991 accident. Further, in May 1994, Dr. Dinneen stated that claimant had deltoid symptoms shortly after the August 1991 accident. As such, Dr. Dinneen's causation opinion is based on an inaccurate history and therefore, is accorded little persuasive weight.

Finally, we decline to rely on Dr. Kho's opinion because, while he agrees with Dr. Dinneen's opinion, Dr. Kho offered an inadequate explanation to support his opinion. Specifically, while Dr. Kho attributes claimant's impingement syndrome to degenerative/ideopathic factors, he fails to offer a persuasive explanation to support his opinion.

Accordingly, we conclude that the major contributing cause of claimant's shoulder impingement syndrome was her August 1991 injury. Consequently, the insurer's denial of that condition is set aside.

Attorney Fees

Relying on amended ORS 656.262, the ALJ found that claimant was not entitled to an assessed attorney fee award for overcoming the insurer's "de facto" denial at hearing of claimant's deltoid strain and chronic neuritis conditions. We agree based on the following reasoning.

On review, claimant contends that retroactive application of amended ORS 656.262 to preclude an attorney fee award is unconstitutional because it unjustly holds claimant accountable for time and notice requirements which were not in existence at the time of the hearing. Further, claimant asserts that her right shoulder impingement syndrome included her deltoid injury. Therefore, according to claimant, the insurer's acceptance of her deltoid condition at hearing was a partial retraction of the insurer's April 13, 1994 denial. As such, claimant asserts that she is entitled to an attorney fee award for partially overcoming the insurer's denial.

Because the ALJ's August 2, 1995 order did not become final, the amended version of ORS 656.262(6)(d) applies to this case. See Guillermo Rivera, 47 Van Natta 1723 (1995).

Here, claimant's first allegation of a "de facto" denial of her deltoid strain and chronic neuritis condition was at hearing. As such, claimant did not object in writing to the insurer notice of acceptance. Amended ORS 656.262(6)(d); Guillermo Rivera, supra. Moreover, even if claimant had objected in writing at the hearing, the insurer had 30 days in which to accept claimant's "claim." Inasmuch as the insurer accepted claimant's "claim" at hearing, it did so within the 30 day time period. Consequently, there is no "denied" claim to support an attorney fee award. See ORS 656.262(6)(d).

Finally, claimant's contention that her deltoid strain was part of her shoulder impingement syndrome is not supported by the medical evidence, and therefore, the insurer's acceptance of the deltoid strain can not be interpreted as partially overcoming the insurer's April 13, 1994 denial. On deposition, Dr. Bert stated that the deltoid muscle is part of the shoulder. (Ex. 44-20). However, when asked if a contusion to the deltoid muscle would be part of claimant's impingement syndrome, Dr. Bert answered that it was not (although a contusion to the deltoid can mimic an impingement syndrome). (Ex. 44-10, 11, 30). Therefore, we find that claimant's shoulder impingement syndrome did not include her deltoid strain. Consequently, the insurer's acceptance of claimant's deltoid strain did not act as a partial acceptance of her shoulder impingement syndrome which the insurer denied on April 13, 1994. Accordingly, claimant is not entitled to an assessed attorney fee for allegedly overcoming a denial of her deltoid strain.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review for prevailing over the insurer's denial of the right shoulder impingement syndrome. 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 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 2, 1995 is reversed in part and affirmed in part. That portion of the ALJ's order which upheld the insurer's denial of claimant's right shoulder condition is reversed. The denial is set aside and the claim is remanded to the insurer for processing. Claimant's attorney is awarded an attorney fee of $3,000, payable by the insurer. The remainder of the order is affirmed.

April 3, 1996 Cite as 48 Van Natta 743 (1996)

In the Matter of the Compensation of
JOHN FLETCHER, Claimant
WCB Case No. 93-11157
ORDER ON REVIEW
Myrick, Seagraves, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Spangler's order which set aside an alleged "back-up" denial of claimant's right shoulder condition. On review, the issue is compensability.

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

Claimant sustained a compensable injury to his right shoulder in July 1992. Claimant's injury occurred when a heavy box that he was lifting slipped and he attempted to catch it. Claimant stated on the "801" form that he "felt pain in [his] right shoulder" and the part of his body affected was the right shoulder/arm. (Ex. 2). Dr. Perry diagnosed right shoulder sprain with possible rotator cuff tendonitis. Claimant's claim was closed by a December 1992 Determination Order which awarded 8 percent unscheduled permanent disability. (Ex. 21).

In January 1993, claimant was examined by Dr. Renaud, who diagnosed anterior and inferior subluxation of the right shoulder. Dr. Appleby, on referral by Dr. Renaud, diagnosed subacromial impingement secondary to anterior instability and osteophyte formation. (Ex. 23-2). Dr. Appleby recommended arthroscopic surgery. Id.

In February 1993, claimant requested reconsideration of the December 1992 Determination Order. On April 21, 1993, Drs. Townsend and Appleby performed arthroscopic surgery for right shoulder anterior and inferior instability, and subacromial impingement. (Ex. 32). The post-operative diagnosis was severe degenerative disease, anterior labral detachment and a Hill-Sach's lesion.

The insurer reopened claimant's claim and, on April 29, 1993, it issued an evaluation "closure summary." (Ex. 35-1). The closure summary stated that claimant's compensable condition after the reopening of his claim was "right shoulder surgery." (Ex. 35-1). On April 30, 1993, an Order on Reconsideration affirmed the December 1992 Determination Order. (Ex. 37). Claimant filed a request for hearing to contest the reconsideration order.

In July 1993, claimant became medically stationary and his claim was reclosed by an October 1993 Determination Order which awarded an additional 22 percent of unscheduled permanent disability and a 10 percent award of scheduled permanent disability for loss of use of his right arm. (Ex. 58). The insurer requested reconsideration of the Determination Order.

On January 14, 1994, claimant underwent a medical arbiter's examination. (Ex. 62). The arbiter diagnosed post arthroscopy and debridement of the right shoulder with removal of loose body. The arbiter opined that claimant's range of motion findings were due to claimant's July 1, 1992, work injury.

On January 27, 1994, an Order on Reconsideration affirmed the October 1993 Determination Order. Dissatisfied with the January 27, 1994 Order on Reconsideration, the insurer requested a hearing.

The ALJ found that the insurer's request for reconsideration of the October 1993 Determination Order constituted a "back up" denial of claimant's Hill-Sachs lesion and degenerative disease. In so doing, the ALJ determined that the insurer "accepted" these conditions when it reported claimant's compensable conditions as "right shoulder surgery" on the evaluation closure summary.

On review, the insurer contends that it did not accept claimant's Hill-Sachs lesion and degenerative condition. According to the insurer, the ALJ erred by finding that it accepted claimant's Hill-Sachs lesion and degenerative disease when it allegedly accepted a claim for right shoulder surgery.

We acknowledge the insurer's contention that the scope of its acceptance did not include claimant's Hill-Sachs lesion and degenerative condition. However, we need not resolve this issue because regardless of whether the insurer accepted the disputed conditions, we are persuaded that these conditions are compensable.

Under ORS 656.262(6), if a carrier accepts a claim in good faith and "later obtains evidence" that the claim is not compensable, it may revoke its acceptance of a claim and issue a denial as long as the denial is issued no more than two years after the date of the initial acceptance. If the worker requests a hearing on the "back -up" denial, the carrier has the burden of proving the claim is not compensable.

When a condition or need for treatment is caused by the industrial accident, a worker must establish that the work injury was a material contributing cause of the condition. Albany General Hospital v. Gasperino, 113 Or App 411 (1992). When the condition or need for treatment is caused by the compensable injury that resulted from the accident, the worker must prove that the compensable injury was the major contributing cause of the consequential condition. ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, supra.

We need not resolve the appropriate legal standard in this case, because even under the higher standard, "major contributing cause" claimant has proven the compensability of his Hill-Sachs lesion and degenerative disease. We base this conclusion on the following reasoning.

On review, the insurer asserts that the medical opinions of Drs. Perry and Appleby fail to support the compensability of claimant's Hill-Sachs lesion and degenerative disease. We disagree.

Dr. Appleby's post-operative diagnosis was severe degenerative arthritis, labral detachment anteriorly and superiorly (i.e. SLAP lesion) and a moderate Hill-Sachs area. (Ex. 32-4). He explained that a Hill-Sachs lesion is an impaction fracture caused by the compression of the posterior head and neck of the humerus against the anterior rim of the glenoid in a dislocated shoulder of the posterior humeral head. Id.

According to Dr. Appleby, the SLAP lesion and the anterior capsular detachment created an unstable shoulder which recurrently dislocated or partially dislocated (subluxed) which led to the degenerative changes of the articular surface and the Hill-Sachs lesion. Id. Dr. Appleby stated that the degree of degenerative changes were greater than expected given claimant's history. (Ex. 66-2). He was of the opinion that the frequency and severity of subluxations and/or dislocations determined the progression of degenerative changes. Finally, Dr. Appleby stated that claimant's July 1, 1992, industrial injury was the primary cause of claimant's need for surgery. Id.

In January 1994, Dr. Perry, initial treating physician, stated that claimant's degenerative conditions did not correspond with his industrial injury. (Ex. 63-2). Dr. Perry opined that the major contributing cause of claimant's ongoing treatment was his preexisting condition. Id.

In May 1994, Dr. Perry was asked to concur with a letter authored by claimant's attorney. In the letter, Dr. Perry agreed (after reviewing literature concerning SLAP lesions and Dr. Cronin's report) that chronic subluxations of the shoulder caused claimant's degenerative changes. (Ex. 68-2). Dr. Perry opined that the major contributing cause of claimant's need for surgery was the compensable accident. Id.

Dr. Woolpert reviewed medical records for the insurer and stated that claimant's industrial accident could not have resulted in either a SLAP lesion or a Hill-Sach's lesion. (Ex. 69-4). According to Dr. Woolpert, because claimant's injury did not involve a forward fall onto outstretched arms, it was unlikely that claimant could have sustained a SLAP lesion as a result of his industrial accident.

However, on deposition, Dr. Woolpert changed his opinion regarding the etiology of a SLAP lesion, stating that it could result from catching a heavy falling object. (Ex. 72-21). He opined that a Hill-Sach's lesion always requires a dislocation of the shoulder. (Ex. 72-30).

Dr. Thompson reviewed medical records for the insurer and opined that claimant's degenerative disease and Hill-Sachs lesion were not caused by the July 1992 compensable incident. (Ex. 60-3). According to Dr. Thompson, the presence of an anterior labral detachment, severe degenerative disease and Hill-Sachs lesion suggested that claimant had a recurrent dislocating shoulder. Id. Dr. Thompson agreed with Dr. Appleby that a Hill-Sachs lesion requires a dislocation of the shoulder in order to develop. Because claimant's medical records did not report a history of his shoulder dislocating, Dr. Thompson opined that claimant's Hill-Sachs lesion could not have been caused by claimant's July 1992 industrial accident. (Ex. 70-4). Further, Dr. Thompson opined that it would take 5-10 years to create the degree of degenerative changes found in claimant's shoulder. (Ex. 70-3).

Claimant testified that after the July 1992 accident he had excruciating pains in his shoulder. (Tr. 47). Claimant stated that every time he would lift a spoon to eat it felt like his shoulder was dislocating. (Tr. 50).

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).

Here, we find no persuasive reason to discount the opinions of claimant's former and current treating physicians, Drs. Perry and Appleby. Dr. Appleby's opinion is well reasoned and based on a complete history. For instance, Dr. Appleby opined that the SLAP lesion and the anterior capsular detachment resulted in claimant having an unstable shoulder which recurrently dislocated or subluxed and it was these processes which led to the degenerative changes and Hill-Sachs lesion. Such an opinion is consistent with claimant's credible testimony regarding constant pain and "dislocating" feelings of his shoulder. Finally, as claimant's treating surgeon, Dr. Appleby is in the best position to render an opinion concerning claimant's condition and impairment. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988). As such, we find Dr. Appleby opinion persuasive because it relies on an accurate history and is well explained. See Somers v. SAIF, supra. Similarly, we find Dr. Perry's opinion persuasive because it is based on a complete history. For example, Dr. Perry (after reviewing medical literature concerning SLAP lesions) agreed that the major contributing cause of claimant's current condition was the July 1992 compensable injury.

In contrast, we do not find persuasive the opinion of Dr. Thompson because it primarily relies on a history that claimant would initially need to sustain a complete dislocation of his shoulder (which would require medical intervention to reduce) in order to develop a Hill-Sachs lesion. However, based on the medical article relied upon by Dr. Thompson (C. R. Rowe and Bertram Zarins, Recurrent Transient Subluxation of the Shoulder), of the sixty shoulders examined 24 had the presence of a Hill-Sachs lesion with no evidence that there had to be a complete dislocation (requiring medical intervention) in order to develop. (Ex. 72-93). As such, the medical literature on which Dr. Thompson relied supports a conclusion that a Hill-Sachs lesion can develop in the absence of "dislocation."

Further, we find that Dr. Appleby adequately refuted Dr. Thompson's opinion that claimant's degenerative changes would take 5 to 10 years to develop. For instance, Dr. Appleby opined that claimant's degenerative changes would be predicated upon the frequency and severity of subluxations and/or dislocations. As such, based on claimant's credible testimony, after the July 1992 industrial accident his shoulder would "feel like it was dislocating" constantly. Such constant feeling of dislocating are consistent with Dr. Appleby's belief that claimant's degenerative changes could have occurred after and were the result of his July 1992 injury. Accordingly, based on Dr. Appleby's persuasive opinion, we find that the major contributing cause of claimant's Hill-Sachs lesion and degenerative disease was his industrial accident of July 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 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,800, 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 18, 1995, as reconsidered May 26, 1995, is affirmed. For services on review, claimant's attorney is awarded $1,800, payable by the insurer.

In the Matter of the Compensation of
PATRICIA R. GADE, Claimant
WCB Case No. 94-11098
ORDER ON REVIEW
Cobb & Woodworth, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Balasubramani's order which dismissed her request for hearing for lack of jurisdiction. The self-insured employer moves to strike claimant's references to a "post-hearing" Order on Reconsideration. On review, the issues are jurisdiction, temporary total disability, evidence, penalties and attorney fees.

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

Reasoning that claimant was seeking a temporary disability award in excess of that granted by the Notice of Closure, the ALJ declined to decide the issue of claimant's entitlement to TTD. The ALJ relied on Michael J. Drake, 45 Van Natta 1117 (1993), and Galvin C. Yoakum, 44 Van Natta 2403, 2404, on recon 44 Van Natta 2492 (1992).

On review, claimant contends that the employer's unilateral termination of her TTD is a procedural matter which the ALJ could consider. We disagree.

Under ORS 656.268(5), the Hearings Division lacks initial jurisdiction to address challenges regarding an injured worker's substantive entitlement to temporary disability. See Galvin C. Yoakum, supra. However, an ALJ has original jurisdiction over disputes concerning an injured worker's procedural entitlement to temporary disability because that issue is ripe for adjudication prior to claim closure. Id.

In Yoakum, we established the criteria for distinguishing whether a dispute concerns procedural entitlement to temporary disability benefits. First, the hearing request must be filed before the claim was closed. Second, the request must raise issues regarding the carrier's "pre-closure" conduct. Third, the claimant must not be seeking a greater temporary disability award than that granted by the Notice of Closure or Determination Order.

Here, claimant's initial hearing request, which was filed prior to closure, raised the issues of penalties and attorney fees for the employer's alleged failure to pay compensation within 30 days of a prior ALJ's order setting aside an aggravation denial. Thereafter, on September 21, 1994, the employer issued a Notice of Closure which closed claimant's claim. In March 1995, claimant requested reconsideration of the Notice of Closure, requesting additional temporary total disability (TTD). Finally, on April 16, 1995, claimant filed an amended hearing request seeking temporary disability.

Based on these findings, we reach the following conclusions. Claimant's amended hearing request which raised the issue of claimant's TTD benefits was filed after the claim was closed. Moreover, claimant seeks a greater temporary disability award than that granted by the Notice of Closure. In light of such circumstances, we conclude that the ALJ properly dismissed claimant's hearing request. Galvin C. Yoakum, supra. Instead, the appropriate route of appeal rests with the Director's reconsideration process. Michael J. Drake, supra.

In light of our aforementioned conclusion regarding claimant's request for TTD, the sole issue remaining is claimant's alleged entitlement to an assessed penalty under ORS 656.262(11). As such, the Director has exclusive jurisdiction over whether the employer's claims processing constitutes an unreasonable delay in the payment of claimant's TTD benefits. See Corona v. Pacific Resource Recycling, 125 Or App 47 (1993); Monte W. Kentta, 46 Van Natta 1460 (1994).

ORDER

The ALJ's order dated May 24, 1995 is affirmed.

April 3, 1996 Cite as 48 Van Natta 747 (1996)

In the Matter of the Compensation of
JOSEPH J. GYMKOWSKI, Claimant
WCB Case No. 95-07434
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Menashe's order that dismissed claimant's request for hearing without prejudice. Claimant cross-requests review of that portion of the ALJ's order that declined to reinstate his hearing request. On review, the issue is the propriety of the ALJ's dismissal order. We modify in part and affirm in part.

FINDINGS OF FACT

On April 27, 1978, claimant sustained an injury to his cervical spine. The injury was accepted by SAIF and processed as a compensable cervical strain.

On April 25, 1995, SAIF issued a denial letter which stated *inter alia*:

> "Based on the information in file, and without waiving other questions of compensability, we find we must hereby deny your current care, treatment, and/or surgery as it is not related to the injury of April 27, 1978 injury. Also surgery to your low back is not reasonable and necessary.

We find we must also clarify presentation of billings for your treatment for alcohol and psychiatric problems. This we must also deny as it appears these conditions are not related to your injury of April 27, 1978. Therefore, without waiving other questions of compensability were [sic] hereby denying treatment for your cervical condition, low back condition, psychiatric condition and alcohol abuse."

On June 20, 1995, claimant requested a hearing concerning SAIF's April 25, 1995 denial. On July 11, 1995, the Board issued a Notice of Hearing which designated the matter as WCB Case No. 95-07434 and set a hearing for September 18, 1995 in Portland, Oregon.

On August 15, 1995, SAIF issued an amended denial which denied C2 to C7 cervical spinal stenosis and lumbar L3-4 bulging disc with severe degenerative disc disease on the basis that those conditions were not related to claimant's compensable injury. In addition, SAIF also denied claimant's current treatment for alcohol and psychiatric problems on the grounds that they were unrelated to the compensable injury. On August 21, 1995, claimant filed an amended hearing request pertaining to SAIF's August 15, 1995 amended denial. Claimant's amended hearing request was not assigned a new WCB Number and was forwarded to WCB Case No. 95-07434.

By order dated September 19, 1995, the ALJ dismissed, without prejudice, claimant's request for hearing in WCB Case No. 95-07434 on the basis that claimant had withdrawn his request for hearing. Thereafter, both SAIF and claimant requested reconsideration of the Order of Dismissal.

On October 31, 1995, the ALJ wrote the parties acknowledging that the Hearings Division had received a new request for hearing and new supplemental request for hearing from claimant. The ALJ advised the parties that a new WCB case number would be assigned to those requests. On the same day, the ALJ issued a reconsideration order, denying SAIF's motion to dismiss claimant's request for hearing with prejudice and denying claimant's motion to reinstate the hearing request.

CONCLUSIONS OF LAW AND OPINION

Dismissal Without Prejudice

Because claimant's amended hearing request was joined with the original hearing request, the ALJ found that the hearing was set faster than normal. The ALJ therefore concluded that claimant should be permitted to withdraw his request for hearing without sanction and dismissed claimant's request for hearing without prejudice. We disagree.

When a party requesting a hearing moves for dismissal, and there is no cross-request for hearing, the ALJ has discretion to set the terms and conditions of an order of dismissal as he or she deems proper. We will not disturb the terms and conditions imposed by the ALJ except under a showing of an abuse of discretion. Ronald D. Robinson, 44 Van Natta 2500, 2501 (1992); Julie Mayfield, 42 Van Natta 871 (1990).

In Robinson, we stated that a party that requested a hearing cannot circumvent the Board's postponement and continuance rules by obtaining a dismissal without prejudice and then subsequently filing a hearing request on the same issues. We concluded that the moving party must provide an explanation for withdrawing the hearing request and having the hearing request dismissed without prejudice. We based our conclusion on the basic tenet that the party filing the hearing request initiates the hearing process and must therefore be prepared to present its case at the scheduled hearing. To hold otherwise, we reasoned, would delay litigation, encourage lack of preparation, and prejudice the opposing party that has prepared for the hearing. 44 Van Natta at 2502.

Here, the ALJ concluded that Robinson was distinguishable because claimant's amended request was joined with the original request for hearing and therefore set faster than normal. We recently rejected a similar argument in Cathy A. Inman, 47 Van Natta 1316 (1995).[1] In Inman, the claimant argued that Robinson was distinguishable because, by adding a subsequent denial as an issue to an already scheduled hearing, she was being deprived of the fullest opportunity to prepare her case. We disagreed and stated that whether an issue is first raised in the original hearing request or subsequently designated as an additional issue for hearing, the party raising the issue must still exercise due diligence in preparing the case for hearing. That requirement cannot be bypassed by withdrawing the hearing request and refiling at a later time. Inman at 1319.

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[1] In accordance with the doctrine of *stare decisis*, Chair Hall acknowledges that he is compelled to follow the Board's decision in Cathy A. Inman, supra. However, because he continues to feel that the Board's decision in that case was in error, he directs the reader to his dissent in that case.

We conclude that our holding in Inman is controlling. That is, claimant is alleging that there was insufficient time to prepare for hearing because his amended request for hearing raised an additional issue.[2] Claimant chose to file his amended request for hearing immediately, presumably to take advantage of the scheduled hearing date set rather than wait for a new hearing at a later date. In this regard, we note that claimant still had a significant amount of time left on the 60-day time period in which to request a hearing on the August 15, 1995 denial. Claimant is now asserting that the "quick set" is the reason for his request for a dismissal without prejudice. However, claimant cannot have it both ways. If he chooses to file quickly, then he must be prepared to go forward with his case or risk a dismissal with prejudice. In sum, we conclude that there are insufficient reasons to allow a dismissal without prejudice. Consequently we conclude that the ALJ abused his discretion by not dismissing claimant's request for hearing with prejudice.

Reinstatement of Hearing Request

We adopt the conclusions and reasoning as set forth in the ALJ's order.

ORDER

The ALJ's order dated September 19, 1995, as reconsidered October 31, 1995, is modified in part and affirmed in part. That portion of the ALJ's order which dismissed claimant's request for hearing without prejudice is modified. Claimant's request for hearing is dismissed with prejudice. The remainder of the order is affirmed.

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[2] It is questionable whether the issues raised by claimant's original hearing request and his amended request are significantly different. SAIF's original denial denied claimant's current neck and low back condition on the basis that they were unrelated to claimant's compensable injury. While SAIF's amended denial narrows the issues to specific levels of the cervical and lumbar spine, the basis for the denial remains the same, i.e., that those conditions are unrelated to claimant's compensable injury.

In addition, claimant asserts that he did not ask for the hearing requests to be joined. However, claimant was aware of the impending scheduled hearing and yet entitled his subsequent hearing request as "amended" rather than filing a new request for hearing.

In the Matter of the Compensation of
MARY R. MARCUM, Claimant
WCB Case No. 95-02745
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Bottini, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order which upheld the self-insured employer's denial of claimant's right knee aggravation claim. On review, the issue is aggravation.

We adopt and affirm the ALJ's order.[1]

ORDER

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

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[1] Although ORS 656.273 applies retroactively to this case, OR Laws 1995, ch 332, § 66; Volk v. America West Airlines, 135 Or App 545 (1995), we would reach the same conclusion under the prior version of the statute.

Board Chair Hall dissenting.

In the case of an off-work aggravation, the employer has the burden of proving that the claimant's off-work injury is the major contributing cause of her worsened condition. Fernandez v. M & M Reforestation, 124 Or App 38 (1993); see ORS 656.273(1). Here, the employer relies on the opinions of Dr. Lantz, treating physician. (Exs. 26, 27). In January 1995, Dr. Lantz responded to a letter from the carrier, stating, "I do believe the [off-work] incidence in August of 1994 [slipping in muddy grass and apparently falling] was a new and discreet incident. It did aggravate [claimant's] problem. Her condition is materially worsened in that she has further restricted range of motion as documented in my clinic note." (Ex. 26).

In March 1995, Dr. Lantz opined that claimant's range of motion was less after her slip in the mud, but that the majority of claimant's underlying condition and pathology preexisted the slip in the mud. (Ex. 27).

I find that Dr. Lantz's references to claimant's current condition are scant and unexplained. Furthermore, assuming that Dr. Lantz adequately evaluated the relative contribution of both claimant's compensable injury, and the off-work fall, his opinion actually supports a finding that claimant's compensable condition is the major contributing cause of the aggravation. (Ex. 27). See Dietz v. Ramuda, 130 Or App 397 (1994) (the relative contributions of each cause must be compared to establish major causation).

The majority finds such ambiguous, unexplained evidence adequate to carry the burden of proving major contributing cause. I am not persuaded that these two statements by Dr. Lantz prove that the off-work injury is the major contributing cause of claimant's right knee aggravation. Therefore, I respectfully dissent.

April 3, 1996 Cite as 48 Van Natta 750 (1996)

In the Matter of the Compensation of
SHELLEY C. NIKOLAUS, Claimant
WCB Case Nos. 94-12888, 94-09121, 94-12887 & 94-12751
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
G. Joseph Gorciak III, Defense Attorney
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board en banc.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Black's order that declined to award an attorney fee under ORS 656.307(5). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following additions. The claim with Safeco closed November 21, 1991. The claim with Farmers' had not closed as of the date of hearing.

CONCLUSIONS OF LAW AND OPINION

At hearing, the issue was responsibility between Safeco Insurance Company (Safeco) and Farmers' Insurance Company (Farmers') of claimant's cervical condition.[1] Claimant's attorney was present at the hearing and took the position that Farmers' should be found responsible.

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[1] The case arose under former ORS 656.307, which limited our review to questions of law. Former ORS 656.307(2). Subsequent to the ALJ's order, the legislature amended the statute to provide for de novo review by the Board. Or Laws 1995, ch 332, § 36. Because amended ORS 656.307(2) retroactively applies to this case, we have conducted a de novo review. Dan J. Anderson, 47 Van Natta 1929 (1995).

The ALJ's first order set aside Farmers' denial and disclaimer and ordered Farmers' to pay claimant's attorney an assessed fee of $2,400. On reconsideration, the ALJ found that claimant's attorney was not entitled to an assessed award. In reaching this conclusion, the ALJ found that, by asserting that Farmers' was responsible, claimant's counsel did not advocate for the party having a "material, substantial interest."

ORS 656.307(5) provides, in relevant part:

> "If the claimant appears at any such proceeding [under ORS 656.307] and actively and meaningfully participates through an attorney, the Administrative Law Judge may require that a reasonable fee for the claimant's attorney be paid by the employer or insurer determined by the [ALJ] to be the party responsible for paying the claim."

Relying on Darrell W. Vinson, 47 Van Natta 356 (1995), claimant on review contends that her attorney is entitled to a reasonable fee under ORS 656.307(5).

We first find that claimant's attorney "actively" participated in the hearing. Counsel appeared at the hearing and expressly took a position regarding responsibility. Thus, we next consider whether claimant's attorney "meaningfully" participated.

In Darrell W. Vinson, the claimant's attorney participated in a proceeding conducted under ORS 656.307 and asserted that one of the carriers joined in the proceeding should be found responsible. The ALJ found another carrier responsible and refused to award an attorney under ORS 656.307(5).

On review, we reversed, finding that the claimant's attorney "meaningfully" participated in the ".307" proceeding. In particular, we held that "where counsel takes a position that, if adopted, would advance the interests of his client, it can safely be said that counsel's participation has 'significance' and 'purpose' and, therefore, has meaning." 47 Van Natta at 359. Thus, we concluded that the "fact that counsel's position does not ultimately prevail does not render his participation meaningless, although that fact may be considered in determining the amount of the fee award." Id. (emphasis in original).

Here, the ALJ apparently found that, although claimant's attorney's participation was active in that claimant advocated a position regarding the responsibility issue, such participation was not "meaningful" because, by asserting that Farmers' was responsible, she did not advocate to put responsibility on the carrier providing a higher temporary disability rate. We have found that an attorney fee is warranted under ORS 656.307(5) when the claimant's attorney advocates such a position. Michael J. Joseph, 47 Van Natta 2043, 2050 (1995). Nothing in our order in Vinson, however, suggests that temporary disability is the only "material, substantial interest" that may be furthered by claimant's counsel at a ".307" hearing. Thus, although claimant would have received a higher rate of temporary disability under the Safeco claim, we do not agree with the ALJ that this fact alone prevents an attorney fee award under ORS 656.307(5). Accordingly, we consider whether claimant's attorney's advocacy furthered any other "material, substantial interest."

We conclude that she did. The claim with Safeco was closed November 20, 1991; thus, claimant has within 5 years from that date to file an aggravation claim. ORS 656.273(4)(a). If claimant's condition worsens after the 5-year period, her claim would be under the Board's "own motion" and limited to temporary disability and medical benefits. ORS 656.278(1)(b).

The claim with Farmers', on the other hand, has not closed. Thus, should claimant's cervical condition worsen after the Farmers' claim closes and because Farmers' is responsible for that condition, she will be under a much longer time period to file an aggravation claim than if Safeco was responsible for the cervical condition. We find that this longer period of "aggravation rights" is a "material, substantial interest" because claimant will have a longer opportunity to qualify for all the benefits available under ORS 656.273, as opposed to the limited compensation provided under ORS 656.278. Consequently, we conclude that claimant's attorney "meaningfully" participated in the hearing.

In coming to this conclusion, we acknowledge the holding in Anfora v. Liberty Communications, 88 Or App 30, 33 (1987), that the claimant's attorney was not entitled under ORS 656.386(1) for efforts in successfully overturning the Board's order placing responsibility pursuant to ORS 656.307 on a second employer. Although noting that the claimant's attorney succeeded in securing an extended period of "aggravation rights" for claimant, the court found that compensation was not at risk because only responsibility was disputed. Id. The court also noted that an attorney fee under ORS 656.382(2) was not warranted because claimant had sought judicial review. Id. at 32.

We find that Anfora is not controlling here because it concerned entitlement to an attorney fee under ORS 656.386(1) and 656.382(2) in the context of a ".307" proceeding. Here, ORS 656.307(5) clearly does provide for an attorney fee in such a proceeding if counsel "actively and meaningfully participates" at the hearing. For the reasons discussed, we conclude that claimant satisfied this standard.[2]

Therefore, because we find that claimant's attorney "actively and meaningfully participated" in the proceeding, counsel is entitled to a reasonable fee under ORS 656.307(5). 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 hearing level is $2,400, payable by Farmers'. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record), the complexity of the issue, and the value of the interest involved. In addition, we have taken into account claimant's counsel's advocacy of a position that has been successful (Farmers' as the responsible carrier). See Darrell W. Vinson, supra. Finally, claimant is not entitled to an attorney fee for services on review in securing the attorney fee. See ORS 656.307(5); Allen T. Knight, 48 Van Natta 30 (1996).

ORDER

The ALJ's order dated March 10, 1995, as reconsidered June 1, 1995, is reversed in part and affirmed in part. That portion of the order declining to award an assessed fee for services at hearing is reversed. For services at hearing, claimant's counsel is awarded $2,400, to be paid by Farmers'. The remainder of the order is affirmed.

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[2] The dissent contends that our reasoning essentially deletes the statutory requirement of "active and meaningful participation" in that a claimant's attorney need only "show[] up, make[] a few comments, and advocate[] for that carrier [with the longer aggravation rights]." We disagree with the dissent's assertions.

To begin, as an "officer of the court," a claimant's attorney is ethically bound to advocate those positions that are either warranted under existing law or where there is support for a good faith argument to extend, modify, or reverse existing law. See DR 7-102(A)(2). Thus, we presume that only those positions which are consistent with the aforementioned ethical obligations will be advanced.

Although a higher TTD rate or longer aggravation rights will likely constitute a "material, substantial interest" in most cases, each particular set of circumstances must be evaluated to determine whether the position taken by a claimant's counsel satisfies the statutory prerequisite. In this regard, there may well may be circumstances other than a higher TTD rate or longer aggravation rights which will satisfy the "material, substantial interest" standard.

Finally, as we have previously emphasized in Vinson, our analysis of "meaningfully" solely pertains to a claimant's counsel's entitlement to an attorney fee. In other words, the amount of that fee may well be significantly impacted depending on whether the attorney's advocacy of a position was ultimately successful.

Board Member Haynes dissenting.

I disagree with the majority's conclusion that claimant's attorney is entitled to a fee under ORS 656.307(5). Under that statute, the ALJ may award a reasonable fee "[i]f the claimant appears at [a '.307' proceeding] and actively and meaningfully participates through an attorney[.]"

First, I disagree that claimant's attorney participation was "active." Counsel's actions at the hearing consisted of the following: telling the ALJ that the matter was "strictly a responsibility case"; explaining to the ALJ (in three sentences) that claimant took the position that Farmers' was responsible; and participating in post-hearing closing arguments. Counsel offered no documentary or testimonial evidence, nor questioned any witnesses. Most of the attorney's time was taken with listening to the carriers' lawyers argue to the ALJ concerning responsibility.

Such conduct simply is too minimal to be "active." In my opinion, active participation means that the attorney joins in some aspects of the hearing, such as introduction of documentary evidence, examination of witnesses, and argument to the ALJ. Here, claimant's attorney's participation essentially consisted of providing a closing argument (and, because they were not recorded, there is no evidence showing how much time, thought, or effort this activity required).

I also cannot agree that claimant's attorney's participation was "meaningful" because Farmers', the carrier advocated by claimant to be responsible, provided a longer period of "aggravation rights." First, this clearly was not the reason claimant's attorney asserted putting responsibility on Farmers'. At hearing, claimant's attorney stated that claimant's position, "unfortunately," was that Farmers' was responsible "because we litigated this issue previously and we were attempting to have Safeco held responsible, and we were unsuccessful through an appeal process." (Tr. 9).

This statement shows that claimant advocated for Farmers' based on prior litigation. Neither at hearing nor on review does claimant suggest that her attorney's participation was "meaningful" because Farmers' would provide longer "aggravation rights." Thus, in this case, claimant's attorney benefits from the Board's own creative construction of the statute.

Furthermore, I do not find that, substantively, advocating to put responsibility on a carrier which will provide longer "aggravation rights" than the competing carrier constitutes "meaningful" participation. The fact that the claim will not be under "own motion" jurisdiction at best provides the potential for claimant to qualify for additional benefits not available under ORS 656.278. Claimant still is obliged to prove entitlement to those benefits, such as permanent disability. We previously defined "meaningful" under the statute as "significant" and "purposeful." Darrell W. Vinson, supra, 47 Van Natta at 356-57. In my opinion, advocating for a carrier which will provide the opportunity to prove entitlement to potential benefits does not make the attorney's participation "significant" and "purposeful" and, therefore, "meaningful."

By making an attorney fee contingent on "active and meaningful participation," the legislature clearly intended that a fee awarded under ORS 656.307(5) would not be freely required. That is, because proceedings under ORS 656.307 only concern responsibility (and, thus, claimant is, as a practical matter, guaranteed some compensation), ORS 656.307(5) requires more activity by the attorney, as opposed to awards under ORS 656.386(1), where the claimant need only prevail over a denial of compensability (no matter the level of time and work by claimant's attorney). With this order, the Board essentially has deleted the requirement of "active and meaningful participation." I say this because there are few "307" proceedings involving at least one claim that is still within the 5-year "aggravation rights" period; as long as claimant's attorney shows up, makes a few comments, and advocates for that carrier, this order will ensure an attorney fee is forthcoming under ORS 656.307(5).

In conclusion, the majority simply stretches the language of the statute too far to fit the facts of this case. Because I find that claimant's attorney's participation was neither sufficiently "active" nor "meaningful" to warrant the award of a fee under ORS 656.307(5), I dissent.

April 3, 1996 Cite as 48 Van Natta 753 (1996)

In the Matter of the Compensation of
DUANE B. ONSTOTT, Claimant
WCB Case No. 95-05619
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that affirmed an Order on Reconsideration awarding claimant 9 percent (13.50 degrees) scheduled permanent disability for loss of use or function of the left wrist. On review, the issues are evidence and extent of scheduled permanent disability. We affirm.

FINDINGS OF FACT

We affirm the ALJ's findings of fact, and summarize the pertinent facts as follows:

Claimant injured his left wrist on June 5, 1994 while working as a meat cutter. On June 24, 1994, Dr. Gill became claimant's attending physician. Dr. Gill examined claimant and authorized his return to regular work as of mid-August 1994. The claim was closed by a Notice of Closure dated October 18, 1994, declaring claimant medically stationary as of October 18, 1994 and awarding temporary disability only.

On November 29, 1994, Dr. Gill examined claimant and noted that although claimant's wrist condition appeared stable, he continued to have significant pain and an appreciable loss of grip and pinch strength.

Claimant filed a request for reconsideration of the Notice of Closure on January 13, 1995. Claimant submitted Dr. Gill's report to the Director and requested promulgation of a temporary rule.

On January 26, 1995, the Director postponed reconsideration to consider the promulgation of a temporary rule. In February 1995, the Director requested clarification of claimant's impairment from Dr. Gill. Dr. Gill responded. In April 1995, the Director requested further clarification from Dr. Gill. Again, Dr. Gill responded and provided an explanation of his findings on examination. Dr. Gill opined that claimant's muscle strength was a 2/5, or approximately 40 percent of his normal strength.

On July 11, 1995, the Director adopted a temporary rule to determine claimant's impairment, WCD Admin. Order 95-055. On July 13, 1995, the Director published an Order on Reconsideration awarding claimant 9 percent (13.50 degrees) scheduled permanent disability for loss of use or function of the left wrist in accordance with WCD Admin. Rule 95-055. Noting an "apparent discrepancy" between the attending physician's 2/5 graded loss of grip strength and claimant's return to meat cutter work without restrictions, the Director found that, based on the Department's muscle grading system, claimant had a serious functional impairment of his left wrist equal to a 4/5 loss of strength.

CONCLUSIONS OF LAW AND OPINION

Evidence

Applying amended ORS 656.283(7), the ALJ found that claimant was not permitted to present evidence at hearing concerning the extent of his disability that was not part of the record developed by the Director on reconsideration. The ALJ further found, based on the reconsideration record, that the temporary rule had been properly applied in evaluating claimant's permanent disability.

Claimant contends on review that amended 656.283(7) is unconstitutional because it deprives him of his "due process" right to be heard and prevents him from correcting a factual error in the Order on Reconsideration that significantly affected the Director's evaluation of his impairment. We disagree.

Amended ORS 656.283(7) provides, in part that "[e]vidence 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." That statute went into effect on June 7, 1995, shortly before the Order on Reconsideration issued in this case. Therefore, the amended statute applies here. See Joe R. Ray, 48 Van Natta 325 (1996) (amended ORS 656.283(7) applied where case had not yet been finally resolved on appeal).

We held in Joe R. Ray, supra, that under amended ORS 656.283(7), evidence that was not submitted at reconsideration and not made part of the reconsideration record is statutorily inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent disability. We also found that the retroactive application in a pending case of the amended statute's ban on evidence that is not included in the reconsideration record did not violate the claimant's procedural due process rights.[1] Id. Therefore, we held that the claimant's testimony at the hearing regarding the extent of his permanent disability was inadmissible.

Claimant asserts essentially the same "due process" arguments as did the claimant in Joe R. Ray. We rejected them in Ray, and do so again here. In so doing, we note that here, claimant's argument focuses on his inability to correct an alleged factual error in the Order on Reconsideration. As we said in Ray, however, the reconsideration process:

> "vest[s] 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). * * *

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[1] Although a signatory to this order, Board Member Gunn directs the parties to his dissenting opinion on this issue in Joe R. Ray, supra.

> [Therefore], 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." Joe R. Ray, supra.

Because claimant had the opportunity, under either version of ORS 656.283(7), to correct any alleged error in the Order on Reconsideration (at least until he requested a hearing), we reject his due process arguments.[2] We conclude that the ALJ did not err in refusing to allow claimant to present additional evidence at hearing about the extent of his disability which was not submitted at reconsideration and made part of the reconsideration record.

Extent of Permanent Disability

Claimant contends that, based on Dr. Gill's 2/5 rating of strength retained, he is entitled to an award of 36 percent scheduled permanent disability for his left forearm.[3] We disagree, and adopt and affirm that portion of the ALJ's order concluding that, based on the admissible evidence, the Director properly calculated claimant's impairment and disability by applying temporary rule OAR 436-35-500 (B75-0788).

ORDER

The ALJ's order dated August 6, 1995, as amended on September 7, 1995, is affirmed.

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[2] We also reject claimant's contention that he knew nothing of the Director's alleged "confusion" concerning his return to work until after he received the Order on Reconsideration. During the reconsideration proceeding, claimant was sent a copy of the Director's correspondence to Dr. Gill. In its April 5, 1995 letter to Dr. Gill, the Director's office indicated that "we are trying to clarify the seeming inconsistency between a 2/5 measured muscle strength and the worker's return to regular (meat cutter) work without restrictions." Although Dr. Gill responded with an explanation of his impairment findings on examination, claimant did not seek to submit additional evidence to correct the Director's understanding that he had returned to work without restrictions.

[3] Claimant seeks a value of 33 percent for loss of strength combined with a 5 percent chronic condition award for loss of repetitive use, for a total loss of 36 percent for the left forearm.

In the Matter of the Compensation of
JAMES H. PATRICK, Claimant
WCB Case No. 95-07433
ORDER ON REVIEW
Lavis, Alvey, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order which: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for a cervical condition; and (2) declined to award penalties or an attorney fee for the employer'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.

Upholding the employer's denial of claimant's occupational disease claim, the ALJ found that the medical evidence was insufficient to establish that claimant's work activity as a hyster driver was the major contributing cause of a pathological worsening of claimant's preexisting cervical condition and of the "combined condition." See amended ORS 656.802(2)(b). In reaching this conclusion, the ALJ stated that there needed to be a degree of "medical certainty" in order for claimant to prevail. The ALJ then determined that Dr. Mason, claimant's attending neurosurgeon, had acquiesced in the medical report of an examining neurosurgeon, Dr. Rosenbaum, who stated that claimant's preexisting degenerative cervical condition was the major factor in claimant's cervical condition, and had not persuasively articulated why Dr. Rosenbaum's conclusion was incorrect. Thus, the ALJ concluded that claimant had failed to sustain his burden of proof.

While we agree with the ALJ that claimant failed to satisfy his burden of proof, we note that the appropriate standard for medical evidence is not medical certainty, but rather "medical probability." Gormley v. SAIF, 52 Or App 1055, 1059-60 (1981); Joann Kilmer, 46 Van Natta 829, 830 (1994). Applying the appropriate standard, we nonetheless find that the medical evidence does not establish to a degree of medical probability that claimant's work activity is the major contributing cause of a pathological worsening of claimant's preexisting cervical condition and of the "combined condition" under ORS 656.802(2)(b).

After he initially issued two medical reports in which he concluded without explanation that claimant's cervical condition was "work-related," Dr. Mason subsequently opined that it was "entirely possible" that repetitive movements of claimant's head and neck at work played a contributing part in claimant's condition. However, Dr. Mason noted that in a "general sense" claimant's medical treatment was an "extension" of his preexisting condition. (Ex. 38).

Dr. Mason later issued several additional reports addressing the causation issue. On June 23, 1995, Dr. Mason wrote that work activity was the primary cause of the onset of claimant's current episode of "symptoms." (Ex. 40). On July 10, 1995, Dr. Mason opined without explanation that claimant's work activity pathologically worsened his preexisting cervical condition and that employment conditions were the major contributing cause of claimant's current condition, disability and need for treatment. (Ex. 42).

Dr. Rosenbaum performed his examination of claimant on August 10, 1995. In his report, Dr. Rosenbaum concluded that, to a degree of medical probability, claimant's work activities as a hyster driver did not cause in major part claimant's degenerative cervical condition or pathologically worsen that condition. (Ex. 43-6). Dr. Rosenbaum opined that the contribution of claimant's repetitive neck motion was "far below" that of non-work related progressive degenerative changes. Id. Finally, Dr. Rosenbaum concluded that it was likely that claimant would have required surgery in the absence of his work exposure. Id. at 7.

On August 28, 1995, Dr. Mason stated that he agreed with Dr. Rosenbaum's responses to the questions posed to him. (Ex. 44). In a September 8, 1995 follow-up report to claimant's counsel, Dr. Mason explained that he concurred in a "general sense" with Dr. Rosenbaum, but that it was "impossible to accurately determine which factor in any particular patient is the more significant with respect to the resulting clinical state that occurs." (Ex. 46). Dr. Mason further wrote that "I don't disagree with this [Dr. Rosenbaum's] opinion." Id.

In a final "check-the-box" report, Dr. Mason agreed that claimant's work activity was the major contributing cause of his current disability and need for treatment. (Ex. 47-2). Dr. Mason, however, also agreed that Dr. Rosenbaum's opinion was reasonable. Id.

Claimant contends that we should defer to Dr. Mason's medical opinion over that of Dr. Rosenbaum. Claimant argues that Dr. Mason only concurred with Dr. Rosenbaum in a "general sense" and that his concurrence should not defeat the claim. Claimant's contentions notwithstanding, his occupational disease claim is not compensable.

Although claimant emphasizes Dr. Mason's comment that he concurred with Dr. Rosenbaum's conclusions in a "general sense," Dr. Mason's earlier concurrence was unqualified. Dr. Mason stated that "in essence I agree with his [Dr. Rosenbaum's] description of his [claimant's] clinical problem, and agree with his [Dr. Rosenbaum's] responses to the specific questions posed to him." (Ex. 44, emphasis added). Moreover, Dr. Mason stated in his September 8, 1995 report that he did not disagree with Dr. Rosenbaum's opinion. (Ex. 46-2).

Based on our review of the medical record, we conclude that Dr. Mason's August 28, 1995 concurrence with Dr. Rosenbaum's medical opinion and his September 8, 1995 follow-up report weaken claimant's case and do not support a finding that this occupational disease claim is compensable. Dr. Mason's other medical opinions are conclusory and/or expressed in terms of medical possibility. Therefore, we find persuasive reasons not to rely on the medical opinion of claimant's attending physician. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Inasmuch as Dr. Rosenbaum's medical opinion does not support compensability, we agree with the ALJ that claimant has failed to sustain his

burden of proving that his work activities are the major contributing cause of his "combined condition" and of a pathological worsening of his preexisting degenerative cervical disease. ORS 656.802(2)(b). The ALJ properly upheld the employer's denial.[1]

ORDER

The ALJ's order dated September 27, 1995 is affirmed.

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[1] Claimant also argues on review that a penalty or penalty-related attorney fee should be assessed because of the employer's failure to include notice of appeal rights in its denial. (Ex. 39). Since there is no evidence that there was compensation due, we cannot award a penalty pursuant to ORS 656.262(11)(a). See Gustavo Cantu-Rodriguez, 46 Van Natta 1801 (1994). Moreover, absent a compensable claim, we cannot award an attorney fee under amended ORS 656.382(1) for unreasonable resistance to the payment of compensation. Id. at 1802.

April 3, 1996 Cite as 48 Van Natta 757 (1996)

In the Matter of the Compensation of
MICHAEL SALBER, Claimant
WCB Case No. C600766
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Nancy F.A. Chapman, Claimant Attorney
Vavrosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

On March 15, 1996 the Board received the parties' claim disposition agreement in the above-captioned matter. Pursuant to that agreement, claimant releases certain rights to future workers' compensation benefits, except medical services, for the compensable injury. We disapprove the proposed disposition.

First, the CDA provides the consideration underlying the agreement is the insurer's waiver of its lien against "the proceeds of a confidential third party settlement." Generally, we disapprove CDAs in which the consideration consists of the carrier's reduction of a lien, but the CDA contains no information concerning the amount of the third party settlement or judgment and/or the amount of the carrier's lien. E.g., Kenneth Hoag, 43 Van Natta 991 (1991). We reach this conclusion because we are unable to ascertain the "value" of any consideration flowing to the claimant as a result of the third party settlement and the carrier's waiver of its lien. Id.

Here, we are unable to determine the value of any consideration claimant will receive because the CDA neither provides the amount of the lien being waived nor the amount of the third party settlement. Although it is conceivable that we may not need to know all of the provisions in the "confidential" settlement, it is imperative for us to be provided with information regarding the amount of the settlement and the dimensions of the insurer's "waived" third party lien.

The proposed agreement also provides that "medical care in the future will be covered only if it is not primarily due to aging or further injury." Such a limitation on medical services is deemed unreasonable as a matter of law. E.g., Kenneth D. McDonald, 42 Van Natta 2307 (1990).

Thus, because the CDA does not provide adequate information concerning the value of consideration and limits medical services, we find the agreement unreasonable as a matter of law. Thus, we disapprove it. ORS 656.236(1)(a)(A).

Inasmuch as the proposed disposition has been disapproved, the insurer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 438-009-0030(1).

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 438-09-035(1).

IT IS SO ORDERED.

In the Matter of the Compensation of
GAYLE A. JAYNES, Claimant
WCB Case No. 94-12653
ORDER ON REVIEW
Bischoff, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order which set aside its denial of claimant's bilateral shoulder condition. On review, the issue is compensability.

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

The insurer contends that claimant's complaints of pain are wholly subjective and, thus, under amended ORS 656.005(19)[1], claimant has failed to establish verifiable indications of injury. The insurer, therefore, argues that claimant has failed to establish a compensable injury supported by objective findings.

On July 15, 1994, claimant sought treatment for complaints of right shoulder pain and tenderness. Dr. Webb's examination findings included tenderness to palpation, limited ranges of motion and positive impingement testing. Inasmuch as these findings were measurable and observable, they are not excluded as an objective finding under amended ORS 656.005(19). See Naomi Whitman, 48 Van Natta 605 (1996) (reduced range of motion and spasm resulting from work injury sufficient to constitute "objective findings"); Kenneth E. Smith, 48 Van Natta 572 (1996) (limited range of motion findings sufficient to constitute "objective findings" if provided by persuasive physician's opinion); Rosalie A. Peek, 47 Van Natta 1432 (1995) (bruising and reduced range of motion were verifiable, observable indications of injury); compare Jario J. Garcia, supra (no "verifiable indications of injury" where the claimant's treating physician indicated that the claimant had pain but all other findings were normal).

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

ORDER

The ALJ's order dated March 15, 1995 is affirmed. For services on review, claimant's counsel is awarded an attorney fee of $900, payable by the employer.

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[1] Amended ORS 656.005(19) now defines objective findings as "verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable." The statute applies retroactively. Jario J. Garcia, 48 Van Natta 235 (1996); Volk v. America West Airlines, 135 Or App 565 (1995).

In the Matter of the Compensation of
WILLIAM E. ANDERSON, Claimant
WCB Case No. 94-04964
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Miller, Nash, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) found that claimant's inner ear concussion syndrome and associated BPPN was part of the accepted claim; (2) upheld the self-insured employer's denial of claimant's current BPPN condition and need for treatment after October 24, 1989; and (3) declined to assess penalties or attorney fees for an allegedly unreasonable denial. On review, the issues are scope of acceptance, compensability and penalties and attorney fees.

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

The ALJ found that the employer had accepted claimant's inner ear concussion syndrome and BPPN in May 1988 when it accepted claimant's claim for a "concussion - head injury." The ALJ also upheld the employer's "current condition" denial of claimant's inner ear concussion syndrome and need for treatment after October 24, 1989. On review, claimant contends that inner ear concussion syndrome and BPPN were not part of the accepted claim, but were "de facto" denied by the employer. The employer seeks to have the ALJ's order affirmed and asserts that it accepted claimant's inner ear concussion syndrome in May 1988 on the form 801 (claim form).

We agree with the ALJ that claimant's inner ear concussion syndrome was part of the May 1988 accepted claim.

Claimant was compensably injured on April 29, 1988 when a 3 pound sand bag, which fell from a 30 foot ceiling rope, struck him on the left side of his head. Claimant filed a claim with the employer and described the nature of his injury as "concussion - head injury." The employer accepted the claim on the claim form on May 27, 1988 as a nondisabling injury.

Where, as here, the carrier's acceptance does not identify the specific condition accepted, we look to the contemporaneous medical records to determine the scope of the acceptance. Norval W. Park, 47 Van Natta 2085 (1995); Cecilia A. Wahl, 44 Van Natta 2505 (1992). A form 827, completed on May 20, 1988, listed claimant's complaints as headaches, back pain, balance and coordination, shoulder pain right side and nausea - stomach pain. (Ex. 8). Based on this contemporaneous medical evidence, we conclude that the employer's acceptance of "concussion - head injury" included claimant's symptoms of balance and coordination problems and nausea.

According to Dr. Coale, an otolaryngologist who treated claimant for his inner ear concussion syndrome, balance and coordination problems, confusion, nausea and memory loss are associated with inner ear concussion and BPPN. Based on his examinations of claimant and his review of the records and medical histories, Dr. Coale opined that the 1988 compensable injury probably included some minor inner ear concussion and associated BPPN symptoms.

Because the employer accepted the symptoms of inner ear concussion and BPPN identified by Dr. Coale, balance and coordination problems and nausea, we conclude that the employer accepted the underlying concussion syndrome and BPPN conditions which caused those symptoms. See Georgia Pacific v. Piwowar, 305 Or 494 (1988) (acceptance of a symptom of an underlying condition is an acceptance of the disease causing the symptom). Accordingly, we agree with the ALJ that claimant's inner ear concussion syndrome and BPPN are part of the accepted claim.

Based on the uncontroverted medical evidence, we agree with and adopt the ALJ's conclusion that claimant's current BPPN condition after the October 24, 1989 motor vehicle accident is not compensable.

ORDER

The ALJ's order dated September 25, 1995 is affirmed.

In the Matter of the Compensation of
BRIAN HARRY, Claimant
WCB Case No. 95-04427
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Emmons, Kropp, et al, Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order which upheld the insurer's denial of his injury claim for left inguinal hernia. On review, the issue is compensability.

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

Relying on the opinion of Dr. Gross, medical reviewer, the ALJ found that the major contributing cause of claimant's indirect inguinal hernia was a preexisting congenital defect.

On review, claimant first contends that the application of ORS 656.005(24) to determine that his congenital defect of a patent processus vaginalis is a preexisting condition, violates the Americans With Disabilities Act ("ADA"), 42 U.S.C. § 12132, and is therefore preempted by federal law.

We decline to address claimant's "preemption" argument because this issue is being raised for the first time on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) (Board can refuse to consider issues on review that are not raised at hearing). At hearing, claimant's counsel identified the compensability of claimant's hernia condition, penalties and unreasonable denial as the only issues before the ALJ. (Tr. 5). Since medical evidence at the time of hearing suggested that claimant's hernia condition may have been the result of a preexisting congenital defect, claimant's contention that ORS 656.005(24) is in violation of federal law could have been raised at hearing. Because claimant did not raise this argument until now, we do not consider it.

Next claimant contends that the insurer is precluded from denying claimant's hernia condition because it had previously accepted a "left groin strain" which he characterizes as a symptom of his indirect inguinal hernia. Georgia Pacific Corp. v. Piwowar, 305 Or 494, 753 P2d 948 (1988). We disagree. Where a carrier has accepted a symptom of a disease, it is deemed to have also accepted the underlying disease causing that symptom. Georgia Pacific Corp. v. Piwowar, supra.

Here, claimant was treated by Dr. Goby, who diagnosed a left groin strain and a possible early forming hernia. (Ex. 1). On December 5, 1995, Dr. Goby reported that claimant's left groin strain was resolving and stated that claimant could return to work with no restriction. (Ex. 7). On January 10, 1995, the insurer accepted "left groin strain." (Ex. 10). Finally, in April 1995, Dr. Goby stated that at the time of claimant's initial examination there was no hernia present and that there was tenderness as a result of claimant's groin strain. (Ex. 17).

Considering these facts, we conclude that the scope of the insurer's acceptance was limited to left groin strain, a specific condition diagnosed and treated by Dr. Goby, which is separable from the hernia condition. Accordingly, we find that the insurer did not accept claimant's indirect hernia.

ORDER

The ALJ's order dated August 16, 1995 is affirmed.

In the Matter of the Compensation of
MICHAEL C. JOHNSTONE, Claimant
Own Motion No. 96-0147M
OWN MOTION ORDER
O'Neill, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable right knee and low back strain injuries. Claimant's aggravation rights expired on May 17, 1978. SAIF opposes reopening of the claim, 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.

On January 18, 1996, claimant underwent right knee chondroplasty (patellar groove) and lateral compartment surgery. 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).

SAIF contends that claimant was not in the work force because, at the time of current disability, he was receiving "continuous temporary disability from February 3, 1995 in Claim No. 7810226H."

Claimant sustained a compensable right knee and low back injury on April 1, 1972 with an employer insured by SAIF. Claimant sustained an industrial injury to his left shoulder and left arm on January 25, 1995, with a subsequent employer while SAIF was on the risk. Claimant is currently receiving temporary disability compensation under his 1995 claim. SAIF contends that claimant's attending physician in both claims, Dr. Stevens, has not released claimant to work in either claim. Thus, SAIF argues that claimant was not in the work force at the time of the right knee surgery on January 18, 1996. We disagree.

Claimant was not working or seeking work at the time of current disability. However, by definition, while claimant is receiving time loss due to a compensable injury, he remains in the work force because he is unable to work due to a compensable injury. William L. Halbrook, 46 Van Natta 79 (1994); Dawkins v. Pacific Motor Trucking, supra. Here, claimant has not voluntarily removed himself from the work force, but he has sustained a more recent compensable injury which prevented him from working at the time of his current disability. In addition, because claimant's primary physician had not released him to return to work at the time of current disability, we are further persuaded that he was unable to work or to seek work at that time.

On this record, we conclude that claimant has established that he remained in the work force at the time of current disability.

Accordingly, we authorize the reopening of claimant's 1972 injury claim to provide temporary disability compensation commencing January 18, 1996, the date he was hospitalized for surgery.[1] When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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[1] Parenthetically, we note that an injured worker in not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability resulting from multiple disabling injuries. See Fischer v. SAIF, 76 Or App 656, 661 (1985); Petshow v. Portland Bottling Co., 62 Or App 614 (1983), rev den 296 Or 350 (1984). Therefore, if any concurrent temporary disability compensation is due claimant as a result of this order, SAIF may petition the Workers' Compensation Division of the Department of Consumer and Business Services for a pro rata distribution of payments. OAR 438-60-020(8) and (9); Morris B. Grover, 48 Van Natta 486 (1996); William L. Halbrook, supra.

Finally, claimant's attorney is entitled to a reasonable attorney fee, payable out of the increased compensation awarded by this order. However, we cannot approve such a fee unless claimant's attorney files a retainer agreement. See OAR 438-015-0010(1). Because no retainer agreement has been received to date, an attorney fee shall not be approved.

IT IS SO ORDERED.

April 8, 1996 Cite as 48 Van Natta 762 (1996)

In the Matter of the Compensation of
JUAN C. RODRIGUEZ, Claimant
WCB Case No. 95-04968
ORDER ON REVIEW
Dye/Malagon & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Holtan's order that: (1) found that claimant's low back injury was not prematurely closed; (2) declined to award additional temporary disability benefits; and (3) affirmed an Order on Reconsideration which awarded no permanent disability benefits. In his brief, claimant requests that the Board remand his claim to the Appellate Review Unit (ARU) for "adequate development of the record" used during the reconsideration process. On review, the issues are remand, premature closure, temporary disability, and permanent disability (scheduled and unscheduled).

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's motion to remand.

At hearing, claimant argued that it was not clear what evidence was included in the reconsideration record the ARU relied on in issuing the April 19, 1995 Order on Reconsideration. Therefore, claimant requested the ALJ to remand the claim to the ARU for compilation of the reconsideration record for inclusion in the hearings record. (Tr. 12-18). The ALJ declined to postpone or continue the hearing to remand the claim to the ARU. (Tr. 18). On review, claimant renews his arguments and his request to remand the claim to the ARU for "adequate development of the record" used during the reconsideration process.

Claimant cites no authority for either the Hearings Division or the Board to remand this claim to the ARU to obtain copies of the evidence in the reconsideration record. In any event, even if we had such authority, such a remand would not be appropriate under the circumstances of this case.

To begin, to the extent that claimant's arguments on review can be interpreted as contending that the ALJ erred in denying continuance or postponement of the hearing, we disagree. The ALJ has discretion to continue a hearing under certain circumstances. Former OAR 438-06-091. Incomplete case preparation is not grounds for a continuance unless the ALJ finds that the completion of the record could not be accomplished with due diligence. See former OAR 438-06-091(4). We review for abuse of discretion. See Mark G. Smith, 43 Van Natta 315 (1991).

Approximately six weeks prior to the July 19, 1995 hearing on the present claim, Senate Bill 369 was enacted. Or Laws 1995, ch 332 (SB 369). One of the statutes amended by SB 369 was ORS 656.283(7), which provides 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, 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 a worker, insurer or self-insured employer to present the reconsideration record at hearing to establish by a preponderance of that evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268." (Emphasis added).

At hearing and on review, claimant argues that either the Hearings Division or the Board should obtain the reconsideration record from the ARU for presentation at hearing. However, by the clear language of the statute, the worker, insurer, or self-insured employer is not limited in "presenting" the reconsideration record at hearing. Therefore, under the terms of the statute, it is the party asserting the right who is to "present" the reconsideration record at hearing, not the Hearings Division or the Board.

Here, there is no evidence that, during the six weeks preceding the hearing, claimant made any attempt to obtain copies of the reconsideration record from the ARU prior to the hearing. Under these circumstances, we do not consider it an abuse of discretion for the ALJ to have denied claimant's request to continue the hearing for admission of the reconsideration record. Likewise, to the extent that claimant's request can be considered as a motion to postpone the hearing, we agree that the motion should be denied due to lack of due diligence in preparing the case for hearing. See former OAR 438-06-081(4); 438-06-091(4).

Regarding claimant's request that the Board remand the claim to the ARU to obtain copies of the reconsideration record, assuming without deciding that the Board has such authority, we would find that the necessary elements to justify remand have not been met. 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). Specifically, a compelling reason must be shown to merit remand. A compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable with due diligence 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).

Here, as explained above, there is no evidence that the reconsideration record was not obtainable with due diligence at the time of hearing. In addition, claimant has made no showing that the reconsideration record is reasonably likely to affect the outcome of the case. In this regard, claimant simply asserts that it cannot be determined what evidence the ARU used in making its decisions regarding the issues on reconsideration. In the first place, we disagree with that assertion. It is apparent from explanations provided in the Order on Reconsideration that the ARU relied on the July 15, 1994 and March 20, 1995 opinions from Dr. Donovan, claimant's attending physician at claim closure.[1] (Ex. 30). However, even assuming that claimant's assertion is correct, he neither submits nor refers to any specific evidence that, if it were in the reconsideration record, might change the result. Therefore, under the facts of this case, we do not find remand appropriate, assuming without deciding that we could remand the claim to the ALJ for further remand to the ARU. Accordingly, we deny claimant's motion for remand.

ORDER

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

[1] These opinions from Dr. Donovan are admitted in the hearings record as Exhibits 14 and 28.

April 8, 1996 Cite as 48 Van Natta 763 (1996)

In the Matter of the Compensation of
DAWN N. SHOOP, Claimant
WCB Case Nos. 95-04699, 95-04698 & 94-09430
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Thaddeus J. Hettle, Defense Attorney
Robert, et al, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Liberty Northwest Insurance Corporation, on behalf of Pioneer Cut Stock (Liberty/Pioneer), requests review of those portions of Administrative Law Judge (ALJ) Daughtry's order that: (1) set aside its denial of claimant's claim for an upper extremity condition; (2) upheld the denial of Liberty Northwest/Point Adams Packing Company (Liberty/Point Adams) of claimant's claim for the same condition; and (3) upheld Crawford & Company/Del Monte's (Crawford/Del Monte) denial of claimant's 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

The ALJ found claimant's bilateral upper extremity condition compensable and assigned responsibility for that condition to Liberty/Pioneer.

On review, Liberty/Pioneer contends that Liberty/Point Adams and Crawford/Del Monte have previously accepted claimant's "underlying inflammatory condition." We disagree. We understand Liberty/Pioneer to argue that claimant's current upper extremity condition is the same as the "underlying inflammatory condition" and that the prior carriers remain responsible for that condition under ORS 656.308(1).

The record does not support a conclusion that an underlying inflammatory condition was part of either Crawford/Del Monte's or Liberty Point Adams' accepted claims. Both Liberty/Point Adams and Crawford/Del Monte issued non-specific acceptances. When an acceptance does not identify the specific condition, we look to the contemporaneous medical records to determine what condition was accepted. Timothy Hasty, 46 Van Natta 1209 (1994); Cecilia A. Wahl, 44 Van Natta 2505 (1992).

Claimant filed her claim for a left hand condition with Crawford/Del Monte in 1979. At the time that Crawford/Del Monte accepted claimant's claim, the contemporaneous medical records indicated that she was being treated by Dr. Neumann for triggering of fingers of the left hand. Ultimately, claimant was treated for triggering of the left ring, middle and index fingers. In 1983, the possibility of an atypical rheumatoid disease was investigated by Drs. Ladd and Bennett, but this possibility was never confirmed by Dr. Ladd. (Ex. 91-2). Based on the medical records contemporaneous with the 1979 claim, we conclude that the scope of Crawford/Del Monte's acceptance was limited to triggering of the left ring, middle and index fingers.

Liberty/Pioneer next argues that Crawford/Del Monte accepted the "underlying inflammatory condition" in 1983 when it accepted an aggravation claim. (Ex. 83). We disagree.

At the time of the 1983 acceptance, the physicians treating claimant found her case puzzling and were looking into the possibility of an underlying rheumatoid condition. Although it was being investigated, no rheumatoid condition diagnosis existed at the time of the 1983 acceptance. Thus, we conclude that such a condition was not a part of Crawford/Del Monte's accepted claim.

Claimant filed a claim with Liberty/Point Adams for a right wrist, arm and shoulder condition in January 1986. The claim was accepted by Liberty/Point Adams in a January 1987 stipulation. In the stipulation, Liberty/Point Adams accepted claimant's claim for "right wrist, forearm and shoulder" conditions. (Ex. 113). The contemporaneous medical records indicate that claimant's then attending physician, Dr. Scheinberg, diagnosed her condition as subacromial bursitis, adhesive capsulitis, muscle strain of the flexor tendon and bilateral carpal tunnel syndrome. (Exs. 103; 145). Claimant underwent left and right carpal tunnel releases. We rely on Dr. Scheinberg's contemporaneous chart notes to determine the scope of Liberty/Point Adams' acceptance.[1] Thus, we conclude that the conditions accepted by Liberty/Point Adams were subacromial bursitis, adhesive capsulitis, muscle strain of the flexor tendon and bilateral carpal tunnel syndrome.

Liberty/Point Adams and Crawford/Del Monte argue that claimant's current upper extremity condition is not the same as their prior accepted claims. We agree. The medical evidence establishes that claimant's current upper extremity condition is bilateral wrist strain or "overuse phenomenon." (Exs. 123c; 124-6; 131; 145). Claimant's prior accepted conditions are triggering of the left ring, middle and index fingers (claimant's accepted claim with Crawford Del Monte) and subacromial bursitis, adhesive capsulitis, muscle strain of the flexor tendon and bilateral carpal tunnel syndrome (claimant's accepted claim with Liberty/Point Adams).

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[1] Although examining physician, Dr. Button, suggested that claimant had an underlying, nonspecific soft tissue inflammatory process, we are more persuaded by the attending physician's contemporaneous chart notes which do not diagnose any underlying condition at the time of Liberty/Point Adams' acceptance.

Because claimant's current and prior accepted conditions are not the same, ORS 656.308(1) is not applicable. SAIF v. Yokum, 132 Or App 18, 23 (1994). Accordingly, we analyze this case under the last injurious exposure rule unless actual causation has been established with respect to a particular carrier. Here, based upon the persuasive medical opinion of Dr. Scheinberg, we conclude that claimant's employment at Liberty/Pioneer actually caused her bilateral wrist strain. See Eva R. Billings, 45 Van Natta 2142 (1993) (Where actual causation with respect to a specific identifiable employer is proven, it is not necessary to rely on judicially created rules of assignment pertaining to successive or concurrent employments).

The ALJ found the medical opinion of Dr. Scheinberg, claimant's prior attending physician, to be more persuasive than the opinions of examining physicians Smith and Rich and the check-the-box opinion of Dr. Jackson. We agree.

Dr. Scheinberg was claimant's attending physician at the time of her claim with Liberty/Point Adams and performed claimant's bilateral carpal tunnel releases. Dr. Scheinberg reviewed the exhibits, including the opinion of Drs. Smith and Rich, and concluded that claimant's complaints related to her work at Liberty/Pioneer were a new independent condition of bilateral wrist strain which was not merely a continuation claimant's symptoms from her accepted claim with Liberty/Point Adams. Dr. Scheinberg opined that the major contributing cause of the bilateral wrist strain condition was claimant's work at Liberty/Pioneer. Dr. Scheinberg noted that claimant had not had significant trouble with her upper extremities and did not necessitate treatment for a number of years prior to her work at Pioneer in spite of working in a cannery, in a laundry and pruning blueberry bushes.

Examining physicians Rich and Smith diagnosed claimant's condition as overuse phenomenon in both wrists. Drs. Rich and Smith opined that claimant's symptoms represented a waxing and waning of her prior condition rather than a new injury. Dr. Jackson, attending physician, signed a check-the-box form indicating that he concurred with the report of Drs. Rich and Smith.

We find Dr. Scheinberg's opinion more persuasive than the opinions of Drs. Rich and Smith who only examined claimant on one occasion and who are not as familiar with claimant's prior compensable condition as Dr. Scheinberg. Scheinberg treated claimant for her claim with Liberty/Point Adams and performed claimant's carpal tunnel releases. Although Scheinberg did not recently examine claimant, he reviewed the medical record and is familiar with claimant's prior compensable conditions.

We likewise find Dr. Scheinberg's opinion more persuasive than that of Dr. Jackson who offered only a conclusory check-the-box concurrence. Dr. Jackson only saw claimant twice and is less familiar with claimant's previous compensable conditions than is Dr. Scheinberg. Under these circumstances, we find Dr. Scheinberg's opinion to be more persuasive than those of the other experts.

Liberty/Pioneer argues that Dr. Scheinberg had an incorrect history that claimant's symptoms came on rapidly after lifting "30 to 40 pounds" on a repetitive basis. Liberty/Pioneer asserts that this history is incorrect since the pieces of wood claimant lifted weighed less than a pound a piece. However, Dr. Scheinberg's history is the same history recorded by Drs. Rich and Smith who examined claimant on behalf of Liberty/Pioneer. In addition, the record suggests that claimant stacked the wood and lifted the stack, so that she was lifting more than an individual piece of wood. (Tr. 49). Based on this record, we believe that Dr. Scheinberg was in a better position than the other physicians to give an opinion concerning claimant's condition. Accordingly, based on the persuasive opinion of Dr. Scheinberg, we conclude that claimant's work activities at Pioneer actually caused her bilateral wrist strain.

Alternatively, applying the last injurious exposure rule, we still conclude that Liberty/Pioneer is responsible for claimant's upper extremity condition. Under that rule, claimant's disability due to the bilateral wrist strain occurred while Liberty/Pioneer was on the risk. Therefore, responsibility is initially placed with Pioneer. In order to shift responsibility back to one of the prior carriers, Liberty/Pioneer would have to prove that claimant's work exposure at Liberty/Point Adams was the sole cause of claimant's upper extremity condition or that it was impossible for conditions while Liberty/Pioneer to have caused the condition. FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985). Based on Dr. Scheinberg's persuasive opinion, we conclude that Pioneer has not shown that claimant's work at Del Monte or Point Adams was the sole cause of her condition or that claimant's work activities at Pioneer could not have caused the condition. Accordingly, responsibility for claimant's upper extremity condition remains with Pioneer.

Finally, even assuming that claimant's current upper extremity condition is the same condition previously accepted by Del Monte or Point Adams, we would conclude, for the reasons given by the ALJ, that claimant sustained a new compensable injury at Pioneer and that responsibility shifts to Pioneer under ORS 656.308(1).

Claimant's attorney is entitled to an assessed fee for services on review. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by Liberty Northwest on behalf of Pioneer Cut Stock. 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 11, 1995 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by Liberty Northwest, on behalf of Pioneer Cut Stock.

In the Matter of the Compensation of
CHARLES V. CLEWELL, Claimant
WCB Case Nos. 95-02584 & 94-10476
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Lundeen, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

Liberty Northwest Insurance Corporation requests review of Administrative Law Judge (ALJ) Baker's order that: (1) set aside its compensability and responsibility denials of claimant's claim for his current low back condition; and (2) upheld the SAIF Corporation's denial of claimant's "new injury" claim for the same condition. On review, the issues are compensability and responsibility. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. We do not adopt his "Ultimate Findings."

CONCLUSIONS OF LAW AND OPINION

Compensability

Because compensability of his current condition has been denied, claimant must establish compensability as a threshold issue, prior to a determination of responsibility. Additionally, because claimant has a prior low back injury, a degenerative condition and an intervening motor vehicle accident injury involving his low back, the issue of medical causation is a complex question requiring expert medical opinion. Kassahn v. Publishers Paper Co., 76 Or App 105 (1985), rev den 300 Or 546 (1986). For the following reasons, we conclude that claimant has failed to establish compensability of his current low back condition, either under a standard of "major" or "material" cause.

The ALJ found that, although claimant's treating doctor, Dr. Bert, took a history of an on-the-job injury in April 1994, while claimant was working for SAIF's insured, the accuracy of the "history has not been established by a preponderance of credible evidence." We agree that the record does not establish that claimant sustained a slip and fall injury in April 1994.

At hearing, claimant testified that in April 1994, a day after beginning work for Compco (SAIF's insured), he slipped and fell on a log. Claimant testified that he was unable to work and he told the rigging slinger about his injury. Claimant testified that he also told two others, "Bud" and "Kenney," about his injury. Finally, claimant testified that he made an appointment with Dr. Bert after the injury, but he did not see him for approximately 40 days after the incident. Claimant testified that, for three weeks after the incident, he was off his feet and unable to work.

Mr. Younkers, the rigging slinger who was working with claimant at the time, testified that he did not see claimant fall, and claimant never mentioned a fall to him. Rather, Mr. Younkers testified that claimant stated that he was not going to be able to take that kind of work, and claimant walked off the job.

Bud Compton, the owner of CompCo, testified that after claimant walked off the job, he gave him an hour's pay. Mr. Compton testified that claimant stated that his back was sore, due to a car accident and fusion surgery. Mr. Compton further testified that he asked claimant several times if he had injured his back on the job, and claimant specifically said "no."

Finally, Ken Sharp testified that he was working on the crew with claimant on the day that claimant allegedly injured himself. Mr. Sharp testified that claimant stated that he was unable to do the work and did not want to risk hurting his back. Mr. Sharp also heard claimant tell Bud Compton that he had not injured his back at work that day.

After considering the testimony at hearing, we agree with the ALJ that claimant has not established that he injured himself on the job while working for SAIF's insured in April 1994. Specifically, we find that the preponderance of the evidence, including the consistent testimony of three different individuals who were present at the worksite, establishes that claimant left work because he felt that he was unable to perform the work, not because he slipped and fell on a log that day.

Consequently, because claimant gave a history of a slip and fall incident to both Dr. Bert, and to the Medical Consultants, we conclude that none of the doctors in this case have an accurate medical history. Miller v. Granite Construction Co., 28 Or App 473 (1977)(In order to be persuasive, a medical opinion must be based on an accurate history).

Specifically, in deposition, Dr. Bert stated that claimant's current condition was related to the 1986 injury and exacerbated by the April 1994 injury. However, Dr. Bert testified that his opinion was based on claimant's history, and "[i]f the history is in error....in any way, that would alter my opinion as to causation and in the absence of any history of an injury, I would have to assume that his pain or pain behavior was either real and related to ongoing degeneration of the disks or drug seeking behavior." (Tr. 34).

Accordingly, we construe Dr. Bert's testimony to mean that, unless claimant had provided an accurate history, Dr. Bert could not render an opinion with respect to causation. Therefore, because we have agreed with the ALJ's conclusion that there was no April 1994 work injury, we conclude that neither Dr. Bert nor the Medical Consultants had an accurate medical history. Consequently, we conclude that claimant has failed to prove causation, and we reverse the ALJ's decision on the issue of compensability.

Responsibility

As claimant has failed to prove the compensability of his current condition, the issue of responsibility is moot.

ORDER

The ALJ's order dated October 27, 1995 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside Liberty Northwest Insurance Corporation's denials of compensability and responsibility are reversed. Liberty's denials are reinstated and unpheld. The ALJ's attorney fee award of $3,000 is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Gunn dissenting.

For the following reasons, I respectfully dissent from the majority's decision with respect to the issue of compensability. Dr. Bert, who performed claimant's laminectomy and fusion following the 1986 industrial accident, opined that the 1986 injury and the subsequent fusion accelerated degenerative changes in claimant's lumbar spine. (Ex. 35). Dr. Bert also testified that the major contributing cause of claimant's current condition was the 1986 injury, with the increase in symptomatology more related to the 1994 accident and claimant's motor vehicle accident of October 31, 1994.

Consequently, even when claimant's motor vehicle accident and the 1994 incident are considered, claimant has established a compensable aggravation of his accepted 1986 injury. Therefore, based on Dr. Bert's opinion which found a worsening of the degenerative condition attributable to the 1986 compensable injury and the subsequent fusion surgery, I would find that claimant has proven a compensable aggravation.

April 9, 1996 Cite as 48 Van Natta 768 (1996)

In the Matter of the Compensation of
SHARMAN R. CROWELL, Claimant
WCB Case No. 93-13236
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

This case is before the Board on remand from the Court of Appeals. Viking Industries, Inc. v. Crowell, 138 Or App 703 (1996). The court has reversed our order in Sharman R. Crowell, 46 Van Natta 1728 (1994), in which we affirmed an Administrative Law Judge's order that set aside a Determination Order's classification of claimant's injury claim as nondisabling. The court has remanded for reconsideration in light of the 1995 amendments to ORS 656.005(7) and ORS 656.212. In accordance with the court's instructions, we now proceed with our reconsideration.

FINDINGS OF FACT

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

CONCLUSION OF LAW AND OPINION

We briefly recite the factual background from our prior order. Claimant, a vinyl frame welder, suffered a compensable left shoulder and right elbow injury on October 21, 1992. Dr. Barnhouse, her attending physician, released claimant for modified work that involved minimal repetitive bending of the right elbow and minimal work at or above the left shoulder level. Claimant later was restricted to lifting no more than 20 pounds.

Since claimant was not able to perform her regular work with the above restrictions, the employer assigned claimant to a light-duty job putting scotch-tape on parts. Claimant was paid her regular wage and incurred no time loss because of the compensable injury. The employer customarily assigned workers on light duty to do claimant's modified work, but regular workers would do the job if no workers on light duty were available.

On April 14, 1993, the insurer accepted the claim as "nondisabling." Dr. Barnhouse subsequently released claimant for regular work and stated that she would have no permanent impairment. (Exs. 9, 15). On November 3, 1993, in response to claimant's request for reclassification, a Determination Order ordered that the claim remain classified as nondisabling.

Citing Stone v. Whittier Wood Products, 124 Or App 117 (1993), the ALJ concluded that the claim was properly classified as disabling because the injury entitled claimant to temporary disability, but for the employer's ability to accommodate her disability. We affirmed, citing our decisions in Kenneth W. Metzker, 45 Van Natta 1631 (1993), and Valorie L. Leslie, 45 Van Natta 929 (1993), rev'd on other grounds Leslie v. U. S. Bancorp, 129 Or App 1 (1994). We noted that claimant was restricted to modified work, although at her pre-injury wage. We reasoned that, even though her rate of TPD may be zero, the mere fact that claimant was required by the compensable injury to work at modified employment meant that she was temporarily and partially disabled.

The court has now reversed our order and remanded for reconsideration in light of amended ORS 656.005(7) and ORS 656.212. Having summarized the factual background and procedural posture of this case, we now begin our reconsideration.

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." Therefore, in order for a claim to be disabling, there must be temporary disability benefits "due and payable" or a reasonable expectation of permanent disability. Karren S. Maldonado, 47 Van Natta 1535 (1995).

Although claimant was on modified employment, no temporary disability benefits were due and payable, inasmuch as claimant was receiving her regular wages. Moreover, claimant's treating physician, Dr. Barnhouse, stated that she would have no permanent impairment. The record does not establish a reasonable expectation of permanent disability. Under these circumstances, the claim properly is classified as nondisabling. ORS 656.005(7)(c); Janice K. Ott-Pettry, 48 Van Natta 525 (1996). Accordingly, we reverse the ALJ's decision that reclassified the claim as disabling.

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, be prevented from establishing a disabling claim. We recently rejected precisely that constitutional argument in Janice K. Ott-Pettry, supra. We decline to depart from that reasoning in this case.

Claimant alternatively argues that, if the new law applies, the case should be remanded. According to claimant, 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 expectation of permanent disability," claimant asserts that the claim should be remanded to the Hearings Division for the taking of additional evidence regarding the "reasonable expectation" standard.

We rejected a similar argument in Janice K. Ott-Pettry, supra, and do so again in this case. As previously noted, Dr. Barnhouse opined that claimant would have no permanent impairment. In light of this opinion, we conclude that the record is sufficiently developed with respect to the "reasonable expectation" standard. See ORS 656.295(5); Clifford E. Clark, 47 Van Natta 2310, 2312 (1995). Consequently, we decline to remand for further proceedings.

On reconsideration, the ALJ's order dated February 10, 1994 is reversed. The November 3, 1993 Determination Order's classification of this claim as "nondisabling" is affirmed.

IT IS SO ORDERED

April 9, 1996 Cite as 48 Van Natta 769 (1996)

In the Matter of the Compensation of
JOHN H. DAVILA, Claimant
WCB Case No. 95-00590
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Brian Pocock, Defense Attorney

Reviewed by Board Members Gunn and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Black's order which upheld the self-insured employer's January 6, 1995 denial, as amended on February 14, 1995, of claimant's occupational disease claims for bilateral carpal tunnel syndrome and left wrist strain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact." We do not adopt the ALJ's "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Claimant seeks compensation for his bilateral carpal tunnel syndrome (CTS) and left wrist strain. The ALJ found that claimant's current condition involves a preexisting condition (i.e. slow nerve conduction velocities (NCV's) resulting from alleged predisposed risk factors). As such, the ALJ concluded that claimant failed to prove that his work was the major contributing cause of the combined condition and pathological worsening of the disease. ORS 656.802(2)(b).

On review, claimant asserts that the opinions from treating physicians, Drs. Panum and Matteri, are sufficient to prove compensability. We agree.

Initially, our inquiry is whether the "risk factors" which Dr. Radecki identified are preexisting conditions which may have combined to cause claimant's current condition. Under ORS 656.802(2)(c), occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7). 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."

Moreover, ORS 656.005(24), which was added to the workers' compensation law by Oregon Law 1995, ch 335, § 1, defines "preexisting condition" as "any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease."

Here, Dr. Radecki has identified four noncompensable risk factors that he believed predisposed claimant to CTS: obesity, increased wrist ratio, age, and heredity. Assuming without so deciding that these "risk factors" constitute preexisting conditions, our first inquiry is whether any of these conditions combined with claimant's CTS to cause or prolong disability or a need for treatment and our second inquiry is whether claimant's work conditions are the major contributing cause of his current CTS. After our de novo review of the record, we conclude that none of the specified conditions combined with claimant's CTS to cause or prolong his disability or need for treatment and that his work activities are the major contributing cause of his condition. See Beth D. Moore, 47 Van Natta 2178 (1995).

Dr. Panum, initial treating physician, indicated that claimant's work was the major contributing cause of his carpal tunnel syndrome. (Exs. 9A). Dr. Panum had a complete history of claimant's work activities (i.e. jackhammer work, shoveling, hammering, grasping with his hands). (Ex. 8). Dr. Panum disagreed with Dr. Radecki's findings. Specifically, Dr. Panum stated that while claimant's "risk factors" may predispose claimant to CTS, all of these "risk factors" did not equal the major cause of claimant's CTS. (Ex. 9A).

Dr. Matteri, treating surgeon, diagnosed claimant's condition as bilateral CTS. (Ex. 11B). Dr. Matteri opined that the cause of claimant's CTS was his work. (Ex. 16A; 19). Dr. Matteri rebutted Dr. Radecki's opinion that claimant's CTS was the result of predisposed factors. Dr. Matteri explained that, while some people may have a tendency to develop CTS, the question that should be addressed is what was the cause of claimant's CTS (not whether claimant had a tendency to develop CTS). Id.

Dr. Radecki, who evaluated claimant at the employer's request, diagnosed bilateral median nerve slowing in claimant's carpal tunnel. Dr. Radecki attributed claimant's condition to age, obesity, increased wrist ratio and heredity. (Ex. 9). Dr. Radecki also indicated that claimant's work as a driver would require usage of both of his hands in an equal manner. However, because claimant's NCV's were asymmetrical, Dr. Radecki stated that this further supported a finding that claimant's non-work factors were the cause of claimant's current condition. Id.

Dr. Jewell reviewed the medical records at the employer's request, and opined that claimant's work activities were not the major contributing cause of the carpal tunnel syndrome. He stated that while claimant's work can contribute to symptomatology, it did not cause claimant's underlying process. (Ex. 17).

We generally defer to the opinion of an injured worker's treating physician, absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983). In this case, we find no such reasons to discount the opinion of claimant's treating physician, Dr. Matteri, who opined that claimant's CTS was caused by claimant's work. Dr. Matteri persuasively addressed the opinion of Dr. Radecki, stating that while claimant may have a certain predisposition to develop CTS, the cause of claimant's CTS was his work.[1] Further, as claimant's treating surgeon, Dr. Matteri had an advantageous position to determine the cause of claimant's condition. Because of this advantageous position, we give significant probative value to Dr. Matteri's opinion. Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988).

Finally, we also find Dr. Panum's opinion persuasive because it is well reasoned and based on an accurate history. Somers v. SAIF, 77 Or App 259 (1986). For instance, Dr. Panum had a complete history of claimant's work activities and treated claimant on several occasions. Additionally, Dr. Panum addressed Dr. Radecki's opinion, stating that while claimant's "risk factors" may predispose claimant to CTS, they were not the major cause of claimant's CTS. Accordingly, we conclude that the major contributing cause of claimant's current condition was his work activities. ORS 656.802(2)(a). Consequently, we set aside the employer's denials.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated September 15, 1995 is reversed. The self-insured employer's January 6, 1995 denial as amended on February 14, 1995, is set aside and the claim remanded to the employer for processing according to law. Claimant's attorney is awarded an attorney fee of $3,500 for services at hearing and on review, to be paid by the employer.

[1] The employer alleges that Dr. Matteri's opinion focused on the "causation of symptoms" rather than the underlying condition. We note that Dr. Matteri had an accurate history regarding claimant's employment activities. Dr. Matteri opined that claimant's condition was carpal tunnel syndrome. Accordingly, we conclude that when read in its entirety, Dr. Matteri's opinion establishes that claimant's work was the major contributing cause of claimant's condition.

April 9, 1996 Cite as 48 Van Natta 771 (1996)

In the Matter of the Compensation of
JAMES F. FOWLKES, Claimant
WCB Case No. 94-02953
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order that: (1) declined to award temporary total disability benefits beginning February 1, 1993, the date of claimant's early retirement; and (2) declined to assess penalties and attorney fees for the self-insured employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are entitlement to temporary disability benefits, penalties and attorney fees.

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

Claimant initially sought treatment in early April 1992 for depression and anxiety after a co-worker accused him of sexual harassment.[1] He was diagnosed with major depressive disorder and

[1] The employer was unable to verify the co-worker's complaint, and no discipline resulted from the alleged incident.

released from work from March 31, 1992 until April 14, 1992. Claimant returned to regular employment on April 14, 1992. The employer accepted claimant's claim for disabling "anxiety reaction" on August 21, 1992.

In January 1993, in anticipation of a pending reduction in force, the employer offered voluntary early retirement to employees with sufficient seniority. Claimant elected to take early retirement, effective February 1, 1993.

In December 1993, claimant again sought treatment for depression. On February 14, 1994, the employer issued an amended Notice of Acceptance, accepting disabling "major depression."

In March 1994, claimant sought treatment from his regular physician, Dr. Reynolds. On May 25, 1994, Dr. Reynolds opined that it was appropriate for claimant to leave work in February 1993 and that it was medically contraindicated for him to remain in such an environment due to his psychological condition.

In June 1994, claimant sought treatment with Dr. Phillips, a psychiatrist. On January 31, 1995, Dr. Phillips authorized time loss and agreed that it would have been medically contraindicated for claimant to return to his prior employment. When the employer did not pay temporary disability, claimant requested a hearing.

The ALJ found that, because of their conclusory nature and inaccurate histories, the opinions of claimant's treating doctors were not persuasive evidence that claimant was disabled and unable to work as a result of his compensable condition. The ALJ discounted Dr. Reynolds' report because it assumed that claimant was subjected to a hostile work environment when he returned to work in 1992, which assumption was not supported by the record. The ALJ faulted Dr. Phillips' report because it erroneously assumed, among other things, that the allegation of harassment and claimant's early retirement were closely linked in time.

On review, claimant argues that his voluntary withdrawal from the work force does not affect his entitlement to benefits under his accepted claim (which has never been closed) and that the opinions of Drs. Reynolds and Phillips are sufficient to reinstate his right to temporary total disability compensation. Claimant also argues that SB 369 has not altered his entitlement to time loss benefits. We disagree with both contentions.

Like the ALJ, we are not persuaded that claimant's current disability arose prior to his voluntary withdrawal from the work place or that his retirement was causally related to his compensable condition. Although claimant was disabled for two weeks in April 1992 as a result of his compensable condition, the record establishes that he was released by his then-treating doctor and returned to his regular employment without further incident or complaint until his voluntary retirement on February 1, 1993. The record does not show that he accepted the employer's offer of early retirement because he again became disabled.[2] To the contrary, claimant's supervisor testified that claimant's job performance remained consistent until his retirement.

In addition, we find the retrospective time loss authorizations of Drs. Reynolds and Phillips unpersuasive because neither physician had the opportunity to evaluate claimant at the pertinent time, i.e., contemporaneous with his retirement.[3] The physicians who did treat claimant several months

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[2] For this reason, this case is distinguishable from Weyerhaeuser Co. v. Kepford, 100 Or App 410 (1990), where the court held that entitlement to temporary disability benefits does not depend on whether a claimant has withdrawn from the workforce if the claimant's disability arose before the withdrawal. In Kepford, the claimant had been off work due to his compensable injury at the time he withdrew from the workforce. Here, on the other hand, although his claim remained in open status, claimant was not disabled at the time he voluntarily retired. When he again became disabled, claimant was not working for reasons unrelated to his compensable condition. Cf. Dean L. Watkins, 48 Van Natta 60 (1996) (although the claimant had been previously denied temporary disability based on a finding that he had voluntarily withdrawn from the workforce, he was later entitled to temporary disability benefits because, while his claim remained open, he had reentered the workforce and then later became disabled due to surgery for his compensable injury).

[3] Dr. Reynolds first saw claimant for depression in March 1994, more than a year after he had withdrawn from the work force. Dr. Phillips first saw claimant in June 1994.

before his retirement found him capable of employment despite his compensable condition. We therefore agree with the ALJ that claimant has not established that he is disabled as a result of his accepted condition.

Finally, we note that even assuming claimant had established his entitlement to temporary disability benefits (which he has not), the authorizations of Drs. Reynolds and Phillips would not be effective to retroactively authorize the payment of time loss benefits from the date of claimant's February 1, 1993 retirement because amended ORS 656.262(4)(f) (1995 Or Laws, ch 332 § 28 (SB 369, § 28)) limits the effectiveness of retrospective time loss authorizations to no more than 14 days prior to their issuance. See Delores L. Holmes, 47 Van Natta 2359 (1995) (holding amended ORS 656.262(4)(f) applies retroactively to all claims of causes of actions existing or arising after the effective date of SB 369).

ORDER

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

April 9, 1996 Cite as 48 Van Natta 773 (1996)

In the Matter of the Compensation of
RONALD L. FRENCH, Claimant
WCB Case No. 95-09144
ORDER ON REVIEW
Bischoff, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that declined to award a penalty or attorney fee for an allegedly unreasonable delay of claim closure. On review, the issues are jurisdiction and, potentially, penalties and attorney fees. We vacate the ALJ's order and dismiss claimant's hearing request.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

A September 1995 Determination Order awarded permanent disability totaling approximately $15,000. After deducting an overpayment of approximately $9,000, the insurer paid claimant the balance of the award.

Claimant filed a request for hearing, asserting that he was entitled to penalties and attorney fees for the insurer's unreasonable delay in closing the claim. Claimant asserted that the "amounts then due" upon which to base the penalty should be the entire award of permanent disability provided by the Determination Order. The ALJ disagreed, finding that the "net effect of insurer's conduct is that claimant received in advance the major portion of his permanent disability compensation."

We first note that neither the parties nor the ALJ cite to the specific statute at issue in this case. Because the central issue, however, apparently is whether there are "amounts then due" to assess a penalty, we understand claimant's request for hearing as based on ORS 656.262(11)(a).[1]

Under that statute, "the director shall have exclusive jurisdiction over proceedings regarding solely the assessment and payment of the additional amount described in this subsection." When the

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[1] ORS 656.382(1) is the only other statute providing an award for a carrier's unreasonable refusal or delay of payment of compensation. Unlike ORS 656.262(11)(a), however, the statute does not require "amounts then due." Thus, we find it more reasonable in construing claimant's position as based on ORS 656.262(11)(a) rather than solely ORS 656.382(1).

claimant makes a viable request for a penalty under ORS 656.262(11)(a), and the unreasonable conduct that supports the penalty is the sole issue, the Director has exclusive jurisdiction. Corona v. Pacific Resource Recycling, 125 Or App 47, 51 (1993). This result does not change if the claimant also asserts entitlement to an attorney fee under ORS 656.382(1) if the misconduct asserted in support of the attorney fee is identical to the misconduct asserted in support of the penalty. Id. at 51-52.

Here, claimant argues that the insurer unreasonably delayed claim closure; that is the only misconduct alleged by claimant. As discussed above, because we also understand claimant as basing his entitlement to a penalty on ORS 656.262(11)(a), exclusive jurisdiction of this matter is with the Director, whether or not claimant also is asserting an attorney fee under ORS 656.382(1). Corona v. Pacific Resource Recycling, supra. Thus, we dismiss claimant's request for hearing.

ORDER

The ALJ's order dated December 1, 1995 is vacated. Claimant's request for hearing is dismissed.

April 9, 1996 Cite as 48 Van Natta 774 (1996)

In the Matter of the Compensation of
DANNY R. FULLER, Claimant
WCB Case No. 93-12935
ORDER ON RECONSIDERATION
Schneider, Hooton, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On March 1, 1996, we withdrew our February 2, 1996 Order on Review that reversed an Administrative Law Judge's (ALJ's) order which: (1) set aside the insurer's denial of claimant's aggravation/current condition claim for an upper neck condition; (2) set aside the insurer's partial denial of claimant's rights shoulder impingement syndrome; and (3) assessed a penalty for an allegedly unreasonable denial. We took this action to consider claimant's motion for reconsideration. Having received the insurer's response, we proceed with our reconsideration.

In our prior order, we found that the insurer's payment of permanent disability benefits for claimant's surgery and foraminal stenosis did not preclude the insurer from contesting the compensability of claimant's foraminal stenosis. Craig L. Hiatt, 47 Van Natta 2287 (1995). However, in that order we did not address whether claimant's disputed foraminal stenosis C5-6 condition was compensably related to claimant's accepted cervical strain.

On reconsideration, claimant contends that his degenerative process at C5-6 is compensable. Specifically, claimant relies on Dr. Waller's opinion that a material contributing cause of claimant's degenerative process was a C5-6 disc herniation. Based on the following reasoning, we conclude that claimant has not established the compensability of his current degenerative condition.

In June 1990, Dr. Waller performed cervical surgery, believing that claimant had a disc herniation at C5-6. However, Dr. Waller's post-surgical finding was a bone spur which caused right C5-6 foraminal stenosis (i.e. narrowing the entrance into the intervertebral foramen causing compression of C6 nerve root). (Ex. 8). At deposition, Dr. Waller stated that claimant's bone spur was not directly due to claimant's work accident. (Ex. 44-6). Rather, Dr. Waller stated that bone spurs are degenerative processes which can result from disc herniations.

As such, we find no direct relationship between claimant's work injury and his foraminal stenosis condition. However, based on Dr. Waller's opinion, claimant contends that his degenerative process was a consequence of the C5-6 disc herniation. Therefore, assuming that the C5-6 disc herniation was a compensable condition, claimant would need to prove that the major contributing cause of his degenerative process was the disc herniation at C5-6. 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).

Here, the record establishes that claimant's injury claim was accepted as a cervical strain. There is no persuasive evidence in the record to support a finding that the insurer has accepted a claim for C5-6 disc herniation. Therefore, any condition (i.e. degenerative process) which may have arisen from the disc herniation would not be compensable unless claimant establishes that the alleged herniation was due to his work accident or the accepted strain. The medical evidence does not establish a causal relationship between either claimant's work or his accepted strain and the alleged disc herniation.

In any event, assuming claimant's disc herniation was accepted, there is no persuasive medical evidence which supports a finding that claimant's disc herniation was the major contributing cause of his degenerative process at C5-6. Although Dr. Waller believed that a material contributing cause of claimant's degenerative process was the disc herniation at C5-6, it fails to satisfy claimant's requisite burden of proof.

Impingement Syndrome

In our previous order, we did not find persuasive the opinion of Dr. Gerry because it was inconsistent and offered no explanation for the inconsistency. Specifically, we found that Dr. Gerry initially believed that claimant's work was a possible cause of his impingement syndrome. However, without explanation, Dr. Gerry changed his opinion believing that claimant's work injury probably caused his impingement syndrome.

On reconsideration, claimant contends that Dr. Gerry, who is an expert in the diagnosis of impingement syndrome, offered a consistent opinion which was thoroughly challenged at deposition. As such, according to claimant, the opinion of Dr. Gerry supports the compensability of claimant's impingement syndrome. We continue to adhere to the reasoning in our previous order. In addition, we offer the following supplementation.

At deposition, Dr. Gerry stated that claimant's symptoms in May 1990 were consistent with either cervical radiculopathy or an impingement syndrome. (Ex. 51-29). As such, Dr. Gerry opined that he was unable to determine if claimant's condition at that time was a cervical radiculopathy or an impingement syndrome because the symptomatology would be similar for both conditions. (Ex. 51-24). Additionally, based on a temporal relationship that claimant did not experience pain in his shoulder before the February 1990 accident, Dr. Gerry agreed that it was medically probable that claimant's impingement syndrome was related to claimant's work incident. (Ex. 51-27, 65).

Dr. Gerry stated that a disc herniation at C5-6 and impingement syndrome elicit similar symptoms. Because of this similarity, Dr. Gerry opined that he was unable to determine if claimant's condition in 1990 was a cervical radiculopathy or an impingement syndrome. Therefore, Dr. Gerry stated that his opinion relating claimant's impingement syndrome to claimant's work accident was based on a temporal relationship. Such reasoning, based almost entirely on a temporal relationship between the onset of symptoms and claimant's work accident, is not persuasive. See Allie v. SAIF, 79 Or App 284, 288 (1986). In addition, Dr. Gerry related claimant's symptoms to a C5-6 disc herniation, a condition which we have found not to be compensable.

Under such circumstances, we decline to find persuasive the opinion of Dr. Gerry. Therefore, because we find no other persuasive evidence which supports the compensability of claimant's impingement syndrome, we reinstate and uphold the insurer's denial.

In conclusion, on reconsideration, as supplemented herein, we republish our February 2, 1996 order in its entirety, subject to the following correction. Our February 2, 1996 order is corrected to state that Liberty Northwest Insurance Corporation's denial of October 22, 1993 is reinstated and upheld.

IT IS SO ORDERED.

In the Matter of the Compensation of
JULIE A. GARCIA, Claimant
WCB Case No. 94-14967
ORDER ON REVIEW
John M. Hoadley, Claimant Attorney
Roy W. Miller (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Galton's order which upheld the SAIF Corporation's denial of her right ankle injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant worked as a residential staff person in a group home for adults with chronic mental illness. On September 18, 1993, claimant, a co-worker, and her supervisor participated in a skydive. On her second dive, claimant broke her ankle.

The employer did not sponsor the skydiving outing. Rather, a co-worker, Ms. Moore, originated the idea and encouraged other co-workers to participate. Participation was voluntary.

The activity did not occur on the employer's premises, or on a day that claimant was scheduled to work.

CONCLUSIONS OF LAW AND OPINION

Claimant contends that she participated in the skydiving as an employer-sponsored "team building activity" to reduce the great amount of stress employees in her position experience while caring for their patients. Thus, claimant argues that she did not skydive primarily for her personal pleasure. See ORS 656.005(7)(b)(B). The ALJ found that claimant had engaged in her second dive primarily for her own personal pleasure. The ALJ reasoned that, if claimant had injured her ankle on her first jump, her claim would have been compensable. In light of this reasoning, the ALJ found the injury not compensable. We agree with the ALJ's ultimate conclusion, but for the following reasons.

ORS 656.005(7) defines a "compensable injury" as an accidental injury arising out of and in the course of employment. It does not include, however, any injury incurred while engaging in recreational activity primarily for the worker's personal pleasure. ORS 656.005(7)(b)(B); Michael W. Hardenbrook, 44 Van Natta 529, aff'd mem Hardenbrook v. Liberty Northwest Insurance Corporation, 117 Or App 543 (1992). The statute excludes certain activities from the definition of compensable injury. However, the statute does not automatically exclude those recreational activities that have a close work nexus and are not performed "primarily" for the worker's personal pleasure. See Ester E. Edwards, 44 Van Natta 1065 (1992), aff'd mem Liberty Northwest Insurance Corporation v. Edwards, 118 Or App 748 (1993) (knee injury incurred during an employer-sponsored volleyball game found compensable, where primary purpose of recreational activity was to enhance interoffice working relationships). Nevertheless, in order to constitute a benefit to the employer the benefit must be beyond an improvement in employee health and morale. Elias Gonzalez, 46 Van Natta 439 (1994); Steven M. Chambers, 42 Van Natta 2600 (1990).

Here, claimant's supervisor testified that management personnel of the group home was not involved in the planning of the activity, and that management did not "give their backing to the project." (Tr. II [April 13, 1995], 5). Ms. Moore, the co-worker who originated the skydiving idea, testified that she was not directed by management to organize the outing. (Tr. I [March 7, 1995], 97). Rather, participation in the skydiving was a "personal thing," and the employer did not encourage employees to go "from a business standpoint." (Tr. I, 98).

Only three people, less than half of the employees, participated in the activity. All the employees but claimant believed that the skydiving activity was optional. (Tr. I, 68, 84, 98, 104.) Furthermore, the employees who participated were required to pay their own way. The employees were not paid by the employer for the time spent at the activity. (Tr. I, 98). On these facts, we conclude that this recreational activity did not have a close work nexus and was performed "primarily" for claimant's personal pleasure.

Moreover, the Court of Appeals has 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) is 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, for the reasons we found the activity a noncompensable recreational activity, we likewise find it unrelated to work under the Norpac Foods' analysis. Consequently, we find that the risk of injury from participating in skydiving 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 May 5, 1995 is affirmed.

April 9, 1996 Cite as 48 Van Natta 777 (1996)

In the Matter of the Compensation of
BEVERLY A. GREATHOUSE, Claimant
WCB Case Nos. 95-03324 & 94-14538
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
William J. Blitz, Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order which upheld Liberty Northwest's denial of claimant's aggravation claim for bilateral knee condition. On review, the issue is aggravation.

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

Relying on the opinion of Dr. Webb, treating physician, the ALJ found no evidence of an actual worsening of claimant's compensable condition. Specifically, Dr. Webb opined that claimant's reduced range of motion in her knees were not indicative of a worsening of claimant's compensable condition.

On review, claimant contends that her reduced range of motion in both knees establishes an actual worsening of her condition. As such, according to claimant, the insurer's aggravation denial should be set aside.

To establish a compensable aggravation, claimant must show an actual worsening resulting from the original injury. ORS 656.273(1); Gloria T. Olson, 47 Van Natta 2348 (1995). An aggravation has two components: causation and actual worsening. 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.

Dr. Webb, responding to a letter from claimant's attorney, stated that the major cause of claimant's current condition was her injury in August 1990. (Ex. 16). However, Dr. Webb believed that claimant's reduced range of motion (when comparing range of motion findings taken in 1990 with Dr. Webb's measurements in 1994) in her knees was not indicative of a worsening of claimant's condition. (Ex. 16).

Here, we find that claimant has failed to prove that her compensable condition has actually worsened. Although claimant's range of motion findings are reduced, we rely on Dr. Webb's opinion that such reduced findings do not indicate a worsening of claimant's underlying condition. See Kelly O. Sullivan, 46 Van Natta 2144 (1994) (aggravation claim not established where the claimant's physician failed to indicate that the compensable condition worsened although the claimant had decreased range of motion findings). Accordingly, we conclude that claimant has failed to prove an aggravation of her compensable condition. Consequently, the ALJ's order is affirmed.

ORDER

The ALJ's order dated October 25, 1995, as amended November 7, 1995, is affirmed.

April 9, 1996 Cite as 48 Van Natta 778 (1996)

In the Matter of the Compensation of
DENNIS L. KELLER, Claimant
WCB Case Nos. 93-11978 & 93-07002
ORDER ON REMAND
Welch, Bruun, et al, Claimant Attorneys
Larry D. Schlecht (Saif), Defense Attorney
Scheminske, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. In our prior order, we held that the SAIF Corporation was barred by claim preclusion from denying that claimant's degenerative spinal condition was part of his 1980 accepted claim with SAIF, and that SAIF was responsible for that condition. Dennis L. Keller, 47 Van Natta 734 (1995). Citing Cabex Mills, Inc. v. Duval, 137 Or App 525 (1995), the court has remanded the case for reconsideration.

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 back in August 1980, while he was working for SAIF's insured. (Ex. 1). On September 3, 1980, SAIF issued a Notice of Claim Acceptance that identified claimant's injury by an unexplained code; it did not specify which condition was being accepted. (Ex. 4). The claim was eventually closed in 1986. Meanwhile, claimant's degenerative spinal condition manifested itself.

In 1991, claimant sustained a nondisabling low back and right leg injury while working for Standard Fire Insurance Company's (Standard's)[1] insured. Claimant again sought treatment in 1993 for low back and right leg symptoms. His diagnoses included recurrent back pain, muscle strain, chronic mild lumbar subluxation sprain and sprain complex, and degenerative spinal disease. (E.g., Exs. 84, 86, 89, 92, 106, 109, 110). SAIF denied the compensability of and responsibility for claimant's 1993 condition; Standard denied responsibility for that condition.

Claimant requested a hearing. The ALJ concluded that, in 1980, SAIF had accepted claimant's degenerative back condition. Then, applying the material contributing cause test of former ORS

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[1] As we stated in our prior order, Aetna Casualty & Surety Company currently is the insurer for Standard's (former) insured. For convenience' sake, we shall continue to refer to Aetna's insured as Standard's insured.

656.245(1)[2], the ALJ concluded that claimant had established the compensability of his current need for medical services.

SAIF requested Board review. On review, SAIF asserted that its 1980 acceptance was limited to a low back strain. It then contended that, because the medical evidence established that claimant's need for treatment in 1993 was caused, in major part, by his preexisting degenerative spinal condition, his current low back condition was not compensable under former ORS 656.005(7)(a)(B).[3]

We did not address either of SAIF's arguments in our prior order. Rather, relying on Messmer v. Deluxe Cabinet Works, 130 Or App 254, rev den 320 Or 507 (1995), we concluded that SAIF was barred by claim preclusion from denying that claimant's degenerative spinal condition was part of his 1980 back claim. That conclusion was based on SAIF's failure to challenge two Determination Orders that included an award for claimant's noncompensable degenerative condition. Accordingly, we affirmed the ALJ's conclusion that claimant's current low back condition was compensable. Dennis Keller, supra.

SAIF sought judicial review by the Court of Appeals. Thereafter, the parties jointly moved for remand to the Board under Cabex Mills, Inc. v. Duval, 137 Or App 525 (1995). In Duval, the employer sought judicial review of a Board order holding that the employer's failure to contest a previous determination order precluded it from contesting the compensability of the claimant's condition. The court reversed and remanded for reconsideration in light of the intervening amendments to the Workers' Compensation Act. Or Laws 1995, ch 332. In view of Duvall the court has remanded the instant case for our reconsideration.

SAIF asserts that, in light of our decision in Craig L. Hiatt, 47 Van Natta 2287 (1995) (order on remand), Messmer v. Deluxe Cabinet Works, supra, is no longer good law and, hence, that it is not precluded from contesting the compensability of claimant's current low back condition. We agree.

Messmer 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. However, pursuant to amended ORS 656.262(10)[4] and Craig L. Hiatt, supra, 47 Van Natta at 2288 n 1,

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[2] Former ORS 656.245(1)(a) provided that, "[f]or every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions resulting from the injury for such period as the nature of the injury or the process of the recovery requires * * *." The Court of Appeals interpreted that statute to mean that medical services for conditions resulting from a work injury are compensable if the need for treatment bears a material relationship to the compensable condition. Beck v. James River Corp., 124 Or App 484, 487 (1993), rev den 318 Or 478 (1994).

The Legislature has amended ORS 656.245(1)(a). As amended, the statute now provides:

"For every compensable injury, the insurer or the self-insured employer shall cause to be provided medical services for conditions caused in material part by the injury for such period as the nature of the injury or the process of the recovery requires * * *. In addition, for consequential and combined conditions described in ORS 656.005 (7), the insurer or the self-insured employer shall cause to be provided only those medical services directed to medical conditions caused in major part by the injury." (Emphasis added).

That statute applies retroactively to this case. Or Laws 1995, ch 332, § 66(5)(a) e.g., Robert F. Shelton, 48 Van Natta 133 (1996).

[3] The Legislature also has amended ORS 656.005(7)(a)(B). The statute now refers to "combined" instead of "resultant" conditions, and applies retroactively to this case. SB 369, § 66(5)(a); e.g., Robert F. Shelton, supra, 48 Van Natta at 133.

[4] 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.

Claimant asserts that the retroactive application of amended ORS 656.262(10) to this case violates his substantive due process rights under the Fourteenth Amendment to the federal constitution. We rejected a similar argument in Betty S. Tee, 47 Van Natta 2396, 2400 (1995), on recon 48 Van Natta 67 (1996), and do so here.

2289 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.[5]

Our first inquiry, then, is whether SAIF 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 (1987). Because the specific condition SAIF accepted was not identified in the written notice, we look to the contemporaneous medical records to determine what SAIF accepted. John Q. Emmert, 46 Van Natta 997 (1994).

In August 1980, after claimant injured his back while working for SAIF's insured, he had normal spinal x-rays; his diagnosis was lumbosacral strain. (Exs. 1, 3). Claimant's degenerative condition did not become apparent until after SAIF issued its notice accepting the August 1980 injury. On this record, we find that, in September 1980, SAIF accepted claimant's lumbosacral strain, but not his degenerative spinal condition. SAIF v. Tull, supra; John Q. Emmert, supra. That SAIF may have subsequently paid for services related to claimant's degenerative condition does not warrant a different finding. See amended ORS 656.262(10) ("Merely paying or providing compensation shall not be considered acceptance of a claim * * *.").

The remaining issue concerns the compensability of claimant's current low back condition. The record establishes that claimant's degenerative disease preexisted either or both of his original back injuries. Therefore, the current condition is compensable, if at all, under amended ORS 656.005(7)(a)(B).[6] Under that statute, claimant must prove that one or both of his compensable low back injuries is the major contributing cause of his current disability or need for treatment. Claimant has not met that burden.

Examining physicians, Drs. Reimer, neurologist, Peterson, orthopedist, and McKillop, orthopedic surgeon, concluded that claimant's current need for treatment was caused, in major part, by his degenerative spinal condition. (Exs. 106 - 109). They reasoned that, in view of the relatively simple nature of claimant's 1980 and 1991 back injuries, his recurring low back symptoms were more likely related to his degenerative spinal condition. (See id.) Dr. Bower, treating general practitioner, concurred with Dr. McKillop's report. (Ex. 110).[7]

The only contrary opinion is authored by Dr. Cowan, treating chiropractor, who concluded that claimant's 1991 low back injury with Standard's insured was the major contributing cause of his current low back condition. (Ex. 111).[8] That report is unpersuasive. It is conclusory. Moreover, Cowan never

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[5] Arguing that amended ORS 656.262(10) does not overrule Messmer, claimant invites us to revisit our holding in Hiatt. We decline the invitation.

[6] See note 3, supra. There is minimal evidence to establish that claimant's degenerative condition combined with either or both of his earlier injuries to produce his current need for treatment. Therefore, it is arguable that amended ORS 656.005(7)(a)(B) does not even apply. Because there is no evidence to support compensability under any other theory (direct or consequential injury or occupational disease), to give claimant the benefit of the doubt, we will assume that it does.

As an aside, we reiterate our rejection, stated in our prior order, of claimant's argument that this claim is one for medical services, to which the material contributing cause standard applies. As we stated in that order, the compensability of claimant's current condition is the central issue, whereas, ORS 656.245(1) presupposes that the compensability of a claimant's condition has already been established. 47 Van Natta at 735 n 2. In any event, it is no longer to claimant's advantage to assert that this is a medical services dispute. Because this case involves a "combined" condition, the major contributing cause standard applies whether this case is analyzed under amended ORS 656.005(7)(a)(B) or amended ORS 656.245(1)(a). 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)).

[7] In his brief on review, claimant urged us to rely on Drs. McKillop's and Reimer's reports. (Exs. 108, 109).

[8] Before he concurred with Dr. McKillop, Dr. Bower issued a one-sentence opinion stating his belief that claimant's current condition stemmed back to his 1980 injury. (Ex. 98). That conclusory report is not persuasive.

addressed claimant's degenerative spinal condition in that report, or in any of his other numerous reports. Therefore, his causation opinion is unpersuasive. Accordingly, we give it minimal, if any, weight.

On balance, we find the opinions opposing compensability more compelling than those supporting the claim. Consequently, we conclude that claimant has failed to establish the compensability of the claim. Therefore, we reverse the ALJ's decision to set aside SAIF's compensability denial.

Responsibility

Having found that claimant's current low back condition is not compensable, we also reverse the ALJ's decision assigning responsibility for the condition to SAIF.

Penalties

We adopt and affirm the ALJ's conclusions regarding penalties.

ORDER

The ALJ's order dated February 4, 1994 is reversed in part and affirmed in part. That portion of the ALJ's order setting aside the SAIF Corporation's denial of claimant's current low back condition is reversed, and SAIF's denial is reinstated and upheld in its entirety. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

April 9, 1996 Cite as 48 Van Natta 781 (1996)

In the Matter of the Compensation of
BRIAN A. McKINNEY, Claimant
WCB Case No. 95-07153
ORDER ON REVIEW
Davis, Wright, et al, Claimant Attorneys
Judy C. Lucas, Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that dismissed his hearing request for lack of jurisdiction. On review, the issues are jurisdiction and, potentially, medical services.

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

As a result of compensable injuries sustained on January 26, 1989, claimant was rendered a paraplegic. Subsequently, claimant and a third party reached a settlement totaling $1.525 million. Part of this settlement was paid to the SAIF Corporation in $1,000 monthly installments during claimant's lifetime to compensate SAIF for claimant's future medical expenses paid on his workers' compensation claim. In addition, claimant and SAIF entered into a Claim Disposition Agreement (CDA) whereby claimant agreed to release his rights to workers' compensation benefits, except medical services, in exchange for $60,000.

At hearing and on review, the medical services dispute in question involves payment for services of a personal trainer or attendant to assist claimant in his regular weight lifting program. Based on the language of the CDA, which specifically referred to compensable medical services "defined and described in ORS 656.245" and referred to palliative care which is "necessary, reasonable and appropriate," all of which are terms defined by statutes and administrative rules, the ALJ determined that the Director had jurisdiction over the medical services dispute. We agree. B. D. Schlepp, 44 Van Natta 1637 (1992); Kevin A. Haines, 43 Van Natta 1041 (1991).

On review, claimant contends that SAIF is challenging the compensability of the requested medical services and that SAIF did not previously challenge the reasonableness and necessity of these medical services. Based on this contention, claimant argues that jurisdiction lies with the Hearings Division. We disagree with claimant's underlying contention.

In Senate Bill 369 (SB 369), 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. 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, there is no evidence that SAIF disputes the compensability of claimant's underlying claim, which includes paraplegia. To the contrary, the evidence establishes that SAIF disputes whether the requested medical services for claimant's compensable paraplegia condition are reasonable or necessary. (Exs. 8A, 10A, 12, 24, Tr. 2, 7, 8). Accordingly, review of this dispute lies with the Director, not the Hearings Division. ORS 656.245(6); Richard L. Wheeler, 47 Van Natta 2011 (1995); John L. Willhite, 47 Van Natta 2334 (1995).

In reaching this conclusion, we are not saying that the CDA language regarding medical services is not enforceable. Instead, we are simply saying that the Director is the proper forum for resolution of this medical services dispute under the language of the CDA. ORS 656.245(6); 656.327(1).

ORDER

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

April 9, 1996 Cite as 48 Van Natta 782 (1996)

In the Matter of the Compensation of
CYNTHIA I. MEDLEY, Claimant
WCB Case No. 94-13488
ORDER ON REVIEW
Bradley P. Avakian, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that dismissed claimant's hearing request for lack of jurisdiction. On review, the issues are jurisdiction and, alternatively, compensability and medical services. We reverse the ALJ's dismissal order, reinstate claimant's hearing request, and uphold the insurer's denial.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Concluding that this case involves a medical services question over which the Director of the Department of Consumer and Business Services has exclusive jurisdiction, the ALJ dismissed claimant's hearing request for lack of jurisdiction. Claimant asserts that, because the insurer denied the compensability of her underlying condition, jurisdiction rests with the Board and the Hearings Division. We agree.

ORS 656.245(6), which was added to the statute as part of Senate Bill 369, 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 656.183.310 to 183.550."

That statute applies retroactively to this case. Walter L. Keeney, 47 Van Natta 1387 (1995). Accordingly, the issue is whether the insurer disapproved of claimant's claim for medical services "for any reason other than the formal denial of the compensability of the underlying claim." If the answer is "yes," the Director has exclusive jurisdiction over this matter. If the answer is "no," jurisdiction rests with the Board and the Hearings Division. The answer is "no."

Claimant initially sustained a compensable low back strain on May 21, 1991. In November 1992, the Board approved the parties' Claim Disposition Agreement (CDA), pursuant to which claimant received $18,000 in consideration for the release of all benefits except medical services. (Ex. 2). In May 1994, claimant sustained an off-work fall; thereafter, she experienced increased low back, left hip and lateral leg pain. (Ex. 4). Dr. Kendrick, treating physician, requested authorization to provide palliative care. (Ex. 3). The insurer issued a denial, which recounted the history of claimant's low back, left hip and lateral leg pain, and stated, in part:

> "Upon review of the claim documentation, it appears to us that this is a new and separate injury, not associated with your on-the-job injury of May 21, 1991, or related to your employment with [the insurer's insured]. Therefore we must respectfully advise you that we are unable to accept your claim for benefits. We hereby deny your claim." (Ex. 9-1).

That denial amounts to a formal denial of the compensability of claimant's current low back, left hip and lateral leg condition. It states that claimant's current condition is neither associated with claimant's original 1991 compensable injury, nor related to her employment. That language manifests the insurer's intent to deny formally the compensability of claimant's current condition and need for treatment. ORS 656.245(6) vests jurisdiction in the Director in cases other than those that involve denials that formally deny the compensability of a worker's underlying claim. Because this case involves such a compensability denial, the Board and Hearings Division have jurisdiction over it. See Richard Wheeler, 47 Van Natta 2011 (1995) (Board retained jurisdiction over dispute that involved compensability of condition on which medical services were based).

In reaching this conclusion, we recognize that this dispute arose out of a request to provide palliative care that listed a 1991 injury date. Nevertheless, in view of the express language in the insurer's denial stating that claimant's current injury constitutes a new injury that is not related to her 1991 injury or her employment, we reject the insurer's argument that its denial only disapproved palliative medical services.

The insurer asserts that, in light of the parties' CDA, the only benefit to which claimant conceivably is entitled is medical services. Therefore, it asserts, because the Director has exclusive jurisdiction over medical services disputes, the ALJ correctly dismissed claimant's hearing request. We disagree. The Director has exclusive jurisdiction over medical services cases except for those cases involving the formal denial of the compensability of a worker's underlying condition. See ORS 656.245(6). This is such a case. Accordingly, the CDA's impact, if any, on claimant's current claim would be limited to the type of benefits to which she may be entitled should she establish the compensability of the current condition.

In sum, we reverse the ALJ's decision to dismiss claimant's hearing request. Accordingly, we reinstate the hearing request.[1] Because a full evidentiary hearing was held, we can resolve this matter pursuant to our de novo review. Accordingly, we proceed to address the compensability issue.

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[1] In reaching this decision, we recognize that the ALJ's dismissal was, in effect, limited to that portion of the hearing request that pertained to the propriety of claimant's treatment as opposed to the compensability of claimant's underlying condition. Because the ALJ dismissed claimant's entire hearing request, however, we reinstate the entire request.

Compensability

Claimant's current low back, left hip and lateral leg condition is compensable, if at all, under a consequential condition theory.[2] To prevail under that theory, claimant must establish that her May 1991 compensable low back strain is the major contributing cause of her current condition. ORS 656.005(7)(a)(A).

Dr. Kendrick characterized claimant's condition following her May 1994 off-work fall as an "[a]ccepted low back condition with recent exacerbation of low back pain, no new injury." (Ex. 3).[3] Kendrick later concluded that claimant had experienced an aggravation of her old injury. (Ex. 12). In a subsequent unexplained concurrence report, Dr. Kendrick agreed that claimant's 1991 work accident remained the major contributing cause of her current condition and need for treatment. (Ex. 14). In a later concurrence report, Dr. Kendrick agreed that claimant's May 1994 fall had "significantly contributed" to her current need for treatment. (Exs. 15-1, 17-2). The report also stated that claimant's current need for treatment was precipitated by the May 1994 fall. (Ex. 15-2, 17-3; see Ex. 15A).[4] In a final report, Dr. Kendrick concluded that, although the May 1994 fall was significant, the 1991 injury was the major cause of claimant's current condition. (See Ex. 18). On the basis of his evaluation of claimant, and a orthopedic/ neurological examination and a musculoskeletal assessment, Dr. Rhead, consulting chiropractor, concluded that claimant's May 1994 fall was the major contributing cause of her current condition. (Ex. 13).

This evidence is insufficient to meet claimant's burden of proof. Dr. Kendrick's major cause opinions are essentially unexplained; moreover, those opinions are undercut by Kendrick's eventual recognition that the May 1994 off-work fall played a significant role in claimant's current condition. Most important, however, Dr. Kendrick's final concurrence report reveals his belief that claimant's 1994 fall was, at most, the precipitating cause of her current need for treatment. Because the precipitating cause of a worker's condition is not necessarily the major contributing cause of that condition, Dietz v. Ramuda, 130 Or App 397, 401 (1994), that report is insufficient to establish that claimant's current low back condition was caused, in major part, by her May 1991 compensable low back strain. In view of the lack of any other persuasive evidence supporting compensability, and Dr. Rhead's report opposing compensability, we agree with the ALJ's decision to uphold the insurer's denial of claimant's current condition.

Because we reach this conclusion, we need not address the insurer's arguments regarding the impact, if any, of the CDA on this case.

ORDER

The ALJ's order dated August 31, 1995 is reversed. The insurer's denial is upheld in its entirety.

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[2] There is no persuasive evidence to support a combined condition theory.

[3] In later reports, Dr. Kendrick characterized claimant's May 1994 incident as a new injury. (Ex. 15-1, 18).

[4] The report also states that claimant had told Dr. Kendrick that, in May 1994, she was still experiencing minor symptoms from the 1991 injury. (Exs. 15-1, 17-2). According to the report, based on that history, Kendrick was unable to identify the cause of claimant's current condition. (Exs. 15-1, 17-2). In a hand-written addendum, however, Dr. Kendrick stated that claimant's ongoing symptoms were not necessarily minor. (Exs. 15-2, 17-3). That portion of the report is confusing. Consequently, we discount it.

Board Member Gunn concurring in part and dissenting in part.

I agree that we have jurisdiction over this case for the reasons stated by the majority. I also believe, however, that jurisdiction rests with us, because this case, whether it pertains to medical services or other benefits, arises from the enforcement of a Board order approving a Claim Disposition Agreement.

I disagree with the majority's decision to address the substance of this case without affording the Administrative Law Judge (ALJ) that opportunity first. Instead, I would remand this case to the ALJ for a decision on the merits before I conducted any review of this matter. To the extent that the majority concludes otherwise, I dissent.

In the Matter of the Compensation of
CAROLYN A. MILLER, Claimant
WCB Case Nos. 95-10302 & 95-03606
ORDER ON REVIEW
Emmons, Kropp, 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) Howell's order that upheld the SAIF Corporation's denials of claimant's injury and occupational disease claims for a low back condition. On review, the issue is compensability.

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

Amended ORS 656.802(2)(b) applies to claimant's claim. Newell v. SAIF, 136 Or App 280 (1995); Volk v. America West Airlines, 135 Or App 565, 569 (1995); see Or Laws 1995, ch 332, § 66 (SB 369, § 66).

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 employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." Thus, under amended ORS 656.802(2)(b), work must be the major contributing cause of both the combined condition and the pathological worsening of the preexisting disease. In this regard, we have held that the language of amended ORS 656.802(2)(b) provides that it is no longer sufficient for a claimant to prove that work conditions were the major contributing cause of the worsening of the preexisting disease; he or she must also prove that work conditions were the major contributing cause of the "combined condition" itself. Dan D. Cone, 47 Van Natta 2220, 2221 (1995).

Claimant argues that Dan D. Cone is distinguishable and she need not separately prove that the work activities were the major contributing cause of the "combined condition" because, in her case, the "combined condition" is a not a separate condition but a pathological worsening of her previous noncompensable fusion, i.e., the pseudarthrosis. We need not address this argument because, on this record, the evidence does not establish that the work conditions were the major contributing cause of the pathological worsening of the preexisting condition. Amended ORS 656.802(2)(b).

Of the medical opinions in the record, only Dr. Tiley's opinion might possibly be read to support compensability. However, for the following reasons, we find that Dr. Tiley's opinion does not meet claimant's burden of proof.

Claimant has a long history of low back problems prior to her employment by the employer in November 1992. In March 1988, claimant underwent noncompensable lumbar surgery, including a fusion of the L4-5 and L5-S1 levels performed by Dr. Tiley. (Exs. 11, 14). Dr. Tiley presents two causation opinions regarding claimant's current occupational disease claim. (Exs. 37, 40). On March 20, 1995, although disagreeing with the description of the 1988 surgery recorded by Drs. Wilson and Arbeene, examining physicians, Dr. Tiley agreed with their hypothesis about claimant's persistent back symptoms, noting that claimant "does have a pseudarthrosis at L4-5 and that is probably leading to her symptoms. She has probably had a pseudarthrosis all along." (Ex. 37). Dr. Tiley also opined that claimant "has had a pseudarthrosis at L4-5 for quite an extended period of time, but that heavy occupational activities over the last 2-3 years have probably contributed to recurrence of symptoms in the low back related to pseudarthrosis and mediated by heavy lifting, etc." Id.

On August 9, 1995, Dr. Tiley noted that claimant had recently underwent a "re-do of her lumbar stabilization." (Ex. 40). He opined that "[t]he reason for the pseudarthrosis is failure of the first surgery with intervening work exposures. Specifically, it is my opinion that the reason [claimant] needed the second surgery is related to breakdown of the back, i.e., pseudarthrosis of the previous fusion procedure and further degenerative disease on the basis of repetitive heavy lifting while working in a retail market." Id.

In his first report, Dr. Tiley indicated only that work activities contributed to a symptomatic increase in the low back. (Ex. 37). This opinion does not support a pathological worsening caused in major part by the work activities. In his second report, Dr. Tiley indicated that the "breakdown of the back" was caused by a combination of the pseudarthrosis of the previous surgery and further degenerative disease on the basis of repetitive lifting at work. (Ex. 40). This second opinion represents a change of opinion. Because this change of opinion is unexplained, we do not find it persuasive.

In any event, Dr. Tiley's second opinion does not support a finding that the work activities were the major contributing cause of the pathological worsening of the preexisting low back condition. The most this second opinion says is that the pathological worsening is caused by a combination of the failure of the first surgery and further degenerative disease based on work activities. This opinion does not indicate that the pathological worsening of the pseudarthrosis is caused in major part by the work activities.

We acknowledge that no incantation of "magic words" or statutory language is required, provided that the opinion otherwise meets the appropriate legal standard. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992); McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). However, here, even if Dr. Tiley's second opinion was otherwise persuasive, it does not meet the appropriate standard. Accordingly, we agree with the ALJ that claimant has failed to meet her burden of proving a compensable occupational disease claim.

ORDER

The ALJ's order dated November 16, 1995 is affirmed.

April 9, 1996 Cite as 48 Van Natta 786 (1996)

In the Matter of the Compensation of
RITO N. NUNEZ, Claimant
WCB Case Nos. 91-17477, 91-10770, 91-17476 & 91-16978
ORDER ON REMAND
Coons, Cole, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. SAIF v. Nunez, 137 Or App 531 (1995). The court reversed our prior order, Rito N. Nunez, 45 Van Natta 25 (1993), which affirmed a then-Arbitrator's order that found that the first carrier (Liberty) had successfully shifted responsibility to the second carrier (SAIF) by proving that claimant had sustained a new compensable injury under former ORS 656.308. In so holding, the Arbitrator relied on our decision in Rosalie S. Drews, 44 Van Natta 36 (1992), requiring Liberty to prove that the subsequent injury was a material contributing cause of claimant's condition. Citing Or Laws 1995, ch 332, § 37, and SAIF v. Drews 318 Or 1 (1993), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact."[1]

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[1] At the time of hearing, the ALJ decided this case as an "Arbitrator" under former ORS 656.307. Subsequent to the ALJ's order, the legislature amended ORS 656.307 to provide, inter alia, that the Board shall appoint an "Administrative Law Judge" to determine the responsible paying party. Amended ORS 656.307(2); Dan J. Anderson, 47 Van Natta 1929, 1929 n.1 (1995).

CONCLUSIONS OF LAW AND OPINION

We summarize the relevant facts as follows. Claimant has been employed by a sawmill since 1979. In December 1988, he sustained a right hip injury while working, which Liberty accepted as a nondisabling claim. The 1988 claim was never formally closed, and claimant received neither temporary nor permanent disability compensation. However, claimant received periodic treatment for right hip pain, from the time of his 1988 injury up to March 1991.

In April 1991, claimant sustained another on-the-job injury to his right hip when he jumped two to three feet from an engine. At that time, the employer was insured by SAIF.

On July 22, 1991, SAIF issued a compensability denial. (Ex. 16). On October 9, 1991, SAIF issued a disclaimer of responsibility and claim denial. (Ex. 19). Liberty denied compensability and responsibility on October 30, 1991. (Ex. 21). After both carriers conceded that only responsibility was in issue, an Order Designating a Paying Agent Pursuant to ORS 656.307 was entered on December 9, 1991, which directed SAIF to pay benefits pending an Arbitrator's decision. (Ex. 22).

Liberty insured the employer from July 1, 1987 through July 1, 1989.

Claimant requested a hearing, contesting SAIF's and Liberty's denials. At hearing, the sole issue was responsibility. The Arbitrator found that the 1991 injury was a material contributing cause of claimant's disability and need for treatment. Therefore, relying on Rosalie S. Drews, supra, the Arbitrator found that Liberty had proved that claimant sustained a new compensable injury while SAIF was on the risk. Thus, the Arbitrator concluded that SAIF was responsible for claimant's injury.

SAIF requested review of those portions of the Arbitrator's decision that set aside its denial of claimant's "new injury" claim for a right hip condition, and that upheld Liberty's aggravation denial for the same condition. We reviewed the Arbitrator's decision for questions of law under former ORS 656.307(2) and affirmed the Arbitrator's decision. In doing so, we relied on our decision in Rosalie S. Drews, supra, which held that the material contributing cause standard applies to establish a new compensable injury and shift responsibility under former ORS 656.308.

The court reversed our decision, citing SAIF v. Drews, supra, and Or Laws 1995, ch 332, § 37, and has remanded for reconsideration. SAIF v. Nunez, supra. Pursuant to the court's mandate, we proceed with our reconsideration.

In SAIF v. Drews, the Supreme Court considered the 1990 legislature's amendments to ORS 656.005(7)(a)(B) and 656.308. The Supreme Court concluded that the legislature intended the "major contributing cause" standard of former ORS 656.005(7)(a)(B) to apply to the shifting of responsibility among employers under former ORS 656.308(1). SAIF v. Drews, supra, 318 Or at 9.

The legislature again amended ORS 656.005(7)(a)(B) and 656.308 in 1995. Or Laws 1995, ch 332, §§ 1, 37 (SB 369, §§ 1, 37).[2] Amended ORS 656.308(1) provides, in material part:

> "When a worker sustains a compensable injury, the responsible employer shall remain responsible . . . unless the worker sustains a new compensable injury involving the same condition. * * * The standards for determining the compensability of a combined condition under ORS 656.005(7) shall also be used to determine the occurrence of a new compensable injury or disease under this section." (Emphasis added).

The underscored language was added by the legislature in 1995. Amended ORS 656.005(7)(a)(B) now provides that if an otherwise compensable injury combines at any time with a preexisting condition, the combined condition is compensable only if the compensable injury is the major contributing cause of the disability or need for treatment due to the combined condition.

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[2] Except as provided otherwise, the amendments of 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, 572-73 (1995). Because amended ORS 656.005(7)(a)(B) and 656.308 (1) are not among the exceptions to this general rule, see SB 369, § 66 (listing exceptions to general retroactivity provision), the amended versions of the statutes apply here. SAIF v. Nunez, supra.

Amended ORS 656.308(1) now explicitly provides that the major contributing cause standard of ORS 656.005(7)(a)(B) shall be applied to determine whether a "new compensable injury" has occurred under ORS 656.308. The amended statute codifies the court's holding in SAIF v. Drews, supra. Keith Thomas, 48 Van Natta 510, 511 (1996). Accordingly, we conclude that under amended ORS 656.308(1) and SAIF v. Drews, in order to establish a new compensable injury and shift responsibility to SAIF, Liberty must prove that the 1991 injury was the major contributing cause of claimant's disability and need for treatment.

This case arose under former ORS 656.307. Under former ORS 656.307(2), our review was limited to questions of law. See Rito N. Nunez, supra. Subsequent to our review, the legislature amended ORS 656.307. The amended statute now provides that our review shall be de novo. Amended ORS 656.307(2); Allen T. Knight, 48 Van Natta 30 (1996); Dan J. Anderson, supra n.1. Except as provided otherwise, the amendments of 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, supra n.2. Amended ORS 656.307 is not among the exceptions to the general rule. See SB 369, § 66. Consequently, since the amended statute applies here, we review this case de novo under amended ORS 656.307. See Allen T. Knight, supra; Dan J. Anderson, supra.

We turn now to the medical evidence. Drs. Peltzer, Macha and Feldman, all of whom treated claimant at different times, offered opinions regarding the causation of his current condition. After our de novo review of the record, we agree with the ALJ's evaluation of the medical opinions, and conclude that Dr. Peltzer's opinion is most persuasive.

Dr. Feldman examined claimant once on June 7, 1991. (Ex. 13A). He obtained a history of chronic right hip pain since an injury about two years ago. Dr. Feldman stated he was not advised of a recent injury to the right hip, although a recent injury was noted on the medical processing form. (See Exs. 13B, 15). Dr. Feldman indicated that claimant told him that he has had chronic right hip pain since his 1988 injury, which has never really resolved and which is exacerbated by climbing, walking, lifting and jumping. (Ex. 15). Based on the chronicity of claimant's pain and the fact that claimant did not mention a recent injury to him, Dr. Feldman opined that claimant's current condition was related to his 1988 injury with "minimal if any contribution by a recent injury." (Id.).

Dr. Feldman referred claimant to Dr. Macha, an orthopedic surgeon, who began treating him June 10, 1991. (Ex. 14). Dr. Macha also obtained a history of a work-related injury to the right hip in 1988, with persistent symptoms since that time. (Exs. 14-1, 17). He did not obtain a history of a recent injury. Claimant testified that although he related his problems to the 1988 injury when he saw Dr. Macha, he also told Dr. Macha that he experienced more pain after the April 1991 incident. (Tr. 20). Dr. Macha diagnosed claimant's condition as a chronic trochanteric bursitis, which he related to claimant's 1988 work injury. (Ex. 17). Based on claimant's history of persistent right hip pain since the 1988 injury, Dr. Macha opined that the major cause of claimant's current need for treatment was the 1988 injury. (Exs. 18, 24).

Dr. Peltzer, a chiropractor, treated claimant both before and after the 1991 incident. (See Exs. 7, 7A, 10). In May and June 1990, Dr. Peltzer felt claimant improved with treatment, and that his condition from the 1988 injury had stabilized by the time he stopped treatment in June 1990. (Exs. 8, 9, 9A-3, 23-1). Claimant returned to Dr. Peltzer for treatment in January 1991 for a flare-up of his right hip pain.[3] (Ex. 10). By March 18, 1991, that flare-up had resolved through treatment. (Exs. 10-1, 23-1). On April 16, 1991, claimant returned to Dr. Peltzer for treatment related to a new injury he sustained at work the previous day. (Exs. 10-2, 23-1). Dr. Peltzer treated that injury through May 24, 1991. (Exs. 10-4, 23-1). Based on this treatment history, Dr. Peltzer opined that the April 15, 1991 jumping incident was the major contributing cause of claimant's need for treatment in April and May 1991, and that the April 1991 jumping incident probably anatomically worsened claimant's underlying right hip condition. (Ex. 23-3).

[3] In the interim, claimant treated with orthopedist Dr. Matteri for right hip pain. Dr. Matteri treated claimant in August and September 1990. On October 12, 1990, Dr. Matteri indicated that claimant was medically stationary and released him to regular work without restrictions. (Ex. 9A). Claimant did not again seek medical treatment until January 1991.

When medical opinions differ, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986). Here, only Dr. Peltzer has a complete history of claimant's condition, including both his 1988 and 1991 injuries and related treatment. Moreover, Dr. Peltzer has the advantage of treating claimant both before and after the April 1991 incident. Therefore, since Dr. Peltzer has a basis for comparing claimant's condition before and after the April 1991 incident, his opinion is entitled to greater weight. See Kienow's Food Stores v. Lyster, 79 Or App 416, 421 (1986).

By contrast, neither Dr. Feldman nor Dr. Macha based his opinion on a complete history that included both claimant's 1988 and 1991 injuries. Dr. Feldman stated that claimant did not mention a recent injury to him, although the treatment processing form identified a recent incident causing "reinjury" to the right hip. Dr. Macha obtained a history only of the 1988 injury, although claimant testified that he advised Dr. Macha of the 1991 incident. Therefore, since they relied on incomplete histories, neither Dr. Feldman nor Dr. Macha adequately considered the impact, if any, of claimant's April 1991 jumping incident on his current need for treatment. Under such circumstances, we find Dr. Peltzer's opinion more persuasive.

SAIF contends that Dr. Peltzer's opinion is not persuasive because it is a conclusory, unexplained "check-the-box" opinion. While Dr. Peltzer's opinion is expressed in a concurrence letter, in a "check-the-box" format, we disagree that his opinion is unexplained. Generally, the persuasiveness of a medical opinion depends on the persuasiveness of the foundation on which the opinion is based, regardless of the format in which that opinion is expressed. See Marta I. Gomez, 46 Van Natta 1654 (1994).

Here, the basis for Dr. Peltzer's opinion was set forth in the introductory paragraphs of the opinion letter, which reflected an accurate summary of Dr. Peltzer's conversation with claimant's attorney. (Ex. 23 at 1-2). That summary indicated that Dr. Peltzer treated claimant following his 1988 injury, as well as immediately after the 1991 injury; that claimant improved with treatment in 1990 such that his condition stabilized from the 1988 injury by June 1990 when Dr. Peltzer stopped treating him; and that he treated claimant again for a flare-up of his right hip pain in January 1991, but that that flare-up resolved through treatment by March 18, 1991. In addition, Dr. Peltzer noted that his facility with the Spanish language helped him obtain an accurate history from claimant. With these observations and his history of treating claimant as the foundation for his opinion, Dr. Peltzer opined that the April 1991 work incident was the major contributing cause of claimant's current disability and need for medical treatment, and that the April 1991 jumping incident caused an anatomical worsening of claimant's right hip condition. (Ex. 23-3). Thus, we conclude that Dr. Peltzer did explain the basis for his opinion, and we find no reason to discount his opinion simply because it was presented in a "check-the-box" format. See Marta I. Gomez, supra.

In arguing that Liberty failed to prove that the April 1991 incident under SAIF's insured was the major contributing cause of claimant's current need for treatment, SAIF emphasizes the chronicity of claimant's right hip pain since the 1988 injury. We recognize that claimant received treatment for recurring right hip pain, and that claimant testified that his hip pain never really resolved since the 1988 injury. However, we find that claimant's treatment for his right hip pain was intermittent, rather than continuous, and that after treatment for each "flare-up," his condition substantially resolved. We base this finding on the following evidence.

Dr. Peltzer indicated that claimant's condition had "stabilized with minimal residual related only to very heavy lifting" by June 1990. (Ex. 23-1). Claimant agreed with that characterization, and indicated that his pain had completely subsided when he did not engage in activity. (Tr. 17, 18). Dr. Matteri treated claimant in August and September 1990, but by October 12, 1990, Dr. Matteri believed that claimant was medically stationary, with exacerbations associated only with "really heavy work." (Ex. 9A-3). Dr. Peltzer again treated claimant for a flare-up of his right hip pain in January 1991, but that flare-up had resolved with treatment by March 18, 1991. Dr. Peltzer did not treat claimant again until April 16, 1991, the day after the April 1991 incident which Dr. Peltzer described as a "new injury." (Ex. 10-2). Claimant also testified that his pain since April 1991 was different, indicating that he now has pain even on light work days and that his pain is no longer located only in the hip, but extends down his leg. (Tr. 16).

Thus, while we recognize that claimant received periodic treatment for his right hip since the 1988 injury, including chiropractic treatment up to within one month of the jumping incident, we are

persuaded, based on Dr. Peltzer's comments, that the "flare-up" for which he was treating claimant had resolved by March 18, 1991. Thus, we still find, relying on Dr. Peltzer's history of treatment and persuasive opinion, corroborated by claimant's testimony, that the major cause of claimant's current need for treatment was the April 1991 jumping incident.

Finally, SAIF contends that Dr. Peltzer's opinion is not persuasive because it fails to evaluate the relative contribution from claimant's preexisting right hip condition to his current hip condition. Thus, SAIF contends that Dr. Peltzer's opinion is insufficient to meet claimant's burden of proof under Dietz v. Ramuda, 130 Or App 397 (1994). We disagree.

In Dietz, the claimant had a heart attack after a sustained period of smoke inhalation at work. The claimant had preexisting, albeit asymptomatic, coronary artery disease. The court agreed with our application of former ORS 656.005(7)(a)(B) in determining whether the work incident was the major contributing cause of claimant's resultant heart attack. In doing so, the court rejected the claimant's argument, which relied on U-Haul of Oregon v. Burtis, 120 Or App 353 (1993), that a work event that is a precipitating cause of an injury or disease is necessarily the major cause. The court explained in Dietz that, although a work event that is the precipitating cause 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 determine which is the primary cause. Dietz v. Ramuda, supra, 130 Or App at 401; see also Alec E. Snyder, 47 Van Natta 838 (1995) (In both Burtis and Dietz, the proper analysis under ORS 656.005(7)(a)(B) turns on whether the medical evidence establishes that the injury is the major contributing cause of a claimant's resultant disability and need for treatment).

Here, Dr. Peltzer opined that the April 1991 jumping incident was the major contributing cause of claimant's subsequent need for treatment As discussed above, Dr. Peltzer's opinion was based on the history that claimant related to him, as well as on his prior history of treating claimant for the 1988 injury. Thus, based on his history of treating claimant both before and after the April 1991 incident, as well as the explanation accompanying his opinion, we find that Dr. Peltzer's opinion was based on an evaluation of the relative contribution of claimant's preexisting right hip condition. Therefore, we remain persuaded by Dr. Peltzer's opinion that the April 1991 incident was the major cause of claimant's current need for treatment.

Accordingly, we conclude that Liberty established that claimant sustained a compensable new injury while SAIF was on the risk. Therefore, SAIF is responsible for claimant's current condition.

Accordingly, on reconsideration of our January 8, 1993 order, we affirm the ALJ's April 30, 1992 order which: (1) upheld Liberty's October 30, 1991 denial; (2) set aside SAIF's July 22, 1991 denial, as amended October 9, 1991, and remanded the claim to SAIF for processing according to law; and (3) awarded claimant an attorney fee of $2,800 under ORS 656.307(5), payable by SAIF.

IT IS SO ORDERED.

April 9, 1996 Cite as 48 Van Natta 790 (1996)

In the Matter of the Compensation of
TERRY L. STARNES, Claimant
WCB Case No. 94-03035
ORDER DENYING MOTION TO DISMISS
Gloria D. Schmidt, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Claimant has moved for an order dismissing the SAIF Corporation's request for Board review of Administrative Law Judge (ALJ) Black's order. Noting that SAIF's request for review refers to the ALJ's January 29, 1996 order (rather than the ALJ's February 15, 1996 amended order), claimant contends that SAIF has not timely filed a request for review of a final order. The motion is denied.

FINDINGS OF FACT

On January 29, 1996, ALJ Black issued an Opinion and Order, which set aside SAIF's denial of claimant's psychiatric condition. The order included a notice to the parties that they had 30 days to request Board review of the order.

On February 12, 1996, SAIF requested reconsideration of the ALJ's order, requesting that the ALJ "clarify the benefits which you are finding compensable." On February 15, 1996, ALJ Black issued an Amended Opinion and Order, which contained the following statement: "This opinion, issued January 29, 1996, has been amended to add a sentence to the "Order" section and to correct typographical errors." Specifically, the amended order stated that SAIF "provide medical services to treat claimant's psychiatric condition insofar as such treatment is necessary in conjunction with diagnosis and treatment of claimant's accepted low back condition." That order also contained a notice to the parties, advising that the parties have 30 days from the mailing date of the order within which to request Board review of the order.

On February 27, 1996, SAIF mailed by certified mail a request for review to the Board. The request stated that SAIF was seeking Board review of the ALJ's order "dated January 29, 1996." The request also indicated that copies of the request had been provided to all parties to the proceeding before the ALJ.

On March 5, 1996, the Board mailed its computer-generated letter to the parties acknowledging SAIF's request for review.

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 Co. v. King, 63 Or App 847, 852 (1983). The necessary function of notice statutes is to inform the parties of the issues in sufficient time to prepare for adjudication. Nollen v. SAIF, 23 Or App 420, 423 (1975).

The time within which to appeal an order continues to run unless the order has been "stayed," withdrawn or modified. International Paper Co. v. Wright, 80 Or App 444 (1986); Fischer v. SAIF, 76 Or App 656, 659 (1986). In order to abate and allow reconsideration of an order issued under ORS 656.289(1), at the very least, the language of the second order must be specific. Farmers Insurance Group v. SAIF, 301 Or 612, 619 (1986).

Here, claimant asserts that, although SAIF requested review of the ALJ's January 29, 1996 order, it failed to request review of the ALJ's February 15, 1996 amended order. Reasoning that the January 29, 1996 order was not a final, appealable order, claimant contends that SAIF's request is defective because it neglected to timely appeal the ALJ's February 15, 1996 final, amended order. Based on the following reasoning, we disagree with claimant's argument.

The ALJ's January 29, 1996 order was not expressly abated, stayed or withdrawn; however, it was "amended" by the February 15, 1996 order, which, in response to SAIF's motion for reconsideration, clarified the January 29, 1996 order. In all other respects, the February 15, 1996 order was identical to the ALJ's January 29, 1996 order.

SAIF's February 27, 1996 request for Board review did state that it was seeking review of the ALJ's order "dated January 29, 1996." Nevertheless, since the ALJ's January 29, 1996 order had been expressly amended by the February 15, 1996 order in response to SAIF's motion for reconsideration, we conclude that SAIF's intentions were obvious. SAIF was seeking Board review of the ALJ's January 29, 1996 order, as amended by the February 15, 1996 order. See Michael A. Ferdinand, 44 Van Natta 1167, 1168 (1992).[1] Inasmuch as SAIF's request was mailed within 30 days of the issuance of the ALJ's

[1] Relying on Catlin Abel School v. Turcotte, 103 Or App 340 (1990), claimant contends that the Ferdinand rationale is contrary to the Catlin holding, and, as such, is not good law. We disagree with claimant's reasoning. In Catlin, the court dismissed a party's petition for judicial review of a Board order because, prior to the party's filing of the petition, the order had been withdrawn and republished in a second, unappealed order. Here, in contrast, the ALJ's first order was not withdrawn, but rather amended by the second order. Thus, SAIF did not seek Board review of a non-existent order. Rather, following the issuance of the ALJ's amended order (which had been issued in response to SAIF's clarification request), when SAIF requested Board review of the ALJ's first order, it was appealing the ALJ's "non-withdrawn" order, as amended by the ALJ's second order.

February 15, 1996 amended order, we hold that we have jurisdiction to consider this matter. See ORS 656.289(3); Farmers Insurance Group v. SAIF, supra; Michael A. Ferdinand, supra.

Accordingly, claimant's motion to dismiss is denied. A hearing transcript has been ordered. Upon its receipt, copies will be distributed to the parties and a briefing schedule will be implemented. Thereafter, this case will be docketed for Board review.

IT IS SO ORDERED.

In the Matter of the Compensation of
GARY L. SWANSON, Claimant
WCB Case Nos. 95-07412 & 94-14954
ORDER ON REVIEW
Emerson G. Fisher, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney
Scheminske & Lyons, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's aggravation claim for a thoracolumbar strain condition. Claimant cross-requests review, arguing that the ALJ erred by requiring him to prove an actual worsening in order to obtain a reclassification of his injury claim. On review, the issues are reclassification and aggravation. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

Reclassification

Claimant injured his low back on July 11, 1990 while working for the employer. On January 18, 1991, the claim was accepted as a nondisabling thoracolumbar strain. (Ex. 7). On August 29, 1994, claimant filed a request to reopen his claim on an aggravation basis, based on limited ranges of motion in his back. (Ex. 27). The insurer denied compensability of the aggravation claim on January 10, 1995. (Ex. 28).

Claimant requested a hearing, seeking a change in the classification of his claim from nondisabling to disabling. The ALJ applied ORS 656.277(2) and concluded that claimant was required to prove that after July 10, 1991, he suffered an actual worsening of his compensable condition. The ALJ reasoned that, based on the range of motion findings, claimant's condition had become disabling and the claim should be reclassified.

We first address claimant's cross-request for review. Claimant argues that the ALJ erred by requiring him to prove an actual worsening in order to obtain a reclassification of his injury claim. Claimant agrees that the 1995 amendments to ORS 656.277 apply to this case and he does not dispute that his request to reclassify the claim was made more than one year after the date of injury.[1]

Under former ORS 656.277, if a request for reclassification was not made within one year after the date of injury, a claimant had to make a claim for aggravation pursuant to ORS 656.273. Former ORS 656.277(2); Charles B. Tyler, 45 Van Natta 972 (1992).

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[1] 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). Since none of the exceptions to the general rule apply in this case, we apply amended ORS 656.277.

As amended, ORS 656.277 provides, in part:

"Claims for nondisabling injuries shall be processed in the same manner as claims for disabling injuries, except that:

"(1) If within one year after the injury, the worker claims a nondisabling injury [is] **originally was or has become** disabling, the insurer or self-insured employer, upon receiving notice or knowledge of such a claim, shall report the claim to the Director **of the Department of Consumer and Business Services** for determination pursuant to ORS 656.268.

"(2) A claim that a nondisabling injury **originally was or** has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation." (Added words are in bold face type, deleted words are in brackets).

According to claimant, the 1995 amendments to ORS 656.277 provide that an injured worker does not have to prove an actual worsening to have the claim reclassified unless the worker is alleging that the original injury "has become" disabling. Claimant contrasts that with the situation in which the injury originally was disabling. Claimant argues that he need only prove that his injury was disabling from the outset in order to have the claim reclassified.

In interpreting a statute, our task is to discern the intent of the legislature. ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). The first level of analysis is to examine the text and context of the statute. Id. at 610-11. If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. Id. at 611.

There is no basis in the statutory language to support claimant's interpretation of ORS 656.277(2). Both the former and amended version of ORS 656.277(2) provide that, if the claim for reclassification is made more than one year after the date of injury, it shall be "made pursuant to ORS 656.273 as a claim for aggravation." There is nothing in the text or context of amended ORS 656.277(2) to indicate that the legislature intended to eliminate claimant's burden to establish an aggravation claim under those circumstances.

Our conclusion is supported by the legislative history. In discussing the amendments to ORS 656.277, Representative Mannix testified that "Section 32 [ORS 656.277] rewords the conditions for nondisabling claims to be reclassified as disabling." Tape Recording, House Committee on Labor, March 6, 1995, Tape 45, side B. Representative Mannix commented that he agreed with the summary that this change was for "housekeeping only." Id. Those comments by Representative Mannix indicate that the legislature did not intend to make any major substantive changes by amending ORS 656.277. The legislative history provides no support for claimant's argument that the legislature intended to change the requirement that a worker must make an aggravation claim if the request for reclassification is made more than one year after the date of injury. Consequently, we agree with the ALJ that claimant must make his claim pursuant to ORS 656.273 as an aggravation.[2]

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[2] We note that, in any event, we disagree with claimant's assertion that his injury was disabling from the outset. To classify a claim as disabling, there must be entitlement to temporary benefits or a reasonable expectation of permanent disability resulting from the injury. See ORS 656.005(7)(c); Karren S. Maldonado, 47 Van Natta 1535 (1995).

Claimant testified that he did not stay home after the accident because the job allowed him to sit much of the time and he hoped the problem would go away. (Tr. 11, 12).

Claimant sought treatment for the July 11, 1990 injury from Dr. Thompson on October 31, 1990. (Ex. 3). There is no indication from Dr. Thompson's report that claimant had missed any work. Claimant was examined by Drs. Rich and Clarke on March 28, 1991, who reported that, after the July 11, 1990 injury, claimant continued to work as usual, occasionally taking aspirin. (Ex. 11). They reported that claimant continued to work six days a week. Drs. Rich and Clarke concluded that claimant's prognosis was good for eventual complete recovery, without permanent impairment. (Id.)

We conclude that there were no temporary benefits that were due and payable and there was no proof of a reasonable expectation of permanent disability. Therefore, we are not persuaded by claimant's argument that his injury was disabling from the outset.

Aggravation

The ALJ reasoned that, based on the limited range of motion findings, claimant's condition had become disabling and the claim should be reclassified. The insurer argues that claimant failed to sustain his burden of proving a compensable worsening of the accepted injury.

To prove an aggravation under ORS 656.273, claimant must prove a worsened condition resulting from the original injury. A "worsened condition" is established by "medical evidence of an actual worsening of the compensable condition supported by objective findings." ORS 656.273(1). In Carmen C. Neill, 47 Van Natta 2371, 2377 (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.

Claimant testified that he has had ongoing problems with his back since the July 1990 injury. (Tr. 12). Claimant said that "[f]or the last several years" his back condition has been a lot worse than it was at the beginning. (Tr. 14). Claimant testified that his pain level has depended on his activity level. (Tr. 17, 18).

On October 31, 1990, claimant sought treatment from Dr. Thompson for the July 11, 1990 injury. (Ex. 3). Dr. Thompson reported that claimant's pain had initially been severe, but had subsided and then worsened again. Dr. Thompson commented that claimant's pain was fairly constant. Dr. Thompson diagnosed a thoracolumbar strain.

Claimant was examined by Drs. Rich and Clarke on March 28, 1991, who reported that claimant complained of constant pain in the upper lumbar area. (Ex. 11). Drs. Rich and Clarke diagnosed a thoracolumbar strain injury and concluded that claimant's prognosis was good for eventual complete recovery, without permanent impairment. (Id.)

Claimant returned to Dr. Thompson on February 10, 1992 after an absence of over a year. Claimant complained of pain in his low back and both legs. (Ex.15). Dr. Thompson believed that claimant had a continuation of his lumbar strain and he recommended physical therapy.

Dr. Thompson examined claimant on July 26, 1993 and indicated that claimant "continues to have the same pain he had since the injury." (Ex. 16). Dr. Thompson commented that claimant said the pain "has never changed since day one." (Id.) Claimant had recently quit his job because of the pain. Dr. Thompson diagnosed chronic lumbar spine pain syndrome and recommended physical therapy.

On June 9, 1994, Dr. Thompson reported that claimant's physical examination was essentially the same as on his last visit. (Ex. 22). Dr. Thompson referred claimant to Dr. Sultany because he suspected an inflammatory process in the spine. (Exs. 22, 23). Dr. Sultany diagnosed some spur formation, but found no inflammatory disorder. (Ex. 25).

Based on Dr. Sultany's limited range of motion findings, claimant filed a request to reopen his claim on an aggravation basis. (Ex. 27).

Claimant was examined on March 1, 1995 by Drs. Rich and Gambee, who reported that claimant's 1990 thoracolumbar strain had probably resolved, but claimant was left with a chronic back pain condition. (Ex. 33). Drs. Rich and Gambee found no particular objective medical evidence to indicate any worsening.

On May 26, 1995, claimant was examined by Drs. Reimer and Peterson. They reported that claimant was employed full time as a sales manager. Drs. Reimer and Peterson found no evidence that claimant's condition had worsened and they found nothing to suggest there had been any pathological worsening. (Ex. 40). They commented that claimant's condition had continued the same "since day one." Drs. Reimer and Peterson concluded that claimant's condition remained medically stationary and he was not in need of further treatment. (Id.) Dr. Thompson concurred with the report from Drs. Reimer and Peterson. (Ex. 44).

Although the medical reports indicate that claimant's range of motion findings are limited, Dr. Thompson, claimant's treating physician, concurred with a report from Drs. Reimer and Peterson that found no evidence of a worsening and also found that claimant's condition remained medically stationary. There are no medical opinions that establish that claimant's condition has worsened. Therefore, we conclude that claimant has failed to establish by "medical evidence of an actual worsening of the compensable condition supported by objective findings." ORS 656.273(1). Consequently, claimant's aggravation claim fails.

ORDER

The ALJ's order dated October 16, 1995, as reconsidered November 9, 1995 is reversed. The insurer's aggravation denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

April 9, 1996 Cite as 48 Van Natta 795 (1996)

In the Matter of the Compensation of
ERNEST C. VROMAN, Claimant
WCB Case No. 95-09487
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) Howell's order which found that the SAIF Corporation had properly calculated the rate of claimant's temporary total disability (TTD) benefits. On review, the issue is rate of temporary disability benefits.

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

Claimant worked for a logging company which yarded and loaded logs. Occasionally, the logging company had to shut down its operation for such reasons as poor weather, equipment failure or to move the equipment from one job site to another. During these "shut downs" claimant was laid off. Claimant kept in touch with the logging company during the "lay offs" to determine when work was available.

Usually when he was laid off, claimant filed and collected unemployment benefits. However, in late June 1990 during a "lay off," claimant went to work for another employer. Once the logging company resumed its operation, in late July 1990, claimant returned to work with them, doing basically the same job at the same hourly rate. On his return, claimant did not enter into a new employment contract with the logging company.

On August 9, 1990, claimant was compensably injured. According to the logging company, claimant's weekly wage was $520 and SAIF calculated claimant's TTD based on this amount.

From August 10, 1990 to February 10, 1995, SAIF paid claimant about $89,000 in TTD benefits. The claim remained open throughout this period. In February 1995, following an internal claim audit, SAIF retroactively recalculated claimant's weekly wage using claimant's weekly wages during the 26 weeks prior to his compensable injury. As such, SAIF determined that it had over paid claimant about $52,000. For the period beginning February 9, 1995, SAIF began to pay claimant TTD benefits based on the recalculated wage of $213 dollars per week. Thereafter, claimant requested a hearing.

The ALJ found that SAIF properly recalculated claimant's temporary disability rate 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 claimant's employment with the logging company. See OAR 436-60-025(5)(a). Further, the ALJ determined that claimant did not enter into a new employment contract with his employer in the four weeks prior to his compensable injury.

On review, claimant contends that either he entered into a new employment relationship with his employer in July 1990 or that there were extended gaps in employment during the 26 weeks prior to his compensable injury. As such, claimant asserts that his TTD based on a weekly wage of $520, as originally determined by SAIF, was correct. We disagree.

In Earin J. Hadley, 48 Van Natta 216 (1996) we adhered to our long-standing interpretation of OAR 436-60-025(5)(a), that an extended gap must include a break in the work, and the "break" must cause a change in the work relationship between the employer and the employee. See Steven Caldwell, 44 Van Natta 2566 (1992). We reasoned that each particular work relationship must be examined to determine whether the break in the performance of the work activities constituted a change in that work relationship. As such, we concluded that this determination must be made on a case-by-case basis.

Here, we find, as did the ALJ, that the breaks in claimant's work activities did not change the work relationship, between claimant and his employer. For instance, both parties were aware that periodic breaks in the work activities were going to occur because of the nature of the logging business at that time. Additionally, both claimant and his employer were of an understanding that claimant could, and in fact did, return once work resumed after these "lay offs." Further, the fact that claimant went to work for another employer in June 1990, did not change the employment relationship because both parties continued to believe that claimant could return to employment with the logging company, once the lay off ended.

Under such circumstances, we conclude that the breaks in claimant's work activities did not cause a change in the employment relationship between claimant and his employer. See Steven Caldwell, supra. Therefore, there were no extended gaps in claimant's work activities with his employer. Accordingly, SAIF correctly recalculated claimant's TTD benefits.

Similarly, we find that claimant should not be considered as beginning a "new" employment relationship with the employer when he went back to work in July 1990. For instance, there was nothing about the lay off in June 1990, as well as claimant's return to work, which suggested that claimant and his employer had begun a "new" employment relationship. Further, the fact that claimant did not enter into a "new" employment contract prior to beginning work in July 1990 lends support to our conclusion. Consequently, we conclude that SAIF properly recalculated claimant's average weekly wage based on the previous 26 weeks wages prior to claimant's compensable injury.

ORDER

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

April 10, 1996 Cite as 48 Van Natta 796 (1996)

In the Matter of the Compensation of
RUTH A. BARTON, Claimant
WCB Case No. 94-10608
ORDER ON REVIEW
Myrick, Seagraves, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order which upheld the insurer's denial of his occupational disease claim for bilateral degenerative knee arthritis. 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 upheld the insurer's denial of claimant's occupational disease claim for bilateral degenerative knee arthritis. In doing so, the ALJ reasoned that the medical evidence established that claimant's predisposition to knee cartilage wear and tear was the major contributing cause of her degenerative knee condition. Concluding that claimant's predisposition qualified as a "preexisting

condition" within the meaning of ORS 656.005(24)[1], and, thus, was a cause under ORS 656.802(2)(e), the ALJ found that claimant had failed to establish that her employment as a bartender since 1983 was the major contributing cause of her bilateral knee condition.

On review, claimant contends that the testimony of her consulting orthopedist, Dr. Webb, establishes that her employment, which required that she be on her feet for extended periods, was the major contributing cause of her bilateral degenerative knee disease. While we agree with the ALJ that claimant failed to sustain her burden of proof, our reasoning differs from the ALJ's.

The parties agree that this is an occupational disease claim. Claimant seeks a determination that her degenerative arthritic condition is compensable. Inasmuch as this occupational disease claim is not based on the worsening of a preexisting disease or condition, see ORS 656.802(2)(b), claimant must prove that employment conditions during her work as a bartender were the major contributing cause of her degenerative disease. ORS 656.802(2)(a).

In upholding the insurer's denial, the ALJ cited Dr. Webb's deposition testimony that identified the degree of "toughness" of knee cartilage as playing "a major role" in determining the lifelong function of a knee joint. (Ex. 28-26). Finding that claimant had a predisposition to cartilage wear and tear and that this was the major contributing cause of her bilateral knee condition, the ALJ determined that claimant had failed to satisfy her burden of proving work conditions were the major contributing cause of her occupational disease.

Claimant asserts that the degree of "toughness" of knee cartilage does not qualify as a "preexisting condition" under ORS 656.005(24) and that, if it does, the statute violates Article 1, Section 10 of the Oregon Constitution and the Americans with Disabilities Act (ADA). 42 USC 12132. We need not address these arguments, however.[2]

Whether or not claimant's predisposition to cartilage wear and tear qualifies as a "preexisting condition" under ORS 656.005(24), Dr. Webb's opinion that this "condition" plays a major role in knee joint arthritis does not establish that it was the major contributing cause of claimant's condition. See Arnold D. Schaffer, 47 Van Natta 1667, 1670 (1995) (physician's opinion that injury was a major contributing cause did not establish causation). We, therefore, conclude that Dr. Webb's opinion is insufficient to prove that claimant's alleged predisposition is the major causal factor in her knee condition, whether or not it qualifies as a "preexisting condition."

While we disagree with the ALJ's finding that claimant's predisposition to cartilage wear and tear is the major contributing cause of her bilateral knee condition, we still conclude, based on the following reasoning, that claimant has not sustained her burden of proof.

Claimant's attending physician, Dr. Renaud, opined that claimant's weight was the "overwhelming predisposing factor" in claimant's arthritis condition. (Ex. 25-1). Dr. Renaud explained that claimant's weight placed an "unphysiologic" load with any activity that claimant accomplished, with every step she took and with every twist and turn. Dr. Renaud opined that claimant's weight contributed greater than 51 percent to degenerative changes in her knee.

Generally, we defer to the opinion of the attending physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). Citing Hammons v. Perini Corp., 43 Or App 299 (1979), claimant argues that this case involves expert analysis, rather than expert observation and, therefore, we should not defer to Dr. Renaud's opinion. Instead, claimant argues that Dr. Webb's opinion that claimant's work activity is the major contributing cause of her bilateral knee condition is more persuasive. (Ex. 27). We disagree with claimant's contentions.

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[1] ORS 656.00(24) provides:

"'Preexisting condition' means any injury, disease, congenital abnormality, personality disorder or similar condition that contributes or predisposes a worker to disability or need for treatment and that precedes the onset of an initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273."

[2] Claimant concedes that she did not raise a constitutional issue before the ALJ, nor do we find that she raised her argument based on the ADA at the hearing. Under these circumstances, we are not inclined to address those issues on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991).

Dr. Webb, who had examined claimant one time, commented in his deposition on the issue of whether an attending physician, who has the opportunity to observe a medical condition for an extended period, has an advantage in addressing causation issues.[3] Dr. Webb testified: "Again, I think that if a physician has an opportunity to see a patient over five, six, seven years, you have a better feel as to what they do in their work, you have a better feeling of what they do in their recreational lives, and how either one may contribute to a particular condition that they're seeing you for." (Ex. 28-15, emphasis added).

Moreover, Dr. Webb was specifically asked if he was in as good a position to comment on causation as Dr. Renaud. (Ex. 28-15). Dr. Webb did not confirm that he was, testifying only that "I am in a position to render an opinion regarding causation." (Ex. 28-16). Based on our review of Dr. Webb's testimony, we do not find that this is a case of expert analysis rather than expert observation. Nor do we find Dr. Webb's opinion to be more persuasive than Dr. Renaud's.

Dr. Webb testified that arthritis is "multifactorial" and that he could not say claimant's degenerative condition was "related to one thing or another." Ex. 28-6). Dr. Webb also conceded that he could not answer the question of why knee cartilage wears out in some people and not in others. (Ex. 28-22). In contrast to Dr. Webb's equivocal testimony, we find Dr. Renaud's medical opinion to be unequivocal, sufficiently explained and based on long-term experience with claimant's knee condition. Accordingly, we find Dr. Renaud's opinion more persuasive than Dr. Webb's. See Somers v. SAIF, 77 Or App 259 (1986).

In summary, we agree with the ALJ that claimant failed to sustain her burden of proof, although for different reasons. Accordingly, we affirm the ALJ's decision upholding the insurer's denial.

ORDER

The ALJ's order dated October 3, 1995 is affirmed.

[3] Dr. Renaud began treating claimant in 1988.

April 10, 1996 Cite as 48 Van Natta 798 (1996)

In the Matter of the Compensation of
ELIZABETH K. BENJAMIN, Claimant
WCB Case No. 94-01828
ORDER ON REVIEW (REMANDING)
Black, Chapman, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Claimant requests review of those portions of Administrative Law Judge (ALJ) Stephen D. Brown's order that: (1) found that claimant's claim was not prematurely closed; (2) upheld the insurer's denial of claimant's aggravation claim for a low back condition; and (3) affirmed an Order on Reconsideration that affirmed a Notice of Closure which awarded 16 percent (51.2 degrees) unscheduled permanent disability for a low back injury. The insurer cross-requests review of that portion of the ALJ's order that set aside its denial of claimant's current low back condition. On review, the issues are premature closure, compensability, aggravation and extent of unscheduled permanent disability. We affirm in part and vacate and remand in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Finding that claimant's low back condition had symptomatically worsened, but that claimant had not established that she was less able to work, the ALJ upheld the insurer's aggravation denial. Nevertheless, concluding that claimant's current low back condition was compensably related to her accepted injury claim, the ALJ set aside the insurer's denial of claimant's current low back condition. The ALJ also found that the claim was not prematurely closed and affirmed the Notice of Closure/Order on Reconsideration award of 16 percent unscheduled permanent disability. In affirming the Order on Reconsideration, the ALJ declined to rely on the medical arbiter's impairment findings because claimant

had increased symptoms due to her compensable injury at the time of the medical arbiter's exam (although a compensable aggravation had not been established).

Premature Closure

Before addressing whether claimant's condition worsened after closure, but before the Order on Reconsideration, it is necessary to determine whether claimant's claim was prematurely closed. Claimant raises the contention that her claim was prematurely closed because she was not medically stationary on the date of closure. Claimant's claim was closed by a June 2, 1993 Notice of Closure which found claimant medically stationary on April 29, 1993. The medically stationary finding was based on the closing report of Drs. Rich and Donahoo (with which Dr. Gooding, claimant's then-attending physician, concurred). The only evidence that claimant was not medically stationary on the date of closure comes from Dr. Thomas, claimant's present attending physician.

Dr. Thomas believed that claimant had probably never attained a medically stationary status after her compensable injury.[1] Dr. Thomas based his opinion on the belief that claimant's condition was never correctly diagnosed and treated. (Ex. 71-20, 21). Dr. Thomas first saw claimant in October 1993, after claimant had suffered a symptomatic aggravation of her low back condition.

Because Dr. Thomas did not examine claimant at the time of claim closure and was not able to observe her condition on that date, we do not find his opinion persuasive concerning claimant's medically stationary status. Instead, we rely on the opinions of Drs. Rich, Donahoo and Gooding. Those physicians were able to examine claimant at the time of closure and were more familiar with her condition at that time. Thus, we defer to their opinions concerning claimant's medically stationary status. Accordingly, we conclude that claimant has not established that she was not medically stationary at the time of claim closure.

Compensability

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

The ALJ concluded that claimant's current low back condition was compensable.[2] The insurer relies on the medical opinion of Dr. Battalia and argues that claimant's current low back condition is the result of her preexisting degenerative disc disease and an off-work incident where she "stepped wrong" rather than the compensable injury. Claimant relies on the opinion of her treating physician, Dr. Thomas.

Dr. Battalia, a general surgeon, performed a records review and opined that claimant has degenerative disc disease which was not caused or worsened by the work injury. Dr. Battalia further opined that the degenerative disc disease was the major cause of claimant's continued intermittent need for treatment with waxing and waning of her recurrent back strain.

Dr. Thomas, D.O., began treating claimant in October 1993, after her original low back injury claim had been closed. He explained that there was no such diagnosis as the "disc strain" which had been accepted by the insurer. Rather, Dr. Thomas diagnosed an L5-S1 disc herniation which had been caused by the September 1992 compensable injury. Dr. Thomas attributed claimant's symptoms to the disc herniation. He explained that the L5-S1 disc condition had been overlooked and misdiagnosed. Because the condition was overlooked, Dr. Thomas believed that it was inadequately treated and had worsened. Although he was aware of the "stepping off the curb" incident, Dr. Thomas opined that the major contributing cause of the disc condition and need for treatment was the September 1992 injury.

Of the two medical opinions concerning causation, we are more persuaded by that of Dr. Thomas. Dr. Thomas' medical opinion is well reasoned and is based on a complete history. We chose not to rely on Dr. Thomas' opinion concerning claimant's medically stationary status only because Dr.

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[1] Dr. Thomas' opinion regarding claimant's medically stationary status was given "post-reconsideration" order. Therefore, the admissibility of Dr. Thomas opinion is questionable under amended ORS 656.283(7). Joe R. Ray, 48 Van Natta 325 (1996). We need not, however, resolve the admissibility of Dr. Thomas' "post-reconsideration" order opinion, because even if that opinion is considered, we conclude that claimant has not established that her claim was prematurely closed.

[2] Assuming that Dr. Potter's "post-reconsideration" order opinion concerning the cause of claimant's need for treatment in the Fall of 1993, we agree with the ALJ that his opinion is conclusory and therefore unpersuasive.

Thomas did not observe claimant at the time of closure. On that basis, we accorded more weight to the physicians who had examined/treated claimant at that time.

Regarding the issue of causation, the only contrary medical opinion is that of Dr. Battalia. Dr. Battalia performed only a records review and did not examine claimant. By contrast, Dr. Thomas has treated claimant's low back condition and has given a well reasoned opinion concerning causation. Based on this record, we rely on the opinion of Dr. Thomas and conclude that the September 1992 injury is the major contributing cause of claimant's current low back condition. Somers v. SAIF, 77 Or App 259 (1986); Weiland v. SAIF, 64 Or App 810, 814 (1983).

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 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.

Aggravation

The ALJ found that claimant had suffered a symptomatic worsening, but that this worsening did not rise to the level of a compensable aggravation. Claimant contends that she suffered a compensable aggravation of her low back condition between the date her claim was closed and the date she was examined by the medical arbiter, Dr. Potter. Claimant argues that the ALJ could not reject the medical arbiter's impairment findings on the grounds that claimant's condition had worsened and also uphold the insurer's aggravation denial. Finally, claimant asserts that her condition has either compensably worsened, or that she is entitled to a greater permanent disability award based on the medical arbiter's findings.

The insurer agrees that claimant's condition symptomatically worsened in September 1993. However, the insurer argues that claimant did not establish that the worsening rendered her less able to work. On this basis, the insurer seeks to have the ALJ's decision that claimant did not establish a compensable aggravation affirmed.

Subsequent to the ALJ's order, the 1995 legislature has 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 evidence of an actual worsening of the compensable condition supported by objective findings." (Emphasis added). The 1995 amendments do not define the term "actual worsening." In Carmen C. Neill, 47 Van Natta 2371 (1995), 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 been resolved on appeal. See Newell v. SAIF, 136 Or App 280 (1995). Under amended ORS 656.273(1), 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. Carmen C. Neill, supra.

Here, there is no medical evidence that claimant suffered a pathological worsening. Thus, the issue is whether claimant's symptomatic worsening constitutes an "actual worsening," i.e., was more than a waxing and waning contemplated by her previous permanent disability award.

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, e.g., Helen M. Callendar, 47 Van Natta 626 (1995); 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).

Here, Board review of this case was pending when the "actual worsening" standard of amended ORS 656.273(1) went into effect. The record is devoid of evidence concerning whether claimant sustained an "actual worsening" of her compensable low back condition. In light of the fact that the

parties lacked the opportunity to generate medical evidence regarding whether claimant's symptomatic worsening constitutes an "actual worsening" of her condition, we consider the record to be incompletely and insufficiently developed to determine whether claimant's sustained a compensable aggravation. Moreover, because amended ORS 656.273(1) went into effect after this record was developed/closed and prior to our order 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" of her low back condition.

Because of our decision to remand this case for further development concerning the aggravation issue, we do not resolve the remaining issues of permanent disability arising from the closure of claimant's claim. We do so because the outcome of the aggravation issue may have an impact on the persuasiveness of the medical arbiter's report and findings. See former OAR 436-30-050(11)(d) (medical arbiter exam not appropriate where worker has become non-medically stationary or where a subsequent unrelated worsening has occurred); see also ORS 656.268(7)(h)(B) (if worker's condition has substantially changed since claim closure, upon the consent of all parties, the director shall postpone the reconsideration proceeding). On remand, once the record concerning aggravation has been further developed and the ALJ has resolved that issue, the ALJ should then proceed to reconsider the permanent disability issue. However, in addressing the permanent disability issue, only the previously admissible evidence in this record shall be considered.[3]

Accordingly, the ALJ's order dated February 14, 1995 is affirmed in part and vacated in part. We affirm those portions of the ALJ's order which found that claimant's claim is not prematurely closed, which set aside the insurer's denial of claimant's current low back condition, and awarded a $2,800 attorney fee. For services on Board review concerning the compensability issue, claimant's attorney is awarded $750, to be paid by the insurer. We vacate those portions of the ALJ's order that upheld the insurer's denial of claimant's aggravation claim and affirmed the Order on Reconsideration's permanent disability award. The aggravation and extent of permanent disability portions of this case are remanded to ALJ Stephen Brown for further proceedings consistent with this order. Those further proceedings may be conducted in any manner that the ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order concerning the aforementioned issues.

IT IS SO ORDERED.

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[3] In reaching our decision to remand, we distinguish this case from Aurora M. Arevalo, 48 Van Natta 517 (1996). In Arevalo, we declined to remand for further development regarding the "actual worsening" standard of amended ORS 656.273(1). In Arevalo, 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 had sustained an "actual worsening." Here, the new law went into effect after the record concerning the aggravation had been developed. Thus, Arevalo is distinguishable.

We likewise find this case distinguishable from Solio C. Diaz, 48 Van Natta 371 (1996). In Diaz, we declined to remand although the record was developed, closed and the ALJ's order was issued prior to the effective date of Senate Bill 369. In Diaz, the record revealed that the insurer had contended at hearing that the claimant's symptomatic increase did not exceed the waxing and waning contemplated by his previous award of 50 percent unscheduled permanent disability. We reasoned that, whether the case was analyzed under the former or current legal standard, the question remained whether the claimant's symptomatic increase exceeded the "waxing and waning" contemplated by his prior permanent disability award. Thus, because of the similarity of the former and current legal standards, we found no compelling reason to remand.

Here, unlike in Diaz, the record does not reflect whether the insurer contended at hearing that claimant's worsening was more than a "waxing and waning" contemplated by her previous permanent disability award. In addition, under the law in effect at the time the record was developed and closed, there had to be medical evidence predicting future flare-ups in order to establish that waxing and waning was contemplated by the prior award. See Lucas v. Clark, 106 Or App 687 (1991).

In this case, the record does not contain medical evidence predicting future flare-ups of claimant's condition. Thus, when this case was tried, it was unnecessary for claimant to establish that her symptomatic worsening was more than a contemplated waxing and waning. As a result of amended ORS 656.214(7), all permanent disability awards now contemplate future waxing and waning of symptoms. Under such circumstances, we conclude that a compelling reason to remand exists in this case in order to afford the parties the opportunity to develop the record regarding the new standard contained in amended ORS 656.273(1) and 656.214(7).

In the Matter of the Compensation of
BRIAN A. BERGRUD, Claimant
WCB Case No. 95-03165
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside an Order on Reconsideration; and (2) remanded the claim to the Appellate Unit for a medical arbiter's examination. On review, the issues are extent of permanent disability (scheduled and unscheduled) and claim processing. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. Claimant has a compensable low back injury diagnosed as a left herniated disc at L5-S1. (Exs. 31, 32). Dr. Louie, neurologist, is claimant's attending physician for his low back injury. A July 29, 1994 Determination Order, as corrected on August 16, 1994, awarded claimant 13 percent (41.6 degrees) unscheduled permanent disability for the low back injury. (Exs. 35, 38). Claimant requested reconsideration, disputing, inter alia, the impairment findings used to rate his impairment and requesting a medical arbiter examination.

On February 3, 1995, the Department issued an Order on Reconsideration based on a record review conducted by the medical arbiter, Dr. Martens, orthopedist. (Exs. 41, 42). This Order on Reconsideration left the unscheduled permanent disability award unchanged, awarded 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of the left foot, and affirmed the Determination Order in all other aspects. (Ex. 42). Claimant requested a hearing, contesting the Department's instructions to the medical arbiter to conduct a record review rather than perform an examination.

CONCLUSIONS OF LAW AND OPINION

Claim Processing

Following claimant's request for reconsideration, a medical arbiter's examination was scheduled for January 20, 1995. On January 10, 1995, claimant's attorney notified the Appellate Unit that claimant had injured his knee and collar bone in an motor vehicle accident; however, claimant would keep the scheduled appointment with the medical arbiter. The Appellate Unit requested the medical arbiter to address only the accepted lumbar injury and indicate whether any findings were a result of a subsequent injury. (Ex. 42-4).

On January 17, 1995, the Appellate Unit received from the employer a copy of a letter from Dr. Versteeg,[1] "wherein Dr. Versteeg indicated that the medical arbiter examination should be postponed and rescheduled in approximately two months. Dr. Versteeg indicated, by not checking the provided statement, that a medical arbiter examination would be affected by the injuries sustained in the 12-19-94 car accident." (Ex. 42-5, emphasis in the original).[2]

While acknowledging that the injuries claimant sustained in the December 1994 car accident involved body parts other than those involved in the compensable lumbar injury, the Appellate Reviewer concluded "those recent injuries would compromise the validity of a medical arbiter examination." (Ex. 42-5). Therefore, citing former OAR 436-30-015(11)(d), the Appellate Reviewer requested that the medical arbiter perform a record review rather than the scheduled examination. Dr. Martens served as the medical arbiter and performed that record review. Id. The February 3, 1995 Order on Reconsideration was based on Dr. Martens' record review and the closing reports from Dr. Louie, attending physician. Id.

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[1] Dr. Versteeg's capacity is not identified in the record. However, in his respondent's brief, claimant states that Dr. Versteeg was treating claimant's knee injury that resulted from the motor vehicle accident. (Respondent's Brief, page 1).

[2] A copy of Dr. Versteeg's letter is not in the record. This summary of the contents of Dr. Versteeg's letter is taken from the Order on Reconsideration. The parties do not dispute the contents of Dr. Versteeg's letter as summarized in the Order on Reconsideration.

The ALJ determined that the Appellate Reviewer's reliance on former OAR 436-30-015(11)(d) to cancel the scheduled medical arbiter's examination and order a record review in its place was not appropriate because there was no "unrelated worsening" of the compensable condition. In addition, the ALJ found that the Director did not comply with ORS 656.268(7)(h)(B).[3] Therefore, the ALJ remanded the claim to the Appellate Unit to "hold an arbiter's exam and issue an Order on Reconsideration." (Opinion and Order, page 3). For the following reasons, we disagree with the ALJ that the Appellate Reviewer erred in ordering a record review.[4]

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). ORS 656.268(7)(h) 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, ORS 656.268(7)(h)(B) applies here, provided that the facts of this case come within the terms of that statute.

ORS 656.268(7)(h)(B) provides that the Director must postpone the proceeding "until the worker's condition is appropriate for claim closure" under amended ORS 656.268(1), if the following two conditions are met: (1) "the worker's condition has subsequently changed since the notice of closure or the determination;" and (2) all of the parties to the claim consent to the postponement. Here, the record does not establish that all parties consented to a postponement of the reconsideration proceeding. Therefore, by its terms, ORS 656.268(7)(h)(B) does not apply under the circumstances of this case.

However, that does not end our inquiry. The ALJ also relied on former OAR 436-30-015(11)(d)[5] in determining the Appellate Reviewer's cancellation of the medical arbiter's examination and ordering of a record review in its place was not appropriate.

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[3] Senate Bill 369 added ORS 656.268(7)(h), which provides:

"(A) When the basis for objection to a notice of closure or determination order issued under this section is a disagreement with the impairment used in rating the worker's disability, and the director determines that the worker is not medically stationary at the time of reconsideration, the director is not required to appoint a medical arbiter prior to the completion of the reconsideration proceeding.

"(B) If the worker's condition has subsequently changed since the notice of closure or the determination, upon the consent of all the parties to the claim, the director shall postpone the proceeding until the worker's condition is appropriate for claim closure under subsection (1) of this section."

[4] In any event, even if the Appellate Reviewer had erred in restricting the medical arbiter's review to a record review, the remedy would not lie in a remand to the Appellate Unit because neither the Hearings Division nor the Board has authority to remand a claim to the Department under the facts of this case. Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993); Linda M. Cross, 45 Van Natta 2130 (1993); Carl R. Alatalo, 46 Van Natta 338 (1994); but see Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993) (the Board has inherent authority to remand a claim to the Director for adoption of a temporary rule amending the standards to address a worker's disability).

[5] The ALJ, the Appellate Reviewer, and the parties cite former OAR 436-30-050(11)(d) as applying to this case. WCD Admin Order No. 5-1992 (eff. 2/20/92). However, effective January 1, 1995, former OAR 436-30-050(11)(d) was renumbered as former OAR 436-30-165(5), with minor changes in its language. WCD Admin. Order No. 94-059. Pursuant to former OAR 436-30-003(4), the provisions of former OAR 436-30-165 apply to all determinations for workers who become medically stationary after July 1, 1990. WCD Admin. Order No. 94-059. Here, claimant became medically stationary on April 12, 1993. Therefore, former OAR 436-30-165(5) applies to claimant's claim. Former OAR 436-30-003(4), WCD Admin. Order No. 94-059.

We note that, at one point in his reasoning, the ALJ relied on former OAR 436-30-165(4)(a) in support of his conclusion that the Appellate Reviewer abused his discretion in not postponing the medical arbiter's examination. However, by its terms, former OAR 436-30-165(4)(a) does not apply to the facts of this case. Former OAR 436-30-165(4)(a) applies where a worker fails to appear for a medical arbiter examination. Here, claimant did not fail to appear for the examination; instead, the medical arbiter examination was canceled and a record review was ordered in its place by the Appellate Reviewer. Under the circumstances of this case, we find that former OAR 436-30-165(5) is the applicable rule.

Former OAR 436-30-165(5) provides:

> "When a medical arbiter examination is requested by a party and the worker has subsequently become non-medically stationary and/or the claim has been reopened, or where a subsequent unrelated worsening has occurred, a medical arbiter examination is not appropriate. In such cases, the Department may order a record review by an arbiter and base its impairment rating on the medical arbiter's opinion regarding impairment at the time of claim closure." (WCD Admin. Order No. 94-059).[6]

The employer argues that the "subsequent unrelated worsening" referred to in former OAR 436-30-165(5) relates to any intervening worsening, not just an unrelated worsening of the compensable injury. Therefore, the employer contends, the phrase "'subsequent unrelated worsening' . . . means that if an intervening worsening of the claimant's physical status makes it difficult or impossible to reach an objective conclusion about residual disability from the claim, the Department may rely on a record review." (Appellant's Brief, page 3). We agree.

Neither the ALJ nor claimant cites any authority for the proposition that the worsening referred to in former OAR 436-30-165(5) refers only to a worsening of the compensable condition. Furthermore, we find no such authority.

We note that the standard for determining whether impairment is related to a compensable injury is specifically set out by statute. ORS 656.214(5) provides that the criteria for the rating of unscheduled disability "shall be the permanent loss of earning capacity due to the compensable injury." Pursuant to ORS 656.214(2), the criteria for rating scheduled disability "shall be the permanent loss of use or function of the injured member due to the industrial injury." However, neither statute necessarily requires that "a subsequent unrelated worsening," as that phrase is used in former OAR 436-30-165(5), refers only to a unrelated worsening of the compensable condition. Thus, as long as the requirement that impairment is rated according to the permanent disability due to the compensable injury is met, the requirements of ORS 656.214 (2) and (5) will be fulfilled. We conclude that a record review will meet these requirements under the facts of this case.

Here, unrebutted medical evidence indicated that a worsening of an unrelated noncompensable condition would affect the medical arbiter's ability to rate claimant's disability due to the compensable condition. Therefore, in order to meet the requirements of ORS 656.214(2) and (5) and rate only disability due to the compensable lumbar condition, a record review was appropriate. Accordingly, the Appellate Reviewer did not err in limiting the medical arbiter's review to a record review under the circumstances of this case.

Having found that the limitation to a record review was appropriate, we proceed to address the merits of the extent issue. We apply the disability standards in effect on the date of the Determination Order 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 July 29, 1994, as corrected August 16, 1994. Accordingly, those standards contained in WCD Admin. Orders 6-1992, 17-1992, and 93-056 apply to claimant's claim. Claimant has the burden of proving the extent of disability resulting from his compensable injury. ORS 656.266.

Extent of Unscheduled Permanent Disability

Impairment

Due to his compensable lumbar injury, claimant underwent a left L5-S1 microlumbar discectomy, which is valued at 9 percent impairment. Former OAR 436-35-350(2)(a).

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[6] The language is essentially the same in both former OAR 436-30-050(11)(d) and former OAR 436-30-165(5). The parties inaccurately cite former OAR 436-30-050(11)(d) in their arguments. However, in order to avoid confusion, we will cite former OAR 436-30-165(5) when referring to the parties' arguments during the remainder of our order.

Dr. Martens noted that there were no recorded inclinometer measurements in the records he reviewed.[7] (Ex. 41-2). In addition, Dr. Martens assumed that claimant's range of motion was within normal limits, based on the fact that the records he reviewed showed claimant and Dr. Louie were pleased with the results of the surgery. Id.

Dr. Louie performed inclinometer measurements in his April 12, 1993 closing exam, when he found claimant medically stationary. (Ex. 28-2, -3). Claimant remained medically stationary during the subsequent litigation regarding the compensability of his lumbar injury. After claimant's lumbar injury was found compensable by a prior ALJ's order and accepted by the employer, claimant returned to Dr. Louie for another closing exam on June 22, 1994. (Ex. 33). Dr. Louie did not repeat the inclinometer studies.

We find Dr. Louie's range of motion measurements more persuasive than Dr. Marten's "assumption" that claimant's ranges of motion were normal based on good surgical results. In addition, claimant remained medically stationary between the two closing examinations. Therefore, we find Dr. Louie's April 1993 measurements persuasive evidence of permanent impairment due to loss of range of motion caused by the compensable injury.

Dr. Louie measured 55 degrees lumbar flexion and 20 degrees lumbar extension. (Ex. 28-3). These losses of ranges of motion are each valued at 2 percent impairment. Former OAR 436-35-360(19) and (20). These values are added for a total of 4 percent impairment due to loss of range of motion. Former OAR 436-35-360(22).

The value for loss of range of motion (4) is combined with the value for the surgical procedure (9), for a total impairment value of 13 percent. Former OAR 436-35-360(23).

Age and Education Factors

Claimant's date of birth is October 9, 1964. Thus, claimant was under 40 years old at the time of the February 3, 1995 Order on Reconsideration. Accordingly, the value for the age factor is zero. Former OAR 436-35-290(1).

Claimant has a high school diploma. Therefore, the value for formal education is zero. Former OAR 436-35-300(2)(a). The value for a worker's Specific Vocational Preparation (SVP) time is the highest SVP of any job that the worker has met in the five years prior to determination. Former OAR 436-35-300(3)(b). Core feeder (millwork-plywood) (DOT 569.685-018), the at-injury job, is claimant's job with the highest SVP in the five years prior to determination. This job has a SVP of 3, which is rated as an SVP value of 3. Former OAR 436-35-300(4). Adding together the formal education value (0) and the SVP value (3) results in an education factor of 3.

Adaptability Factor

Adaptability is measured by comparing the Base Functional Capacity (BFC) to claimant's maximum Residual Functional Capacity (RFC) at the time of becoming medically stationary. Former OAR 436-35-310(2). Claimant did not undergo a second-level physical capacity evaluation. Therefore, claimant's BSF is determined by the highest strength category assigned in the DOT for the most physically demanding job that he successfully performed in the five years prior to determination. Former OAR 436-35-310(4). The job that meets this standard is claimant's core feeder job, which has a strength category of medium. (DOT 569.685-018). Thus, claimant's BSF is medium.

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[7] We note that claimant argues that inadequacies in Dr. Martens' record review, including the apparent lack of inclinometer measurements in the records Dr. Martens reviewed, support claimant's request that the claim be remanded to the Director for a medical arbiter examination. However, claimant had a remedy available through the Department's reconsideration process to correct any errors in Dr. Martens' record review. Under its administrative rules, the Department may rescind its order and issue a new one at the request of either party for the correction of inadvertent errors or omissions brought to the Department's attention before a hearing is requested. Former OAR 436-30-008(1); Joseph E. Steele, 47 Van Natta 119 (1995). Insofar as claimant is alleging an inadvertent error or omission, that contention could have been submitted to the Department after he received his copy of either the medical arbiter's report or the Department's Order on Reconsideration. Claimant failed to do so.

Given the fact that claimant did not undergo a second-level physical capacity evaluation or any other medical evaluation that would meet the qualifications of former OAR 436-35-310(5)(b), claimant's RFC is the greatest capacity evidenced by the attending physician's release. Former OAR 436-35-310(5)(a). In his closing exam, Dr. Louie released claimant to a maximum lifting capacity of 50 pounds, with a maximum repetitive lifting capacity of 20 pounds. (Exs. 28-2, 33). He also noted claimant was limited to sitting one hour at a time, four hours in an eight hour day. Id. These lifting limitations indicate that claimant has the ability to do more than light activities, but less than the full range of medium activities; therefore, claimant has an RFC between the medium and light categories. Former OAR 436-35-310(3)(f), (g). In addition, claimant is permanently limited to sitting less than two hours at a time; thus, claimant has "restrictions" within the meaning of the rules. Former OAR 436-35-310(3)(l)(A). When a worker has an RFC between two categories and also has restrictions, the next lower classification is used. Former OAR 436-35-310(7). Therefore, claimant's RFC is light. Id.

Comparing claimant's BFC (medium) to his RFC (light) gives claimant an adaptability factor of 3. Former OAR 436-35-310(6).

Assembling the Unscheduled Disability Factors

We now proceed to calculate claimant's unscheduled permanent disability award. Claimant's age (0) and education (3) factors are added for a total of 3. Former OAR 436-35-280(4). This result is multiplied by the adaptability factor (3) for a product of 9, which is added to the impairment value (13), for a total unscheduled permanent disability award of 22 percent. Former OAR 436-35-280(6) and (7). Therefore, we increase claimant's unscheduled permanent disability award from 13 percent, as awarded by the Order on Reconsideration, to 22 percent.

Extent of Scheduled Permanent Disability

In the chart note regarding claimant's June 22, 1994 examination, Dr. Louie noted "decreased light touch in the lateral left foot." (Ex. 33). Relying on this chart note, Dr. Martens stated that Dr. Louie noted "some decreased light touch in the lateral aspect of the plantar surface of the left foot." (Ex. 41-2). Dr. Martens concluded that "[t]his is a partial loss of sensation consistent with a S1 radiculopathy." (Ex. 41-2). Based on Dr. Martens' statement, the Order on Reconsideration awarded claimant 5 percent scheduled disability for a partial loss of sensation on the plantar surface of the left foot. Former OAR 436-35-200(1). For the following reasons, we find that claimant has not establish any scheduled permanent impairment.

In the first place, Dr. Louie did not state that claimant had a partial loss of sensation in the plantar area of the foot. (Exs. 33, 34). In addition, in a July 20, 1994 letter, Dr. Louie questioned the left foot findings listed in his June 22, 1994 chart note, stating that the loss of sensation findings were "minimal," were not present at claimant's previous closing examination, and would be "difficult to reproduce." (Ex. 34).

However, in concluding that Dr. Louie found loss of plantar sensation, Dr. Martens does not address these aspects of Dr. Louie's opinion. For this reason, we do not find persuasive Dr. Martens' opinion regarding any loss of plantar sensation. In addition, given the fact that Dr. Louie questions the loss of sensation findings, we do not find that his opinion establishes any permanent impairment due to loss of sensation. Former OAR 436-35-007(1).

Finally, Dr. Louie does not indicate that claimant has any loss of strength or any other permanent impairment in his legs. The only indication regarding strength is Dr. Louie's notation that claimant "has good toe rise at 5/5." (Ex. 33). Therefore, on this record, we find that claimant has failed to establish any scheduled permanent disability.

ORDER

The ALJ's order dated June 23, 1995, as corrected on July 21, 1995, is reversed. In addition to the 13 percent (41.6 degrees) unscheduled permanent disability for a low back injury granted by the Determination Order, as affirmed by the Order on Reconsideration, claimant is awarded 9 percent (28.8 degrees) unscheduled permanent disability, for a total unscheduled permanent disability award to date

of 22 percent (70.4 degrees). The 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of the left foot awarded by the Order on Reconsideration is reversed. Claimant's counsel is awarded 25 percent of the increased unscheduled permanent disability compensation created by this order, not to exceed $3,800, payable directly to claimant's attorney.

In the Matter of the Compensation of
CYNTHIA R. BOE, Claimant
WCB Case No. 94-13479
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order which upheld the SAIF Corporation'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.

ORDER

The ALJ's order dated September 25, 1995 is affirmed.

Board Member Gunn dissenting.

Here, the majority has adopted the ALJ's opinion, which found that claimant has not met her burden of proof in establishing a compensable occupational disease pursuant to ORS 656.802. For the following reasons, I would find that claimant has proven the compensability of her bilateral carpal tunnel condition.

The ALJ found that claimant's job required hand intensive activities at least six hours per day. Claimant's treating doctor, Dr. McLennon, prescribed a wrist brace and physical therapy and concluded that claimant's work activity was the major contributing factor in her bilateral carpal tunnel condition becoming symptomatic and requiring her to seek treatment. (Ex. 7). In reaching his conclusion, Dr. McLennon noted that claimant had problems while on the job and her symptoms subsided while she was laid off. Dr. McLennon explained that, after claimant's return to work, claimant was required to perform 7 to 8 hours of keyboarding, which caused her to again become symptomatic. (Ex. 7).

On review, SAIF argues that Dr. McLennon's opinion cannot meet claimant's burden because there is no evidence to support a finding that claimant's symptoms are the disease. I disagree with SAIF's contentions.

Here, even Dr. Nathan has agreed that claimant has a bilateral carpal tunnel syndrome. More importantly, however, Dr. Nathan has found that claimant's nerve conduction studies show slowing of both median nerves at the distal carpal tunnel. Additionally, Dr. Nathan reported that claimant "would benefit from bilateral carpal tunnel releases." (Ex. 5-5).

Under the circumstances, I believe that the medical record in this case shows that claimant's symptoms are the disease. Although SAIF argues that no doctor has specifically stated that the symptoms are the disease, I do not find support in the case law for the proposition that "magic words" are required in carpal tunnel cases. In actuality, the court has agreed with the Board in cases where there was no such recitation. See e.g. Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990) (The court agreed with the portion of the Board's decision which found that the claimant's symptoms were the disease. The Board had relied on the employer's expert, who testified that although the claimant experienced only temporary problems with no permanent tissue damage, the claimant experienced physical changes and not just symptoms. The court agreed that the medical evidence constituted substantial evidence to support the Board's conclusion that the claimant had a disease.)

After reviewing the medical record in this case, I conclude that claimant's symptoms are the disease. This conclusion is supported by Dr. Nathan's objective findings and his diagnosis. If the symptoms are not the "disease," then why would Dr. Nathan have recommended carpal tunnel release surgery? Additionally, the opinion of claimant's treating doctor supports the required causal connection.

Under these circumstances, I conclude that claimant has proven a compensable bilateral carpal tunnel condition. Accordingly, I respectfully dissent from the majority's opinion.

In the Matter of the Compensation of
JOHN A. BRAY, Claimant
WCB Case No. 95-10206
ORDER ON REVIEW
Robert J. Guarrasi, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that declined to award an assessed 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.

On May 20, 1994, claimant cut his right hand at work. He advised his employer of the injury, and immediately sought treatment. When the employer asked whether claimant intended to file a workers' compensation claim, claimant responded that he did not intend to do so. Claimant actually billed the costs of his medical treatment to his welfare coverage.

On September 9, 1994, claimant injured his back at work, and promptly filed an 801 form. In March 1995, in dealing with the SAIF Corporation in connection with claimant's back injury claim, claimant's attorney advised SAIF that claimant had also injured his hand at work in May 1994. Claimant's attorney then asked SAIF to process the hand injury claim separately from the back injury claim.

SAIF forwarded an 801 form to the employer, which the employer promptly completed. Immediately after receiving the employer-completed 801 form, SAIF accepted the hand injury as a nondisabling claim.

The only issue before the ALJ at hearing was claimant's attorney's entitlement to an assessed attorney fee under ORS 656.386(1) for obtaining compensation for claimant's hand injury. Applying amended ORS 656.386(1), the ALJ determined that claimant's attorney was not entitled to an assessed fee because SAIF did not expressly deny the hand injury claim.

On review, claimant contends that ORS 656.386(1) "amounts to a strict liability fee statute" and that SAIF is liable for an attorney fee for the "de facto" denial of the hand injury arising out of the employer's failure to comply with the processing requirements of ORS 656.262.[1] We disagree.

As the ALJ found, the amended version of ORS 656.386(1) applies retroactively in this case. See Guillermo Rivera, 47 Van Natta 1723 (1995). Under amended ORS 656.386(1), a claimant's attorney is entitled to an attorney fee "in cases involving denied claims" where the attorney "is instrumental in obtaining a rescission of the denial." A "denied claim" is defined in the statute as "a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the

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[1] ORS 656.262(3) places an affirmative duty on employers to immediately report to their insurer "any claims or accidents which may result in a compensable injury claim" of which they have notice. Therefore, even though claimant expressed an intention not to file a claim, the employer should have reported the incident to SAIF.

injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to compensation." (Emphasis added). We held in Michael J. Galbraith, 48 Van Natta 351 (1996) that there was no "denied claim" under amended ORS 656.386(1) where the carrier paid all benefits for the compensable condition and did not expressly contend that the condition was not compensable. Cf. Guillermo Rivera, supra (finding a "denied claim" where the employer questioned the causation of the "de facto" denied condition).

In this case, as in Michael J. Galbraith, supra, there is no evidence that SAIF refused to pay compensation on the express ground that the injury was not compensable or did not give rise to an entitlement to compensation. Therefore, no "denied claim" has been established and no attorney fee may be awarded under amended ORS 656.386(1).

ORDER

The ALJ's order dated December 19, 1995 as amended January 9, 1996, is affirmed.

April 10, 1996 Cite as 48 Van Natta 809 (1996)

In the Matter of the Compensation of
MARLIE D. BRUCE, Claimant
WCB Case No. 93-07131
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that awarded claimant permanent total disability. On review, the issue is permanent total disability. 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

Claimant, 42 years old at the time of the hearing, was compensably injured on May 23, 1988 when the log truck he was driving rolled off a cliff. Claimant suffered serious facial injuries and a closed head injury. He also sustained injuries to his upper and lower back, right knee and right arm. A December 4, 1992 Determination Order awarded claimant 88 percent (281.6 degrees) unscheduled permanent disability, 75 percent (225 degrees) scheduled permanent disability for loss of binocular vision from both eyes, and 11 percent (21.12 degrees) scheduled permanent disability for loss of use or function of the right arm.

A June 3, 1993 Order on Reconsideration reduced claimant's unscheduled award from 88 to 86 percent (275.2 degrees) and increased claimant's scheduled award for his right arm to 15 percent (28.8 degrees). The Order on Reconsideration affirmed the Determination Order award of 75 percent scheduled permanent disability for loss of binocular vision.

Claimant requested a hearing on the Order on Reconsideration seeking permanent total disability benefits. The ALJ awarded claimant permanent total disability as of his medically stationary date, June 11, 1992. SAIF has appealed the ALJ's award and asserts that claimant is not permanently and totally disabled. Claimant seeks to have the ALJ's order affirmed.

In order to establish entitlement to permanent total disability, claimant must prove either that: (1) he is completely physically disabled and therefore precluded from regularly performing any work at a gainful and suitable occupation; or (2) his physical impairment, combined with a number of social and vocational factors, effectively precludes him from regularly performing any work at a gainful and suitable occupation under the "odd lot" doctrine. Welch v. Bannister Pipeline, 70 Or App 699 (1984); Wilson v. Weyerhaeuser, 30 Or App 403 (1977).

In this case, no physician has opined that claimant is medically permanently and totally disabled. Accordingly, we conclude that claimant is not precluded from gainful employment due to complete physical disability. Thus, his claim falls under the "odd-lot" doctrine. In addition, because there is no dispute about whether the jobs identified for claimant are "gainful," the question is simply whether claimant is "employable," i.e., whether he is currently able to sell his services on a regular basis in a hypothetically normal labor market. See Harris v. SAIF, 292 Or 683 (1982).

The nonmedical factors to be considered in an "odd-lot" analysis include age, education, adaptability to nonphysical labor, mental capacity, emotional condition and conditions of the labor market. Welch v. Bannister Pipeline, supra.

Three vocational experts testified regarding claimant's employability.[1] Andy Huckfeldt, a vocational rehabilitation counselor, testified on behalf of claimant. Mr. Huckfeldt opined that claimant is permanently and totally disabled. (Ex. 66-8). Huckfeldt based his opinion, in part, on his belief that claimant was limited to performing work "at the sedentary level or less in terms of physical capacity." (Ex. 66-9). The record does not support Huckfeldt's belief that claimant is limited to sedentary work. Instead, the record supports the conclusion that claimant can perform work in the light category. (Ex. 29-6; 40-5). Because Mr. Huckfeldt's opinion is based on an incorrect belief that claimant was limited to sedentary work, we are not persuaded by his opinion regarding claimant's employability.[2]

Richard Ross, a vocational evaluator and consultant, also testified on claimant's behalf. Mr. Ross opined that claimant is permanently and totally disabled. Ross based his opinion largely on the state of the labor market where claimant resides. Ross indicated that his opinion that claimant was permanently and totally disabled "has to do with the labor market that [claimant] resides in. It is, as others describe it, tight . . ." (Ex. 67-7). We have previously held that where a claimant has not found work because of the competitiveness of the labor market and the more limited labor market in the area where he lives, and not because he is unable to perform work, the worker has not sustained his burden of proof to show that he is permanently and totally disabled. Vivian F. Foltz, 43 Van Natta 119 (1991); see also Mary J. Kamm, 47 Van Natta 1443 (1995) (vocational opinion found unpersuasive where it was based on a lack of job openings in a claimant's geographical area rather than on whether the claimant was employable).

Because vocational expert Ross' opinion is based, in part, on the "tight" labor market where claimant lives, and not on whether he is currently able to sell his services on a regular basis in a hypothetically normal labor market, we do not find it persuasive.

Given that the only other vocational evidence in the record indicates that claimant is employable, we conclude that claimant has not met his burden of proof to establish that he is unemployable. Consequently, we reverse the ALJ's award of permanent total disability. Because claimant is not permanently and totally disabled, we turn to the extent of claimant's permanent disability.

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[1] In addition to claimant's vocational experts, Ross and Huckfeldt, the record also contains testimony from vocational consultant Stipe, who testified on behalf of SAIF. The deposition testimony of all three vocational experts was taken after the reconsideration order. 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 * * *" Arguably, amended ORS 656.283(7) precludes the admissibility of the "post-reconsideration order" vocational evidence. Joe R. Ray, 48 Van Natta 325 (1996). However, we need not resolve the admissibility of the vocational evidence, because, for the reasons given above, we do not find claimant's vocational experts persuasive. Thus, regardless of whether the vocational evidence is admissible, we conclude that claimant has failed to establish that he is permanently and totally disabled.

[2] We disagree with the dissent's assertion that Huckfeldt is persuasive in spite of his conclusion that claimant is limited to sedentary as opposed to light work. As a vocational expert, Huckfeldt is not in a position to determine what claimant's medical restrictions are. A physical capacities evaluation indicated that claimant was in the light work category. In addition, Dr. Witczack, at the Head Trauma Rehabilitation Program, concluded that claimant was released to work in the "moderate" category based upon his limitations. (Ex. 40-5). Thus, Mr. Huckfeldt's conclusion that claimant is limited to sedentary work, is not supported by the medical record. Huckfeldt's incorrect understanding of claimant's physical restrictions may have caused him not to consider jobs for claimant which were in the light work category. In other words, had Huckfeldt had a correct understanding of claimant's physical limitations, he may have reached a different conclusion regarding claimant's employability.

Extent Unscheduled Permanent Disability.

The disability rating standards in effect on the date of the December 4, 1992 Determination Order apply to claimant's claim (WCD Admin. Order 6-1992). OAR 436-35-003(2).

Right Shoulder

Claimant retains 135 degrees of abduction, 90 degrees of forward flexion and 35 degrees of internal rotation in his right shoulder. According to former OAR 436-35-330(1),(5) and (9), this entitles claimant to 5.5 percent impairment, which is rounded to 6 percent, for the right shoulder (1 percent for loss of abduction, 4 percent for loss of forward flexion and .5 percent for loss of internal rotation).

Cervical Condition

Claimant has the following findings of lost range of motion (as measured by inclinometer) in his cervical spine: 48 degrees cervical flexion, 25 degrees cervical extension, 48 degrees right cervical rotation, 65 degrees left cervical rotation, 35 degrees right lateral flexion and 25 degrees left lateral flexion. Pursuant to former OAR 436-35-360 (13) to (16), these findings result in the following values for impairment: 1.2 percent impairment for cervical flexion, 4 percent for cervical extension, 1.6 for right rotation, .75 left rotation, .67 right lateral flexion, 1.33 for left lateral flexion. Claimant has 9.55 percent impairment of the cervical spine. This is rounded, pursuant to former OAR 436-35-007(11), to 10 percent.

Brain Injury

Claimant's cognitive disability has been rated as Class III. Pursuant to former OAR 436-35-390(10), claimant is entitled to 50 percent impairment for his cognitive disability.

Mental Condition

As a result of his compensable injury, claimant has post-traumatic stress disorder with reactive depression and anxiety. The Order on Reconsideration found that claimant was functioning in the Class 2 range for anxiety and depression and that he was functioning in the mild range of that class. Under former OAR 436-35-400(5)(b)(A) and (B), claimant is entitled to an award of 23 percent impairment for his mental disability.

The values for claimant's unscheduled permanent disability are combined. See former OAR 436-35-320(3). Combining 50, 23, 10 and 6 results in a total of 68 percent impairment.

Age, Education and Adaptability

Claimant is over age 40, consequently, the age factor is 1. Former OAR 436-35-290(1). Claimant has not acquired a high school diploma or GED certificate. Therefore, the value for formal education is 1. Former OAR 436-35-300(3)(b). Claimant's highest SVP is 4, as a log truck driver, (DOT number 904.683-010). Thus, he is entitled to a value of 3 for skills. Former OAR 436-35-300(4). Claimant has an SVP below 5 and has no current license or certificate. Accordingly, claimant is entitled to a value of 1. Former OAR 436-35-300(5). The value for the education factor is 5 (obtained by adding the values for formal education, skills and the value for lack of a license or certificate).

Claimant is able to perform work in the light to medium range. He has restrictions in climbing, crawling and reaching. His at injury job as a log truck driver was classified in the medium range. Pursuant to former OAR 436-35-270(3)(e) and 436-35-310(3) and (4), claimant's adaptability factor is 3.

When the age factor (1) is added to the value for education (5), the result is 6. This value (6) is multiplied by the adaptability factor (3) to equal 18. This value is then added to the value for impairment (68) to equal 86. Claimant's unscheduled permanent disability under the standards is 86 percent. Thus, that portion of the Order on Reconsideration is affirmed.

Scheduled Permanent Disability

Visual Loss

As a result of the compensable injury, claimant has double vision in all visual fields. This condition is present constantly with near vision and intermittently with distant vision. We affirm the Order on Reconsideration's award of 75 percent for visual loss. Former OAR 436-35-260(4)(b).

Right Arm

Claimant has 4/5 strength of the triceps (radial nerve) and 4/5 strength of the biceps (musculocutaneous nerve). Pursuant to former OAR 436-35-110(8) as modified by former OAR 436-35-007(14), claimant is entitled to 11 percent for loss of strength of the triceps and 5 percent for loss of strength in the biceps. These values are combined to equal 15 percent impairment of the right arm.

After our review, we conclude that the June 3, 1993 Order on Reconsideration is correct and should be affirmed.

ORDER

The ALJ's order dated is reversed. The June 3, 1993 Order on Reconsideration is reinstated and affirmed.

Board Member Gunn dissenting.

I disagree with the majority's conclusion that the vocational evidence is unpersuasive and would conclude that claimant has established an entitlement to permanent total disability based on that evidence. In addition, for the reasons set forth in the dissenting opinions in Joe R. Ray, 48 Van Natta 325 (1996), I would conclude that the vocational evidence submitted in this case is admissible even though it was submitted "post-reconsideration."

The majority avoids deciding whether the evidentiary prohibition of ORS 656.283(7) is applicable to permanent total disability (PTD) cases by concluding that the "post-reconsideration" vocational evidence is unpersuasive. I do not agree that the evidence is unpersuasive.

In this regard, the majority dismisses the opinion of vocational expert, Huckfeldt, on the basis that he incorrectly believed that claimant was limited to work at the sedentary level or less. I would not dismiss Huckfeldt's opinion on these grounds. Huckfeldt reviewed a physical capacities evaluation which indicated that claimant could lift 19 pounds and concluded that claimant was capable of work in the light category. Huckfeldt explained that according to the Department of Labor and the "Dictionary of Occupational Titles," a worker must occasionally lift 20 pounds in order to fall within the light work category. Because the physical capacities report found that claimant could only lift 19 pounds, Huckfeldt concluded that claimant was limited to sedentary work. Given this explanation, I would conclude that Huckfeldt's opinion is persuasive.

The majority also dismisses Mr. Ross' vocational opinion on the grounds that it is based on the "tight" labor market in the community where claimant resides. The condition of the labor market is one of the nonmedical factors which is considered in the "odd lot" analysis. Because of this, I believe that the state of the labor market is a valid consideration in determining whether claimant is permanently and totally disabled. Consequently, I do not find Ross' opinion unpersuasive because it is based partly on the condition of the labor market. See Welch v. Bannister Pipeline, supra.

Because the vocational evidence is persuasive, the evidentiary question must be addressed. In my dissenting opinion in Ray, I expressed the opinion that the application of ORS 656.283(7) to permanent disability cases is equally harsh to both carriers and injured workers. Because this case involves the issue of permanent total disability, the results of the evidentiary ban are even more harsh to both sides of the workers' compensation cases. If the statute is applicable to PTD cases, the results would equally harsh to both parties. Carriers would not be allowed to submit "post-reconsideration" evidence such as surveillance videos establishing that a worker is not severely disabled or vocational evidence which proves that a worker is employable. Likewise, injured workers would be barred from submitting evidence that establishing that they are permanently disabled.

Finally, from a constitutional standpoint, because the majority's decision takes away an award of permanent total disability benefits, the property interest in this case is much more substantial than was the property interest at issue in Joe R. Ray, supra. Accordingly, for these reasons, I would conclude that the vocational evidence is persuasive and admissible and would affirm the ALJ's order.

In the Matter of the Compensation of
EUPORA L. BUTTS, Claimant
WCB Case No. 94-12387
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that: (1) set aside its "de facto" denial of claimant's injury claim for a thoracic outlet syndrome (TOS) condition; (2) found that claimant's injury claim was prematurely closed; and (3) awarded temporary partial disability compensation from March 19, 1994 until at least December 3, 1994. On review, the issues are compensability, premature closure, and claim processing. We affirm in part and vacate 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

Compensability & Premature Closure

We adopt the ALJ's opinion and conclusion on these issues.

Claim Processing (Temporary Disability)

The ALJ directed the insurer to pay temporary disability compensation for the period beginning March 19, 1994 (the medically stationary date identified by the premature April 20, 1994 Determination Order) until at least December 3, 1994. Based on the following reasoning, we vacate that portion of the order.

As a result of our finding that the claim was prematurely closed, the claim remains open. Thus, additional temporary disability benefits may be payable prior to closure of the claim. However, the issue of claimant's procedural entitlement to additional temporary disability under this claim did not arise until the closure of the claim was set aside. Moreover, claimant has acknowledged that her entitlement to temporary disability is a matter "attendant to the processing of the claim." (Tr. 8).

Under such circumstances, we consider it premature to address claimant's procedural entitlement to temporary disability until the insurer has had an opportunity to process the claim. In other words, consistent with its statutory obligation to process the claim, the insurer must determine whether claimant is entitled to temporary disability and, if so, when such entitlement arises. Thereafter, if claimant is dissatisfied with the insurer's processing of the claim, she may request a hearing.

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 and premature closure issues is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interests involved.

ORDER

The ALJ's order dated August 17, 1995 is vacated in part and affirmed in part. That portion of the order that directed the insurer to pay temporary partial disability benefits from March 19, 1994 through at least December 3, 1994 is vacated. Instead, the claim is remanded to the insurer for processing according to law. For services on review regarding the compensability and premature closure issues, claimant's counsel is awarded a $1,000 attorney fee, payable by the insurer. The remainder of the order is affirmed.

In the Matter of the Compensation of
ELOY CUELLAR, Claimant
WCB Case No. 95-06977
ORDER ON REVIEW
Tooze, Shenker, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Gunn.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that awarded a $3,500 attorney fee under ORS 656.386(1) when the insurer rescinded its current condition denial prior to hearing. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We offer the following summary of relevant facts.

Claimant suffered a compensable bilateral foot injury in 1971. The claim was initially closed in 1974 and claimant's aggravation rights expired on January 4, 1978. (See Ex. 4).

Claimant has had ongoing foot and knee problems and multiple surgeries. In March 1995, Dr. Baskin, attending physician, recommended left knee surgery.

The insurer partially denied claimant's current left knee condition on May 15, 1995. (Ex. 39). The written denial advised claimant of his right to request a hearing with the Board. (Id).

Claimant's attorney requested a hearing on claimant's behalf. He devoted 15.5 hours of legal services to preparing for the hearing.

Just prior to commencement of the hearing, the insurer withdrew its denial. The sole issue at hearing was claimant's counsel's entitlement to an attorney fee.

Claimant's counsel submitted an affidavit describing his pre-hearing services regarding this matter and requested a $3,500 attorney fee, based on his regular hourly rate for time expended and a "1.5:1" contingency factor. The ALJ awarded a $3,500 attorney fee for claimant's attorney's services in obtaining the pre-hearing rescission of the compensability denial.

The insurer requested review, contending that claimant is not entitled to an assessed fee or, alternatively, that the ALJ's fee award was excessive. We modify the ALJ's award.

The insurer argues that claimant is not entitled to an assessed attorney fee in this matter because claimant's 1971 injury is in "Own Motion" status. Thus, the insurer contends that claimant (at most) would be entitled to an "out-of-compensation" fee, if the "Own Motion" claim is reopened. See OAR 438-015-0080.

However, claimant's "Own Motion" claim is a matter separate and distinct from the compensability issue raised by the insurer's partial denial of claimant's current condition in this case. (In other words, the compensability of claimant's current condition is not an "Own Motion" matter.) Under these circumstances, we agree with the ALJ that claimant's counsel is entitled to an attorney fee under ORS 656.386(1) for services associated with obtaining the insurer's pre-hearing rescission of its current condition denial. See Pamela J. Vinyard, 47 Van Natta 263 (1995); George L. Gates, on remand, 47 Van Natta 80 (1995). Accordingly, we adopt the ALJ's opinion on this issue. (Opinion and Order p. 3).

The insurer also argues that the ALJ's $3,500 attorney fee (for services associated with the pre-hearing rescission of the denial) is excessive. Specifically, the insurer objects to the 50 percent "contingency factor" added to claimant's customary rate.

On de novo review, we consider the amount of claimant's counsel's attorney fee for services at the hearings level by applying 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. Because the risk of an attorney's efforts going uncompensated is already a factor which must be considered under the rule, we decline to apply a contingency multiplier in determining a reasonable attorney fee under ORS 656.386(1). See Rosalie Naer, 47 Van Natta 2033 (1995); Lois J. Schoch, 46 Van Natta 1816 (1994), aff'd mem Schoch v. Leupold & Sims, 137 Or App 633 (1995).

Our review of the record (including claimant's counsel's affidavit, Ex. 43) reveals the following information. The issues in dispute were the compensability of claimant's current left knee condition and his attorney's entitlement to an attorney fee. Claimant's counsel submitted an affidavit attesting to 15.5 hours of services at an hourly rate of $140. Such services would total $2,295 (including 2.5 hours of legal assistant's time). See Candace L. Spears, 47 Van Natta 2393 (1995). However, asserting that a "1.5:1" contingency factor should be applied, claimant sought an attorney fee totaling $3,500.

As compared to typical compensability cases, the issue here was of normal complexity. Likewise, the claim's value and the benefit secured are of approximately average proportions. Claimant's attorney generated a medical report from claimant's treating physician, Dr. Baskin, which clarified that claimant's current condition was causally related to the compensable injury and prompted rescission of the denial shortly before the rescheduled hearing convened. There was a risk that claimant's counsel might go uncompensated.

In light of his successful advocacy of claimant's position, claimant's attorney is unquestionably entitled to an attorney fee award for such efforts in obtaining compensation for claimant without a hearing. See ORS 656.386(1). Nevertheless, we disagree with the ALJ's determination of a reasonable attorney fee award. Based on the previously enumerated factors, we conclude that $2,300 is a reasonable assessed attorney fee for claimant's counsel's services at the hearing level regarding the compensability issue. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's counsel's affidavit), 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 September 26, 1995 is modified in part and affirmed in part. In lieu of the ALJ's $3,500 attorney fee award, claimant's counsel is awarded a $2,300 attorney fee, payable by the insurer. The remainder of the 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 better decided before the ALJ.

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.

April 10, 1996 Cite as 48 Van Natta 816 (1996)

In the Matter of the Compensation of
BARBARA J. CUNIFF, Claimant
WCB Case Nos. 95-02029 & 94-09979
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Lindsay, Hart, et al, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer, May Department Stores Company ("Meier & Frank") requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of claimant's "new occupational disease" claim for a left shoulder condition; and (2) upheld CNA Insurance Companies' denial of claimant's aggravation claim for the same condition. On review, the issues are responsibility and aggravation. 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:

In May 1989, while working for CNA's insured, claimant developed pain and numbness in her right finger. She was diagnosed with tendonitis and carpal tunnel syndrome in her right wrist. On July 25, 1989, CNA accepted claimant's claim for right arm strain and, in August 1989, claimant had carpal tunnel release surgery on her right hand. Claimant had a difficult recovery from the release surgery and began using her left arm rather than her right.

In July 1990, claimant began to experience left shoulder pain. On November 21, 1990, CNA accepted claimant's claim for "left shoulder complaints" as part of her May 1989 claim.

Also in July 1990, claimant began working for Meier & Frank as a bill collector. After a month on this job, she developed numbness in the left hand and pain and stiffness in the left shoulder. By February 1991, claimant's left shoulder pain had radiated down through her left biceps, elbow and hand. Dr. Weintraub diagnosed a subacrominal impingement syndrome.

In August 1991, Dr. Weintraub performed arthroscopic surgery on claimant's left shoulder and an open rotator cuff repair. Following the surgery, claimant returned to full-time work with Meier & Frank, although she continued to have persistent pain in the left shoulder and neck.

Dr. Harris declared claimant's left shoulder medically stationary as of December 2, 1992. Her left shoulder claim with CNA was closed by Determination Order on April 9, 1993, based on a February 8, 1993 closing examination by Dr. Morton. Claimant was awarded 31 percent unscheduled permanent disability for loss of use or function of the left shoulder.

From April 1994 through October 1994, claimant reduced her work schedule at Meier & Frank to part-time in an attempt to minimize her ongoing shoulder symptoms. She terminated her employment with Meier & Frank in October 1994 as a result of her left shoulder pain.

Dr. Harris concluded that claimant's left shoulder had worsened as a result of her work activities with Meier & Frank. In July 1994, Drs. Labs, Lammers, Dordevich and Morton, who examined claimant at CNA's request, opined that claimant's left shoulder had not objectively worsened since the last arrangement of compensation. Instead, the panel reported that claimant was experiencing a waxing and waning of her initial condition.

In November 1994, claimant was examined by Dr. Radecki, who concluded that claimant's left shoulder condition was unchanged since her 1991 rotator cuff surgery. He also found no evidence of increased permanent impairment and no objective evidence of nerve conduction changes.

In March 1995, Dr. Weintraub reported that claimant may have had renewed symptoms, but there was no evidence of a pathological worsening of her condition. He further explained that any residual inflammation would be a waxing and waning of her original condition, and that her work at Meier & Frank was not the major cause of her present need for treatment.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's work activities at Meier & Frank from 1992 through 1994 were the major contributing cause of a pathological worsening of her left shoulder condition and, therefore, responsibility for that condition shifted from CNA to Meier & Frank pursuant to former ORS 656.308(1).

On review, Meier & Frank argues the medical evidence is insufficient to show that claimant experienced a pathological worsening of her shoulder condition as a result of her employment. Specifically, Meier & Frank contends that a preponderance of the evidence shows, at best, that claimant has suffered only a "symptomatic" worsening of her condition because the objective findings of Dr. Harris, i.e. pain and spasms, are merely symptoms of the underlying pathology of her shoulder.

CNA and claimant, on the other hand, argue that Dr. Harris' findings and opinion are sufficient evidence of a worsening of claimant's condition so as to shift responsibility to Meier & Frank under ORS 656.308(1).[1] CNA also argues, in the alternative, that if Dr. Harris' opinion is not persuasive, then a preponderance of the medical evidence indicates that claimant's condition has not objectively worsened enough to sustain even an aggravation claim under amended ORS 656.273(1).[2]

Aggravation

As noted above, CNA contends that claimant has not proven a worsening of her compensable condition sufficient to sustain an aggravation claim. Under amended ORS 656.273(1), a claimant is entitled to additional compensation for "worsened conditions" resulting from the original accepted injury or disease. "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). Where permanent disability has previously been awarded for the accepted condition, the claimant must also establish that "the worsening is more than waxing and waning of symptoms of the condition contemplated by the previous permanent disability award." ORS 656.273(8).

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."

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[1] We agree with CNA and Meier & Frank that amended ORS 656.308(1) applies retroactively in this case. See Volk v. America West Airlines, 135 Or App 565 (1995). Although claimant raises several constitutional challenges to the retroactive application of SB 369, we are not inclined to address these arguments because they are not adequately developed for our review. See Ronald B. Olson, 44 Van Natta 100 (1992); see also Sandra L. Deel, 43 Van Natta 2482 (1991). We note, however, that we have rejected a similar due process/property right challenge to the retroactive application of other SB 369 provisions in Kathleen M. Butler, 47 Van Natta 2202 (1995).

[2] Because this matter has not been finally resolved on review, the amended aggravation statute applies retroactively as well. See Helen M. Callendar, 47 Van Natta 1626 (1995).

In Carmen C. Neill, 47 Van Natta 2371 (1995), we analyzed the text, context and legislative history behind amended ORS 656.273(1) and found that the term "actual worsening" as used in that section means a pathological worsening of the underlying condition or a symptomatic worsening of the condition that is greater than anticipated by the prior award of permanent disability.[3]

In this case, claimant received a 31 percent unscheduled permanent disability award for her left shoulder in 1993. Therefore, she must prove that the "worsening" of her left shoulder exceeded the waxing and waning contemplated by her prior award. See Carmen C. Neill, supra; ORS 656.273(8).

Dr. Harris, claimant's long-time treating physician, reported that claimant's condition had "worsened" and that she was experiencing inflammation, spasms and pain with use of her shoulder. Dr. Harris did not, however, opine whether these findings constituted a "pathological" worsening of claimant's condition or whether claimant's symptoms exceeded the waxing and waning contemplated by her prior award of permanent disability.[4] Drs. Weintraub and Radecki, on the other hand, specifically opined that claimant's current symptoms represented nothing more than waxing and waning of her accepted condition which had not resolved. They found no objective change in her condition since the last arrangement of compensation.[5] Drs. Labs, Lammers, Dordevich and Morton similarly determined that claimant had not experienced any worsening of her condition.

Accordingly, even if we defer to the opinion of Dr. Harris as claimant's treating physician (see Weiland v. SAIF, 64 Or App 810 (1983)), it is not sufficient to sustain claimant's burden of proof on "actual worsening." Claimant has not shown a pathological worsening or a symptomatic worsening in excess of the waxing and waning of her compensable left shoulder condition contemplated by her prior award of permanent disability.

Responsibility

There is no dispute that claimant's current complaints involve the "same condition" as the prior accepted left shoulder claim processed by CNA. Therefore, the responsibility question in this is case is governed by amended ORS 656.308(1). Smurfit Newsprint v. DeRossett, 118 Or App 368 (1993). Under this provision, CNA remains responsible for claimant's left shoulder condition unless it is established that claimant experienced a "new" compensable injury or occupational disease with her subsequent employer, Meier & Frank. Liberty Northwest Ins. Corp. v. Senters, 119 Or App 314 (1993).

In this context, as Meier & Frank correctly argues, a "new" compensable occupational disease requires proof that claimant's work activities with the subsequent employer are the major contributing cause of a pathological worsening of the accepted condition. See amended ORS 656.802(2); Liberty Northwest Ins. Corp. v. Senters, supra; Shelly K. Funkhouser, supra.

As noted above, although Dr. Harris opined on numerous occasions that claimant's work with Meier & Frank had "worsened" claimant's condition. (E.g., Exs. 116,122, 127, 129, 134-2), he did not opine that his findings of pain, inflammation and spasms represented a "pathological" worsening of claimant's compensable left shoulder condition. In the absence of any evidence that claimant's work with Meier & Frank caused a pathological worsening of claimant's shoulder condition, no "new" occupational disease claim has been established. CNA therefore remains responsible for claimant's condition under ORS 656.308(1).

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[3] In Carmen C. Neill, supra, we remanded the matter because the "actual worsening" standard went into effect after the record was developed and the parties did not have the opportunity to generate medical evidence regarding whether the claimant's symptomatic worsening constituted an "actual worsening" of her condition. There, unlike this case, the claimant's claim was classified as nondisabling and she did not receive a prior award of permanent disability. Cf. Soilo C. Diaz, 48 Van Natta 371 n 2 (1996) (Board declined to remand "aggravation" case to ALJ for additional evidence where the claimant received a prior permanent disability award and the record was sufficiently developed to analyze whether claimant's symptomatic worsening exceeded the "waxing and waning" contemplated by that prior award).

[4] Whether physical findings represent a pathological, as opposed to symptomatic, worsening of a claimant's condition is a medical, rather than legal question. Shelly K. Funkhouser, 47 Van Natta 126 (1995) Thus, expert medical evidence is necessary to establish the nature of the physical findings. Id.

[5] Dr. Weintraub, who treated claimant in 1991 and reexamined her in 1995, expressly opined that claimant had not suffered a pathological worsening of her left shoulder condition. (Ex. 138).

ORDER

The ALJ's order dated June 1, 1995 is reversed in part and affirmed in part. The May Department Stores Company's denial is reinstated and upheld. In addition, the ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
VINCENT D. DRENNEN, Claimant
WCB Case No. 95-07547
ORDER ON REVIEW
Pozzi, Wilson, 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) Podnar's order that awarded a carrier-paid attorney fee under ORS 656.382(2) for defending against SAIF's attempt to have a 39 percent (124.8 degrees) unscheduled permanent disability award (granted by an Order on Reconsideration) reduced to 7 percent (22.4 degrees). Claimant cross-requests review of those portions of the order that: (1) reduced claimant's unscheduled permanent disability award for a back condition from 39 percent (124.8 degrees), as awarded by the Order on Reconsideration, to 18 percent (57.6 degrees); and (2) reversed a penalty under ORS 656.268(4)(g). On review, the issues are extent of unscheduled permanent disability, penalties and attorney fees. We reverse in part and affirm in part.

FINDINGS OF FACT

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

We do not find that claimant was returned to his regular work, or was released to his regular work, after his compensable back injury.

We do not find that claimant experienced an 18 percent loss of earning capacity as a result of his compensable injury.

CONCLUSIONS OF LAW AND OPINION

Extent

The only substantive issue in dispute is the extent of claimant's unscheduled disability for his low back, specifically, adaptability.

The ALJ found that claimant was not entitled to an adaptability factor, based on a conclusion that claimant returned to his regular work following his injury. See ORS 656.726(3)(f)(D). Thus, because a "zero" adaptability factor is a multiplier which would negate all non-impairment factors, the ALJ reasoned that the sole basis for claimant's permanent disability award was impairment.

Claimant argues that he did not return to regular work and that his doctor's release to return to work was, in fact, a release to modified work only. Consequently, he contends that he is entitled to an adaptability factor of 5, as awarded by the Order on Reconsideration. We agree.

"'Regular work' means the job the worker held at the time of injury, or employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities." OAR 436-35-270(3)(c). (WCD Admin. Order 93-056).

Dr. Karty, treating physician, initially released claimant to light duty work. (Ex. 10). On several subsequent occasions, Dr. Karty stated that claimant was released to regular work and that he had returned to regular work. (See Exs. 9-3, 12, 14-1, 15, 17, 18). However, Dr. Karty issued the release to regular work because no light duty work was available for claimant and claimant requested a full release. (Exs. 9-2, 14-2). Claimant then returned to his regular job as a steel fabricator's helper. Although he "managed" to perform at work, he did so by modifying his regular work duties. Specifically, he avoided bending, stooping, twisting, and heavy lifting as much as he could. (Ex. 9-2).

Under these circumstances, we find that Dr. Karty's release was not a medical release and claimant did not actually return to his at-injury job.[1] See Kathy R. Monfort, 47 Van Natta 906, 907 (1995) (Where the claimant no longer performed her full range of job duties, she had not returned to regular work); Jim M. Greene, 46 Van Natta 1527, 1529 (1994); Kathleen M. Glenn, 46 Van Natta 1130, 1131 (1994) (Where the release to work was not given on the basis of medical evaluation, it was not persuasive evidence that the claimant was able to perform her regular work duties); George O. Hamlin, 46 Van Natta 491, 493 (1994) (The claimant did not return to "regular" job when he returned to former bus driving job, but could no longer operate manual steering buses).

Because we have determined that claimant did not return to his regular work (and he was not released to his regular work), and the parties do not otherwise dispute claimant's permanent disability award, we reinstate that award--as corrected pursuant to claimant's stipulation that his total unscheduled award should be 38 percent.[2]

Penalties and Attorney Fees

The ALJ awarded a carrier-paid attorney fee for claimant's attorney's "efforts in defending claimant's unscheduled permanent disability benefits in excess of 7 percent [i.e., the award advocated by SAIF at hearing]." Opinion and Order p. 4. The ALJ awarded a carrier-paid attorney fee in "an amount equivalent to 25 percent of the difference between the 7 percent sought by defendant and the 18 percent awarded by the Opinion and Order." Id. The ALJ also set aside the reconsideration order's penalty under ORS 656.268(4)(g), in light of the reduction of claimant's permanent disability award below 20 percent. We reinstate the penalty under ORS 656.268(4)(g) and modify the attorney fee award.

Claimant is entitled to a penalty under former ORS 656.268(4)(g),[3] 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). However, because the Order on Reconsideration award is properly reduced from 39 percent to 38 percent (pursuant to claimant's stipulation, see n.2, supra), the amount of the penalty must be adjusted accordingly.

The employer requested a hearing, seeking reduction in claimant's unscheduled permanent disability award. By this order, we have found that claimant's award (as granted by that Order on Reconsideration) should not be disallowed or reduced (except as stipulated).[4] Under such circumstances, claimant is entitled to an attorney fee award under amended ORS 656.382(2).

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 counsel's services at hearing is $1,200 to be paid by the SAIF Corporation. This award is in lieu of the ALJ's attorney fee award. 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.

Finally, claimant's attorney is also awarded an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by our order (the difference between the ALJ's 18 percent award and our 38 percent award), not to exceed $3,800, payable directly to claimant's attorney. See amended ORS 656.386(2); OAR 438-015-0055(1).

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[1] Claimant's modified work activities were entirely consistent with Dr. Karty's original medical release. (See Ex. 10).

[2] (5 [adaptability] x 4 [age+education]) + 18 (impairment) = 38. See OAR 436-035-0280. Claimant agreed that his impairment rating should be 18 percent, instead of 19 percent, as awarded by the Order on Reconsideration. (Opinion and Order, p.2).

[3] The newly enacted amendments to ORS 656.268(4)(g) apply only to claims that become medically stationary on or after June 7, 1995. SB 369, 68th Leg., Reg. Sess., § 66(4) (June 7, 1995). Claimant became medically stationary before June 7, 1995; therefore, the amendments to ORS 656.268(4)(g) do not apply to this case.

[4] Claimant is entitled to an attorney fee under ORS 656.382(2) because SAIF requested a hearing seeking reduction in his permanent disability award and, by virtue of our order, the award has not been reduced beyond the stipulated amount. See Tommy V. Drennen, 47 Van Natta 1524 (1995).

ORDER

The ALJ's order dated September 27, 1995 is reversed in part and affirmed in part. In lieu of the ALJ's unscheduled permanent disability award, the Order on Reconsideration award of 39 percent (124.8 degrees) unscheduled permanent disability for claimant's low back condition is reduced to 38 percent (121.6 degrees). The penalty assessed by the Order on Reconsideration under ORS 656.268(4)(g) is reinstated, except that claimant shall receive a penalty equal to 25 percent of his 38 percent (121.6 degrees) unscheduled permanent disability award. Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order (the 20 percent difference between the ALJ's 18 percent award and our 38 percent award), not to exceed $3,800, payable directly to claimant's attorney. In lieu of the ALJ's carrier-paid attorney fee award, claimant's attorney is also awarded a fee of $1,200 for services at hearing regarding the permanent disability issue, payable by SAIF. The remainder of the order is affirmed.

April 10, 1996 Cite as 48 Van Natta 821 (1996)

In the Matter of the Compensation of
VICKIE M. EMERSON, Claimant
WCB Case No. 95-09853
ORDER ON REVIEW
Heather Holt, Claimant Attorney
Dennis Martin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Christian.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order which awarded an assessed attorney fee of $1,400 pursuant to ORS 656.386(1) for claimant's counsel's efforts in obtaining the rescission of the SAIF Corporation's aggravation denial. On review, the issue is attorney fees.

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

Claimant sustained a compensable right wrist injury on December 9, 1994. SAIF accepted the claim as "nondisabling" on March 30, 1995. (Ex. 6). SAIF denied reopening on August 18, 1995 on the ground that there had been no worsening of claimant's condition. (Ex. 14). On August 28, 1995, claimant's attorney filed a request for hearing appealing SAIF's denial. That same day, claimant requested that SAIF reclassify her claim to "disabling." (Ex. 15A).

On November 3, 1995 (18 day's prior to the scheduled hearing), SAIF withdrew its aggravation denial on the ground that it was "null and void" because no aggravation claim had been made. (Ex. 17). At the November 21, 1995 hearing originally scheduled to address the aggravation claim, claimant sought an attorney fee under ORS 656.386(1).

The ALJ held that claimant's counsel was entitled to an attorney fee, reasoning that the current version of ORS 656.386(1)[1] only required that claimant obtain a "rescission" of a denial prior to a decision by an ALJ. Inasmuch as claimant had obtained a rescission of SAIF's aggravation denial prior to a hearing, the ALJ concluded that claimant's counsel was entitled to an attorney fee.

Citing Mindi M. Miller, 44 Van Natta 1671, on recon 44 Van Natta 2144 (1992), SAIF contends that the ALJ erred in awarding an attorney fee under ORS 656.386(1) because, having been issued less than a year after claimant's nondisabling injury, its aggravation denial was a nullity under ORS 656.277. We disagree.

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[1] Amended ORS 656.386(1) provides, in pertinent part:

"In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall allow a reasonable attorney fee. In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed. . . ." (Emphasis added).

SAIF correctly observes that, in Miller, we affirmed an ALJ's order that declined to award a carrier-paid attorney fee for prevailing on a null aggravation denial. 44 Van Natta at 1672. However, in Miller, we were interpreting the former statute, which required an attorney be instrumental in "obtaining compensation."[2] The current version of ORS 656.386(1) only requires that a claimant obtain a "rescission" of a denial. Thus, the crucial inquiry under amended ORS 656.386(1) is whether there was a "denied claim" and whether there was a "rescission." If so, then claimant's counsel is entitled to an assessed attorney fee under amended ORS 656.386(1). There is no requirement that the denial be validly issued or that the claimant "prevail" where there has been a "rescission" of a denial prior to a decision by an ALJ.

We recognize that, in William C. Becker, 47 Van Natta 1993, 1934 (1995) (Member Hall dissenting), we held that a claimant must "prevail" under amended ORS 656.386(1) in order to be entitled to an attorney fee. In Becker, the claimant had withdrawn his claim. Since he would receive no benefits as a result of our decision that the carrier's denial of a "withdrawn" claim was a nullity, we reasoned that the claimant had not "prevailed" and was, therefore, not entitled to an attorney fee. We find Becker distinguishable, however, from this case. In Becker, the claimant withdrew his claim prior to issuance of the carrier's denial, but the carrier did not withdraw its denial. A hearing was then held before the ALJ. Thus, the issue in Becker was whether the claimant had "prevailed" in a hearing before the ALJ. In this case, however, claimant did not withdraw a claim and obtained a rescission of SAIF's aggravation denial prior to the hearing. Thus, the issue is not whether claimant "prevailed" in a hearing before an ALJ, but rather whether claimant's counsel is entitled to a fee for obtaining a "rescission" of a denial before a decision by the ALJ.

SAIF notes that its denial was based solely on an assertion that claimant's condition had not worsened. SAIF contends that it did not refuse to pay compensation on the express ground that claimant's injury or condition was not compensable or otherwise did not give rise to an entitlement to any compensation. Thus, it asserts that there was no "denied claim" within the meaning of amended ORS 656.386(1). We disagree. While SAIF's denial based on a lack of a compensable worsening of claimant's wrist condition may not have placed the compensability of that condition at issue, we conclude that it did expressly deny that claimant was otherwise entitled to any compensation. When a carrier denies an aggravation claim, even on the sole ground that there has been no compensable worsening, it is in effect denying that the claimant is entitled to compensation, such as temporary and permanent disability, that may result from a compensable aggravation claim. Cf. Fidel D. Chavez, 43 Van Natta 2515 (1991) (Rescission of denial and acceptance of the claimant's "new injury" claim established the claimant's entitlement to all benefits, including medical services, as set forth in ORS Chapter 656, which result from the compensable injury). In the absence of a clear legislative intention to eliminate attorney fee awards in the context of aggravation claims, we reject SAIF's contention that amended ORS 656.386(1) precludes an attorney fee award for setting aside a "worsening-based" aggravation denial.

Based on the aforementioned reasoning, we hold that there was a "denied claim" within the meaning of amended ORS 656.386(1). Through her hearing request, claimant obtained a "rescission" of SAIF's aggravation denial prior to the hearing. The ALJ, therefore, correctly determined that claimant's counsel was entitled to an attorney fee pursuant to ORS 656.386(1).

Claimant is not entitled to a fee for services on review regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated December 18, 1995 is affirmed.

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[2] Former ORS 656.386(1) provided, in pertinent part, as follows:

"In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. If an attorney is instrumental in obtaining compensation for a claimant and a hearing is not held, a reasonable attorney fee shall be allowed. . . ." (Emphasis added).

In the Matter of the Compensation of
JANICE I. ERWIN, Claimant
WCB Case No. 95-00839
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Mills' order which declined to award her additional temporary disability. On review, the issue is temporary disability.

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

At hearing, claimant argued that the medically stationary date (May 17, 1994) in the December 20, 1994 Order on Reconsideration was incorrect because there was no medical evidence that she was medically stationary on that date. The ALJ observed that there was no evidence in the record indicating when claimant became medically stationary other than references to documents not in the record.[1] The ALJ, nevertheless, affirmed the May 17, 1994 medically stationary date, finding that claimant had failed to sustain her burden of proving that her medically stationary status should be changed. The ALJ, therefore, affirmed the award of temporary disability in the reconsideration order, which had granted claimant temporary disability through May 17, 1994.

On review, claimant contends that competent evidence in the record establishes that she became medically stationary on July 28, 1994, as found by the August 1, 1994 Determination Order, and that the Board should reinstate her award of temporary disability through that date. The employer responds that claimant is precluded from raising the premature closure/medically stationary issue because the issue was not raised until closing argument. See Robert D. Lawrence, 47 Van Natta 1619 (1995) (Board will not consider issue first raised in closing argument). Moreover, the employer asserts that, even if the Board can address this issue, the ALJ correctly determined that claimant failed to sustain her burden of proving that the medically stationary date in the Order on Reconsideration was incorrect.

We need not address the issue of whether claimant properly raised the medically stationary/premature closure issue.[2] We find that, even if it was, claimant failed to prove that the medically stationary date in the Order on Reconsideration was incorrect.

" '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 has the burden of proving that she was not medically stationary on May 17, 1994. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981); Wendy Youravish, 47 Van Natta 1999, 2000 (1995). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12 (1980).

Claimant asserts that, while there is no direct evidence in the record of when she became medically stationary, the medical evidence that is present is consistent with the Determination Order's medically stationary date of July 28, 1994. Claimant cites the April 8, 1994 medical report of her attending physician. In that report, Dr. Watkins stated that he would be making a final evaluation of

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[1] No hearing was held. The case was decided based on the 47 exhibits that were submitted to the ALJ and on the parties' written closing arguments.

[2] The employer requested a hearing on January 19, 1995 contesting the December 20, 1994 reconsideration order's award of permanent disability. Claimant issued a series of responses to the employer's hearing request. On February 9, 1995, claimant asserted that the Order on Reconsideration should be affirmed. However, in "amended" responses to employer's hearing request issued on February 27 and March 9, 1995, claimant requested that the Order on Reconsideration be affirmed, but also that the period of temporary disability awarded be adjusted. While claimant's responses to the employer's hearing request are less than ideal, they likely were sufficient to raise the medically stationary/premature closure issue. See Liberty Northwest v. Alonzo, 105 Or App 458 (1991); Connie G. Johnson, 47 Van Natta 1984, 1987(1995), on recon 48 Van Natta 239 (1996). However, as explained below, we need not decide that issue.

permanent impairment in July 1994. (Ex. 35). Claimant also cites the August 1994 Determination Order's reference to a form 873 that was returned in July 1994. (Ex. 37). Finally, claimant notes that there is no chart note in Dr. Watkins' medical records pertaining to a May 17, 1994 office visit (May 17, 1994 is the "medically stationary date" found by the Order on Reconsideration).

Although the above evidence suggests that claimant was not medically stationary on May 17, 1994, the record likewise fails to persuasively establish that claimant's condition was medically stationary on July 28, 1994, as found by the Determination Order. Since the burden of proving the medically stationary date in the Order on Reconsideration was inaccurate rests with claimant, we agree with the ALJ that claimant failed to satisfy her burden of proof. See ORS 656.266; Berliner, supra. Therefore, the ALJ properly affirmed the award of temporary disability in the Order on Reconsideration.

ORDER

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

April 10, 1996 Cite as 48 Van Natta 824 (1996)

In the Matter of the Compensation of
NOVENA FORBES, Claimant
WCB Case No. 95-06721
ORDER ON REVIEW
Gatti, Gatti, et al, 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) Daughtry's order that: (1) set aside its denial of claimant's aggravation claim for a cervical condition; and (2) awarded an assessed attorney fee of $3,300. On review, the issues are aggravation and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the last paragraph, with the following changes.

In the first paragraph of the findings of fact on page 1, we delete the sentence reading "A cervical contusion and strain were the accepted conditions." We replace that sentence with the following: "SAIF accepted a cervical contusion and cervical strain, as well as a strain of the thoracic spine and left shoulder strain. (Exs. 4, 7)."

We delete the second sentence of the first paragraph on page 2.

In the third paragraph on page 2, we change the fifth sentence to reflect that claimant was seen in April 1995 by Dr. Ulrich, rather than in April 1994. At the end of that paragraph, we add the following sentence: "However, Drs. Tesar and Wilson commented that they found no organic basis for the decreased range of motion."

CONCLUSIONS OF LAW AND OPINION

On March 18, 1994, claimant injured her neck at work. SAIF accepted a cervical contusion and cervical strain, as well as a strain of the thoracic spine and left shoulder strain. (Exs. 4, 7).

Claimant's claim was closed by a Notice of Closure on July 14, 1994 that awarded 4 percent unscheduled permanent partial disability. (Ex. 8). That award was affirmed by a November 8, 1994 Order on Reconsideration. (Ex. 10).

Claimant requested a hearing to appeal the Order on Reconsideration and raise other issues. In a Stipulation and Order dated February 16, 1995, claimant's unscheduled permanent partial disability award was increased to 5 percent. (Ex. 13). In addition, claimant's request for hearing was dismissed with prejudice.

On April 11, 1995, Dr. Ulrich wrote to SAIF, asking that claimant's claim be reopened. (Ex. 15). SAIF denied claimant's request to reopen the claim on the ground that claimant's condition had not worsened since the last award or arrangement of compensation. (Ex. 17).

The ALJ found that claimant's range of motion findings compared to closure confirmed a worsening. The ALJ concluded that claimant had established a medically verified worsening of her cervical condition.

SAIF argues that the ALJ erred in concluding that claimant satisfied her burden of proving an actual worsening of her compensable cervical condition since the last award or arrangement of compensation. SAIF contends that there is no medical evidence established by objective findings that claimant's condition had worsened since the Stipulation and Order dated February 16, 1995.

To prove an aggravation under ORS 656.273, claimant must prove a worsened condition resulting from the original injury. A "worsened condition" is established by "medical evidence of an actual worsening of the compensable condition supported by objective findings." ORS 656.273(1). In Carmen C. Neill, 47 Van Natta 2371, 2377 (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. In addition, ORS 656.214(7) provides that "[a]ll permanent disability contemplates future waxing and waning of symptoms of the condition."

Claimant relies on the opinion of Dr. Ulrich to prove that she sustained an actual worsening of her compensable cervical condition. SAIF contends that the medical evidence fails to satisfy the essential elements of an aggravation claim.

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). In this case, we find Dr. Ulrich's reports insufficient to carry claimant's burden of proof.

Dr. Ulrich reported that there had been an "apparent objective pathological worsening" of claimant's condition since July 14, 1994. (Exs. 19, 20). Dr. Ulrich commented that "the industrial injury of March 18, 1994 could be a contributing cause of the aggravation she suffered and was experiencing when I examined her." (Ex. 19; emphasis added). Dr. Ulrich amended that report to say that the industrial injury "with in a reasonable medical probability is a contributing cause of the aggravation she suffered and was experiencing when I examined her." (Ex. 20). In a later "check-the-box" report from claimant's attorney, Dr. Ulrich agreed that "the major contributing cause" of the aggravation was the March 18, 1994 industrial injury. (Ex. 21). However, Dr. Ulrich did not explain why he changed his opinion from stating that the work injury "could be" a cause of the aggravation to later stating that the work injury was "the major contributing cause" of the worsening.

In a later report, Dr. Ulrich agreed with Drs. Tesar and Wilson that claimant's original injury had resolved and he also agreed that "there is no current objective evidence that would limit her ability to work." (Ex. 22). On the other hand, Dr. Ulrich commented that the "objective worsening" of claimant's condition compared to her closing evaluation was noted in her cervical range of motion. Dr. Ulrich noted that Dr. Bolin had mentioned the "possible need for palliative care to control her symptoms and maintain her status, and I believe this is [claimant's] current condition." (Id.)

In light of Dr. Ulrich's report that claimant's March 1994 injury had "resolved" and that there was no objective evidence that claimant was unable to work, his conclusory report that claimant suffered "apparent objective pathological worsening" of her condition since July 14, 1994 is inconsistent. Since Dr. Ulrich did not explain this inconsistency, his conclusion is not persuasive. See Kelso v. City of Salem, 87 Or App 630 (1987); Moe v. Ceiling Systems, 44 Or App 429 (1980). Moreover, Dr. Ulrich's reports did not indicate whether claimant's alleged worsening exceeds the waxing and waning of symptoms contemplated by the February 1995 permanent partial disability award. See ORS 656.214(7). Finally, Dr. Ulrich's reports did not address the proper time frame. Dr. Ulrich's reports indicated that there had been a worsening since July 1994. However, Dr. Ulrich's reports do not establish claimant sustained an actual worsening since February 16, 1995, the last arrangement of compensation.

Similarly, Dr. Atkisson's reports do not address the proper time frame. Dr. Atkisson reported on February 28, 1995 that claimant's condition had worsened since July 1994. (Ex. 14A). On December 28, 1994, Dr. Atkisson had reported that claimant's neck was "supple with a full range of motion," but there were increased symptoms of pain with flexion and extension and with rotation. (Ex. 10A). Dr. Atkisson recommended a diagnostic MRI "[b]ecause of the protracted nature of her symptoms despite the lack of neurologic findings." (Id.) The MRI showed no abnormalities. (Exs. 11, 12). In light of Dr. Atkisson's December 28, 1994 report that claimant had no neurologic findings, we are not persuaded by his subsequent conclusory report that claimant's condition had worsened.

Drs. Tesar and Wilson observed a decreased range of motion as compared to claimant's closing examination, but they found no organic basis for this and they found that it was hard to relate claimant's decreased range of motion to her industrial injury. (Ex. 16). They found no organic basis for claimant's subjective complaints and no objective evidence that would limit claimant's ability to work." (Id.) Finally, as previously noted, Drs. Tesar and Wilson concluded that claimant's March 18, 1994 injury had "completely resolved" and they found no objective worsening of her condition.

In conclusion, based on Dr. Ulrich's inconsistent and insufficiently explained opinions, Dr. Atkisson's inadequate opinion and Drs. Tesar and Wilson's contrary opinion, we hold that the medical evidence is insufficient to establish that claimant sustained "an actual worsening of the compensable condition supported by objective findings" since the February 16, 1995 Stipulation and Order. Consequently, claimant has not established a compensable aggravation claim.[1]

ORDER

The ALJ's order dated September 19, 1995 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

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[1] In light of our conclusion that claimant's aggravation claim is not compensable, we do not address SAIF's argument that the ALJ's attorney fee award was excessive.

In the Matter of the Compensation of
SUZANNE N. GIBERT, Claimant
WCB Case No. 95-09416
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Schultz's order that set aside its denial of claimant's "new injury" claim for a thoracolumbar strain. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the findings of ultimate facts, with the following changes.

We delete the first sentence of the second paragraph on page 2 and insert the following:

> "On May 2, 1995, Dr. Thomasson reported that claimant was off work. (Ex. 3-1). Dr. Thomasson commented that claimant "went back to work the following Monday" and noted increasing symptoms with increasing driving over the last week. (Id.) Claimant had pain in the lower thoracic and upper lumbar area, as before, which was worse with bending, twisting and prolonged driving. Dr. Thomasson diagnosed muscle spasm due to strain. Dr. Thomasson prescribed physical therapy and noted that claimant was "off work this wk." (Id.)

On May 15, 1995, Dr. Thomasson reported that claimant had pain, "[n]ow a 5," and commented that claimant "[h]urts worse after physical therapy." (Ex. 3-2). Dr. Thomasson noted that claimant could return to work on May 17, 1995. (Id.)

Claimant was involved in another motor vehicle accident on May 24, 1995."

We also change the fourth paragraph on page 2 to read: "Claimant filed a new claim form on May 25, 1995, for the May 24, 1995 injury. (Ex. 6)."

CONCLUSIONS OF LAW AND OPINION

Claimant, a school bus driver, was injured on April 17, 1995 when the bus she was operating was struck by another vehicle. Dr. Thomasson diagnosed a strain in the lower thoracic lumbar area. (Ex. 3-1). The injury was accepted as a thoracolumbar strain. (Ex. 10).

Claimant was involved in another motor vehicle accident on May 24, 1995. The second accident also occurred while she was driving a bus for the employer. Dr. Thomasson reported that claimant had a recurrence of low mid lumbar pain and diagnosed "[l]umbar strain recurrent due to accident." (Ex. 3-2).

On June 26, 1995, the employer advised claimant that it would treat the May 24, 1995 injury as an aggravation of the accepted April 17, 1995 thoracolumbar strain. (Ex. 10).

At hearing, claimant argued that she had virtually recovered from the initial injury and the major contributing cause of her need for medical care and treatment after May 24, 1995 was the second motor vehicle accident. The ALJ found that claimant's argument was well supported by her testimony and the medical and non-medical evidence. We disagree.

Claimant testified that she was off work for a week and a half before returning to her regular bus route, which she continued to do for about three weeks. (Tr. 8). Claimant's testimony, however, is not supported by the medical record.

On April 18, 1995, Dr. Thomasson diagnosed claimant with a lower thoracic lumbar strain resulting from a motor vehicle accident the day before. (Ex. 3-1). Dr. Thomasson reported that claimant was off work for the week.

On May 2, 1995, Dr. Thomasson reported that claimant was off work. (Id.) Dr. Thomasson commented that claimant "went back to work the following Monday" and noted increasing symptoms with increasing driving over the last week. (Id.) Claimant had pain in the lower thoracic and upper lumbar area, as before, which was worse with bending, twisting and prolonged driving. Dr. Thomasson diagnosed muscle spasm due to strain. Dr. Thomasson prescribed physical therapy and noted that claimant was "[o]ff work this wk." (Id.)

On May 15, 1995, Dr. Thomasson reported that claimant had pain, "[n]ow a 5," and commented that claimant "[h]urts worse after physical therapy." (Ex. 3-2). Dr. Thomasson noted that claimant could return to work on May 17, 1995. (Id.)

Based on Dr. Thomasson's reports, we are not persuaded that claimant had "virtually recovered" from the April 17, 1995 injury. Rather, the medical reports indicate that claimant was not free from disability at the time of the May 24, 1995 accident and her April 17, 1995 thoracolumbar strain had not resolved. Therefore, we find the situation sufficiently complicated to require proof of causation by expert medical opinion. See Gene R. Jones, 47 Van Natta 238 (1995) (because the claimant previously injured his neck and back in June 1993 and was continuing to treat for that injury until shortly before the December 1993 accident, the causation issue was a complex medical question requiring expert medical evidence to resolve).

Claimant does not dispute that the major contributing cause standard applies to this case. Claimant must prove that the May 24, 1995 injury is the major contributing cause of her disability or need for treatment for the treatment of the combined condition. See ORS 656.005(7)(a)(B).

Dr. Thomasson is the only physician who has commented on this question. As we mentioned earlier, Dr. Thomasson reported that, after the May 24, 1995 accident, claimant had a recurrence of low mid lumbar pain and Dr. Thomasson diagnosed "[l]umbar strain recurrent due to accident." (Ex. 3-2). In a "check-the-box" letter from the employer, Dr. Thomasson agreed that claimant had had a "reinjury of the previous injury." (Ex. 9). Although "magic words" are not required, we are unable to conclude from Dr. Thomasson's reports that claimant's May 24, 1995 work incident was the major contributing cause of her current back condition. We conclude that claimant has failed to prove that the May 24, 1995 injury should be treated as a separate claim.[1]

ORDER

The ALJ's order dated November 20,1995 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

[1] In light of our conclusion, we do not address the employer's arguments regarding the propriety or the amount of the attorney fee award.

Board Member Gunn dissenting.

Although there is no dispute that claimant was involved in two separate compensable motor vehicle accidents, the majority concludes that claimant's second injury should not be treated as a separate claim. I dissent.

Claimant went back to work after the April 17, 1995 motor vehicle accident and was working 30 to 35 hours a week. (Tr. 9-10). As a result of the May 24, 1995 motor vehicle accident, claimant developed new symptoms, including radiating pain in her back and having her foot fall asleep, which she had not experienced after the April 17, 1995 accident. (Tr. 8-9; Ex. 3-2). After the May 24, 1995 accident, claimant was off work from May 30, 1995 through July 10, 1995. At the time of the hearing, claimant was only working ten hours a week.

Despite the fact that claimant had two separate compensable accidents and developed new symptoms as a result of the second accident, the majority concludes that claimant's second injury should not be treated as a separate claim. The result of the majority's decision is to merge two distinct compensable events into a single incident. Because I agree with the ALJ that the second injury on May 24, 1995 should be processed as a separate claim, I respectfully dissent.

In the Matter of the Compensation of
FRANK D. GRAY, Deceased, Claimant
WCB Case No. TP-95010
THIRD PARTY DISTRIBUTION ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Georgia Pacific Corporation, as paying agency, requests reconsideration of our April 2, 1996 Third Party Distribution Order which resolved the parties' dispute regarding a "just and proper" distribution from a third party settlement. See ORS 656.593(3). Specifically, Georgia Pacific seeks clarification of an apparent inconsistency regarding the amount of the settlement proceeds that Georgia Paeific is to receive.

We withdraw our April 2, 1996 order for reconsideration. After conducting our reconsideration, we make the following clarification. Georgia Pacific shall receive $215,254.09 (less the $50,000 it has already been paid). In other words, the reference to $215,146.51 set forth in the first sentence of the second paragraph on page 1 of our order is replaced with the proper sum of $215,254.09.

Accordingly, on reconsideration, as supplemented and corrected herein, our April 2, 1996 order is republished. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES S. GROVE, Claimant
WCB Case No. 95-07596
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) affirmed an Order on Reconsideration awarding claimant 15 percent (28.8 degrees) scheduled permanent disability for loss of use or function of the right arm; and (2) awarded an insurer-paid attorney fee under ORS 656.382(2). Claimant cross-requests review, asking the Board to vacate the portion of the ALJ's order that found that claimant's right triceps muscles and nerves were not injured. On review, the issues are scope of review, extent of scheduled permanent disability and attorney fees. We modify in part and reverse 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

Claimant compensably injured his right arm on February 14, 1994. SAIF accepted a claim for "ruptured bicep tendon, right arm." (Ex. 3). A Notice of Closure dated March 7, 1995 awarded only temporary disability benefits.

Dr. Logan, medical arbiter, examined claimant on May 20, 1995 and reported that claimant's muscle strength loss of the right biceps and triceps each measured 4/5. (Ex. 11). The June 5, 1995 Order on Reconsideration awarded 15 percent (28.8 degrees) scheduled permanent partial disability for loss of use or function of the right arm. (Ex. 12). The worksheet attached to the Order on Reconsideration indicated that the impairment value for the right biceps was 5 percent and the value for the right triceps was 11 percent, for a combined value of 15 percent. SAIF requested a hearing contesting the Order on Reconsideration.

At hearing, claimant asserted that the right triceps muscle injury was a "medical sequelae" to the original accepted condition, although he acknowledged that no formal claim had been made as to the compensability of the right triceps. (Tr. 4, 5). Claimant argued that there should have been an acceptance and there was no specific denial of the triceps injury. Claimant requested a postponement to allow him to litigate compensability of the triceps condition. (Tr. 4). Alternatively, claimant asked the ALJ to find that there was a "direct medical sequelae" and he contended that, pursuant to ORS 656.268(16), the Order on Reconsideration correctly rated the triceps disability because there was no specific denial of it. (Tr. 4).

The ALJ denied claimant's request for postponement. (Tr. 5). The ALJ did not find any extraordinary circumstances beyond claimant's control that prevented him from raising the issue and complying with the new provisions of ORS 656.262. (Tr. 6). Despite finding that claimant's right triceps muscles and nerves were not injured, the ALJ affirmed the Order on Reconsideration award.

Scope of Review

Claimant argues that the ALJ erred by deciding that claimant had not injured his right triceps muscles and nerves. Claimant asks the Board to vacate only that portion of the ALJ's order.

SAIF agrees that the sole issue at hearing was the extent of scheduled permanent partial disability resulting from claimant's compensable injury, i.e., a ruptured biceps tendon. According to SAIF, it was incongruous for the ALJ to have decided that the triceps muscle was not injured and at the same time affirm the Order on Reconsideration that awarded claimant scheduled permanent disability for the right triceps.

Although claimant raised the issue of the right triceps muscle injury at hearing, he acknowledged that no formal claim had been made as to the compensability of the right triceps. The first mention of any injury or impairment to claimant's right triceps was in the medical arbiter's report.[1] 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 written notice of the claim. ORS 656.262(7)(a) further provides that a worker may initiate a new medical condition claim at any time.

There is no evidence that claimant clearly requested formal written acceptance of a triceps injury from SAIF before the hearing. Since claimant had not complied with ORS 656.262(7)(a) and both parties agree that the compensability of claimant's triceps muscle was not at issue, we vacate that portion of the ALJ's order.[2]

Extent of Scheduled Disability

As a preliminary matter, claimant asks us not to consider SAIF's "Cross-Respondent's Brief" because it was not responsive to claimant's cross-appellant's brief. Claimant asserts that his cross-appeal challenged only the ALJ's ultimate finding of fact that claimant did not injure his right triceps muscles and nerves. Claimant argues that SAIF failed to timely file its appellant's brief and is now using a cross-respondent's brief to bring up new issues.

The Board may make such disposition of a case as determined to be appropriate. ORS 656.295(6); Destael v. Nicolai Co., 80 Or App 596 (1986). The scope of our de novo review encompasses all issues considered by the ALJ's order. Accordingly, because the ALJ decided the extent of scheduled permanent disability and SAIF has requested Board review of the ALJ's order, we are authorized to consider all issues addressed by the ALJ's order. However, because SAIF failed to timely file its appellant's brief and since claimant's cross-appellant's brief only addressed the "scope of review" issue, we consider SAIF's cross-respondent's brief only insofar as it addressed the issue presented in claimant's cross-appellant's brief.

The ALJ affirmed the Order on Reconsideration award that included an impairment value for the right triceps. Citing Edith N. Carter, 46 Van Natta 2400 (1994), and David J. Schafer, 46 Van Natta 2298 (1994), the ALJ reasoned that since Dr. Logan did not indicate that claimant's loss of use or function of the triceps muscle should be considered a separate or unrelated disability, the impairment of the triceps muscle should be construed as "due to" the compensable injury.

Claimant was found to be medically stationary as of December 1, 1994 and the Notice of Closure was issued on March 7, 1995. (Ex. 9). Therefore, the disability standards contained in Workers' Compensation Department Administrative Orders Nos. 6-1992 and 93-056 apply to claimant's claim. Former OAR 436-35-003(2).

Even if we assume, without deciding, that claimant's triceps impairment muscle was "due to" the compensable injury, we conclude that he is not entitled to a rating under former OAR 436-35-110(8) because there is no evidence that claimant's loss of strength of the triceps muscle was caused by a peripheral nerve injury, loss of muscle or disruption of the musculo tendonous unit.

Loss of strength is rated when the cause is a peripheral nerve injury. Former OAR 436-35-110(8) (WCD Admin Order 6-1992). The value of impairment is determined based upon the specific nerve affected as described in the table in OAR 436-35-110(8) and as modified pursuant to 436-35-007(14). Id. Loss of strength due to loss of muscle or disruption of the musculo tendonous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired. Former OAR 436-35-110(8)(a).

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[1] ORS 656.262(6)(d) provides, inter alia, that a worker who believes a condition has been incorrectly omitted from a notice of acceptance first must communicate in writing to the carrier the worker's objections to the notice. Here, the record indicates that claimant did not have notice of an injury or impairment to his right triceps until the medical arbiter examination. Therefore, a "claim acceptance" challenge under ORS 656.262(6)(d) would not be appropriate. In any event, even if claimant relied on ORS 656.262(6)(d), there is no evidence in the record that claimant "communicated in writing" to the carrier his objections to the notice of acceptance.

[2] We note that claimant does not request a remand, nor does he assign error to the ALJ's denial of his request for postponement. In light of claimant's acknowledgment that no formal claim had been made as to the compensability of the right triceps, the compensability issue was not properly before the ALJ and remand would not be appropriate.

On February 18, 1994, Dr. Kopp performed surgery on claimant's ruptured proximal biceps tendon. An examination on December 12, 1994 indicated that claimant continued to "show residual weakness of right biceps, esp. in mid-range and towards elbow flexion." (Ex. 5). Dr. Kopp reported on January 17, 1995 that claimant "has a 30 to 40% deficit of elbow flexion strength." (Ex. 6). On January 17, 1995, SAIF wrote to Dr. Kopp, noting that his January 17, 1995 report had showed a loss of strength and asking him to clarify the reason for the loss of strength. (Ex. 7). Dr. Kopp checked the box "Muscle/Musculotendinous" and wrote: "Injury and surgery have led to weakness. Much less than if he had no surgery. [Therefore,] residual weakness in injury biceps." (Id.) Dr. Kopp did not comment on weakness in claimant's right triceps.

Dr. Logan reported that claimant's right biceps appeared to be 4/5 on testing and his right triceps appeared to be 4/5 on testing, a loss of about 25 percent of the biceps and triceps in the right arm. (Ex. 11-2). Dr. Logan concluded that claimant's muscle strength loss of the right biceps and triceps each measured 4/5. (Ex. 11-3).

The June 5, 1995 Order on Reconsideration awarded 15 percent (28.8 degrees) scheduled permanent partial disability for loss of use or function of the right arm. (Ex. 12). The worksheet attached to the Order on Reconsideration indicated that the impairment value for the right biceps was 5 percent and the value for the right triceps was 11 percent, for a combined value of 15 percent. (Ex. 12-3). The work sheet referred to the right biceps as "4/5 = musculocutaneous nerve = 25% x 20% = 5%." (Id.) Similarly, the work sheet referred to the right triceps as "4/5 = radial nerve = 55% x 20% = 11%." (Id.)

Under former OAR 436-35-110(8)(a), loss of strength due to loss of muscle or disruption of the musculo tendonous unit shall be valued as if the nerve supplying that muscle or muscle group were impaired. Based on Dr. Logan's determination that claimant's muscle strength loss of the right biceps was 4/5 and in light of Dr. Kopp's comment that claimant's loss of strength in the biceps was due to loss of muscle or disruption of the musculo tendonous unit, we find that claimant's musculocutaneous nerve has an impairment value of 25 percent. Former OAR 436-35-110(8). Applying OAR 436-35-007(14) gives claimant 5 percent for loss of strength of the biceps.

Although Dr. Logan reported that claimant's muscle strength loss of the right triceps was 4/5, he did not explain the cause of the weakness and there is no evidence in the record to establish that claimant's loss of strength of the triceps muscle was caused by a peripheral nerve injury, loss of muscle or disruption of the musculo tendonous unit.[3] As we mentioned earlier, the worksheet attached to the Order on Reconsideration referred to the "radial nerve" in connection with rating claimant's right triceps. However, there is no evidence in the record that indicates claimant's radial nerve was impaired. On this record, we conclude that claimant has failed to prove loss of strength in the triceps muscle attributable to nerve injury, loss of muscle, or disruption of the musculo tendonous unit. Therefore, claimant is not entitled to a value for loss of strength for the triceps muscle under former OAR 436-35-110(8).

In reaching this conclusion, we distinguish this case from Lawrence K. Donaghy, 47 Van Natta 1031 (1995). In Donaghy, the medical reports assessing the claimant's permanent disability arising from the compensable injury established that his right quadriceps and hamstring strength was 4/5. We found that evidence sufficient to establish that the claimant's loss of strength was due to loss of muscle or disruptions of the musculo tendonous units relating to his right quadriceps and hamstring. Former OAR 436-35-230(10). We concluded that, because the medical reports specifically addressed the claimant's permanent disability, if any, relating to his compensable right knee injury, those reports implicitly supported the conclusion that his weakness in the right quadriceps and hamstring was due to loss of muscle or disruption of the musculo tendonous unit as a result of his compensable injury.

Here, in contrast, claimant's triceps award was based on impairment of the radial nerve, not on loss of muscle or a disruption of the musculo tendonous unit. Yet, there is no medical evidence from claimant's treating surgeon or the medical arbiter that claimant's radial nerve was impaired. Moreover, Dr. Kopp, claimant's treating surgeon, did not even mention any triceps impairment. Under these circumstances, there is no support, implicit or otherwise, for a conclusion that claimant's loss of strength in the triceps muscle was attributable to nerve injury, loss of muscle, or disruption of the musculo tendonous unit.

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[3] We note that the Department's letter to Dr. Logan asked him to include a comment as to whether muscle strength loss was due to pain, loss of muscle, nerve damage, disruption of the musculo tendonous unit, range of motion loss, or other. (Ex. 10).

Consequently, we modify the Order on Reconsideration to award 5 percent scheduled permanent partial disability for loss of strength of the right biceps. Furthermore, since claimant did not prevail over SAIF's request for hearing seeking a reduction of the compensation awarded by the Order on Reconsideration, we also reverse the ALJ's attorney fee award.

ORDER

The ALJ's order dated September 18, 1995 is modified in part and reversed in part. In lieu of the ALJ and Order on Reconsideration awards, claimant is awarded 5 percent (9.60 degrees) scheduled permanent disability for loss of use or function of the right biceps muscle. The ALJ's attorney fee award is also reversed.

April 10, 1996 Cite as 48 Van Natta 832 (1996)

In the Matter of the Compensation of
DAVID A. HALL, Claimant
WCB Case No. 95-09577
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that upheld the SAIF Corporation's denial of claimant's injury or occupational disease claim for a positive purified protein derivative (PPD) skin test condition. In his brief, claimant argues that his diagnostic medical services are compensable. On review, the issues are compensability and medical services.

We adopt and affirm the ALJ's order regarding the compensability issue and offer the following supplementation regarding the medical services issue.

Claimant argues that his medical services related to diagnosis of the positive PPD skin test condition are compensable even if the condition is not compensable. We disagree.

ORS 656.245 does not provide for payment for diagnostic services if the claimant has not suffered a work-related injury or injurious exposure. See Genevieve V. Brooks-Bishop, 47 Van Natta 759 (1995). Here, because claimant has not established that he was exposed to tuberculosis at work,[1] medical services related to the PPD diagnosis are not compensable.

ORDER

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

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[1] Board Member Gunn acknowledges that he is required by the doctrine of stare decisis to follow the Board's holding in Ruben G. Rothe, 45 Van Natta 369, 372 (1993) (ORS 656.266 requires a claimant to affirmatively prove that his condition is, in fact, related to the work environment). However, for the reasons stated in his dissenting opinion in Lynne D. Gibbons, 46 Van Natta 1698, 1699 (1994), he continues to disagree with the Rothe holding and the underlying analysis. Instead, where a claimant who works in a "high risk" occupation shows that the work environment has a hazardous substance, establishes that he was exposed to such substance, and there is evidence that exposure was the major contributing cause of the occupational disease, the condition should be considered compensable. See Fred W. Hodgen, 47 Van Natta 413, 414 n. 1 (1995). Thus, but for the Rothe precedent, Member Gunn would find the present claimant's PPD skin test condition compensable, including diagnostic medical services related to that condition.

In the Matter of the Compensation of
JERRIE L. JONES, Claimant
WCB Case No. 95-05160
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that declined to award penalties and/or attorney fees based on the insurer's alleged "de facto" denial of her L5-S1 disc protrusion in the low back. In its brief, the self-insured employer challenges that portion of the ALJ's order that denied its motion for dismissal of claimant's hearing request. On review, the issues are dismissal, compensability, 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 compensably injured her low back on September 14, 1994 while lifting a bale of peat moss at work. She was diagnosed with a low back strain and possible disc injury. Her symptoms improved initially, but in mid-October she developed radiating pain into her left leg. A subsequent MRI scan showed a midline protruding L5-S1 disc, slightly eccentric to the right, which was not compromising either the L5 or S1 nerve roots.

The employer's denial of claimant's low back injury claim was set aside by a February 28, 1995 Opinion and Order. By letter dated April 3, 1995, the employer notified claimant that it had accepted her claim for a disabling lumbosacral strain. Claimant requested a hearing seeking penalties and attorney fees arising out of the employer's alleged "de facto" denial of her L5-S1 disc protrusion.

CONCLUSIONS OF LAW AND OPINION

Dismissal

We adopt and affirm that portion of the ALJ's order denying the employer's motion to dismiss claimant's hearing request due to abandonment.

"De Facto" Denial

The ALJ found that the employer's claim acceptance reasonably apprised claimant of the nature of the compensable condition, and that as of the April 3, 1995 claim acceptance, there was no "de facto" denial of her protruded disc condition. Alternatively, the ALJ found that had there been a "de facto" denial, there was no basis for an assessed fee under amended ORS 656.386(1) because it did not amount to a "denied claim" within the meaning of that statute. Finally, the ALJ determined that even under the former (pre-SB 369) version of ORS 656.386(1), claimant had not established a "de facto" denial of her compensable low back condition.

Claimant contends on review that the insurer's failure to respond to its written communication (i.e., the request for hearing) objecting to the employer's notice of acceptance constitutes a "de facto" denial of her L5-S1 disc protrusion. Specifically, claimant argues that her disc protrusion is a separate diagnosis, and not part of the lumbosacral strain specifically accepted by the employer following the prior ALJ's order declaring claimant's "low back injury" compensable.

For the following reasons, we agree with the ALJ that claimant is not entitled to an attorney fee for the alleged "de facto" denial of the disc protrusion. Under amended ORS 656.386(1), which is applicable in this case, a claimant's attorney is entitled to an attorney fee "in cases involving denied claims" where the attorney is instrumental in obtaining a rescission of the denial. A "denied claim" is defined 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 compensation." We held in Michael J. Galbraith, 48 Van Natta 351 (1996) that there was no "denied claim" under amended ORS 656.386(1) where the carrier paid all benefits for the compensable condition and did not expressly contend that the allegedly "de facto" denied condition was not compensable. Cf. Guillermo Rivera, 47 Van Natta 1723 (1995) (finding a "denied claim" where the employer questioned the causation of the "de facto" denied condition).

In this case, as in Michael J. Galbraith, supra, the employer has paid all benefits due for claimant's compensable low back injury. In addition, the record does not establish that the employer refused to pay compensation on the express ground that the L5-S1 disc protrusion was not compensable or did not give rise to an entitlement to compensation. We therefore conclude that a "denied claim" has not been established and no attorney fee may be awarded under amended ORS 656.386(1).

In addition, because no benefits have gone unpaid, there are no amounts "then due" upon which to base a penalty under ORS 656.262(11)(a) and no unreasonable resistance to the payment of compensation under ORS 656.382(1).

ORDER

The ALJ's order dated November 20, 1995 is affirmed.

In the Matter of the Compensation of
KENNETH A. KEEHNER, Claimant
WCB Case No. 95-08581
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Steven Maher, Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that found that claimant's right wrist injury claim was prematurely closed. On review, the issue is premature closure and, if the claim was not prematurely closed, aggravation or extent of scheduled permanent disability and offset. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," on pages 2-3 of the Opinion and Order, except for finding number 6.

CONCLUSIONS OF LAW AND OPINION

Premature Closure

The ALJ found that claimant's right wrist injury claim was prematurely closed, based on the opinion of Dr. Weller, treating physician. We disagree.

Under ORS 656.268(1), claims shall not be closed if the worker's condition has not become medically stationary. "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). It is claimant's burden to prove that he was not medically stationary on the date of closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). In determining whether claimant has carried this burden, we examine medical evidence available at the time of closure, as well as evidence submitted after closure; however, medical evidence submitted after closure that pertains to changes in claimant's condition subsequent to closure is not properly considered.[1] See Scheuning v. J. R. Simplot & Company, 84 Or App 622, 625 rev den 303 Or 590 (1987). 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).

In this case, the medical evidence regarding claimant's condition and his prognosis is provided by Drs. Weller and Neumann.

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[1] There is no contention that the medical evidence on the premature closure issue was not contained in the reconsideration record. (See Ex. 50-4). Thus, we need not address the admissibility of "post-reconsideration" evidence in light of Amended ORS 656.283 (7) and Joe R. Ray, 48 Van Natta 325 (1996).

We agree with the ALJ that Dr. Weller was in the best position to evaluate claimant's condition because she was claimant's treating physician. However, we do not agree that Dr. Weller had a reasonable expectation of material improvement in claimant's condition when the claim was closed.

Dr. Weller initially found claimant medically stationary on October 19, 1994. (Exs. 23-2; 25). On March 15, 1995 (without examining claimant in the interim), Dr. Weller checked a box indicating concurrence with Dr. Neumann's opinion that claimant was medically stationary. (Exs. 28-5, 29). On April 7, 1995 (the day after the claim was closed), Dr. Weller reexamined claimant and reported: "Will followup the carpal tunnel syndrome with followup electrodiagnostic studies. Consider possible surgical options." (Ex. 31). On April 24, 1995, Dr. Weller circled "No" in answer to the question "Medically stationary?" (Ex. 36-3). On May 12, 1995, Dr. Weller acknowledged that claimant had been declared medically stationary on October 19, 1994 and noted that claimant had not wished to pursue surgical options at that time. Further noting that claimant's symptoms had persisted, without significant changes in electrodiagnostic findings, Dr. Weller concluded: "I do not feel further conservative treatment would be of any benefit, however consideration for [sic] carpal tunnel release would be appropriate."[2] (Ex. 40-2).

Based on her April 7, 1995 chartnote, we think that Dr. Weller may have believed that consideration of surgical options would have been appropriate for claimant as of April 6, 1995 (when the claim was closed). However, a recommendation to consider surgery does not indicate reasonable anticipation of material improvement in claimant's condition. Instead, contingent upon claimant's consideration, surgery might be appropriate for claimant. Under these circumstances, we cannot say that there was a reasonable expectation of material improvement in claimant's condition as of claim closure.[3] Accordingly, on this record, we find that claimant has not carried his burden of establishing that his claim was prematurely closed.

Aggravation

The ALJ found that claimant did not perfect an aggravation claim on this record. We agree and adopt his opinion and conclusions in this regard.

Extent of Scheduled Permanent Disability

The ALJ found that claimant failed to prove entitlement to scheduled permanent disability for his right wrist. We agree and adopt his opinion and conclusion in this regard.

Offset

The ALJ denied the employer's request for authorization to offset its overpayment, because he found the claim prematurely closed.

By virtue of our order, the claim is properly closed. Accordingly, the employer is authorized to offset overpaid temporary disability compensation against future temporary or permanent disability awards, pursuant to ORS 656.268(13)&(15)(a). (See Ex. 34).

ORDER

The ALJ's order dated November 17, 1995 is reversed in part and affirmed in part. That portion of the order that set aside the April 6, 1995 Notice of Closure and the July 7, 1995 Order on Reconsideration is reversed and those orders are reinstated and affirmed. The ALJ's attorney fee award is reversed. The self-insured employer is authorized to offset overpaid temporary disability benefits against future awards of temporary or permanent disability. The remainder of the order is affirmed.

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[2] As we have noted, claimant did not wish to pursue surgical options as of October 19, 1994 (the date of Dr. Weller's last examination prior to claim closure). There is no indication that claimant's negative response to that option had changed when the claim was closed. See Karen T. Mariels, 44 Van Natta 2452, 2453 (1992) ("In those cases where a claimant's medically stationary status is contingent upon undergoing recommended surgery, we have held that a claim is not prematurely closed if the claimant refuses the surgery.") (citing Stephen L. Gilcher, 43 Van Natta 319, 320 (1991)).

[3] We acknowledge claimant's contention that a condition which is improving cannot be medically stationary. However, because the dispositive issue concerns expectations as of closure, we do not find that then-current improvement necessarily indicates expected (i.e., continued) improvement.

Board Member Gunn dissenting.

Considering Dr. Weller's ongoing recommendation for surgery, her opinion that claimant was "medically stationary" is unpersuasive. I would focus on the recommendation which, incidentally, has not changed. Such a recommendation necessarily means there is a reasonable expectation of improvement in claimant's condition -- with the surgery. Thus, because the claim was closed despite Dr. Weller's expectation of improvement with surgery, I agree with the ALJ that claimant carried his burden of proving that his claim was prematurely closed. Accordingly, I must respectfully dissent.

In the Matter of the Compensation of
JOHN W. KELSO, Claimant
WCB Case No. 94-05567
ORDER ON REVIEW
James L. Francesconi, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) upheld the self-insured employer's denial of claimant's neck injury claim; and (2) declined to assess a penalty and attorney fees. In its brief, the employer objects to the ALJ's ruling to continue the hearing and subsequent admission of additional evidence. On review, the issues are evidence, compensability, and penalties and attorney fees.

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

The ALJ concluded that claimant did not prove compensable his claim for a herniated cervical disc. Specifically, the ALJ found claimant not credible because claimant inaccurately indicated to physicians and on the 801 form that he had not previously injured his neck, and his explanation at hearing for not having done so was not persuasive. Based on this finding, the ALJ concluded that claimant had not demonstrated that he was injured at work on April 11, 1994 and, therefore, the medical reports relying on such a history were not sufficiently persuasive to carry claimant's burden of proof.

On review, claimant asserts that, because there is medical evidence taking into account claimant's prior 1989 injury (procured following a continuance), and because such evidence continues to attribute claimant's herniated cervical disc in major part to an April 11, 1994 work injury, he proved compensability.

For the reasons stated by the ALJ, we agree that claimant is not credible. As the ALJ explained, claimant was the only source of evidence concerning an April 11, 1994 injury. In view of claimant's lack of credibility and the absence of corroborating evidence concerning an April 11, 1994 incident, we agree that claimant did not prove such a history.

As claimant indicates, the record contains medical opinion from physicians who considered claimant's prior 1989 injury for which he received cervical treatment. Claimant also correctly notes that, despite this history, these physicians continue to indicate that an April 11, 1994 incident is a "very significant" or the major contributing cause of claimant's herniated cervical disc. (Exs. 18-24, 19-33). As indicated above, however, because claimant did not prove such an injury, we conclude that claimant also did not establish that such opinions are based on an accurate history. Thus, claimant did not carry his burden of proof. ORS 656.005(7)(a), 656.005(7)(a)(B).

Finally, we note the employer's objection to the ALJ's continuance of the hearing and subsequent admission of rebuttal evidence. The ALJ made such rulings after the employer's attorney introduced at hearing documentary evidence concerning claimant's 1989 injury. The ALJ continued the hearing to allow claimant the opportunity to rebut such evidence; in doing so, the ALJ rejected the employer's argument that the evidence was for impeachment, rather than substantive, purposes. At the continued hearing, the ALJ admitted transcripts of depositions obtained following the first hearing.

We agree with the ALJ that the evidence did not solely relate to claimant's credibility. Although the employer introduced the evidence in order to reveal that claimant had not accurately related his medical history, because the evidence also concerned a prior injury to claimant's neck, it also related to the issue of causation. This becomes apparent during the depositions following the continuance when the employer's attorney asked the physicians if knowledge of the 1989 injury changed their opinions concerning causation. Consequently, we agree with the ALJ that the additional evidence related to substantive, as well as impeachment, purposes. Thus, we find no abuse of discretion by the ALJ in continuing the hearing and admitting the rebuttal evidence. OAR 438-006-0091(3).

ORDER

The ALJ's order dated November 20, 1995 is affirmed.

April 10, 1996 Cite as 48 Van Natta 837 (1996)

In the Matter of the Compensation of
RONALD J. LAMB, Claimant
WCB Case Nos. 94-10554 & 94-02799
ORDER ON REVIEW
Bischoff, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's denial of claimant's left knee injury claim. In its respondent's brief, the employer contests that portion of the ALJ's order that held that claimant was a de jure employee of Space Solutions.[1] The employer also contests the ALJ's rulings at hearing that: (1) allowed claimant to submit a deposition during closing arguments; and (2) declined to allow the employer access to a witness's file. On review, the issues are whether claimant's injury arose out of and in the course of employment and, alternatively, subjectivity and evidence. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Course and Scope of Employment

We adopt and affirm the ALJ's reasoning and conclusions regarding this issue, with the following supplementation.

Determining whether a worker's misconduct involved activities that are outside the course and scope of employment requires us to ascertain whether the misconduct "involves a prohibited overstepping of the boundaries defining the ultimate work to be done by the [worker]," or whether it "involves a violation of regulations or prohibitions relating to the method of accomplishing that ultimate work[.]" 1A Larson, Workmen's Compensation Law 6-8, § 31.00 (1985) (emphasis in original). If it is the former, the prohibited act falls outside the course of employment. Conversely, if it is the latter, it does not. Id. A worker's violation of a specific directive not to work is tantamount to a violation of an "ultimate work" rule and, therefore, falls outside the course of employment. Davis v. R & R Truck Brokers, 112 Or App 45, 49 (1992); Michael Thornton, 45 Van Natta 743, 743-44 (1993).

Here, the employer told claimant not to come to work on the day that he was injured. That directive established the boundaries of claimant's ultimate work that day. Consequently, claimant's violation of that directive fell outside the course of his employment. It follows that his left knee injury that day also fell outside the course of his employment.

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[1] Space Solutions is one of Barrett Business Services' (Barrett's) clients. Only Barrett has appeared at hearing and on review. For convenience' sake, we refer to it as the employer.

For these additional reasons, we agree with the ALJ's decision upholding the employer's denial of claimant's left knee injury claim.

Subjectivity / Evidentiary Rulings

he employer asserts that claimant's claim fails, because it is not a subject employer and claimant is not a subject employee. It also asserts that the ALJ erred by allowing claimant to submit a deposition into evidence during closing arguments, and by declining to allow the employer access to a witness's file. Because we have affirmed the ALJ's decision upholding the denial, we need not, and do not, address those arguments.

ORDER

The ALJ's order dated October 3, 1995, as amended October 6, 1995, is affirmed.

April 10, 1996 Cite as 48 Van Natta 838 (1996)

In the Matter of the Compensation of
LAURA MADEROS, Claimant
WCB Case No. 94-14383
ORDER ON RECONSIDERATION (REMANDING)
Welch, Bruun & Green, Claimant Attorneys
Roberts, et al, Defense Attorneys

Claimant requests reconsideration of our March 13, 1996 Order on Review in which we: (1) reversed that portion of the Administrative Law Judge's (ALJ's) order which set aside the self-insured employer's denial of claimant's AC joint calcification condition; (2) affirmed that portion of the ALJ's order which set aside the employer's denial of claimant's right shoulder capsulitis condition; (3) vacated that portion of the ALJ's order which upheld the employer's aggravation denial and remanded to the ALJ for further proceedings regarding the compensability of claimant's aggravation claim; and (4) modified the ALJ's attorney fee award from $2,500 to $1,250. Claimant contends that we should have awarded an attorney fee pursuant to ORS 656.382(2) for his counsel's services on review regarding the compensability of her right shoulder capsulitis condition. Having received the employer's response, we proceed with our reconsideration.

After further consideration, we agree with claimant's contention.[1] Her attorney is entitled to an assessed fee for services on review regarding counsel's successful defense of the ALJ's compensability decision regarding claimant's right shoulder capsulitis condition. ORS 656.382(2).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case,

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[1] The employer asserts that claimant's counsel is not entitled to a fee for services on review because claimant's compensation was reduced as a result of its successful appeal of the ALJ's decision to set aside its denial of claimant's AC Joint calcification condition. We disagree.

It is true that our order reinstated the employer's denial of claimant's AC joint calcification condition. However, we also affirmed that portion of the ALJ's order setting aside the employer's denial of claimant's right shoulder capsulitis condition. Thus, while claimant's overall compensation may have been reduced, it was not reduced with respect to the right shoulder capsulitis condition. 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. Debra Cooksey, 44 Van Natta 2102, on recon 44 Van Natta 2197, 2198 (1992). We take this approach even though compensation for the other conditions was reduced (perhaps resulting in an overall reduction of permanent disability) because the claimant must defend against separate and distinct arguments for each condition. Id.

This case is analogous to Cooksey. Claimant's AC joint calcification and right shoulder capsulitis condition were considered separately for the purposes of determining compensability. Claimant had to defend against separate and distinct arguments against each condition. Moreover, the employer urged the Board in its reply brief to consider each right shoulder condition separately in determining compensability. Under these circumstances, it is appropriate to award a fee pursuant to ORS 656.382(2) for claimant's counsel's services on review regarding the specific condition (right shoulder capsulitis) for which compensation was not reduced by the employer's appeal. Debra Cooksey, supra.

we find that a reasonable fee for claimant's attorney's services on review regarding the compensability of the right shoulder capsulitis condition is $500, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

Accordingly, we withdraw our March 13, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our March 13, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 10, 1996 Cite as 48 Van Natta 839 (1996)

In the Matter of the Compensation of
DAYN C. MARTIN, Claimant
WCB Case No. 95-08991
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Gunn, Christian and Haynes.

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

We adopt and affirm the ALJ's order. David Bottom, 46 Van Natta 1485 (1994), aff'd mem Liberty Northwest v. Bottom, 133 Or App 449 (1995).[1]

Claimant's attorney is entitled to an assessed fee for prevailing over the SAIF Corporation's request for review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, 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 November 29, 1995 is affirmed. Claimant's attorney is awarded $1,500 for services on Board review, to be paid by the SAIF Corporation.

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[1] Although the majority appreciates the dissent's interpretations of legislative action in amending ORS 656.005(7)(b)(C), the legislative history does not reveal an explicit intent to overrule the Bottom case or to otherwise remove the injured worker from the course and scope of employment where the injury, as here, was not caused by the consumption of alcohol and/or any controlled substance.

Board Member Haynes dissenting.

The Majority Summarily Cites To David Bottom, 46 Van Natta 1485 (1994), aff'd mem Liberty Northwest v. Bottom, 133 Or App 449 (1995) to conclude that claimant's violation of the employer's drug and alcohol policy did not take him out of the course and scope of employment. Because I believe that the statutory changes of Senate Bill 369 overruled the Bottom rationale, I dissent.

Here, as in Bottom, there is no contention that claimant's injury was caused by his consumption of a controlled substance. In Bottom, the majority rejected my proposal that the claimant's violation of an employer's drug and alcohol policy took the claimant out of the course and scope of employment. The majority implied that to do so would instill fault in a no-fault workers' compensation system.[1] The majority further reasoned that such a rule would enable employers to circumvent the high burden of

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[1] The majority stated that "such a rule would exclude from coverage cases such as this, where an employee was performing assigned work, albeit after consuming alcohol, when, through no fault of his own, and in the absence of any causal connection with his drinking, he is injured."

proof standard in former ORS 656.005(7)(b)(C). 46 Van Natta at 1488 n. 3. Lastly, the majority weighed the social policies in favor of the claimant. The majority's reasons have been dismissed by amended ORS 656.005(7)(b)(C).

The legislature amended ORS 656.005(7)(b)(C)[2] by reducing the employer's burden of proof from clear and convincing to a preponderance of the evidence. This change expresses a clear intent to discourage workers to perform their work in an encumbered state by imposing the sanction of a denial of workers' compensation benefits, if a worker is injured while in such a state.

The legislative history supports my position enunciated in Bottom. First, exceptions to the no-fault concept already exist. By enacting ORS 656.005(7)(b)(C) as part of the 1990 workers' compensation reform, the legislature created another situation in which the injured worker must be responsible for the consequences of his actions. Senate Labor and Government Operations Committee and the House Labor Committee, January 30, 1995, Tape 39A.

Second, the reduction in the evidentiary standard from clear and convincing to a preponderance of the evidence was to make the "employer's burden of proof equal the worker's burden of proof in establishing compensability of a typical workers' compensation claim." Id. Thus, the majority's concern that the employer could somehow bypass the higher burden of proof under former ORS 656.005(7)(b)(C) no longer exists.

Finally, the change also reflects a strong social policy[3] to make it more difficult for workers who work under the influence of drugs and/or alcohol to establish compensability of a workers' compensation claim. Senate Labor and Government Operations Committee and the House Labor Committee, January 30, 1995, Tape 38B. In doing so, the legislature considered the prevention of accidents by discouraging workers to come to work or to work encumbered by drugs and/or alcohol by knowing that they could be denied benefits. Id. at Tape 54A.

For the above reasons, I believe that the legislature intended that if a worker is under the influence of drugs and/or alcohol, the worker has taken himself or herself outside the course and scope of employment. The legislature recognized that consuming drugs or alcohol is a prohibited activity that is no part of work and is outside the course of employment. This intent is consistent with my position that if a worker violated the employer's no alcohol policy, that worker has also deviated from employment. Accordingly, because I would conclude that by violating the employer's no alcohol policy, claimant was acting outside the course and scope of his employment when injured, I dissent.

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[2] ORS 656.005(7)(b)(C) now provides that a compensable injury does not include: "[i]njury the major contributing cause of which is demonstrated to be by a preponderance of the evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance ***."

[3] An adjunct policy change requires us to no longer liberally construe the Workers' Compensation Act in favor of the injured worker, but rather in an impartial and balanced manner. ORS 656.012(3). See also Senate Labor and Government Operations Committee and the House Labor Committee, January 30, 1995, Tapes 16A, 17A, 19A.

April 10, 1996 Cite as 48 Van Natta 840 (1996)

In the Matter of the Compensation of
CHRISTI L. McCORKLE, Claimant
Own Motion No. 95-0353M
OWN MOTION ORDER OF ABATEMENT
Pozzi, et al, Claimant Attorneys

The self-insured employer requests reconsideration of our March 14, 1996 Own Motion Order Reviewing Carrier Closure, which set aside the employer's November 28, 1995 closure in this claim.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. Claimant is requested to file a response to the motion within 14 days of the date of this order. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHARLES R. MORGAN, Claimant
WCB Case Nos. 94-13071, 94-13069, 94-13065, 94-13063,
94-11386, 94-02635, 94-13068, 94-13066, 94-13067, 94-13064 & 94-11387
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys
Garrett, Hemann, et al, Defense Attorneys
Bostwick, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Kevin L. Mannix, Defense Attorney
Steven T. Maher, Defense Attorney
Meyers, Radler, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Gunn and Christian.

The SAIF Corporation, on behalf of Chambers Plumbing & Heating, Inc. (Chambers/SAIF), requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that awarded an assessed attorney fee of $4,000 payable in equal shares by Chambers/SAIF and McKinstry Company, insured by Liberty Northwest Insurance Corporation (McKinstry/Liberty). McKinstry/Liberty cross-requests review of that portion of the ALJ's order that awarded this $4,000 assessed attorney fee. Argonaut Insurance Company, on behalf of Swinerton & Walberg (Swinerton/Argonaut), cross-requests review of those portions of the ALJ's order that: (1) set aside its denial of claimant's occupational disease claim for a bilateral hearing loss condition; (2) upheld Chambers/SAIF's denial of the same condition; (3) upheld McKinstry/Liberty's denial of the same condition; (4) upheld Cigna Insurance Companies' denial, on behalf of University Mechanical (University/Cigna), of the same condition; (5) upheld SAIF's denial, on behalf of Triad Mechanical (Triad/SAIF), of the same condition: (6) upheld Liberty Northwest Insurance Company's denial, on behalf of Harder Mechanical (Harder/Liberty), of the same condition; (7) upheld SAIF's denial, on behalf of Granston Industrial Contractors (Granston/SAIF), of the same condition; (8) upheld SAIF's denial, on behalf of Hollinger Construction (Hollinger/SAIF), of the same condition; and (9) upheld SAIF's denial, on behalf of J. H. Kelly, Inc. (Kelly/SAIF), of the same condition. In addition, in its brief, Harder/Liberty argues that claimant failed to timely request a hearing regarding its denial. On review, the issues are responsibility, timeliness, and attorney fees. We reverse in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exceptions, correction, replacement, and supplementation. We do not adopt the ALJ's description of claimant's work at Triad Mechanical, nor do we adopt the last sentence of the findings of fact.

The first sentence of the 11th paragraph of the findings of fact should read: claimant consulted Alfred Schroeder, M.D., in November 1993. (Ex. 15).

We replace the 16th paragraph of the findings of fact with the following: Both Triad/SAIF and Harder/Liberty requested additional information from Dr. Ediger. (Exs. 57, 58). In rendering his opinion, Dr. Ediger did not have an accurate history of the extent of hearing protection worn at either Triad Mechanical or Harder Mechanical.

Claimant is exposed to two types of noise in his work as a pipe fitter: (1) the background noise of the job site itself; and (2) the pipe fitting work activity noise created by the boom trucks, welding equipment and grinding equipment. Claimant worked as a pipe fitter at Triad/SAIF from August 24, 1993 through August 26, 1993. This work involved some grinding of six and eight-inch carbon steel pipe, an activity that creates a lot of noise. The work was performed outside and the background noise at the Triad job site was not bad.

At hearing, the parties agreed that only Chambers/SAIF and McKinstry/Liberty conceded compensability. (Tr. 1-3).

CONCLUSIONS OF LAW AND OPINION

Responsibility

The ALJ held that Swinerton/Argonaut was responsible for claimant's bilateral hearing loss claim. We disagree.

We begin with a brief summary of the relevant facts. Since 1963, claimant has worked as a pipe fitter, a job that frequently exposes him to high noise levels. The noise exposure consists of both the background noise at the various job sites and the noise created by claimant's own work activities. Claimant's job duties include operating machinery, installing plumbing and pipe, joining pipe, welding, and grinding. The grinding activities create the most noise, with cutting and grinding of carbon steel and stainless steel being the noisiest. Claimant has not consistently worn hearing protection during his work activities. He has worn it when it was required by his supervisors. Most of his use of hearing protection has been more recent. During his entire work history as a pipe fitter, claimant has worked out of a Union Hall. As a result, claimant has worked for many employers over the years.

Claimant has work-related bilateral hearing loss. At hearing, the issues were compensability and responsibility for that condition. On review, the issue is which carrier, of the nine carriers brought into this proceeding, is responsible for that condition.

No one has accepted the hearing loss claim; accordingly, we apply the last injurious exposure rule. SAIF v. Yokum, 132 Or App 18 (1994); Mary A. Kelley, 47 Van Natta 822 (1995). 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); Meyer v. SAIF, 71 Or App 371, 373 (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 claimant receives treatment for a compensable condition before experiencing time loss due to the compensable condition, the "onset of disability" occurs when the worker first receives treatment for the compensable 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. SAIF v. Kelley, 130 Or App 185 (1994)

Here, claimant first sought treatment for his compensable hearing loss on November 22, 1993. At that time, claimant saw Dr. Schroeder, M.D., on referral from his treating physician, Dr. Miller, regarding claimant's significant hearing loss. (Exs. 13-2, 15). As part of this examination, claimant underwent an audiogram performed by Ms. Brady, CFYA. (Ex. 14-3). Dr. Schroeder related claimant's hearing loss to his work activities and recommended hearing aids. (Ex. 15).

In May and June 1994, claimant was examined by Dr. Ediger, audiologist, on behalf of SAIF. (Exs. 24, 29). Dr. Ediger performed an audiogram. Although Dr. Ediger noted that the audiogram he performed and the one performed by Ms. Brady differed, he opined that claimant's work as a pipe fitter caused a bilateral hearing loss.

Triad/SAIF argues that, because there is some dispute as to whether Ms. Brady was fully qualified to perform audiograms, we should find that claimant did not first seek treatment until May/June 1994, when Dr. Ediger examined claimant. We disagree.

Even assuming there was a problem with the audiogram performed by Ms. Brady, that assumption does not change the fact that claimant sought treatment from Dr. Schroeder regarding his compensable hearing loss. Furthermore, there is no dispute regarding Dr. Schroeder's qualifications. Dr. Schroeder performed a clinical examination and took a history from claimant regarding his noise exposure; he did not rely solely on the audiogram in reaching his opinion regarding claimant's hearing loss and need for treatment. In addition, although noting some differences in the audiograms, Dr. Ediger basically agreed that claimant had a work-related hearing loss and needed hearing aids. Under these circumstances, we find that claimant first sought treatment for his compensable hearing condition on November 22, 1993. Accordingly, we designate November 22, 1993 as the date of "onset of disability." See Timm v. Maley, supra; SAIF v. Kelley, supra.

We note that the last potentially causal employment prior to the November 22, 1993 examination was claimant's two weeks of work as a pipe fitter for a Washington state employer. However, in Progress Quarries v. Vaandering, 80 Or App 160 (1986), the court held that out-of-state employment could not be considered for purposes of determining responsibility. The court held that "basic overall fairness can be achieved only if application of the rule remains under control of the Oregon workers' compensation system." Progress Quarries v. Vaandering, supra, 80 Or App at 166. Compare Silveira v. Larch Enterprises, 133 Or App 297 (1995) (out-of-state employment can be considered for purposes of determining compensability). Therefore, we may not consider the Washington employment in determining responsibility.

The last potentially causal Oregon employment prior to the November 22, 1993 examination was with Triad/SAIF. Claimant worked as a pipe fitter for Triad from August 24, 1993 through August 26, 1993. The work at Triad involved "[b]oom trucks, welding machines, grinders, [the] same old stuff" that claimant dealt with in other pipe fitting jobs. (Tr. 31). The Triad work required grinding six and eight inch carbon steel pipe, which was noisy work. (Ex. 54-15-16, Tr. 51). This work was the type of work that Drs. Schroeder and Ediger implicated as causing claimant's hearing loss. (Exs. 15, 24, 29). As the last potentially causal employer on the risk prior to the onset of disability, Triad/SAIF is assigned initial responsibility for the work-related hearing loss condition. See Boise Cascade Corp. v. Starbuck, supra; Meyer v. SAIF, supra; Michael J. Joseph, 47 Van Natta 2043 (1995).

Triad/SAIF can shift responsibility to a prior employer by showing that the prior employments were the sole cause of claimant's hearing loss condition, or that it was impossible for conditions while Triad/SAIF was on the risk to have caused the hearing loss condition. See FMC Corp. v. Liberty Mutual Ins. Co., 70 Or App 370, 374, on recon 73 Or App 223, rev den 299 Or 203 (1985). There is no evidence that the prior employments were the sole cause of claimant's hearing loss. Triad/SAIF argues that an August 2, 1995 opinion from Dr. Ediger establishes that it was impossible for conditions while Triad/SAIF was on the risk to have caused the hearing loss condition. For the following reasons, we disagree.

Dr. Ediger was provided with seven pages of claimant's deposition regarding his work at Triad. (Ex. 57-1). In addition, Dr. Ediger was informed that the work claimant did at Triad was performed outdoors, lasted only a few days, involved intermittent grinding, for which claimant wore hearing protection, and claimant did not consider the Triad job site "an unnaturally noisy work environment." Id. Given this information, Dr. Ediger stated that "[e]ven if this outdoor job was continued indefinitely, [I] would not expect it to contribute to the progression of claimant's hearing loss, as long as [claimant] continued to wear hearing protection and was grinding intermittently."[1] Id.

Dr. Ediger's opinion is based on an assumption that claimant wore hearing protection at the Triad job. Claimant stated that he wore hearing protection when grinding in the open air and when running a grinder while inside of one of the big pipes, a job not required at the Triad site. (Ex. 54-56). However, both in his testimony and in his deposition claimant testified that he removed his hearing protection at times to hear people talking to him. (Tr. 60, Ex. 54-18-19). This part of the deposition was not provided to Dr. Ediger. (Ex. 57-1). Claimant also testified that he sometimes forgot to replace the hearing protection after removing it or that he would not wear hearing protection if he needed to talk with people a lot. (Tr. 15). In addition, claimant testified that, regarding his work at Triad, he thought he wore hearing protection "sometimes," but he did not recall if he wore it all the time. (Tr. 32). Claimant also testified that he wore hearing protection when his supervisors required it, but he could not recall whether any of the employers joined in this claim required the use of hearing protection. (Tr. 68).

Claimant testified that the work at Triad was performed outside and the background noise at the job site was not bad. (Tr. 32, 61-62, 54-15). However, given the fact that the Triad work activities

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[1] We note that Triad/SAIF characterizes Dr. Ediger's opinion as concluding that work at Triad, "even if done indefinitely, would not contribute [to the hearing loss condition] as long as claimant wore hearing protection while grinding." (Triad/SAIF Respondent's Brief, page 8). However, that is not what Dr. Ediger stated, as is shown by the language quoted above. (Ex. 57-1). In any event, as explained below, it is not clear that claimant wore hearing protection at all times during the grinding activities.

required grinding carbon steel, one of the loudest noises claimant's work as a pipe fitter exposed him to, and claimant's statements regarding removing his hearing protection and not recalling the extent to which he wore hearing protection at the Triad job, we do not find that Dr. Ediger's assumption regarding claimant's use of hearing protection accurate. Therefore, we do not find Dr. Ediger's opinion regarding Triad/SAIF's potential responsibility persuasive. Somers v. SAIF, 77 Or App 259 (1986).

In addition, we note that, as explained above, application of the last injurious exposure rule assigns initial responsibility for claimant's work-related hearing loss to Triad/SAIF. Dr. Ediger's opinion is expressed in terms of not expecting work at Triad "to contribute to the progression of claimant's hearing loss." (Ex. 57-1). Under the circumstances of this case, in order to shift responsibility back to previous employments, Triad/SAIF must establish that it was impossible for the work at Triad/SAIF to have caused the compensable hearing loss condition, this standard does not focus on contributing to the "progression" of the compensable condition. On this record, we find that Triad/SAIF has not established that it was impossible for the work at Triad/SAIF to have caused the compensable hearing loss condition.

Triad/SAIF can also shift responsibility forward to a subsequent employer by proving that subsequent employment conditions actually contributed to a worsening of the hearing loss condition.[2] See Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); Spurlock v. International Paper Co., 89 Or App 461, 465 (1988). After the November 1993 onset of disability, claimant worked as a pipe fitter for Hoffman Construction and subsequently for Fullman Company. Claimant testified that these were electronics jobs where the pipe fitting work involved cutting PVC pipe, without any grinding of metal pipes. There is no evidence that claimant's work at either Hoffman or Fullman actually contributed to a worsening of his compensable hearing loss condition. Accordingly, we conclude that Triad/SAIF is responsible for the compensable hearing loss condition.

Attorney Fees

Citing Safeway Stores, Inc. v. Hayes, 119 Or App 319 (1993), the ALJ awarded claimant's attorney an assessed fee of $4,000 for services at hearing, payable in equal shares by Chambers/SAIF and McKinstry/Liberty. We modify.

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(1) (SB 369, § 43(1)).

We have determined that Triad/SAIF is responsible for claimant's compensable hearing loss condition. At hearing, all the parties, including Triad/SAIF, agreed that only two of the carriers had conceded compensability, namely, Chambers/SAIF and McKinstry/Liberty. (Tr. 1-3). By agreeing that it had not conceded compensability, Triad/SAIF, in effect, refused to pay compensation on the ground that the condition was not compensable, thereby requiring claimant's participation in order to establish

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[2] Relying on Charlene A. Dieringer, 48 Van Natta 20 (1996), Triad/SAIF argues that it can shift responsibility forward even if the later employment did not actually contribute to a worsening of the compensable condition. Triad/SAIF misunderstands the reasoning in Dieringer. In that case, the employment that ordinarily would have been initially assigned responsibility under the last injurious exposure rule could not be considered for purposes of determining responsibility because that employment was not subject to Oregon workers' compensation law. 48 Van Natta at 22. Therefore, relying on Silveira v. Larch Enterprises, supra, 133 Or App at 302, we found that we had to determine whether the subsequent Oregon employment was injurious and provided potentially causal conditions for the claimant's compensable condition. Applying that standard, we found the subsequent Oregon employer responsible. Dieringer did not hold that an employer initially assigned responsibility under the last injurious exposure rule can shift responsibility forward if the later employment did not actually contribute to a worsening of the compensable condition.

compensability of the claim.[3] Therefore, Triad/SAIF is liable for an assessed attorney fee under amended ORS 656.386(1) for claimant's attorney's efforts in establishing compensability of the hearing loss condition. See Western Pacific Construction v. Bacon, 82 Or App 135 (1986) (where multiple carriers, including the carrier ultimately found responsible for the claim, denied both compensability and responsibility, the carrier found responsible for the claim was liable for the attorney fee at hearing pursuant to former ORS 656.386(1)); compare Safeway Stores, Inc. v. Hayes, 119 Or App at 323-24 (holding that, when the non-responsible carrier creates the need for the claimant to establish the compensability of a claim, that carrier is responsible for payment of an attorney fee at hearing pursuant to former ORS 656.386(1)).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the compensability issue is $3,000,[4] payable by Triad/SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

In addition, claimant may also be entitled to an attorney fee pursuant to ORS 656.308(2)(d)[5] 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)).

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, supra.

Claimant's counsel fully participated in the hearing. The hearing lasted almost three hours; there were two witnesses; and the transcript is 97 pages long. The record consists of 71 exhibits, including a 64 page deposition of claimant. Nine employers were joined in this case, with eight of the employers represented at hearing. The responsibility issue was actively and skillfully litigated both at

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[3] In reaching this conclusion, we find the present case distinguishable from our recent decision in Donald P. James, 48 Van Natta 563 (1996). In James, we concluded that the claimant was not entitled to an assessed attorney fee award under amended ORS 656.386(1). In reaching that conclusion, we determined that the fact that the responsible carrier's denial did not contain a specific concession of compensability and included "notice of hearing" provisions was not determinative. Instead, given the fact that the responsible carrier captioned its denial as a "DENIAL OF RESPONSIBILITY," requested designation of a paying agent, and did not contend at hearing that the claimant's claim was not compensable or that claimant was not entitled to compensation, we determined that the responsibility denial issued by the responsible carrier did not raise an issue of compensability.

Here, Triad/SAIF's denial also did not contain a specific concession of compensability and included "notice of hearing" provisions. (Ex. 48). It also indicated that "SAIF Corporation has requested the designation of a paying agent pursuant to ORS 656.307." (Ex. 48-2). However, given the fact that SAIF represents multiple employers in the present claim, it is not clear that this reference to SAIF's request of a .307 paying agent refers to a request by SAIF on Triad's behalf. (Exs. 23, 44). More importantly, at hearing, Triad/SAIF agreed that only Chambers/SAIF and McKinstry/Liberty had conceded compensability. Given this, we find the present case distinguishable from James.

[4] We note that several of the carriers argue that, pursuant to ORS 656.308(2)(d), claimant is limited to a total assessed attorney fee of $1,000. We disagree. As explained below, ORS 656.308(2)(d) provides for an assessed attorney fee for prevailing over a responsibility denial. Here, the $3,000 fee is awarded for claimant's attorney's efforts in successfully prevailing on the compensability issue. A fee awarded pursuant to ORS 656.308(2)(d) may be in addition to any fee awarded under ORS 656.386(1). Julie M. Baldie, 47 Van Natta 2249 (1995).

[5] That statute was added as part of Senate Bill 369, which became effective June 7, 1995. Or Laws, ch 332, § 37 (SB 369, § 37).

hearing and on review. In addition, at hearing and on review, claimant's attorney argued that Triad/SAIF was the responsible carrier, the carrier we have found responsible. On this record, we find that claimant's attorney actively and meaningfully participated in finally prevailing against a responsibility denial.

Accordingly, we conclude that claimant's attorney is entitled to an attorney fee award of $1,000 for claimant's counsel's services at hearing and on review for prevailing against a responsibility denial. In making this award, we note that claimant did not argue that this case presented "extraordinary circumstances" that would justify an attorney fee award greater than $1,000. Rather, claimant sought affirmance of the ALJ's $4,000 attorney fee award. Under such circumstances, we find that the maximum cumulative attorney fee for claimant's counsel's services at hearing and on review regarding the responsibility denial is $1,000. ORS 656.308(2)(d); Tammy Locke, 48 Van Natta 250 (1996).

Finally, both compensability and responsibility were decided by the ALJ. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252-53 (1992), mod on recon, 119 Or App 447 (1993); Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Swinerton/Argonaut's appeal to the Board placed claimant's award at risk. Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by Swinerton/Argonaut. ORS 656.382(2); International Paper Co. v. Riggs, 114 Or App 203 (1992); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $1,000, to be paid by Swinerton/Argonaut. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's respondent's brief), the complexity of the issue, and the value of the interest involved.

Finally, claimant is not entitled to an attorney fee for his counsel's services on review devoted to the attorney fee issue.

ORDER

The ALJ's order dated September 28, 1995 is reversed in part and modified in part. The SAIF Corporation's denial on behalf of Triad Mechanical (Triad/SAIF) is set aside and the claim is remanded to Triad/SAIF for processing according to law. Triad/SAIF is responsible for the ALJ's $4,000 attorney fee award ($3,000 pursuant to amended ORS 656.386(1) and $1,000 pursuant to ORS 656.308(2)(d)), to be paid directly to claimant's attorney. SAIF's denials on behalf of Chambers Plumbing & Heating, Inc., Granston Industrial Contractors, Hollinger Construction, and J. H. Kelly, Inc. are reinstated and upheld in their entirety. Liberty Northwest Insurance Corporation's denials on behalf of McKinstry Company and Harder Mechanical are reinstated and upheld in their entirety. Argonaut Insurance Company's denial on behalf of Swinerton & Walberg (Swinerton/Argonaut) is reinstated and upheld in its entirety. Cigna Insurance Companies' denial on behalf of University Mechanical is reinstated and upheld in its entirety. For services on review regarding the compensability issue, claimant's attorney is awarded an assessed fee of $1,000 under ORS 656.382(2), payable by Swinerton/Argonaut directly to claimant's attorney.

In the Matter of the Compensation of
ALBERT NACOSTE, JR., Claimant
WCB Case No. 95-06313
ORDER ON REVIEW
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Otto's order that affirmed an Order on Reconsideration that found claimant no longer permanently and totally disabled (PTD). On review, the issue is permanent total disability.

We adopt and affirm the ALJ's order,[1] with the exception of the last sentence, and with the following supplementation.[2]

The ALJ concluded that the insurer had established that claimant was no longer PTD. Thus, the ALJ affirmed an Order on Reconsideration which had reversed a Determination Order that continued claimant's PTD benefits on the ground that there had been no physical change in his condition since the last arrangement of compensation. We agree.

When an injured worker has received an award for permanent total disability, the award may be revoked or diminished only upon the employer or insurer showing by a preponderance of the evidence 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 make such a showing by proving that a claimant is presently capable of performing some work. A worker's capacity to perform some work 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 Or 301 Or 765 (1986); Ralph L. Reed, 47 Van Natta 483 (1995). In this case, we conclude that SAIF has proved that claimant is capable of performing work, as demonstrated by circumstantial evidence of his employability.

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[1] We modify the date of the initial Determination Order closing claimant's claim from January 15, 1996 to January 15, 1976.

[2] We note that Exhibits 104 through 114 were provided subsequent to the Department's reconsideration. Neither party objected to the admission of this evidence either at hearing or on review. The ALJ concluded that Dr. Janzen's statement that claimant was not employable based on the alleged effects of his post-concussion syndrome (Exs. 105, 113, 114) was not persuasive. We agree.

Pursuant to former ORS 656.268(7), we are expressly prohibited from considering "post-arbiter" medical evidence pertaining to impairment. Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). Furthermore, we have determined that we cannot consider such evidence regardless of a party's failure to object. David J. Rowe, 47 Van Natta 1295 (1995).

Both ORS 656.268(7) and 656.283(7) were amended by the 1995 legislature prior to hearing. 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 Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure." (Emphasis added). Amended ORS 656.283(7) provides in part:

> "Evidence on an issue regarding a *** 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. However, nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present the reconsideration record at hearing to establish by a preponderance of 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 pursuant to ORS 656.268."

Taken together, these statutes limit to the reconsideration record the evidence that may be considered at a hearing on a Determination Order. See Joe R. Ray, 48 Van Natta 325 (1996). Whether or not Exhibits 104-114 are considered, however, our conclusion is the same.

In July 1994, claimant was referred to the Progressive Rehabilitation Associates (PRA) for a permanent total disability reevaluation, which included a physical capacities evaluation, neuropsychological tests, and psychological tests. This evaluation was concurred in by Dr. Janzen, claimant's attending physician.

Claimant was also evaluated by two vocational rehabilitation counselors. Considering claimant's barriers to employment, which included limited education and length of time off work, and the results of the physical capacities evaluation, six jobs were identified as suitable for claimant and which are available in significant numbers in the Portland metropolitan area: (1) Electronic Assembler of circuit boards; (2) Motel Clerk; (3) Small Product Assembler; (4) Parking Lot Cashier; (5) Production Assembler, and (6) Storage Facility Rental Clerk (Exs. 95, pp. 2-12; 96). Dr. Janzen approved all of these jobs as within claimant's capabilities. (Id.). Claimant was subsequently examined by medical arbiters Gancher, neurologist, and Howell, psychiatrist, who found no objective neurological or psychological findings that would prevent claimant from working. (Ex. 101).

Thus, the persuasive medical and vocational evidence does not establish the existence of current physical or vocational impairments which would preclude claimant from performing work activities in a suitable and gainful occupation. Consequently, we conclude, as did the ALJ, that SAIF has proved by a preponderance of the evidence that claimant is currently able to engage in suitable and gainful employment. Harris v. SAIF, supra.

Considering claimant's long-standing receipt of PTD benefits, we recognize his frustration at losing such benefits. However, in light of the persuasive medical and vocational evidence, such a conclusion is mandated by the law.

ORDER

The ALJ's order dated October 18, 1995 is affirmed.

April 10, 1996 Cite as 48 Van Natta 848 (1996)

In the Matter of the Compensation of
KAREN B. NOONAN, Claimant
WCB Case No. 95-09305
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) McCullough's order which declined to award an assessed attorney fee pursuant to either ORS 656.386(1) or ORS 656.382(1). On review, the issue is attorney fees.

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's entitlement to a fee pursuant to ORS 656.386(1).

The ALJ declined to award an attorney fee under ORS 656.386(1), reasoning that there had been no "denied claim" which would support the assessment of an attorney fee under that statute. On review, claimant contends that she is entitled to an attorney fee for obtaining the SAIF Corporation's acceptance of her diagnosed sacroiliac and costal/intercostal sprains. We disagree.

SAIF initially accepted claimant's compensable injury claim for thoracic and lumbar strains, based on the diagnoses of her first attending physician, Dr. Dover. Claimant later sought treatment from a chiropractor, Dr. Johnson, who also diagnosed thoracic sprain, but sacroiliac and costal/intercostal sprains as well. Dr. Johnson would later confirm that claimant's rib pain was not a separate condition from her thoracic sprain and that his use of the term "sacroiliac sprain" pertained to the same low back pain that provided the basis for Dr. Dover's initial diagnosis of lumbosacral sprain. (Exs. 12-2, 17).

Claimant sent SAIF a letter advising that she believed that SAIF's' claim acceptance had incorrectly omitted the conditions diagnosed as sacroiliac and costal/intercostal sprain. (Ex. 18A). SAIF responded that all compensation related to the conditions identified by claimant had been paid and that it was not denying the compensability of those conditions. (Ex. 21).

At the hearing, SAIF agreed that the sacroiliac and costal/intercostal sprains were compensable. The parties also agreed that all benefits due claimant had been paid.

We agree with the ALJ that there was no "denied claim" within the meaning of ORS 656.386(1). The record contains no evidence that SAIF refused to pay any compensation. To the contrary, the parties agreed that all benefits had been paid. There is no indication that SAIF questioned the causal relationship of claimant's diagnosed sacroiliac and costal/intercostal sprains to the compensable injury. Under such circumstances, the record does not establish that SAIF refused to pay compensation on the "express ground" that the above conditions were not compensable or that they did not otherwise give rise to an entitlement to compensation. ORS 656.386(1). Consequently, we conclude that there has been no "denied claim." See Michael J. Galbraith, 48 Van Natta 351 (1996).[1] We, therefore, agree with the ALJ that an attorney fee may not be awarded under ORS 656.386(1).

ORDER

The ALJ's order dated December 21, 1995 is affirmed.

[1] Moreover, we also find that the medical evidence does not establish that claimant sought treatment for a new or different condition from the ones accepted by SAIF, despite Dr. Johnson's use of different terminology. See Leslie C. Muto, 46 Van Natta 1685 (1994), aff'd mem 133 Or App 770 (1995) (no "de facto" denial when the claimant's condition was the same as that accepted by the carrier even though different medical terminology used to describe the condition); Cf. Gerald A. Keipinger, 47 Van Natta 1509 (1995) (right hand condition different and separate from that accepted by the employer). For this additional reason, we conclude that an attorney fee under ORS 656.386(1) is not appropriate.

April 10, 1996 Cite as 48 Van Natta 849 (1996)

In the Matter of the Compensation of
DWIGHT M. PAGE, Claimant
WCB Case No. 94-13688
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order which: (1) upheld the SAIF Corporation's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) declined to award an assessed attorney fee under ORS 656.386(1). On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, but note that claimant's attending physician is Dr. Hohl, not Dr. Hare.

CONCLUSIONS OF LAW AND OPINION

Claimant, an electrician, worked for SAIF's insured from 1983 to 1993.[1] Claimant then went to work for an employer insured by Wausau. Although he had experienced symptoms of wrist numbness for ten years, claimant did not report any symptoms to his employer or miss any time from work.

In the summer of 1994, claimant's symptoms worsened. Dr. Hohl suspected carpal tunnel syndrome and referred claimant to Dr. Rosenbaum, neurosurgeon, who confirmed that claimant had bilateral carpal tunnel syndrome for which surgery was required.

[1] It appears that SAIF began providing coverage after September 30, 1992. (Ex. 10).

In September 1994, claimant filed a claim with SAIF. On November 1, 1994, SAIF specifically denied the compensability of claimant's bilateral carpal tunnel condition and also disclaimed responsibility, listing prior carriers of its insured, as well as Wausau's insured, as potentially responsible for claimant's condition. (Ex. 10). Claimant filed a claim against Wausau, which resulted in Wausau accepting claimant's claim prior to the hearing. (Tr. 17).

The only parties present at the hearing were claimant and SAIF. Claimant did not contest Wausau's acceptance of his claim. Instead, he contended that he was entitled to have the compensability portion of SAIF's denial set aside and attorney fees assessed.

The ALJ rejected claimant's request for attorney fees under ORS 656.386(1) and 656.382(1). With respect to ORS 656.386(1), the ALJ reasoned that, because claimant's compensation was not at risk by virtue of Wausau's acceptance of his carpal tunnel claim, claimant's attorney was not entitled to an attorney fee under that statute. The ALJ denied claimant's request for a penalty-related attorney fee under ORS 656.382(1), concluding that SAIF had a reasonable doubt regarding its liability for claimant's claim and that, even if its denial was unreasonable, there was no proof of unreasonable delay or resistance to the payment of compensation.

Claimant requested reconsideration of the ALJ's order, asking for a specific ruling on whether his carpal tunnel claim was compensable. The ALJ expressed doubt that such a ruling was necessary, given his earlier finding that claimant was making no claim for compensation against SAIF. However, the ALJ determined that the medical evidence from Dr. Mayhall, an examining physician, and Dr. Rosenbaum was insufficient to establish that claimant's work activities with SAIF's insured were the major contributing cause of his carpal tunnel syndrome. Thus, the ALJ determined that claimant's condition was not compensable.

On review, claimant contends that the ALJ erred in not finding his carpal tunnel condition compensable. Moreover, should we agree, claimant asserts that he is entitled to an attorney fee under ORS 656.386(1) for prevailing against SAIF's compensability denial. Noting that claimant does not seek compensation from SAIF, and that claimant is satisfied with Wausau's acceptance of his claim, SAIF responds that the compensability issue is moot. Because claimant has not obtained compensation from SAIF, it further asserts that claimant is not entitled to an attorney fee under ORS 656.386(1). For the following reasons, we agree with SAIF.

In responsibility disputes concerning an aggravation versus a "new injury" claim, we have held that a claimant is entitled to proceed under a "new injury" theory notwithstanding the fact that the aggravation claim has been accepted. Finding that significant benefits have been at stake, we have concluded that a claimant is not procedurally barred from challenging an acceptance and arguing that another carrier is responsible for the claim. See Geraldine M. Bradshaw-Coe, 43 Van Natta 518 (1991); Jon F. Wilson, 42 Van Natta 2595 (1990); Karen L. Nichols, 41 Van Natta 2414 (1989).

The circumstances in this case are somewhat similar, except, in this case, claimant conceded that he was not seeking compensation from SAIF and is, therefore, not dissatisfied with Wausau's acceptance of his claim. Thus, we find this case distinguishable from those cited above, in which the claimants were dissatisfied with one carrier's acceptance and instead alleged that another carrier was responsible for their claim.

Had claimant been dissatisfied with Wausau's acceptance and sought a finding that SAIF was responsible for his occupational disease claim, then he would not be procedurally barred from litigating the compensability issue against SAIF. This is not the case, however. Accordingly, we conclude that the ALJ correctly determined in his initial order that a finding regarding the compensability issue was not necessary.[2] It follows that the compensability finding in his Order on Reconsideration must be vacated.

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[2] We note claimant's concern that allowing SAIF's compensability denial to stand may adversely affect his ability to assert a claim against SAIF in the future. We reject that rationale as a basis for a finding on compensability. Claimant has acceded to Wausau's acceptance of his claim. Under such circumstances, Wausau remains responsible for claimant's carpal tunnel condition until he sustains a "new compensable injury." See ORS 656.308(1). In other words, as insurer for the prior employer, SAIF will never be found responsible for claimant's carpal tunnel condition.

Moreover, inasmuch as claimant is procedurally barred from litigating SAIF's compensability denial, it follows that he has not "prevailed finally" in a denied claim. See ORS 656.386(1). Therefore, we agree with the ALJ that claimant is not entitled to an attorney fee under that statute.

ORDER

The ALJ's order dated April 24, 1995, as reconsidered July 25, 1995, is affirmed.

April 10, 1996 Cite as 48 Van Natta 851 (1996)

In the Matter of the Compensation of
DANA QUACKENBUSH, Claimant
WCB Case No. 95-05061
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that increased claimant's unscheduled permanent disability award for a cervical condition from 24 percent (76.8 degrees), as awarded by an Order on Reconsideration, to 36 percent (115.2 degrees). On review, the issues are evidence and extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with one change. We change the second sentence in the second finding to read: "During the five years prior to determination, in addition to being employed as a dietary aide, claimant was employed at a laundry."

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant, a dietary aide at a medical center, sustained a compensable C5-6 disc herniation at work on November 25, 1993. Dr. Kirkpatrick performed surgery on June 13, 1994. After the surgery, claimant returned to his regular work.

An Order on Reconsideration dated April 18, 1995 awarded claimant 24 percent (76.8 degrees) unscheduled permanent disability. (Ex. 29). Claimant requested a hearing.

The ALJ increased claimant's award by an additional 12 percent, finding that claimant's base functional capacity (BFC) was "heavy" and his current residual functional capacity (RFC) was "medium." The ALJ assigned an adaptability factor of "3."

The employer argues that claimant's adaptability factor should be zero, rather than "3." The employer contends that claimant's testimony concerning his BFC was not admissible pursuant to ORS 656.283(7). The employer asserts that since there was no other evidence establishing a "heavy" BFC, the Order on Reconsideration should be affirmed.

In Joe R. Ray, 48 Van Natta 325 (1996), we held that the 1995 amendments to ORS 656.283(7) retroactively apply to exclude any evidence (including at-hearing testimony), which was not submitted at the reconsideration proceeding, at a subsequent hearing concerning the extent of permanent disability. Relying on the plain language of amended ORS 656.283(7), as supported by the legislative history, we concluded that the legislature intended to limit evidence concerning issues arising from a Notice of Closure or Determination Order to that evidence submitted at the reconsideration and made a part of the reconsideration record.

Here, claimant's testimony was not submitted at the reconsideration proceeding. Therefore, it cannot be considered in determining the extent of his permanent disability. See Joe R. Ray, supra. Consequently, we do not consider any of claimant's testimony on review.

Extent of Unscheduled Permanent Disability

Claimant was found to be medically stationary as of September 15, 1994 and the Determination Order was issued on October 31, 1994. (Ex. 25). Therefore, the disability standards contained in Workers' Compensation Department Administrative Orders Nos. 6-1992 and 93-056 apply to claimant's claim. Former OAR 436-35-003(2).

The parties do not contest the values assigned for claimant's age (0), education (0), or skills (4). Rather, the parties dispute the value for adaptability.

Adaptability is measured by comparing claimant's BFC to his maximum RFC at the time of becoming medically stationary. Former OAR 436-35-310(2). Under former OAR 436-35-310(4)(a), claimant's BFC is the highest strength category assigned in the DOT for the most physically demanding job he has successfully performed in the five years before determination.

The ALJ found that the most appropriate Dictionary of Occupational Titles (DOT) code for claimant's job at injury (dietary aide at a medical center) was DOT # 319.677-014, which assigns a strength category of "medium."[1]

Dr. Kirkpatrick's March 14, 1994 report indicates that claimant had worked at the employer for three years and "before that worked in a laundry." (Ex. 8-2). The Dictionary of Occupational Titles includes several different laundering occupations, with varying strength and training requirements. Although a medical report indicates that claimant worked in a laundry in the five years before determination, there is no evidence that indicates what claimant's job duties were at the laundry. Under these circumstances, we conclude that the record does not establish claimant's strength category while working at the laundry. Consequently, we conclude that claimant's most physically demanding job in the five years before determination was his job at injury. Therefore, we compare the strength demands of that job with claimant's residual functional capacity to determine his adaptability value.

The ALJ found that claimant's RFC was medium. The RFC is evidenced, in part, by the attending physician's release. Former OAR 436-35-310(5)(a). Here, Dr. Kirkpatrick, claimant's attending physician, reported on August 29, 1994 that the plan was to return claimant to work on a light duty basis for two weeks and then to "full duty." (Ex. 21). Dr. Kirkpatrick declared claimant medically stationary as of September 15, 1994. (Ex. 23). The medical arbiter, Dr. Dinneen, reported on March 24, 1995 that claimant was "doing his usual work, full time." (Ex. 28).

Based on this evidence, we conclude that claimant's RFC is equal to or greater than his BFC (medium).[2] Former 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. See also former OAR 436-35-310(6).

Subsequent to the ALJ's order, the Court of Appeals determined that 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., supra. The court relied on the Supreme Court's opinion 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.

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[1] We note that the ALJ's Order on Reconsideration refers to DOT # 355.677-010, rather than DOT # 319.677-014. The ALJ referred to the strength level as "medium," although the strength level for DOT # 355.677-010 is "light." It is not clear whether the ALJ intended to change the DOT code.

In any event, we conclude that the most appropriate job title for claimant's job at injury is a hospital food-service worker, dietary aide or tray worker, which is DOT # 319.677-014. In contrast, DOT # 355.677-010 refers to a caterer helper, who prepares and serves food and refreshments at social affairs. The record establishes that claimant worked as a dietary aide at a medical center rather than as a caterer helper. (Exs. 1, 8).

[2] In light of our finding that claimant's RFC is equal to or greater than his BFC and based on Carroll v. Boise Cascade Corp., 138 Or App 610 (1996), we need not address the employer's alternate argument that claimant was released to full-time employment without limitation.

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, supra. 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). 48 Van Natta at 335.

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. Id.

This case also comes under the standards set forth in WCD Admin. Order 93-056. Based on our reasoning in Joe R. Ray, supra, the rule is inconsistent with ORS 656.726(3)(f)(A). Consequently, we assign adaptability a value of one and add the value of the remaining factors of age, education and skills to impairment.

The total value of claimant's age (0), education (0) and skills (4) is (4). That value is multiplied by the adaptability value of (1) for a total of 4. Former OAR 436-35-280(6). When this value is added to the value for impairment (24), the result is 28. Former OAR 436-35-280(7). Therefore, claimant's unscheduled permanent disability is 28 percent (89.6 degrees). Consequently, we modify the ALJ's order to reduce claimant's unscheduled disability award from 36 percent to 28 percent.

ORDER

The ALJ's order dated August 24, 1995, as reconsidered September 22, 1995, is modified. In lieu of the ALJ's award, and in addition to the Order on Reconsideration award of 24 percent (76.8 degrees), claimant is awarded 4 percent (12.8 degrees) for a total award of 28 percent (89.6 degrees) unscheduled permanent partial disability. Claimant's attorney fee, as awarded by the ALJ's order, is modified accordingly.

April 10, 1996 Cite as 48 Van Natta 853 (1996)

In the Matter of the Compensation of
BENJAMIN SANCHEZ, Claimant
WCB Case No. 95-09003
ORDER ON REVIEW
Michael R. Dehner, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis's order that declined to award an out-of-compensation attorney fee based on temporary disability benefits previously paid to claimant. On review, the issue is claimant's entitlement to an approved attorney fee.

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

Here, a February 3, 1995 Determination Order reclassified claimant's claim as disabling. The Department's "reclassification" order did not award an out-of-compensation attorney fee. Claimant requested a hearing and ALJ Peterson awarded claimant an "out-of-compensation" attorney fee for obtaining reclassification of his claim. The attorney fee was based on temporary disability benefits which would result from the reclassification.

An August 4, 1995 Determination Order awarded claimant temporary disability benefits, in addition to an award of unscheduled permanent disability. Claimant sought reconsideration of the Determination Order. At the time of hearing, an Order on Reconsideration had not issued.

Claimant also requested a hearing seeking enforcement of the prior ALJ's order which awarded an "out-of-compensation" attorney fee. ALJ Davis agreed that, following reconsideration, SAIF was required to pay claimant the "out-of-compensation" fee awarded under ALJ Peterson's order. However, ALJ Davis further concluded that there was no basis for an "out-of-compensation" fee based on any other temporary disability benefits that may have arisen separately from the reclassification.

On review, claimant contends that he is also entitled to an approved attorney fee based on two temporary disability benefits paid to claimant prior to ALJ Peterson's order. We disagree.

We have previously held that, where a claimant's attorney has failed to take preventive action to secure an "out-of-compensation" fee, the attorney must seek payment of the fee from the claimant. See e.g. Theresa G. Peterson, 47 Van Natta 2352 (1995); Felipe J. Casas, 45 Van Natta 2128 (1993). In Casas, the claimant obtained a Director's order requiring the insurer to recalculate the claimant's temporary disability benefits, and the time loss was recalculated and paid to the claimant. The claimant then requested a hearing and sought an approved attorney fee. However, the record failed to establish that the claimant's fee request to the Director was accompanied by a copy of an executed retainer agreement. As such, we held in Casas that the claimant's counsel failed to take preventive action to secure an "out-of-compensation" fee for obtaining the recalculation of benefits. Consequently, we held that the claimant's attorney must look to the claimant for payment of the fee, rather than to the insurer.

Here, we find no evidence that claimant's counsel took any action to secure the "out-of-compensation" fee before SAIF paid temporary disability benefits to claimant, prior to ALJ Peterson's order. Accordingly, as that compensation has apparently been paid to claimant, claimant's counsel should seek his fee from this previously paid increased temporary disability compensation directly from claimant, rather than SAIF. Peterson, supra; 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).

Finally, we agree with the ALJ that 25 percent of any temporary disability compensation provided to claimant is payable to claimant's counsel, until such time as claimant's attorney fee equals $1,050.

ORDER

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

April 10, 1996 Cite as 48 Van Natta 854 (1996)

In the Matter of the Compensation of
GERARD R. SCHILLER, Claimant
WCB Case No. 94-08820
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Garrett, Hemann, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that: (1) declined to award an attorney fee under ORS 656.382(2) for the SAIF Corporation's withdrawal of its hearing request from an Order on Reconsideration; and (2) declined to award an attorney fee under ORS 656.386(1) for the noncomplying employer's withdrawal of its hearing request from the Department's "noncomplying employer" order in a prior WCB case. The alleged noncomplying employer (NCE) asserts that claimant's attorney should be assessed sanctions pursuant to ORS 656.390 for his allegedly frivolous request for review. On review, the issues are attorney fees and sanctions.

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

The ALJ found that claimant's current attorney did not have standing to request attorney fees under ORS 656.382(2) and 656.386(1). Alternatively, the ALJ held that, even if claimant's current attorney had standing to request these attorney fees, his request fails on the merits. We agree with the ALJ's alternative holding. Because claimant's request for attorney fees under ORS 656.382(2) and 656.386(1) fails on the merits, we need not decide whether claimant's current attorney has standing in this matter.

ORS 656.382(2)[1] 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); Karen K. Deaton, 48 Van Natta 44 (1996).

Claimant argues that the fact that SAIF withdrew its request for hearing after the hearing was convened entitles him to an attorney fee because there was a threat of a reduction in his benefits. However, the deciding factor is not whether or not the hearing convened before SAIF withdrew its hearing request. The deciding factor is the fact that, as a result of SAIF's withdrawal of its hearing request, the ALJ did not decide on the merits that claimant's award of compensation should not be disallowed or reduced. Thus, the terms of ORS 656.382(2) are not met; accordingly, claimant is not is not entitled to an attorney fee pursuant to ORS 656.382(2). Strazi v. SAIF, supra; SAIF v. Curry, supra; Karen K. Deaton, supra.

Amended ORS 656.390(1) gives us the authority to impose an appropriate sanction against an attorney who files a frivolous request for review. "'[F]rivolous' means that matter is not supported by substantial evidence or the matter is initiated without reasonable prospect of prevailing." ORS 656.390(2)[2]; see Westfall v. Rust International, 314 Or 553 (1992) (defining "frivolous" under former ORS 656.390); Rhonda Hittle, 47 Van Natta 2124 (1995).

Here, claimant's request for review was not frivolous. He raised colorable arguments regarding the applicable legal standards. Furthermore, claimant's arguments are sufficiently developed so as to create a reasonable prospect of prevailing on the merits. In this regard, while acknowledging that a carrier's withdrawal of a hearing request does not entitle a claimant to an attorney fee, claimant argued that the fact that SAIF withdrew its hearing request after the hearing was convened took claimant's claim out of that situation and entitled him to an attorney fee.

Karen K. Deaton, supra, was decided after claimant's appeal of the ALJ's order. In Deaton, the claimant raised a similar argument, asserting that she was entitled to an attorney fee under ORS 656.382(2) because the NCE withdrew its hearing requests after the hearing was convened. Because we concluded that there was no basis under the statute for an award of an attorney fee, we declined to address the claimant's argument regarding the affect of the convened hearing. Here, we have addressed that argument and find that the convening of a hearing prior to the withdrawal of the carrier's hearing request does not entitle a claimant to an attorney fee under ORS 656.382(2), because the determinative factor is whether the ALJ decided on the merits that claimant's award of compensation should not be disallowed or reduced. While we reject claimant's arguments, we do not find them legally frivolous. Accordingly, we do not impose a sanction under ORS 656.390(1).

ORDER

The ALJ's order dated July 5, 1995, as reconsidered October 31 and November 17, 1995, is affirmed.

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

[2] ORS 656.390(1) was amended and 656.390(2) was added to the Act by SB 369, § 45. Because that section is not excluded from the general retroactivity provisions of the bill, it applies to this case. SB 369, § 66; Volk v. America West Airlines, 135 Or App 565 (1995).

In the Matter of the Compensation of
PAIGE SCOTT, Claimant
WCB Case No. 94-01285
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Gunn.

The insurer requests review of that portion Administrative Law Judge (ALJ) Hazelett's order which set aside its denial of claimant's bilateral carpal tunnel syndrome (CTS) condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In 1989, claimant sought treatment for right wrist pain. In January 1990, the insurer accepted "right wrist strain." (Ex. 3). While treated by Dr. Bell, neurologist, claimant was diagnosed with bilateral carpal tunnel syndrome (CTS). An April 1991 Determination Order awarded temporary disability only. (Ex. 10). The Determination Order was not appealed.

In November 1993, claimant again sought treatment for her hands and wrists with Dr. Hylton. The insurer denied compensability, alleging that claimant's current need for treatment was not related to the 1990 accepted claim. (Ex. 29).

Citing Messmer v. Deluxe Cabinet Works, 130 Or app 254 (1994), rev den 120 Or 507 (1995), the ALJ found that claimant's current condition was the same as that for which she was awarded temporary disability benefits by the 1991 Determination Order. Although finding that claimant had not proved a compensable aggravation, the ALJ concluded claimant was entitled to medical services for her current wrist condition.

The insurer challenges this conclusion, asserting that claimant did not prove a compensable relationship between her 1990 claim and her 1993 medical treatment. Claimant responds that the 1991 Determination Order precludes the insurer from denying her current bilateral CTS condition. According to claimant, the insurer accepted her bilateral CTS when it failed to contest the Determination Order which stated that claimant's accepted condition was bilateral CTS. Claimant relies on Messmer v. Deluxe Cabinet Works, supra, which 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.

Subsequent to the date of the ALJ's decision, the legislature amended ORS 656.262(10) (formerly ORS 656.262(9)) to provide:

> "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).

The statute retroactively applies. Craig L. Hiatt, 47 Van Natta 2287, 2288 (1995). Furthermore, because the holding in Messmer conflicts with amended ORS 656.262(10), that case no longer is good law. Lisa R. Dawson, 48 Van Natta 246, 247 (1996). Therefore, we reject claimant's argument that the insurer is precluded from denying her current wrist condition, even assuming that Messmer would have applied to the award of temporary disability awards in the absence of permanent disability, as in this case. Thus, we now address whether claimant proved compensable her claim for bilateral CTS.

In April 1994, claimant returned to Dr. Bell for treatment of her wrists. (Ex. 32). Dr. Bell noted that claimant's current symptoms were identical to the symptoms that he originally treated claimant for in 1990 and diagnosed claimant's current condition as bilateral CTS based on clinical symptomatology. Dr. Bell indicated that claimant's condition "primarily relates to her original injury with her recent work [as a deck hand for a subsequent employer] exacerbating the original condition." (Ex. 32).

Examining hand surgeon Dr. Button diagnosed intermittent CTS. (Ex. 34-3). Addressing congenital factors which might have predisposed claimant to CTS, Dr. Button believed that despite a possible predisposition for CTS, physical activity would usually cause or exacerbate the condition/symptoms. (Ex. 34-4). Noting claimant's normal nerve conduction findings, Dr. Button concluded that claimant's CTS had not pathologically worsened. Finally, Dr. Button opined that the major contributing factor for claimant's increased exacerbation of her CTS symptoms was her work exposure as a tug boat deck hand for a subsequent employer.

Examining neurologist Dr. Rosenbaum diagnosed bilateral wrist strain. (Ex. 24). Dr. Rosenbaum noted that claimant's wrist pain had waxed and waned over the years, beginning with her work for the insurer's employer and increasing with her current job as a deck hand. (Ex. 24-4). Dr. Rosenbaum further opined, however, that claimant's prior work with the insurer's employer did not lead to any ongoing pathology. As such, Dr. Rosenbaum stated that claimant's current wrist strain condition was related to her work as a tug boat deck hand. (Ex. 24-4). Dr. Hylton concurred with Dr. Rosenbaum's findings. (Ex. 31).

We generally afford greater weight to the opinions of the claimant's attending physician, absent persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to those medical opinions which are well reasoned and thorough. See Somers v. SAIF, 77 Or App 259 (1986).

Here, we find persuasive reasons to discount the opinions of Dr. Bell. Dr. Bell opines that claimant's current condition was the same condition he diagnosed in 1990. However, the condition (bilateral CTS) has not been accepted by the insurer and, therefore, is not determinative regarding whether claimant's medical treatment relates to her compensable/accepted right wrist strain. As such, Dr. Bell's opinion is not persuasive because it addresses a condition which has not been accepted. Weiland v. SAIF, supra.

In contrast, we are persuaded by the opinions of Drs. Rosenbaum, Hylton and Button. These physicians have related claimant's current wrist condition to claimant's tug boat work with another carrier. As such, we conclude that claimant has not proved even a material contributing cause relationship between her current need for medical treatment and her compensable condition (right wrist strain). Consequently, we conclude that claimant has not proved the compensability of her current bilateral carpal tunnel syndrome condition. ORS 656.005(7)(a); 656.245(1).

ORDER

The ALJ's order dated April 17, 1995 is reversed in part and affirmed in part. That portion of the ALJ's order which set aside the insurer's denial of claimant's current bilateral wrist condition is reversed. The insurer's denial is reinstated and upheld in its entirety. The ALJ's attorney fee award is reversed. The remaining portions of the ALJ's order are affirmed.

Board Member Gunn dissenting.

In this case, a Determination Order awarded claimant TTD benefits for a bilateral CTS condition. The ALJ found, and I agree, that the condition which currently requires claimant to seek medical services is the same condition for which claimant was awarded temporary disability benefits.

In the Messmer case, the court cited Drews v. EBI Companies, 310 Or 134 (1990), for the principle that a Determination Order that is not appealed and has become final can give rise to application of the principle of claim preclusion. Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994). Furthermore, citing Hammon Stage Line v. Stinson, 123 Or App 418 (1993), the court recognized that a Determination Order is based on certain underlying facts. Consequently, the court

held that, where an award had been made based on certain underlying facts (i.e., the order included an award for an unaccepted degenerative condition), once the order became final, the employer was barred by claim preclusion from denying compensability of the degenerative condition.

Here, the facts in existence at the time that the Determination Order awarded temporary disability benefits for claimant's bilateral CTS condition are the same facts underlying this medical services dispute. Thus, claimant's Determination Order award and her current need for medical service are inextricably linked.

Under the circumstances, I would find that because the Determination Order was not appealed by the insurer and has become final by operation of law, it has a preclusive effect and the insurer may not contest the compensability of claimant's bilateral CTS. Accordingly, I dissent from the majority's decision.[1]

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[1] I also disagree with the majority's suggestion that amended ORS 656.262(10) may apply to this case. That statute specifically refers to permanent disability benefits, while the present case involves temporary disability benefits. The majority has cited no reasoning or legislative history to support extending the application of the statute to the payment of temporary disability benefits.

In the Matter of the Compensation of
TERRY L. SHEELEY, Claimant
WCB Case No. 94-03090
ORDER ON REVIEW
Andrew H. Josephson, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Christian, Gunn and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its partial denials of claimant's claim for a right knee strain, right knee synovitis and patella tendinitis; and (2) found claimant's claim was prematurely closed. On review, the issues are compensability, premature closure and, alternatively, extent of permanent disability.

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

We supplement this order only to respond to the points made in the dissent. We have adopted the ALJ's order, as we conclude that the medical evidence, in addition to claimant's testimony, support the ALJ's conclusion that claimant experienced a knee complaint resulting from the July 1993 work incident.

Specifically, claimant had no prior knee complaints or condition. On July 29, 1993, claimant and a co-worker were moving a heavy steel beam. When the co-worker let go of the beam to move another object out of the way and claimant took on the full weight, he felt a sudden pain shoot through his body. He sought treatment that same day and was diagnosed with a lumbosacral strain.

During August 1993 physical therapy for his back injury, claimant complained of right knee pain in addition to mid and low back pain. Additionally, at the October 6, 1993 physical therapy session, the therapist noted that claimant was walking with a mild antalgic gait favoring his right leg. Claimant continued to complain of pain in his right knee. The doctors treating his low back were unable to relate the knee pain to any nerve root impingement, and referred claimant to Dr. Baum, who opined that claimant suffered from synovitis originating from the July 29, 1993 incident.

Accordingly, although the dissent maintains that there was no evidence of a knee problem immediately following the injury, as noted by the ALJ, a delay in the onset of a condition following the compensable injury is not determinative of whether or not a condition arose directly from the accident.

Susan Day-Henry, 44 Van Natta 1792 (1992). Additionally, in this case, claimant's immediate complaints and treatment were focused on the low back. Knee complaints were documented only five days after the initial injury. Specifically, a physical therapy chartnote dated August 4, 1993, provided that claimant complained of "mid and low back pain as well as R knee pain secondary to OJI lifting on 7/29/92." (Ex. 10). Consequently, the fact that there is no emergency room documentation of knee problems is not dispositive.

Next, the dissent contends that there are no "objective findings" to support a compensable knee condition. We disagree. Claimant's knee complaints were supported by observed swelling in the right knee. (Exs. 23, 44, 75, 82, 83, 84). Additionally, an October 24, 1994 MRI showed joint effusion. (Ex. 85).

After reviewing the medical record, we conclude that claimant has proven "objective findings," sufficient to meet the standard set forth in amended OAR 656.005(19). Furthermore, after considering the fact that Dr. Baum measured claimant's knee to determine the amount of swelling, and then later agreed that claimant's knee condition arose from the July 1993 injury, we conclude that the objective findings are due to the July 1993 work incident. (Exs. 83, 96).

Finally, we disagree with the dissent's conclusion that Dr. Baum's opinion should be disregarded because it is not persuasive. Dr. Baum's opinion was based on an accurate history, as substantiated by the physical therapy chartnotes which confirm claimant's knee complaints following the injury. Even Dr. Rischitelli, who examined claimant shortly after the work injury, agreed that claimant had knee complaints, although Rischitelli did not see an "organic" reason for those complaints. Finally, we conclude that Dr. Baum's opinion establishes the requisite causal relationship between the work incident and claimant's knee condition. (Ex. 92, 96). Accordingly, we conclude that the ALJ correctly relied on Dr. Baum's opinion in finding this claim 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 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated September 22, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the insurer.

Board Member Haynes dissenting.

The majority has adopted and affirmed the ALJ's conclusion that claimant's July 29, 1993 lifting incident at work was a material cause of his right knee condition, diagnosed as synovitis. The ALJ's finding was based on the determination that, in the course of setting down the heavy beam, claimant sustained an injury to his right knee unrelated to the compensable low back injury. Unlike the majority, I do not believe that claimant has established the compensability of his right knee synovitis because (1) the record does not support the finding of a separate knee injury; (2) there are no "objective findings" to verify the injury; and (3) Dr. Baum's opinion, the only medical evidence relating claimant's anterior compartment knee pain to the July 29, 1993 incident, is unpersuasive.

In evaluating the cause of claimant's knee problems more than a year and a half after the work incident, Dr. Baum specifically noted that "there is some question as to whether this patient, in fact, did sustain a knee injury at the time of the back injury" and rendered his causation opinion without resolving the question. (Ex. 92). Moreover, on his initial emergency room evaluation (the day of the incident), claimant's knee reflexes were tested bilaterally and no symptoms were noted. It seems to me that if claimant had in fact sustained a separate injury to his right knee during the lifting incident, he would have exhibited some symptoms on the initial examination. In any event, I find no evidence of a separate knee injury.

Second, even if there was evidence of a knee injury arising out of the July 29, 1993 incident, I do not believe it is supported by "objective findings." A physician's report that the worker experiences pain is not sufficient to constitute "objective findings" under ORS 656.005(7)(a) and amended ORS 656.005(19). See Jairo J. Garcia, 48 Van Natta 235 (1996) (overruling Suzanne Robertson, 43 Van Natta 1505 (1991) and excluding from "objective findings" subjective responses that are not reproducible, measurable or observable). Here, claimant initially reported pain to his physical therapist on August 4, 1993, but there is no diagnosis of any right knee condition nor any objective finding of injury to the knee. Following claimant's complaints of pain, Dr. Rischitelli examined claimant's knee but found no objective evidence of injury. Similarly, the panel of physicians who examined claimant on the insurer's behalf noted claimant's complaints of some knee pain, but found normal range of motion, and no effusion, warmth or other signs of injury. Indeed, even Dr. Baum noted that claimant's complaints of anterior compartment pain subsequent to the work incident were not really supported by objective findings.[1] (Ex. 92-2).

Finally, I would find Dr. Baum's opinion unpersuasive because it is conclusory and speculative. See Moe v. Ceiling Systems, 44 Or App 429 (1980) (rejecting conclusory medical opinion). For example, Dr. Baum did not address the mechanism of injury, but simply reported that claimant's right knee anterior compartment pain was related because he had persistent pain complaints following the work incident. An inference of causation should not be drawn based upon a temporal relationship alone. See Allie v. SAIF, 79 Or App 284 (1986). Further, even though he is now claimant's treating physician, Dr. Baum did not begin treating claimant until more than a year after the July 29, 1993 event. Therefore, unlike Dr. Rischitelli (who found no causal connection between claimant's knee pain and the work incident), Dr. Baum did not have the opportunity to evaluate claimant contemporaneously with the work incident and over an extended period of time. Because Dr. Baum's treatment followed so long after the key event, it should not be given the greater weight ordinarily accorded to attending physicians' opinions. See Cody L. Lambert, 48 Van Natta 115 (1996).

In summary, because I would find that claimant has failed to prove the compensability of his right knee synovitis by a preponderance of the evidence, I respectfully dissent.

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[1] I note that both Dr. Aversano and Dr. Baum found in October 1994 that claimant's right knee swelled slightly after physical therapy. Because neither doctor related this swelling to any specific knee injury arising out of the July 1993 work incident, it does not satisfy the "objective findings" requirement.

In the Matter of the Compensation of
ALTON D. SIMONS, Claimant
WCB Case No. 95-03369
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Yeager's order that: (1) declined to admit Exhibit 41 (claimant's attending physician's concurrence with an examining physician's report) into the record; and (2) set aside its denial of claimant's current right shoulder condition. Claimant cross-requests review of that portion of the ALJ's order that upheld the insurer's partial denial of his degenerative disc disease. On review, the issues are evidence and the propriety of the insurer's denials. 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

Evidence

As a preliminary matter, we address the insurer's contention that Exhibit 41 (Dr. Whitney's concurrence with the report of examining physician, Dr. Wilson), should have been included by the ALJ in the evidentiary record. In his order, the ALJ indicated that Exhibit 41 was not included as an exhibit submission and was therefore not a part of the evidentiary record.

Notwithstanding the ALJ's belief, the record contains a June 27, 1995 letter from the insurer submitting Exhibit 41 for inclusion in the record. The insurer's written closing argument also seeks admission of Exhibits 1 through 49 (including Exhibit 41). In addition the insurer refers to Exhibit 41 in its written closing argument. Furthermore, there is no indication in the record or in his brief that claimant objected to the admission of Exhibit 41. Finally, Exhibit 41 was included in the record submitted to the Board for review pursuant to ORS 656.295.

Here, given the presence of the document in the record, the insurer's letter and written closing argument seeking admission of Exhibit 41, and the lack of objection by claimant, we conclude that the ALJ was mistaken in concluding that the exhibit was not included as part of the evidentiary record. Because we conclude that the exhibit is part of the evidentiary record, we consider it on review.

Partial Denial of Right Shoulder Condition

The insurer contends that the ALJ erred in concluding that its partial denial of claimant's right shoulder condition was premature. The insurer characterizes the partial denial as a permissible "precautionary" denial and asserts that the denial was necessary to protect it from a contention that claimant's preexisting right shoulder condition had been accepted. Claimant responds by asserting that no claim for the preexisting shoulder condition had been made and that the insurer's claim acceptance of "temporary aggravation of pre-existing right shoulder strain and right clavicular fracture" made it clear that the preexisting right shoulder condition was not part of the accepted claim.

A carrier may issue a "precautionary" denial to avoid the appearance of having accepted a condition, when it is put on notice of a possible claim for that condition. See, e.g., Chaleunsak S. Xayaveth, 47 Van Natta 942 (1995). A denial is premature if there is no claim for the denied condition. See William H. Waugh, 45 Van Natta 919 (1993).

Here, the insurer accepted "temporary aggravation of pre-existing right shoulder strain and right clavicular fracture." On the same date, the insurer issued a partial denial of claimant's preexisting right shoulder strain and right clavicular fracture. The denial stated that claimant's work exposure was no longer the major contributing cause of claimant's need for treatment of the right shoulder and that claimant's work exposure was not the major contributing cause of a pathological worsening of the preexisting right shoulder condition.

The insurer's acceptance was based on the report of examining physician, Dr. Wilson, who diagnosed claimant's condition as "temporary aggravation of his pre-existing right shoulder situation, post clavicular fracture with deformity." Dr. Wilson indicated that the condition had long since cleared up and was no longer a problem. Claimant's treating physicians, Drs. Kitchel, Gerber and Whitney, concurred with Dr. Wilson's report.

To the extent that the insurer's partial denial denies a "preexisting strain," we agree with the ALJ that the denial is inappropriate. Dr. Wilson did not diagnose any "preexisting strain" nor does the record reflect that claimant had a preexisting right shoulder strain. Nevertheless, to the extent that the insurer's partial denial denied claimant's preexisting post-clavicular fracture and deformity, we conclude that the denial was appropriate.

The accepted condition was an aggravation of a preexisting condition. Although the insurer's claim acceptance was specific, the partial denial further delineated the scope of the accepted claim and emphasized that the preexisting "post-clavicular fracture with deformity" was not accepted. The insurer's partial denial protects it from the possibility that the preexisting condition might later be determined to be encompassed in an acceptance of the claim involving claimant's right shoulder. See

Weyerhaeuser Co. v. Warrilow, 96 Or App 34, 38 (1989). Because the preexisting right shoulder condition could reasonably be interpreted to be encompassed in the compensable claim, we conclude that the insurer's partial denial was appropriate to the extent that it denied "preexisting post-clavicular fracture with deformity." Consequently, we proceed to determine the compensability of the right shoulder fracture and deformity.

Inasmuch as the medical evidence does not support a conclusion that the preexisting fracture and deformity was caused or pathologically worsened by claimant's work, we uphold those portions of the denial.

Because we have concluded that a portion of the insurer's denial of claimant's right shoulder condition should be upheld, we modify the ALJ's $2,000 attorney fee award.

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 hearing level regarding the preexisting strain issue is $1,700, 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 claimant's counsel might go uncompensated.

Claimant's attorney is also entitled to an assessed fee for services on review regarding the portion of the right shoulder denial (preexisting strain) which remains set aside. 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 that issue 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.

Denial of Lumbar Degenerative Disease

We adopt and affirm the reasoning and conclusion of the ALJ concerning this issue.

ORDER

The ALJ's order dated January 5, 1996 is reversed in part, modified in part, and affirmed in part. That portion of the ALJ's order that set aside the insurer's partial denial of claimant's right shoulder condition in its entirety is reversed. That portion of the denial that denied claimant's post-clavicular fracture with deformity is reinstated and upheld. The remainder of the denial remains set aside. The ALJ's award of a $2,000 attorney fee is modified. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded $1,700, payable by the insurer. The remainder of the ALJ's order is affirmed. For services on review regarding the right shoulder (preexisting strain) denial, claimant's attorney is awarded $500, to be paid by the insurer.

In the Matter of the Compensation of
SADIE R. SYMONDS, Claimant
Own Motion No. 95-0347M
OWN MOTION ORDER OF ABATEMENT
Popick & Merkel, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Claimant requests reconsideration of our March 29, 1996 Own Motion Order of Dismissal, in which we declined to review the carrier's Notice of Closure in this claim, or to modify its contents pursuant to a proposed Stipulation and Order. Claimant contends that she did not receive the Notice of Closure until "well after the 60-day period in which to appeal had expired." Claimant requests that the Board approve the Stipulation as submitted.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The self-insured employer 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
ARTHUR J. SMITH, Claimant
WCB Case No. 95-05505
ORDER ON REVIEW
John DeWenter, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Livesley's order that set aside its denial of claimant's aggravation claim for a right shoulder condition. On review, the issue is aggravation. We reverse.

FINDINGS OF FACT

On June 28, 1988, claimant dislocated his right shoulder while working as a police officer. He was treated at the emergency room with a closed reduction and shoulder immobilizer. The employer accepted a disabling right shoulder injury.

A November 15,1988 MRI did not reveal any evidence of glenoid pathology or a compromised rotator cuff. Work hardening exercises failed to increase claimant's shoulder strength beyond 65 pounds, which rendered him unable to return to his job at injury. Dr. Schachner declared claimant medically stationary as of December 6, 1988, and in need of vocational assistance.

Claimant's shoulder x-rays revealed a Hill-Sachs lesion of the humeral head, which may have been a congenital predisposing factor or acquired at the time of the dislocation. Dr. Schachner was unable to determine when the lesion occurred because of time that had transpired between claimant's injury and Dr. Schachner's evaluation.

Claimant's claim was closed with a 6 percent unscheduled permanent disability award by an April 29, 1989 Determination Order. The permanent disability award was increased to 21.5 percent unscheduled and 17 percent scheduled for loss of use or function of the right forearm by a November 16, 1989, Opinion and Order.

On July 22, 1990, claimant sustained a second right shoulder dislocation while swimming. X-rays revealed a small Hill-Sachs deformity and Bankart lesions. Claimant filed an aggravation claim, which was denied by the employer. By stipulation entered February 8, 1991, the parties agreed that the denial should be upheld because claimant had not sustained an aggravation, but that the second dislocation had been primarily caused by the original compensable injury.

X-rays taken January 31, 1991 indicated that claimant's Hill-Sachs lesion remained unchanged and that a Bankart fracture from the inferior glenoid had healed. Dr. Schachner noted that if claimant experienced another dislocation, he would be a chronic dislocator and should consider a shoulder repair.

On March 31, 1991, claimant dislocated his right shoulder while throwing a ball to his son. Dr. Schachner recommended shoulder reconstruction surgery, which was authorized by the employer on May 15, 1991. Although he suffered two more dislocations during the summer of 1991, claimant did not proceed with the surgery. Dr. Schachner opined that claimant's condition was expected as a result of his original injury and that there had been no material worsening of claimant's condition, other than the fact he was experiencing recurrent dislocations.

Claimant saw Dr. Schachner for a reevaluation on July 20, 1992. He reported an additional dislocation which he was able to self-reduce. Dr. Schachner found a functional range of motion with no evidence of any weakness, and some anteroposterior play in the right shoulder despite claimant's report of repeated exercises.

Claimant returned to Dr. Schachner on June 14, 1993, reporting no dislocations over the past year. Dr. Schachner again noted full range of motion, relatively good power and anteroposterior play indicative of the residual capsular laxity.

On April 8, 1994, claimant saw Dr. Schachner complaining of elbow pain. He was diagnosed with lateral epicondylitis and given a tennis elbow loop. That same day, claimant's attorney wrote to the employer's claims processor requesting that his shoulder claim be reopened as an aggravation.

Claimant returned to Dr. Schachner for his annual shoulder evaluation on July 18, 1994. He reported no intercurrent dislocations and no change in his shoulder symptoms, although pain referable to his epicondylitis. Dr. Schachner reported that claimant "effectively remains stable without any further problems."

Claimant saw Dr. Brooks on May 9, 1995 for recurrent right shoulder dislocations. Dr. Brooks found an unstable right shoulder with abnormal movement passively but full range of motion.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that because claimant required surgery subsequent to the parties' February 1991 Stipulation, claimant had established a compensable aggravation under amended ORS 656.273(1).

The employer argues on review that claimant has not proven an "actual worsening" of his compensable condition between 1991 and 1994 and is therefore not entitled to have his claim reopened as an aggravation. Claimant, on the other hand, argues that he has established an actual worsening because his injury has resulted in recurrent right shoulder dislocations.

The parties agree that claimant's last award of compensation arose out of the February 8, 1991 stipulation, where the insurer's denial of claimant's first aggravation claim was partially set aside with regard to medical services arising out of claimant's second dislocation.[1] The parties also agree that the pertinent issue is whether claimant sustained an actual worsening of his compensable condition in March 1991, when he experienced another dislocation and Dr. Schachner recommended surgery.

Unlike the ALJ, we find no persuasive evidence that claimant sustained an aggravation of his shoulder condition in March 1991 or anytime during the 5-year aggravation period.[2] The only physician to examine claimant during the pertinent time period was his treating doctor, Dr. Schachner. In connection with his request for authorization to perform the reconstructive surgery, Dr. Schachner advised the employer in May 1991 that claimant's then-current condition was expected as a result of claimant's original injury. He also opined that "there has been no material worsening of [claimant's] condition."[3] (Ex. 11B). Then, in August 1991, Dr. Schachner reported that "worsening has obviously occurred considering that [claimant] is now a habitual dislocator and that is the indication for shoulder

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[1] We note that the "last arrangement of compensation" was actually the November 1989 Opinion and Order increasing claimant's permanent disability award, although the February 8, 1991 stipulation determined that claimant's right shoulder condition had not worsened as of that date. In any event, regardless of which date is used, the outcome in this aggravation case is not affected.

[2] Claimant's aggravation rights expired on April 11, 1994. See ORS 656.273(4). Although there is evidence in the record indicating that claimant experienced another shoulder dislocation in May 1995, we do not address that incident here because it occurred after the expiration of claimant's aggravation rights. See Perry v. SAIF, 93 Or App 631 (1988), rev'd on other grounds, 307 Or 654, on remand, 99 Or App 52, n.2 (1989).

[3] Dr. Schachner continued to examine claimant's shoulder on an annual basis between 1991 and July 1994 and, on each occasion, reported that claimant's condition was essentially unchanged. Claimant had full range of motion and relatively good power with some paterposterior play indicative of the residual capsular laxity. (Ex. 12).

reconstruction." (Ex. 3A-5) Dr. Schachner continued to examine claimant's shoulder on an annual basis between 1991 and July 1994 and, on each occasion, reported that claimant's condition was essentially unchanged. (Ex. 12).

At no point did Dr. Schachner offer any explanation for his differing opinions regarding the worsening (or lack thereof) of claimant's compensable condition. For that reason alone, we attach minimal probative weight to his reports. See Moe v. Ceiling Systems, 44 Or App 429 (1980); see also Kelso v. City of Salem, 87 Or App 630 (1987). We also give no weight to the opinion of Dr. Brooks because he did not examine claimant during the relevant time period.[4] Accordingly, we conclude that claimant has not established an "actual worsening of the compensable condition supported by objective findings" after his last award or arrangement of compensation. Amended ORS 656.273(1).

ORDER

The ALJ's order dated August 31, 1995 as amended September 12, 1995 is reversed in part and affirmed in part. The employer's denial of the aggravation claim is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the order is affirmed.

[4] Dr. Brooks first examined claimant in May 1995 for dislocations that occurred after the April 11, 1994 expiration of claimant's aggravation rights. For example, Dr. Brooks reported in July 1995 that claimant's shoulder function had worsened because he "is no longer able to do the heavy lifting and work which he was capable of doing until fairly recently." As we understand his opinion, any worsening of claimant's shoulder results from dislocations that occurred in April and May 1995, well after the 5-year aggravation period.

April 10, 1996 Cite as 48 Van Natta 865 (1996)

In the Matter of the Compensation of
RUSSELL A. SOMFLETH, Claimant
WCB Case No. 95-07630
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Gunn.

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

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated October 16, 1995 is affirmed.

Board Member Gunn dissenting.

Finding that claimant's injury did not result from an act that was an ordinary risk of, or incidental to, his employment as a pipe layer, the ALJ concluded that claimant's injuries did not "arise out of" his employment. On review, my colleagues have adopted and affirmed the ALJ's order. Inasmuch as the risk in this case was distinctly associated with claimant's employment, see Henderson v. S.D. Deacon Corp., 127 Or App 333 (1994), I dissent.

Claimant was injured during the work day while crossing the street to purchase replacement work gloves which he felt were necessary to perform his job. The SAIF Corporation never investigated the circumstances of the accident giving rise to claimant's injuries. Instead, SAIF denied the claim based on its erroneous assumption that claimant was going to lunch.

If the Court of Appeals can find a lawyer bicycling to a meeting of other lawyers a compensable injury in the course and scope of employment, see McKeown v. SAIF, 116 Or App 295 (1992), a pipe layer going to buy work gloves is surely in the course and scope of his employment. It is clearly apparent that none of the principals involved in this case has ever done any measurable work with a pick and shovel. I suggest they try it before they determine gloves are not necessary.

On these facts, I would reverse the ALJ's order and find claimant's injury claim compensable. Therefore, I must respectfully dissent.

April 10, 1996 Cite as 48 Van Natta 866 (1996)

In the Matter of the Compensation of
BURTON I. THOMPSON, Claimant
WCB Case Nos. 94-14904, 94-14905, 94-07248, 94-11385, 94-11384, 94-11383, 94-11381 & 94-11382
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
David O. Horne, Defense Attorney
Williams, Zografos, Defense Attorneys
Lundeen, et al, Defense Attorneys
Norman D. Cole (Saif), Defense Attorney
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Liberty Northwest Insurance Corporation, on behalf of Farmers Co-op Creamery (Liberty/Farmers), requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of responsibility for claimant's occupational disease claim for asbestosis; and (2) assessed a penalty for allegedly untimely claims processing. Claimant cross-requests review of those portions of the order that: (1) failed to award a penalty and related attorney fee for Liberty/Farmers' allegedly unreasonable denial of compensability; and (2) awarded an attorney fee of $2,500. On review, the issues are responsibility, penalties and attorney fees. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we supplement and briefly summarize as follows.

Claimant, age 52, worked for six different employers between 1967 and 1985 as an insulator, where he was exposed to asbestos fibers. Between 1968 and 1973, claimant worked at employers covered by the Longshore and Harbor Workers' Compensation Act (LHWCA). (Exs. 40D; 56-30 and -31; 56-46 and -47; and 56-53 through -55). In March 1988, claimant went to work for Liberty/Farmers as a machinery and maintenance person. In late 1988, he began working as a butter maker. In early 1993, claimant was exposed to asbestos fibers when he entered an area where a 1942 Babcock and Wilcox industrial boiler was being demolished. Claimant first sought medical treatment for lung symptoms in June 1993 and was diagnosed with work-related asbestosis in September 1993.

Claimant filed Oregon workers' compensation claims with the seven employers/insurers he had worked for since 1967 and a claim against E.J. Bartells under the LHWCA. The federal claim was denied on January 20, 1994. On May 19, 1994, Liberty/Farmers, claimant's most recent employer/insurer, denied compensability and responsibility on the grounds that: (1) claimant was not exposed to asbestos fibers at its employment; and (2) the claim may be subject to federal jurisdiction. (Ex. 47).

The hearing lasted two and one-half hours. The transcript is 56 pages long. The record consists of 73 exhibits, including one 262-page deposition.

CONCLUSIONS OF LAW AND OPINION

Responsibility

We adopt and affirm the ALJ's opinion on this issue, which we supplement as follows.

Relying on the last injurious exposure rule, the ALJ found Liberty/Farmers responsible for claimant's lung condition. On review, Liberty/Farmers challenges this conclusion, first asserting that, because claimant was not exposed to asbestos at its employment, work conditions there could not have caused claimant's lung condition.

Under the last injurious exposure rule, 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 initially 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 before experiencing time loss due to the condition, the date the claimant first receives treatment related to the compensable condition is determinative for purposes of assigning initial responsibility for the claim. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

In about March 1993, while claimant was employed as a butter-maker at Liberty/Farmers, he was required on several occasions to enter an area where a 1942 Babcock and Wilcox industrial boiler was being demolished with a jackhammer, backhoe and cutting torch. (Tr. 21). This process filled the air in the boiler area with dust. (Id.). No respirators were available to claimant. (Id.). Claimant, who had about 18 years' experience as an asbestos insulator, and who had dismantled asbestos-containing applications himself, had seen asbestos insulation on the boiler when he had worked as a maintenance man with the same employer. (Tr. 19). Given the 1942 date of the boiler's construction, claimant's eyewitness view of insulation sticking to the pipes and tubes of the boiler (Tr. 29), and the admission by Liberty/Farmers' witnesses that they were not aware that the mud on the boiler contained asbestos, we conclude that the firebrick and insulating mud contained asbestos. Moreover, the preponderance of the evidence indicates that claimant was exposed to airborne asbestos fibers when he entered the area where the boiler was being dismantled. (Tr. 14 through 22; 28, 29, 31 through 34; compare 38 through 47 and 54, 55).

Based on such evidence, we find that work conditions at Liberty/Farmers could have caused claimant's lung condition. Furthermore, because claimant sought treatment for his condition while employed at Liberty/Farmers, we assign initial responsibility to Liberty/Farmers. Liberty/Farmers can shift responsibility to a prior carrier by showing that claimant's work exposure when a prior carrier was on the risk was the sole cause of claimant's lung condition, or that it was impossible for conditions at Liberty/Farmers to have caused the 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).

Dr. Smith, who specializes in chest diseases and evaluated claimant for the insurer, reasoned that any exposure to asbestos below the ambient level in the atmosphere would have no effect on claimant's condition, but any exposure above that level would contribute over the long term. However, because he was unable to ascertain the actual amount of claimant's asbestos exposure at Liberty/Farmers, Dr. Smith was unable to say whether claimant's asbestos exposure there contributed to his condition. (Exs. 46A, 52A).

In contrast, Dr. Dreisin, claimant's attending pulmonologist, explained that, theoretically, any exposure to asbestos might lead to development of asbestosis, given enough time. Since claimant had inhaled a large amount of asbestos in the past, Dr. Dreisin opined that each incremental exposure to asbestos could contribute to his condition at some time in the indefinite future. Because claimant had occasion to inhale asbestos during the demolition of the boiler, Dr. Dreisin opined that the inhalation would potentially contribute to claimant's lung condition. (Ex. 73).

There are no persuasive reasons not to defer to the opinion of Dr. Dreisin as the treating physician. Consequently, we find his opinion to be persuasive. Weiland v. SAIF, 64 Or App 810, 814 (1983). Based on Dr. Dreisin's opinion, we conclude that Liberty/Farmers has failed to prove that the

sole cause of claimant's lung condition was his prior employment or that it was impossible for work conditions at Liberty/Farmers to have caused the condition. Thus, Liberty/Farmers remains responsible for claimant's asbestosis.[1]

Penalty for Untimely Claims Processing

The ALJ assessed a 25 percent penalty against Liberty/Farmers for an untimely denial of claimant's lung condition. Liberty/Farmers admits that its denial was issued more than 90 days after the claim was filed. (Appellant's Brief at 5). Nevertheless, Liberty/Farmers contends that the ALJ erred in considering the issue, as claimant did not raise the issue of its untimely claim processing until written closing argument.

Claimant raised the issue of penalties and attorney fees in his request for hearing. The request did not specify that the penalty/attorney fee issue was based on an untimely denial from Liberty/Farmers. At the outset of the hearing, claimant agreed with the ALJ's framing of the penalty issue as alleged unreasonable delay against the SAIF Corporation and all four of its employers and against Wausau/E.J. Bartells. (Tr. 4). Neither the ALJ nor claimant specifically raised the issue of a penalty for unreasonable delay against Liberty/Farmers at the beginning of the hearing. Moreover, claimant concedes that he initially raised the issue of the late denial against Liberty/Farmers in his written closing argument.

We have consistently held that we will not consider an issue raised for the first time during closing argument. Leslie Thomas, 44 Van Natta 200 (1992); John C. Schilthuis, 43 Van Natta 1396, 1399 (1991); Edward A. Rankin, 41 Van Natta 1926, on recon 41 Van Natta 2133 (1989). See also Donald A. Hacker, 37 Van Natta 706 (1985) (fundamental fairness dictates that parties have a reasonable opportunity to present evidence on an issue and such an opportunity does not exist if there is no notice that the issue is in controversy). Inasmuch as claimant did not raise the issue of a penalty against Liberty/Farmers for an untimely denial of his lung condition claim until his closing argument, we reverse that portion of the ALJ's order which assessed a 25 percent penalty against Liberty/Farmers for late denial of the claim.

Penalties for Unreasonable Denial

The ALJ determined that claimant was not entitled to a penalty for Liberty/Farmers' allegedly unreasonable denial of compensability because, at the time it issued its denial, Liberty/Farmers had evidence from its lay witnesses that there was no asbestos on its boiler. In his brief, claimant contends that Liberty/Farmers' failure to acknowledge that claimant's asbestosis condition was caused by his employment generally prevented the issuance of a ".307" order and was therefore unreasonable. We affirm the ALJ, but for the following reasons.

On review, Liberty/Farmers argues that, at the time it issued its denial, there was evidence that claimant was exposed to asbestos during work covered by the LHWCA and had filed a federal workers' compensation claim. Thus, under Kevin P. Silveira, 45 Van Natta 1202 (1993), the law at the time of its denial established that claimant's federal exposure could not be considered in determining causation, because at the time of that exposure claimant was not a "subject worker" under Oregon law.[2]

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[1] In coming to this conclusion, we note Liberty/Farmers' argument that it was impossible for its work exposure to have caused claimant's lung condition because there was medical evidence of a latency period of 20 to 30 years between exposure and development of the disease and, thus, its exposure would not be the cause of claimant's current condition.

Although there was medical evidence of such a latency period, according to Dr. Dreisin, claimant's work exposure at Liberty/Farmers "might potentially have contributed very slightly to the degree of asbestosis he has now." (Ex. 73-2). As discussed above, we find Dr. Dreisin's opinion most persuasive. Furthermore, based on his opinion, it was not impossible for work exposure at Liberty/Farmers to have caused claimant's current lung condition. Consequently, we reject Liberty/Farmers' "latency period" argument. See also Strametz v. Spectrum Motorwerks, 135 Or App 67, 74 (1995) (holding that a claimant need only prove that conditions are of a kind which could have caused (rather than actually caused) the disease for responsibility to be assigned under the last injurious exposure rule).

[2] ORS 656.027(4) provides that a person for whom a rule of liability for injury or death arising out of and in the course of employment is provided by the laws of the United States is a nonsubject worker.

Consequently, Liberty/Farmers argues, it was denying that claimant's Oregon employment, as compared to his nonsubject federal employment, was the major contributing cause of his condition or its worsening.

A penalty may be assessed when an employer "unreasonably delays or unreasonably refuses to pay compensation." ORS 656.262(11). 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)). Thus, if the employer had a legitimate doubt about its liability, 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 Kevin P. Silveira, supra, we had concluded that, if a claimant has been covered by a foreign employer during the genesis of his disease, he must prove that his employment in Oregon was the major contributing cause of his condition or its worsening. Accordingly, we examine the record to see whether the insurer's denial was reasonable, given the standard of proof under Silveira.

At the time Liberty/Farmers issued its May 16, 1994 denial (Ex. 47), claimant had filed a LHWCA claim against E.J. Bartells, a prior employer. (Exs. 40A, 40B, 40D). On his claim form, claimant specified the date of injury as "progressive." Claimant's counsel identified claimant's employment with E.J. Bartells as "an insulator out of Local 36 at which time he worked on or about the navigable waters of the United States," and that claimant's last maritime asbestos exposure occurred while working for E.J. Bartells in the Dillingham Shipyards. (Ex. 40D). No dates for claimant's federally covered employment are specified. The medical records prior to Liberty/Farmers' denial are equally vague in regard to the extent of claimant's federal exposure: "[Claimant] began working in 1967 as an asbestos worker * * * for a total of about 20 years. * * * for the first few years there was a lot of heavy asbestos exposure. [Claimant] thinks he was exposed for a total of about 10 years, intermittently, to asbestos * * * [Claimant] worked intermittently in shipyards * * * * [Claimant] thinks he worked one year in the shipyards." (Ex. 46-1). The LHWCA claim was denied on January 20, 1994. (Ex. 42A).

The evidence, medical and otherwise, available at the time of Liberty/Farmer's denial indicates that claimant had exposure to asbestos of unknown intensity and duration at a foreign employer. Because, under Silveira, supra, claimant was required to prove that the major contributing cause of his condition or its worsening was his Oregon employment, and because the information available to Liberty/Farmers at the time of its denial did not reveal the extent or duration of claimant's relative exposures to asbestos, we conclude that Liberty/Farmers had reasonable doubt as to the compensability of claimant's claim. Moreover, Liberty/Farmers' reliance on the case law that governed at the time of its denial is not unreasonable.[3] Zwahlen v. Crown Zellerbach, 67 Or App 3 (1984); Maria Porras, 42 Van Natta 2625 (1990).[4]

Attorney Fees - ORS 656.386(1)

The ALJ awarded claimant a $2,500 attorney fee for his counsel's services at hearing. Claimant asserts that the ALJ's attorney fee award was not reasonable in light of the factors set forth in OAR 438-015-0010(4)[5], particularly considering the complexity of the case and the time expended. Specifically, claimant seeks a $5,000 attorney fee. We modify the ALJ's attorney fee award.

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[3] Although our decision in Kevin P. Silveira, supra, was reversed while the hearing was still open, Silviera v. Larch Enterprises, 133 Or App 297 (March 8, 1995), it remained subject to appeal until after the record closed on March 21, 1995. Consequently, it was not unreasonable for Liberty/Farmers to sustain its denial until the ALJ's order issued on April 20, 1995. Brown v. Argonaut Insurance Company, supra.

[4] Because we have found Liberty/Farmers' denial of compensability to be reasonable on the grounds stated above, we decline to address claimant's argument.

[5] Formerly OAR 438-15-015(4). OAR 438-015-0010(4) became effective January 1, 1996. The sole change in OAR 438-015-0010(4) is the substitution of "Administrative Law Judge" for "Referee."

Under 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. Under ORS 656.308(2)(d), a claimant may also be entitled to an attorney fee for prevailing against a responsibility denial that is separate from and in addition to the 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 order that addressed the compensability issue. Paul R. Huddleston, 48 Van Natta 4, on recon 48 Van Natta 203 (1996).

Here, at the hearings level, claimant prevailed against Liberty/Farmers' denial of compensability of his lung condition. Thus, he is entitled to a carrier-paid attorney fee award under ORS 656.386(1) for his counsel's services provided at the hearings level. In determining a reasonable attorney fee, we apply the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issues involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefits secured for the represented party; (7) the risk in a particular case that an attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

Our review of the record reveals the following. The issue in dispute was whether claimant's asbestosis condition was compensable. Claimant's counsel successfully argued that claimant's claim was compensable. Seventy-three exhibits were received into evidence, only two, apparently, generated by claimant's counsel. The hearing lasted approximately two and one-half hours, resulting in a 56 page transcript, plus written closing arguments. Claimant's attorney did not submit a statement of services.

As compared to typical compensability cases, the issue at hearing in this case was of somewhat above average complexity and involved seven carriers. The value of the claim and the benefit secured are of above average proportions, consisting of temporary disability, medical services and, potentially, permanent disability and/or survivor's benefits. Moreover, claimant's counsel skillfully advocated claimant's claim in the face of a vigorous defense and there was a substantial risk that claimant's counsel's efforts might go uncompensated.

After considering these factors, we conclude that the ALJ's attorney fee award should be increased. Specifically, we conclude that $3,500 is a reasonable assessed attorney fee for claimant's counsel's services at hearing. We modify the ALJ's award accordingly.

Attorney Fees - ORS 656.308(2)(d)

Claimant is also entitled to a carrier-paid attorney fee award under ORS 656.308(2) for his attorney's active and meaningful participation in the responsibility dispute at hearing and on Board review. Claimant filed a hearing request contesting Liberty/Farmers' responsibility denial and has successfully prevailed over that denial.

Under ORS 656.308(2)(d), an attorney fee shall not exceed $1,000 at hearing and on review, absent a showing of extraordinary circumstances. ORS 656.308(2)(d); Paul R. Huddleston, supra; Tammy Locke, 48 Van Natta 250 (1996).

Although claimant's attorney's arguments regarding the responsibility issue were successful and, as noted above, the value of the claim was above average proportions, the complexity of the issue or value of the benefits do not differ appreciably from those in most cases litigated before this forum. Consequently, claimant has not demonstrated extraordinary circumstances to justify an attorney fee greater than the $1,000 cap. Accordingly, after considering the factors set forth in OAR 438-015-0010(4), we award $1,000 for claimant's attorney's services at hearing and on Board review, to be paid by Liberty/Farmers. 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 nature of the proceeding, and the value of the interest involved.

Attorney Fees - ORS 656.382(2)

Both compensability and responsibility were decided by the ALJ. Therefore, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. See Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252-53 (1992), mod on recon, 119 Or App 447 (1993);

Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989). Liberty/Farmers' appeal to the Board placed claimant's award at risk. Since this proceeding was not limited solely to a responsibility denial, ORS 656.308(2)(d) is not applicable to the potential compensability issue. Paul R. Huddleston, supra. Consequently, claimant's counsel is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by Liberty/Farmers. See International Paper Co. v. Riggs, 114 Or App 203 (1992); Cigna Insurance Companies v. Crawford & Company, 104 Or App 329 (1990).

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $500. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney'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 devoted to his unsuccessful cross-request regarding the penalty and attorney fee issues.

ORDER

The ALJ's order dated April 20, 1995 is affirmed in part, reversed in part, and modified in part. That portion of the order awarding a penalty payable by Liberty/Farmers for untimely claims processing is reversed. In lieu of the ALJ's attorney fee award, claimant is awarded $3,500 under ORS 656.386(1), payable by Liberty/Farmers. The remainder of the order is affirmed. For services at hearing and on review, claimant's attorney is awarded $1,000 under ORS 656.308(2)(d), to be paid by Liberty/Farmers. For services on Board review regarding the compensability issue, claimant is awarded $500 under ORS 656.382(2), payable by Liberty/Farmers.

April 10, 1996 Cite as 48 Van Natta 871 (1996)

In the Matter of the Compensation of
CHERYL A. TRASK, Claimant
WCB Case No. 95-06752
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Gunn and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) directed SAIF to pay claimant temporary disability benefits from September 19, 1992 through February 1, 1995, less time worked; and (2) assessed a penalty based on SAIF's allegedly unreasonable resistance to the payment of compensation. 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, and summarize the pertinent facts as follows:

In June 1992, while employed as a millworker, claimant developed bilateral carpal tunnel syndrome. SAIF accepted the claim. Claimant had right carpal tunnel release surgery on May 12, 1992, and was released for modified duty on May 19, 1992.

After returning to her full-wage light duty position, claimant developed increasing pain in her neck, arms and shoulders. On July 31, 1992, while still performing modified work, claimant sought treatment for complaints of myofascial syndrome involving the right trapezius with radicular pain into the arm.

On September 4, 1992, claimant informed the employer that she would be resigning as of September 18, 1992. Claimant left her job to return to school and because of the physical discomfort in her neck and shoulders caused by her work activity.

By September 22, 1992, claimant became medically stationary with respect to her carpal tunnel syndrome. She was not, however, medically stationary with regard to her fibromyalgia condition. She enrolled in community college, where she remained until graduating in September 1994. While in school, claimant participated in a work-study program and worked part-time.

SAIF denied claimant's fibromyalgia condition on September 15, 1993. A March 1, 1995 Order on Review reversed a prior ALJ's order upholding SAIF's denial. Cheryl A. Trask, 47 Van Natta 322, on recon 47 Van Natta 462 (1995). The Order on Review also set aside as premature an October 29, 1992 Determination Order and a June 3, 1993 Order on Reconsideration relating to claimant's carpal tunnel syndrome.

In August 1995, claimant's treating physician, Dr. Randle, retroactively authorized time loss based on her fibromyalgia condition from July 1993 to August 1995. Dr. Randle noted that, although he did not start treating claimant until July 1993, he would conclude, based on claimant's history, that she was unable to perform her modified work as a result of her compensable conditions since March 1992.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant left her modified work in September 1992 for reasons related to her compensable conditions and that she did not withdraw from the work force by attending school. In addition, based on Dr. Randle's reports, the ALJ found that claimant was disabled as a result of one or both of her compensable conditions until February 1, 1995.[1]

Citing Delores L. Holmes, 47 Van Natta 2359 (1995), SAIF contends that claimant is not procedurally entitled to temporary disability benefits for the time period in question because Dr. Randle's retroactive authorization is prohibited by amended ORS 656.262(4)(f). We agree.

Amended 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."

In Delores L. Holmes, supra, we held that this provision applies retroactively to all pending cases. Therefore, to the extent that an attending physician's report constitutes a retroactive authorization for the payment of temporary disability, it is effective no more than 14 days prior to its issuance. Id.; see also Maria R. Fuentes, 48 Van Natta 110, n.4 (1995).

In this case, the only attending physician to authorize temporary disability compensation subsequent to claimant's September 1992 termination of employment was Dr. Randle, who did so on August 3, 1995. Under the plain language of amended ORS 656.262(4)(f), this authorization may only retroactively authorize time loss for 14 days prior to its issuance. See Delores L. Holmes, supra. Consequently, as a matter of law, Dr. Randle's August 3, 1995 authorization is ineffective to trigger claimant's entitlement to time loss benefits for the time period of September 19, 1992 to February 1, 1995.

Because we conclude that amended ORS 656.262(4)(f) prevents claimant from relying on Dr. Randle's report to retroactively establish her entitlement to temporary disability benefits, we need not decide whether claimant left work in September 1992 primarily to attend school or because she was having physical difficulties performing her modified duty. We note, however, that there is no contemporaneous medical evidence to verify that claimant was disabled from her modified work in September 1992.

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[1] On February 1, 1995, claimant began full time employment at a wage greater than her millworker wage.

ORS 656.262(4)(a) provides that the first installment of temporary disability shall be paid no later than the 14th day after the attending physician authorizes the payment of temporary disability compensation. Here, there was no such authorization until August 3, 1995. Therefore, SAIF had no obligation to pay temporary disability during the contested period (September 19, 1992 through February 1, 1995).

Having found that claimant is not procedurally entitled to time loss benefits for the time period in issue, we also reverse that portion of the order awarding a penalty based on SAIF's allegedly unreasonable claims processing.

ORDER

The ALJ's order dated October 17, 1995 is reversed.

Board Member Gunn specially concurring.

Although I am bound by statutory law and stare decisis to conclude in this case that claimant is not entitled to time loss benefits because she did not obtain a contemporaneous authorization of temporary disability from her attending physician, I write separately to address my concerns about the practical effect of the recent amendments to ORS 656.262(4).

Amended ORS 656.262(4)(a) allows for the payment of temporary disability compensation only if authorized by the attending physician. Amended ORS 656.262(4)(f) provides, in pertinent part, that no authorization of temporary disability compensation by the attending physician shall be effective to retroactively authorize the payment of temporary disability for more than 14 days. As I understand these two provisions, they are designed to protect insurers and self-insured employers from unscrupulous claimants who may feign their inability to work after filing a workers compensation claim in order to take unearned time off with pay. The problem is that, in presupposing that all claimants are out to manipulate the workers' compensation system, these laws operate to deny temporary disability benefits to claimants with legitimate claims who are legitimately unable to return to work due to their injuries.

For example, in this case, although claimant's carpal tunnel syndrome may have been medically stationary at the time she terminated her employment, her fibromyalgia symptoms were just developing. She testified that she left work in September 1992 at least in part because her modified job in the employer's small parts room was causing her neck and shoulder discomfort. Although we now know that claimant's fibromyalgia condition was disabling and that it is compensable as a consequence of her carpal tunnel syndrome, claimant is not entitled to any time loss for the extended period in question simply because she did not solicit a contemporaneous confirmation from her treating physician that her fibromyalgia affected her ability to perform her modified work.

I believe it is truly unfortunate that a workers' compensation system initially created to, among other things, provide "fair, adequate and reasonable income benefits to injured workers and their dependents" and restore injured workers physically and economically to a self-sufficient status to the greatest extent possible, see ORS 656.012(2), can now operate to deny such benefits simply because a claimant is not savvy enough to immediately solicit an attending physician's authorization when his or her ability to work is hampered by an industrial injury or occupational disease.

April 11, 1996 Cite as 48 Van Natta 873 (1996)

In the Matter of the Compensation of
LANA L. RUNKEL, Claimant
WCB Case No. 93-14247
ORDER OF ABATEMENT
William H. Skalak, Claimant Attorney
Michael O. Whitty (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our March 12, 1996 Order on Review that: (1) affirmed an Administrative Law Judge's (ALJ's) order that found claimant's psychological conditions (including a personality disorder) to be compensable; (2) awarded interim compensation from June 29, 1993 to August 20, 1993; and (3) vacated and remanded that portion of the ALJ's decision which pertained to a claimant's aggravation claim for her psychological condition. Contending that we erred in

awarding interim compensation and in finding claimant's psychological conditions (including a personality disorder) to have been accepted, SAIF seeks reconsideration of our decision.

In order to further consider this matter, we withdraw our March 12, 1996 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
RITA J. WIMMER, Claimant
WCB Case No. 95-10131
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Gunn and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) McCullough's order that affirmed an Order on Reconsideration award of 8 percent (25.6 degrees) unscheduled permanent disability for a cervical spine injury. In her brief, claimant argues that the ALJ erred in failing to consider her testimony at hearing concerning the extent of her unscheduled permanent disability. On review, the issues are evidence and extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the following supplementation. At the time of determination, claimant was 39 years old. Claimant has a high school degree. Claimant's highest SVP for the past five years is a 2, for the occupation of truck driver.

CONCLUSIONS OF LAW AND OPINION

Evidence

The ALJ declined to consider claimant's testimony regarding her chronic condition. Additionally, the ALJ determined that, because claimant was required to establish her impairment by "medical evidence" as required by ORS 656.283(7), claimant's testimony on the issue was not determinative. Finally, because the medical evidence in the record did not support claimant's claim for additional impairment, the ALJ declined to increase claimant's award.

On review, claimant contends that her testimony was admissible and the ALJ erred in not considering it. However, subsequent to the ALJ's order, we issued our decision in Joe R. Ray, 48 Van Natta 325 on recon 48 Van Natta 458 (1996). In Ray, we concluded that, pursuant to amended ORS 656.283(7), evidence (which included a claimant's testimony) that was not submitted at reconsideration and, therefore, not made a part of the reconsideration record, was not admissible at a subsequent hearing concerning extent of permanent disability. Furthermore, we rejected constitutional arguments made by the claimant in Ray as we found that procedures afforded during the reconsideration proceeding were adequate to protect the claimant's interest in additional permanent partial disability benefits, despite the absence of a full evidentiary hearing. Joe R. Ray, supra. Consequently, in light of our decision in Ray, we conclude that the ALJ correctly declined to admit or consider claimant's testimony on the chronic condition issue.

The ALJ did consider claimant's testimony regarding the effort she gave during the range of motion test administered by the medical arbiter. The ALJ concluded that claimant's testimony was admissible because it was an issue which arose out of the reconsideration order itself. Amended ORS 656.283(7). For the following reasons, we need not address whether the aforementioned matter is an "issue" arising out of the reconsideration order itself, or whether the evidentiary restrictions of ORS 656.283(7) would preclude claimant's testimony.

The ALJ found that the arbiter's report did not provide a basis for a value for lost range of motion. Additionally, the ALJ concluded that there was no other medical evidence in the record which indicated permanent loss of range of motion. Under the circumstances, we agree with the ALJ that claimant has failed to prove entitlement to an increased award based on lost range of motion.

Finally, in her reply brief, claimant cites to the court's recent decision in Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996). We construe claimant's cite to Carroll, supra, as a contention that she is entitled to additional unscheduled permanent disability. Although the ALJ stated that there was no dispute regarding the non-impairment factors, we consider claimant's position at hearing to be consistent with the "standards" and case law in effect at the time, which awarded no value for adaptability where the claimant had returned to regular work. See e.g. Michelle Cadigan, 46 Van Natta 307 (1994). However, the Carroll case, which was decided subsequent to the hearing in this matter, now provides a basis for an adaptability value where claimant has returned to regular work. Finally, we do not find that claimant's position at hearing precludes her from raising the adaptability value argument on review, where the issue at hearing was extent of permanent disability. See Elmer F. Knauss, 47 Van Natta 826 (1995) (Argument that the claimant had waived the issues of social and adaptability factors at hearing rejected, where the claimant raised the issue of unscheduled permanent disability and there was no specific and intentional relinquishment of a right to litigate values other than impairment).[1]

Here, claimant was not awarded a value for adaptability, as the Department found that claimant had been released for and returned to regular work. Nevertheless, the court in Carroll 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, supra, we held that 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 (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 (8), the result is 12. OAR 436-35-280(7). Therefore, claimant's unscheduled permanent disability is 12 percent.

ORDER

The ALJ's order dated December 27, 1995 is modified. The August 31, 1995 Order on Reconsideration is also modified. In addition to the Determination Order award of 8 percent (25.6 degrees), claimant is awarded 4 percent (12.8 degrees) for a total award to date of 12 percent (38.4 degrees) unscheduled permanent disability. 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.

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[1] Although a signatory to this order, Board Member Haynes does not necessarily agree with the rationale expressed in Knauss. However, the principles of stare decisis bind Member Haynes to that decision.

In the Matter of the Compensation of
STEVEN D. WINDSOR, Claimant
WCB Case Nos. 95-03437 & 95-03436
ORDER ON RECONSIDERATION
Parker, Bush & Lane, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our March 19, 1996 Order on Review that adopted and affirmed the ALJ's order upholding the SAIF Corporation's denial, on behalf of C.K. Claggett Contractor, Inc., of claimant's cervical condition and finding that claimant did not timely appeal SAIF's denial, on behalf of Clackamas Community College, of a thoracic condition. Our order also considered whether remand was appropriate for admission of additional documents that were not part of the record developed at hearing. Finding no compelling reason for remanding, we declined to do so. Having received SAIF's response, we proceed with our reconsideration.

Claimant has an accepted claim for thoracic strain as a result of a January 1993 accident with C.K. Claggett. In October 1993, claimant sought treatment following a nonwork-related motor vehicle accident. In December 1993, claimant was diagnosed with a herniated cervical disc.

At hearing and on review, claimant asserted that the January 1993 injury caused his herniated disc and, therefore, it is a compensable condition for C.K. Claggett. Claimant relied on the opinions of treating neurosurgeon Dr. Grewe and consulting physician Dr. Irvine that the onset of thoracic symptoms from the January 1993 accident actually were early manifestations of the cervical disc herniation, thus showing that the accident caused the herniation.

The ALJ, with whom we agreed on review, found more persuasive Dr. Mandiberg's opinion that, because claimant did not exhibit cervical symptoms until after the October 1993 motor vehicle accident, that event, rather than the January 1993 accident, caused the cervical condition.

On review, claimant submitted a report from Dr. Mandiberg dated January 11, 1996, contending that it showed that Dr. Mandiberg had changed his opinion to agree with Drs. Irvine and Grewe that the January 1993 accident caused the herniated disc. In our order, we disagreed, finding that the report reiterated Dr. Mandiberg's opinion that the cervical condition was caused by the October 1993 motor vehicle accident. Thus, we concluded that there was no compelling reason for remanding the case to the ALJ for admission of the additional evidence.

On reconsideration, claimant has again submitted the January 11, 1996 report from Dr. Mandiberg, arguing that it provides Dr. Mandiberg's "new opinion" agreeing with Drs. Irvine and Grewe. Claimant also submits February 12 and 20, 1996 reports from Dr. Rothstein, a March 2, 1996 report from Dr. Grewe, and March 23, 1996 and March 29, 1996 reports from Dr. Anderson, asserting that the documents "verify" Dr. Mandiberg's "new opinion." SAIF objects to claimant's motion to remand for admission of additional evidence, arguing that the reports could have been generated prior to hearing and their content would not change the outcome of the case.

After again examining the January 11, 1996 report from Dr. Mandiberg, we continue to adhere to our conclusion that it does not represent a change of opinion. Dr. Mandiberg stated that his opinion had been "distorted" concerning the onset of claimant's thoracic symptoms and that he would defer to claimant's current physician concerning the thoracic symptoms. Nothing in the report, however, indicates that Dr. Mandiberg no longer considers claimant's cervical symptoms as beginning until after the October 1993 motor vehicle accident; because this understanding of claimant's history was the basis for his opinion that the motor vehicle accident caused the herniated disc, we find no indication that Dr. Mandiberg has a different opinion concerning causation. Thus, we continue to conclude that admission of the report would not affect the outcome of the hearing.

We reach the same conclusion concerning the remaining reports. For the most part, the documents summarily attribute the herniated disc to the January 1993 accident with minimal discussion of any underlying rationale for such a conclusion, as well as limited analysis of the potential contribution to claimant's condition from the October 1993 motor vehicle accident. Thus, we find nothing in the reports lessen the persuasiveness of Dr. Mandiberg's opinion and lead to a different conclusion concerning the compensability of the cervical condition.

In sum, we find no compelling reason for remanding the case for admission of the additional evidence. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986). Consequently, we conclude that the case has not been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Thus, claimant's motion to remand is denied.

Accordingly, we withdraw our March 19, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our March 19, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 12, 1996 Cite as 48 Van Natta 877 (1996)

In the Matter of the Compensation of
KENNETH P. McCORMICK, Claimant
WCB Case Nos. 95-01711 & 94-13457
ORDER OF ABATEMENT
Malagon, Moore et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Zimmerman, Rice et al, Defense Attorneys

On March 27, 1996, we affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of claimant's aggravation claim for a low back injury. We have now received the parties' Disputed Claim Settlement (DCS), which is designed to resolve all issues raised or raisable between them, including the insurer's aggravation denial. We treat the submission of the agreement as a motion for reconsideration of our March 27, 1996 order. The motion is granted and our prior order is withdrawn.

After reviewing the DCS, we have no objection to those portions of the proposed settlement which purport to resolve the compensability of claimant's current low back condition because it appears that a bona fide dispute concerning the compensability of that condition exists. See OAR 656.289(4); OAR 438-009-0010(2). The agreement also properly contains a provision reciting that claimant retains his rights to benefits under ORS 656.245, 656.273, 656.278, and 656.340 insofar as those rights may be related to his original April 1993 low back strain. See OAR 438-009-0010(4)(b). However, because other provisions in the settlement are considered to be contrary to statutory and administrative requirements, the present agreement cannot receive approval.

In accordance with ORS 656.313(4)(c), a proposed DCS must include a list of medical service providers who shall receive reimbursement pursuant to the statute, including the specific reimbursement amount and the parties' acknowledgment that the reimbursement allocation complies with the statutory reimbursement formula prescribed by ORS 656.313(4)(d). See OAR 438-009-0010(2)(g). There is an exception to this rule. When the settlement provides that the carrier has paid all medical bills in its possession through the date the settlement terms were agreed on, the "list" and "acknowledgment" requirements are deemed inapplicable. See Robert E. Wolford, 46 Van Natta 522 (1994). Furthermore, where a carrier agrees to pay all outstanding unidentified medical bills in its possession through the settlement date, such a settlement is approvable, provided that the agreement contains a provision acknowledging that the proposed distribution exceeds the statutory "40 percent" distribution. Jodi G. Palmer, 47 Van Natta 1925 (1995).

The parties' proposed DCS provides that, in addition to the settlement proceeds, the insurer agrees to pay any outstanding medical billings related to the denied conditions which were incurred up to February 7, 1996. Since the DCS also includes a provision acknowledging that the proposed distribution exceeds the statutory reimbursement scheme, such a proposal would be acceptable if the "settlement date" had been on or before February 7, 1996. However, the "settlement date" has been set as March 25, 1996. Thus, the DCS does not confirm that there are no medical billings in the insurer's possession that remain outstanding as of March 25, 1996 (the "settlement date"). Alternatively, if such outstanding bills do exist, the DCS does not explain in what manner those bills will be reimbursed. Under such circumstances, the agreement as presently drafted cannot receive our approval.

Finally, another provision of the proposed DCS requires clarification. One section of the agreement recites that claimant's counsel should be paid 25 percent of the first $12,500 of settlement proceeds (Page 4, Lines 15 - 21). Since the settlement proceeds equal $1,500, 25 percent would equal $375. Yet, another section of the DCS lists claimant's attorney fee as $200 (Page 5, Line 1). Inasmuch as the agreement is already being returned for supplementation, these portions of the settlement should likewise be clarified.

Accordingly, the proposed DCS is being returned to claimant's counsel for supplementation in the manner previously described. Once the revised agreement is finalized, it can be returned to us for our expeditious consideration. In order to retain jurisdiction to consider the parties' amended agreement, our prior order shall remain abated. Pending our receipt of the supplemented agreement, the parties are requested to keep us apprised of any future developments regarding this case.

IT IS SO ORDERED.

April 12, 1996 Cite as 48 Van Natta 878 (1996)

In the Matter of the Compensation of
CHARLES TEDROW, Claimant
Own Motion No. 94-0095M
OWN MOTION ORDER OF ABATEMENT
Emmons, et al, Claimant Attorneys
Bailey & Associates, Defense Attorneys

Claimant requests reconsideration of our March 29, 1996 Own Motion Order, in which we declined to award claimant further temporary disability benefits, and found that neither a penalty or related attorney fee was warrented.

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
ROBERTO GARCIA, Claimant
WCB Case No. 95-06750
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) admitted into the hearings record Exhibit 59 (a copy of an August 23, 1994 report from Dr. Dinneen, examining orthopedist, and Dr. Davies, examining psychologist) and Exhibit 59A (a copy of the insurer's September 20, 1994 denial that denied compensability of claimant's L5-S1 bulging disc and his current low back condition); (2) reduced claimant's unscheduled permanent disability award for a low back injury from an award by an Order on Reconsideration of 18 percent (57.6 degrees), to zero; and (3) declined to award an attorney fee pursuant to ORS 656.382(2). On review, the issues are evidence, extent of unscheduled permanent disability, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following replacement and supplementation. We replace the last sentence of the eighth paragraph of the findings of fact with the following. Dr. Neumann, medical arbiter, measured loss of lumbar range of motion, which he indicated was valid. (Exs. 63-4, -5). In addition, in response to a question about other permanent impairment, Dr. Neumann stated that "I am unable to find any objective evidence of permanent impairment." (Ex. 63-6).

On August 23, 1994, Dr. Dinneen, orthopedist, and Dr. Davies, psychologist, examined claimant on behalf of the insurer. (Ex. 59). Dr. Dinneen found that claimant had no impairment related to the compensable injury. (Ex. 59-5). Dr. Davies opined that psychological factors were the major contributing cause of claimant's symptomatic presentation and need for treatment. (Ex. 59-11, -12). Dr. Davies also opined that these psychological factors were not work-related. Id. On September 26, 1994, Dr. Lundsgaard, claimant's attending physician at claim closure, concurred with the August 23, 1994 report from Drs. Dinneen and Davies. (Ex. 61).

The August 23, 1994 report from Drs. Dinneen and Davies, Dr. Lundsgaard's concurrence with that report, and the insurer's September 20, 1994 denial were all part of the reconsideration record. (Exs. 59, 59A, 61, 64-3, -4).

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, claimant objected to four exhibits submitted by the insurer, contending that they were inadmissible pursuant to amended ORS 656.283(7). (Tr. 1-3). Specifically, claimant objected to the admission of Exhibits 59, 59A, 61,[1] and 62. (Tr. 3). Of these contested exhibits, the ALJ admitted Exhibit 62 (a copy of a prior ALJ's order), and Exhibits 59 and 59A. In determining the admissibility of Exhibits 59, 59A, and 61, the ALJ noted that the Order on Reconsideration stated that the record consisted of the claim file at closure and the May 20, 1995 medical arbiter's report. From the dates of Exhibits 59, 59A, and 61, the ALJ reasoned that Exhibits 59 and 59A were included in the claim file at closure and Exhibit 61 was not. Based on this reasoning, the ALJ concluded that Exhibits 59 and 59A were in the reconsideration record and Exhibit 61 was not.

We find that Exhibits 59, 59A, and 61 were admissible at hearing because all three of these exhibits were in the reconsideration record. Our reasoning for this conclusion is as follows.

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[1] Exhibit 59 is a copy of an August 23, 1994 report from Dr. Dinneen, examining orthopedist, and Dr. Davies, examining psychologist. Exhibit 59A is a copy of the insurer's September 20, 1994 denial, which denied compensability of claimant's L5-S1 bulging disc and his current low back condition. Exhibit 61 is a copy of Dr. Lundsgaard's (claimant's attending physician) September 26, 1994 concurrence with Drs. Dinneen's and Davies' August 23, 1994 report.

Senate Bill 369 amended ORS 656.283(7) to provide, in relevant 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. . . ." Or Laws 1995, ch 332, § 34(7) (SB 369, § 34(7)). Here, in her "explanatory notes," the Appellate Reviewer sufficiently identified the documents submitted by the insurer as Exhibits 59, 59A, and 61 to establish that those documents were in the reconsideration record. Specifically, the Appellate Reviewer stated that "on 8/23/94, Dr. Jack Davis [sic] and James Dinneen examined the worker and declared him medically stationary." (Ex. 64-4). Because the date of the report, and the name of Dr. James Dinneen and Dr. Jack Davies are nearly identical to the names identified by the Appellate Reviewer in her "explanatory notes", we conclude that the August 23, 1994 report from Drs. Dinneen and Davies is sufficiently identified to find that it was in the reconsideration record.

In addition, the Appellate Reviewer stated that "[o]n 9/26/94, Dr. Lundsgaard concurred with the 8/23/94 reports, including medically stationary status." (Ex. 64-4). This specific reference to the dates of the reports from Drs. Dinneen, Davies and Lundsgaard and Dr. Lundsgaard's concurrence with the August 23, 1994 report, establishes that Dr. Lundsgaard's report, submitted as Exhibit 61 at hearing, was in the reconsideration record.

Finally, the Appellate Reviewer identified the "denied condition" as "L5-S1 bulging disc." (Ex. 64-3). Based on this reference in the "explanatory notes," we find that the September 20, 1994 denial, which used the same language ("L5-S1 bulging disk") in identifying the denied condition, was also in the reconsideration record. (Ex. 59A).

Thus, it is clear from the "explanatory notes" in the Order on Reconsideration that the documents submitted at hearing as Exhibits 59, 59A, and 61 were included in the reconsideration record. Because these documents were in the reconsideration record, they are admissible at hearing under either version of the statute. Therefore, we find that Exhibits 59, 59A and 61 are admissible. Accordingly, we consider these exhibits on review.

Extent of Unscheduled Permanent Disability

The ALJ reduced claimant's unscheduled permanent disability award from 18 percent, as granted by the Order on Reconsideration, to zero. In doing so, the ALJ found that claimant had not established any permanent impairment due to the accepted lumbar strain and contusion injury. We agree.

Claimant became medically stationary after July 1, 1990, and he requested reconsideration pursuant to ORS 656.268. Therefore, in rating his permanent disability, we apply the disability rating standards in effect on the date of the September 20, 1994 Notice of Closure. OAR 438-010-0010, 436-35-003(2). Those standards are provided in WCD Admin. Order 6-1992 and 93-056.

With the exception of a medical arbiter, findings concerning a claimant's impairment can be made only by the attending physician at the time of claim closure. Dennis E. Conner, 43 Van Natta 2799 (1991). Medical evidence regarding permanent impairment must come from the findings of the attending physician or other physicians with whom the attending physician agrees. See Roseburg Forest Products v. Owen, 129 Or App 442 (1995); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666, 670 (1994). Reports of insurer-arranged medical examiners are not admissible for the purpose of rating impairment unless those findings are ratified by the claimant's attending physician. See OAR 436-35-007(8); Tektronix, Inc. v. Watson, 132 Or App 483 (1995) (attending physician rated claimant's impairment where he incorporated the findings of the consulting physician and noted that claimant had no significant impairment).

Because Dr. Lundsgaard concurred with the opinions of Drs. Dinneen and Davies, those opinions are admissible for the purpose of rating impairment. In addition, the opinion of the medical arbiter, Dr. Neumann, may be considered in rating claimant's impairment.

Dr. Neumann measured loss of range of motion in claimant's lumbar spine. (Ex. 63-4). In addition, Dr. Neumann stated that these measurements were valid. (Ex. 63-5). Moreover, he appeared to attribute this loss to the accepted injury, in that he referenced the Department's instructions to report objective permanent impairment resulting only from the accepted injury. Id. However, in response to a question from the Department regarding "any other findings of permanent impairment as a result of the accepted condition and/or sequelae," Dr. Neumann stated "I am unable to find any objective evidence of permanent impairment." (Ex. 63-6). Dr. Neumann's response creates a potential ambiguity as to whether he finds any impairment due to the accepted injury.

On the other hand, Dr. Dinneen opined that claimant had no impairment related to the compensable injury. (Ex. 59-5). In addition, Dr. Davies opined that psychological factors unrelated to work were the major contributing cause of claimant's symptomatic presentation and need for treatment. (Ex. 59-11, -12). Dr. Lundsgaard, claimant's attending physician, concurred with these opinions. (Ex. 61).

Where a medical arbiter is used on reconsideration, impairment is determined by the medical arbiter, except where a preponderance of the medical evidence establishes a different level of impairment. OAR 436-35-007(9). Here, given the potential ambiguity in Dr. Neumann's report, we do not find his opinion persuasive evidence of impairment due to the compensable injury. Instead, we find persuasive Dr. Lundsgaard's opinion that claimant has no impairment related to the compensable injury. Therefore, we find that a preponderance of the medical evidence establishes that claimant has no impairment due to the compensable injury. Accordingly, claimant is not entitled to an award for permanent disability. OAR 436-35-270(2).

Finally, because the Order on Reconsideration's award of unscheduled permanent disability remains reduced to zero, claimant is not entitled to an assessed attorney fee pursuant to ORS 656.382(2).

ORDER

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

April 17, 1996 Cite as 48 Van Natta 881 (1996)

In the Matter of the Compensation of
GREGORY A. BARRELL, Claimant
WCB Case No. 95-00279
ORDER ON REVIEW
Lavis, Alvey, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Hoguet's order that: (1) affirmed a Director's order that concluded that the insurer's calculation of claimant's temporary disability rate was reasonable; and (2) affirmed an Order on Reconsideration that awarded claimant no scheduled permanent disability benefits for a chronic right arm condition. On review, the issues are temporary disability rate and extent of scheduled permanent disability.

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

Relying on OAR 436-60-025(5), the ALJ concluded that it was reasonable for the insurer to calculate claimant's time loss rate on the basis of a three-day work week. Claimant asserts that the insurer's calculation should have been based on a five-day work week. We disagree.

OAR 436-60-025(5) provides, in part,

> "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 four weeks, insurers shall use the intent of the most recent wage earning agreement as confirmed by the employer and the worker[.]" (Emphasis added).

Claimant does not dispute that the rule, particularly the emphasized language, applies to this case. Rather, he asserts that "the most recent wage earning agreement" between him and the employer reflects the parties' intent that claimant work a five-day work week. We disagree.

On claimant's first (and only) day of employment, the employer represented to him that it had plenty of work opportunities for him and that he could work as long as he wanted. In view of the employer's status as a temporary employment service and claimant's status as a day laborer, however, we conclude that the employer's representation was not sufficient to establish an agreement that claimant would be regularly employed on a full-time basis. Under the circumstances, therefore, we agree with the ALJ that it was appropriate for the insurer to base claimant's time loss rate on a three-day work week.

ORDER

The ALJ's order dated October 20, 1995 is affirmed.

April 17, 1996 Cite as 48 Van Natta 882 (1996)

In the Matter of the Compensation of
BROOK BODEN, Claimant
WCB Case No. 95-08492
ORDER ON REVIEW
Bottini, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) upheld the insurer's partial denial of claimant's preexisting cervical spine osteoarthritic condition; and (2) affirmed an Order on Reconsideration that awarded claimant no unscheduled permanent disability for a neck injury. On review, the issues are compensability and extent of unscheduled permanent disability.

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

In March 1995, claimant sustained a neck strain at work superimposed on preexisting degenerative spondylosis. Because the work injury was identified as the major contributing cause of claimant's disability and need for treatment, on June 27, 1995, the insurer accepted a claim for a disabling "right cervical strain." On that same date, the insurer issued a partial denial of claimant's "pre-existing osteoarthritic condition." The denial letter also observed: "Dr. Davis has released you to regular work due to your injury, and without any restrictions."

At hearing, claimant contended that the insurer had denied both her underlying arthritic condition and the combined condition. The ALJ disagreed, and instead found that the disputed portion of the letter denied that claimant had disability related to the accepted combined condition and, thus, concerned extent of disability, not compensability. Finding that all the doctors agreed claimant had degenerative spondylosis before the March injury, that there was no medical evidence that the injury worsened the disease condition, and that claimant did not contend otherwise, the ALJ upheld the denial.

On review, claimant renews her contention that, insofar as the denial denied that the March 1995 injury was the major contributing cause of her disability, it must be set aside. For the reasons expressed by the ALJ, we find that this was a partial denial of the preexisting osteoarthritic condition.

Turning to the extent of disability issue, the ALJ found that Dr. Davis was claimant's attending physician at the time of claim closure. Relying on the opinions of the Orthopedic Consultants, Dr. Davis' concurrence with their report, and the opinion of the medical arbiter, the ALJ affirmed the Order on Reconsideration that awarded no disability.

On review, claimant contends that Dr. Calhoun was her attending physician. Specifically, claimant argues that under ORS 656.245(2)(a), an injured worker "may chose the initial attending physician and may subsequently change attending physicians two times without approval from the director." Claimant thus asserts that it was against the insurer's contract with its own Managed Care Organization (MCO) and statutory law for the insurer to block claimant from changing to Dr. Calhoun as her attending physician. Claimant's assertion is unsupported by any authority.

Amended ORS 656.005(12)(b) provides, in part: " Except as otherwise provided for workers subject to a managed care contract, 'attending physician' means a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury[.]" (Emphasis supplied). For those worker's subject to a managed care contract, amended 656.245(4) provides: "Notwithstanding subsection (2)(a) of this section, when . . . an insurer contracts with a managed care organization certified pursuant to ORS 656.260 for medical services required by this chapter to be provide to injured workers: (a) those workers who are subject to the contract shall receive medical services in the manner prescribed in the contract." (Emphasis supplied).

Under the insurer's MCO contract, Dr. Davis was authorized as claimant's attending physician. Dr. Davis referred claimant to specialist Calhoun. As a specialist, Dr. Calhoun did not qualify as an attending physician under the MCO rules, and the insurer so informed claimant. (Ex. 37). Dr. Davis was claimant's attending physician at the time of claim closure.

ORDER

The ALJ's order dated October 31, 1995 is affirmed.

April 17, 1996 Cite as 48 Van Natta 883 (1996)

In the Matter of the Compensation of
WARREN N. BOWEN, Claimant
WCB Case No. 91-15616
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

This case is on remand from the Court of Appeals. SAIF v. Bowen, 136 Or App 222, mod on recon 137 Or App 598 (1995). The court has remanded with instructions to reconsider our decision in Warren N. Bowen, 44 Van Natta 2064 (1992). In that case, we affirmed an ALJ's order that: (1) set aside the SAIF Corporation's denial of a proposed weight loss program on the ground that it was not causally related to claimant's compensable injury; and (2) dismissed for lack of jurisdiction claimant's request for hearing as it related to the reasonableness and necessity of that treatment.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the finding that claimant's pre-injury weight was around 250-260 pounds. Claimant testified that his pre-injury weight was 235-240 pounds. (Tr. 8).

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his right foot in July 1986. After his injury, claimant gained approximately 20 pounds. In April 1991, claimant's attending physician, Dr. Nagel, advised claimant to lose weight. In October 1991, claimant's attorney made a formal demand for a weight loss program. The SAIF Corporation issued a denial on October 21, 1991, on the ground that the weight loss program was not related to claimant's compensable injury and was not reasonable or necessary treatment for the accepted condition.

By opinion and order of February 21, 1992, then-Referee (now ALJ) Nichols set aside SAIF's denial to the extent that it denied the causal relationship of the weight loss program to claimant's compensable injury, and awarded a $1,000 fee to claimant's counsel for prevailing on the compensability portion of the denial. In reaching the causation issue, the ALJ noted that SAIF was asserting that claimant's weight loss was a separate condition and that the "resultant condition" was not caused in major part by claimant's accepted foot injury. The ALJ, however, dismissed claimant's request for hearing as it related to the reasonableness and necessity of the weight loss program, on the ground that the Hearings Division lacked jurisdiction under former ORS 656.327. The ALJ cited our decision in Stanley Meyers, 43 Van Natta 2643 (1991) as authority for dismissing that portion of claimant's request for hearing.

SAIF requested Board review. In doing so, SAIF did not contest the ALJ's reasoning regarding the causation issue. Instead, SAIF argued that claimant was not entitled to a carrier-paid attorney fee under ORS 656.386(1).

On October 6, 1992, we affirmed the ALJ's order. Warren N. Bowen, supra. The Court of Appeals affirmed our order. SAIF v. Bowen, 126 Or App 412 (1994). The Supreme Court then allowed SAIF's petition for review, vacated the Court of Appeals' decision and remanded for reconsideration in light of Niccum v. South Coast Lumber Co., 320 Or 189 (1994) and Martin v. City of Albany, 320 Or 175 (1994), which held that he Board had jurisdiction to determine the appropriateness of proposed medical treatment for claimant. SAIF v. Bowen, 320 Or 501 (1995).

Noting that the amendments to Oregon workers' compensation law made by Oregon Laws 1995, chapter 332 were applicable, see Volk v. America West Airlines, 135 Or App 565 (1995), the Court of Appeals on remand held that those amendments gave the Director exclusive authority to decide whether medical treatment is excessive, inappropriate, ineffectual or in violation of applicable rules. SAIF v. Bowen, 136 Or App 222 (1995). Inasmuch as the Board lacked jurisdiction to determine the appropriateness of proposed treatment for claimant, the court remanded with instructions to dismiss claimant's hearing request.

Claimant moved for reconsideration, arguing that the court's disposition of the case, remanding to the Board with instructions to dismiss, was in error. On reconsideration, the court agreed that its conclusion that the Board lacked jurisdiction was premature, and concluded that the case should be remanded to the Board to reconsider the issue of whether the Director's exclusive authority to determine whether treatment is appropriate includes authority to decide whether treatment is causally related to the compensable injury, or whether the Board has jurisdiction to consider that question. SAIF v. Bowen, on recon 137 Or App 598 (1995).

Having summarized the factual background and procedural posture of this case, we now proceed with our reconsideration in light of the court's remand.

Generally, the changes made to the Workers' Compensation law 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).

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 was 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, SAIF contends that there is no dispute regarding the compensability of an "underlying claim" within the meaning of ORS 656.245(6) since it does not contest the compensability of claimant's foot condition.[1] It, therefore, asserts that the Board does not have jurisdiction to determine whether the proposed weight loss program is causally related to claimant's compensable foot injury. We disagree.

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[1] ORS 656.245(6) provides in part 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, the insurer or self-insured employer shall request administrative review by the director pursuant to this section, ORS 656.260 or ORS 656.327..." (emphasis supplied)

As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard v. Renalds, 132 Or App 288 (1995) and Michele K. Dibrito, 47 Van Natta 970 (1995)). Claimant is 6 feet tall and testified that his pre-injury weight was around 235 to 240 pounds. Following his injury, claimant's weight rose to approximately 270 pounds. (Ex. 33). Because of this "post-injury" weight gain, Dr. Nagel recommended that claimant undergo a weight loss program to treat his foot condition. (Ex. 29). Under such circumstances, we conclude that claimant's weight gain represents either a "consequential" or a "combined" condition. See ORS 656.005(7)(a)(A)&(B). In either case, claimant must prove that his compensable foot injury is the major contributing cause of the combined or consequential condition. Id.

Although SAIF insists that there is no dispute regarding the compensability of an "underlying claim," the "underlying claim" in this case is the "consequential" or "combined" condition (claimant's weight gain). Moreover, as the ALJ noted, SAIF argued at hearing that claimant must prove that the "resultant condition" is caused in major part by claimant's compensable injury. This demonstrates that SAIF has previously contested the compensability of the "underlying claim." Under these circumstances, we conclude as we did in Zeller and Anderson, that this dispute concerns the compensability of an "underlying claim." See also Richard Wheeler, 47 Van Natta 2011 (1995). Consequently, we retain jurisdiction to consider the parties' dispute concerning causation. See ORS 656.245(6); Janet Anderson, supra; Lynda J. Zeller, supra.

Having resolved the jurisdictional issue, we now turn to the merits of the parties' dispute. After conducting our review of this record, we agree with the ALJ's reasoning that claimant's compensable injury is the only explanation for his need for a weight loss program. Therefore, we find that claimant's compensable injury is the major contributing cause of his need for a weight loss program. Accordingly, we conclude that the ALJ properly set aside that portion of SAIF's denial based on lack of causation. While we have determined that claimant's weight loss program is compensable, we emphasize that our determination is limited to the causation dispute. The Board is without authority to address the propriety of the proposed medical treatment, which is an issue within the jurisdiction of the Director. Linda Zeller, supra.

Inasmuch as claimant has prevailed finally after remand from the Court of Appeals with regard to the compensability issue, he is entitled to an assessed attorney fee for his counsel's services before every prior forum. ORS 656.388(1); 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 before the Board, the Court of Appeals, Supreme Court and the Board on remand is $4,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the causation issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, the skill and standing of counsel, and the risk that counsel may go uncompensated. This award is in lieu of any and all prior attorney fee awards.

Accordingly, on reconsideration of our October 6, 1992 order, we affirm the ALJ's February 21, 1991 order. For services before the Board, Court of Appeals, Supreme Court and the Board on remand, claimant's attorney is awarded a $4,000 fee, to be paid by SAIF. This fee is in lieu of any and all prior attorney fee awards.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT J. CARROLL, Claimant
WCB Case No. 93-09021
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996). The court has reversed our prior order which reduced claimant's unscheduled permanent disability for a low back injury from 10 percent (32 degrees) to 6 percent (19.2 degrees). Relying on former OAR 436-35-310(2) (WCD Admin. Order 6-1992), which provided that the value for the factor of adaptability is zero when a worker has been released to or returned to regular work, we concluded that claimant's adaptability value was zero because he had returned to regular work. Reasoning that former OAR 436-35-310(2) was invalid because it was inconsistent with ORS 656.214(5) and ORS 656.726(3)(f), the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" from our prior order.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his back, and was subsequently released to regular work. A Notice of Closure did not award unscheduled permanent disability, and an Order on Reconsideration affirmed the Notice of Closure. Claimant requested a hearing. The ALJ, relying on a temporary Director's rule, OAR 436-35-310(2) (WCD Admin. Order 93-052), concluded that claimant was entitled to an adaptability factor of 1. Based on claimant's age, education, training, and permanent impairment, the ALJ awarded 10 percent unscheduled permanent disability.

Subsequent to the ALJ's order, the temporary rule expired. Therefore, in our order, we applied the prior rule, former OAR 436-35-310(2), which provided for an adaptability factor of zero. The effect of our application of the former rule was to convert the combined value of claimant's age and education factors to zero. Accordingly, we reduced claimant's unscheduled permanent disability award to 6 percent (consistent with claimant's permanent impairment).

In reversing our prior order, the court relied on the Supreme Court's opinion in England v. Thunderbird, 315 Or 633 (1993). In England, the Court held that former OAR 436-35-290(2)(a), former OAR 436-35-300(2)(a), and former OAR 436-35-310(2)(a), which held that no values are given for age, education, or adaptability for workers who have returned to their usual and customary work, were inconsistent with former ORS 656.214, which provided that "[e]arning 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." In Carroll, the Court of Appeals also held that OAR 436-35-310(2), which gave a zero adaptability value when a worker had returned to work, conflicted with ORS 656.214(5) and 656.726(3)(f)(A), and was, therefore, invalid. Carroll v. Boise Cascade Corporation, supra.

We recently applied the Carroll decision to former OAR 436-35-280(1) (WCD Admin. Order No. 93-056). Joe R. Ray, 48 Van Natta 325 (1996). In Ray, because the claimant's residual functional capacity (RFC) was equal to his base functional capacity (BFC), his adaptability factor under the former OAR 436-35-280(1)(a) was zero. Moreover, because that factor was used as a multiplier, former OAR 436-35-280(6), the claimant was not allowed a value for age, education, or skills. In light of Carroll, however, we concluded that former OAR 436-35-280(1) was inconsistent with ORS 656.726(3)(f)(A). Joe R. Ray, supra. Therefore, we declined to apply the rule. Rather, we found that the value for the age, education and skills factor should be added to the impairment value to determine the amount of the unscheduled permanent disability award. That analysis essentially resulted in assigning a value of 1 to the adaptability factor.

This case is governed by the same rules as those that were at issue in Joe R. Ray. Here, as in Ray, claimant's BFC and RFC are equal. Consequently, under former OAR 436-35-280(1)(a), claimant's

adaptability value is zero. That analysis is inconsistent with Carroll and Ray. Consequently, in accordance with Ray, we add the value for claimant's age, education and skills factor to his impairment value to determine the amount of his unscheduled permanent disability award. In other words, we assign a value of 1 to claimant's adaptability factor. Joe R. Ray, supra.

Accordingly, because the factors for age and education must be applied, we assign claimant an adaptability factor of 1. See Donna J. England, 45 Van Natta 1480 (1993); Carroll v. Boise Cascade Corporation, supra; Joe R. Ray, supra; see also Jerry S. Quillen, 48 Van Natta 526 (1996) (where we declined to apply a similarly invalid rule in determining extent of unscheduled permanent disability).

Assembling the factors, the total value for claimant's age, education and skills (4) is multiplied by the adaptability factor of 1 for a total of 4. This value is added to the value 6 for impairment, for a total of 10 percent (32 degrees) unscheduled permanent disability.

Accordingly, on reconsideration, the ALJ's order dated November 18, 1993 is affirmed.

IT IS SO ORDERED.

April 17, 1996 Cite as 48 Van Natta 887 (1996)

In the Matter of the Compensation of
DONALD P. JAMES, Claimant
WCB Case Nos. 95-02921 & 94-09030
ORDER ON RECONSIDERATION
Patrick K. Mackin, Claimant Attorney
Robert Yanity (Saif), Defense Attorney
Lundeen, et al, Defense Attorneys

The SAIF Corporation requested reconsideration of those portions 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.

In order to allow sufficient time to consider SAIF's motion, we abated our prior order on March 20, 1996. Claimant has filed a response to SAIF's motion. Consequently, we proceed with our reconsideration.

SAIF contends that, pursuant to amended ORS 656.245(1), the Director has sole jurisdiction over this matter (as it involves medical services). Alternatively, SAIF argues that, even if the Board does have jurisdiction, claimant has not established an entitlement to medical services.

With respect to SAIF's argument, as we stated in our prior order, 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 the compensable injury. Arthur R. Morris, 48 Van Natta 349 (1996); 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, 47 Van Natta 1581, on recon 47 Van Natta 2337 (1995).

Here, because SAIF's denial pertained to the "compensability of the underlying claim," which means that SAIF disputed the causal relationship between the compensable injury and the medical services, we continue to conclude that we have jurisdiction over this matter. In reaching this conclusion, we do not mean to imply that we have decided the reasonableness and necessity of the medical services claim. Rather, we have merely concluded that claimant's current condition is related to the compensable injury.

With respect to SAIF's second argument concerning the merits of our decision, we adhere to the reasoning expressed in our prior order.

Claimant's attorney is entitled to an attorney fee for services on reconsideration. After considering the factors recited in OAR 438-015-0010(4), we find that a reasonable attorney fee for such services is $500, to be paid by SAIF. In particular, we have considered the time devoted to the case (as represented by claimant's response), the complexity of the issues, 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 February 22, 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
JOE D. LEONARD, Claimant
WCB Case No. 94-10749
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) found that claimant's claim for his current low back condition was not barred by res judicata; (2) set aside its partial denial of claimant's current low back condition; (3) found that claimant's low back claim had been prematurely closed; (4) found that the issue of aggravation was moot; (5) awarded an assessed attorney fee; and (6) awarded an approved attorney fee. On review, the issues are res judicata, compensability, premature closure, aggravation, and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

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

Res judicata

The ALJ found that claimant was not precluded from litigating the compensability of his current condition, which includes a herniated disc and a degenerative condition (stenosis). On review, the employer contends that claimant had an opportunity to litigate compensability of his current low back condition in a hearing before a prior ALJ. Claimant contends, however, that the issue before the prior ALJ was premature closure, rather than compensability, and although the ALJ may have made some references to claimant's preexisting conditions and herniated disc, the issue was not essential to the ALJ's final decision.

The doctrine of res judicata precludes litigation of claims and issues previously adjudicated. North Clackamas School District v. White, 305 Or 38, 50, modified 305 Or 468 (1988). The general rule of claim preclusion bars the litigation of a claim based on the "same factual transaction" that was or could have been litigated between the parties in a prior proceeding. Drews v. EBI Companies, 305 Or 134 (1990). It does not require actual litigation of an issue, nor does it require that the determination of the issue be essential to the final result reached in the proceeding. Only the opportunity to litigate is required. Id.

Here, the litigation between the parties in the prior proceeding arose from the employer's attempt to set aside an Order on Reconsideration which found that claimant was not medically

stationary at the time of claim closure. (Ex. 53). The "factual transaction" that led to the premature closure issue was claimant's psychological condition and his need for a psychological evaluation. (Ex. 53-5). Accordingly, although the prior ALJ made brief references to claimant's preexisting congenital condition, the factual transaction in the prior proceeding is not the same as the factual transaction in the present case which involves the compensability of claimant's current low back condition. Additionally, as found by ALJ Johnson, a component of claimant's current condition (the herniated disc) was not confirmed until after the prior ALJ's Opinion and Order issued. Consequently, the opportunity to litigate compensability of claimant's current herniated disc condition was not present at the time of the prior hearing.

Accordingly, we agree with the ALJ's conclusion that the compensability issue is not precluded by res judicata.

Compensability

In finding claimant's current condition compensable, the ALJ relied on the opinions of Dr. Lewis, claimant's attending physician, Dr. Todd, consulting physician, and Dr. Lax, who briefly treated claimant and requested surgery authorization in 1994. On review, the employer contends that the ALJ should have relied, instead, upon the opinions of the doctors who examined claimant on the employer's behalf. We disagree.

The ALJ explained his reasons for rejecting the opinions of the examining doctors as not persuasive, and we herein adopt that reasoning. Moreover, we conclude that Dr. Lewis' opinion, which was based on the reports of the doctors who operated on claimant, is persuasive as it discusses the surgical findings and their relation to the causation of claimant's condition. See, e.g., Argonaut Ins. v. Mageske, 93 Or App 698 (1988).

Premature closure

We adopt the ALJ's conclusions on this issue.

Aggravation

We adopt the ALJ's conclusions on this issue.

Claimant's attorney is entitled to an assessed fee for defending against the employer'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 $1,500. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated September 8, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the employer.

In the Matter of the Compensation of
INDIRA D. HALE, Claimant
WCB Case Nos. 94-14095 & 94-08092
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Employer Defense Counsel, Defense Attorneys

Reviewed by Board Members Christian and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Odell's order that set aside its denial of claimant's injury claim for a right thumb strain and a cervical condition/disc herniation at C5-6. On review, the issue is compensability.

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

Relying on claimant's testimony and the medical opinion of Dr. Gallo, the ALJ found that claimant suffered a compensable cervical injury on July 15, 1991 which was the cause of her C5-6 disc herniation. In so holding, the ALJ specifically rejected the opinions of Drs. Podemski and Duff because "they did not review the MRI which identified a herniated C5-6 disc."

Although the ALJ's reason for rejecting the opinion of Drs. Podemski and Duff was flawed (because it is evident from their report that they did review the MRI of claimant's cervical spine),[1] it does not detract from the ALJ's reliance on Dr. Gallo's opinion. Of all the treating and examining physicians, only Dr. Gallo was advised of the specific incident on July 15, 1991, during which claimant, an endoscopy assistant, was required to restrain and hold the hands of a large and combative patient for the course of a 15 or 20 minute medical procedure. Dr. Gallo opined that this incident would be of sufficient force and stress to cause a cervical disc injury and that the injury was the etiology of her disc herniation. (Ex. 35-1).

Despite the ALJ's finding that claimant was credible based on demeanor, the insurer argues on review that claimant's testimony concerning the incident on July 15, 1991 is not to be believed. It is well settled that, unless the substance of the witness' testimony and other inconsistencies in the record raise such doubt that we are unable to conclude that the material testimony is credible, we will generally defer to the ALJ's finding that the witness is credible. See, e.g., Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Gail A. Albro, 48 Van Natta 41 (1996); David A. Peper, 46 Van Natta 1656 (1994). In this case, we find no persuasive reason to overturn the ALJ's demeanor-based credibility determination.

The insurer argues that claimant's failure to report a specific neck injury on July 15, 1991 to her treating and examining physicians in early 1994 fatally undermines her credibility. We disagree. Claimant consistently maintained that her neck pain had its onset in 1991, and that it gradually worsened to the point that it interfered with her work and sleep. The medical record confirms that she sought treatment in early 1992 for cervical spasms, and that by April 1994, she was also experiencing pain radiating to the base of her skull and her shoulders and arms. The fact that claimant initially related her symptoms to her day-to day work activities rather than directly to the events of July 15, 1991 does not mean that this incident did not occur or that it was not the mechanism of her injury.

Claimant has the burden of proving the compensability of her cervical condition by a preponderance of the evidence. ORS 656.266. Like the ALJ, we accept claimant's history of the July 15, 1991 incident. We also find Dr. Gallo's medical opinion, based on the history of that incident, to be the most complete and persuasive. See Somers v. SAIF, 77 Or App 259 (1986) (when the medical evidence is divided, we give the most weight to opinions that are both well-reasoned and based on complete information).

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[1] Based in part on the fact they were "unable to obtain any specific injury or event that may have caused the disc protrusion" Drs. Podemski and Duff opined that claimant's neck and head pain was myofascial in origin.

The employer also argues that the ALJ erred in finding claimant's 1991 thumb strain compensable because claimant has not submitted a claim for that injury. While claimant did not submit a claim for the injury to her thumb (she only sought in-house treatment for her thumb the one time following the July 15, 1991 incident), the employer raised the compensability issue by denying her right thumb strain in its November 9, 1994 denial. Although the employer specifically denied that the thumb injury was related to claimant's work, the record establishes otherwise. We agree with the ALJ that claimant's 1991 thumb strain 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 438-015-0010(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 interests involved.

ORDER

The ALJ's order dated September 18, 1995 is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by the insurer.

April 18, 1996 Cite as 48 Van Natta 891 (1996)

In the Matter of the Compensation of
NAOMI WHITMAN, Claimant
WCB Case No. 95-00647
ORDER ON RECONSIDERATION
Vanvoorhees & Larson, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

The self-insured employer requests reconsideration of our March 27, 1996 order that affirmed an Administrative Law Judge's (ALJ's) order that set aside its denial of claimant's upper back and shoulder injury claim. The employer disagrees with our conclusion that claimant was a credible witness. The employer also contends that we erred by concluding that amended ORS 656.005(7)(a)(B) does not apply to the claim and by determining that claimant had objective findings of an injury.

The employer contends that the inconsistencies between claimant's testimony and the testimony of other witnesses are directly related to compensability and are not collateral to the issues presented. We have considered the inconsistencies between claimant's testimony and the testimony of other witnesses. However, we agree with the ALJ that 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. In other words, we continue to be persuaded that the record as a whole supports claimant's testimony.

The employer also argues that we inappropriately placed the burden of proof on the employer to establish a combined condition by medical evidence in order to invoke amended ORS 656.005(7)(a)(B). The employer asserts that we have the "power" to find a combined condition.

It is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995) and Michelle K. Dibrito, 47 Van Natta 970 (1995)). In other words, the application of amended ORS 656.005(7)(a)(B) is contingent on the presence of a compensable injury which "combined" with a preexisting condition. Leon M. Haley, 47 Van Natta 2056, on recon 47 Van Natta 2206 (1995). Here, as explained in our prior order, there is no medical evidence that claimant's December 12, 1994 injury "combined" with a preexisting back condition. Consequently, we adhere to our conclusion that 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, supra.

Finally, the employer argues that we created an "illusion of objective findings." The employer contends that claimant failed to prove a compensable injury to her mid-back because there were no objective findings of an injury.

If claimant's physician had reported that claimant had a normal range of motion and no spasms, we would agree with the employer that there were no objective findings under amended ORS 656.005(19). Here, however, claimant's physician found that claimant had mid thoracic spine tenderness at the T 6-7-8 area, but her ROM (range of motion) was "otherwise okay" and he commented that claimant had "no significant paraspinous spasm." (Ex. 1). Under these circumstances, for the reasons discussed in our prior opinion, we continue to find that claimant's reduced range of motion and her paraspinous spasm resulting from the sprain injury constituted "objective findings" under amended ORS 656.005(19).

Accordingly, our March 27, 1996 order is withdrawn. As supplemented herein, we adhere to and republish our March 27, 1996 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

April 18, 1996 Cite as 48 Van Natta 892 (1996)

In the Matter of the Compensation of
GAYLE J. WILLIAMS, Claimant
WCB Case No. 91-10443
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Williams, 138 Or App 298 (1995). In our prior order, we adopted and affirmed the Administrative Law Judge's (ALJ's) order that had awarded claimant's counsel an attorney fee pursuant to former ORS 656.386(1). The court has remanded for reconsideration in light of amended ORS 656.386(1).

FINDINGS OF FACT

The parties stipulated to the following facts:

Claimant sustained a compensable injury in March of 1986. In December 1990, she submitted certain mileage and expense vouchers to the SAIF Corporation for reimbursement. SAIF returned them and requested documentation in the form of receipts. Claimant responded by sending the requested receipts. SAIF received them on April 27, 1991. Because the receipts were inadvertently placed in the bill section of SAIF's claim file, the reimbursements were not paid in a timely manner.

On August 5, 1991, claimant's attorney simultaneously filed a request for hearing and wrote to SAIF demanding payment of the unpaid reimbursements. On August 9, 1991, SAIF issued a check to claimant in the amount of $462.70, the full amount of the claim reimbursements.

Claimant's attorney was instrumental in obtaining the aforementioned reimbursements for claimant.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the reimbursements had been "de facto" denied and that, consequently, the compensability of those reimbursements was directly at issue. On this basis, the ALJ concluded that claimant's attorney was entitled to an attorney fee under former ORS 656.386(1). On Board review, we adopted and affirmed the ALJ's order.

Relying on its decision in SAIF v. Allen, 124 Or App 183 (1993), the Court of Appeals initially reversed our award of attorney fees. SAIF v. Williams, 124 Or App 203 (1993). Claimant appealed to the Supreme Court, which reversed the decision of the Court of Appeals. SAIF v. Williams, 320 Or 406 (1994).

On remand, the Court of Appeals, relying on the Supreme Court's decision in SAIF v. Allen, 320 Or 192 (1994), initially affirmed our award of attorney fees. SAIF v. Williams, 133 Or App 766 (1995). SAIF then appealed to the Supreme Court, which again remanded for the Court of Appeals for reconsideration in light of the amendments to ORS 656.386(1). 321 Or 559 (1995).

Because the 1995 amendments might affect the outcome of the case, the Court of Appeals has also remanded for reconsideration in light of the new law. SAIF v. Williams, 138 Or App 298 (1995). We proceed with our reconsideration.

ORS 656.386(1) was amended by the 1995 legislature. As amended, the statute provides in relevant part:

> "In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed. For purposes of this section, a "denied claim" is a claim for compensation which an insurer or self-insured employer refuses to pay on the express ground that the injury or condition for which compensation is claimed is not compensable or otherwise does not give rise to an entitlement to any compensation. 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 timely fashion."

We addressed the question of what constitutes a "denied claim" for the purposes of amended ORS 656.386(1) in Michael J. Galbraith, 48 Van Natta 351 (1996). In Galbraith, we distinguished Guillermo Rivera, 47 Van Natta 1723 (1995), where a carrier had accepted a claim prior to hearing and had asserted that it had "reason to question the causation of the accepted condition" and had acknowledged that an attorney fee award for a "de facto" denial was warranted. On the basis of the carrier's concession that an attorney fee was warranted and its statement that it had reason to question causation, we concluded that there was a "denied claim" in Rivera.

In contrast to Rivera, we found that there was no concession in Galbraith that an attorney fee was justified and no indication that the carrier contested the causal relationship between the condition for which compensation was claimed and the industrial injury. Inasmuch as the carrier had not refused to pay compensation on the express ground that the condition was not compensable or otherwise did not give rise to an entitlement to any compensation, we concluded that no "denied claim" had been established.

As in Galbraith, we conclude that there has been no "denied claim" in this case. Here, as in Galbraith, there is no concession that an attorney fee is justified and no indication that the carrier contested the causal relationship between the condition for which compensation was claimed and the industrial injury.

In addition, there has been no refusal to pay compensation 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 compensation. Michael J. Galbraith, supra. It is undisputed that SAIF did not pay the compensation at issue in a timely manner.[1] However, it is also undisputed that the reason compensation was not paid was because the mileage and expense receipts were misplaced in the claim file. Accordingly, the "refusal to pay" was not on the express ground that claimant's injury was not compensable or otherwise did not give rise to an entitlement to compensation. Rather, the failure to pay was the result of a claim processing error. Although such conduct could support the assessment of a penalty under ORS 656.262(11) for unreasonable claim processing, it does not establish that there has been a "denied claim" for purposes of ORS 656.386(1).[2] Consequently, there is no entitlement to attorney fees under that statute.

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[1] Under ORS 656.386(1), a "denied claim" cannot be presumed merely from the failure to timely pay compensation for a previously accepted claim.

[2] The ALJ's order assessed a 25 percent penalty against SAIF under former ORS 656.262(10), now ORS 656.262(11). That portion of the ALJ's order has not been contested.

Claimant contends that amended ORS 656.386(1) should not be retroactively applied because it changes a procedural time limit in violation of § 66(6)[3] of SB 369. Specifically, claimant argues that amended ORS 656.386(1) eliminates the 90 day period to accept or deny a claim contained in ORS 656.262(6). We disagree.

Amended ORS 656.386(1) limits the entitlement to attorney fees to those cases where there is a "denied claim." However, there is nothing in the language of the statute that affects any time limitation in any other statute. Under ORS 656.262(6), a carrier is still required to accept or deny a claim within 90 days. In addition, penalties and fees can still be assessed under ORS 656.262(11) and ORS 656.382(1) for the failure to timely accept or deny a claim (provided there are amounts of compensation then due or unreasonable resistance to the payment of compensation). Neither former nor amended ORS 656.386(1) affect any procedural time limits. Accordingly, we reject claimant's argument that retroactive application of the statute is barred by § 66(6).[4]

On reconsideration, we reverse that portion of the ALJ's November 14, 1991 order that awarded an attorney fee under ORS 656.386(1). The remainder of the ALJ's order is affirmed.

IT IS SO ORDERED.

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[3] Section 66(6) of SB 369 provides that the amendments to the Act do not extend or shorten procedural time limitations with regard to any action on a claim taken prior to the effective date of the Act.

[4] Claimant raises several other arguments to the effect that amended ORS 656.386(1) conflicts with other statutes and policies of the Workers' Compensation Law. As we have stated herein, we believe that the sole effect of the statute is to limit attorney fees to those cases where there is a "denied claim." Nothing in the statute excuses a carrier from its claim processing obligations and responsibilities under the law. In fact, as previously noted, SAIF has been assessed a penalty for its untimely and unreasonable response to claimant's reimbursement claim.

April 19, 1996 Cite as 48 Van Natta 894 (1996)

In the Matter of the Compensation of
BENNER E. COX, Claimant
WCB Case Nos. 95-00434
ORDER ON REVIEW
Bogardus & Nichols, Claimant Attorneys
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 upheld the SAIF Corporation's denial of claimant's aggravation claim for his current L3-4 disc condition. On review, the issue is compensability.

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

In lieu of the ALJ's first ultimate finding of fact, we find that claimant's present condition arises from a different condition than that accepted by SAIF as a nondisabling injury.

Claimant compensably injured his low back in October 1989. SAIF accepted the claim as a nondisabling lumbar strain. An April 1991 CT scan demonstrated no disc herniations. After operating a tractor for a couple of days in late summer of 1994, claimant experienced increased low back pain with pain radiating into the left calf. An October 1994 CT scan demonstrated a herniated disc at L3-4.

The ALJ applied the major contributing cause standard of proof under ORS 656.005(7)(a)(A) to the analysis of this aggravation claim under ORS 656.273(1). Finding that claimant did not sustain his burden of proof under that standard, the ALJ concluded that the L3-4 herniated disc is not compensable.

Effective June 7, 1995, the Legislature enacted Senate Bill 369 which amended numerous provisions in ORS Chapter 656. Among the amended provisions was ORS 656.273. Amended ORS 656.273(1) 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).

Amended ORS 656.273(1) requires proof of two specific elements in order to establish a worsened condition: (1) "actual worsening"; and (2) a compensable condition. Both elements must be satisfied in order to establish "a worsened condition resulting from the original injury." Gloria T. Olson, 47 Van Natta 2348, 2350 (1995).

Since the compensability of a condition is established under ORS 656.005(7)(a), the statute requires that a condition which is not already compensable be established as compensable in order to prove "a worsened condition resulting from the original injury" under ORS 656.273. Id. We turn to a determination of claimant's compensable condition.

Claimant's accepted low back condition was diagnosed as a lumbar strain. The worsened condition is a herniated disc. The herniated disc is not an accepted condition; rather, it developed some five years after the original 1989 injury. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the herniated disc is a compensable condition.

Claimant first contends that the herniated L3-4 disc resulted directly, although belatedly, from the original injury. Thus, claimant asserts that he has carried his burden of proof under a material contributing cause standard. See Albany General Hospital v. Gasperino, 113 Or App 411, 415 (1992) (notwithstanding its belated onset, where a condition arises directly from an accident, the claimant need only establish that the condition was materially caused by the industrial accident). Claimant relies on the reports of SAIF-arranged medical examiners Mendius and Neumann, SAIF record reviewer White, and treating neurosurgeon Belza to establish a direct causal relationship between the 1989 injury and the 1994 disc herniation.

Drs. Mendius and Neumann opined only that claimant's current low back condition and need for medical treatment were related in material part to claimant's subsequent work activities driving a tractor which were superimposed upon the October 1989 industrial injury. Dr. White specifically opined that if claimant sustained a back injury in 1989, it was not reasonable to find that such an injury led to a delayed disc herniation five years later. Dr. Belza found, at best, only that it was medically probable for a lumbar back strain to worsen as in claimant's case. Consequently, there is no medical opinion which affirmatively states, or from which it can be found, that claimant's herniated disc arose directly from the 1989 injury.

Alternatively, claimant argues that under the holding enunciated by the court in Iocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), the standard of proof in aggravation claims is material contributing cause. For the following reasons, we agree with the ALJ that the major contributing cause standard set forth in ORS 656.005(7)(a)(A) applies.

In Iocelyn, the court reasoned that since former ORS 656.273(1) did not refer to the term "compensable injury," subsection (B) of ORS 656.005(7)(a) did not apply to aggravation claims. Iocelyn, supra, 132 Or App at 171. However, the legislature has now inserted the term "compensable injury" into the aggravation statute. Thus, the unambiguous language of amended ORS 656.273(1) modifies the court's holding in Iocelyn by specifically defining the elements of proof which establish a "worsened condition resulting from the original injury." Gloria T. Olson, supra at 2350.

As noted, the compensability of a condition is established under ORS 656.005(7)(a). That statute defines "compensable injury" with the following limitation: "(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."[1] Inasmuch as ORS 656.005(7)(a)(A) specifies how consequential conditions are to be considered in establishing compensability, consistent with our decision in Gloria T. Olson (that ORS 656.005(7)(a)(B) is applicable in aggravation claims), we conclude that ORS 656.005(7)(a)(A) is applicable in aggravation claims.

Having identified the appropriate legal standards for application to this case, we proceed with our review. For the reasons expressed by the ALJ, we too find that claimant has failed to establish that the 1989 compensable lumbar strain injury is the major contributing cause of the herniated disc condition and need for treatment in 1994.

Accordingly, we conclude that claimant failed to establish that he has a "compensable condition" under amended ORS 656.273. Therefore, his aggravation claim fails.

ORDER

The ALJ's order dated June 1, 1995 is affirmed.

[1] ORS 656.005(7)(a)(A) was not among the provisions amended by Senate Bill 369. See Or Laws 1995, ch 332, § 1.

In the Matter of the Compensation of
JIM FLETCHER, Claimant
WCB Case No. 94-09857
ORDER ON REVIEW
Bruce D. Smith, Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Baker's order which affirmed a Director's order that found claimant was not a subject worker at the time of an alleged right elbow injury. On review, the issue is subjectivity.

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

Claimant must be a "subject worker" in order to receive "compensation" under the Worker's Compensation Act. ORS 656.027. The first determination to be made in a subjectivity case such as this is whether claimant is a "worker" within the meaning of ORS Chapter 656.[1]

On February 25, 1994, claimant filed a claim for a right elbow injury which allegedly occurred on January 27, 1994 while working for Jeri and/or Harold Lovin. Claimant subsequently revised the date of injury to January 27, 1994. The Lovins deny that claimant ever worked for them.

After an investigation, the Department of Consumer and Business Services informed claimant that the claim could not be processed, because it could not determine whether claimant was a subject worker of the Lovins at the time of injury. Claimant requested a hearing from the Department's subjectivity decision.

After considering extensive testimony and the documentary evidence, the ALJ was unable to determine that claimant was a subject worker. The ALJ therefore affirmed the Department's subjectivity determination.

[1] A worker is any person who engages to furnish services for remuneration, subject to the direction and control of an employer. ORS 656.005(30); see Woody v. Waibel, 276 Or 189 (1976). One who is not a "worker" is not subject to workers' compensation coverage, and the inquiry ends. S-W Floor Covering Shop v. National Council on Compensation Insurance, 318 Or 614, 630 (1994).

For the reasons expressed by the ALJ, we agree that claimant has failed to prove by a preponderance of the evidence that he furnished services to the putative employer(s) for remuneration. Consequently, claimant has not established that he was a subject worker on the date of the alleged injury.

ORDER

The ALJ's order dated September 22, 1995 is affirmed.

April 19, 1996 Cite as 48 Van Natta 897 (1996)

In the Matter of the Compensation of
DEWEY W. KENNEDY, Claimant
WCB Case No. 94-06412
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Larry Schucht (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that declined to assess a penalty for the SAIF Corporation's allegedly unreasonable failure to pay for medical services pending SAIF's appeal of a prior ALJ and Board order. On review, the issues are jurisdiction and, alternatively, penalties. We vacate the ALJ's order and dismiss claimant's hearing request.

FINDINGS OF FACT

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

In Dewey Kennedy, 47 Van Natta 394 (1995), we affirmed a prior ALJ's order holding that the disputed medical services are reasonable and necessary. After SAIF appealed that case, the Court of Appeals remanded the matter to us for reconsideration. On reconsideration, we held that, because the case involved a Managed Care Organization dispute, the Director of the Department of Consumer and Business Services had exclusive jurisdiction over it. Therefore, we vacated the prior ALJ's order and dismissed claimant's hearing request. Dewey W. Kennedy, 48 Van Natta 186 (1996).

CONCLUSIONS OF LAW AND OPINION

In this present (second) matter, the ALJ concluded that, because SAIF was entitled to stay compensation pursuant to former ORS 656.313 (since amended by Or Laws 1995, ch 332, § 38), it was not unreasonable for SAIF to stay payment of certain disputed medical services pending appeal of the prior ALJ's order. Claimant asserts that, because the version of ORS 656.313 in effect during the year of his injury did not authorize SAIF to stay payment of compensation pending appeal, SAIF's failure to pay for the medical services was unreasonable. Therefore, he asserts, he is entitled to a penalty. We lack jurisdiction over that issue.

In our order on remand, we held that the Director now has exclusive jurisdiction over the merits of the parties' medical services dispute. Dewey W. Kennedy, supra. Likewise, we lack the authority to award penalties for matters arising under the Director's jurisdiction. ORS 656.385(5); SB 369, § 42d(5); e.g., Thomas L. Abel, 47 Van Natta 1571, 1574 (1995). Here, the basis of a penalty is the disputed medical services. Because disputes regarding those services now arise under the Director's jurisdiction, we are without authority to award a penalty relating to such disputes.

In conclusion, we lack jurisdiction over claimant's request for the assessment of a penalty. Consequently, we vacate the ALJ's decision and dismiss claimant's hearing request.

ORDER

The ALJ's order dated March 30, 1995 is vacated. Claimant's hearing request is dismissed.

In the Matter of the Compensation of
CHERYL A. LOSLI, Claimant
WCB Case No. 95-00049
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Mills' order which: (1) set aside an Order on Reconsideration and Notice of Closure because the claim was prematurely closed; (2) directed the insurer to pay any additional temporary disability to which claimant is entitled; (3) assessed a penalty on the amounts due for unreasonable claim processing regarding claim closure; (4) set aside the insurer's denial of claimant's current low back condition and need for treatment; and (5) assessed attorney fees for an allegedly unreasonable current condition denial, unreasonable claim processing, and unreasonable failure to provide discovery. On review, the issues are premature closure, temporary disability, compensability, and penalties/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.

The insurer accepted claimant's 1993 injury as a low back strain. (Ex. A).

The insurer's March 8, 1995 denial denied that claimant's current claims were related to the accepted 1993 claim. (Ex. 16).

We also adopt the ALJ's findings of ultimate fact, but we add the following finding of ultimate fact: "The 1993 industrial injury is not the major contributing cause of claimant's current condition."

CONCLUSIONS OF LAW AND OPINION

Premature Closure/Temporary Disability (Claim Processing)

The ALJ found that the preponderance of medical evidence establishes that claimant was not medically stationary at the time of claim closure on August 31, 1994. We agree and adopt his opinion in this regard.

The ALJ also directed the insurer to pay "any additional temporary time loss" to which claimant is entitled, until her claim is properly closed. (Opinion and Order, p.7).

On review, the insurer argues that claimant is not entitled to additional time loss, citing amended ORS 656.268(3)(b). However, because ORS 656.268(3) sets out conditions for unilateral termination of temporary disability, it does not apply to this case.

Moreover, as a result of our affirmance of the ALJ's finding that the claim was prematurely closed, the claim remains open. Thus, additional temporary disability benefits may be payable prior to closure of the claim. However, the issue of claimant's procedural entitlement to additional temporary disability under this claim does not arise until the closure of the claim has been set aside and the claim has been reopened. Under such circumstances, we consider it premature to address claimant's procedural entitlement to temporary disability until the insurer has had an opportunity to process the claim.

Consistent with its statutory obligation to process the claim, the insurer must determine whether claimant is entitled to temporary disability and, if so, when such entitlement arises. Thereafter, if claimant is dissatisfied with the insurer's processing of the claim while the claim is open, she may request a hearing.

Compensability of current condition

The insurer issued a denial on March 8, 1995, denying an aggravation claim and need for treatment for claimant's current low back condition as unrelated to her accepted 1993 low back claim. (Ex. 16). The parties agreed to litigate a current condition denial as well. (Tr. 1).

The ALJ found that claimant's current condition was related to her industrial injuries of 1992 and 1993 and, therefore, set aside that portion of the denial that denied claimant's current condition. The insurer contends that claimant has preexisting degenerative disease of the low back.[1] Therefore, the insurer argues that it is claimant's burden to prove that the 1993 injury was the major contributing cause of claimant's current low back condition. We agree with the insurer.

Before addressing the merits of claimant's claim, we first respond to claimant's position that the insurer cannot argue that a prior work injury is the major cause of claimant's current condition because the insurer failed to issue a responsibility disclaimer under ORS 656.308. We addressed this question in Joyce A. Crump, 47 Van Natta 466 (1995), rev'd Crump v. Safeway Stores, Inc., 138 Or App 702 (1996) (remanded to Board for consideration of SB 369 amendments to ORS 656.308).[2]

In Joyce A. Crump, the claimant sustained a knee injury at work in 1991, for which she did not file a claim. Thereafter, she sustained another knee injury in 1992 while working for a different employer. The second employer neither accepted nor denied the knee claim, and it did not issue a disclaimer of responsibility pursuant to ORS 656.308. Claimant requested a hearing from the employer's "de facto" denial. The ALJ held that, because the employer failed to issue a disclaimer of responsibility, it was precluded from relying on ORS 656.005(7)(a)(B) by arguing that the major contributing cause of claimant's knee condition was her 1991 injury. We disagreed with the ALJ's analysis.

Instead, we held that compensability must be proven as a threshold to determining responsibility. Joyce A. Crump, supra, 47 Van Natta at 466. We reasoned that ORS 656.308, by its terms, refers only to the issue of responsibility; it does not refer to denials of compensability. Id. at 467. Thus, we concluded that responsibility becomes an issue only if the claim is proven compensable. Accordingly, we followed the approach, consistent with our prior orders, that claimant must first prove compensability of the claim before responsibility becomes an issue. Id.

We follow the same approach here.[3] Accordingly, we turn now to a determination of the compensability of claimant's condition.

If a preexisting condition combines with an otherwise compensable injury to cause or prolong disability or the need for treatment, the combined condition is compensable only so long as the compensable injury remains the major contributing cause of the disability or need for treatment for the combined condition. Amended ORS 656.005(7)(a)(B). A "preexisting condition" is defined as "any injury, disease . . . 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. . . ." Amended ORS 656.005(24). A preexisting condition may be either compensable or not compensable. SAIF v. Drews, 318 Or 1, 8-9 (1993).

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[1] The insurer contends, based on Exhibits 3 and F, that claimant had a preexisting degenerative disease of the low back. We agree that claimant has a "preexisting condition," but we are not persuaded that the evidence the insurer relies on establishes the existence of a preexisting degenerative disease. The evidence cited by the insurer, which was generated after claimant's 1993 injury, establishes only the existence of certain lumbar findings in 1993 and 1994. (Exs. F, 3). The evidence does not establish the cause of those findings or when they developed. Instead, our finding that claimant has a "preexisting condition" is based on Dr. Mawk's opinion as expressed in his deposition. (Ex. 18). As explained further below, we rely on Dr. Mawk's opinion that claimant's lumbar findings most likely were caused by her 1992 injury and, therefore, preexisted her 1993 injury.

[2] Although a signatory to this order, Member Hall calls attention to his dissenting opinion in Joyce A. Crump, supra, 47 Van Natta at 469-71.

[3] Although the Court of Appeals reversed our order, Crump v. Safeway Stores, Inc., supra, it did so not on the merits of our decision, but to permit us to consider the effects of the 1995 amendments to ORS 656.308. Accordingly, unless and until our decision is reversed on the merits, we continue to apply the analysis in Joyce A. Crump, supra.

Here, the subject injury occurred on August 26, 1993. Therefore, any condition that preceded the onset of the 1993 injury is a "preexisting condition" with respect to that injury. Amended ORS 656.005(24). Subsequent to the 1993 injury, imaging studies revealed degenerative changes in claimant's low back at the L4-5 and L5-S1 levels. (Ex. F; see also Ex. 3-1). Dr. Mawk, a neurosurgeon who became claimant's attending physician in August 1994, found that claimant had bulging disks at the L4-5 and L5-S1 levels. (Ex. 18-11; 18-33, 18-39). He opined that the most likely cause of those findings was claimant's 1992 injury. (Ex. 18-10). There is no other medical opinion regarding the cause of the lumbar findings. Therefore, we find, based on Dr. Mawk's opinion that the lumbar findings were probably caused by claimant's 1992 injury, that claimant had a low back condition that preexisted her 1993 injury.

Even if claimant has a preexisting condition, there must be medical evidence that the preexisting condition combined with a compensable injury to cause or prolong disability or the need for treatment before compensability must be established under amended ORS 656.005(7)(a)(B). Leon M. Haley, 47 Van Natta 2056 (1995), on recon 47 Van Natta 2206 (1995). On this issue, we again rely on Dr. Mawk's opinion. Dr. Mawk opined that both the 1992 and 1993 injuries were the major cause of claimant's disk protrusions. (Ex. 18-20). He explained that the 1993 injury represented a worsening or reinjury of the areas that were previously injured in 1992. (Ex. 18-20 to -21). He opined that the 1993 injury worsened claimant's symptoms and reexacerbated her low back problem. (Ex. 18-21). There are no other medical opinions on this issue. Under such circumstances, we find that Dr. Mawk's opinion establishes that claimant's preexisting condition (caused by the 1992 injury) combined with the compensable 1993 injury to cause or prolong her disability and need for treatment.

Because we have found that claimant had a condition that preexisted the 1993 injury, and that the condition combined with the 1993 injury, it is claimant's burden to establish that the 1993 injury is the major contributing cause of her current condition, disability and need for treatment. Amended ORS 656.005(7)(a)(B). Dr. Mawk opined that both the 1992 and 1993 injuries were the major contributing cause of claimant's current condition and need for treatment. (Ex. 18-20). He also opined that claimant's current need for treatment is more related to the 1992 injury than to the 1993 injury. (Ex. 18-27). There are no other medical opinions on this issue.

Accordingly, we conclude that claimant failed to establish that the 1993 injury was the major contributing cause of her current condition, disability and need for treatment. Therefore, we uphold the insurer's denial of claimant's current condition and need for treatment.

Penalties/attorney fees

The ALJ assessed a penalty under former ORS 656.262(10) (renumbered 656.262(11)) on the increased temporary disability resulting from his order for the insurer's unreasonable claim processing in closing the claim and in failing to provide Dr. Mawk's reports to the Department during the reconsideration process. We adopt and affirm this portion of the ALJ's order.

The ALJ also assessed penalty-related attorney fees under ORS 656.382(1) for the insurer's unreasonable current condition denial, failure to approve medical treatment, and failure to provide discovery. Inasmuch as we have found claimant's current condition not compensable, we reverse that portion of the ALJ's order that assessed a $250 penalty-related attorney fee for an unreasonable denial.

Regarding the remaining penalty-related attorney fees assessed by the ALJ under ORS 656.382(1), we adopt and affirm that portion of the ALJ's order that assessed a $250 penalty-related attorney fee for the insurer's unreasonable failure to approve medical treatment and another $250 fee for the insurer's unreasonable failure to provide discovery. We offer the following supplementation.

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).

Here, we agree with the ALJ's determination that the insurer's conduct in failing to approve medical treatment and in failing to provide discovery amounted to "unreasonable resistance to the payment of compensation." There are amounts due, but we have already assessed a penalty on those amounts pursuant to ORS 656.262(11). We cannot assess another penalty on the same amount of compensation. However, a separate attorney fee award under ORS 656.382(1) may be granted for separate unreasonable conduct that relates to a different factual basis. See, e.g., Oliver v. Norstar, Inc., supra, 116 Or App at 336. Accordingly, since the insurer's conduct constituted separate acts of unreasonable resistance to the payment of compensation, relating to different factual bases, claimant is entitled to penalty-related attorney fees assessed under ORS 656.382(1). See Lucille G. Major, 47 Van Natta 617, 619 (1995)(where a penalty was already assessed on amounts due, an attorney fee under ORS 656.382(1) was assessed for separate unreasonable conduct).

We adopt and affirm that portion of the ALJ's order that awarded an attorney fee to be paid out of claimant's increased compensation. ORS 656.386(2).

Because we have upheld the insurer's current condition denial, we reverse the ALJ's $2,250 attorney fee award under ORS 656.386(1) for setting aside the insurer's current condition denial.

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

ORDER

The ALJ's order dated May 19, 1995 is affirmed in part and reversed in part. Those portions of the ALJ's order that set aside the insurer's current condition denial and assessed a $250 penalty-related attorney fee for an unreasonable denial are reversed. The insurer's March 8, 1995 denial is reinstated and upheld. The ALJ's $2,250 attorney fee award for setting aside the denial is also reversed. The remainder of the order is affirmed. Claimant's attorney is awarded $1,000 for services on Board review, to be paid by the insurer.

April 19, 1996 Cite as 48 Van Natta 901 (1996)

In the Matter of the Compensation of
SHARON M. SESSIONS, Claimant
WCB Case No. 93-12616
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that affirmed an Order on Reconsideration awarding 9 percent (28.8 degrees) unscheduled permanent disability for a cervical condition and no scheduled permanent disability. On review, the issue is extent of scheduled and unscheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Unscheduled Permanent Disability

Claimant argues that it was improper for the Director to appoint a medical arbiter to determine her impairment because she agreed with the impairment findings of her attending and consulting

physicians. We disagree, and adopt that portion of the ALJ's order finding that this case is controlled by amended ORS 656.268(7)(a).[1] Or Laws 1995, ch 332, § 30(7)(a) (SB 369, § 30(7)(a)). Pursuant to that section, the Director has discretion to refer a claim to a medical arbiter to obtain additional medical information when the submitted medical evidence is insufficient to rate disability, even though the parties do not disagree with the attending physician's impairment findings. Moreover, to the extent that amended ORS 656.268(7)(a) permits the appointment of a medical arbiter where the Director determines the available medical information insufficient, our pre-SB 369 decision in Flor Irajpanah, 47 Van Natta 189 (1995), has been overruled.[2]

Claimant also argues that even with the arbiter's report, a preponderance of the evidence establishes a different level of impairment. See OAR 436-35-007(9). Again, we disagree.

In his December 1992 closing examination, claimant's chiropractor, Dr. Freeman, made findings concerning claimant's decreased range of motion in the cervicothoracic spine.[3] Nine months later, in September 1993, the medical arbiter, Dr. Burr, measured claimant's range of motion of the cervical and thoracic spine using the double inclinometers. 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, we rely on the arbiter's findings over those of Dr. Freeman. 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).

Based on Dr. Burr's examination findings, claimant is entitled to a total impairment value of 6 under the disability rating standards (a 4 percent loss of cervical motion combined with a 2 percent loss for thoracic motion). See former OAR 436-35-360.

As for claimant's age, education and adaptability values, SAIF argues on review that the ALJ erred in applying the temporary rules set forth in WCD Admin. Order 93-052 because those rules have since expired. We agree, although as explained below, application of the appropriate rules in this case does not change claimant's award of permanent disability.

In Karen S. Boling, 46 Van Natta 2522 (1994), we held that, where, as here, the worker became medically stationary after July 1, 1990 but the Determination Order issued before the effective date of the permanent rules set forth in WCD Admin. Order 93-056, the standards in effect at the time of the Determination Order or Notice of Closure are applicable. Because the temporary rules have expired and the Determination Order issued on June 4, 1993, we apply the standards as set forth in WCD Admin. Order 6-1992.

The Court of Appeals recently invalidated one of the standards applicable in this case. In Carroll v. Boise Cascade Corp., 138 Or App 610 (1996), the court held that former OAR 346-35-310(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). ORS 656.726(3)(f)(A) provides that in calculating a worker's loss of earning capacity, permanent impairment shall be "modified by" the factors of age, education and adaptability to perform a given job. Relying on the Supreme Court's reasoning in England v. Thunderbird, 315 Or 633 (1993), the Carroll court found that using a multiplier of zero to artificially reduce a claimant's age, education or adaptability factors because of a worker's return to regular work is contrary to the statutory requirement that extent of disability be calculated on the basis of loss of earning capacity, rather than earnings. Carroll v. Boise Cascade Corp., supra.

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[1] In the absence of a specific exception to the retroactive application of the law, the amendments to the Workers' Compensation law made by Senate Bill 369 apply to cases currently pending. Volk v. America West Airlines, 135 Or App 565 (1995).

[2] In Flor Irajpanah, supra, we held that the Department lacked the authority under former ORS 656.268(5) and (7) to appoint a medical arbiter if the parties did not disagree with the impairment used in rating disability.

[3] Claimant's attending physician, Dr. Danner, concurred with Dr. Freeman's December 31, 1992 report on February 18, 1993.

Like former OAR 436-35-310(2), both former OAR 436-35-290(2) (addressing the age factor) and former OAR 436-35-300(2) (addressing the education factor), which are applicable in this case, also provide for a value of zero when the worker has been released to or has returned to regular work. Although the Carroll decision expressly invalidated only the adaptability rule, former OAR 436-35-310(2), we conclude, based on the reasoning in Carroll, that the age and education rules (former OAR 436-35-290(2) and former OAR 436-35-300(2), respectively) suffer from the same infirmity insofar as they assign a zero value where the worker has been released to or returned to regular work. See Joe R. Ray, 48 Van Natta 325 (1996) (invalidating OAR 436-35-280(1) as inconsistent with ORS 656.726(3)(f)(A)).

Because we cannot use the invalid portions of the applicable disability standards discussed above, we look to the remaining portions in calculating claimant's age, education and adaptability values in this case. Former OAR 436-35-290(1) states that the impact is based on the worker's age at the time of determination. Because claimant was 42 years old at the time of determination, we assign a value of +1. Former OAR 436-35-300(4) provides for value for a worker's skills based on the jobs performed during the ten years preceding the time of determination. Claimant's highest skill level for the relevant time period was acquired while working as a "classroom aide" (DOT Code 355.377-018, SVP 6), entitling claimant to an education value of +2. Finally, we assign an adaptability value of one because claimant returned to her regular work and her Residual Functional Capacity is no less than her Base Functional Capacity. See Joe R. Ray, supra.

In assembling the factors, the total value of claimant's age, education and skills (3) 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 for impairment (6), the result is 9. Former OAR 436-35-280(7). Therefore, claimant's total unscheduled permanent disability is 9 percent.

Scheduled Permanent Disability

We adopt and affirm that portion of the ALJ's order finding no persuasive evidence that claimant sustained a permanent loss of use or function of her left arm due to the compensable September 1988 injury.

ORDER

The ALJ's order dated October 16, 1995 is affirmed.

April 19, 1996 Cite as 48 Van Natta 903 (1996)

In the Matter of the Compensation of
VIRGIL C. SHORTEN, Claimant
WCB Case No. 95-07504
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that decreased claimant's unscheduled permanent disability award for a low back injury from 9 percent (28.8 degrees), as awarded 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.

In determining that claimant proved no impairment as a result of a 1991 injury, the ALJ found the opinion of claimant's treating chiropractor, Dr. Braman, more persuasive than that of the medical arbiter, Dr. Stanford, and claimant's treating family physician, Dr. Risser. Claimant contends that we should defer to Dr. Risser's opinion and award 20 percent unscheduled permanent disability or, at minimum, reinstate the Order on Reconsideration awarding 9 percent unscheduled permanent disability.

Although Dr. Risser reported that claimant has permanent disability as a result of his 1991 injury, Dr. Risser also indicated that he could not state whether claimant had lost range of motion. Thus, we find no evidence from Dr. Risser from which we could determine claimant's impairment. Hence, we conclude that Dr. Risser does not aid claimant in establishing scheduled permanent disability.

Furthermore, for the reasons stated by the ALJ, we agree that Dr. Braman, who indicated that claimant had no impairment from the January 1991 injury, provided the most persuasive medical opinion. Consequently, we affirm the ALJ's conclusion that claimant is not entitled to scheduled permanent disability.

ORDER

The ALJ's order dated October 20, 1995 is affirmed.

April 19, 1996 Cite as 48 Van Natta 904 (1996)

In the Matter of the Compensation of
SENETRA SMITH-WAMPLER, Claimant
WCB Case No. 93-15113
ORDER OF ABATEMENT
Martin J. McKeown, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

On March 22, 1996, the Board affirmed an Administrative Law Judge's (ALJ's) order that: (1) declined to dismiss claimant's request for hearing; and (2) set aside the self-insured employer's partial denial of claimant's current left shoulder condition. Contending that the Board's decision contains legal and factual errors, the employer seeks reconsideration.

In order to further consider the employer's contentions, we withdraw the Board's March 22, 1996 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT K. SCHILLER, Claimant
WCB Case No. 95-05299
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Janelle Irving (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that affirmed an Order on Reconsideration that had classified claimant's right sacroiliac strain claim as nondisabling. 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

Concluding that the evidence failed to establish that claimant had a permanent loss of hip range of motion, the ALJ concluded that claimant had failed to establish a reasonable expectation of permanent disability sufficient to justify classifying this claim as disabling. Claimant asserts that a report of his treating physician, Dr. Peterson, is sufficient to establish that expectation. 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). The issue here is whether there was a reasonable expectation that permanent disability would result from claimant's right sacroiliac strain.[1]

Dr. Peterson signed a concurrence report, agreeing that "[claimant] suffers from chronic sacroiliac strain. There is a reasonable expectation that permanent disability will result form [sic] the injury based on the chronicity of [claimant's] symptoms." (Ex. 11-2). In a later concurrence report, which referred to an earlier report indicating that claimant had right thigh numbness and lack of full active flexion of the right hip (Ex. 6), Dr. Peterson reiterated his agreement that there was a reasonable expectation of permanent impairment. (Ex. 12).[2]

Those reports are uncontroverted. Therefore, although Peterson's opinion is rather cursory, in the absence of any evidence to the contrary, we conclude that it is sufficient to establish a reasonable expectation that permanent disability will result from claimant's injury. Accordingly, we reverse the ALJ's order denying claimant's reclassification request.

Claimant's counsel is entitled to an "out-of-compensation" attorney fee, payable from the increased compensation created by this order, not to exceed $3,800, to be paid directly to claimant's attorney. ORS 656.386(2); OAR 438-015-0055(1).

ORDER

The ALJ's order dated September 19, 1995 is reversed. The SAIF Corporation is directed to reclassify the claim as disabling and process it according to law. Claimant's attorney is awarded 25 percent of any increased compensation created by this order, not to exceed $3,800, payable directly by SAIF to claimant's attorney.

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[1] There is no evidence that claimant is entitled to any temporary disability compensation as a result of his injury.

[2] The later report clarified that the reasonable expectation of permanent impairment existed on August 8, 1994, within a year of the date of claimant's injury. (Ex. 12).

In the Matter of the Compensation of
PAUL M. OLDS, JR., Claimant
WCB Case No. 95-08239
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Bottini, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Galton's order that set aside its denial of claimant's occupational disease claim for a myocardial infarction. On review, the issue is compensability.

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

On review, the employer contends that the firefighters' presumption, ORS 656.802(4), does not apply because the statute requires firefighters to undergo a physical examination upon becoming a firefighter, or subsequently thereto, which failed to reveal any evidence of such condition or impairment of health which preexisted employment. In particular, the employer argues that claimant did not undergo the type of examination designed to reveal any evidence of preexisting conditions. See SAIF v. Bales, 107 Or App 198 (1991). The employer contends that, although the court recently held that cardiac stress tests or stress electrocardiograms (EKGs) were sufficient to meet the statutory requirement, see Winston-Dillard RFPD v. Addis, 134 Or App 98 (1995), claimant in this case did not undergo such stress tests. We disagree.

In Addis, prior to his infarction, the claimant had undergone regular physical examinations, including a stress test or test EKG. The court rejected the employer's contention that the claimant was required to undergo an angiogram before meeting the predicate of ORS 656.802(4). The court distinguished Bales, supra, in which the "test" consisted of the worker's doctor listening to the claimant's lungs in order to detect a viral infection. In Bales, the exam was found insufficient to meet the statutory requirement, as the court concluded that the exam was not the rigid or competent type of physical examination that the legislature contemplated for the purposes of the statute.

In Addis, however, the court concluded that the claimant, who had taken cardiac stress tests or stress EKGs, had undergone the customary tests that the medical profession would use for detecting cardiovascular disease. Consequently, the court held that the stress tests taken by the claimant were sufficient to meet the requirements of ORS 656.802(4). Addis, supra.

We find the present case to be similar to Addis.[1] As noted by the ALJ, prior to his infarction, claimant underwent tests (EKGs, a chest x-ray, and a heart treadmill test) in 1991, which were

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[1] The employer argues that this case is similar to John Q. Emmert, 46 Van Natta 997 (1994). We disagree. In Emmert, the claimant underwent a physical examination prior to his myocardial infarction. However, the claimant's operating physician explained that the examination did not rule out CAD at the time. In the present case, the tests taken by claimant specifically for the purpose of ruling out CAD were found to be normal.

We find that the second case relied upon by the employer, Robert Winkel, 45 Van Natta 991 (1993), is also distinguishable from this case. In Winkel, we did not rely on an EKG performed prior to the claimant's myocardial infarction. We concluded that, because the claimant had previously experienced clinical symptoms consistent with heart disease, and no medical opinion discussed the significance of a subsequently normal EKG, we could not find sufficient medical evidence as required by the statute. Winkel, supra.

Here, however, Dr. Atkisson believed that claimant had chest pain of "uncertain etiology," (Ex. 17), which could be attributed to either CAD, or possibly an esophageal disease. (Ex. 16). Therefore, Dr. Atkisson recommended tests to rule out CAD. Dr. Toren's opinion provides that, if claimant's studies were negative, he concurred that there was a low probability for CAD being the cause of claimant's chest pain. (Ex. 20-2). Accordingly, unlike the medical record in Winkel, the record in the present case contains medical opinions which discuss the fact that, even in light of claimant's symptoms, CAD was ruled out as a cause for claimant's chest pains.

specifically performed to rule out coronary artery disease.[2] Additionally, on July 25, 1991, Dr. Toren reported that claimant's "standard stress test has been negative," and a dobutamine stress echocardiogram performed that day was reported to be "normal" by Dr. Toren. (Ex. 19, 20). Dr. Atkisson subsequently reported that claimant's chest x-ray and stress echocardiogram were normal and "in light of his prior normal treadmill stress tests and present dobutamine stress echocardiogram, it was felt unlikely that the patient was suffering from coronary artery disease." (Ex. 23-1).

Consequently, after reviewing the medical record, we agree with the ALJ that the tests taken by claimant were sufficient to bring claimant within the statute and the firefighters' presumption.[3] Furthermore, although Dr. Toren later opined that claimant had preexisting coronary artery disease, in light of Dr. Toren's initial opinion and his reported finding regarding claimant's normal stress tests, we do not find Dr. Toren's opinion regarding a preexisting disease to be persuasive.

Under the circumstances, we conclude that the statutory "presumption" has been established, and the employer has failed to prove by clear and convincing medical evidence that claimant's myocardial infarction was unrelated to his work activities.[4] Therefore, we adopt the ALJ's conclusion on the issue of compensability.

Claimant's attorney is entitled to an assessed fee for defending against the employer'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 $1,900, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 13, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,900, to be paid by the self-insured employer.

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[2] The employer argues that claimant testified that he had not undergone any stress or treadmill tests prior to his December 1995 hospitalization. However, the question posed to claimant on cross-examination was whether he had undergone such tests at the time of his examination in 1981. (Tr. 23).

[3] We acknowledge that Dr. Toren reported that such tests would not eliminate the presence of coronary artery disease. Dr. Toren stated that only an angiogram would have ruled out such a disease. (Ex. 70). Nevertheless, as previously explained, the court in Addis has specifically rejected a similar argument that only an angiogram will suffice for purposes of the statute. Addis, supra.

[4] Although the employer argues that claimant's symptoms did not arise until ten days after claimant stopped working, we do not find such a fact to be dispositive. Rather, we are persuaded by the medical evidence discussed above regarding claimant's stress tests. In other words, it is the cause of claimant's condition which is important, rather than when his symptoms began.

April 15, 1996 Cite as 48 Van Natta 907 (1996)

In the Matter of the Compensation of
MARLENE J. ANDRE, Claimant
Own Motion No. 95-0458M
INTERIM OWN MOTION ORDER
Doblie & Associates, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requested 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 compensable condition worsened requiring surgery. With her request for reconsideration, claimant submitted evidence referred to in, and which was supposed to be attached to, her January 11, 1996 letter. In our February 21, 1996 order, the Board acknowledged that the evidence was missing from the record.

On March 26, 1996, we abated our prior order to allow the SAIF Corporation sufficient time to consider claimant's motion. SAIF responded that it would request that the Board either reject claimant's evidentiary submission, or grant it an additional 30 days in which to respond to the newly discovered evidence.

Because the proffered evidence is relevant, we grant SAIF's request for an extension of time within which to submit evidence supporting its position that claimant was not in the work force at the time of disability. Accordingly, SAIF's response shall be due 21 days from the date of this order. Claimant will be allowed 14 days from the mailing date of SAIF's response to file her reply. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARIANNE L. SHERIDAN, Claimant
WCB Case No. 91-09220
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Schwabe, et al, Defense Attorneys

This matter is on remand from the Court of Appeals. Pursuant to its March 12, 1996 order, the court has remanded for reconsideration of our prior order, Marianne L. Sheridan, 46 Van Natta 2185 (1994), in which we reversed the Administrative Law Judge's (ALJ's) order upholding the insurer's partial denial of claimant's current right elbow condition. In accordance with the court's mandate, we now proceed with our reconsideration in light of the 1995 amendments to ORS 656.268 and ORS 656.262.

FINDINGS OF FACT

We adopt the ALJ's findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The insurer accepted a claim filed for a chipped bone in claimant's right elbow, after she fell and struck her elbow on July 9, 1990. Dr. Wade, claimant's initial attending physician, performed arthroscopic surgery on August 28, 1990 to remove a loose body in the elbow. Claimant's symptoms continued, however, which prompted her to seek treatment from Dr. Berselli in November 1990. Despite claimant's ongoing symptoms and medical treatment, the claim was closed by a December 14, 1990 Notice of Closure that found claimant medically stationary on November 26, 1990.

On June 7, 1991, claimant requested reconsideration of the closure notice, contending that the claim had been prematurely closed. On July 2, 1991, the insurer issued a denial of the compensability of and responsibility for claimant's elbow condition on the grounds that the compensable injury was not the major contributing cause of claimant's condition after November 26, 1990.

On July 9, 1991, an Order on Reconsideration issued, rescinding the Notice of Closure and finding that it had been prematurely issued. On July 11, 1991, claimant filed a request for hearing. An order was issued by the Appellate Review Unit on July 30, 1991, withdrawing the July 9, 1991 reconsideration order on the grounds that it had no jurisdiction to reconsider the insurer's Notice of Closure because of the July 2, 1991 denial. The ALJ affirmed the July 30, 1991 withdrawal order and the July 2, 1991 denial of claimant's current right elbow condition.

We affirmed the ALJ's decision upholding the insurer's denial of claimant's current elbow condition. Marianne L. Sheridan, 45 Van Natta 394 (1993). However, we also concluded that the purported withdrawal of the July 9, 1991 reconsideration order was an amendment of the reconsideration order which effectively affirmed the December 1990 Notice of Closure. We still held that the July 9, 1991 Order on Reconsideration was invalid because claimant challenged the impairment findings and no medical arbiter was appointed as required by ORS 656.268(7). Claimant petitioned for judicial review of our order.

The court held that the Appellate Review Unit had no authority to issue its July 30, 1991 order withdrawing its July 9, 1991 reconsideration order. Sheridan v. Johnson Creek Market, 127 Or App 259 (1994). Therefore, the court determined that the July 30, 1991 order was a nullity. Inasmuch as the July 9, 1991 reconsideration order remained in effect, the court ruled that the December 1990 closure notice was prematurely issued.

Finally, the court noted that the insurer's July 1991 denial had relied on ORS 656.005(7)(a)(B). Citing United Airlines, Inc. v. Brown, 127 Or App 253 (1994) which held that former ORS 656.005(7)(a)(B) does not provide a procedural mechanism for the denial of an accepted claim), the court instructed us to reconsider our order in light of that case. Sheridan v. Johnson Creek Market, supra.

On remand, we determined that the insurer's July 2, 1991 denial was an invalid "pre-closure" denial of claimant's current elbow condition, distinguishing our decision in Zora A. Ransom, 46 Van Natta 1287 (1994) (upholding "pre-closure" denial not based on ORS 656.005(7)(a)(B)). Marianne L. Sheridan, supra. Accordingly, we set aside the insurer's denial.

The insurer petitioned for judicial review. Based on the amendments to the workers' compensation law contained in Senate Bill 369, the court has remanded for reconsideration. Having summarized the factual and procedural background of this case, we now proceed with our analysis.

In Brown, supra, the court held that the language of former ORS 656.005(7)(a)(B), which provided that, if a compensable injury combines with a preexisting condition or disease, "the resultant condition is compensable only to the extent that the compensable injury is and remains the major contributing cause of the disability or need for treatment," does not provide the procedural authority to deny an accepted claim. Instead, the court reasoned that the appropriate procedure is claim closure under ORS 656.268. 127 Or App at 256-57.

Amended ORS 656.262(7)(b) now provides that "Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed." (Emphasis supplied).

Inasmuch as the insurer's denial here was based on the presence of a preexisting elbow condition and on the provisions of ORS 656.005(7)(a)(B), the insurer's denial was procedurally proper even though it was issued prior to a valid claim closure. Having made that determination, we now proceed to an analysis of the merits of the insurer's denial; i.e., whether claimant's compensable injury "combined" with a preexisting condition and, if so, whether the injury is the major contributing cause of the disability or medical treatment of the "combined condition."

The ALJ found that claimant's current right elbow condition was not compensable under former ORS 656.005(7)(a)(B). The ALJ reasoned that the medical opinion of Dr. Wade, claimant's former treating physician, was more persuasive than that of her current attending physician, Dr. Berselli.

We agree with the ALJ that the medical evidence from Dr. Wade persuasively establishes that claimant had a loose body in her right elbow that preexisted the July 1990 work incident and that was dislodged by the traumatic work incident. (Ex. 22). The medical evidence from Dr. Wade, therefore, shows that claimant's compensable injury "combined" with the preexisting loose body to cause her disability and need for treatment. (Ex. 22). Thus, 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).

Dr. Berselli reported that his diagnosis of "some early arthritic changes of the right elbow" was supported by an MRI scan and findings obtained from an arthroscopy. (Ex. 19). He stated that the "etiology of the diagnosed condition in my opinion is due to the injury which occurred on July 9, 1990. I believe that [claimant] sustained an osteochondral fracture at the time of this injury [and that a loose fragment of cartilage was excised by Dr. Wade]." (Id.). Dr. Berselli's opinion, therefore, is that claimant's fall at work caused a fragment of cartilage to fracture, which in turn caused the arthritic changes.

Dr. Wade opined that it was "conceivable" that mechanical locking of the elbow had caused some damage to the articular surfaces. However, Dr. Wade stated that any arthritic changes in

claimant's elbow were not directly related to the compensable injury in any other fashion. (Ex. 22). Dr. Wade later stated that "the free body existed prior to the industrial injury. This is based on the fact that examination of the free body demonstrated no evidence of recent injury." (Ex. 26-2). Dr. Wade also agreed to statements drafted by the insurer's attorney that, while surgically removing the free body, he found "no cartilage damage to the articular surfaces or other arthritic change in the anterior or lateral aspect of the elbow joint," where the free body was found, and that, since such changes were found in the olecranon area, located at the back of the elbow, it was not "medically probable that the presence of the free body there and resultant locking of the elbow caused cartilage damage or other arthritic changes there that would be responsible for [claimant's] ongoing complaints." (Id. at 2-3).

We conclude that Dr. Wade's opinion is more persuasive than Dr. Berselli's opinion. We reach this conclusion in part because Dr. Wade based his opinion on direct examination of the free body. Argonaut Insurance Company v. Mageske, 93 Or App 698, 702 (1988) (deference to treating physician who was able to observe the affected body part during surgery).

Moreover, although we generally defer to the opinion of the attending physician, see Weiland v. SAIF, 64 Or App 810 (1983), we find that Dr. Berselli's opinion is not entitled to deference in this case. Because Dr. Berselli did not begin treating claimant until November 28, 1991, we find that his opinion is less persuasive than that of Dr. Wade, who was claimant's previous attending physician and who was, thus, in a better position to analyze the causation issue. See McIntyre v. Standard Utility Contractors, Inc., 135 Or App 298, 302 (1995). Although Dr. Berselli also performed arthroscopic surgery on claimant's right elbow, he was not the surgeon who personally observed the key piece of evidence, i.e., the free body. Moreover, we do not find that Dr. Berselli's opportunity to view the donor site of the free body during the arthroscopy he performed gives him an advantage over Dr. Wade. Dr. Wade removed the free body from the lateral and anterior aspect of the elbow joint, a different location than the donor site. Since Dr. Berselli opines that the free body, rather than the donor site, was the cause of claimant's current symptoms, we find that his actual viewing of this portion of the elbow joint does not provide him with a more persuasive basis for his opinion.

Giving greater weight to the opinion of Dr. Wade, we conclude that claimant failed to prove that the work injury is the major contributing cause of her need for treatment of the "combined condition." Accordingly, we affirm the ALJ's decision upholding the insurer's denial.

In conclusion, on reconsideration of our October 11, 1994 order, the ALJ's order dated December 23, 1991 is affirmed.

IT IS SO ORDERED.

April 24, 1996 Cite as 48 Van Natta 910 (1996)

In the Matter of the Compensation of
GRACE E. CASSIDY, Claimant
WCB Case No. 93-14898
ORDER OF ABATEMENT
Coons, Cole, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of our March 27, 1996 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of her occupational disease claim for a psychological condition. Contending that we misconstrued the medical opinions, claimant asserts that she has established that the work-related incident was the major contributing cause of her "combined condition" and, as such, her claim is compensable under ORS 656.802(2)(b).

In order to further consider this matter, we withdraw our March 27, 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 shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
WCB Case No. 94-14407
KELLY J. CLAY, Claimant
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Schultz's order which: (1) set aside its denial of claimant's aggravation claim for a cervical condition; and (2) set aside its alleged "de facto" denial of claimant's request for surgery for the same condition. On review, the issues are aggravation and jurisdiction. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

On November 1, 1988, claimant sustained an injury that included abdominal strain and lumbar, thoracic and cervical strain. In August 1989, claimant's claim was closed by Determination Order that awarded 23 percent unscheduled permanent disability. A March 1990 Stipulation and Order awarded an additional 5 percent unscheduled permanent disability.

By Opinion and Order dated April 29, 1994, a prior ALJ ordered SAIF to accept a C6-7 disc bulge as part of claimant's accepted injury. In August 1994, claimant returned to Dr. Brett, treating physician, with complaints of increased neck and shoulder pain. (Ex. 8). Subsequently, Dr. Brett suggested surgery at C6-7. (Ex. 16A). The managed care organization (MCO) denied Dr. Brett's request for surgery as well as his appeal of that decision. (Exs. 13, 17). After the denial by the MCO, SAIF did not respond to claimant's surgery request.

Relying on former ORS 656.273, the ALJ concluded that claimant had proven an aggravation of his C6-7 disc condition. The ALJ based his conclusion on MRI findings of a worsened disc herniation, and Dr. Brett's having placed claimant on permanent work restrictions if claimant did not have surgery. SAIF contends that claimant has failed to prove a worsening of his condition, or that claimant's increased symptoms are more than a waxing and waning of his condition. We agree with the ALJ's conclusion, and offer the following reasoning.[1]

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). We have recently held that an "actual worsening" of the compensable condition is established by a pathological worsening of the underlying condition, or by a symptomatic worsening of the condition that is greater than anticipated by the prior award of permanent disability. Carmen C. Neill, 47 Van Natta 2371 (1995).

Here, claimant obtained an MRI on August 15, 1994. (Ex. 10). Results of that MRI, as compared with a previous study, showed that claimant had "a very broad disc herniation or bulging," whereas before there was a more midline disc herniation. (Id.). Dr. Burke, radiologist, reported that claimant had progressive discogenic changes at C6-7.

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[1] Had the aggravation issue been expressly contingent on the parties' surgery dispute, we would have likely deferred action regarding the merits of claimant's aggravation claim. See Lisa L. Daulton, 48 Van Natta 273 (1996). However, since the aggravation issue was not contingent on resolution of the surgery dispute, we have proceeded with our review.

Relying on Dr. Burke's report, Dr. Brett concluded that claimant had a "radiographic" worsening of his condition, as evidenced by the August 1994 MRI, in comparison with his condition in March 1993. (Ex. 19). Dr. Brett further opined that claimant was not medically stationary because surgery could potentially cure his condition.

On September 6, 1994, claimant was examined by Dr. Hummel on behalf of the MCO. (Ex. 11). After reviewing claimant's myelogram and two MRI studies, Dr. Hummel opined that all of claimant's radiologic studies showed essentially the same mild midline posterior protrusion at C6-7. (Ex. 12).

On October 26, 1994, claimant was examined for SAIF by Dr. Fuller. (Ex. 14). Dr. Fuller noted no appreciable difference in the C6-7 disc bulge when comparing the two MRI studies. (Ex. 15).

We generally defer to the treating physician's opinion absent persuasive reasons not to do so. See Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reason not to defer to Dr. Brett's opinion that claimant had a "radiographic" worsening of his cervical spine. His opinion is supported by comparative radiologic studies, and Dr. Burke's opinion that claimant had progressive discogenic changes at C6-7. Furthermore, we conclude that Dr. Brett's opinion establishes that claimant has suffered a "pathological" worsening of his cervical condition. See Carmen C. Neill, supra. Accordingly, claimant has met his burden of proving an aggravation of his compensable condition.

Jurisdiction

The ALJ concluded that SAIF had "de_facto" denied claimant's request for surgery. Therefore, he set aside SAIF's alleged "de_facto" denial.

Subsequent to the ALJ's order, the legislature amended ORS 656.260. 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 [of the Department of Consumer and Business Services (DCBS)] or the director's designated representatives, or as otherwise provided in this section." SB 369, § 27 (emphasis added). After considering the legislature's amendment to ORS 656.260(6), we concluded that exclusive jurisdiction over an MCO's denial of a proposed surgery rests with the Director. Ronald R. Streit, 47 Van Natta 1577 (1995). Accordingly, we vacate that portion of the ALJ's order that set aside SAIF's alleged "de facto" denial of claimant's surgery request.

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

ORDER

The ALJ's order dated March 6, 1995 is vacated in part and affirmed in part. That portion of the order that addressed the medical services issue is vacated for lack of jurisdiction. Claimant's hearing request concerning the "MCO" issue is dismissed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded an assessed attorney fee of $1,000, payable by the SAIF Corporation.

In the Matter of the Compensation of
CHERYL L. LEHNE, Claimant
WCB Case No. 95-02747
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Davis' order that: (1) found that claimant had established good cause for failing to timely request a hearing on the insurer's denial; and (2) set aside the insurer's denial of claimant's occupational disease claim for a bilateral upper extremity condition. On review, the issues are timeliness and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's findings of ultimate facts.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's delay in filing her request for hearing was caused by claimant's reliance on Dr. Nye's opinion that her claim was not compensable. The ALJ further concluded that claimant's reliance on Dr. Nye's opinion constituted good cause for her failure to timely request a hearing on the insurer's denial. Based on the following reasoning, we do not agree that claimant has established good cause for her failure to request a hearing within 60 days.

We briefly set out the relevant facts. Claimant, a dental assistant, began having symptoms in both arms in January 1994. These symptoms involved aching in both forearms with occasional shooting pain above the elbow on the left, and numbness in the small and ring fingers of the left hand when claimant awoke in the morning.

Claimant believed the symptoms were related to her dental assistant job. She left that job in September 1994. In October 1994, she filed a workers' compensation claim for her arm symptoms. Claimant saw Dr. Nye, a hand specialist, on November 8, 1994. Dr. Nye did not feel that claimant's dental assisting duties were sufficient to cause claimant's condition. He believed that claimant's pain and numbness were idiopathic. Apparently, Dr. Nye told claimant that he believed her symptoms were related to the manner in which she slept on her arms.

On December 5, 1994, the insurer denied claimant's claim. Claimant received the denial on December 8, 1994. Claimant understood that the claim was being denied, but did not thoroughly read the denial and did not fully understand the letter. Claimant believed the denial was correct based on Dr. Nye's comments.

Claimant's symptoms got better in January 1995. In January or February 1995, claimant's symptoms resolved. Thereafter, claimant concluded that Dr. Nye's opinion that her condition was not work-related was wrong since the only thing that had changed was that she was no longer working at the dental assisting job. Claimant concluded that her symptoms were caused by her work and decided to challenge the denial of her claim. Claimant saw an attorney on March 3, 1995. Claimant's hearing request was filed the same day.

A request for hearing must be filed not later than the 60th day after claimant is notified of a denial of a claim. Former ORS 656.319(1)(a).[1] A hearing request that is filed after 60 days, but within 180 days of a denial, confers jurisdiction if a claimant had good cause for the late filing. Former ORS 656.319(1)(b). 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(1) and former ORS

[1] We note that ORS 656.319(1) has been amended by the 1995 legislature. Or Laws 1995, ch 332, § 39 (SB 369, § 39). However, according to § 66(6) of SB 369, the 1995 amendments "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 amendments to ORS 656.319 change the procedural time lines for requesting a hearing on a denial, we conclude that the former version of the statute is applicable here. Nevertheless, regardless of whether the former or amended statute is applicable, our decision in this case would be unaffected.

18.160. Anderson v. Publishers Paper Co., 78 Or App 513, 517, rev den 301 Or 666 (1986). Lack of due diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). Claimant has the burden of proving good cause. Id.

Here, when her symptoms went away, claimant realized that Dr. Nye was wrong and decided to appeal the denial. The 60 day appeal period from the December 5, 1994 denial did not run until February 6, 1995. Although at hearing claimant was uncertain whether her symptoms improved in January or February 1995, on review she has adopted the ALJ's factual finding that her symptoms improved in January 1995. (Respondent's Brief, p. 1). Thus, before expiration of the 60-day period to request a hearing from the denial, claimant was aware that the factual premise on which Dr. Nye's opinion was based was not reliable. Under such circumstances, she has failed to establish good cause for her untimely hearing request.

In concluding that claimant had established good cause, the ALJ relied on a footnote in Patricia E. Lee, 44 Van Natta 1048 (1992).[2] The claimant in Lee contended that her failure to timely appeal a denial was caused by her reliance on her physician's opinion that her claim was not compensable. However, the evidence in Lee established that, within the 60-day appeal period, the claimant's physician told her he would support her workers' compensation claim. Under those circumstances, where the claimant was notified within the 60-day period that the doctor supported compensability, we concluded that good cause for failing to appeal the denial within 60 days had not been established.

In Lee, there was evidence that before the 60-day period had run, the claimant was aware that her physician had changed his opinion regarding compensability and was supportive of her claim. In other words, the implication was that since the 60 day period had not run when the claimant discovered that her doctor believed her claim was compensable, she had time to appeal the denial and thus did not establish good cause for her failure to do so.

Here, in her respondent's brief, claimant has adopted the ALJ's factual finding that her symptoms improved in January 1995. (Respondent's Brief, page 1). Because claimant knew that Dr. Nye was wrong after her symptoms improved in January 1995 (within the 60 day appeal period), she, like the claimant in Lee, has failed to establish good cause.

This case is also analogous to Anderson v. Publishers Paper Co., 93 Or App 516 (1988). In Anderson, after working out-of-state, the claimant went to see the employer's physician rather than returning to the physician who had performed the surgery on his hand and forearm. The employer's physician told the claimant that his condition was due to overuse and was related more to his recent employment out-of-state than to his past work for the employer. The claimant received a denial of his claim. He did not file a request for hearing because he did not believe he could do anything about the denial. Prior to the expiration of the 60-day appeal period, the claimant returned to his own physician who noted that the claimant's symptoms were related to his injury with the employer.

The court found that the claimant knew or should have known that his condition was related to his previous injury before 60 days had passed and intentionally did nothing. The court affirmed our decision in Anderson that the claimant had received the employer's denial letter, read it, understood it and chose not to act within 60 days.

Here, as previously noted, claimant has accepted and adopted the ALJ's findings of fact. Since the ALJ found that claimant's symptoms resolved in January 1995, claimant has effectively acknowledged that the circumstances leading to three disagreement with her physician's opinion occurred prior to the expiration of the 60 day appeal period. In other words, as in Anderson, claimant knew or should have known that the basis for her physician's opinion was ill-founded (at least in her opinion) while time still remained to request a hearing from the insurer's denial. Consequently, claimant has not, on this record established good cause for her untimely appeal of the denial.

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[2] In a footnote in Lee, we indicated, in dicta, that we agreed with the basic proposition that an unrepresented worker who does not appeal a denial based on the uncontroverted opinion of her doctor that a claim would not be medically supported, and who promptly appeals the denial after her doctor reverses his opinion, establishes, by such reliance, good cause. The factual scenario set out in the Lee footnote did not occur in this case. In this case, claimant's physician did not change his mind and conclude, after the expiration of the appeal period, that her condition was compensable. Rather, in this case, claimant apparently knew in January 1995, before expiration of the appeal period, that Dr. Nye's opinion was not reliable and that the denial should be challenged.

ORDER

The ALJ's order dated July 5, 1995 is reversed. The insurer's denial is reinstated and upheld. Claimant's hearing request is dismissed as untimely. The ALJ's award of a $2,500 attorney fee is also reversed.

Board Chair Hall specially concurring.

It is claimant's burden to establish good cause. Cogswell v. SAIF, supra. The good cause issue in this case arises in the context of claimant being told by her physician that her condition was not work-related. The case law does not foreclose the possibility that reliance on a physician's opinion may constitute good cause for failure to timely request a hearing on a denial. In the Anderson case cited by the majority, for example, the court left open the question of whether reliance on a physician's opinion could constitute good cause for failing to timely request a hearing. See also Patricia E. Lee, supra, at n. 1 (Board suggested that reliance by a claimant on her physician could, in some circumstances, constitute good cause).

Here, claimant relied on her physician's opinion that her condition was not work-related. I believe that reliance on a physician's opinion can constitute good cause. The question that remains unanswered, however, is when does reliance on a physician's opinion cease being good cause. In the present case, claimant argued that her reliance on her physician's opinion excused her failure to request a hearing. I agree that such reliance can be good cause. However, I believe that good cause, once established, does not evaporate and cease to be good cause unless something objective occurs which terminates good cause.

In this case, I believe the majority has established a subjective standard to determine when good cause ceases. We have found, in essence, that good cause ceases when the claimant realizes that the physician's opinion is wrong. I believe that a subjective standard such as this is problematic. Instead, I believe that the standard for determining when good cause ceases to be good cause should be an objective standard, such as a change in the physician's opinion. In a case where a claimant has established good cause based on reliance on a doctor's opinion, I believe that good cause continues until the claimant has been told by a physician that her condition is work-related.

Although I concur, in this particular case, that claimant has failed to establish that reliance on her physician caused her untimely hearing request, I disagree with the majority's reasoning to the extent that it creates a subjective standard to determine when good cause ceases to exist.

In the Matter of the Compensation of
MONTY L. WALL, Claimant
WCB Case Nos. 95-00999, 95-00460 & 94-08742
ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Yturri, Rose, et al, Defense Attorneys

Liberty Northwest Insurance Corporation requests reconsideration of that portion of the Board's March 26, 1996 Order on Review that affirmed an Administrative Law Judge's (ALJ's) determination that claimant's right hip condition was compensable and Liberty was responsible. Specifically, Liberty requests that we clarify whether the Board's order intended to do anything other than affirm the ALJ's order which held that, due to a previous Claim Disposition Agreement (CDA), claimant was entitled only to medical benefits for his right hip condition.

We withdraw the Board's March 26, 1996 order for reconsideration. After considering Liberty's motion and supporting memorandum, we adhere to the Board's prior order and offer the following clarification.

At hearing and on review, Liberty disputed the compensability of and its responsibility for claimant's right hip condition. The ALJ found claimant's right hip condition compensable and Liberty

responsible. In doing so, the ALJ explained that, since claimant had entered into a CDA on his accepted right knee claim, and if the right hip condition were found to be compensably related to the accepted right knee claim, then the only benefits available to claimant on the right hip condition would be medical services. The Board agreed with that reasoning. However, since there was no dispute concerning the ALJ's reasoning regarding the effect of the CDA, the Board had no occasion to discuss or reiterate the ALJ's reasoning on that issue. Therefore, in the Board's original order, the ALJ's order was simply affirmed, with supplementation to clarify the basis on which the Board found claimant's right hip condition compensable and Liberty responsible. The Board's silence regarding the effect of the CDA should not be interpreted as in any way undermining or disavowing the ALJ's reasoning on that issue.

The ALJ's order provided, in relevant part, that Liberty's January 18, 1994 denial of claimant's right knee and hip condition was set aside insofar as it denied the compensability of claimant's current medical services claim. In its original order, the Board affirmed the ALJ's order. In doing so, the Board intended no more nor less than to affirm the ALJ's order regarding the right hip condition.

Accordingly, on reconsideration, as clarified herein, we adhere to and republish the Board's March 26, 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
REX BRINK, Claimant
WCB Case No. 95-04411
ORDER ON REVIEW
Max Rae, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that upheld the insurer's denial of his occupational disease claim for bilateral carpal tunnel syndrome and bilateral trigger fingers. 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, age 58 at the time of hearing, has worked for more than 25 years as a maintenance technician, installing cable television hookups. He first noticed pain and locking in his left thumb and fingers and numbness and tingling in his wrists. Dr. Ellison diagnosed bilateral carpal tunnel syndrome, left greater than right, and left and right trigger fingers. Dr. Ellison performed release surgery on claimant's left trigger fingers and left wrist on April 10, 1995, and on the right trigger finger and right wrist on May 15, 1995.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to establish that his work activities were the major contributing cause of his bilateral carpal tunnel syndrome and trigger fingers. In so finding, the ALJ rejected claimant's challenge to the major contributing cause standard of ORS 656.802 and the exclusive remedy provision of amended ORS 656.018(1) under Article I, Section 10 of the Oregon Constitution. In addition, the ALJ held that the Hearings Division lacked jurisdiction to consider claimant's challenge to the definition of "preexisting condition" in amended ORS 656 under the Americans With Disabilities Act (ADA).

After reviewing the medical evidence, we agree with the ALJ that claimant has failed to sustain his burden under the occupational disease statute, ORS 656.802(2). The causation of claimant's bilateral

carpal tunnel syndrome and trigger fingers involves a complicated medical question, and therefore expert medical opinion is necessary for claimant to prove compensability. See Uris v. Compensation Dept., 247 Or 420 (1967). Although both Dr. Ellison, claimant's treating physician, and Dr. Filarski, a consulting orthopedic surgeon, attributed claimant's carpal tunnel syndrome and trigger fingers in major part to his work activities, neither doctor explained why claimant's trigger finger symptoms were worse on the left when claimant, who is right handed, predominantly uses his right hand at work. In addition, neither physician considered the relative contribution of other, non-work related factors, as is required under the major contributing cause analysis. See Dietz v. Ramuda, 130 Or App 387 (1994) (determining major contributing cause involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the *primary* cause). Accordingly, like the ALJ, we find the opinions of Drs. Ellison and Filarski conclusory and insufficient to establish medical causation. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980) (unexplained medical report discounted).

We note that Dr. Radecki, who examined claimant on the insurer's behalf, attributed claimant's finger and wrist condition to aging, heredity and/or idiopathic factors, and opined that claimant's work activity was, at most, a minor cause of his trigger fingers and median nerve slowing in the carpal tunnel. Claimant argues that Dr. Radecki's opinion is based on a flawed statistical analysis and contrary to conventional medical wisdom concerning the etiology of soft-tissue disorders. In addition, claimant contends that, to the extent his age, heredity, body mass or wrist size affected his condition, these factors are mere predispositions rather than actual causes. Even if we rejected Dr. Radecki's opinion as unpersuasive and did not consider "predisposing" factors as preexisting conditions,[1] for the reasons previously discussed we find no persuasive medical evidence establishing the compensability of claimant's occupational disease claim. Consequently, we need not resolve the specific contentions raised by claimant in challenging Dr. Radecki's opinion.

On review, claimant renews his contention that the major contributing cause standard set forth in ORS 656.802, applied in conjunction with the exclusive remedy provision of amended ORS 656.018(1), effectively deprives him of a remedy in violation of Article I, section 10 of the Oregon Constitution. Claimant also challenges our decision in Jim M. Greene, 47 Van Natta 2245 (1995), to the extent we held that a claimant must first obtain a legal ruling that amended ORS 656.018 prohibits a civil action regarding the allegedly work-related condition before his or her constitutional challenge to the major contributing cause standard is ripe. Claimant argues that he should not be required to engage in the "frivolous and futile act" of filing a circuit court action and having that action dismissed for failure to state a claim before the Board will consider his constitutional challenge. We adhere to the reasoning expressed in Greene.

It is a fundamental rule that courts will not decide a case upon constitutional grounds unless absolutely necessary to determination of the issue before it. See State v. House, 299 Or 78, 81 (1985); Elliott v. Oliver, 22 Or 44 (1892). Even where a constitutional question may be legitimately presented by the record, we, like the courts, are not inclined to consider the issue unless it is essential to the disposition of the case. See Jim M. Greene, supra, citing McKinney v. Watson, 74 Or 220, 223 (1915). In this case, as in Jim M. Greene, supra, we do not consider claimant's Article 1, Section 10 challenge because claimant has not demonstrated that he has been injured by operation of amended ORS 656.018.

Finally, we adopt and affirm the ALJ's conclusion that claimant's ADA challenge to amended ORS 656.005(24) falls outside the Board's jurisdiction. See Sandra J. Way, 45 Van Natta 876 (1993), aff'd on other grounds, Way v. Fred Meyers, Inc., 126 Or App 343 (1994). We, therefore, do not address claimant's federal preemption argument.

ORDER

The ALJ's order dated November 22, 1995 is affirmed.

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[1] Under amended ORS 656.005(24), a "preexisting condition" includes any condition that contributes or predisposes a worker to disability or need for treatment.

In the Matter of the Compensation of
JULIANNE CARTWRIGHT, Claimant
WCB Case No. 94-06978
ORDER ON REVIEW
Foss, Whitty, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) McWilliams' order which: (1) declined to admit a medical report (Exhibit 70) into evidence; (2) set aside its denial of claimant's aggravation claim for a low back condition; and (3) awarded a 25 percent penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are evidence, aggravation and penalties. We affirm in part, modify in part, and reverse in part.

FINDINGS OF FACT

Claimant, a certified nursing assistant, sustained a compensable low back injury on March 28, 1993. After seeking medical treatment from several physicians (Drs. Boye, Garcia and Patel), claimant eventually came under the care of Dr. Kirkpatrick, a neurosurgeon, who performed a L4-5 discectomy and nerve root decompression on August 25, 1993. Although the insurer had initially accepted a low back strain, it later expanded its acceptance on November 17, 1993 to include the L4-5 disc herniation. (Ex. 30).

On January 27, 1994, the insurer issued a partial denial of a mild bulging disc at L5-S1. In the meantime, the insurer closed the accepted portion of the claim on March 4, 1994 by Determination Order which awarded 46 percent unscheduled permanent disability and determined claimant to be medically stationary on January 14, 1994. Reconsideration of the Determination Order was not requested.

On April 12, 1994, claimant sought care from Dr. Silver, reporting that she had aggravated her back four days previously while lifting a patient at work. (Ex. 44). Dr. Silver diagnosed chronic low back pain, as well as an aggravation of a prior work-related low back injury. Dr. Silver began authorizing temporary disability. (Exs. 45, 50).

In a stipulation approved on May 11, 1994, the insurer agreed to withdraw its January 27, 1994 denial. The insurer also agreed that the denial was "void" and that it would "process the claim in accordance with applicable statutes and regulations." (Ex. 55).

On June 1, 1994, the insurer issued another denial. (Ex. 58). The denial letter stated that the insurer was denying claimant's "claim for benefits" on the ground that her treatment and temporary disability did not arise out of and in the course of her employment. The denial letter also explained that medical information did not indicate that there was a new claim or that there was an aggravation claim with respect to the previously accepted low back claim. Claimant appealed the denial.

CONCLUSIONS OF LAW AND OPINION

At the September 8, 1994 hearing, claimant described the issues as the insurer's denial, as well as current condition, aggravation, temporary disability, penalties and attorney fees for unreasonable denial and failure to process the L5-S1 claim pursuant to the parties' stipulation. (Tr. 3). The insurer's counsel did not dispute claimant's characterization of the issues. After testimony was taken, the hearing was continued for the deposition of Dr. Silver.

On November 8, 1994, the insurer offered a medical report (Exhibit 70) from Dr. Sasser, a psychiatrist. The ALJ sustained claimant's objection to its admission into the record on the ground that the sole purpose of the continued hearing was for the deposition of Dr. Silver.

Regarding the merits of the parties' dispute[1], the ALJ reasoned that, when the insurer agreed to process the L5-S1 claim in the May 11, 1994 stipulation, there was an open claim with respect to that

[1] The ALJ's order issued on May 2, 1995. However, the employer moved for reconsideration on May 24, 1995. On May 26, 1995, the ALJ issued an abatement order, allowing claimant time to respond to the employer's argument. Following enactment of Senate Bill 369 on June 7, 1995, the ALJ gave the parties the opportunity to address the affect of those legislative amendments to Chapter 656. The ALJ issued an amended order on October 19, 1995.

condition. Concluding that claimant was not seeking medical treatment for a new injury or condition different from the accepted disc herniation conditions at L4-5 and L5-S1, the ALJ determined that claimant had sustained her burden of proving a compensable aggravation claim. The ALJ reasoned that Dr. Silver's deposition testimony, which indicated that claimant's increased symptomatology was due to scarring and increased nerve root irritation, established that claimant's low back condition had "actually worsened." See ORS 656.273(1).

Finally, the ALJ assessed a 25 percent penalty under ORS 656.262(11) because of the insurer's allegedly unreasonable pre-closure partial denial issued after it had accepted claimant's L5-S1 condition in the May 1994 stipulation. Although determining that the insurer unreasonably failed to process the L5-S1 claim to closure, the ALJ declined to award an additional penalty because of the prior penalty assessment.

On review, the insurer contends that the ALJ should have admitted Dr. Sasser's medical report. The insurer also asserts that the ALJ erred in raising and addressing the procedural validity of the June 1, 1994 denial when claimant did not do so. Finally, the insurer argues that the aggravation denial should have been upheld because claimant did not prove a compensable worsening of her low back condition. We conclude, for the following reasons, that, while there was no abuse of discretion in excluding Dr. Sasser's medical report, the insurer's denial of claimant's aggravation claim should be upheld.

Evidence

ALJ's are not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. They may conduct a hearing in any manner that will achieve substantial justice. ORS 656.283(7); Armstrong v. SAIF, 67 Or App 498 (1984). We review the ALJ's evidentiary rulings for abuse of discretion. See James D. Brusseau II, 43 Van Natta 541 (1991).

In this case, we do not find that the ALJ abused her discretion in excluding Dr. Sasser's medical report where the hearing was continued for the sole purpose of Dr. Silver's deposition. (Tr. 1). To the extent that the insurer's argument can be construed as a motion to remand, we deny such motion because, based on the following discussion, the evidence that the insurer seeks to have introduced is not reasonably likely to affect the outcome of the case. See Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Claim processing

As previously noted, the ALJ concluded that the June 1, 1994 denial was an invalid "pre-closure" partial denial of the L5-S1 claim the insurer accepted in the May 1994 stipulation. The insurer contends that the ALJ should not have raised and decided an issue concerning the procedural validity of its denial because claimant never raised the issue. See Nikki Burbach, 46 Van Natta 265, 268 (1994) (ALJ's review limited to issues raised by the parties); but see Zinaida I. Martushev, 46 Van Natta 1601, on recon 46 Van Natta 2410, 2411 (1994) (the claimant's contention that the employer's "pre-closure" denial was invalid addressed on reconsideration). We disagree with that contention, given that claimant raised the issues of unreasonable denial and of failure to process an open claim. (Tr. 3). Therefore, we find that claimant sufficiently raised a challenge to the procedural validity of the insurer's denial. Having made that determination, we, nevertheless, disagree with the ALJ's conclusion that the insurer denied an "open" claim.

When the March 4, 1994 Determination Order issued, claimant's L5-S1 disc bulge had been denied. It was not until after the Determination Order had issued that the insurer agreed to "withdraw" its denial of the disc bulge and "process" the claim. However, for the following reasons, we do not construe the insurer's agreement as requiring it to "reopen" the claim and process the claim to another closure.

The insurer's stipulation that it would "withdraw" its denial and "process" the claim meant that it was responsible for claimant's L5-S1 disc bulge and was, therefore, obligated to pay the benefits to which claimant was entitled. On the other hand, the insurer's agreement to "process" the claim did not automatically require it to "reopen" the claim when claimant never requested reconsideration of the March 4, 1994 Determination Order.

Finality attaches to uncontested closure orders, barring future litigation of any issue determined by the order. See e.g., Hammon Stage Line v. Stinson, 123 Or App 418, 423 (1993). Inasmuch as claimant never contested the March 1994 claim closure, we conclude that the March 4, 1994 Determination Order is "final" and claimant is barred from challenging it. See Rex A. Howard, 46 Van Natta 1265, 1266 (1994); see also Terrance Nohrenberg, 47 Van Natta 2005, 2007 n. 5 (1995). Moreover, even if claimant could challenge the Determination Order on the ground that it prematurely closed her claim, we would, nevertheless, find that all of claimant's compensable conditions were medically stationary at claim closure.

A claim is not prematurely closed simply because a compensable condition was in a denied status at the time of the Determination Order. Virgil R. Hutson, 43 Van Natta 2556, 2557 (1991), aff'd Hutson v. Precision Construction, 116 Or App 10 (1992). To establish that the L5-S1 disc bulge claim was "open" at the time of the June 1, 1994 denial, claimant must show that the denied L5-S1 disc bulge was not medically stationary at the time of claim closure on March 4, 1994. Virgil Hutson, supra. For the following reasons, we conclude that this condition was medically stationary at claim closure.

Dr. Kirkpatrick performed surgery at L4-5 on August 25, 1993. A bulging disc at L5-S1 was also identified by MRI scan, but this condition did not require surgery. After some initial improvement with surgery, claimant continued to experience significant low back pain. On January 11, 1994, Dr. Kirkpatrick recommended a lumbar CT scan. (Ex. 34). Dr. Kirkpatrick's chart note on that date states that he requested that claimant call him later that week to discuss the results of the CT scan. Id.

Claimant called Dr. Kirkpatrick's office on January 14, 1994, as instructed, to determine the results of the CT scan performed on January 11, 1994. (Ex. 36-2). On January 18, 1994, Dr. Kirkpatrick declared claimant medically stationary as of January 14, 1994, the date of claimant's phone call. (Ex. 36-1). Dr. Kirkpatrick commented that the disc bulge at L5-S1 would not require treatment and would not result in temporary disability or permanent impairment. Id.

The ALJ found Dr. Kirkpatrick's January 18, 1994 declaration that claimant was medically stationary unpersuasive because Dr. Kirkpatrick never examined claimant on that date. However, the ALJ misread Dr. Kirkpatrick's January 18, 1994 report.

Clearly, Dr. Kirkpatrick declared claimant medically stationary as of January 14, 1994, the date of claimant's phone call. While a medically stationary date corresponding to January 11, 1994 may have been more appropriate, we are persuaded, in light of Dr. Kirkpatrick's comment that the L5-S1 disc bulge required no treatment and would result in no permanent impairment or temporary disability, that claimant was medically stationary from all compensable conditions, including the L5-S1 disc bulge, prior to the March 1994 claim closure. (See also Ex. 59).

Having determined that claimant's disc bulge was medically stationary at the time of the March 1994 claim closure, the employer is correct that its agreement to "process" the L5-S1 disc bulge claim in the May 1994 stipulation did not obligate it reopen the low back claim and process the L5-S1 claim to another claim closure. Virgil Hutson, supra. It further follows that, inasmuch as the March 1994 Determination Order was a valid claim closure, the insurer's June 1, 1994 denial was not a "pre-closure" partial denial of an open claim.[2] We now proceed to an analysis of the insurer's contention that claimant failed to prove a compensable worsening.

Aggravation

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." (emphasis added). The 1995 amendments do not define the term "actual worsening." Under former ORS 656.273(1), a symptomatic or pathologic worsening was sufficient to establish an aggravation. E.g., Caroline F. Wood, 46 Van Natta 2278 (1994).

[2] In light of this conclusion, we do not address the merits of the ALJ's reasoning regarding the affect of amended ORS 656.262(6)(c) on this claim.

Subsequent to the ALJ's order, we issued our order 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 that is in excess of the waxing and waning contemplated by a prior award of permanent disability.

The ALJ, here, found that claimant had sustained a pathological worsening of claimant's L5-S1 condition based on Dr. Silver's deposition testimony that claimant's increased symptomatology was the result of scarring or increased never irritation at L5. (Ex. 69-38). The ALJ cited the January 11, 1994 CT scan, which was interpreted as showing scarring from claimant's L4-5 surgery, as support for Dr. Silver's opinion. (Ex. 35). However, we do not find that this CT scan provides persuasive evidence of an "actual worsening" since the March 1994 claim closure because it preceded both the claim closure and claimant's alleged worsening in April 1994. Janet L. Lundsten, 46 Van Natta 1747 (1994) (In order to prove a compensable aggravation, a claimant must prove that the compensable condition has worsened since the last award of compensation).

An MRI scan was performed in July 1994. It was interpreted as showing scarring at the site of claimant's previous surgery, but the radiologist concluded that there was no significant abnormality revealed by the MRI. (Ex. 58C-2). There is no indication that claimants' scarring had worsened since the previous diagnostic study in January 1994. Under these circumstances, we conclude that this diagnostic evidence also does not support a pathological worsening of claimant's low back condition as a result of the April 1994 aggravation claim.

Dr. Silver testified that he believed that the July 1994 MRI showed some inflammation around the nerve roots in claimant's low back. (Ex. 69-10). However, he was unable to determine the etiology of that finding. Moreover, Dr. Silver testified that he was not sure if he reviewed the MRI or had just reviewed the radiologist's interpretation. After reviewing the radiologist's report of the July 1994 MRI, he conceded that a finding of inflammation was not present in the report. (Ex. 69-12).

Based on our review of both the diagnostic studies and Dr. Silver's testimony, we are not convinced that claimant experienced a pathological worsening of her low back condition. Indeed, the preponderance of the medical evidence indicates that claimant's worsening consisted of increased symptoms only. (Exs. 51, 58AA, 58A, 58AB, 58C, 65).

Claimant has received a total of 46 percent unscheduled permanent disability. Dr. Kirkpatrick, who was treating claimant at the time of the March 4, 1994 claim closure and who reexamined claimant on June 14, 1994, after claimant's alleged aggravation, agreed that claimant's condition represented normal waxing and waning from a medically stationary injury. (Ex. 58AA). Inasmuch as Dr. Kirkpatrick examined claimant in January 1994 and after the alleged aggravation in April 1994, we find his medical opinion persuasive. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986). 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.[3] Cf. Soilo C. Diaz, 48 Van Natta 371 (1996) (where the claimant had received 50 percent unscheduled permanent disability, symptomatic worsening did not exceed the waxing and waning contemplated by prior disability award).

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[3] In reaching this conclusion, we acknowledge that the record was developed and closed 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, supra. However, in this case, the parties developed medical evidence addressing whether claimant's symptomatic worsening exceeded the "waxing and waning" contemplated by his prior permanent disability award. (e.g. Ex. 58AA). 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 Soilo C. Diaz, supra; 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).

Accordingly, we find that claimant has failed to sustain her burden of proving that her compensable low back condition "actually worsened." The ALJ's decision setting aside the insurer's denial of claimant's aggravation claim is reversed.

Finally, the ALJ determined that claimant is not seeking treatment for a condition or injury different from the accepted disc conditions. The insurer does not challenge the ALJ's causation finding on review. In addition, we agree with the ALJ's finding. Accordingly, we set aside the insurer's denial to the extent that it denies the compensability of claimant's current low back condition. Claimant's attorney is, thus, entitled to an assessed fee for services at hearing concerning the compensability issue. ORS 656.386(1).

However, since the ALJ awarded a $5,000 attorney fee for overturning the insurer's aggravation denial and we have decided that only the current condition portion of the denial should be set aside, it is necessary to modify the ALJ's attorney fee award. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing concerning the compensability issue is $3,000, 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.

Penalties and Attorney Fees

The ALJ assessed a 25 percent penalty because of the insurer's allegedly unreasonable "preclosure" denial, finding that there was no justification for the issuance of the insurer's June 1, 1994 denial. However, we have found that the June 1, 1994 denial was not issued prior to a valid claim closure. We, accordingly, conclude that the insurer's issuance of the June 1, 1994 denial of claimant's April 1994 aggravation claim was not unreasonable and reverse the ALJ's penalty assessment.

ORDER

The ALJ's order dated May 2, 1995, as amended on October 19, 1995, is reversed in part, modified in part and affirmed in part. That portion which set aside the insurer's denial of aggravation is reversed. The insurer's June 1, 1994 denial of aggravation is reinstated and upheld to the extent that it denies that claimant's low back condition has worsened. The insurer's denial is set aside to the extent that it denies the compensability of claimant's current low back condition. That portion of the ALJ's order which awarded a 25 percent penalty is also reversed. In lieu of the ALJ's $5,000 attorney fee award, claimant's counsel is awarded an attorney fee of $3,000, payable by the insurer. The remainder of the ALJ's order is affirmed.

April 25, 1996 Cite as 48 Van Natta 922 (1996)

In the Matter of the Compensation of
JOYCE A. CRUMP, Claimant
WCB Case No. 93-08718
ORDER ON REMAND
Ransom & Gilbertson, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Crump v. Safeway Stores, Inc., 138 Or App 702 (1996). The court has reversed our prior order, Joyce A. Crump, 47 Van Natta 466 (1995), which had held that the self-insured employer's failure to comply with the disclaimer notice provisions of former ORS 656.308(2) did not relieve claimant from her burden of proving the compensability of her right knee injury claim. Citing Volk v. America West Airlines, 135 Or App 565 (1995), the court has remanded for reconsideration in light of the 1995 amendments to ORS 656.308.

After conducting our reconsideration, we adhere to our prior decision that claimant's right knee condition is not compensable.[1] We supplement that conclusion with the following reasoning.

To begin, we hold that the notice of disclaimer provisions of former ORS 656.308(2) remain applicable. In reaching this conclusion, we rely on the reasoning expressed by the court in Motel 6 v. McMasters, 135 Or App 583(1995), which determined that, since the "60-day" filing requirement of former ORS 656.308(2) involved a procedural time limit, the amendments to ORS 656.308(2) were not retroactively applicable. See John W. Gray, Jr., 47 Van Natta 2303 (1995). Here, since the issue pertains to the employer's failure to issue a responsibility disclaimer within the 30-day period provided in former ORS 656.308(2) we likewise conclude that the former statute involved a procedural time limit and, as such, the amended version of the statute cannot be retroactively applied.

In any event, even if the aforementioned statutory amendments were applicable, their application would have no effect on the outcome of this case. In other words, for the reasons expressed in our prior opinion, the responsibility requirements of ORS 656.308(2) only become relevant if claimant establishes the compensability of her disputed right knee condition. Since we continue to find the condition not compensable, the responsibility denial provisions of amended ORS 656.308(2) have no relevance.

Finally, in reaching our conclusion regarding the compensability of claimant's right knee condition, we continue to find that her work-related injury combined with her preexisting condition.[2] Therefore, since the work injury was not the major contributing cause of claimant's current right knee condition (whether that condition is identified as "resultant" or "combined"), the condition is not compensable under either version of ORS 656.005(7)(a)(B).

Accordingly, on reconsideration, as supplemented and modified herein, we republish our March 29, 1995 order.

IT IS SO ORDERED.

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[1] We note that this case arose from claimant's hearing request which raised as an issue a "de facto" denial of her right knee condition. Inasmuch as the employer had previously accepted claimant's low back condition in connection with this same injury claim, this matter could arguably involve either an objection to the employer's notice of claim acceptance or a new medical condition claim. See ORS 656.262(6)(d), (7)(a). We need not resolve those questions because, considering the employer's consistent opposition to the compensability of claimant's right knee condition, it would be unnecessary to remand this claim for compliance with either one of those statutory procedures. See Renee Willshire, 47 Van Natta 1339 (1995). Consequently, we have proceeded with our review of the parties' compensability dispute.

[2] The medical evidence on which we relied in our prior decision also persuasively establishes that claimant had a "preexisting condition" under amended ORS 656.005(24) which "combined" with claimant's industrial injury.

Board Chair Hall dissenting.

I agree with that portion of the majority's reasoning which concludes that since the "30-day" filing requirement of former ORS 656.308(2) involves a procedural time limit, the amendments to that statute are not retroactively applicable. See Motel 6 v. McMasters, 135 Or App 583 (1995); John W. Gray, Jr., 47 Van Natta 2303 (1995). However, for the reasons previously expressed in my dissenting opinion in Joyce A. Crump, 47 Van Natta 466 (1995), I continue to believe that, by virtue of the employer's failure to comply with the disclaimer notice provisions, the employer cannot effectively rely on a "responsibility" defense by asserting that claimant's prior employment-related injury constitutes a "preexisting condition" which is the major contributing cause of her current "combined" condition. As I previously explained, such a conclusion renders the disclaimer provisions meaningless and allows carriers to flaunt their claim processing responsibilities.

In the Matter of the Compensation of
MARY A. DYER, Claimant
WCB Case Nos. 95-05955 & 95-05859
ORDER ON REVIEW
Bischoff, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

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, and the contingent nature of the fee 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 16 exhibits, five of which were generated by claimant's counsel. The transcript consisted of 17 pages, and the hearing lasted approximately 40 minutes. Claimant's counsel did not present a statement of services.

The Order on Reconsideration challenged by the employer awarded $6,094.43 in compensation. Claimant's counsel skillfully advocated claimant's position of 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 October 3, 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 Chair Hall 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).

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. Taking into consideration all the factors in OAR 438-015-0010(4), the ALJ's attorney fee award in this case was reasonable. This is especially true in light of the fact that claimant's counsel's efforts preserved an unscheduled permanent disability award of $6,094.43. I also note that, if the employer had prevailed in its efforts to reduce this award to zero, claimant would not have been entitled to vocational assistance benefits in the future. Therefore, I would affirm the ALJ's award.

In the Matter of the Compensation of
RANDY L. FIELDS, Claimant
WCB Case No. 95-07323
ORDER ON REVIEW
Scott M. McNutt, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Christian.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for lumbar and thoracic strains relating to an October 1994 work-related motor vehicle accident. In March 1995, claimant's symptoms worsened; claimant's treating orthopedic surgeon, Dr. Bert, recommended back surgery. The insurer denied the current back condition.

The ALJ found that claimant has preexisting spondylolisthesis and spondylolysis and that such conditions combined with his October 1994 work injury. The ALJ further found that the work injury was the major contributing cause of claimant's need for treatment and, therefore, concluded that claimant proved compensability of his current condition. Amended ORS 656.005(7)(a)(B). The insurer challenges this conclusion, asserting that the medical evidence shows that claimant's need for treatment was for his preexisting conditions.

In concluding that claimant satisfied this statute, the ALJ relied upon the opinions of Dr. Bert and consulting orthopedic surgeon Dr. Kitchel. According to both physicians, claimant has preexisting spondylolisthesis. (Exs. 33-1, 34). Dr. Bert also diagnosed a herniated disc at L4-5. (Exs. 34, 36). Dr. Bert indicated that the October 1994 motor vehicle accident caused the disc herniation and "aggravated" the spondylolisthesis by causing further disc slippage, resulting in increased pain. (Ex. 36-1). Dr. Bert found that the October 1994 incident was the "major cause of symptoms and the current need for treatment." (Id. at 2).

Dr. Kitchel first indicated that the spondylolisthesis was the major cause of claimant's need for surgery. (Ex. 33-1). Dr. Kitchel subsequently explained that claimant's muscular strain caused by the accident had significantly improved or resolved by March 1995 and that claimant's continuing symptoms were from the spondylolisthesis condition. (Ex. 37-7, 37-11). Because the preexisting condition had not been symptomatic before the October 1994 injury, however, Dr. Kitchel found that the incident caused

the spondylolisthesis to become symptomatic. (Exs. 35, 37-8). In this context, Dr. Kitchel agreed that the preexisting condition combined with the October 1994 accident to create the need for treatment and claimant's disability. (Ex. 37-11). Dr. Kitchel expressed doubt, however, that the spondylolisthesis had pathologically worsened as a result of the October 1994 accident, explaining that, for the trauma to have caused increased slippage, it would have also caused a fracture of the vertebra, which was not present in claimant's case. (Id. at 9-10).

In evaluating the medical opinions, we first find persuasive reasons not to rely on Dr. Bert's opinion. Weiland v. SAIF, 64 Or App 810 (1983). After Dr. Bert provided his opinion, he performed surgery and found no herniated disc. (Ex. 36A). Thus, we discount that portion of his opinion indicating that the October 1994 incident caused a herniated disc. In stating that the incident aggravated claimant's spondylolisthesis by causing increased slippage, we understand Dr. Bert to indicate that the accident pathologically worsened the preexisting condition. In view of Dr. Kitchel's explanation, however, that there is no increased slippage in the absence of a fractured vertebra, we also are not persuaded by this portion of Dr. Bert's opinion.

According to Dr. Kitchel, claimant's compensable strain conditions were having little or no effect on claimant's condition and the preexisting spondylolisthesis was the cause of claimant's symptoms. His agreement that claimant's preexisting condition had combined with the October 1994 incident was in the context that the event had caused the spondylolisthesis to become symptomatic. We find the opinion insufficient to satisfy amended ORS 656.005(7)(a)(B).

That statute provides:

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

When interpreting a statute, we begin with its text and context. PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). Here, we find that the text of ORS 656.005(7)(a)(B) clearly indicates that, when a preexisting condition combines with a compensable injury, the compensable injury must be the major contributing cause of the disability or the need for treatment of the combined condition.[1] Accord Dietz v. Ramuda, 130 Or App 397 (1994) (interpreting former ORS 656.005(7)(a)(B)).

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[1] Although, having found the text of the statute clear, we need not resort to legislative history, PGE v. Bureau of Labor and Industries, supra, 317 Or at 611-12, we note that the legislative history of ORS 656.005(7)(a)(B) supports our interpretation. Representative Mannix testified:

> "If [the injury is] otherwise compensable and it combines at any time with that preexisting condition to cause or prolong disability the resultant condition is compensable only if, so long as, and to the extent that. In other words, when that combination is over you are no longer at major contributing cause--it drops off again.
>
> "* * * * *
>
> "[For example,] say you have degenerative disc disease * * * and you suffer a strain and the strain combined with your degenerative disc disease * * * to make your immediate disability greater than it would have been. * * * But eventually the strain resolved or becomes a very minimal strain, it's still interacting some with the degenerative disc disease. * * * That strain will remain compensable but the degenerative disc disease is no longer going to be eligible for treatment as part of your claim because the injury is not the major contributing cause of that degenerative disc disease." Tape Recording, House Committee on Labor, March 1, 1995, Tape 39A.

Governor Kitzhaber similarly testified:

> "So treatment of symptoms of the preexisting condition are compensable, but only if it can be demonstrated that the compensable injury is the major contributing cause of the need for treatment. So, essentially, what I am telling you here is that the distinction we need to draw is not between the major contributing cause and the need for treatment, but rather we need to clarify the language for the courts that one must clearly show that the compensable injury is the major contributing cause." Tape Recording, House Committee on Labor, March 13, 1995, Tape 53A.

Because there is little or no contribution from claimant's compensable strain, the major contributing cause of claimant's need for treatment is his preexisting spondylolisthesis. Thus, claimant did not carry his burden under ORS 656.005(7)(a)(B).

Our conclusion is not changed by Dr. Kitchel's opinion that the October 1994 injury caused the preexisting condition to become symptomatic. Under ORS 656.005(7)(a)(B), the dispositive question is whether the compensable injury or the preexisting condition is the major cause of the need for treatment and/or disability. Here, claimant's symptoms are from the preexisting spondylolisthesis; thus, the major contributing cause of his need for treatment is the preexisting condition.

There is no dispute that the remaining opinions do not support causation. Consequently, we conclude that claimant did not prove the compensability of his spondylolisthesis. ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated December 18, 1996 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

April 25, 1996 Cite as 48 Van Natta 927 (1996)

In the Matter of the Compensation of
RICHARD E. STIENNON, Claimant
WCB Case No. 95-03302
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Lane, Powell, et al, Defense Attorneys

Reviewed by Board Members Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that declined to award temporary disability. On review, the issue is temporary disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and briefly summarize the pertinent facts as follows:

Claimant sustained a compensable injury on July 11, 1988, which resulted in a herniated disc at the C5-6 level. Claimant had surgery and the claim was closed by a March 5, 1990 Determination Order, which awarded 28 percent unscheduled permanent disability.

In December 1991, claimant's elderly parents moved in with claimant and his wife, and claimant and his wife began providing health care for claimant's ailing father. In the spring of 1992, claimant began receiving monthly payments from the State of Oregon to assist with his father's care. In September 1992, claimant enrolled at Southwestern Oregon Community College as a full-time student.

On December 1, 1993, claimant sought treatment for recurring and progressive pain in his neck and upper extremities. Claimant dropped out of school in February 1994 because of continuing neck pain. Meanwhile, claimant's father passed away in August 1994.

The insurer's denial of claimant's aggravation claim was set aside by an earlier ALJ's February 21, 1995 order. The insurer then accepted claimant's aggravation claim, but denied that claimant was entitled to time loss benefits because he was not in the work force at the time of his aggravation. Claimant requested a hearing.

CONCLUSIONS OF LAW AND OPINION

The parties framed the issue as whether claimant was in the work force at the time of his aggravation. In that regard, the ALJ found that claimant was in the work force on December 1, 1993 because he was being paid for the in-home care of his elderly father. The ALJ concluded, however, that since there was no evidence indicating that claimant was unable to continue caring for his father in the aftermath of his aggravation, claimant had not established an entitlement to time loss benefits.

Claimant contends on review that he is entitled to temporary disability benefits because he was not able to continue with a substantial portion of his caregiver duties after his aggravation. In addition, claimant contends that his worsened condition prevented him from undertaking other employment as a maintenance worker.

We agree with and adopt the ALJ's conclusion that claimant was in the work force at the time of his aggravation. Claimant was under contract with the state to provide in-home services to his father (Ex. 60A) and was paid wages by the Senior and Disabled Services Division. (Ex. 60B). In addition, claimant received $300 a month from his parents for the in-home health care. (Tr. 9). Therefore, claimant was "employed" at the time of his aggravation. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989) (a worker is in the work force if engaged in "regular and gainful employment").

We disagree, however, with the ALJ's conclusion that claimant was not entitled to time loss because he did not prove he was unable to perform this in-home health care work. Claimant has established an entitlement to temporary disability benefits because he was in the work force at the time of his aggravation.[1] To the extent the insurer contends the amount of those benefits should be zero because claimant has not experienced any actual wage loss, that is a claim processing issue which is not currently before us.[2]

Claimant's attorney is entitled to an "out-of-compensation" fee equal to 25 percent of any increased compensation resulting from this order, not to exceed $3,800, payable directly to claimant's attorney. OAR 438-015-0055(1).

ORDER

The ALJ's order dated November 13, 1995 is reversed. Claimant's temporary disability claim is remanded to the insurer for processing according to law. Claimant's attorney is awarded a fee equal to 25 percent of the increased temporary disability, if any, resulting from this order, not to exceed $3,800, payable directly to claimant's attorney.

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[1] The insurer issued a denial of time loss benefits solely on "work force" grounds. The denial states "[i]nformation in our file indicates you were not an active member of the work force at the time of your aggravation." (Ex. 73-1).

[2] If there is a subsequent dispute concerning the calculation of temporary disability benefits, the parties may request a hearing at that time to resolve the claim processing dispute.

In the Matter of the Compensation of
JEFFREY C. MICHAEL, Claimant
WCB Case No. 95-07698
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order which set aside its denial of claimant's aggravation claim for his current low back condition. On review, the issue is aggravation. We reverse.

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

Relying on the opinion of Dr. Flaiz, attending physician, the ALJ found that claimant's worsened condition was attributable to his compensable injury. On review, the insurer contends that there is no medical evidence which supports a finding that claimant's compensable condition (lumbar strain) has worsened.

To establish a compensable aggravation, claimant must show an actual worsening resulting from the original injury. ORS 656.273(1)[1]; Gloria T. Olson, 47 Van Natta 2348 (1995). An aggravation has two components: (1) "actual worsening;" and (2) a compensable condition. 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. ORS 656.273(8).

In April 1993, claimant developed low back and left leg pain while working. Dr. Gamber, examining physician, diagnosed lumbosacral strain with probable disc involvement. (Ex. 2). Results of an April 1993 MRI of claimant's lower back revealed a small disc herniation at L4-5 and no evidence of disc herniation at L5-S1. (Ex. 3).

In May 1993, Dr. Flaiz, attending physician, diagnosed "mechanical back pain." (Ex. 6). On referral from Dr. Gamber, Dr. Washington diagnosed claimant's condition as lumbar strain. (Ex. 8). On July 1, 1993, the insurer accepted a lumbar strain. (Ex. 10). A Determination Order closed claimant's claim in April 1994 awarding 5 percent unscheduled permanent disability. (Ex. 16). After closure, claimant worked in an auto parts store. (Tr. 18).

On February 21, 1995, Dr. Flaiz reported that claimant "had a recurrence of his back pain." (Ex. 17).

Drs. Peterson and Reimer, who performed an insurer-arranged examination, diagnosed "history of lumbar strain with L4-5 disk herniation." (Ex. 20-5). The examiners stated that claimant's current condition "appeared" to be more than a simple waxing and waning of symptoms contemplated by claimant's prior permanent disability award. (Ex. 20-6). However, because of claimant's considerable pain behavior, the examiners requested another MRI in order to objectively substantiate claimant's condition. They stated that if the "new" MRI showed no appreciable change from claimant's April 1993 MRI, they would feel comfortable stating that claimant's condition had remained stable and there would be no need for additional treatment.

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[1] ORS 656.273(1), 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).

On March 29, 1995, Dr. Flaiz concurred with the medical examiner's report. (Ex. 23). A MRI performed in May 1995 revealed degenerative disc disease and mild disc herniation at L4-5 and slight to mild disc herniation at L5-S1. (Ex. 25). On June 19, 1995, Dr. Peterson interpreted the May 1995 MRI as showing a "small change" at L5-S1. Dr. Peterson stated that the "small change" may have been present in April 1993, but he could not be certain unless he was able to view claimant's April 1993 MRI. Dr. Peterson recommended conservative treatment. (Ex. 26).

Here, we find no persuasive medical evidence that claimant's current condition is attributable to his compensable lumbar strain. For instance, Dr. Flaiz, who treated claimant both before and after claimant's claim was closed, reported that claimant "had a recurrence of back pain." However, such a statement does not persuasively relate claimant's current condition to his compensable lumbar strain, particularly where the MRI revealed degenerative disc disease and mild herniations.

Further, assuming that Dr. Flaiz's report does relate claimant's current condition to his compensable condition, there is no persuasive evidence in the record relating claimant's "small change" at L5-S1 to his compensable lumbar strain condition or that his current condition represents a pathological worsening of his compensable strain or is more that just a waxing and waning of symptoms contemplated by claimant's prior permanent disability award. See Carmen C. Neill, supra; Gloria T. Olson, supra.

Specifically, there is no persuasive evidence that claimant's lumbar strain has pathologically worsened. For instance, although claimant's May 1995 MRI showed a change at L5-S1, no physician has related this change to claimant's accepted lumbar strain condition. Finally, we decline to find dispositive Drs. Peterson and Reimer's statement that claimant's range of motion findings were more than a waxing and waning contemplated by the last award of permanent disability because the May 1995 MRI failed to objectively substantiate the findings (which the examiners believed was necessary given claimant's considerable pain behavior). Considering the contingent nature of their opinion, we do not find it persuasive. Accordingly, claimant has failed to prove a compensable aggravation of his lumbar strain.

ORDER

The ALJ's order dated October 19, 1995 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
BILLY L. ONEAL, Claimant
WCB Case Nos. 94-07683, 93-13555 & 94-07682
ORDER DENYING MOTION TO DISMISS
Pozzi, et al, Claimant Attorneys
David Jorling, Defense Attorney

Claimant has requested review of Administrative Law Judge (ALJ) Herman's February 20, 1996 order which: (1) upheld the self-insured employer's denial of claimant's occupational disease claim for a mental stress condition in WCB Case No. 93-13555; and (2) dismissed claimant's requests for hearing in WCB Case Nos. 94-07682 and 94-07683. Noting that claimant is only contesting the ALJ's decision in WCB Case No. 93-13555, the parties seek dismissal of claimant's request for review insofar as it pertains to WCB Case Nos. 94-07683 and 94-07682. The motion to dismiss is denied.

FINDINGS OF FACT

Claimant filed three separate hearing requests regarding denials issued by the employer. Two hearing requests concerned denials issued on May 27, 1994, one denying an "aggravation" claim under claimant's March 1980 accepted injury claim and the other based on a March 1994 "new injury" claim. These hearing requests, which were assigned WCB Case Nos. 94-07682 and 94-07683, were consolidated with WCB Case No. 93-13555. The latter case number pertained to claimant's appeal from the employer's November 10, 1993 denial of his occupational disease claim for a mental disorder.

At the hearing, claimant stated that he was withdrawing his hearing requests in WCB Case Nos. 94-07682 and 94-07683, while only pursuing his appeal of the employer's November 10, 1993 denial (WCB Case No. 93-13555). On February 20, 1996, ALJ Herman issued an Opinion and Order. Pursuant to that order, the employer's November 10, 1993 denial was upheld. In addition, the ALJ dismissed claimant's hearing requests in the remaining WCB case numbers.

On March 18, 1996, claimant timely requested Board review of ALJ Herman's order. On March 26, 1996, the Board mailed letters to all parties to the proceeding acknowledging claimant's request for review. Thereafter, claimant announced that he had only intended to appeal that portion of the ALJ's order which pertained to WCB Case No. 93-13555. Based on that announcement, the employer sought dismissal of claimant's appeal insofar as it pertained to WCB Case Nos. 94-07683 and 94-07682.

CONCLUSIONS OF LAW AND OPINION

Although the ALJ's conclusions and opinions in consolidated cases may be separately stated, if the ALJ's decisions are contained in one final order, we retain jurisdiction to consider all matters contained therein. Donald L. Melton, 47 Van Natta 2290 (1995); Riley E. Lott, Jr., 42 Van Natta 239 (1990); William E. Wood, 40 Van Natta 999 (1988).[1]

Here, the ALJ's compensability determination in WCB Case No. 93-13555 and dismissals of claimant's requests for hearing in WCB Case Nos. 94-07683 and 94-07682 were contained in one final, consolidated order. Inasmuch as that consolidated order has been appealed, we retain jurisdiction over that entire decision, and WCB Case Nos. 94-07683 and 94-07682 remain cases consolidated with this proceeding. See Zurich Ins. Co. v. Diversified Risk Management, 300 Or 47 (1985); Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992); Donald L. Melton, supra. Nevertheless, since both parties apparently do not wish to proceed further with either of the aforementioned cases, any issue arising from the ALJ's dismissal of claimant's hearing requests in those cases will not be considered on review unless subsequently raised by one of the parties.

Accordingly, the motions to dismiss are denied. A hearing transcript has been ordered. Upon receipt of the transcript, copies will be distributed to the parties and a briefing schedule will be implemented. Thereafter, the case will be docketed for Board review.

IT IS SO ORDERED.

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[1] Had the ALJ issued separate orders to address the three separate case numbers and decisions, claimant could have requested Board review of one or all of the separate orders. However, inasmuch as the February 20, 1996 order contained all three decisions and referenced all three case numbers, the ALJ's decisions cannot be separated by means of "dismissing" particular WCB case numbers. See Shawn C. Mann, 47 Van Natta 855 (1995); Jerry R. Miller, 44 Van Natta 1444 (1992).

In the Matter of the Compensation of
KATHLENE M. YORK, Claimant
WCB Case No. 93-05627
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Steven A. Wolf (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's December 11, 1995 order, we have been directed to reconsider our prior order (which declined claimant's request to reclassify her claim as disabling) under amended ORS 656.005(7)(c).[1]

Subsequent to the court's decision, we granted the parties' request to file supplemental briefs on remand. Having received the parties' supplemental briefs, we proceed with our reconsideration.

FINDINGS OF FACT

We adopt the findings of fact contained in the Administrative Law Judge's (ALJ) order.

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a strain of the right hand while working as a clerk in the employer's trust department. Claimant first sought treatment in October 1991 for complaints of right hand/wrist pain and numbness. Claimant treated with a wrist splint and aspirin. The employer accepted the claim for a nondisabling strain of the right wrist and thumb. In November or December of 1992, due to a phase out of her position, claimant transferred to another job in the customer service department, which required far fewer repetitive motions of the hand. Claimant's symptoms significantly diminished, but did not completely resolve. Claimant has lost no time from work and has not sought treatment since June 1992.

Based upon a preponderance of the medical evidence, the ALJ found that claimant sustained no permanent impairment of her condition. The ALJ, therefore, concluded that there was not a substantial likelihood that claimant was entitled to a scheduled permanent disability award. Accordingly, the ALJ declined to reclassify claimant's claim. We adopted and affirmed the ALJ's order.

Claimant petitioned for judicial review. Upon motion by the parties, the court has remanded to determine the reclassification issue under amended ORS 656.005(7). Consistent with the court's mandate, we proceed with our reconsideration.

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

Subsequent to the ALJ's order, in Karren S. Maldonado, 47 Van Natta 1535 (1995), we held that, under amended ORS 656.005(7)(c), for an injury to be disabling "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 (overruling Sharman R. Crowell, 46 Van Natta 1728 (1994)).

Here, claimant lost no time from work and, therefore, is not entitled to temporary disability. 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.

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[1] 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." The statute applies retroactively. Karren S. Maldonado, supra n. 1; see Volk v. America West Airlines, 135 Or App 565 (1995).

The ALJ found that the medical evidence showed no objective findings of permanent impairment. Accordingly, the ALJ concluded that claimant had failed to prove that there was a substantial likelihood[2] that she was entitled to a scheduled permanent disability award for her right wrist/thumb condition. We agree that the medical evidence fails to establish a reasonable expectation of permanent disability resulting from the injury. Our analysis is as follows.

Dr. Kaesche, orthopedist, examined claimant on referral from Dr. Lisook, claimant's treating physician. Dr. Kaesche declared claimant medically stationary on March 16, 1992 and stated that Dr. Button's exam would most likely serve as a closing examination. Dr. Kaesche, however, recommended a rheumatological examination by Dr. Wernick regarding a possible collagen vascular disease of the hands.

Dr. Wernick found no inflammatory arthritis or rheumatological disease. He felt that claimant had tendinitis of the right hand with decreased grip strength. Dr. Wernick, however, provided no explanation concerning the cause of the lost grip strength and no indication that the loss of grip strength was the result of nerve damage, atrophy, or other anatomical changes due to the compensable condition. Thus, Dr. Wernick's opinion is insufficient to establish a reasonable expectation of permanent impairment under the standards. See David A. Kamp, 46 Van Natta 389 (1994) (where no physician rated loss of grip strength in the manner required by the standards, any loss of grip strength that the claimant might have is not ratable under the standards).

Dr. Button examined claimant on March 27, 1992. Dr. Button found decreased grip strength on the right, but claimant had satisfactory muscle bulk and her sensory examination was normal. He noted that claimant was improving and that there were no objective abnormalities. Dr. Button concluded that claimant's prognosis was excellent and that he anticipated continued improvement with full resolution.

On June 24, 1992, Dr. Lisook found no evidence of permanent impairment. However, he did not feel claimant was medically stationary as long as she continued to work as a claims clerk. Dr. Wernick also recommended adaptive behaviors at work. Claimant later transferred to another job in the customer service department which required less repetitive hand motions.

In Jacqualyn M. Marvin, 46 Van Natta 1814 (1994), the claimant's treating physician qualified his opinion, of no permanent impairment, with the statement that the claimant would continue to have symptoms in her wrists. He further provided that the claimant would not have "complete resolution as long as she [was] doing the type of work at present which [was] actively using both wrists repetitively." Relying on Barbara Addington, 46 Van Natta 1474 (1994) (doctor's statement, that the claimant's physical problem would be present for a long time, implied an eventual resolution of her pain complaints), we found that the doctor's statement was insufficient to establish that the claimant's condition was permanent or that she suffered impairment. Id. at 1815.

Here, as in Marvin, we find that Dr. Lisook's opinion regarding claimant's medically stationary status is insufficient to establish a reasonable expectation of permanent impairment. Furthermore, Dr. Lisook's opinion of no permanent impairment is consistent with the opinions provided by Dr. Button and Dr. Kaesche. Finally, the doctors' recommendations to modify claimant's work activities to prevent an increase in symptoms is insufficient to establish permanent impairment. See Rae L. Holzapfel, 45 Van Natta 1748 (1993), aff'd mem Holzapfel v. M. Duane Rawlins, Inc., 127 Or App 208 (1994).

Based on the above, we conclude that there is no reasonable expectation that permanent disability will result from the injury. See Clifford E. Clark, supra; Julie M. Russo, 48 Van Natta 436

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[2] In Clifford E. Clark, 47 Van Natta 2310 (1995), we stated that both the new "reasonable expectation" standard and the old "substantial likelihood" standard required the same type of evidence that a permanent disability award was likely or expected. Here, because the medical evidence satisfies neither standard, we need not address claimant's contention that amended ORS 656.005(7) invalidates former OAR 436-30-045(5).

(1996). Claimant, therefore, is not entitled to reclassification of her claim.[3] Consequently, claimant's claim shall remain classified as "nondisabling."

Accordingly, on reconsideration of our prior order, we continue to affirm the ALJ's order dated August 11, 1993.

IT IS SO ORDERED.

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[3] Claimant also argues that amended ORS 656.005(7)(c) and (d) are unconstitutional under Article I, section 10 of the Oregon Constitution because they deny her a remedy. Specifically, claimant contends that her claim does not fit the statutory definition of either a nondisabling or a disabling claim. Noting that a nondisabling claim is one that requires medical services only, claimant asserts that in addition to medical treatment her claim required "the modification of employment duties." We reject claimant's contention that her claim does not fit the definition of a nondisabling claim. Because claimant's claim does not entitle her to temporary disability benefits, and because there is no reasonable expectation of permanent disability, her claim is a "nondisabling" claim as defined by statute. Thus, her claim is one which requires medical services only and does not result in temporary or permanent disability.

In the Matter of the Compensation of
JAMES J. LUNSKI, Claimant
WCB Case No. 95-09021
ORDER ON REVIEW
Estell & Associates, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Gunn.

Claimant requests review of Administrative Law Judge (ALJ) McCullough's order that upheld the insurer's denial of his aggravation claim for a neck and 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, claimant has received a prior award of 22 percent unscheduled permanent disability. Thus, 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." Under that provision, 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 his prior award.[2] Accordingly, we agree with the ALJ that claimant has not proven an aggravation.

ORDER

The ALJ's order dated November 7, 1995 is affirmed.

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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). Neill, supra.

[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.

In the Matter of the Compensation of
HARVEY L. JAMES, Claimant
Own Motion No. 66-0430M
OWN MOTION ORDER
SAIF Legal Department, Defense Attorney

On March 19, 1996, the SAIF Corporation submitted claimant's request for medical treatment for claimant's compensable back, hip and pelvis injury. SAIF requested that the Board disallow payment for treatment for claimant's current left lower back, left hip and thigh pain, as well as erectile dysfunction conditions. In addition, SAIF requests that the Board allow reimbursement for diagnostic procedures undertaken to determine the compensability of claimant's current condition.

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

SAIF advised that claimant's original record was destroyed or otherwise unavailable. On March 22, 1996, the Board requested the parties' positions regarding the compensability of claimant's current condition, including medical evidence used to determine the parties' respective positions. SAIF resubmitted its March 18, 1996 medical report from Wayne A. Eklund, RN, Nurse Consultant. No evidence from claimant has been received.

Mr. Eklund's March 18, 1996 report indicated that the first available record for claimant is an April 1970 urethral stricture treatment record, and that no records of the initial pelvic fractures and urethral rupture were present in the file. Mr. Eklund reported that, unfortunately, "the records are non[-]specific and deal solely with the issue of urethral stricture and statements that urethral stricture [was] result of ruptured urethra in conjunction with pelvic fractures."

Mr. Eklund also reported that, in his record review, he utilized x-rays of claimant's pelvis and lumbar spine as well as left hip and SI views, and CT scan of claimant's lower back which were taken in October 1995, after the onset of claimant's current condition. Mr. Eklund opined that:

> "The x-rays revealed old healed right inferior and superior pubic rami fractures, degenerative changes of the lumbar spine, possible fusion of the SI joints. No abnormality of the left hip was noted."

In addition, Mr. Eklund opined that the peripheral vascular disease in the abdomen was most likely the cause of erectile dysfunction in a 62-year-old male claimant.

In summary, based on his review of the available records, Mr. Eklund opined that:

> "The HNP and degenerative changes of the lumbar spine are more likely than not related to idiopathic degenerative or arthritic changes. The SI joint fusion is also from degenerative change: however, because of the fracture of both right[-]sided pelvic rami, there would also have been disruption of the SI ligaments. It is an established pattern of mechanism of injury in pelvic fractures, particularly on the ipsalateral side of the fracture. Because there are no surviving records of the 1955 injury, it is impossible to state whether the contralateral ligaments were actually involved. Irrespective of the SI fusion, the left[-]sided pain pattern is consistent with one or both of two conditions: peripheral vascular disease or the degenerative HNP in question at L3-4. Neither of these 2 conditions is likely related to the original pelvic fracture."

Here, claimant submits no evidence to support his position that his current condition is related to his original 1955 injury. Thus, Mr. Eklund's record review and opinions regarding medical evidence and the compensability issue are unrebutted.

Thus, we find that the medical evidence in the record does not establish that claimant's current condition and requested medical services are reasonable and necessary and causally related to the compensable injury.

Accordingly, we decline to authorize payment of requested medical services for claimant's left lower back, left hip and thigh pain, or erectile dysfunction conditions. Should claimant disagree with this decision, he may request reconsideration within 30 days from the date of his order and submit any evidence supporting his position.

Finally, SAIF requests reimbursement for copying costs ($5.75) incurred in obtaining medical records from Kaiser Permanente. Although we may authorize reimbursement for diagnostic services, we find no authority that would permit us to grant reimbursement for the costs of obtaining copies of medical records. Consequently, we decline to authorize SAIF's request for reimbursement of copying costs.

IT IS SO ORDERED.

Board Chair Hall concurring in part and dissenting in part.

I concur with that portion of the majority's opinion which declines to authorize reimbursement for the carrier's copying costs. However, since I disagree with the majority's decision to reject claimant's request for reimbursement for medical services provided for his current conditions, I respectfully dissent.

I acknowledge that the burden of establishing a causal relationship between the compensable injury and the current need for medical treatment ultimately rests with claimant. Nevertheless, where, as here, claimant's prior medical records have been destroyed (through no fault of his own), I submit that it does not achieve substantial justice to base our decision on a record that consists of an "interoffice" memorandum from the carrier's nurse consultant.

At a minimum, the original physicians should be contacted to determine their opinions regarding the relationship between claimant's compensable 1955 compensable injury and his current condition. Likewise, the carrier should be directed to provide the "available records" on which the consultant's opinion was formed. To do otherwise severely limits the reviewable record on which this Board is asked to make an important determination.

In conclusion, considering the dearth of evidence in this undeniably complex medical causation claim, I am not prepared to rely on the unsubstantiated "expert" opinion from a non-physician.[1] Instead, before rendering a decision, I would require that the record be further developed. Because the majority chooses to base its decision on this inadequately developed record and the aforementioned opinion, I must respectfully dissent.

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[1] In this regard, I would further note that the record lacks either direct or corroborating evidence attesting to the qualifications of the carrier's nurse consultant to render an "expert" opinion concerning this complex medical issue.

April 30, 1996 Cite as 48 Van Natta 937 (1996)

In the Matter of the Compensation of
JAMES W. JONES, Claimant
WCB Case No. 93-06575
ORDER ON REMAND
Peter O. Hansen, Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Jones, 138 Or App 484 (1996). In our prior order, James W. Jones, 46 Van Natta 2218 (1994), we affirmed an Administrative Law Judge's (ALJ's) order that set aside the SAIF Corporation's denial of claimant's occupational disease claim for claimant's current facio-scapulo-humeral dystrophy (FSHD). The court has reversed and remanded for reconsideration, citing amended ORS 656.802(2).

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In April 1992, claimant began performing work that required strenuous use of his upper extremities. (Ex. 17). He subsequently developed aching and numbness in his wrist and hands. His condition was initially diagnosed as bilateral carpal tunnel syndrome (CTS). Claimant filed a claim for CTS on July 10, 1992. (Ex. 3).

Claimant continued to have upper extremity problems, including shoulder weakness. (Ex. 7). On January 16, 1993, claimant filed a claim for a bilateral upper arm and shoulder condition. (Ex. 17). Claimant was subsequently diagnosed as having FSHD. (Exs. 21, 23A-3).

SAIF denied compensability of the condition, and claimant requested a hearing. The ALJ, applying former ORS 656.005(7)(a)(B), concluded that claimant's work activities had combined with his preexisting condition, and that the work activities were the major contributing cause of the need for treatment of the resultant condition.

In our prior order, we affirmed the ALJ. James W. Jones, supra. However, because the parties agreed that the claim is one for an occupational disease, we analyzed compensability of the condition under former ORS 656.802. We concluded that claimant had proven that his employment conditions were the major contributing cause of a pathological worsening of his preexisting condition. Id.; see Wheeler v. Boise Cascade Corp., 298 Or 452, 457-58 (1985); Weller v. Union Carbide Corp., 288 Or 27 35 (1979). SAIF petitioned for judicial review.

The Court of Appeals agreed that our conclusion in the prior order (that employment conditions were the major contributing cause of a pathological worsening of claimant's preexisting condition) was supported by substantial evidence. SAIF v. Jones, supra. Nevertheless, noting that the occupational disease statute had been amended, the court reversed our prior decision and remanded for reconsideration. In accordance with the court's mandate, we proceed with our reconsideration.

Claimant's occupational disease claim for his bilateral arm and shoulder condition is based on the worsening of preexisting FSHD.[1] Therefore, in accordance with amended ORS 656.802(2)(b), claimant must prove that "employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." See Dan D. Cone, 47 Van Natta 222 (1995). We apply the same reasoning here, and proceed with our reconsideration.

It is undisputed that FSHD is a genetically inherited muscle disorder. Dr. Ellison, treating neurologist, stated that claimant would likely never have been diagnosed with FSHD if he had not worked in a job so demanding to his arm and shoulder muscles. (Ex. 25). Further, Dr. Ellison opined that it was "medically probable that [claimant's] diagnosis was made because of the demands and strenuousness of his work." (Id.; see also Exs. 16A-1, 18, 28-1).

Dr. Johnston, neurologist, stated that "if [claimant] did not do such heavy labor, nor had he changed jobs when he did, we might not have seen him in consultation." (Ex. 23A-3). Dr. Johnston opined that claimant had preexisting FSHD (Ex. 29-1), and that claimant's heavy labor, in light of his abnormal muscle histology, was the cause of the irritation of the brachial plexus. (Ex. 23A-3).

Because claimant's occupational disease claim is based on a worsening of his preexisting FSHD, amended ORS 656.802(2)(b) requires that claimant establish that his employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease. See Tivis E. Hay, 48 Van Natta 558 (1996).

SAIF argues that claimant's "combined condition" is muscular dystrophy. Therefore, it asserts that claimant must prove that work activities were the major contributing cause of his muscular dystrophy. We do not agree that the combined condition is the muscular dystrophy. Rather, the combined condition is claimant's bilateral arm/shoulder muscle pain, weakness and wasting, due to the preexisting dystrophy and his work activities. We base this conclusion on the following reasoning.

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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).

Relying on the opinions of Drs. Ellison and Johnston, as set out above, we find that claimant's FSHD preexisted his work exposure with the employer (see also Ex. 21-3). Nevertheless, claimant had no symptoms of FSHD until he began the strenuous work at his employment. The opinions of Drs. Ellison and Johnston indicate that claimant's current condition includes weakness, pain and muscle wasting, which would not have occurred without the strenuous work activities. (See Exs. 19, 23A, 25). Dr. Mass and Dr. Cline further support this conclusion. (Exs. 21-3, 27-2). Accordingly, we conclude that claimant's work activities combined with his preexisting FSHD, and that the work activities are the major contributing cause of the "combined condition;" i.e., preexisting FSHD combined with employment related muscle pain, weakness and wasting involving both arms and shoulders. We now address whether claimant's work exposure was the major contributing cause of the "combined condition." See ORS 656.802(2)(b).

Because SAIF contends that claimant's "combined condition" is muscular dystrophy, it argues that claimant has failed to prove that his employment activities were the major contributing cause of his muscular dystrophy condition. That is not the correct analysis.

We have concluded that claimant's "combined condition" is the preexisting FSHD, combined with employment related muscle pain, weakness and wasting involving both arms and shoulders. We have further concluded that work conditions were the major contributing cause of the combined condition. Thus, in order to prove a compensable occupational disease, claimant must show that his employment conditions were the major contributing cause of a pathological worsening of the preexisting disease, not the major cause of the preexisting disease itself. ORS 656.802(2)(b); Dan D. Cone, supra.

Absent persuasive reasons to do otherwise, we generally give greater weight to the conclusions of the treating physician. Taylor v. SAIF, 75 Or App 583 (1985); Weiland v. SAIF, 64 Or App, 810 (1983). We also give more weight to those opinions which are well-reasoned and based on accurate and complete histories. Somers v. SAIF, 77 Or App 259, 263 (1986). In our prior order, relying on Drs. Ellison and Johnston, we found that claimant's work conditions were the major contributing cause of a pathological worsening of the FSHD, which would not have been diagnosed except for claimant's strenuous work conditions. James W. Jones, supra; (see Exs. 25, 28, 29).

On reconsideration, we find no reason not to rely on the opinions of the attending neurologist, Dr. Ellison, and consulting neurologist, Dr. Johnston. Dr. Ellison performed claimant's initial neurological examination in November 1992, on referral from claimant's family physician. (Ex. 8). At that time, Dr. Ellison suspected FSHD. She continued to follow up, recommending additional testing to verify her diagnosis, and referring claimant to Dr. Johnston for a second opinion. (See Exs. 16A-1, 23A).

In our prior order, we acknowledged that both Dr. Ellison and Dr. Johnston had initially mentioned increased symptoms when describing claimant's complaints arising from his work activities. Nevertheless, both physicians subsequently explained that work activities were the major contributing cause of a worsening of claimant's preexisting condition. (Exs. 25, 28, 29). This worsening was primarily manifested through muscle weakness and atrophy. Further, both opined that, if claimant had not performed these strenuous work activities, the preexisting FSHD probably would not have manifested itself in claimant's lifetime. Based on our analysis of these opinions, we continue to find that claimant's work activities were the major contributing cause of a pathological worsening of his preexisting disease.

Accordingly, in light of our conclusion that work activities were the major contributing cause of claimant's combined condition, and our conclusion that claimant's work activities were the major contributing cause of a pathological worsening of his preexisting disease, we find that claimant has established a new occupational disease. See ORS 656.802(2)(b). Consequently, on reconsideration, we affirm the ALJ's decision which found the occupational disease claim compensable.

Finally, claimant is entitled to an attorney fee for services before the Court of Appeals.[2] After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a

[2] We granted the parties an opportunity to submit supplemental briefs to the Board on remand. We have received SAIF's appellant's brief, but claimant has not submitted a respondent's brief within the time period set forth in our supplemental briefing schedule. Therefore, claimant's additional attorney fee is confined to his attorney's services before the court.

reasonable fee for claimant's counsel's services before the court is $2,000. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's appellate brief before the court), the complexity of the issues, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. This attorney fee award is in addition to the ALJ's $2,500 award for services at hearing, and our $1,000 award for previous services on Board review.

Accordingly, on reconsideration, as supplemented and modified, we republish our October 19, 1994 order that affirmed the ALJ's order dated January 25, 1994. For services before the court, claimant's counsel is awarded $2,000, to be paid by SAIF. This attorney fee is in addition to those attorney fee awards previously granted by the ALJ's order and our prior order.

IT IS SO ORDERED.

April 30, 1996 Cite as 48 Van Natta 940 (1996)

In the Matter of the Compensation of
SADIE SYMONDS, Claimant
Own Motion No. 93-0347M
OWN MOTION ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Claimant requests reconsideration of our March 29, 1996 Own Motion Order of Dismissal in which we dismissed as untimely claimant's request for review of the self-insured employer's Notice of Closure. In addition, because we were without authority to review the Notice of Closure, we found that we lacked authority to consider the parties' Stipulation, which essentially purported to amend the temporary disability award granted by the employer's July 19, 1995 Notice of Closure. On reconsideration, claimant requests that we approve the parties' Stipulation, contending that the parties agreed to this approach rather than pursuing litigation concerning the timeliness of claimant's request for review of the July 19, 1995 Notice of Closure.

On April 10, 1996, we withdrew our order for reconsideration. The employer has responded to claimant's motion by advising that it has no objection to claimant's request. We proceed with our reconsideration.

As a preliminary matter, we note that it is our duty to raise a want of jurisdiction on our own motion. See Southwest Forest Industries v. Anders, 299 Or 205 (1985). Although the parties attempt to waive the issue of untimely request, the provisions for timely request for review of a carrier closure are established by rule and cannot be waived. See Duane Fresh, 42 Van Natta 864 (1990) (applying ORS 656.319(1), the Board held that the provisions for timely request for hearing are statutory and cannot be waived).

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. Claimant's attorney asserts that neither claimant nor his office received the Notice of Closure until after the 60-day period in which to appeal had expired. He further contends that it was not until January 30, 1996 that his office verified that claimant had never received a copy of the Notice of Closure. Under these circumstances, he argues, the parties agreed to a stipulated amount of temporary disability rather than pursuing litigation regarding the timeliness issue.

The problem with this argument is that we have no jurisdiction to review the Notice of Closure if review was not timely requested. Furthermore, claimant's attorney's assertions do not establish that review was timely requested. In fact, these assertions indicate that claimant did not request review until

more than 180 days following the July 19, 1995 Notice of Closure. There is no provision that allows review of a Notice of Closure when the review is requested more than 180 days after the mailing date of the Notice of Closure. Former OAR 438-12-060(1); see Wright v. Bekins Moving & Storage Co., 97 Or App 45, rev den 308 Or 466 (1989) (applying ORS 656.319, the court held that a hearing request filed more than 180 days after the denial was mailed could not be timely).

In addition, former OAR 438-12-060(1) provides that the running of the filing time is triggered by the mailing date, not the date of receipt. See Giusti Wine Co. v. Adams, 94 Or App 175 (1988) (applying former ORS 656.319, the court determined that the running of the statutory filing time to request a hearing on a denial was triggered by the date of mailing of the denial, not the date of receipt). In Anton V. Mortensen, 40 Van Natta 1177, on recon 40 Van Natta 1702 (1988), the Board interpreted former ORS 656.268(6), which required a party requesting a hearing on a Determination Order to request such hearing within one year after copies of the determination were mailed. The Board found that if the facts rebut the presumption that mailing produces actual delivery of notice, then the statutory period does not begin to run until the date of successful mailing or actual notice. 40 Van Natta 1179. Finding that the record was insufficiently developed as to whether there was a successful mailing, the Board remanded the case to the Hearings Division.

On remand, the Referee dismissed the claimant's hearing request for lack of jurisdiction on an untimely appeal. Anton V. Mortensen, 42 Van Natta 1183 (1990). Finding that the Determination Order was mailed to the claimant's correct address on the date of issuance, the Referee concluded that the mere fact that the claimant did not receive the Determination Order was not sufficient to rebut the presumption of a successful mailing. The Referee specifically noted the absence of any evidence of processing errors, incorrect address, lack of mailing, or any other circumstance which would rebut the presumption of a successful mailing. Id. The claimant requested Board review, and on review, the Board affirmed the Referee's order, adopting the Referee's aforementioned findings and conclusions. Compare Bruce C. Darr 45 Van Natta 305, on recon 45 Van Natta 498 (1993) (where facts rebutted presumption that there was a successful mailing of a Determination Order to the claimant's residence, statutory appeal period did not begin to run until the claimant actually received the Determination Order); Raymond A. Baker, 47 Van Natta 309, on recon 47 Van Natta 481 (1995) (where carrier failed to establish the fact of improper mailing of a Reconsideration Order, statutory appeal period ran from the date of the Reconsideration Order, not from the date the carrier was actually notified of the Reconsideration Order).

We find the reasoning in Mortensen, Darr, and Baker applicable to the facts of the present case. In other words, claimant has the affirmative burden of rebutting the presumption of a successful mailing. If claimant rebuts this presumption, the appeal period will not begin to run until claimant actually received the Notice of Closure. However, merely showing that she did not receive the Notice of Closure is insufficient to toll the running of the appeal period, given the fact that, pursuant to former OAR 438-12-060(1), running of the time to request review of the Notice of closure is triggered by the mailing date, not the date of receipt. Here, claimant offers no evidence that Notice of Closure was not properly mailed; she simply states that she did not timely receive it. Thus, claimant has failed to rebut the presumption of successful mailing and the appeal period runs from the date of mailing.

On this record, claimant has not established that she timely requested review of the July 19, 1995 Notice of Closure. Therefore, we have no jurisdiction to review that Notice of Closure.

Finally, if the parties do not wish to pursue the timeliness issue, both the statute and rules allow for the employer to voluntarily reopen the claim for payment of benefits. ORS 656.278(5); OAR 438-012-0030(3). Such a voluntary reopening would permit the parties to carry out their agreement regarding the additional temporary disability benefits without seeking approval from the Board. However, subsequent authorization of such benefits will not be granted by the Board unless the claim qualifies for own motion relief under ORS 656.278 and OAR 438-012-001 et seq.

Accordingly, we withdraw our March 29, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our March 29, 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
TERESA A. SZEREMI, Claimant
WCB Case Nos. 95-07582 & 95-07581
ORDER ON REVIEW (REMANDING)
Coons, Cole, et al, Claimant Attorneys
William J. Blitz (Saif), Defense Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation (on behalf of Roseburg Country Club) requests, and claimant cross-requests, review of Administrative Law Judge (ALJ) Kekauoha's order that dismissed claimant's hearing requests concerning Liberty Northwest Insurance Corporation's (on behalf of Roseburg Elks Lodge #326) and SAIF's (on behalf of La Hacienda Tambien) compensability and responsibility denials of claimant's claims for a right upper extremity condition. On review, the issue is the propriety of the ALJ's dismissal under ORS 656.308(2)(c). We vacate the ALJ's order and remand.

FINDINGS OF FACT

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

In the second paragraph of the findings of fact on page 2, after the first sentence, we add the following:

> "Both claimant and SAIF/Roseburg Country Club wrote to the ALJ, opposing the motions to dismiss filed by Liberty/Roseburg Elks Lodge and SAIF/La Hacienda Tambien."

CONCLUSIONS OF LAW AND OPINION

Claimant requested a hearing concerning the compensability and responsibility denials issued by Liberty/Roseburg Elks Lodge and SAIF/ La Hacienda Tambien regarding her right carpal tunnel syndrome and right thoracic outlet syndrome. (Exs. 20, 23). Therefore, both of the aforementioned carriers moved for their dismissal from the proceeding. See ORS 656.308(2)(c). The ALJ found that there was no evidence that related claimant's right upper extremity condition to her employment exposures with either Liberty/Roseburg Elks Lodge or SAIF/La Hacienda Tambien. Pursuant to ORS 656.308(2)(c), the ALJ dismissed claimant's hearing requests against both Liberty/Roseburg Elks Lodge and SAIF/La Hacienda Tambien.

SAIF/Roseburg Country Club argues that the ALJ erred by dismissing Liberty/Roseburg Elks Lodge and SAIF/La Hacienda Tambien because the record was not complete and because ORS 656.308(2)(c) does not apply to issues of compensability. Claimant agrees with the arguments from SAIF/Roseburg Country Club and also argues that the Order of Dismissal was erroneous in light of claimant's motion to postpone the hearing.

To begin, we disagree with Liberty/Roseburg Elk Lodge's assertion that neither SAIF/Roseburg Country Club nor claimant objected to its motion to dismiss prior to issuance of the ALJ's order.

On December 7, 1995, Liberty/Roseburg Elks Lodge filed a motion for dismissal pursuant to ORS 656.308(2)(c). On December 12, 1995, SAIF/La Hacienda Tambien renewed its previous motion to dismiss under ORS 656.308(2)(c).

On December 14, 1995, claimant responded to the motions to dismissal filed by both Liberty/Roseburg Elks Lodge and SAIF/La Hacienda Tambien. Claimant questioned the applicability of ORS 656.308(2)(c) in circumstances where both compensability and responsibility was denied by the parties. Furthermore, claimant argued that the medical record was not complete. On December 19, 1995, Liberty/Roseburg Elks Lodge replied to claimant's response to its motion to dismiss.

On December 20, 1995, SAIF/Roseburg Country Club wrote to the ALJ, opposing any motion to dismiss and requesting that any ruling be withheld until SAIF/Roseburg Country Club's attorney received a copy of all motions to dismiss.

Thus, contrary to Liberty/Roseburg Elk Lodge's assertion, both claimant and SAIF/Roseburg Country Club objected to both motions to dismiss prior to the issuance of the ALJ's order.[1] We proceed to address the propriety of the ALJ's dismissal of claimant's hearing requests against Liberty/Roseburg Elks Lodge and SAIF/La Hacienda Tambien.

Subsequent to the issuance of the ALJ's order, in Ernest L. Chavez, 48 Van Natta 529 (1996), we held that the "motion to dismiss" provision in ORS 656.308(2)(c) did not apply to a carrier who had issued a compensability denial and had not conceded compensability prior to the proceeding. In Chavez, the claimant requested a hearing concerning an "aggravation" carrier's responsibility denial and a "new injury" carrier's compensability / responsibility denial. Asserting that there was no substantial evidence to support a finding of responsibility against it, the "new injury" carrier moved for its dismissal. Finding that the claimant did not sustain a new injury or increased symptoms during his employment with the "new injury" employer, the ALJ dismissed the "new injury" carrier pursuant to ORS 656.308(2)(c).

Based on the text of ORS 656.308(2)(c), we noted in Chavez that the statute does not refer to findings of compensability or compensability denials. Turning to the context of the statute, we pointed out that subsections (a), (b), and (d) of ORS 656.308 all focus on responsibility issues. Finally, we found no reference in ORS 656.308 or elsewhere in 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. Under such circumstances, we concluded that the dismissal procedures of ORS 656.308(2)(c) apply only to responsibility issues.

We reach the same conclusion in this case. Both Liberty/Roseburg Elks Lodge and SAIF/La Hacienda Tambien denied compensability and responsibility of claimant's right upper extremity condition. (Exs. 20, 23). Furthermore, neither Liberty/Roseburg Elks Lodge nor SAIF/La Hacienda Tambien conceded that claimant's condition was compensable. Under these circumstances, we conclude that the ALJ had no statutory authority to dismiss claimant's hearing requests against Liberty/Roseburg Elks Lodge and SAIF/La Hacienda Tambien on the basis that the record did not contain substantial evidence to support a finding of compensability regarding those claims. See Ernest L. Chavez, supra.

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).

As discussed above, Liberty/Roseburg Elks Lodge and SAIF/La Hacienda Tambien denied compensability and there is no evidence that either carrier later conceded compensability. No hearing was convened and the parties did not have an opportunity to litigate the compensability of claimant's right upper extremity condition. Unless a carrier concedes compensability, a claimant has the burden of proving that an injury or occupational disease is compensable. See ORS 656.266.

Accordingly, we vacate the ALJ's order and remand this case to the Presiding ALJ, with instructions to assign this case to an ALJ. The designated ALJ shall conduct further proceedings consistent with this order.[2] Those proceedings may be conducted in any manner that the designated ALJ determines will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] In light of this finding, we need not address Liberty's argument that SAIF/Roseburg Country Club lacks standing to challenge its dismissal.

[2] In light of our conclusion, we need not address the parties' arguments concerning postponement and whether the record was complete.

In the Matter of the Compensation of
VALDEN H. BRICKLEY, Claimant
WCB Case No. 94-14671
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests, and the SAIF Corporation cross-requests, review of Administrative Law Judge (ALJ) O'Dell's order which: (1) declined to admit into the record a "post-reconsideration order" medical report from claimant's attending physician; and (2) awarded claimant an additional 2 percent (6.4 degrees) unscheduled permanent disability for a low back condition, whereas an Order on Reconsideration had not awarded additional permanent disability beyond the 36 percent (115.2 degrees) claimant had been granted by prior closure orders. On review, the issues are evidence and permanent disability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable low back injury on February 24, 1992. Claimant ultimately was awarded 36 percent unscheduled permanent disability by an amended Determination Order of April 14, 1993.

The claim was reopened as a result of a February 1994 aggravation claim. Claimant 's attending physician, Dr. Davis, declared claimant medically stationary on June 7, 1994, and adopted the range of motion findings in a May 1994 physical capacities evaluation. (Ex. 38-2). Dr. Davis also placed claimant under the same work restrictions effective at the time of the first closure. (Ex. 41A).

A Notice of Closure was issued on January 10, 1995, which did not award any additional permanent disability. An Order on Reconsideration of March 20, 1995 affirmed the Notice of Closure. A hearing was held on July 28, 1995.

The ALJ found that claimant was entitled to a reevaluation of the extent of his unscheduled permanent disability following issuance of the January 10, 1995 Notice of Closure. The ALJ reasoned that, even though claimant had not experienced a reduction of earning capacity pursuant to OAR 436-35-005(9),[1] that rule was inconsistent with amended ORS 656.726(3)(f)(D)(i)[2] and, was, therefore, invalid. Applying the disability standards in effect at the time of the January 1995 closure, the ALJ calculated claimant's unscheduled permanent disability to be 38 percent. Accordingly, the ALJ increased claimant's total unscheduled permanent disability award by 2 percent. The ALJ also sustained SAIF's objection to the admissibility of a "post-reconsideration order" medical report from Dr. Davis, dated July 13, 1995. See amended ORS 656.283(7); Joe R. Ray, 48 Van Natta 325 (1996) (evidence not submitted at reconsideration, and not made part of the reconsideration record, not admissible at a subsequent "pre-Senate Bill 369" hearing concerning extent of permanent disability under amended ORS 656.283(7)). But see Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996) ("post-reconsideration" testimony considered on review when properly admitted at "pre-Senate Bill 369" hearing).

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[1] The ALJ incorrectly referred to the administrative rule as OAR 436-35-007(5).

[2] 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. Or Laws 1995, ch 332, § § 66(2)-(6). One such provision concerns the amendments to ORS 656.656.726(3)(f) contained in Section 55 of Senate Bill 369. According to Section 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 June 7, 1994, prior to the June 7, 1995 effective date of Senate Bill 369, amended ORS 656.726(3)(f) is inapplicable.

On review, claimant contends that the ALJ should have admitted Dr. Davis' July 1995 medical report and that he is entitled to increased unscheduled permanent disability. SAIF responds that the ALJ should not have reevaluated claimant's permanent disability because he failed to show a permanent worsening of his condition under Stepp v. SAIF, 304 Or 375 (1987), and OAR 436-35-005(9).[3] SAIF also contends that the ALJ mistakenly calculated claimant's range of motion findings and, therefore, even if permanent disability is recalculated under Stepp, claimant is not entitled to more than 36 percent unscheduled permanent disability previously awarded. Finally, SAIF argues that the ALJ correctly excluded Dr. Davis' "post-reconsideration" medical report.

We need not address the parties' arguments regarding the admissibility of Dr. Davis' medical report or the issue of whether claimant's permanent disability should have been reevaluated. That is, even if we considered the "post-reconsideration" medical report, and even if that report supported a permanent worsening of claimant's low back condition, claimant would not be entitled to additional unscheduled permanent disability.

The ALJ, in determining claimant's permanent impairment, relied on the range of motion findings adopted by Dr. Davis. (Ex. 35-3). Inasmuch as no medical arbiter's examination was conducted, we agree that these findings should be used to determine the impairment value for reduced range of motion in claimant's lumbar spine. At closing, claimant's low back range of motion findings were 20 degrees flexion, 5 degrees extension, 6 degrees left lateral flexion and 8 degrees right lateral flexion. The ALJ determined that the total loss of range of motion was 22 percent. Combining this value with 9 percent impairment for a June 1992 low back surgery, the ALJ concluded that claimant's impairment was 29 percent. The ALJ then added claimant's impairment value to the product of claimant's adaptability factor and his age and education values (9), and arrived at a total disability rating of 38 percent.[4]

As previously noted, SAIF asserts that the ALJ miscalculated claimant's range of motion impairment pursuant to OAR 436-35-360(19)-(22). We agree.

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 Notice of Closure dated January 10, 1995 . Accordingly, those standards contained in WCD Admin. Orders 6-1992 and 93-056 apply to claimant's claim. Claimant has the burden of proving the extent of disability resulting from her compensable injury. ORS 656.266; Harriet Olson, 47 Van Natta 1917 (1995).

Pursuant to OAR 436-35-360(19), 20 degrees of flexion equals 7 percent impairment. Five degrees of extension equals 6 percent impairment. OAR 436-35-360(20). Six degrees of left lateral flexion equals 3.8 percent impairment and 8 degrees of right lateral flexion equals 3.4 percent impairment. OAR 436-35-360(21). These values are added. OAR 436-35-360(22). The result is 20.2 percent impairment which is 20 percent impairment when rounded to the nearest whole number. OAR 436-35-007(11).

Thus, we conclude that claimant is entitled to 20 percent impairment for reduced range of motion. It follows that claimant's total permanent disability award is 36 percent rather than 38 percent. In light of this conclusion, it does not matter whether Dr. Davis' medical report is admissible or whether claimant's permanent disability is reevaluated because claimant's permanent disability award would be no greater than the 36 percent previously awarded.

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[3] 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."

[4] The parties do not dispute the calculation of the values for claimant's surgery or his social/vocational factors.

ORDER

The ALJ's order dated November 13, 1995 is reversed. The March 20, 1995 Order on Reconsideration is affirmed. The ALJ's attorney fee is also reversed.

May 1, 1996 Cite as 48 Van Natta 946 (1996)

In the Matter of the Compensation of
RONALD D. CRAM, Claimant
WCB Case No. 94-11298
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the self-insured employer's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked for the employer for 16 years. In May 1994, claimant sought treatment from Dr. Bitter, hand surgeon, for bilateral carpal tunnel syndrome symptoms. The ALJ found that claimant had not proved the compensability of his CTS. Claimant challenges this conclusion, asserting that the more persuasive medical evidence shows that his work was the major contributing cause of his condition.

Examining orthopedic surgeon, Dr. Nathan, found "no evidence that the work has done more than contribute to a flare-up of symptoms." (Ex. 8-4). After viewing claimant's demonstration of hand movements at work, Dr. Nathan explained that, although claimant used his hand at work "in a variety of grasping positions for using tools and driving a backhoe," claimant did not "describe any positions which require the wrists and elbows to be held in extreme positions of flexion, which could compress the median nerve in the palm or the ulnar nerve at the elbow." (Id.) Dr. Nathan also stated that, because claimant had performed essentially the same work for 16 years, claimant would have become symptomatic at an earlier date if work had caused his condition. (Id.)

Dr. Radecki, electrodiagnostic medicine specialist, examined claimant at the employer's attorney's request. Dr. Radecki found that advanced age, increased body mass and increased wrist squareness constituted the major contributing cause of claimant's CTS. (Ex. 16-6).

Dr. Bitter first reported that, because claimant's work required repetitive strong gripping with wrist extension and flexion, it was the major contributing cause of the CTS. Dr. Bitter based his opinion on "medical literature" associating such hand movement with the onset of CTS. (Exs. 11-2, 20-3). Subsequently, in response to Dr. Nathan's comment that claimant should have become symptomatic earlier since he had performed the same work for a long period of time, Dr. Bitter stated that claimant's work changed from operating a backhoe to "ground work" requiring digging, operating a jackhammer, and installing pipes. (Ex. 15). According to Dr. Bitter, this change preceded claimant's symptoms and precipitated the symptoms. (Ex. 20-5).

During a deposition, Dr. Bitter was asked by the employer's counsel whether he would have the same opinion if a change in work activities had not preceded the onset of claimant's symptoms. Dr. Bitter responded that he would continue to find that the major contributing cause was work activities due to the association between CTS and hand-intensive work. (Ex. 21-34, 21-51, 21-52).

In evaluating the medical opinions, we first note that, because determining causation concerns expert analysis rather than external observation, Dr. Bitter, as the treating physician, is not entitled to special deference. See Allie v. SAIF, 79 Or App 284, 287 (1986). We also find that Dr. Bitter's initial opinion was based on the inaccurate history that claimant's symptoms preceded a change in work activity; as the ALJ found, claimant's work changed after the onset of symptoms. Thus, Dr. Bitter's initial opinion is not persuasive. Somers v. SAIF, 77 Or App 259 (1986). Because Dr. Bitter, however, during the deposition, continued to implicate claimant's work based on an accurate history, we examine whether this opinion is sufficiently persuasive to carry claimant's burden of proof.

On the whole, we conclude that Dr. Bitter's opinion does not overcome those of Dr. Nathan and Dr. Radecki. In particular, Dr. Nathan witnessed claimant's demonstration of his hand movements at work and found that they were not the kind to suppress the median or ulnar nerves. Dr. Bitter, on the other hand, only referred to "medical literature" in stating that repetitive strong gripping caused CTS; there is no indication that Dr. Bitter saw any hand demonstration and he never specifically explained how such movement could cause the condition. Furthermore, Dr. Bitter (when told to assume that a work change did not precede symptoms) did not explain why claimant worked at his job for 16 years before he experienced symptoms; Dr. Nathan had found such a delay showed that claimant's work did not cause his condition.

Given these deficiencies in Dr. Bitter's opinion, we find the medical evidence insufficient to establish the compensability of claimant's occupational disease claim for bilateral CTS. ORS 656.802(2).

ORDER

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

April 30, 1996 Cite as 48 Van Natta 947 (1996)

In the Matter of the Compensation of
CHARLES TEDROW, Claimant
Own Motion No. 94-0095M
OWN MOTION ORDER ON RECONSIDERATION
Emmons, et al, Claimant Attorneys
Bailey & Associates, Defense Attorneys

Claimant requests reconsideration of our March 29, 1996 Own Motion Order, in which we found that: (1) we lacked authority to award additional temporary disability compensation beyond the amounts already paid by the insurer; (2) neither a penalty or attorney fee was warranted for the insurer's allegedly unreasonable failure to pay compensation; and (3) claimant's attorney was not entitled to an assessed attorney fee. Specifically, claimant contends that his May 23, 1994 letter which requested that the Board "enforce" its February 9, 1994 Own Motion Order, is "tantamount to asking the Board the review the carrier[s'] claim closure notice."

On April 12, 1996, we abated our March 29, 1996 order to allow the insurer sufficient time to respond to claimant's motion. We have received the insurer's response, and, after conducting our reconsideration and reviewing claimant's motion and supporting argument as well as the insurer's rebuttal argument, we reject claimant's argument that his May 23, 1994 request for enforcement of the February 9, 1994 Own Motion Order issued by the Board was "tantamount" to requesting review of a February 21, 1994 insurer-issued Notice of Closure. Because we continue to find that claimant did not seek review of the insurer's February 21, 1994 Notice of Closure, we have nothing further to add to our prior order. Consequently, we adhere to and republish our March 29, 1996 order in its entirety. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY F. KRIEGER, Claimant
WCB Case No. 95-02572
ORDER ON REVIEW
Empey & Dartt, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the self-insured employer's denial of claimant's claim for her bilateral shoulder tendonitis, low back strain, bilateral knee strains and bilateral hand strains. On review, the issue is compensability.

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

On review, claimant contends that she is seeking only to establish the compensability of her various strain and tendinitis conditions, as opposed to her degenerative osteoarthritis condition. Notwithstanding claimant's position, however, we have previously held that we are bound to apply the proper legal standard to the facts of the case. Daniel S. Field, 47 Van Natta 1457 (1995).

Here, the medical evidence establishes that claimant's work-related strain combined with her preexisting degenerative condition. For example, in March 1995, claimant was referred to Dr. Jacobs by her treating doctor, Dr. Karty. Dr. Jacobs diagnosed claimant's condition as "pain in the shoulders, hips, back, knees and hands...related to underlying degenerative arthritis and...some superimposed strain related to work activities." Dr. Jacobs further described claimant's condition as a "combination of underlying degenerative joint disease and superimposed soft tissue strain..." (Ex. 24-2).

Consequently, we conclude that this case is properly analyzed under ORS 656.005(7)(a)(B). See e.g., Daniel S. Field, supra (The claimant's work incident caused a thoracic sprain which was superimposed on top of a spine with preexisting spondylosis. Therefore, although the claimant argued that the only condition subject to review was the strain, not the underlying degenerative disease, we held that the case was appropriately analyzed as a "combined" condition). Thus, claimant has the burden of proving that her work activities were 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.

After reviewing the numerous medical opinions provided in this case, we find that claimant has failed to meet that burden of proof. Specifically, claimant's treating doctor, Dr. Karty, has opined that claimant's work is not the cause of claimant's conditions, but that her joints problems are "related" to her work. (Ex. 45-3). We conclude that, although "magic words" are not necessary, see McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986), Dr. Karty's opinion does not establish that work is the major cause of claimant's combined condition or her need for treatment of the combined condition. Specifically, because Dr. Karty has opined that work did not cause claimant's condition, we conclude that his use of the term "related" does not meet the "major contributing cause" standard.

Finally, the remaining medical opinions do not assist claimant's case. For example, Dr. Corrigan, who saw claimant on referral from Dr. Karty, reported that claimant's preexisting conditions were the major cause of her current problems. Although he found that claimant's work caused her to become symptomatic, he further reported that "her job has not been the true cause of these entitities." (Ex. 17A-4). Similarly, Drs. McMillan and Jacobs agreed only that claimant's work activities had caused her preexisting degenerative disease to become symptomatic. (Exs. 10, 28). See Dietz v. Ramuda, 130 Or App 397 (1994) (Even though a work injury precipitates symptoms in a previously asymptomatic, preexisting condition, the work injury must still be the major contributing cause in order for the resultant condition to be compensable).

Finally, Dr. Griffin, who conducted a medical placement evaluation for claimant reported that "all of claimant's current medical complaints are preexisting and completely unrelated to her work situation." (Ex. 42-2). Drs. Wilson, Tesar Corrigan and Brem concurred with Dr. Griffin's opinion. (Exs. 43, 44, 46, 47).

Accordingly, we conclude that claimant has failed to show medical evidence that work is the major contributing cause of her combined condition or need for treatment of the combined condition. ORS 656.005(7)(a)(B).[1] Therefore, we affirm the ALJ's order on the issue of compensability.

ORDER

The ALJ's order dated October 6, 1995 is affirmed.

[1] Alternatively, we would conclude that, even under an occupational disease theory, claimant has not met her burden of proof. See e.g. Dan D. Cone, 47 Van Natta 2220 (1995) (Pursuant to amended ORS 656.802(2)(b), it is no longer sufficient for the claimant to prove that work conditions were the major contributing cause of a worsening of the preexisting disease; he must also prove that work conditions were the major contributing cause of the "combined condition" itself.)

May 1, 1996 Cite as 48 Van Natta 949 (1996)

In the Matter of the Compensation of
JEFFERY J. CAMPAU, Claimant
WCB Case Nos. 95-05320 & 94-07426
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) upheld the self-insured employer's denial of claimant's 1994 low back injury claim; and (2) upheld the employer's denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and aggravation.

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

The only physician to support a causal relationship between claimant's 1992 compensable injury and his current condition is Dr. Weinman, who did not begin treating claimant until 1994. Dr. Weinman diagnosed a "lumbosacral strain aggravation spondylolisthesis, Grade I, L5-S1." (Ex. 18). He opined that the 1994 work incident destablized claimant's spondylolisthesis and was the cause of his problems. (Ex. 32). In a later opinion, Dr. Weinman indicated that the the major cause of claimant's condition was the 1992 compensable injury. (Ex. 34). Dr. Weinman based this changed opinion on the fact that claimant had experienced symptoms after the 1992 injury. (Ex. 34). In reaching this conclusion, Dr. Weinman speculated that claimant's 1992 injury had been misdiagnosed and opined that the 1992 injury had made claimant's preexisting spondylolisthesis symptomatic. (Ex. 34).

Like the ALJ, we are not persuaded by Dr. Weinman's opinion. To begin, Dr. Weinman's opinions are inconsistent. Moreover, his change of opinion relies on the testimony of claimant concerning low back symptoms after the 1992 injury. In this regard, we agree with the ALJ that claimant's testimony, other than that concerning the March 6, 1994 incident which was independently corroborated, is not reliable. Finally, since Dr. Weinman did not examine claimant until 1994, his opinion that the 1992 injury caused a symptomatic worsening of claimant's spondylosisthesis is speculation and is not supported by the contemporaneous medical evidence. For these reasons, we agree with the ALJ that claimant has not established that his current condition is causally related to the 1992 compensable injury.

ORDER

The ALJ's order dated August 23, 1995 is affirmed.

In the Matter of the Compensation of
DONALD M. LEWIS, Claimant
WCB Case Nos. 95-05994 & 95-04858
ORDER ON REVIEW
Bischoff & Strooband, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Christian and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Baker'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 reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact." We do not adopt his "Ultimate Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

Relying on Dr. Daven, consulting physician, the ALJ concluded that claimant's work was the major contributing cause of his bilateral CTS. On review, the employer contends that there is no persuasive evidence which supports the compensability of claimant's claim. We agree and reverse.

Because claimant's bilateral CTS symptoms were gradual in onset, we analyze his condition as an occupational disease. (Tr. 16-18; 26); See Valtinson v. SAIF, 56 Or App 186 (1982). As such, claimant must prove that his work activities were the major contributing cause of his bilateral CTS. See ORS 656.802(2). Generally, a worsening of symptoms alone is not sufficient to prove an occupational disease. See Weller v. Union Carbide, 288 Or 27 (1980). However, if the medical evidence establishes that the claimant's symptoms are the disease, a worsening of symptoms that is caused, in major part, by work conditions, may be compensable. Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498, 501 (1990); Georgia Pacific Corp. v. Warren, 103 Or App 275, 278 (1990), rev den 311 Or 60 (1991).

Due to the number of the various possible causes of claimant's current wrist condition, including a prior work related accident in December 1993 (tendonitis of the left hand), we find that the causation issue is a complex medical question requiring expert medical opinion to resolve. Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985); Uris v. Compensation Department, 247 Or 420, 424 (1967). Medical opinions that are well-reasoned and explained and based on complete and accurate histories are given greater weight. Somers v. SAIF, 77 Or App 259 (1986).

At least since 1991, claimant has worked periodically for the employer (a lumber mill). Following a 4 1/2 month lay-off, claimant returned to work for the employer in February 1995. Claimant's work activities involved feeding wood into a dryer. (Tr. 17). Claimant's hand symptoms began three to four weeks after his return. (Tr. 26). One week prior to claimant seeking treatment for his hand symptoms, claimant unloaded a load of scrap wood from his own pickup. (Tr. 95).

Claimant first sought medical treatment in March 1995 from Dr. Jaworski, attending physician, who reported that claimant had a history of bilateral CTS and excessive alcohol intake with no alcohol problems in the past year and a half. (Ex. 54A; 54B). Dr. Jaworski referred claimant to Dr. Daven for nerve conduction velocities (NCV's) studies. Id. The NCV's revealed mild bilateral CTS with possible superimposed polyneuropathy. (Ex. 59).

In April 1995, Dr. Bitter, who performed surgery on claimant's left hand in 1992, opined that claimant's mild bilateral CTS may be more of a generalized trauma disorder because of the degree of swelling and the possible polyneuropathy revealed by claimant's NCV's. (Ex. 62). Because there were no neurologic deficits in claimant's wrists, Dr. Bitter recommended medical treatment (as opposed to surgery) for six weeks. Id.

In May 1995, Dr. Daven opined that claimant's pain and numbness in his hands were secondary to bilateral carpal tunnel syndrome. (Ex. 67). In June 1995, Dr. Daven opined that claimant's work activities were the substantial contributing cause for his symptoms. (Ex. 68). With respect to claimant's possible polyneuropathy, Dr. Daven stated that [claimant] was asymptomatic for the neuropathy, as his symptoms were most consistent with carpal tunnel disease. Id.

Dr. Jaworski related claimant's polyneuropathy to excessive alcohol intake in the last several years. (Ex. 54B). Dr. Jaworski did not address the cause of claimant's bilateral CTS.

Noting the absence of a medical opinion supporting a conclusion that claimant's bilateral CTS symptoms constituted the "disease", the employer contends that the claim is not compensable. We agree.

In Matthew R. Ross, 47 Van Natta 698 (1995), the claimant asserted that his occupational disease claim for CTS was compensable because having symptoms of CTS were the disease. There, we declined to find persuasive the causation opinions of the two physicians (who rendered opinions on the causation of the claimant's CTS), because neither physician explained that the claimant's symptoms were the disease. Patricia D. Randle, 46 Van Natta 350 (1994); Stephen M. Petricevic, 45 Van Natta 2372 (1994).

Similarly in this case, we decline to find persuasive the opinion of Dr. Daven because he failed to explain that claimant's "symptoms" were the disease (i.e. bilateral CTS). Specifically, Dr. Daven was only able to opine that claimant had symptoms, "secondary" or "consistent" with bilateral CTS. However, he did not conclude that claimant's symptoms were the disease or that claimant's work activities caused claimant's bilateral CTS.

Additionally, Dr. Daven's opinion is not persuasive because it does not address claimant's history of prior hand complaints in relation to claimant's current condition. See Somers v. SAIF, 77 Or App 259 (1986). This lack of explanation is particularly noteworthy given that Dr. Bitter, claimant's former treating surgeon, opined that claimant's current condition may be more of a generalized trauma disorder than bilateral CTS. As such, we find that Dr. Daven's opinion fails to persuasively support the compensability of claimant's claim. See Teledyne Wah Chang v. Vorderstrasse, supra. Consequently, we reverse the ALJ's order which set aside the employer's denial of claimant's occupational disease claim for bilateral CTS.

ORDER

The ALJ's order dated September 8, 1995 is reversed. The employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
KENNETH P. McCORMICK, Claimant
WCB Case Nos. 95-01711 & 94-13457
ORDER ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney
Zimmerman, Rice, et al, Defense Attorneys

On April 12, 1996, we withdrew our March 27, 1996 order that had affirmed an Administrative Law Judge's (ALJ's) order that upheld the insurer's denial of claimant's aggravation claim for a low back injury. We took this action to retain authority to consider the parties' forthcoming revised Disputed Claim Settlement (DCS), which was designed to resolve all issues raised or raisable between them, including the insurer's aggravation denial. Having received the revised settlement, we proceed with our reconsideration.

Pursuant to the settlement, claimant agrees that the insurer's denial, as supplemented in the agreement, "shall remain in full force and effect." In addition, claimant "withdraws the Request for hearing." Finally, the parties stipulate that claimant's hearing request "shall be dismissed with prejudice."

We have approved the parties' settlement, thereby fully and finally resolving this dispute, in lieu of all prior orders. Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

May 1, 1996 Cite as 48 Van Natta 952 (1996)

In the Matter of the Compensation of
OMAR MENDOZA, Claimant
WCB Case No. 93-04031
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Brazeau's order that remanded the claim to the Director for promulgation of a temporary rule regarding permanent disability that addressed claimant's loss of left hand grip strength. On review, the issue is the ALJ's remand ruling.

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

We agree with the ALJ that claimant sufficiently raised the question of the appropriateness of a temporary rule on reconsideration by objecting to the impairment findings and disability rating made by SAIF in closing his claim.

Without expressly finding that the existing standards addressed claimant's disability, the Director issued an Order on Reconsideration which awarded no scheduled permanent disability for claimant's compensable left wrist condition. Although the order expressly found no permanent impairment "as rateable under the standards," it made no finding regarding whether claimant's loss of grip strength is addressed by those standards. (Ex. 10). Moreover, assuming that the standards do not addressed claimant's strength loss (which is due to lost range of motion[1]), the Director has not indicated whether promulgation of a temporary rule addressing that disability has been considered.

Under these circumstances, we agree with the ALJ that the claim must be remanded to the Director for consideration and/or promulgation of a temporary rule under ORS 656.726(3)(f)(C). See Gary D. Gallino, on remand, 46 Van Natta 246 (1994) (Board is compelled to remand to the Director upon a finding that, at the time of the issuance of an Order on Reconsideration, disability is not addressed by the existing standards and the Director neglected to stay further proceedings and adopt a temporary rule); Dennis L. Martindale, 47 Van Natta 299 (1995).

Claimant's attorney is entitled to an assessed fee for prevailing over 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 fee for claimant's attorney's services on review is $800, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 9, 1995, as reconsidered November 27, 1995, is affirmed. For services on review, claimant is awarded an $800 attorney fee, payable by the SAIF Corporation.

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[1] In this regard, we note SAIF's reliance on OAR 436-35-110(8)(c), which provides that "decreased strength due to loss in range of motion receives no rating in addition to that given for the loss of range of motion." (Emphasis added). In this case, no rating has been given for lost range of motion.

In the Matter of the Compensation of
JESUS MUNOZ, Claimant
WCB Case No. 94-04199
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Bonnie V. Laux (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Garaventa's order that reduced claimant's scheduled permanent disability for loss of use and function of the left ankle from 17 percent (22.95 degrees), as awarded by an Order on Reconsideration, to 2 percent (2.7 degrees). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a left ankle injury. A Notice of Closure awarded 2 percent scheduled permanent disability for the left foot. An Order on Reconsideration increased the award to 17 percent scheduled permanent disability based on decreased range of motion in the left ankle and an inability to stand or walk for greater than two hours.

The ALJ reduced the award to 2 percent. The ALJ found that claimant was unable to walk or stand continuously for more than two hours. Nevertheless, the ALJ found that any impairment from claimant's inability to walk or stand continuously for more than two hours did not entitle him to a rating under OAR 436-35-200(4), as claimant's attending physician did not restrict claimant's standing and walking to two hours in an eight-hour day.

Claimant asserts that we should reinstate the Order on Reconsideration's award, as he is unable to stand or walk for greater than two hours in an eight hour day and, thus, the rule is applicable. We agree.

OAR 436-35-200(4) provides in pertinent part:

> "When a preponderance of objective medical evidence indicates an accepted compensable injury to the foot has resulted in a permanent inability to walk or stand for greater than two hours in an 8-hour period, the award shall be 15% of the foot. This value is combined with all other scheduled impairment findings in the foot. * * * This rule is applicable in those cases where the objective medical evidence indicates severe injury to the foot has occurred with residual impairment (e.g. severe soft tissue crush injuries, calcaneal fractures, or post-traumatic avascular necrosis)."

Here, the objective medical evidence indicates that claimant sustained a severe injury to his ankle with residual impairment. He fractured his left fibula and left medial maleolus, which required open reduction and internal fixation. (Ex. 9-82, -146, -147, -151, -152). Dr. DeSitter, claimant's attending physician, performed a closing examination. Claimant reported that he continued to experience pain and swelling after several hours of work or walking. (Ex. 9-33). Dr. DeSitter concluded:

> "Ankle fracture. [Claimant] is medically stationary and the case is closed. At this time, he is where he will probably be for most of his life, and [claimant] is informed of such. He is told that he will get pain and swelling with more than a couple of hours of walking and/or standing and/or moving. * * * I returned [claimant] to eight hours of work, which will be moderate in intensity. [Claimant] will not tolerate eight hours on a ladder or walking up and down hills, because of swelling and tenderness from pain. [Claimant] is encouraged to seek a new profession instead of farm work." (Ex. 9-33).

Based on this evidence, we agree with the ALJ that claimant is unable to stand or walk continuously for more than two hours during an 8-hour period. Furthermore, Dr. DeSitter restricts claimant from performing his present job, which requires standing on a ladder and walking up and down hills for more than two hours in a work day, stating that claimant cannot perform that work. Although Dr. DeSitter does not specifically state that claimant is restricted from standing and walking for more than two hours in an 8-hour work day, we understand Dr. DeSitter's discussion and restrictions to indicate that claimant's injury has resulted in a permanent inability to walk or stand for greater than two hours in an 8-hour period.

We accordingly conclude that this evidence is sufficient to carry claimant's burden to prove his entitlement to an award under OAR 436-35-200(4). Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109, 112 (1991), rev den 312 Or 676 (1992) (No incantation of "magic words" or statutory language is required); see also Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995) (Administrative rule permits the Board to make an award for "chronic condition impairment" even if the record contains no express medical finding that the condition is "chronic," so long as the record contains a medical opinion of the claimant's attending physician from which it can be found that the worker is unable to repetitively use a body part).

Accordingly, claimant is entitled to a 15 percent rating under OAR 436-35-200(4) for permanent inability to walk or stand for greater than two hours in an 8-hour period. The parties do not dispute the 2 percent for loss of range of motion in the ankle joint, OAR 436-35-190(6). Combining these values results in 16 percent impairment of the foot. OAR 436-35-007(14). Thus, we conclude that the Order on Reconsideration award of scheduled permanent disability should be decreased from 17 percent to 16 percent.

Because the compensation awarded by the Order on Reconsideration has been reduced, claimant is not entitled to an attorney fee pursuant to ORS 656.382(2). However, because we have modified the ALJ's order that reduced claimant's scheduled permanent disability, our order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by our order (the 14 percent increase between the ALJ's 2 percent award and our 16 percent award), not to exceed $3,800, payable directly to claimant's attorney. See ORS 656.386(2).

ORDER

The ALJ's order dated November 2, 1995 is modified. In lieu of the ALJ's order, the Order on Reconsideration award of 17 percent (22.95 degrees) is reduced to 16 percent (21.6 degrees) scheduled permanent disability for loss of use or function of the left foot. Claimant's attorney is awarded 25 percent of the additional compensation created by this order (the 14 percent difference between the ALJ's 2 percent award and the Board's 16 percent award), not to exceed $3,800.

In the Matter of the Compensation of
NOBUKO STARR, Claimant
WCB Case No. 95-07099
ORDER ON REVIEW
Darrell E. Bewley, Claimant Attorney
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Michael V. Johnson's order that set aside its denial of claimant's aggravation claim for a right foot condition. On review the issue is aggravation. We affirm.

FINDINGS OF FACT

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

On October 28, 1994, while working in the employer's bakery department, claimant sustained a disabling "crush injury" to the toes of her right foot when a heavy appliance fell to the floor and landed on her right forefoot. The claim was accepted, then closed by a November 28, 1994 Notice of Closure awarding temporary disability only. A December 23, 1994 Order on Reconsideration adjusted the temporary disability compensation, but affirmed the Notice of Closure in all other respects.

On May 12, 1995, claimant sought treatment from Dr. Neuburg, complaining of pain in her second and third toes for the past two months. Dr. Neuburg referred claimant to Dr. Matthews, a podiatrist, who recommended surgical removal of claimant's second and third right toenails to decrease her pain.

Claimant had her second and third toenails removed in late May 1995, but continued to have pain, which increased with walking. Dr. Neuburg referred claimant to Dr. Jacobs, who reported that claimant had myofascial tightening, stiffening and "chronic numbness related to injury of the digital nerves of the [second and third toes of the right foot]." Dr. Jacobs found nerve damage that was likely permanent but not of significance from the standpoint of function, and recommended physical therapy for the soft tissue of the toes.

Claimant continued to follow-up with Dr. Neuburg. On June 15, 1995, Dr. Neuburg noted that claimant remained released for sitting work only. (Ex. 16). On August 18, 1995, Dr. Neuburg concluded that claimant was not medically stationary and that she may have an impairment as a result of her right foot injury which would "affect her everyday life as well as her ability to work." (Ex. 18).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant sustained a major symptomatic worsening of her right forefoot injury which, when coupled with the fact she was restricted to modified work and undergoing further medical treatment of her right toes, constituted an "actual worsening of the compensable condition" under amended ORS 656.273(1).

On review, the employer argues that claimant has merely experienced an increase in symptoms which does not satisfy the "actual worsening" requirement. Specifically, the employer contends there is no medical evidence supported by objective findings establishing that claimant's condition has actually worsened. We disagree.

In Carmen C. Neill, 47 Van Natta 2371 (1995), we analyzed the text, context and legislative history behind amended ORS 656.273(1) and found that the term "actual worsening" as used in that section means a pathological worsening of the underlying condition or a symptomatic worsening of the condition that is greater than anticipated by the prior award of permanent disability.[1]

Noting that claimant did not receive an award of permanent disability, the ALJ concluded that in the absence of an award of permanent disability, there is no presumption of future waxing and waning of symptoms. We need not decide at this juncture whether a symptomatic exacerbation of the compensable condition constitutes an "actual worsening" under amended ORS 656.273(1) where there has been no prior permanent disability award because, in this case, we are persuaded by the medical evidence that claimant has sustained a pathological worsening of her compensable condition.

When claimant's pain became so severe she was unable to tolerate prolonged standing and walking and the removal of claimant's two toe nails failed to alleviate her pain, Dr. Neuburg questioned whether the pain had a "post traumatic neurogenic etiology" and referred claimant to Dr. Jacobs, a physiatrist. (Ex. 14). Dr. Jacobs examined claimant's right foot and determined that claimant had pain and stiffness of the toes as well as "chronic numbness related to injury of the digital nerves" of her second and third toes of the right foot. Dr. Jacobs reported that "nerve damage has been done" and also that "[a]ssociated with this [digital nerve] injury has been the evolution of soft tissue pain." (Ex. 15).

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[1] Because the new law went into effect after the record concerning the aggravation had been developed, we remanded the case to the ALJ for the submission of additional evidence regarding whether the claimant sustained an "actual worsening" with respect to her compensable condition. In this case, the parties had the opportunity to generate medical evidence concerning whether claimant has sustained an "actual worsening." Therefore, unlike Carmen C. Neill, supra, we see no compelling reason to remand.

In a later report, Dr. Neuburg similarly opined that claimant's pain did not fit the pattern of normal waxing and waning, but instead fit more into a "neurogenic pattern." Dr. Neuburg explained that "certainly nerve injuries can result from the type of injury [claimant] experienced in October of 1994." Dr. Neuburg determined that despite completing physical therapy, claimant was not yet medically stationary and could not tolerate being on her feet for long periods of time. In addition, Dr. Neuburg noted that at the suggestion of the physiatrist, claimant was in the process of receiving nerve blocks.

We recognize that neither Dr. Neuburg or Dr. Jacobs used the magic words "pathological worsening" or "actual worsening" in evaluating claimant's current condition. It is well settled, however, that magic words are not necessary. See, e.g. McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986). Both Dr. Jacobs and Dr. Neuburg agree that after returning to her regular work in the bakery department, claimant developed pain from a nerve injury or "neurogenic pattern" in the second and third toes of her right foot as a result of the compensable "crush injury" on October 28, 1994. Further, both Dr. Jacobs and Dr. Neuburg reported that claimant has some form of "impairment" as a result of this nerve injury, i.e., difficulty with prolonged walking or standing, a condition she did not have at the time of claim closure. As a result of this "impairment" Dr. Neuburg limited claimant to sedentary work and, as of August 18, 1995, had not declared her medically stationary.

Based on this evidence, we agree with the ALJ that claimant has established an "actual worsening" of her compensable condition supported by objective findings. See Carmen C. Neill, 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 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,200, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 10, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the employer.

May 1, 1996 Cite as 48 Van Natta 956 (1996)

In the Matter of the Compensation of
FREDERICK W. VAN HORN, JR., Claimant
WCB Case No. 95-04257
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Christian, Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order that: (1) assessed a penalty under ORS 656.268(4)(g) based only on the increased permanent disability awarded by an Order on Reconsideration; and (2) declined to award an attorney fee for obtaining that penalty. On review, the issues are penalties and attorney fees.

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

An August 24, 1994 Notice of Closure awarded claimant 18 percent unscheduled permanent disability for his low back condition. Claimant requested reconsideration. A March 28, 1995 Order on Reconsideration awarded claimant an additional 5 percent unscheduled permanent disability, for a total award of 23 percent. The reconsideration order awarded an "out-of-compensation" attorney fee, but no penalty.

At hearing, SAIF agreed to increase claimant's award by 4 percent. SAIF also agreed that claimant was entitled to a penalty under ORS 656.268(4)(g),[1] based on the Order on Reconsideration award. (Tr. 2). However, the parties disagreed as to whether the penalty would be paid to claimant or apportioned between claimant and his attorney.

The ALJ asked claimant's counsel: "Are we here concerning the -- how the 268(g) penalty is split up?"

Claimant's counsel replied: "That's what we're here about, precisely. That's the only issue that's being contested here today." (Id).

The ALJ noted that the parties stipulated to an additional 4 percent unscheduled permanent disability (so that the total award is 27 percent), but that the net increase, for penalty purposes, was 5 percent (i.e., from 18 to 23). (Tr. 2-3). Claimant did not object to this statement of the penalty issue. Accordingly, we find that the parties understood that the penalty in question would be based on the disability award at the time of reconsideration.

On review, claimant requests a penalty under former ORS 656.268(4)(g) based on his entire permanent disability award (including the 4 percent increase at hearing), not just the increased amount as of reconsideration. However, based on the above-described statements regarding the issues at hearing, we find that the penalty issue was confined to that associated with the increased permanent disability awarded by the Department on reconsideration. See Stevenson v. Blue Cross, 108 Or App 247 (1991) (We decline to address issues on review which were not raised at hearing). Accordingly, we do not address claimant's contention that the at-hearing stipulated 4 percent award should be part of his penalty basis, because that argument was not raised at hearing.[2] Id.

Moreover, to the extent that the parties agreed to litigate the penalty basis issue (see Tr. 4), we agree with the ALJ that the penalty basis is the amount claimant's award was increased upon reconsideration only, based on the following reasoning.

ORS 656.268(4)(g), like ORS 656.262(11) (former, ORS 656.262(10), provides for a penalty based on an amount "then due." Specifically, ORS 656.268(4)(g) requires a penalty "in an amount equal to 25 percent of all compensation determined to be then due the claimant." The phrase "then due" refers to unpaid compensation. See Weyerhaeuser Co. v. Knapp, 100 Or App 615, 619 (1990) (Court rejected the claimant's argument that a penalty (under former ORS 656.262(10)) should be based on all temporary disability benefits payable until claim closure, because such an interpretation of the statute "fails to give effect to the word 'then.'"); Wacker Siltronic Corporation v. Satcher, 91 Or App 654, 658 (1988) (To support a penalty, "there must be an unpaid amount 'then due.'"); see also Jeffrey D. Dennis, 43 Van Natta 857, 858 (1991) (In the context of an untimely denial, "the delay period is the 'then' with regard to the term 'amounts then due.'").

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

> "If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for 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." (Emphasis added).

We note that Senate Bill 369, Section 30, amended ORS 656.268(4)(g) to provide that if an increase in compensation results from "new information" obtained through a medical arbiter examination or from the adoption of a temporary emergency rule, the penalty under that statute shall not be assessed. However, amended ORS 656.268(4)(g) applies only to claims that become medically stationary on or after June 7, 1995, the effective date of the Act. Senate Bill 369, Section 66. Therefore, it is inapplicable to this claim.

[2] If the issue was properly before us, we would not find that the 4 percent additional award, as stipulated at hearing, was "then due" as of reconsideration. As such, it would not be an amount "then due" for purposes of ORS 656.268(4)(g).

Under these circumstances, we find that the ORS 656.268(4)(g) penalty is properly based on the amount claimant's award is increased upon reconsideration,[3] because no other reading of the statute gives effect to the word "then."[4] Accordingly, we conclude that the ALJ properly awarded a penalty under ORS 656.268(4)(g) based on claimant's permanent disability award "determined to be then due" as of reconsideration.

ORDER

The ALJ's order dated July 20, 1995 is affirmed.

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[3] No contention has been made that the carrier neglected to pay the Notice of Closure's permanent disability award. Had such circumstances arisen, such nonpayment would support a penalty under ORS 656.262(11), rather than ORS 656.268(4)(g). We would reach such a conclusion because, since claimant would have been seeking reconsideration of the notice of closure award, the carrier would have had no authority to "stay" any compensation awarded by the notice of closure. See ORS 656.313. In other words, all compensation granted by the notice of closure would have been "then due" within 30 days of its issuance. OAR 436-060-0150(7).

[4] When a reconsideration order's increased permanent disability award is decreased on review, the Board's correction of the permanent disability award relates back to the Order on Reconsideration and the penalty is decreased proportionately. See Mast v. Cardinal Services, Inc., 132 Or App 108, 111 (1990). Such facts are not presented here.

Board Chair Hall dissenting.

Former ORS 656.268(4)(g) provides:

> "If, upon reconsideration of a claim closed by an insurer or self-insured employer, the department orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for 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." (Emphasis added).

The statute clearly provides that a penalty under the circumstances of this case "shall be assessed" in an amount equal to 25 percent of "all compensation" determined to be then due the claimant.

The majority does not explain why the modifying phrase "then due" is more important than the object, or basis, of the penalty, i.e., "all compensation." This is especially critical in light of the equally important companion phrase "determined to be then due." After all, the reconsideration process is a de novo process. The determination of permanent disability made upon reconsideration is a new determination, a substitute for the initial determination, not an addition to or subtraction from the initial determination. The compensation in question is not "then due" until it has been determined to be due--upon reconsideration. Thus, the penalty under ORS 656.268(4)(g) must be based on all compensation determined to be then due upon reconsideration.

The context of ORS 656.268(4)(g) does not require or even implicate the majority's interpretation of the phrase "then due." Moreover, the legislative history of the statute indicates that this penalty is specifically designed to discourage "low balling" of permanent disability awards from the start, i.e., at claim closure.

During the 1990 Special Legislative Session, witnesses testified to this effect before the Special Committee on Workers' Compensation. Witness Ross Dwinnel noted that Senate Bill 1197 moved the penalty in question from hearings to evaluation "to accommodate concerns regarding closure of the claim." Minutes, Interim Special Committee on Workers' Compensation, May 3, 1990, Tape 3, Side A. Witness Cecil Tibbetts explained that the purpose of the 25 percent penalty upon reconsideration is to "keep low balling from happening by that provision, and that penalty then will be an amount equal to 25 percent of all compensation that's determined to be due the claimant." Id. at Tape 1, Side B.

During the 1995 legislative hearings regarding Senate Bill 369, Representative Mannix noted that ORS 656.268(4)(g) "penalizes an employer if it missed the mark by 25 percent on paying permanent disability. Since we allow insurers to close themselves with a notice of closure, if they miss the mark by a 25 percent differential, they have to pay a penalty." Minutes, Legislative Hearings, May 3, 1995, Tape 15, Side B.

The purpose of the statute is to discourage "low balling" of permanent disability awards at claim closure. The key question is whether the closure award was too low. The statute does not refer to unpaid compensation, it refers to all compensation. Moreover, because the penalty amount (25 percent of "all compensation") is not determined until reconsideration, it must be 25 percent of the total award.

In the present case, the parties agree with the ALJ's order regarding the extent of claimant's permanent disability and it is undisputed that claimant is entitled to a penalty under ORS 656.268(4)(g). Inasmuch as claimant's total unscheduled permanent disability award is 27 percent by virtue of the ALJ's order, that is the "compensation determined to be then due" under the statute. Thus, claimant is entitled to a ".268(4)(g)" penalty in an amount equal to 25 percent of the 27 percent award, i.e., 25 percent of all compensation determined to be then due to him. Because the majority reaches a different result, which is contrary to the plain language and purpose of the statute, I must respectfully dissent.

May 1, 1996 Cite as 48 Van Natta 959 (1996)

In the Matter of the Compensation of
EVERETT G. WELLS, Claimant
Own Motion No. 95-0013M
OWN MOTION ORDER ON RECONSIDERATION
Malagon, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 14, 1995 Own Motion Order in which we declined to reopen his 1983 claim for the payment of temporary disability compensation because: (1) he failed to establish that his June 19, 1995 surgery was reasonable and necessary for his compensable low back condition; and (2) he failed to establish that he was in the work force at the time of his current disability.

On October 17, 1995, we abated our prior order, and requested that the SAIF Corporation file a response to claimant's motion. On October 20, 1995, SAIF notified the Board that a Proposed and Final Order Concerning a Bona Fide Medical Services Dispute was issued on October 12, 1995, which "indicates that SAIF Corporation is not liable for the June 15, 1995 surgical procedure performed for [claimant]." A Final Order Concerning a Medical Services Dispute was issued on October 26, 1995. Claimant appealed the October 26, 1995 final order concerning this medical services dispute.

In a February 22, 1996 Proposed and Final Contested Case Hearing Order, Administrative Law Judge (ALJ) Kinsley reversed the October 26, 1995 order, and found the June 19, 1995 lumbar surgery to be "appropriate treatment for claimant's compensable conditions of scarring and arthritic changes in the lumbar spine pursuant to ORS 656.327(1)."

On reconsideration, we issue the following order in place of our September 14, 1995 order.

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

As noted above, SAIF contends that surgery performed by Dr. Freeman, claimant's treating neurosurgeon, which included the neurolysis of large amounts of scar tissue at L5-S1 on the left, mesiofacectomy of L5-S1 on the left, foraminotomy at L5-S1 on the left and hemilaminectomy of S1 on the left, was not reasonable and necessary. Here, pursuant to the February 22, 1996 order, the Director has ordered SAIF to accept claimant's medical services claim for the June 19, 1995 surgery. Thus, we find that claimant has established that the June 19, 1995 surgery was reasonable and necessary for his compensable injury.

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 also contends that claimant was not in the work force at the time of current disability. Claimant contends that he qualifies for temporary disability compensation because was willing to work, but unable to work because of the compensable injury at the time of disability.

In our prior order, we noted that claimant had not established that his compensable injury worsened at the time he "shut down his business on February 9, 1995." Thus, claimant stopped working in February 1995. Because the evidence in the prior record established that the time of disability occurred in June 1995 (when claimant underwent surgery), claimant must provide persuasive evidence that he was unable to work because of the compensable injury since February 1995 or that the actual time of disability was in February 1995.

In response to an October 5, 1995 letter, Dr. Freeman opined that claimant's compensable condition "had worsened when he left work in February of 1995." In addition, Dr. Freeman noted that claimant's condition continued to worsen, and that the worsening disabled him from his ongoing regular employment. Finally, in an October 19, 1995 letter, Dr. Gombart, consulting physician, opined that:

> "The [claimant] stated that the back pain was of a degree that he was unable to work steadily. Since [claimant] was working prior to the worsening of the back pain prompting consultation and eventual surgical referral, one must assume that his back pain was less previously. Between 9/7/9[4] and 1/95 he received medical treatment which was not adequately resolving the pain thus prompting MRI and eventual surgical referral."

We are persuaded by the opinions of Drs. Freeman and Gombart that claimant was unable to work since about February 1995, when his condition worsened requiring surgery. In addition, these opinions are unrebutted. On this record, we conclude that claimant has established that he remained in the work force at the time of disability.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning June 19, 1995, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by SAIF directly to claimant's attorney. See OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

May 2, 1996 Cite as 48 Van Natta 960 (1996)

In the Matter of the Compensation of
CHARLES R. MORGAN, Claimant
WCB Case Nos. 94-13071, 94-13069, 94-13065, 94-13063, 94-11386, 94-02635, 94-13068, 94-13066, 94-13067, 94-13064 & 94-11387
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys
Garrett, Hemann, et al, Defense Attorneys
Bostwick, et al, Defense Attorneys
Jerome P. Larkin (Saif), Defense Attorney
Kevin L. Mannix, Defense Attorney
Steven T. Maher, Defense Attorney
Meyers, Radler, et al, Defense Attorneys
Scheminske, et al, Defense Attorneys

Argonaut Insurance Company, on behalf of Swinerton & Walberg (Swinerton/Argonaut), requests reconsideration of that portion of the Board's April 10, 1996 Order on Review[1] that awarded

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[1] Members Gunn and Christian signed the Board's April 10, 1996 order. Effective April 11, 1996, Member Gunn is no longer a member of the Board.

claimant's attorney an assessed fee of $1,000, pursuant to ORS 656.382(2), for services on review regarding the compensability issue, payable by Swinerton/Argonaut. Swinerton/Argonaut contends that it should not be liable for any assessed attorney fee because the issue on review was responsibility, not compensability. Alternatively, Swinerton/Argonaut contends the assessed fee should be reduced to $100. Liberty Northwest Insurance Corporation, on behalf of McKinstry Company (McKinstry/Liberty), concurs with Swinerton/Argonaut's contentions. In response, claimant asserts that the motion should be denied.

Although the Board addressed only responsibility on review, the April 10, 1996 order explained that, because both compensability and responsibility were decided by the Administrative Law Judge, by virtue of the Board's de novo review authority, compensability remained at risk on review as well. In addition, Swinerton/Argonaut's appeal to the Board placed claimant's award at risk. Therefore, claimant's counsel is entitled to an assessed attorney fee for services on Board review regarding the potential compensability issue, payable by Swinerton/Argonaut. Dennis Uniform Manufacturing v. Teresi, 115 Or App 248, 252-53 (1992), mod 119 Or App 447 (1993); Paul R. Huddleston, 48 Van Natta 4, on recon 48 Van Natta 203 (1996). Furthermore, for the reasons stated in the April 10, 1996 order, we continue to find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by Swinerton/Argonaut.

Accordingly, we withdraw the April 10, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish the April 10, 1996 order effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Member Haynes specially concurring.

My concurrence should not be interpreted as my agreement with each and every finding and conclusion made in the prior decision. Rather, my intention is to merely recognize that Members Christian and Gunn were authorized to render that decision and, based on those findings, the conclusion reached in this reconsideration order is warranted.

May 2, 1996 Cite as 48 Van Natta 961 (1996)

In the Matter of the Compensation of
WALTER C. WINDOM, Claimant
WCB Case No. 93-05126
ORDER ON REMAND
James L. Francesconi, Claimant Attorney
Julene M. Quinn (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Windom v. Dodge Logging, 139 Or App 130 (1996). The court reversed our prior order, Walter C. Windom, 46 Van Natta 1559 (1994), which affirmed a Director's order that had dismissed claimant's request for vocational assistance. Referring to the 1995 statutory amendments, the court has remanded for reconsideration.

FINDINGS OF FACT

We republish the "Findings of Fact" from our previous order.

CONCLUSIONS OF LAW AND OPINION

In August 1992, Dr. Kendrick, treating surgeon, recommended claimant for vocational assistance. At the time of that recommendation, claimant's 5-year aggravation rights had expired. See ORS 656.273(4); 656.278(3). In its Notice of Eligibility, the SAIF Corporation declined claimant's vocational assistance request, stating that such services could not be authorized in "Own Motion" claims. Claimant requested Director review.

The Director dismissed claimant's request for vocational assistance, stating that the "Board's Own Motion reopening cannot be used as a basis for potential eligibility for vocational assistance." Claimant requested a hearing.

Relying on David F. Meissner, 44 Van Natta 249 (1993), the ALJ set aside the Director's order finding that claimant was not disqualified from vocational assistance under former ORS 656.340 merely because his aggravation rights have expired. SAIF requested Board review.

Subsequent to the ALJ's order, the court reversed our decision in Meissner, citing Harsh v. Harsco Corporation, 123 Or App 383 (1993), rev den 318 Or 661 (1994). All American Air Freight v. Meissner, 129 Or App 104 (1994). In Harsh, supra, the court had held that the only benefits available to a claimant whose aggravation rights have expired are those referred to in ORS 656.278(1).

On review, we followed the court's holding in Harsh, finding that claimant was not eligible for vocational assistance because his claim was in Own Motion status. Consequently, we reversed the ALJ's order. Claimant petitioned for judicial review. In light of the 1995 statutory amendments, the court has reversed and remanded this case for our reconsideration.

Pursuant to amended ORS 656.283(2), vocational assistance disputes are subject to Director review. In Ross Enyart, 47 Van Natta 1540 (1995), relying on Volk v. America West Airlines, 135 Or App 565 (1995), we concluded that amended ORS 656.283(2) (which now provides for Director review of vocational assistance disputes) is retroactively applied.

In reaching our decision in Enyart, we recognized that amended ORS 656.283(2)(d) allows 60 days within which to appeal a Director's administrative review order. However, noting that claimant had previously sought a contested case hearing with the Board's Hearings Division within 60 days of the Director's administrative order, we speculated that such a hearing request may serve to preserve claimant's appeal rights. In any event, because the authority over the vocational assistance dispute now rests with the Director, we concluded that resolution of the question was a matter for that forum.

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). Inasmuch as this pending dispute concerns claimant's entitlement to vocational assistance, jurisdiction over this matter rests with the Director. Consequently, on reconsideration of our prior order, we vacate the ALJ's September 21, 1993 order and dismiss claimant's hearing request.

IT IS SO ORDERED.

In the Matter of the Compensation of
ZIDAN ZIDAN, Claimant
WCB Case No. CV 96002
CRIME VICTIM ORDER
Mary Campbell, Assistant Attorney General

Reviewed by Board Members Haynes and Hall.

Zidan Zidan (hereafter referred to as "applicant"), has requested Board review of the Department of Justice's December 5, 1995 Second Order on Reconsideration. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial, in part, on a finding that applicant's injury was substantially attributable to his own wrongful act.

Following our receipt of the request for Board review, applicant was advised that he was entitled to present his case to a hearing officer. To exercise his right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed him a copy of its record. The Department mailed a copy of its record to applicant on March 1, 1996. Having received no hearing request within the requisite time period, we have conducted our review based solely on the record.

FINDINGS OF FACT

On December 17, 1994, applicant went to the Dublin Pub with Craig Swift and Herman Valeur. At some point in the evening, Valeur was asked to leave by employees of the pub because he had

become disruptive after being told that he could not purchase any more beer. After being told to leave the pub, Valeur went out into the parking lot and waited for applicant. Upon being informed that Valeur had been asked to leave, applicant and Swift went outside to look for Valeur.

When applicant approached Valeur in the parking lot, Valeur told applicant that someone was giving him "some shit." Applicant asked the person whether he had a "f---ing problem" or something to that effect. Thereafter, applicant followed the person to the other side of the parking lot and a fight began. Theo Evans, an off-duty police officer who was at the pub, observed employees of the Dublin Pub attempt to break up the fight in the parking lot between applicant and an unknown male. Evans heard the pub employees request that applicant leave the property, but applicant did not do so. Evans then saw Tauni, a former employee of the pub, approach applicant. Tauni and applicant spoke briefly and then applicant attacked Tauni. A pub employee, Baimi, entered the fight and struck applicant in the face with his fist. Evans and four other off-duty police officers approached the fight and identified themselves as police officers. The off-duty police officers then broke up the fight. Evans told an employee of the pub to notify the Washington County Sheriff's office.

Deputy DuPont of the Washington County Sheriff's Office was dispatched to Dublin Pub in response to the report of a fight in the parking lot. Deputy DuPont cited applicant for disorderly conduct and released him. The citation was later dismissed when no police officer appeared for the court date.

Deputy DuPont later advised the Department that he considered applicant to be very intoxicated and obstinate during the investigation of the fight.

On January 11, 1995, applicant applied for crime victims' compensation. On July 19, 1995, after conducting its investigation, the Department denied applicant's request for crime victims' compensation on the grounds that applicant's injury was not the result of a crime perpetrated or attempted against him, and that applicant's injury was substantially attributable to his own wrongful act.

Submitting a written argument, applicant requested reconsideration on July 30, 1995. Among other things, applicant contended that Craig Swift would corroborate applicant's version of the events of December 17, 1994. The Department attempted to contact Swift regarding statements attributed to him by applicant, but was unable to do so. The Department issued an Order on Reconsideration on September 12, 1995. Concluding that applicant had contributed to his injuries by involving himself in the expulsion of Herman Valeur from the pub, and that applicant was involved in the wrongful act of mutual combat, the Department declined to alter its prior decision denying benefits.

Applicant sought Board review of the Department's Order on Reconsideration. Applicant submitted new information, including logs of 911 calls for Dublin Pub from August 1994 through August 1995. Applicant also indicated that Craig Swift would now be available to corroborate applicant's statements. On November 16, 1995, the Board dismissed applicant's request for Board review and remanded the case to the Department for reconsideration in light of the new information.

The Department issued a Second Order on Reconsideration on December 5, 1995. The Department was unable to make any determination as to the relevance of the 911 logs to applicant's case. The Department again attempted to interview Craig Swift, but was unable to do so. After reconsidering the evidence, the Department declined to alter its original decision to deny crime victim's compensation. Thereafter, claimant requested Board review.

CONCLUSIONS OF LAW AND OPINION

The standard of review for cases appealed to the Board under ORS Chapter 147 is de novo on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

A person is eligible for crime victims' compensation if the person is a victim of a "compensable crime." ORS 147.015(1). A "compensable crime" is an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state." ORS 147.005(4). Eligibility for benefits is based in part on a finding that injury to the victim "was not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim." ORS 147.015(5). "Substantial provocation" is "a voluntary act from which there can be a reasonable inference that, had the act not occurred, the crime likely would not have occurred." OAR 137-76-010(8).

Applicant's statement regarding the incident at Dublin Pub differs significantly from the various statements in the police reports, including the statement of Herman Valeur. According to applicant, when he approached Valeur in the parking lot, three Dublin Pub employees were pushing Valeur. Applicant stated that he was caught between the three men and Valeur. He stated that he asked the men what was going on. In addition, applicant acknowledges that he used harsh language and said something like: "Why are you f---ing up with him." Applicant then indicates that three other men came from the pub and that he was beaten by six men for a period of thirty minutes.

Applicant's version of events differs from the statements of off-duty officer Evans, as well as the statements of Valeur and Baimi. Moreover, although applicant indicated that Swift would confirm applicant's version of events, Swift did not respond to the Department's multiple attempts to interview him and has not provided any confirmation of applicant's statement.

Based on this record, we find the statements made by the other witnesses in the police reports to be more reliable than the statements made by applicant. We note that the statements contained in the police reports were taken soon after the incident. Thus, we consider those statements to be more accurate and reliable than applicant's later statements. We find the statement of officer Evans, a disinterested witness, to be particularly persuasive regarding the events surrounding the fight and applicant's behavior on December 17, 1994.

After reviewing the record de novo, we find insufficient evidence that applicant was a victim of a "compensable crime," i.e., that applicant's injuries were the result of an "intentional, knowing or reckless act." Based on the following reasoning, the record establishes that applicant's injuries were not caused by an unprovoked assault. Moreover, even if there was a "compensable crime," we conclude that applicant substantially provoked the assault by becoming involved in the expulsion of Valeur from the pub. Based on the statements of Baimi and Valeur contained in the police reports, we are persuaded that applicant began the fight by using provocative language and by following the "unknown male" across the parking lot. Our conclusions are consistent with Deputy DuPont's statements that applicant was very intoxicated and obstinate during the investigation of the incident. Given officer Evans' report, the statements of Valeur and Baimi, as well as Deputy DuPont's observations of claimant's behavior on the night of the incident, we are not persuaded by applicant's attempts to cast himself in the role of an innocent person who was in the wrong place at the wrong time. Rather, based on this record, we find that applicant substantially provoked the other participants in the fight through his aggressive behavior and provocative language and that applicant's injuries were substantially attributable to his own wrongful act in provoking the fight.

Applicant has submitted 911 logs which he asserts establish that Dublin Pub has had other incidents such as the parking lot fight on December 17, 1994. Even assuming that Dublin Pub is a particularly dangerous place, the issue in this case remains whether applicant was a victim of a "compensable crime," and, if so, whether he substantially provoked his assailants and/or whether his injuries are substantially attributable to his own wrongful act. As we have previously concluded, this record does not establish that applicant was a victim of a compensable crime. In addition, even assuming that a "compensable crime" has been established, the record supports the conclusion that applicant substantially provoked his assailants and that his injuries are substantially attributable to his own wrongful acts. Under such circumstances, applicant does not qualify for crime victims' compensation.

Finally, applicant has argued that his witness, Swift, overheard a police officer tell a Dublin Pub employee that the police should have been called sooner. According to applicant, Swift was left with the impression that similar incidents had occurred previously. First, as we stated earlier, the Department attempted to contact Swift regarding the statements attributed to him and was unable to do so. Second, Deputy DuPont testified that he did not make the statement overheard by Swift and did not hear any other officer on the scene make such a statement. Finally, even assuming that an officer did make the statement overheard by Swift, (that the police should have been called sooner), this does not alter the fact that applicant has not established that he was a victim of a "compensable crime," nor does it alter the fact that applicant substantially provoked his assailants and substantially contributed to his injuries.

Accordingly, the Department of Justice's July 19, 1995 "Findings of Fact Conclusions and Order," as reconsidered on September 12, 1995 and December 5, 1995, is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
CRAIG B. JOHNSON, Claimant
WCB Case No. 95-08588
ORDER ON REVIEW
Richard F. McGinty, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Garaventa's order that: (1) found that claimant does not have a left glenohumeral joint sprain/strain; (2) did not award penalties or attorney fees for the SAIF Corporation's allegedly unreasonable failure to process a claim for that condition; (3) affirmed an Order on Reconsideration which found that claimant was medically stationary on March 27, 1995; (4) declined to award temporary disability compensation for the period from March 28, 1995 through May 8, 1995; and (5) affirmed the Order on Reconsideration's award of 8 percent (25.6 degrees) unscheduled permanent disability for claimant's left shoulder condition. On review, the issues are temporary and permanent disability, compensability, penalties, and attorney fees.

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

Claimant argues that SAIF should be directed to accept and process claimant's claim for a left glenohumeral strain (in addition to the accepted "strain of the left shoulder acromioclavicular joint"). (See Exs. 12, 13). The ALJ found that claimant has no such condition and therefore upheld SAIF's "de facto" denial of the claim. We agree.

An accurate or definitive diagnosis is not required to establish compensability. See Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992). On the other hand, an insurer is not required to separately process a claim representing only a differential diagnosis for the accepted condition. See Butch P. Saloom, 48 Van Natta 341 (1996); see also Karen S. Boling, 46 Van Natta 1522 (1994) (Where different diagnoses employed, but current condition was the same as it had been since the original injury, there was no "de facto" denial).

Here, although Dr. Moll referred to glenohumeral symptoms, his "working diagnosis" was "left shoulder strain." (Exs. 8A-1, 10-1). He repeatedly stated, upon examination, that claimant's diagnosis was "same condition." (Exs. 10-1; 10-2; see Ex. 14-1 ("Dx same chronic shoulder sprain A-C sprain"); see also (Ex. 9). Accordingly, we find that claimant has only one compensable left shoulder condition, whatever the diagnosis. Under these circumstances, we further agree with the ALJ that SAIF is not required to process a claim for a glenohumeral condition separately from the accepted claim. See Warren R. Friend, 46 Van Natta 1520 (1994).

Claimant also contends that, because SAIF did not object to Dr. Moll's ostensible status as attending physician, the ALJ erred in addressing the issue of whether Dr. Moll, chiropractor, was in fact claimant's attending physician at the time of claim closure. We need not address this contention or determine whether Dr. Moll was claimant's attending physician, because the result would be the same.

Even if Dr. Moll was claimant's attending physician, we would find that claimant has not established that his injury-related permanent impairment is greater than that measured on March 27, 1995 (as rated by the July 21, 1995 Order on Reconsideration), when he became medically stationary.[1] In other words, we do not find that claimant's subsequent, arguably reduced range of motion (on May 8, 1995) represents permanent injury-related impairment.

[1] We agree with the ALJ that claimant was medically stationary on March 27, 1995 (when Dr. Moll stated that claimant was "essentially stationary") and we are not persuaded that Dr. Moll's subsequent check-the-box opinion indicates that there was a reasonable expectation of improvement in claimant's compensable condition when the claim was closed on May 19, 1995. (See Ex. 19). Because claimant was medically stationary on March 27, 1995, we further agree with the ALJ that he is not entitled to temporary disability after that date.

In reaching the latter conclusion, we note that, in March 1995, Dr. Moll predicted that claimant would have exacerbations even as he opined that claimant was medically stationary. (Ex. 14-1). In our view, especially considering the variations among claimant's measurements on May 8, 1995 (along with Dr. Moll's prior opinion that claimant would suffer exacerbations), we are not persuaded that claimant's condition that day represents permanent impairment greater than that measured on March 27, 1995.[2]

Finally, inasmuch as claimant has not established entitlement to a higher impairment rating and SAIF has not requested reduction in the award, the Order on Reconsideration's permanent disability award will not be disturbed.

ORDER

The ALJ's order dated October 31, 1995 is affirmed.

[2] In reaching this conclusion, we note that Dr. Moll did not state that his May 8, 1995 measurements represented claimant's permanent injury-related impairment. (Ex. 14-1, see also Ex. 19).

In the Matter of the Compensation of
KHAMPHONG PHETSOMPHOU, Claimant
WCB Case No. 95-07358
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
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) Galton's order that set aside its denial of claimant's claim for an arthralgia condition in his back. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following exceptions. We do not adopt the next to the last paragraph of the findings of fact or the ultimate findings of fact that relate to the "lumbosacral strain."

CONCLUSIONS OF LAW AND OPINION

Relying on the opinions of Dr. Blackthorne, emergency room physician, and Dr. King, treating chiropractor, the ALJ found that the "back component" of the claim was compensable. Therefore, the ALJ set aside "that portion of the [April 27, 1995] denial that rejected compensability of the low back strain."[1] (Opinion and Order, page 4). SAIF argues that this claim must be analyzed as an occupational disease claim and that the ALJ erred in concluding that claimant established a compensable lumbosacral strain. We agree with SAIF.

On March 21, 1995, Dr. Denker treated claimant for joint aches and low back, hand, and arm pain. (Exs. 1, 2, 3). Claimant reported waxing and waning symptoms since November 1994; however, he reported no specific injury. Id. Dr. Denker related claimant's condition to an underlying arthritic problem. (Ex. 3). Dr. Podett, treating M.D., opined that claimant's back complaints came on gradually over a period of several months. (Ex. 23-1). In addition, Dr. Podett agreed with Dr. Denker's causation opinion. Id.

[1] We note that the issue at hearing was the viability of SAIF's April 27, 1995 denial, which denied claimant's condition "diagnosed as arthralgia in hands, elbows, and back." (Ex. 4; Tr. 2). The ALJ upheld the denial as to the hand and elbow condition and set it aside as to the back condition. However, in the order portion of the order, the ALJ identified the denied condition being set aside as "low back strain." Claimant did not appeal the ALJ's determination upholding SAIF's denial as to the hand and elbow condition. Therefore, the only issue on review is compensability of the back condition. As discussed in the body of our order, whether that condition is identified as arthralgia in the back or a lumbosacral strain, the medical evidence does not establish compensability of claimant's back condition.

On June 2, 1995, claimant compensably injured his right fifth finger while working with a buffer at work.[2] On that date, as a result of this injury, claimant sought treatment in the emergency room from Dr. Blackthorne. (Exs. 6, 7, 8). Dr. Blackthorne noted that, in addition to the finger injury, claimant complained of chronic low back pain, "going at least four or five months." (Ex. 8). In addition to diagnosing a contusion of the right fifth digit, Dr. Blackthorne diagnosed "chronic lumbar strain." (Exs. 6, 8-2). However, he offered no opinion as to the cause of the chronic lumbar strain.

In July 1995, claimant began treating with Dr. King, chiropractor. (Ex. 15). On August 22, 1995, Dr. King disagreed with Dr. Denker's opinion regarding the cause of claimant's low back condition, stating that claimant had an "insult directly related to trauma on 6-2-95 to 5th PIP digit and L/S [lumbosacral] spine on 3/21/95." (Ex. 20). However, although there is evidence of a trauma to claimant's finger on June 2, 1995, there is no evidence of a trauma to claimant's back on March 21, 1995. To the contrary, on March 21, 1995, Dr. Denker reported waxing and waning of hand, elbow, and back symptoms since November 1994, but did not indicate any distinct trauma to claimant's back at any time. (Exs. 1, 2, 3). In addition, we note that claimant did not testify to a distinct trauma to his back. Given the fact that the contemporaneous medical record does not support Dr. King's statement that a trauma to claimant's low back occurred on March 21, 1995, we do not find Dr. King's statement persuasive.

The record contains no persuasive evidence of a specific injury to claimant's back and it does not identify a discrete period of employment which prompted his complaints. Rather, the medical records indicate that claimant's low back condition was gradual in onset. Therefore, we analyze the condition 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 back condition. Amended ORS 656.802(2)(a).

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).

Claimant has received treatment from several physicians. Claimant first sought treatment for his low back complaints from Dr. Denker, who opined that claimant's symptoms resulted from a preexisting, underlying arthritic condition and not from his work activities. (Ex. 3). Dr. Denker noted that an arthritic panel was nonconclusive. However, based on his clinical examination and the fact that the arthritic panel demonstrated some mild anemia, which he noted often precedes the development of rheumatoid arthritis, Dr. Denker concluded that claimant had an underlying arthritic condition. He opined that the symptoms of claimant's preexisting arthritic condition were made worse by his "on-the-job injury;" however, the major contributing cause of claimant's symptoms are the preexisting arthritic condition.[3] Id.

Dr. Podett opined that claimant may have an underlying degenerative joint disease involving his lower back and an underlying arthritic condition that may be responsible for the joints swelling in right hand. (Ex. 22). Dr. Podett also agreed with Dr. Denker's opinion that claimant has a preexisting arthritic condition that is the major contributing cause of claimant's disability or need for treatment. (Ex. 23-1).

Dr. Blackthorne diagnosed chronic lumbar strain; however, he offered no opinion as to the cause of this condition. (Exs. 6, 8, 9). Finally, Dr. King diagnosed a L5/S1 capsular sprain, which she related to a March 21, 1995 trauma to the lumbar spine. (Exs. 15, 20). For the reasons discussed above, we do not find Dr. King's opinion persuasive.

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[2] SAIF accepted this injury as a nondisabling right fifth digit contusion. (Ex. 14). The compensability of that injury is not in dispute.

[3] In his causation opinion, Dr. Denker appears to use the term "work activities" and "on-the-job injury" interchangeably. (Ex. 3). However, as addressed above, Dr. Denker recorded no work injury in his chart note and there is no evidence that claimant sustained a work injury to his back. (Exs. 1, 2).

The ALJ discounted Dr. Denker's opinion because Denker concluded that claimant had a preexisting arthritis condition when claimant's arthritic panel was nonconclusive. However, although acknowledging that the arthritic panel was nonconclusive, Dr. Denker persuasively explained the reasons for his conclusion that claimant had a preexisting arthritic condition, including his reliance on his clinical examination of claimant. Given this explanation, we find Dr. Denker's opinion persuasive. Somers v. SAIF, supra.

The ALJ discounted Dr. Podett's opinion based on Podett's reliance on Dr. Denker's opinion, which the ALJ found unpersuasive. Because we find Dr. Denker's opinion persuasive, Dr. Podett's agreement with Denker's opinion does not affect the persuasiveness of Podett's opinion. The ALJ also discounted Dr. Podett's opinion because Podett opined that claimant did not sustain a compensable finger injury on June 2, 1995, an opinion the ALJ found against the law of the case. While we agree that it is settled that claimant compensably injured his finger on June 2, 1995, that does not affect the persuasiveness of Dr. Podett's opinion on the issue of the compensability of claimant's low back condition. Castle & Cook, Inc. v. Porras, 103 Or App 65, 68 n3 (1990) (a factfinder may rely on part of a medical opinion and reject another part of the opinion as long as a subsequent finding does not flow from factors necessarily rejected by the initial finding).

Based on Dr. Denker's opinion, as supported by Dr. Podett's opinion, we find that the major contributing cause of claimant's low back condition is his preexisting arthritic condition. In addition, there is no evidence that claimant's work activities pathologically worsened the preexisting arthritic condition. Amended ORS 656.802(2)(b). On this record, there is no persuasive medical opinion supporting the compensability of claimant's low back condition, whether that condition is identified as a chronic lumbar strain or arthalgia in the back. Accordingly, we conclude that claimant has failed to establish a compensable occupational disease.

ORDER

The ALJ's order dated November 15, 1995 is reversed. the SAIF Corporation's denial is reinstated and upheld. The attorney fee award is reversed.

May 3, 1996 Cite as 48 Van Natta 968 (1996)

In the Matter of the Compensation of
SCOTT J. STORY, Claimant
WCB Case No. 95-06464
ORDER ON REVIEW
Gary L. Tyler, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order which upheld the SAIF Corporation's denial (on behalf of the noncomplying employer) of claimant's claim for a lumbosacral strain. On review, the issue is compensability.

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

Applying the major contributing cause standard, the ALJ found that the medical evidence failed to support the compensability of claimant's lumbosacral strain. Specifically, the ALJ determined that no physician adequately related claimant's injury to his work.

Based on Dr. Versoza's opinion, claimant contends that his low back condition is causally related to his work activities. Additionally, claimant asserts that the ALJ erred in assuming that claimant's employer may have completed part of claimant's duties when claimant was not at work.[1] Finally, claimant contends that his prior back problems are not "linked" to his current condition.

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[1] Claimant also takes exception to the ALJ's statement that no doctor "has quantified the contribution of claimant's condition to his work." Claimant's contentions are well taken. However, given that we find Dr. Versoza's opinion unpersuasive because of an inaccurate history, the result, in this case remains the same.

On review, the parties do not dispute the application of the "major contributing cause" standard. Further, absent persuasive reasons to do otherwise we generally defer to a claimant's attending physician. See Weiland v. SAIF, 64 Or App 810 (1983). Finally, in resolving a complex medical causation issue, such as that 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 July 1995, Drs. Reimer and Scheinberg, who examined claimant on behalf of SAIF, opined that claimant's current condition is a "waxing and waning" of his prior 1986 injury. (Ex. 49). Drs. Reimer and Scheinberg stated that claimant could return to work with the same restrictions which were imposed upon claimant following the 1986 injury.

In February 1995, Dr. Versoza, attending physician, opined that claimant "sustained a new injury" due to his work. (Ex. 41). On August 10, 1995, Dr. Versoza stated that she did not concur with the Drs. Reimer and Scheinberg's report because she "did not have the benefit of reviewing [claimant's] previous records for [determining] the relation of his 1986 injury." (Ex. 51). Finally, Dr. Versoza agreed with the IME report that claimant's restrictions were most likely the result of his 1986 injury. Id.

Here, we decline to rely on the medical opinion of Dr. Versoza, attending physician. Dr. Versoza's opinion is based on an admittedly incomplete history. See Somers v. SAIF, supra. This lack of history is significant, given claimant's prior back problems which have occurred in the same area as his current condition. For instance, in 1986 claimant fell off a table and was diagnosed with a lumbosacral sprain. (Ex. 1). In 1987, claimant treated with Dr. Thompson who diagnosed chronic recurrent lumbosacral strain. (Ex. 5). In 1989, claimant underwent an insurer-arranged examination and was diagnosed with "lumbar contusion and strain, by history, March 1986." (Ex. 26). An MRI performed in 1989 revealed a broad disc bulge at L5-S1. (Ex. 32).

Finally, Dr. Versoza opined that claimant's 1986 injury is the cause of claimant's current restrictions. As such, because Dr. Versoza did not have the benefit of considering claimant's prior back history in relation to claimant's current condition, we find Dr. Versoza's opinion unpersuasive. Consequently, claimant has failed to persuasively relate his current back condition to his work. Accordingly, the ALJ's order is affirmed.

ORDER

The ALJ's order dated September 14, 1995 is affirmed.

May 7, 1996 Cite as 48 Van Natta 969 (1996)

In the Matter of the Compensation of
VINCENT D. DRENNEN, Claimant
WCB Case No. 95-07547
ORDER ON RECONSIDERATION
Pozzi, Wilson, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of that portion of the Board's April 10, 1996 Order on Review that reinstated claimant's 39 percent (124.8 degrees) unscheduled permanent disability award for a back condition as granted by an Order on Reconsideration, whereas an Administrative Law Judge's (ALJ's) order had reduced the award to 18 percent (57.6 degrees).

SAIF argues that claimant is entitled to an adaptability factor of one (rather than five) because he returned to his regular work.

As stated in the Board's Order on Review, claimant's post-injury work activities were "self-modified." The record does not indicate that claimant could or did perform substantially the same job after his injury as he did before his injury. Instead, claimant "managed" to perform at work, by utilizing care, caution, and his back brace. (See Ex. 11-1). Under these circumstances, we are not

persuaded that claimant actually returned to regular work.[1] See OAR 436-35-270(3)(c). (WCD Admin. Order 93-056) ("'Regular work' means the job the worker held at the time of injury, or employment substantially similar in nature, duties, responsibilities, knowledge, skills and abilities.")

Accordingly, the Board's April 10, 1996 Order on Review is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish the Board's prior order in its entirety, effective this date. The parties' appeal rights shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] In reaching this conclusion, we note that the medical arbiter, who examined claimant on April 28, 1995, estimated claimant's physical capacities to be in the "light/medium category of employment, with restriction in frequent lifting, bending, etc., with limitations of weights probably 30 pounds or less." (Ex. 22-4). We find the medical arbiter's estimation of claimant's physical abilities consistent with claimant's self-limitations since the work injury. We reiterate that Dr. Karty released claimant to "regular" work largely because claimant wished to be so released. In light of claimant's ongoing desire to keep working, we further find that Dr. Karty's comments that claimant subsequently "managed" at work similarly indicate claimant's desires did not conform with his physical abilities. Finally, because there is no evidence that claimant ever successfully performed even substantially the same duties as he had before his injury, we continue to conclude that claimant did not return to his regular work after his compensable injury.

May 7, 1996 Cite as 48 Van Natta 970 (1996)

In the Matter of the Compensation of
DANNY R. FULLER, Claimant
WCB Case No. 93-12935
SECOND ORDER OF ABATEMENT
Schneider Hooton, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On April 9, 1996, we republished our February 2, 1996 order that had reversed an Administrative Law Judge's (ALJ's) order which: (1) set aside the insurer's denial of claimant's aggravation/current condition claim for an upper neck condition; (2) set aside the insurer's partial denial of claimant's right shoulder impingement syndrome; and (3) assessed a penalty for an allegedly unreasonable denial. Citing the court's recent decision in Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), claimant seeks reconsideration of the legal analysis and factual findings reached in our prior decisions.

In order to further consider claimant's contentions, we withdraw our prior orders. 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, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
CHRISTI L. McCORKLE, Claimant
Own Motion No. 95-0353M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Pozzi, et al, Claimant Attorneys

The self-insured employer requests reconsideration of our March 14, 1996 Own Motion Order Reviewing Carrier Closure, which set aside the employer's November 28, 1995 Notice of Closure as premature. With its request, the employer submits an April 3, 1996 "proposed" Notice of Closure, as well as a December 4, 1995 medical report from Dr. Carpenter. On April 10, 1996, we abated our prior order to allow claimant sufficient time to respond to the employer's motion. On reconsideration, we adhere to the conclusion reached in our March 14, 1996 order. We base this decision on the following reasoning.

In our March 14, 1996 order, we considered Dr. Carpenter's December 4, 1995 medical report in finding that claimant was not medically stationary on either November 6, 1995, when the employer declared claimant medically stationary, nor was she medically stationary on November 28, 1995, when the employer closed the claim. See Christi McCorkle, 48 Van Natta 551 (1996). Thus, we find no new evidence which would alter our decision pertaining to the impropriety of the employer's November 28, 1995 Notice of Closure.

However, on April 3, 1996, the employer issued a Notice of Closure, which awarded claimant temporary disability compensation from June 27, 1995 through December 4, 1995, and declared claimant medically stationary as of December 4, 1995. No matter how the employer characterizes its April 3, 1996 Notice of Closure, however, it cannot be considered "proposed" once issued. The April 3, 1996 Notice of Closure is an entirely different document than the November 28, 1995 Notice of Closure, as it awarded claimant increased compensation and declared a different medically stationary date. To that effect, the notice is neither proposed nor pending, but is a distinctly new claim closure document with respect to claimant's 1985 injury claim, and which "recloses" her claim. See OAR 438-012-0055. Therefore, we are unable to grant the employer's request to "reconsider" a document we have not yet reviewed or considered.

Claimant requests that the Board not reconsider its March 14, 1996 order based on submission of a "proposed" Notice of Closure. Instead, claimant requests review of the employer's April 3, 1996 Notice of Closure. We grant claimant's request. OAR 438-012-0060.

In light of such circumstances, we grant the parties an opportunity to further develop the record regarding the employer's April 3, 1996 Notice of Closure. Therefore, claimant will be allowed 14 days from the mailing date of this order to submit evidence and argument regarding the propriety of the employer's April 3, 1996 closure of her claim.[1] The employer will be allowed 14 days from the mailing date of claimant's evidence and argument to submit its response to claimant's motion. Claimant will be allowed 14 days from the mailing date of the employer's response to submit her reply. Thereafter, we will proceed with our review of the employer's April 3, 1996 Notice of Closure. See id.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our March 14, 1996 order in its entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] In an April 11, 1996 letter, claimant advised the Board that "chart notes of the attending physician dated December 19, 1995, January 25, 1996, February 13, 1996 and March 7, 1996," were enclosed with her letter. However, the enclosures were not included with claimant's letter to the Board. Although the December 19, 1995 medical report was submitted previously by the employer, the Board requires copies of the other reports mentioned by claimant in order to proceed with its review.

In the Matter of the Compensation of
DWIGHT M. PAGE, Claimant
WCB Case No. 94-13688
ORDER ON RECONSIDERATION
Hollander, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Claimant requests reconsideration of the Board's April 10, 1996 Order on Review which affirmed the Administrative Law Judge's (ALJ's) order that: (1) upheld the SAIF Corporation's denial of his occupational disease claim for bilateral carpal tunnel syndrome; and (2) declined to award an assessed attorney fee under ORS 656.386(1).

In its prior order, the Board determined that claimant was procedurally barred from litigating a compensability issue against SAIF, inasmuch as claimant was not dissatisfied with another carrier's (Wausau's) acceptance of his claim. Claimant argues that he will be prejudiced if SAIF's compensability denial is allowed to stand. In particular, claimant raises the possibility that Wausau could issue a "back-up" denial pursuant to ORS 656.262(6)(a) within two years of its acceptance and, because SAIF's denial would have become final by operation of law, he would be procedurally barred from pursuing a claim against SAIF.

We are not persuaded by claimant's argument. While it is conceivable that Wausau could eventually issue a "back-up denial, we are unable to discern any difference between this hypothetical set of circumstances and the typical responsibility case in which one carrier's denial is set aside and the denial issued by another carrier is upheld. Under those circumstances, the claimant would also be unable to pursue a claim against the nonresponsible carrier should the carrier found responsible subsequently issue a "back-up" denial. In any event, claimant is not entitled to what is in effect an advisory opinion regarding compensability of his claim against SAIF. Cf. Gerald J. Dahl, 47 Van Natta 1055 (1995) (carrier's appeal of ALJ's responsibility order dismissed as moot when appealing carrier accepted claim while case was pending review); Scott C. Clark, 47 Van Natta 133 (1995) (where controversy over compensability is rendered moot, order addressing issue would be advisory). As explained in the Board's prior order, inasmuch as claimant was satisfied with Wausau's acceptance of his claim, a compensability finding is not necessary.

Although we continue to hold that claimant is not entitled to the relief he seeks, we modify that portion of our order that affirmed the ALJ's order upholding SAIF's denial. Inasmuch as claimant has acknowledged his satisfaction with Wausau's acceptance of the claim for the same condition denied by SAIF, we conclude that he is not an aggrieved party and that any "dispute" regarding himself and SAIF has become moot. In light of such circumstances, his hearing request is dismissed without a decision regarding the merits of the claim.[1]

Accordingly, we withdraw the Board's April 10, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish the Board's April 10, 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] In this regard, we disagree with the dissent's reasoning that claimant's hearing request pertains to a matter concerning a claim. Under ORS 656.704(3), matters concerning a claim are defined as those matters where a worker's right to receive compensation, or the amount thereof, are directly in issue. Inasmuch at it is undisputed that no compensation will result from claimant's hearing request regarding SAIF's denial, the request does not pertain to a "matter concerning a claim." Consequently, it is appropriate to dismiss the hearing request.

Board Chair Hall dissenting.

I disagree with the majority's conclusion that claimant cannot receive a determination regarding his claim with SAIF. Consequently, I respectfully dissent.

Notwithstanding claimant's current satisfaction with Wausau's acceptance of his claim for the same condition, he also requested a hearing regarding SAIF's denial of the claim. Since his request raises a question concerning a claim, he is entitled to receive an answer. See ORS 656.283(1). Furthermore, because there has been no resolution of his claim with SAIF, he is not precluded from pursuing his appeal of SAIF's denial.

Although claimant is not an "aggrieved party" insofar as his "Wausau" claim is concerned, he most certainly is regarding the SAIF claim.[1] Without a decision concerning the merits of his claim against SAIF's insured, SAIF's compensability denial will stand. As noted in claimant's motion for reconsideration, such a result may well have profound implications on claimant's future rights to compensation. Inasmuch as the majority's decision prevents claimant from fully protecting his rights to compensation (current, as well as future), it errs.

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[1] The majority's reliance on Gerald J. Dahl, supra, is ill-founded. In Dahl, we dismissed an appealing carrier's request for Board review of an ALJ's responsibility decision when that (i.e., the same) carrier accepted the claim while the appeal was pending. Here, in contrast, claimant is seeking a decision regarding a carrier's denial of a claim which has not been accepted by that carrier. Under such circumstances, claimant's hearing request would not be moot nor would any forthcoming decision regarding that claim denial be advisory.

Likewise, Scott Clark, 47 Van Natta 133 (1995) is distinguishable. In Clark, we dismissed a carrier's request for review of an ALJ's compensability decision because it had accepted the claim while the appeal was pending. We reasoned that claimant was not entitled to an advisory opinion. Here, unlike Clark, claimant is seeking a hearing concerning a carrier's denial of a claim which has not been accepted by that carrier. As such, any decision regarding that denial would not be advisory.

May 7, 1996 Cite as 48 Van Natta 973 (1996)

In the Matter of the Compensation of
STEVEN D. WINDSOR, Claimant
WCB Case Nos. 95-03437 & 95-03436
SECOND ORDER ON RECONSIDERATION
Parker Bush & Lane, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our April 10, 1996 Order on Reconsideration that declined to remand the case to the ALJ for consideration of additional documents and adhered to our conclusions that claimant did not prove the compensability of a cervical condition or timely appeal a denial of a thoracic condition. In again requesting reconsideration, claimant has provided several submissions.

First, claimant submitted a copy of the Order on Reconsideration which included a statement to which Dr. Mandiberg, claimant's former treating physician, concurred. The statement provides:

> "It is not my opinion that [claimant] did not have any radiating pain into his thoracic and particularly his scapular area on the left before October of 1993. I did not ascertain that cause or nature of his complaints in these areas and would object to anyone implying that I did. What I said was that he did not have radiating pain down his left arm prior to the October 1993 MVA and I did not believe it to be work related. [Claimant's] current physicians Dr. Grewe and Irvine have made a diagnosis as to the cause of his thoracic and scapular symptoms which preexisted the October 9, 1993 MVA. It is my position that their opinions be respected."

Based on this statement, claimant contends that "[s]ince Dr. Mandiberg is specifically stating that your interpretation [of his opinion] is wrong, claimant respectfully requests that you reissue your Order on Reconsideration in light of this."

One of the issues to be decided in this case is the compensability of claimant's cervical condition. Claimant has an accepted claim for thoracic strain as a result of a January 1993 accident with C.K. Claggett. In October 1993, claimant sought treatment following a nonwork-related motor vehicle accident. In December 1993, claimant was diagnosed with a herniated cervical disc.

At hearing and on review, claimant asserted that the January 1993 injury caused his herniated disc and, therefore, it is a compensable condition for C.K. Claggett.[1] Claimant relied on the opinions of treating neurosurgeon Dr. Grewe and consulting physician Dr. Irvine that the onset of thoracic symptoms from the January 1993 accident actually were early manifestations of the cervical disc herniation, thus showing that the accident caused the herniation.

On review and on reconsideration, we found more persuasive Dr. Mandiberg's opinion. As discussed above, claimant asserts that, on reconsideration, we misconstrued Dr. Mandiberg's opinion. Apparently, claimant believes that we incorrectly considered Dr. Mandiberg as having provided an opinion concerning claimant's thoracic and scapular symptoms.

Claimant misunderstands the Order on Reconsideration. We have never indicated that Dr. Mandiberg provided an opinion concerning the cause of claimant's thoracic and scapular symptoms. Rather, as we explained in the order, Dr. Mandiberg has addressed only the cause of claimant's cervical symptoms. In particular, Dr. Mandiberg indicated that, because claimant did not exhibit cervical symptoms until after the October 1993 motor vehicle accident, that event, and not the January 1993 compensable injury, caused the cervical condition. (Exs. 37, 41, 45-1, 134).

Because Dr. Mandiberg has not provided an opinion concerning claimant's thoracic symptoms, we have not considered him as disputing that the onset of such symptoms was prior to the motor vehicle accident or as disagreeing with Drs. Grewe and Irvine that the thoracic symptoms result from a herniated cervical disc. That Dr. Mandiberg has not provided any opinion concerning the thoracic symptoms in no way alters the fact that he did provide an opinion concerning the cause of the cervical condition--one of the issues to be decided in this case. Furthermore, for the reasons discussed in our first Order on Reconsideration, we continue to find Dr. Mandiberg's opinion to be persuasive.

In a separate submission, claimant offers an April 20, 1996 report from treating osteopath Dr. Anderson, supporting the compensability of claimant's cervical condition. Although more lengthy and detailed, the report for the most part reiterates the March 23 and 29, 1996 reports from Dr. Anderson that claimant submitted during the initial reconsideration. For the reasons stated in our prior order, we continue to conclude that the admission of the document would not affect the outcome of the hearing. Thus, we find no compelling reason to remand. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Finally, claimant contends that the ALJ violated ORS Chapter 677, which concerns the regulation of medical services, because the ALJ's order diagnosed a condition. Inasmuch as this issue is not a "matter concerning a claim," we do not have jurisdiction to address it. ORS 656.702(4).

Accordingly, we withdraw our prior orders. On reconsideration, as supplemented 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.

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[1] At hearing, claimant also challenged SAIF's denial, on behalf of Clackamas Community College, of a thoracic condition. The ALJ found that claimant did not timely appeal the denial. On review, we agreed with the ALJ's conclusion and further found that, on the merits, there was no evidence that work at Clackamas Community College caused claimant's cervical condition. In twice requesting reconsideration, we have understood claimant as not challenging this portion of our order, instead disputing our conclusion that he failed to prove that his January 1993 compensable injury at C.K. Claggett caused his herniated cervical disc.

In the Matter of the Compensation of
BRYON W. BARNES, Claimant
WCB Case No. 95-06045
ORDER ON REVIEW
Claud A. Ingram, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that upheld the insurer's denial of his hepatitis C infection. On review, the issue is compensability.

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

Claimant sustained compensable injuries to his head, neck, back and left elbow as a result of an October 6, 1993 industrial accident. Claimant took a number of prescription medications for his compensable injuries, which resulted in a bleeding duodenal ulcer. On December 18, 1993, during surgery to relieve his bleeding ulcer, claimant received a transfusion of two units of red blood cells. Chemistry screens taken of claimant on December 18 and 19, 1993 showed normal liver functions.

On December 28, 1993, claimant had a blood screen which showed abnormal liver chemistries. A January 14, 1994 chemistry screen was negative for the hepatitis C antibody, but a February 17, 1994 chemistry screen was positive. Subsequent tests confirmed that claimant was infected with hepatitis C.

Because claimant contends that he contracted the hepatitis C as a result of the blood transfusion, which came about as a result of his compensable ulcer, he must establish compensability of the hepatitis as a consequential condition under ORS 656.005(7)(a)(A). See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). He, therefore, must prove that his compensable ulcer condition was the major contributing cause of the hepatitis C.

The ALJ found that claimant failed to prove by a preponderance of the evidence that his blood transfusion was the cause of the hepatitis C infection. After considering the expert medical opinions, the ALJ gave greater weight to the opinion of Dr. Masterson, the associate director of the blood bank, who testified that claimant probably did not acquire his hepatitis C from the transfusion.

On review, claimant urges us to defer to the opinion of Dr. Wrigley, who reported that claimant likely acquired his hepatitis C through his hospitalization and blood transfusions. Acknowledging that the testing of the blood donors' blood came up negative for hepatitis C, Dr. Wrigley opined that testing for the virus "is less than a perfect science these days." He further indicated that "[i]t would not surprise me if one of these donors was a chronic hepatitis C carrier and inadvertently transmitted it through blood transfusion." Dr. Wrigley also speculated whether claimant acquired the virus elsewhere during his hospitalization, and related the hepatitis to claimant's hospitalization and blood transfusions because there was "no historical clue to another source" for the disease. (Ex. 29B).

Claimant's treating doctor, Dr. Loescher, also concluded that claimant's hepatitis C was acquired through the blood transfusion based on the absence of an alternate explanation for its origin. (Exs. 30, 31). He noted, however, that the fact that the blood donors tested negative "does raise the possibility" that claimant's hepatitis C might have some other cause, and that its appearance soon after the blood transfusion was only coincidental. (Ex. 30-2).

Dr. Masterson testified that a total of six different tests, including the most specific "PCR" test, were performed on the blood samples from each of the donors and all came back negative. (Tr. 33). Contrary to Dr. Wrigley, Dr. Masterson reported that it would be "highly unlikely" for a blood donor to be carrying the hepatitis virus and test negative on the PCR test. (Tr. 34). In addition, Dr. Masterson reported that the onset of claimant's hepatitis C was somewhat inconsistent with having acquired it through the blood transfusion because he developed the abnormal liver chemistry and antibody so shortly afterwards. (Tr. 37-39). Based on the time of the development of claimant's symptoms and antibodies, Dr. Masterson concluded that claimant's hepatitis C was "community acquired" and not related to the blood transfusion.

Where, as here, 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). On this record, we agree with the ALJ that Dr. Masterson's opinion is more complete and better reasoned than the opinions of Drs. Wrigley and Loescher. Therefore, claimant has not proven the compensability of his hepatitis C by a preponderance of the evidence.

ORDER

The ALJ's order dated December 6, 1995 is affirmed.

May 8, 1996 Cite as 48 Van Natta 976 (1996)

In the Matter of the Compensation of
FRANCISCO D. BETONIO, Claimant
WCB Case No. 95-07238
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
Charles Lisle, Defense Attorney

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Livesley's order which set aside its denial of claimant's low back strain injury claim. On review, the issue is compensability.

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

Relying on the opinion of Dr. Jakious, attending physician, the ALJ found that claimant's low back strain was compensable. Specifically, the ALJ determined that there were objective signs of injury in support of the compensability of claimant's low back claim.

On review, the employer contends that there were no objective signs of injury to support claimant's claim. Further, the employer asserts that claimant was not credible and, therefore, any medical evidence supporting claimant's position should be accorded little persuasive weight.

We agree with, and adopt the ALJ's reasoning and conclusion, that this case does not depend upon expert medical evidence. See Uris v. Compensation Department, 247 Or 420 (1967); Barnett v. SAIF, 122 Or App 279 (1993). Further, we adopt the ALJ's finding that the inconsistencies which the employer relies upon to impeach claimant's credibility, go more to the extent of disability rather than to the question of initial compensability. As such, the issue on review is whether there were objective findings of an injury to support claimant's claim.

Relying on ORS 656.005(19), the employer 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."

We analyzed this statute in Jairo J. Garcia, 48 Van Natta 235 (1996). Specifically, we addressed the question of whether claimant's subjective pain complaints of "tenderness" were sufficient to constitute "objective findings" under amended ORS 656.005(19). 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, in the absence of persuasive contrary evidence, we find persuasive the opinion of Dr. Jakious, particularly because she was the only physician who examined claimant the day of his industrial accident. On March 2, 1995, Dr. Jakious reported "limited flexion; only about 10 degrees and limited side bending in both directions." (Ex. 1). As such, we find claimant's limited range of motion findings reported by Dr. Jakious are "verifiable indications of injury" and "measurable." See Jairo J. Garcia, 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 438-015-0010(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 employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated September 22, 1995 is affirmed. For services on review claimant's attorney is awarded $750 payable by the employer.

May 8, 1996 Cite as 48 Van Natta 977 (1996)

In the Matter of the Compensation of
PATRICK HOLTEN, Claimant
WCB Case No. 95-06286
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Meyers, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Podnar's order which set aside its denial of claimant's right wrist injury. In his brief, claimant contends that the ALJ erred in excluding an investigative report and certain medical reports. On review, the issues are evidence and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In July 1993, claimant developed right hip pain while carrying roofing material on a high-pitched roof. The insurer accepted the claim for a right hip strain. In December 1993, claimant experienced a flare-up of his hip discomfort, including new symptoms of popping/snapping. Dr. Young noted that claimant's gait was antalgic and provided crutches. (Ex. 28). Claimant, subsequently, used a cane whenever his hip became irritated. (Tr. 8-9). In February 1994, claimant's hip began to click and pop with hip flexion and extension. (Exs. 26-3, 28-3). On April 1, 1994, Dr. Young reported that claimant continued to have discomfort and snapping and that claimant experienced discomfort with each snap. (Ex. 28-4). Claimant testified that when his hip is irritated, it pops and that it is a more sharp, intense pain. (Tr. 8). Likewise, Dr. Sedgewick reported that claimant's symptoms could be episodic such that at times claimant would have significant pain, limiting his ability to ambulate. (Ex. 58).

While on a family camping trip on April 17, 1994, claimant fell and fractured his right wrist. The accident occurred in the following way: Claimant testified that when he returned to his camp site after a walk with his family, his right hip was very irritated. When walking, around his trailer, claimant's hip popped and he flinched because of a very sharp pain. When claimant flinched, he put all his weight on his cane, his cane gave out and he fell down a small ravine. Claimant put his right hand down to break his fall. He hit his right wrist on the rocks, resulting in a fracture of the right wrist. (Tr. 12-14, 20).

The ALJ found that, at the time of the camping trip, claimant was having increased problems with his hip. The ALJ further found that the hip injury was the major contributing cause of claimant's wrist injury. We agree; however, we base our conclusions on the following reasoning.

In Barrett Business Services v. Hames, 130 Or App 190 (1994), the court held that where reasonable and necessary treatment of a compensable injury is the major contributing cause of a new injury, the compensable injury itself is properly deemed the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A).

Here, we find that claimant's hip snapping/popping is a compensable consequence of his compensable hip condition. Claimant's hip condition required the use of a cane when his hip became irritated. Claimant testified that his hip was irritated after walking while camping.[1] Using the cane caused claimant to fall. As such, the April 1994 fall was a compensable consequence of claimant's hip injury. The fall was the direct cause of claimant's fractured wrist. Accordingly, the April 1994 cane incident is a compensable consequence of claimant's compensable hip injury, and was the major contributing cause of claimant's right wrist fracture. Kathleen A. Robinson, 46 Van Natta 833, on recon 46 Van Natta 1677 (1994); see Gerald W. Weaver, 47 Van Natta 775 (1995)(although accident, where the claimant slipped while using crutches and twisted his back, was a compensable consequence of compensable leg injury, medical evidence failed to establish that the crutches incident was the major contributing cause of a consequential back condition).[2]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $900, 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 attorney is awarded $900 to be paid by the insurer.

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[1] The ALJ find claimant credible, based on his demeanor. We, therefore, defer to the ALJ's credibility findings. International Paper Co. v. McElroy, 101 Or App 61 (1990).

[2] Inasmuch as we have found that claimant has established causation, we need not address the evidentiary issue raised in his brief.

In the Matter of the Compensation of
DANIEL C. KOEPKE, Claimant
WCB Case No. 95-02356
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mills' order that: (1) upheld the self-insured employer's aggravation denial of claimant's carpal tunnel syndrome (CTS); and (2) upheld the employer's "de facto" denial of claimant's occupational disease claim for wrist tendinitis. On review, the issues are aggravation and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Aggravation

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

"De Facto" Denial

Claimant asserts that the ALJ erred in upholding the employer's "de facto" denial of his occupational disease claim for wrist tendinitis, on the ground that he failed to establish the existence of that condition. We need not determine whether claimant has tendinitis because, even assuming that he does, the evidence fails to establish the compensability of that condition.

To establish a compensable occupational disease claim for tendinitis, claimant must prove that his employment conditions were the major contributing cause of the disease. Amended ORS 656.802(2)(a). Dr. Takacs is the only expert to render an opinion regarding the cause of claimant's tendinitis: He signed an unexplained concurrence report, agreeing that claimant's "work activities [were] the major contributing cause of his tendinitis[.]" (Ex. 54-2). That report is unpersuasive, because it is wholly conclusory and lacks any analytical foundation. See Marta I. Gomez, 46 Van Natta 1654 (1994) (persuasiveness of concurrence report depends on underlying explanation). For that reason, we agree with the ALJ that claimant has failed to establish the compensability of his tendinitis.

ORDER

The ALJ's order dated October 6, 1995 is affirmed.

May 8, 1996 Cite as 48 Van Natta 979 (1996)

In the Matter of the Compensation of
JAMES MINTER, Deceased, Claimant
WCB Case No. 95-03846
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

The putative beneficiary (Rita Weeldreyer, hereafter "Weeldreyer") requests review of Administrative Law Judge (ALJ) Holtan's order that found that she had failed to establish "good cause" for her untimely hearing request on the insurer's denial of survivor's benefits. On review, the issues are "good cause" and the entitlement to cohabitant's benefits under ORS 656.226.

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

The deceased worker (decedent) and Weeldreyer were not married, but had lived together for three years. In the spring of 1994, they had one child and were expecting a second child. In August 1993, Weeldreyer and decedent moved into a mobile home that was managed by Weeldreyer's mother. In July 1994, as a result of an argument with Weeldreyer's mother, decedent was evicted from the mobile home. Weeldreyer continued to live in the mobile home, but decedent moved into his mother's house. He took some of his belongings with him and left others.

Decedent and Weeldreyer planned to get married and had purchased wedding rings. Decedent either saw Weeldreyer or spoke with her over the telephone every day after his eviction from the mobile home. Decedent helped pay the expenses of his and Weeldreyer's son and planned to move back in with Weeldreyer after he got a steady job. On October 14, 1994, decedent was killed in a work-related motor vehicle accident.

The insurer accepted a workers' compensation claim for decedent's fatal accident on January 12, 1995. On January 23, 1995, the insurer issued a denial of widow (cohabitant) benefits to Weeldreyer on the grounds that Weeldreyer and decedent had not cohabited for the five months prior to decedent's death. The denial letter stated that decedent's and Weeldreyer's son would continue to receive benefits and that upon the birth of the couple's second child further consideration of benefits would be made for that child. The denial letter contained a notice of hearing rights explaining how to challenge the denial. Weeldreyer's workers' compensation attorney received a copy of the denial letter.

On March 31, 1995, Weeldreyer filed a request for hearing on the denial. The hearing request was filed more than 60 days, but fewer than 180 days, after the mailing date of the denial.

A request for hearing must be filed not later than the 60th day after the mailing of the denial. ORS 656.319(1)(a). If a request is filed more than 60 days, but fewer than 180 days after mailing of the denial, a hearing may be granted if the claimant establishes that there was good cause for failure to timely file the request for hearing. ORS 656.319(1)(b). 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 and former ORS 18.160. Anderson v. Publishers Paper Co., 78 or App 513, 517, rev den 301 Or 666 (1986). Lack of diligence does not constitute good cause. Cogswell v. SAIF, 74 Or App 234, 237 (1985). Claimant has the burden of proving good cause. Id.

Weeldreyer contends that, at the time she received the denial, she was suffering from stress caused by grief over decedent's death, conflict with decedent's family and the imminent birth of her second child. Consequently, she asserts that she established "good cause" for her untimely filed hearing request.

We conclude that Weeldreyer has not established "good cause" for her failure to timely appeal the denial. The record indicates that Weeldreyer received the denial and understood its meaning. Moreover, she discussed the denial with her mother, who urged her to appeal the denial. In addition, Weeldreyer had contact with her workers' compensation attorney, who had received a copy of the denial.

This case is similar to William B. Potts, 41 Van Natta 223 (1989). There, the claimant received a denial of his occupational disease claim, but did not appeal the denial until almost three months after its receipt. During the three month delay period, the claimant was caring for his wife who had been diagnosed with cancer and was receiving daily radiation treatment. After 30 to 45 days of radiation treatment, the claimant's wife began receiving regular chemotherapy. The claimant was responsible for taking his wife to and from the doctor's office. In addition to maintaining a full time job, he also performed all the housework and most of the child care for their four year old child.

There was no contention that the claimant did not understand the denial. Rather, the claimant contended that his wife's illness, his child's care and his own job constituted good cause for his delay in filing a hearing request. On Board review, we concluded that the claimant had not met his burden. We reasoned that, although the claimant's preoccupation with other concerns during the three month delay was legitimate, it did not prevent him from the relatively simple task of filing a hearing request. At most we determined that, these concerns distracted him from filing. Based on this reasoning, we concluded that the claimant's lack of diligence did not constitute good cause.

We reach the same conclusion here. Although Weeldreyer was experiencing understandable grief and stress, it is undisputed that she understood the contents of the denial and was advised by her mother to appeal the denial. In addition, she had access to professional advice from her attorney. Finally, there is no medical evidence that she was mentally incompetent or otherwise unable to conduct her affairs. Given these circumstances, we conclude that the failure to appeal the denial was caused by a lack of diligence which does not excuse the failure to file. Accordingly, good cause has not been established.

In light of our conclusion regarding the "good cause" issue, we do not reach the merits.

ORDER

The ALJ's order dated September 25, 1995 is affirmed.

Board Chair Hall dissenting.

The test to determine whether good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" contained in ORCP 71B and former ORS 18.160 for setting aside civil default judgments. The courts have held that this standard should be liberally construed.[1] See Wagar v. Prudential Ins. Co., 276 Or 827, 832 (1976). In King v. Mitchell, 188 Or 434, 214 (1950), the court discussed the policy considerations involved in setting aside a default judgment and said: "The statute is to be construed liberally to the end that every litigant shall have his day in court and his rights and duties determined only after a trial upon the merits of the controversy. [Citations omitted]." 188 Or at 441-442.

By adopting the civil definition of good cause, we have also adopted the construction of the civil standard of "mistake, inadvertence, surprise or excusable neglect." This standard brings with it the policy that cases should not be thrown out on technical grounds, but should be decided on their merits. The majority has failed to consider and apply this policy here.

As described by the ALJ, the beneficiary was depressed, distraught, emotionally drained and anxious about the future of her family after decedent's death. She received the denial the week that her child was due. Given the circumstances of this case and the construction of the civil standard, I believe that the beneficiary has established good cause for the late hearing request. Accordingly, I dissent from the majority's opinion.

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[1] The dissent recognizes amended ORS 656.012(3) (statute to be interpreted in an impartial and balanced manner). The historical adoption of the default judgment standard for good cause for use in the context of ORS 656.319(1)(b) is impartial and balanced.

May 8, 1996 Cite as 48 Van Natta 981 (1996)

In the Matter of the Compensation of
LOUISE A. RANSIER, Claimant
WCB Case No. 95-01087
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) set aside its partial denial of claimant's right carpal tunnel syndrome, right pronator syndrome and right ulnar neuropathy conditions; and (2) awarded an assessed attorney fee. On review, the issues are compensability and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the following change. In the second paragraph on page 3, we change the date of the examination to "November 30, 1994." (Ex. 70).

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. Claimant was diagnosed with right carpal tunnel syndrome in 1985. On April 23, 1985, Dr. Schwartz performed a right carpal tunnel release. (Ex. C). Claimant's right arm symptoms resolved after surgery. (Ex. A; Tr. 10, 14).

On March 17, 1993, claimant, a certified nurse's aide, had an immediate onset of right arm, neck and shoulder pain after being struck by a patient. Claimant sought treatment from Dr. Zuck on March 19, 1993. (Ex. 3). An MRI examination and a myelogram showed a central and leftward disc herniation at C6-7. (Exs. 4, 13). Claimant was examined by Dr. Misko, neurosurgeon, on April 12, 1993. Dr. Misko subsequently recommended cervical surgery. (Exs. 15, 16).

On May 17, 1993, the insurer accepted a C6-7 disc herniation. (Ex. 11).

Although claimant continued to have symptoms, she returned to modified work.

On July 22, 1994, electrodiagnostic tests were performed. (Ex. 50). Dr. Misko diagnosed right carpal tunnel syndrome, right pronator syndrome and right ulnar neuropathy. (Ex. 51). Dr. Misko believed that claimant's pronator syndrome and right ulnar neuropathy were slow-onset industrially related conditions. Dr. Misko said those conditions were related to claimant's work, which consisted of pouring water, passing it around and bed making. He recommended that claimant be taken off that type of repetitive work and have a repeat study in two months. Dr. Misko commented that if there was no improvement in the pronator syndrome and right ulnar neuropathy, surgery would be indicated. (Id.)

On August 1, 1994, Dr. Zuck authorized claimant's return to modified work, which consisted of passing out medicine to patients.

Dr. Zuck reported on October 5, 1994 that claimant continued to have discomfort and her symptoms had not resolved. (Ex. 59). On November 2, 1994, Dr. Misko reported that claimant was still having the same arm aching, swelling, pronator syndrome and carpal tunnel-type symptoms and ulnar entrapment symptoms in the right hand and arm. (Ex. 63). Dr. Misko recommended further studies, which were performed on November 11, 1994. The repeat nerve conduction studies showed that claimant continued to have abnormalities in the median and ulnar nerves of the right arm. (Ex. 66).

On January 10, 1995, the insurer issued a partial denial of claimant's right carpal tunnel syndrome, right pronator syndrome and ulnar neuropathy. (Ex. 75). Claimant requested a hearing.

The ALJ concluded that the March 17, 1993 work incident was a material contributing cause of the right carpal tunnel syndrome, right pronator syndrome and ulnar neuropathy. Reasoning that a definitive diagnosis was not necessary, the ALJ was persuaded that claimant's right arm problems were likely caused by the March 1993 work incident and possibly exacerbated by the November 1994 incident at work.

The insurer argues that the preponderance of medical evidence establishes that claimant does not have the alleged conditions. We disagree.

A claimant need not prove a specific diagnosis in order to prove compensability if the claimant shows that the symptoms are attributable to work. Boeing Aircraft Co. v. Roy, 112 Or App 10, 15 (1992); Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988). In this case, although the physicians disagreed about the correct diagnosis for claimant's conditions, the majority of physicians attributed claimant's current right arm condition to the March 17, 1993 injury or to repetitive use at work, at least under a material contributing cause standard.[1] We agree with the ALJ that claimant has established that her current right arm pain is attributable to her work activities.

The insurer argues that, even if claimant has the alleged conditions, the ALJ should have applied the major contributing cause standard. First, the insurer relies on Exhibit 86 to argue that claimant's preexisting carpal tunnel syndrome is the sole cause for the nerve conduction findings. According to the insurer, claimant's current disability and need for treatment was solely due to the preexisting carpal tunnel syndrome. See ORS 656.225. We disagree.

Exhibit 86 is a follow-up report from Dr. Laycoe after he had reviewed claimant's medical reports concerning her 1985 carpal tunnel surgery. Dr. Laycoe said that the new information was consistent with the history given by claimant. Dr. Laycoe reported that the new information confirmed

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[1] We note that Drs. Watson and Dinneen reported on January 11, 1994 that claimant's complaints since the injury were "related to the presence of cervical spondylosis at the C6-7 level, a preexisting condition." (Ex. 30-6). However, on December 9, 1994, Drs. Watson and Laycoe diagnosed claimant with, among other things, "cervical spondylosis, minimal C6-7, unrelated." (Ex. 70-7). Since Dr. Watson did not explain his change of opinion, we are not persuaded by his first report that claimant's current right arm condition was related to cervical spondylosis.

the "previous abnormal nerve conduction studies in 1985 and indeed that may be the sole explanation for the nerve conduction studies that Dr. Denekas has done recently, July 22, 1994, as stated in our report." (Ex. 86). However, based on the previous evaluation by Drs. Laycoe and Watson, Dr. Laycoe did not believe that claimant had a right arm condition of carpal tunnel syndrome. Rather, Dr. Laycoe felt that claimant's right arm symptoms were secondary to referred pain from her neck and shoulder.

In their previous report, Drs. Laycoe and Watson said they did not believe that claimant had right carpal tunnel syndrome, right pronator syndrome or right ulnar neuropathy. (Ex. 70-7). Rather, they diagnosed "[c]ontusion and strain, right neck and shoulder with referred right arm pain secondary to injury 3/17/93." (Id.) Drs. Laycoe and Watson believed that claimant's conditions were "due to the original on-the-job injury based principally on the historical fact that she never had symptoms prior to 3/17/93." (Id.)

When the two reports are read as a whole, it is clear that, even if Dr. Laycoe attributed claimant's current nerve conduction findings to her preexisting carpal tunnel syndrome, he did not believe those findings had any bearing on her current right arm condition. Therefore, we are not persuaded by Dr. Laycoe's report that claimant's disability was solely caused by, or her need for medical services was solely directed to her preexisting carpal tunnel syndrome. We conclude that ORS 656.225 does not apply to this case. See Colin J. McIntosh, 47 Van Natta 1965 (1995). Furthermore, the insurer has not referred to any medical evidence that establishes that claimant's preexisting carpal tunnel syndrome combined with her work injury to cause her current disability or need for treatment. See ORS 656.005(7)(a)(B).

Next, the insurer argues that claimant's preexisting diabetes caused her current condition. Although the physicians that examined claimant were aware of her diabetes condition, only three of the reports commented on claimant's diabetes in relation to her current condition.

Drs. Watson and Laycoe reported that claimant had a rash on the dorsum of the forearm which might be related to her diabetes. (Ex. 70-7). They did not attribute claimant's rash to her injury. (Ex. 70-8). As we mentioned earlier, Drs. Watson and Laycoe concluded that claimant's conditions were due to the original on-the-job injury. (Ex. 70-7). Although they mentioned that claimant's rash could be related to her diabetes, there is no indication from their report that they believed that claimant's diabetes had combined with her work injury to cause her current disability or need for treatment.

Dr. Rosenbaum diagnosed a chronic cervical strain. He commented that although claimant had nerve conduction studies demonstrating slowing in the median and ulnar nerves, "she also is diabetic and does not have a syndrome that one would associate with these specific entities." (Ex. 79-4). However, Dr. Rosenbaum did not provide any explanation of what claimant's diabetes had to do with her current condition. Dr. Rosenbaum's conclusory report does not establish that claimant's diabetes "combined" with her work injury.

Dr. Peterson performed a medical arbiter examination on July 25,1995 and reported, among other things, that claimant had impairment of two point discrimination. (Ex. 87A-8). Dr. Peterson was "suspicious [claimant] may be developing a diabetic polyneuropathy and that this may be the cause of the impairment of her two point discrimination. (Id.) Later in the report, Dr. Peterson commented that there was no incontrovertible evidence of ulnar nerve entrapment. (Ex. 87A-10). Dr. Peterson said that "[t]his may well be a diabetic complication as well, and it is unclear whether this ulnar neuropathy is metabolic, entrapment or a combination of both." (Id.)

Neither of Dr. Peterson's comments about claimant's diabetes are couched in terms of medical probability. Rather, her comments indicate only possibilities. Dr. Peterson's report is not sufficient to establish that claimant's diabetes "combined" with her work injury. In sum, we are not persuaded that the medical evidence establishes that claimant's preexisting diabetes combined with her work injury to cause her current disability or need for treatment.

In addition, some of the medical reports indicated that claimant had preexisting cervical spondylosis. On January 11, 1994, Drs. Watson and Dinneen reported that claimant's complaints since the injury were "related to the presence of cervical spondylosis at the C6-7 level, a preexisting condition." (Ex. 30-6). However, on December 9, 1994, Drs. Watson and Laycoe diagnosed claimant with, among other things, "cervical spondylosis, minimal C6-7, unrelated." (Ex. 70-7). Since Dr. Watson did not explain his change of opinion, we are not persuaded by his first report that claimant's

cervical spondylosis combined with her work injury. Furthermore, although Drs. Marten and Gardner diagnosed a cervical spine strain with right arm symptoms and cervical spondylosis, their report does not indicate that the spondylosis combined with the work incident to cause disability or need for treatment. (Ex. 41). We conclude that the medical evidence is not sufficient to establish that claimant's cervical spondylosis combined with her work injury to cause her current disability or need for treatment.

Absent evidence that claimant's preexisting conditions combined with her March 1993 work injury, claimant need only establish that her work injury was a material contributing cause of her disability and need for treatment.[2] ORS 656.005(7)(a); Leon M. Haley, 47 Van Natta 2056 (1995).

Although the physicians disagreed about the correct diagnosis for claimant's condition, the preponderance of medical opinions attributed claimant's current right arm condition to the March 17, 1993 injury. Dr. Zuck, claimant's treating physician since 1993, reported that claimant had experienced significant symptoms since the March 17, 1993 injury. (Ex. 32). Drs. Laycoe and Watson reported that claimant's conditions were "due to the original on-the-job injury based principally on the historical fact that she never had symptoms prior to 3/17/93." (Ex. 70-7). Dr. Rosenbaum reported that a cervical strain was the most appropriate accepted condition with regard to her March 17, 1993 injury. (Ex. 79-5). Although Drs. Marten and Gardner did not specifically comment on causation, they reported claimant's history of symptoms dating from the March 1993 injury and did not refer to any other possible causes. (Ex. 41). Based on these reports, we conclude that claimant's March 17, 1993 work injury was a material contributing cause of her current right arm 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 regarding the compensability issue 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 November 27, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

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[2] The insurer relies on a report from Dr. Misko to argue that claimant must meet the major contributing cause standard under ORS 656.802. In one of his reports, Dr. Misko commented that claimant's pronator syndrome and right ulnar neuropathy were "slow-onset industrially-related conditions." (Ex. 51). Although Dr. Misko's report indicates that an occupational disease analysis would be appropriate, claimant is relying on an injury analysis and the preponderance of persuasive medical reports supports an injury analysis. Consequently, we reject the insurer's argument that claimant must show that her work activities were the major contributing cause of her condition under ORS 656.802.

In the Matter of the Compensation of
SHARMAN R. CROWELL, Claimant
WCB Case No. 93-13236
ORDER OF ABATEMENT
Schneider Hooton, Claimant Attorneys
Schwabe, et al, Defense Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Claimant requests reconsideration of the Board's April 9, 1996 Order on Remand which affirmed a Determination Order that had classified her injury claim as nondisabling. Relying on ORS 656.262(4)(b) (which provides that a self-insured employer's payment to a "disabled" worker at the same pay interval that the worker received at the time of injury shall be deemed timely payment of temporary disability in accordance with ORS 656.210 and 656.212), claimant asserts that she has met the definition of a "disabling compensable injury" under ORS 656.005(7)(c) because temporary partial disability payments are deemed to have been made and paid to her by the self-insured employer when she was paid her regular wages on her return to work at a modified job.

In order to further consider claimant's contentions, we withdraw the Board's April 9, 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 shall proceed with our reconsideration.

IT IS SO ORDERED.

May 9, 1996 Cite as 48 Van Natta 985 (1996)

In the Matter of the Compensation of
THOMAS P. HARRIS, Claimant
WCB Case No. 95-08759
ORDER ON REVIEW
Rasmussen,et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Odell's order that: (1) upheld the self-insured employer's denial of his aggravation claim for a cervical spine injury; and (2) declined to assess penalties or attorney fees for allegedly unreasonable claim processing. With his reply brief, claimant has filed a motion to strike the employer's respondent's brief. On review, the issues are motion to strike, aggravation, penalties and attorney fees. We deny the motion to strike and reverse.

FINDINGS OF FACT

We adopt the ALJ's findings. We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant has moved to strike the employer's respondent's brief, which was due on or before February 20, 1996, on the ground that the brief was untimely filed. Claimant relies on the fact that the post office cancellation on the envelope containing the brief is dated February 22, 1996.

Under OAR 438-005-0046(1)(c), briefs are timely filed if mailed by "first class mail, postage prepaid. An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date." In this case, the certificate of service attached to the brief indicates that it was deposited in the mail on February 20, 1996. Thus, under the applicable administrative rule, the employer's respondent's brief was timely filed. See Elva M. McBride, 46 Van Natta 2206 (1994); Lucy E. Buckallew, 46 Van Natta 115 (1994); Duane R. Paxton, 44 Van Natta 375, 376 (1992). Consequently, the motion to strike is denied.

Aggravation

The ALJ concluded that claimant failed to establish a compensable aggravation claim under amended ORS 656.273(1). We disagree.

ORS 656.273(1) provides, in relevant part:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings."

Under amended ORS 656.273(1), in order to prove a compensable aggravation, a claimant must now show that he sustained "an actual worsening of the compensable condition." Subsequent to the date of the ALJ's order, we held that 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. Carmen C. Neill, 47 Van Natta 2371 (1995).

Here, claimant's original October 1991 claim for a cervical injury was accepted by the employer as nondisabling. Consequently, there is no prior award of permanent disability. Claimant relies on the opinion of his treating physician, Dr. Jensen, to establish that his cervical condition has compensably worsened.

On April 12, 1995, Dr. Jensen opined that claimant's cervical radiculopathy had clinically worsened over time, and that claimant was now suffering from significant pain as well as associated weakness and numbness in the C-7 distribution. After reviewing claimant's April 1995 MRI scan, Dr. Jensen reported that claimant had evidence of a right C6-7 combination of bony spur and disc, causing compression at the C-7 nerve root on the right. Dr. Jensen opined that claimant had a progressive, clinical worsening of a compensable work-related injury in the cervical region.

In October 1995, Dr. Jensen reported that claimant had significant weakness involving the C7 innervated muscles, finger extensors, wrist extensors and triceps. Muscle strength in these muscles was graded at 4 out of 5. Dr. Jensen also noted give way weakness in multiple other muscles compatible with pain. Dr. Jensen reported that claimant's disability was permanent and released claimant to work with the following permanent restrictions:

> "no pushing, pulling or lifting in excess of 10 pounds; no twisting, climbing, stooping, or hammering; no work with the right arm above shoulder level; no work requiring repetitive motion of the head; no repetitive movements with the right wrist or gripping with the right hand; must move around or sit when necessary for comfort; no driving or use of heavy equipment; limited sitting to 30 minutes at [a] time with 5 minute breaks for a total of three hours per day; limited standing to 10 to 15 minute breaks for a total of two hours per day; and a limit of walking 15 to 20 minutes at [a] time, 15 minute breaks in between, for a total of two hours per day."

Based on Dr. Jensen's uncontroverted medical opinion, we conclude that claimant's compensable condition has worsened. Moreover, finding muscle weakness, a right C6-7 combination of bony spur and disc causing compression at the C-7 nerve root on the right (as confirmed by an MRI), Dr. Jensen concluded that claimant had sustained a "progressive, clinical worsening of a compensable work related injury." In light of such circumstances, we conclude that claimant's cervical condition has pathologically worsened.[1]

Because claimant has sustained a pathological worsening of his compensable condition, we conclude that his condition has "actually worsened" as required by ORS 656.273(1). Carmen C Neill, supra. Therefore, it is unnecessary to address whether claimant's compensable condition has symptomatically worsened.

Having determined that claimant's compensable condition has "actually worsened," we next consider whether that worsening is supported by objective findings.[2] Finding significant weakness involving the C7 innervated muscles, finger extensors, wrist extensors, and triceps, Dr. Jensen rated

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[1] We note the term "clinical" is defined as "pertaining to the clinic or to the bedside; pertaining to or founded on actual observation and treatment of patients, as distinguished from theoretical or basic sciences." Dorland's Illustrated Medical Dictionary (25th ed. 1974). Based on this definition, a "clinical" worsening suggests an actual, observable worsening, which would not necessarily equate to a pathological worsening. Thus, our decision should not be interpreted as a determination that a "clinical" worsening is synonymous with a pathological worsening. Rather, our decision that there has been a pathological worsening is based on the totality of the medical evidence, which includes a doctor's opinion that characterized claimant's condition as a "clinical" worsening.

[2] Amended ORS 656.005(19) defines "objective findings" as "verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength and palpable muscle spasm. 'Objective findings' does not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable."

claimant's muscle weakness at 4/5. Inasmuch as Dr. Jensen's findings of 4/5 muscle weakness involving the C7 innervated muscles are measurable, they are not excluded from the definition of an objective finding under amended ORS 656.005(19). See Gayle A. Jaynes, 48 Van Natta 758 (1996) (finding tenderness to palpation, limited ranges of motion and positive impingement testing sufficient to constitute "objective findings" since these findings were measurable and observable); compare Jairo J. Garcia, 48 Van Natta 235 (1996) (no "verifiable indications of injury" where the claimant's treating physician indicated that the claimant had pain but all other findings were normal). Under such circumstances, we conclude that claimant's actual worsening of his compensable condition is supported by objective findings. ORS 656.005(19).

Accordingly, we conclude that claimant has established a compensable aggravation claim.

The employer contends that claimant failed to properly file his aggravation claim as prescribed by amended ORS 656.273(3). Amended ORS 656.273(3) requires a claimant to provide written notice of an aggravation claim in a form and format prescribed by the Director. In Rick A. Webb, 47 Van Natta 1550 (1995), we concluded that retroactive application of amended ORS 656.273(3) would produce an absurd and unreasonable result by requiring a claimant to have complied with notice procedures not even in existence at the time an aggravation claim was filed.

Here, as in Webb, claimant's aggravation claim was filed prior to the enactment of amended ORS 656.273(3) and before the existence of the Director's aggravation claim filing form. For the reasons set forth in Webb, we decline to retroactively apply ORS 656.273(3) to this case.

Penalty

Claimant contends that the employer unreasonably failed to process his aggravation claim and seeks a penalty pursuant to ORS 656.262(11). We agree.

Claimant filed an aggravation claim in April 1995. The employer did not accept or deny the claim within 90 days as required by ORS 656.262(6). ORS 656.262(11)(a) provides for a penalty of up to 25 percent of the amounts then due where a carrier unreasonably delays accepting or denying a claim. The employer offers no explanation for its failure to process the claim. Based on this record, we find that the employer's failure to process the claim was unreasonable. Consequently, we conclude that a 25 percent penalty should be assessed pursuant to ORS 656.262(11)(a), to be equally shared by claimant and his attorney.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the aggravation 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 November 20, 1995 is reversed. The self-insured employer's denial is set aside and the aggravation claim is remanded to the employer for processing according to law. For the employer's unreasonable claim processing, claimant is awarded a penalty equal to 25 percent of the amounts of compensation due as of the date of hearing (as a result of this order). The penalty shall be paid in equal shares to claimant and his attorney. For services at hearing and on review concerning the denial, claimant's attorney is awarded $3,000, payable by the self-insured employer.

In the Matter of the Compensation of
PETER J. LaFRENIERE, Claimant
WCB Case No. 93-05399
ORDER ON REMAND
Craine & Love, Claimant Attorneys
Steve Cotton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. In our prior order, we reversed that portion of an Administrative Law Judge's (ALJ's)[1] order that had set aside the SAIF Corporation's denial of claimant's current low back condition and affirmed that portion of the ALJ's order that upheld SAIF's aggravation denial for the same condition. Pursuant to its March 12, 1996 order, the court has remanded for reconsideration in light of the amendments to the Workers' Compensation Law by Or Laws 1995, ch 332, § 31.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts and procedural history of this case. Claimant sustained a compensable low back injury in 1988, which was accepted as a lumbar strain. (Ex. 7). Claimant also has spina-bifida at L5 and preexisting grade 1 spondylolisthesis at L5-S1. Claimant underwent a compensable surgery in January 1989 for a herniated disc at L4-5.

Claimant became medically stationary on May 30, 1989, and his claim was closed by a Determination Order issued June 16, 1989 which awarded 24 percent unscheduled permanent disability. By a November 22, 1989 stipulation, claimant's award was increased to 39 percent. Claimant sought no medical treatment between May 1989 and December 1992, although he continued to have persisting low back pain.

In December 1992, claimant had an off-work fall and was seen in an emergency room for back and right shoulder pain. He was diagnosed with a lumbosacral strain and disc syndrome, for which he treated until about mid-February. On March 1, 1993, claimant came under the care of Dr. Kent Grewe, neurosurgeon, who proposed surgery and requested reopening of claimant's 1988 claim. On April 26, 1993, SAIF denied the compensability of claimant's aggravation claim for his current condition. Claimant requested a hearing.

At hearing on January 27, 1994, the ALJ held that claimant's aggravation claim was not compensable because claimant failed to prove a material worsening of his compensable 1988 injury. However, the ALJ also held that claimant's current condition was compensable because the 1988 injury remained the major contributing cause of his current disability and need for treatment. SAIF requested Board review of that portion of the ALJ's order that set aside its current condition denial, while claimant cross-requested review of that portion of the ALJ's order that upheld SAIF's denial of his aggravation claim.

On review of the ALJ's order, we held that claimant failed to establish the compensability of his current low back condition, and we reversed that portion of the ALJ's order. We affirmed that portion of the ALJ's order that upheld SAIF's aggravation denial, reasoning that claimant failed to prove the compensability of his current condition.

Claimant petitioned for judicial review, contending that we erred in finding his current low back condition not compensable. While this matter was pending before the court, claimant moved to remand this case to the Board for reconsideration in light of the amendments to the Workers' Compensation Law made by Or Laws 1995, ch 332, § 31. The court granted claimant's motion and remanded this matter for reconsideration in light of the amendments. We now proceed with our reconsideration.

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[1] Formerly referred to as "Referee."

Subsequent to our order, the legislature amended ORS 656.273(1). 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).

We have previously held that the amended statute requires proof of two elements in order to establish a compensable aggravation: (1) a compensable condition; and (2) an "actual worsening." Paul D. Rutter, 48 Van Natta 119 (1996); Gloria T. Olson, 47 Van Natta 2348 (1995). If the allegedly worsened condition is not a compensable condition, compensability must first be established under amended ORS 656.005(7)(a). Id.

Except as provided otherwise, the amendments of Senate Bill 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. Newell v. SAIF, 136 Or App 280 (1995); 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, the amended version of the statute applies here. See SB 369, § 66 (listing exceptions to general retroactivity provision); Gloria T. Olson, supra; Helen Callander, 47 Van Natta 1626 (1995).

We begin our aggravation analysis with a determination of whether claimant's current condition is compensable. Claimant's compensable 1988 injury was accepted as a lumbar strain. (Ex. 7). Claimant's current condition following the December 1992 off-work fall has been variously diagnosed as a lumbar strain and lumbar disc syndrome; chronic low back and bilateral lower extremity radiating pain and L5-S1 spondylolisthesis with bifid L5 lamina; L5-S1 spondylolisthesis with intermittent nerve root compression; and chronic lumbosacral spondylolisthesis and acute lumbar strain. (See Exs. 37A, 39-3, 45-3 and 46-6). Considering that claimant's current diagnoses contain elements of both a lumbar strain and chronic spondylolisthesis, we conclude that claimant's current condition is not the same as his accepted 1988 condition. Therefore, claimant must first establish the compensability of his current condition.

Claimant has L5-S1 spondylolisthesis which preexisted his 1988 work injury. (Exs. 51, 53-1). Dr. Grewe hypothesized that claimant's spondylolisthesis was caused by a crack in the bone, which claimant's body probably partially healed with a fibrous soft tissue bond. (Ex. 53-1). Dr. Grewe further hypothesized that the 1988 fall probably damaged the fibrous union around the spondylolisthesis, resulting in a mechanical problem and causing claimant's ongoing back pain and disability since 1988. (Ex. 53-2). Dr. Grewe proposed surgical decompression and fusion to address claimant's mechanical back problems. (Exs. 41, 53; see also Ex. 45-3). Based on Dr. Grewe's reports and opinion, we conclude that claimant's preexisting spondylolisthesis combined with his compensable 1988 injury to cause or prolong his current disability and need for treatment. Therefore, in order to establish the compensability of his current low back condition, claimant must prove that the compensable 1988 injury is the major contributing cause of his current disability and need for treatment. ORS 656.005(7)(a)(B).

In our prior order, we noted that only Dr. Grewe related claimant's current low back condition, disability and need for treatment to the 1988 injury. However, in a subsequent opinion, after considering the extent of claimant's symptoms and treatment following the 1992 non-work fall, Dr. Grewe opined that the 1992 fall was the major contributing cause of claimant's current need for medical treatment. (Ex. 54). Finding that Dr. Grewe's last opinion was based on an accurate history, we found that his last opinion was most persuasive. Accordingly, we concluded that claimant failed to establish that his 1988 injury was the major contributing cause of his current disability and need for treatment.

After reviewing the record, we adhere to our prior conclusion regarding the persuasiveness of Dr. Grewe's final opinion. Therefore, we continue to find that claimant failed to prove the compensability of his current low back condition. Since we find that claimant's current condition is not compensable, claimant's aggravation claim fails.

Accordingly, on reconsideration, as supplemented and modified herein, we republish our September 19, 1994 order.

IT IS SO ORDERED.

In the Matter of the Compensation of
THERESE L. PETKOVICH, Claimant
WCB Case No. 93-07299
ORDER ON REMAND
Craine & Love, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Petkovich v. Safeway Stores, Inc., 139 Or App 154 (1996). The court has reversed our prior order which awarded claimant 18 percent (57.6 degrees) unscheduled permanent disability for a neck condition. Citing Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) "Findings of Fact."

CONCLUSIONS OF LAW AND OPINION

On June 19, 1990, claimant compensably injured her neck. The employer accepted a disabling cervical/thoracic strain. (Ex. 6). By a November 27, 1991 Opinion and Order, a prior ALJ set aside the employer's denial of two herniated cervical discs.

Claimant was released to regular work. Her claim was subsequently closed by a March 2, 1993 Notice of Closure that awarded 18 percent unscheduled permanent disability. (Ex. 22). On May 21, 1993, an Order on Reconsideration affirmed the Notice of Closure. (Ex. 24). Claimant requested a hearing.

At hearing, the ALJ, relying on a temporary Director's rule, OAR 436-35-310(2) (WCD Admin. Order 93-052), concluded that claimant was entitled to an adaptability factor of 1. Based on claimant's age, education, training, and permanent impairment, the ALJ awarded 24 percent unscheduled permanent disability. The self-insured employer requested Board review.

Subsequent to the ALJ's order, the temporary rule expired. Therefore, in our prior order, we applied the prior rule, former OAR 436-35-310(2) (WCD Admin. Order 6-1992), which provided for an adaptability factor of zero. The effect of our application of the former rule was to convert the combined value of claimant's age and education factors to zero. Accordingly, we reduced claimant's unscheduled permanent disability award to 18 percent (consistent with claimant's permanent impairment). Claimant petitioned for judicial review.

In reversing our prior order, the court cited Carroll v. Boise Cascade Corp., 138 Or App 610, (1996). The court, in Carroll, relied on England v. Thunderbird, 315 Or 633 (1993). In England, the Court held that former OAR 436-35-290(2)(a), former OAR 436-35-300(2)(a), and former OAR 436-35-310(2)(a), which held that no values are given for age, education, or adaptability for workers who have returned to their usual and customary work, were inconsistent with former ORS 656.214, which provided that "[e]arning 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." Furthermore, in Carroll, the Court of Appeals also held that OAR 436-35-310(2), which gave a zero adaptability value when a worker had returned to work, conflicted with ORS 656.214(5) and 656.726(3)(f)(A), and was, therefore, invalid. Carroll v. Boise Cascade Corporation, supra.

We have previously applied the Carroll decision to former OAR 436-35-280(1) (WCD Admin. Order No. 93-056). Joe R. Ray, 48 Van Natta 325 (1996). In Ray, because the claimant's residual functional capacity (RFC) was equal to his base functional capacity (BFC), his adaptability factor under the former OAR 436-35-280(1)(a) was zero. Moreover, because that factor was used as a multiplier, former OAR 436-35-280(6), the claimant was not allowed a value for age, education, or skills. In light of Carroll, however, we concluded that former OAR 436-35-280(1) was inconsistent with ORS 656.726(3)(f)(A). Joe R. Ray, supra. Therefore, we declined to apply the rule. Rather, we found that the value for the age, education and skills factor should be added to the impairment value to determine the amount of the unscheduled permanent disability award. That analysis essentially resulted in assigning a value of 1 to the adaptability factor.

This case is governed by the same rules as those that were at issue in Joe R. Ray. Here, as in Ray, claimant's BFC and RFC are equal. Consequently, under former OAR 436-35-280(1)(a), claimant's adaptability value is zero. That analysis is inconsistent with Carroll and Ray. Consequently, in accordance with Ray, we add the value for claimant's age, education and skills factor to his impairment value to determine the amount of his unscheduled permanent disability award. In other words, we assign a value of 1 to claimant's adaptability factor. Joe R. Ray, supra.

Accordingly, because the factors for age and education must be applied, we assign claimant an adaptability factor of 1. See Donna J. England, 45 Van Natta 1480 (1993); Carroll v. Boise Cascade Corporation, supra; Joe R. Ray, supra; see also Jerry S. Quillen, 48 Van Natta 526 (1996) (Board declined to apply a similarly invalid rule in determining extent of unscheduled permanent disability).

Assembling the factors, the total value for claimant's age (0), and education and skills (5) is multiplied by the adaptability factor of 1, for a total of 5. In our prior order, we concluded that claimant's total impairment value is 18, based on combining a rating of 9 for surgery with a rating of 10 for loss of range of motion. We based impairment for loss of range of motion on the following measurements: extension, 46 degrees; flexion, 31 degrees; left lateral flexion, 30 degrees; right lateral flexion, 27 degrees; left rotation, 57 degrees; and right rotation, 51 degrees. (Ex. 20). Those findings were not disputed on review. Accordingly, claimant's impairment value, 18, is added to the age, education and adaptability value 5, for a total of 23 percent unscheduled permanent disability.[1]

Accordingly, on reconsideration, the ALJ's order dated October 13, 1993 is modified. In lieu of the ALJ's award, and in addition to the Order on Reconsideration award of 18 percent (57.6 degrees) unscheduled permanent disability, claimant is awarded 5 percent (16 degrees), for a total award to date of 23 percent (73.6 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of the increased compensation created by this order (the 5 percent difference between our prior 18 percent award and this 23 percent award), not to exceed $3,800, payable directly to claimant's attorney.[2] The attorney fee is in lieu of the award granted by the ALJ's order.

IT IS SO ORDERED.

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[1] The ALJ awarded a total of 24 percent unscheduled permanent disability, finding, in part, that claimant was entitled to 9 percent impairment for surgery and 11 percent impairment for loss of cervical range of motion. Our award of 23 percent unscheduled permanent disability is based, in part, on 9 percent impairment for surgery and 10 percent impairment for loss of cervical range of motion.

[2] Because the employer had requested Board review contesting the ALJ's 24 percent award, and because we have ultimately reduced that award to 23 percent, claimant is not entitled to a carrier-paid attorney fee under ORS 656.382(2). See e.g. Liberty Northwest Ins. Corp. v. Koitzsch, 135 Or App 524 (1995).

May 9, 1996 Cite as 48 Van Natta 991 (1996)

In the Matter of the Compensation of
TERRY L. SHEELEY, Claimant
WCB Case No. 94-03090
ORDER OF ABATEMENT
Andrew H. Josephson, Claimant Attorney
Steven T. Maher, Defense Attorney

On April 10, 1996, the Board affirmed an Administrative Law Judge's (ALJ's) Herman's order that: (1) set aside its partial denials of claimant's claim for a right knee strain, right knee synovitis and patella tendinitis; and (2) found claimant's claim was prematurely closed. Announcing that the parties are presently negotiating a settlement of their dispute, the insurer seeks abatement of the Board's order so that we may retain authority to consider their proposed agreement.

In light of such circumstances, we withdraw the Board's April 10, 1996 order. On receipt of the parties' proposed settlement, we shall proceed with our review. In the meantime, the parties are requested to keep us fully apprised of any further developments in this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
LORETA C. SHERWOOD, Claimant
WCB Case No. 95-07277
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests, and the self-insured employer cross-requests, review of Administrative Law Judge (ALJ) Daughtry's order that: (1) upheld the employer's partial denial of claimant's back, cervical, and shoulder conditions; (2) set aside the employer's partial denial of a depression/mental condition as premature; and (3) awarded a $3,000 attorney fee award. On review, the issues are "premature" denial, compensability, and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following correction. Dr. Clawson is a podiatrist.

CONCLUSIONS OF LAW AND OPINION

Compensability of Back, Cervical, and Shoulder Conditions

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

Premature Denial

The ALJ found that neither an employer-arranged medical examiner's discussion of claimant's depression nor the treating doctor's description of depression and confusion constituted a claim. Citing amended ORS 656.262(7)(a)[1], the ALJ concluded that claimant had not requested formal written acceptance of those conditions. The ALJ, therefore, set aside the denial of depression and mental confusion as premature. For the following reasons, we agree that that portion of the denial was premature.

An employer may partially deny any condition which it reasonable believes could be a claim. See Weyerhaeuser Co. v. Warrilow, 96 Or App 34 (1989). However, if claimant contends that, in fact, she is not making a claim for the denied condition, the denial will be set aside as premature and ineffective until such time as claimant actually makes a claim for such a condition. Shannon M. Evans, 42 Van Natta 227 (1990); Alvin H. Despain, 40 Van Natta 1823 (1988).

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[1] Amended ORS 656.262(7)(a) provides in part: "New medical condition claims must clearly request formal written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance or any new medical condition from the insurer or self-insured employer. * * *"

The employer argues that amended ORS 656.262(7)(a) does not apply because it had otherwise received notice of a possible claim. We need not decide the applicability of this statute since we have found that no "claim," formal or otherwise, was made.

Where no "claim" for compensation has been made by claimant or someone on the claimant's behalf pursuant to ORS 656.005(6), the issuance of a denial is generally considered to be premature. See Dorothy M. Jackson-Duncan, 42 Van Natta 1122 (1990). The mere diagnosis of a condition by an examining physician, when no treatment is contemplated, is insufficient to make a claim for that condition. Jack Allen, 43 Van Natta 190 (1991).

The employer contends that Dr. Monger's diagnosis of depression and confusion and Dr. Clawson's request for a psychological examination constituted a claim. We disagree.

In March 1995, Dr. Clawson, podiatrist, reported that he had no further treatment to offer claimant for her accepted foot condition. He, therefore, referred claimant back to her primary care physician, Dr. Daskalos, D.O., for an overall physical and psychological evaluation for her bodily complaints and emotional concerns. However, claimant did not return to Dr. Daskalos. Again, the mere recommendation for treatment, by itself, does not constitute a claim.

In a May 17, 1995 change of attending physician form, Dr. Monger, chiropractor, described claimant's complaints as including depression and confusion. Dr. Monger, however, neither recommended nor provided treatment for these complaints. This report, in itself, is insufficient to make a claim for the depression and confusion conditions. Jack Allen, supra.

Next, the employer argues that the medical evidence relates claimant's physical complaints to psychological factors. Specifically, the employer contends that such evidence led it to reasonably conclude that these psychological conditions were encompassed in the claim. We rejected a similar argument in Debra M. Sansburn, 47 Van Natta 1462, 1463 (1995). In Sansburn, the insurer argued that a claim for somatization disorder existed based on the medical evidence which indicated that many of the claimant's physical complaints were caused by her somatization disorder. We disagreed, reasoning that causation arises only after a worker has asserted a claim. Id. at 1463; cf. William H. Waugh, 45 Van Natta 919 (1993) (skin condition reasonably encompassed an accepted knee claim where treating doctor requested exam to rule out whether accepted knee condition caused skin condition and the claimant requested authorization for the "rule out" exam).

Last, the employer contends that a claim was made based on claimant's request for hearing and her position taken at hearing. A claimant may make a "claim" for a condition when the claimant chooses to litigate the merits of a condition at hearing, thereby waiving the procedural defect of a premature denial. Dorothy Jackson-Duncan, supra.

Here, claimant requested a hearing on the employer's denial, but expressly objected to the denial of the depression and mental confusion as premature. Contrary to the employer's argument, we find that claimant did not proceed to litigate the merits of the employer's denial in its entirety nor otherwise waived any procedural defect relating to the denial.

Under the circumstances, we conclude that claimant did not make a claim for the depression and mental confusion. Accordingly, we agree with the ALJ that that portion of the employer's denial was premature.

The ALJ assessed a $3,000 attorney fee for overturning a portion of the employer's denial as premature. The employer does not dispute that claimant is entitled to a fee, but contends that a fee of $3,000 is excessive. Specifically, the employer contends that: (1) the results obtained were minimal since claimant never sought treatment for her mental problems; (2) the efforts to obtain such results were also minimal; and (3) the time devoted on issues which claimant did not prevail should not be considered. After reviewing the relevant factors, we agree that the ALJ's award should be modified.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing for prevailing over the employer's premature denial is $1,200. In reaching this conclusion, we have particularly considered the time devoted to this issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated. In addition, we have not considered claimant's unsuccessful efforts devoted to the compensability issue concerning the back, cervical, and shoulder conditions. We modify the ALJ's attorney fee award accordingly.

Claimant's attorney is also entitled to an assessed fee for services on review concerning the premature denial issue. ORS 656.382(2). We conclude that, for services on review concerning this issue, claimant is entitled to an attorney fee of $500, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of claimant's cross-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 services rendered on review concerning her unsuccessful request for review and concerning the attorney fee issues. See Saxton v. SAIF, 80 Or App 631 (1986); Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated September 2, 1995 is affirmed in part and modified in part. In lieu of the ALJ's award of a $3,000 assessed attorney fee, claimant's attorney is awarded $1,200, to be paid by the self-insured employer. The remainder of the order is affirmed. For services on Board review, claimant is entitled to a $500 attorney fee, payable by the employer.

May 9, 1996 Cite as 48 Van Natta 994 (1996)

In the Matter of the Compensation of
BRIAN D. SHIPLEY, Claimant
WCB Case No. 95-04202
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) held that the Hearings Division lacked jurisdiction over the SAIF Corporation's "de facto" denial of claimant's cervical condition and the parties' vocational assistance dispute; (2) affirmed an Order on Reconsideration holding that claimant's lumbar injury claim was not prematurely closed and awarding claimant temporary disability compensation and 7 percent (22.4 degrees) unscheduled permanent disability; and (3) declined to assess a penalty for SAIF's allegedly unreasonable claims processing. On review the issues are jurisdiction, and alternatively compensability and vocational services, and temporary disability, premature closure, extent of unscheduled permanent disability and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

"De Facto" Denial -- Cervical Condition

Relying on ORS 656.262(7)(a), which was added to the statute as part of Senate Bill 369, the ALJ concluded that, because claimant had not made a formal written request that SAIF accept his cervical condition, the Hearings Division lacked jurisdiction over the matter. Claimant asserts that, because ORS 656.262(7)(a) will extend a procedural time limitation with regard to an action on a claim taken prior to the effective date of the recent amendments to the Workers' Compensation Act, Senate Bill 369, Oregon Laws 1995, chapter 332, it does not apply to this matter. We disagree.

ORS 656.262(7)(a) provides, in part:

"After claim acceptance, written notice of acceptance or denial of claims for aggravation or new medical condition shall be furnished to the claimant by the insurer or self-insured employer within 90 days after the insurer or self-insured employer receives written notice of such claims. New medical condition claims must clearly request formal

> written acceptance of the condition and are not made by the receipt of a medical claim billing for the provision of, or requesting permission to provide, medical treatment for the new condition. The worker must clearly request formal written acceptance of any new medical condition from the insurer or self-insured employer." (Emphasis added).

Our first task is to discern what the legislature intended when it enacted that language. ORS 174.020. We begin by examining the text and context of ORS 656.262(7)(a). ORS 174.020; PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). Only if those sources do not reveal the legislature's intent do we resort to legislative history and other extrinsic aids. PGE v. Bureau of Labor and Industries, supra, 317 Or at 611-12.

On its face, ORS 656.262(7)(a) manifests the legislature's intent that, in cases involving aggravation or new medical condition claims that arise after claim acceptance, the worker must "clearly request formal written acceptance of the [aggravation or new medical] condition" before the carrier has an obligation to issue a written notice accepting or denying that condition. The carrier then has 90 days after it "receives written notice of such claim[]" to either accept or deny the claim. Taken together, we read that language to require that, after claim acceptance, a worker must clearly request in writing the formal written acceptance of an aggravation or new medical condition claim before the carrier is obligated to process the claim.

The context of ORS 656.262(7)(a) supports this interpretation. ORS 656.005(6) defines "claim" as "a written communication from a subject worker or someone on the worker's behalf, or any compensable injury of which the subject employer has notice or knowledge." (Emphasis added). ORS 656.262(6)(d), which was also added to the statute as part of Senate Bill 369, now requires that, for a worker to contest an alleged "de facto" denial, the worker must first communicate in writing to the carrier his or her objections to the notice of acceptance. Guillermo Rivera, 47 Van Natta 1734 (1995). Taken together, these subsections reveal the legislature's intent to require a worker with an accepted claim to request in writing specific processing of any additional conditions that he or she believes may be compensable. To reiterate, the statute imposes on workers the requirement that, after claim acceptance, they request in writing formal written acceptance of any subsequent aggravation or new medical condition. Because the text and context of ORS 656.262(7)(a) clearly reveal the legislature's intent, we need not resort to the legislative history. PGE v. Bureau of Labor and Industries, supra, 317 Or at 611.

The next issue is whether ORS 656.262(7)(a) applies to this case. It does.

Except as otherwise provided, the provisions of Senate Bill 369 apply to matters for which the time to appeal has not expired or, if appealed, has not been finally resolved on appeal. Volk v. America West Airlines, 115 Or App 565, 572-3 (1995); see also SAIF v. Newell, 136 Or App 280, 282 (1995) (1995 amendments to Workers' Compensation Law applied to case pending before court on effective date of legislation). An exception to this general rule is that changes in procedural time limits wrought by Senate Bill 369 do not apply retroactively. Or Laws 1995, ch 332, § 66(6) (SB 369, § 66(6)); see Motel 6 v. McMasters, 135 Or App 583, 587 (1995). Claimant asserts that, because SAIF failed to accept or deny his cervical condition before Senate Bill 369 went into effect, this exception applies. We disagree.

The time limit exception concerns statutory amendments that altered procedural time limitations that were in existence before Senate Bill 369 went into effect. Accordingly, for that exception to apply here, ORS 656.262(7)(a) itself must have altered some procedural time limit that had applied to claimant's claim before Senate Bill 369 went into effect.

In our view, ORS 656.262(7)(a) has altered no time limitation. Both before and after the enactment of Senate Bill 369, carriers had 90 days within which to accept or deny claims, claimants were free to initiate new claims at any time, and carriers were entitled to some notice of claims before being obligated to process them. What has changed is the nature of the event that triggers a carrier's obligation to process a claim.[1]

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[1] In reaching this conclusion, we recognize that, under ORS 656.262(6)(d), a carrier now has 30 days within which to respond to a "communication in writing" that contains a worker's objections to an acceptance notice. See note 2, infra. This case, however, concerns ORS 656.262(7)(a), which governs aggravation and new medical condition claims. Therefore, we do not address the impact, if any of ORS 656.262(6)(d)'s 30-day requirement under section 66(6) of Senate Bill 369.

Under the old law, a request for compensation did not have to take any particular form; for example, a physician's report requesting medical services for a specified condition was enough. Safeway Stores, Inc. v. Smith, 117 Or App 224, 227 (1992). Under the new law, after claim acceptance, a claimant must now formally request written acceptance of claims for aggravation or new medical conditions. ORS 656.262(7)(a). That change does not alter any time limits; rather, it formalizes the event that triggers the running of the 90-day period in which a carrier has to accept or deny a claim. ORS 656.262(7)(a) did not, however, alter the 90-day period itself. Therefore, we decline to apply the time limitation exception to this case. Because the time to appeal this matter has not expired and it has not been finally resolved on appeal, ORS 656.262(7)(a) applies to this case. Volk v. America West Airlines, supra, 115 Or App at 572-3.

The last issue is whether claimant has satisfied the requirements of that subsection. He has not. There is no evidence that claimant requested in writing formal written acceptance of his cervical condition. His hearing requests note only "compensability" among the contested issues; they do not specify that he requested formal written acceptance of the cervical condition. On this record, then, we agree with the ALJ that claimant failed to comply with the requirements of ORS 656.262(7)(a). Therefore, we do not address the compensability of claimant's cervical condition.[2]

Jurisdiction - Vocational Assistance

We adopt the ALJ's reasoning regarding this issue, with the following supplementation.

The Director now has exclusive jurisdiction over vocational assistance disputes. Amended ORS 656.283(2); Ross Enyart, 47 Van Natta 1540 (1995). Accordingly, we affirm the ALJ's conclusion that the Hearings Division lacked jurisdiction over that issue.

Temporary Disability

We adopt and affirm the ALJ's analysis of this issue, with the following supplementation.

Claimant asserts that SAIF incorrectly recalculated his temporary total disability (TTD) rate pursuant to a prior ALJ's February 1995 order and failed to pay him certain TTD. There is no evidence to support those assertions. Therefore, we reject them.

Claimant next asserts that the prior ALJ's order required SAIF to pay TTD beyond claimant's medically stationary date, August 29, 1994. We disagree. Regarding claimant's TTD after August 29, 1994, the issue in the prior case was the proper TTD rate, not entitlement. Consequently, we reject claimant's assertion.

In sum, for the reasons stated in the ALJ's order, as supplemented here, we agree that claimant has been paid all the TTD compensation to which he presently is due.

Premature Closure

We adopt and affirm the ALJ's reasoning and conclusion regarding this issue, with the following supplementation.

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[2] In Guillermo Rivera, supra, the issue was whether the claimant's hearing requests satisfied the notice requirement of ORS 656.262(6)(d), which requires that a worker "first must communicate in writing" to the carrier the worker's objections to an acceptance notice. We found that the claimant's hearing requests, which alleged a "de facto" denial of a specific condition, constituted "communication in writing" to the employer of the claimant's objections to the notice of acceptance pursuant to ORS 656.262(6)(d).

Here, the issue is whether a hearing request noting only "compensability" complies with ORS 656.262(7)(a), which requires that a worker "must clearly request formal written acceptance of the condition." For the reasons stated above, it does not.

Claimant asserts that, because the prior ALJ determined that claimant was not medically stationary, his claim was closed prematurely. We disagree. Premature closure was not an issue at the prior hearing; indeed, the Order on Reconsideration that claimant presently contests did not issue until well after the earlier hearing. Consequently, the prior ALJ's order is entitled to no preclusive effect with respect to the premature closure issue.

Extent of Unscheduled Permanent Disability

We adopt and affirm the ALJ's reasoning and conclusions regarding this issue, with the following supplementation.

Claimant asserts that his base functional capacity (BFC) was heavy and that he has established his entitlement to a 5 percent chronic condition award. We disagree. Claimant offers no evidence or an alternative code from the Dictionary of Occupational Titles to support a heavy BFC. Moreover, his chronic condition arguments are based on several excluded exhibits. Because claimant offers no arguments in opposition to the exclusion of those exhibits, we do not consider the exhibits on review. For those reasons, we reject claimant's assertions.

Penalties and Attorney Fees

Claimant asserts that the ALJ erred in declining to assess penalties for SAIF's allegedly unreasonable processing of his vocational assistance claim and calculation and payment of his TTD compensation. He also asserts that he is entitled to an attorney fee regarding the cervical strain, vocational assistance, TTD and premature closure issues. We disagree.

Because we lack jurisdiction over the vocational assistance matter, we are without authority to assess a penalty. ORS 656.385(5).[3] Moreover, because claimant is not entitled to any additional TTD compensation, there is no amount on which to base a penalty. See ORS 656.262(11)(a). The ALJ did not err in declining to assess a penalty.

The ALJ also did not err in declining to award an attorney fee. Again, because we lack jurisdiction over the vocation assistance issue, we may not assess an attorney fee related to that issue. ORS 656.385(5). In any event, because claimant did not prevail on that, or any of the other issues, there is no basis for awarding an attorney fee. See ORS 656.386(1), (2).

ORDER

The ALJ's order dated August 23, 1995 is affirmed.

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[3] ORS 656.385(5) provides, in part: "Notwithstanding any other provision of 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."

Board Member Haynes concurring.

I agree with the lead opinion's analysis, and write only to express my view that, to the extent that the text and context of ORS 656.262(7)(a) are less than clear, the legislative history supports our reasoning. In addressing ORS 656.262(7)(a), Representative Mannix, a sponsor of Senate Bill 369, testified repeatedly that, when a worker seeks processing of a new medical condition after a claim has already been accepted, his or her recourse is to write a letter asking for written acceptance of the new condition. See Tape Recording, House Committee on Labor, March 6, 1995, Tape 46A. For this additional reason, I agree with the lead opinion that, under ORS 656.262(7)(a), a worker must clearly request in writing the formal written acceptance of an aggravation or new condition claim before the carrier is obligated to process the claim.

In the Matter of the Compensation of
NEVADA J. WILLIAMS, Claimant
WCB Case No. 95-02250
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Hazelett's order that: (1) found that claimant timely requested a hearing from the employer's "back-up" denial of claimant's left carpal tunnel syndrome (CTS) condition; and (2) awarded carrier-paid attorney fees under ORS 656.386(1) totaling $7,000 for prevailing against the employer's denials. On review, the issues are jurisdiction and amount of attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

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

The merits of the employer's February 7, 1995 partial denial and its May 11, 1995 "back-up" denial were tried by agreement of the parties at the May 12, 1995 hearing and the October 20, 1995 continued hearing.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Hearing Request

We adopt the ALJ's opinion and conclusions concerning this issue, with the following exception and supplementation.

We do not adopt the third and fourth paragraphs of the section entitled "Jurisdiction."[1]

On review, the employer argues that the ALJ never acquired jurisdiction over its May 11, 1995 "back-up" denial because claimant failed to timely request a hearing from that denial. We disagree.

On February 7, 1995, the employer partially denied claimant's claim for a left elbow condition. On May 11, 1995, the employer issued a "back-up" denial of claimant's (previously accepted) left carpal tunnel syndrome condition and delivered it to claimant at the May 12, 1995 hearing.

At the outset of the May 12, 1995 hearing, the parties and the ALJ discussed the exhibits to be admitted. The ALJ stated that the hearing would be continued to allow for cross-examination of Drs. Coale and Mollerus by deposition. (Tr. 5). The ALJ identified the issues raised by claimant's request for hearing as "compensability with respect to a denial letter dated February 7, 1995" and penalties and attorney fees. (Tr. 6).

Claimant's attorney responded: "[W]e need to discuss also for the record the denial that was issued and handed to claimant today, which is dated May 11, 1995, and has been numbered as Exhibit 36. Obviously claimant intends to file a request for hearing with regard to the new denial. . . ." (Tr. 6-7, emphasis added). Claimant's attorney explained that claimant would be willing to proceed on all issues raised in the new denial as long as claimant would be permitted latitude to address new issues raised by the "back-up" denial during the examination of Drs. Coale and Mollerus.[2] Claimant's attorney

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[1] The ALJ found that the 1995 amendments to ORS 656.319(1) apply to this case. We have previously held That These amendments do not apply retroactively to cases in litigation at the time of the amendments. See Roger Eli, 47 Van Natta 1938, 1939 n.1. In any event, application of the amendments to ORS 656.319(1) would not affect the outcome in this case.

[2] As noted above, the hearing was already to be continued for the purpose of deposing Drs. Coale and Mollerus.

further explained that, if such latitude would not be allowed, claimant would enter a motion to bifurcate the proceedings concerning the two denials, (Tr. 7-8); counsel also expressed a desire to preserve the "back-up" denial issues if they were not to be litigated at the hearing.

The employer objected to claimant's alternative wish to preserve the issue involving the May 11, 1995 "back-up" denial and stated that the issue "is ripe for litigation at this point in time." (Tr. 16-18).

The ALJ explained that claimant was not contemplating a separate hearing regarding the "back-up" denial, but was supplementing her hearing request to include that denial. The employer responded, "Oh, then I have no problem with going forward on this request for hearing." (Tr. 18-19).

Later, noting that the record would remain open for the subsequent depositions of Drs. Coale and Mollerus, the employer further acknowledged that "the record will still be developed above and beyond those two depositions with regard to the additional issues." (Tr. 47).

After considering the aforementioned portions of the hearing transcript, we conclude that the parties agreed to litigate the merits of the May 11, 1995 "back-up" denial, as well as the February 1995 partial denial.[3] See, e.g., Weyerhaeuser Co. v. Bryant, 102 Or App 432, 435 (1990) (Even though there was no denial, the ALJ should have addressed compensability, because the parties tried the case by agreement with that issue in mind). Accordingly, we conclude that the ALJ properly addressed the merits of the "back-up" denial. Compare Laura L. Brumfield, 45 Van Natta 796 (1993); see also Rodney T. Buckallew, 44 Van Natta 358, 360 (1992) ("Any surprise caused by the raising of the compensability issue at hearing was remedied by the continuance granted by the Referee.").

Attorney Fees

The employer contends that the ALJ's attorney fee award was excessive. Specifically, noting that the ALJ's $7,000 fee award represented a $3,500 award for each denial, the employer asserts that some of claimant's attorney's services regarding the first denial overlapped or duplicated those necessitated by the second denial. Accordingly, the employer contends that the ALJ's $7,000 award constitutes double compensation for claimant's counsel's services.

On de novo review, we consider the amount of claimant's counsel's attorney fee for services at the hearings level by applying 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 42 exhibits, with at least four solicited by claimant's attorney. There are also letters from claimant's counsel responding to the employer's motion to dismiss claimant's hearing request regarding the "back up" denial issues, which was entered between the initial hearing and the reconvened hearing. The hearings lasted almost 3 1/2 hours over two days. The transcript totals over 50 pages, including 2 "post-hearing" depositions which lasted a total of 3 hours.

Having considered the parties' respective positions on the attorney fee issue, we draw the following conclusions from the foregoing findings.

The value of the compensability issues is above average, in that claimant has incurred substantial medical expense. The issues in dispute involved complex factual and legal matters, more complex than those generally presented at hearing and for Board resolution. The parties' respective counsels

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[3] Both parties were offered a continuance to prepare for new issues raised by the "back-up" denial. However, because a continuance had already been granted for the physicians' depositions, neither party found additional time necessary. See Thomas v. SAIF, 64 Or App 193, 197 (1983) (SAIF's failure to object to claimant's premature request for hearing constituted a valid waiver of all procedural errors relating to litigation of the claim.).

presented their positions in a thorough and skillful manner, identifying the relevant factual and legal issues for our resolution. Finally, there was a decided risk that claimant's counsel's efforts might have gone uncompensated.

After considering the above factors and applying them to this case, we agree that claimant's counsel is entitled to an attorney fee award for services rendered at the hearings level regarding the two denials in an amount greater than that generally granted in "compensability denial" cases. However, we consider the ALJ's $7,000 attorney fee award excessive. After considering the factors discussed above, we find that $5,500 is a reasonable fee for claimant's counsel's services at hearing regarding the two denials.

Furthermore, after applying the same factors to this case on review, we find that a reasonable fee for claimant's counsel's services on review concerning the denial 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 services on review concerning the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated November 17, 1995 is modified in part and affirmed in part. That portion of the order that awarded a $7,000 attorney fee is modified. In lieu of the ALJ's attorney fee, claimant is awarded a $5,500 attorney fee, payable by the self-insured employer. For services on review regarding the denial issue, claimant is awarded a $1,000 attorney fee, payable by the self-insured employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
ANA J. CALLES, Claimant
WCB Case No. 93-07622
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Calles, 138 Or App 269 (1995). The court has reversed our prior order, Ana J. Calles, 46 Van Natta 2195 (1994), which awarded an attorney fee under former ORS 656.382(1) for the SAIF Corporation's premature "Notice of Ineligibility" for claimant's vocational assistance claim. The court has remanded for reconsideration in light of the statutory amendments.

Claimant developed right carpal tunnel syndrome as a result of her work activities. She underwent surgery on November 23, 1992 and, by February 1993, claimant was released to modified work.

In March 1993, SAIF sent claimant a "Notice of Ineligibility" for vocational assistance. Claimant sought Director review of SAIF's decision. On May 20, 1993, a Director's order determined that SAIF's notice of ineligibility was premature. SAIF did not contest the Director's order. Thereafter, claimant requested a hearing, seeking penalties and attorney fees for SAIF's allegedly unreasonable resistance to vocational assistance.

The ALJ found that SAIF's notice of ineligibility was unreasonable and assessed SAIF an attorney fee pursuant to former ORS 656.382(1). SAIF requested Board review.

Relying on Gustavo Cantu-Rodriquez, 46 Van Natta 1801 (1994), we found that SAIF's unreasonable conduct resulted in the resistance to the payment of compensation. As such, we affirmed the ALJ's attorney fee award under former ORS 656.382(1).

SAIF petitioned for judicial review. Relying on the 1995 statutory amendments, and Volk v. American West Airlines, 135 Or App 565 (1995), the court has reversed and remanded for reconsideration.

On reconsideration, SAIF asserts that attorney fees arising out of vocational assistance disputes are under the Director's exclusive jurisdiction. See ORS 656.340. In response, claimant contends that at the time of hearing no issue arising out of ORS 656.340 remained by virtue of the Director's order becoming final. Therefore, according to claimant, the Director does not have jurisdiction under ORS 656.340 to assess SAIF an attorney fee for its unreasonable claims processing. Further, claimant contends that the Director has not acquired jurisdiction over penalty issues arising under ORS 656.340 because there has not been a final contested case order by the Director. ORS 656.385(2). Based on the following reasoning, we hold that jurisdiction over this dispute rests with the Director.

Under ORS 656.385(5), neither the Hearings Division nor the Board may award penalties or attorney fees in regard to matters arising under the review jurisdiction of the Director. Further, pursuant to amended ORS 656.283(2), vocational assistance disputes are subject to Director review. In Ross Enyart, 47 Van Natta 1540 (1995), relying on Volk v. America West Airlines, supra, we concluded that amended ORS 656.283(2) (which now provides for Director review of vocational assistance disputes) is retroactively applied. 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).

In Andrew D. Lloyd, 48 Van Natta 129 (1995), we held that attorney fees and penalties arising out of vocational assistance disputes are under the Director's exclusive jurisdiction. ORS 656.385(5). In that case, the sole issue at hearing was attorney fees arising out of a vocational assistance dispute with the carrier.

Similarly, in this case, the sole issue before the ALJ was penalties and attorney fees arising out of a vocational assistance dispute. Since review of the vocational assistance "matter" arose under the review jurisdiction of the Director, the Director likewise has exclusive jurisdiction over related penalties and attorney fees for such "matters." See ORS 656.385(5).

Finally, ORS 656.385(5) does not require the Director to "retain" authority over vocational issues, in order to exercise jurisdiction over penalties and attorney fee issues which arise from a "matter" which was under the jurisdiction of the Director. Thus, regardless of whether the Director retains authority to reconsider the merits of the vocational "matter," the Director has the authority to consider penalties and attorney fees arising from that "matter."

Consequently, on reconsideration of our prior order, we vacate the ALJ's October 20, 1993 order and dismiss claimant's hearing request.

IT IS SO ORDERED.

May 13, 1996 Cite as 48 Van Natta 1002 (1996)

In the Matter of the Compensation of
TERRY L. STARNES, Claimant
WCB Case No. 93-07378
ORDER ON REMAND
Gloria D. Schmidt, Claimant Attorney
Marcia L. Barton (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Starnes v. Oregon Department of Transportation, 138 Or App 700 (1996). In our prior order, we affirmed an Administrative Law Judge's (ALJ's)[1] order that: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition; (2) declined to award interim compensation; and (3) declined to assess penalties and attorney fees for SAIF's allegedly unreasonable failure to pay interim compensation. Pursuant to its January 24, 1996 order, citing Volk v. American West Airlines, 135 Or App 565 (1995), the court has remanded for reconsideration in light of the 1995 amendments to ORS 656.273.

FINDINGS OF FACT

We adopt the findings of fact contained in the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

We first set forth the procedural history of this case. Claimant sustained a compensable low back strain on February 15, 1989. A March 23, 1990 Determination Order closed the claim with no award of permanent disability (beyond the 15 percent permanent disability awarded under a prior low back claim). A June 20, 1990 ALJ-approved stipulation awarded claimant an additional 7 percent permanent disability in contemplation of future waxing and waning of symptoms.

On April 4, 1993, claimant experienced increased low back pain which radiated into the left buttocks, hip and thigh. Claimant left work and sought treatment at an emergency room.

On July 20, 1993, SAIF issued a denial of claimant's aggravation claim. Finding insufficient medical evidence that claimant's compensable low back condition had worsened in excess of the waxing and waning of symptoms contemplated by the July 1990 stipulation, the ALJ upheld SAIF's denial of claimant's low back aggravation claim. Finding further that no attending physician had verified that claimant's compensable condition had worsened in excess of the waxing and waning of symptoms contemplated by the prior award, the ALJ declined to award interim compensation. Claimant requested Board review.

On review, we adopted and affirmed the ALJ's order. Claimant requested judicial review. While this matter was pending before the court, the 1995 legislature amended the Workers' Compensation Law. The court has remanded this matter for reconsideration in light of Senate Bill 369. Consistent with the court's mandate, we proceed with our reconsideration.

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[1] Formerly referred to as "Referee."

Aggravation

Subsequent to the ALJ's order, we issued our decision in Carmen C. Neill, 47 Van Natta 2371 (1995). In Neill, we found that under amended ORS 656.273(1),[2] a claimant must now show that he 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.[3]

As a result of his compensable February 1989 low back injury, claimant received an award of unscheduled permanent disability in contemplation of future waxing and waning of symptoms. Therefore, in the absence of evidence of a pathological worsening, claimant must prove that the "worsening" of his low back condition exceeded the waxing and waning contemplated by his prior award. See ORS 656.273(8); Carmen C. Neill, supra.

Based on the following reasoning, we are not persuaded that claimant's current low back condition constitutes a pathological worsening of his compensable injury or a waxing and waning of symptoms in excess of those contemplated by his prior award.

Here, there is no medical evidence that claimant suffered a pathological worsening. Thus, the issue is whether claimant's symptomatic worsening constitutes an "actual worsening," i.e., was more than a waxing and waning contemplated by the prior permanent disability award.

Dr. Hirons, claimant's long-time treating physician, reported that claimant experienced "a significant increase" in his back discomfort in April 1993 (although his examination of claimant failed to reveal "any objective evidence to correlate with" claimant's increased back pain). Dr. Hirons did not opine, however, whether claimant's increased symptoms exceeded the waxing and waning contemplated by the prior award.

Furthermore, Dr. McGirr, treating physician during April and May 1993, as well as examining Drs. Baker, Barth, Panum, Watson and Dinneen, on the other hand, specifically opined that claimant's current symptoms represent a normal waxing and waning of symptoms consistent with claimant's prior award. These same physicians also determined that claimant had not experienced any worsening of his condition, as measured by objective findings, since the last arrangement of compensation.

Under such circumstances, we conclude that claimant has not shown a symptomatic worsening in excess of the waxing and waning of his compensable low back condition contemplated by the prior award of permanent disability. Therefore, he has not established "an actual worsening."[4] Consequently, we agree with the ALJ that claimant has not proven a compensable aggravation claim.

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[2] 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 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).

[3] In determining what constitutes an "actual worsening," we relied on the legislative 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 further 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.

[4] 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, supra. There, unlike this case, the claimant's claim was classified as nondisabling and she did not receive a prior award of permanent disability. Moreover, 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 12). 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 Soilo C. Diaz, 48 Van Natta 371, 373 n 2 (1996) (Board declined to remand "aggravation" case to ALJ for additional evidence where the claimant received a prior permanent disability award and the record was sufficiently developed to analyze whether claimant's symptomatic worsening exceeded the "waxing and waning" contemplated by that prior award).

Interim Compensation

In an aggravation claim, the first installment of interim compensation shall be paid no later than the 14th day after the insurer had notice or knowledge of a medically verified inability to work in the form of a medical report that constitutes prima facie evidence of a compensable worsening. ORS 656.273(6); Doris A. Pace, 43 Van Natta 2526 (1991), aff'd Stanley Smith Security v. Pace, 118 Or App 602 (1993). Medical verification of an inability to work so as to trigger the insurer's obligation to begin paying interim compensation must come from claimant's attending physician. Amended ORS 656.245(2)(b)(B); Manuel Altamirano, 47 Van Natta 1499 (1995).

Here, Drs. Hirons and McGirr qualified as attending physicians under ORS 656.005(12)(b) who could authorize time loss. Neither one, however, ever provided medical verification to SAIF of claimant's inability to work. Absent such verification, SAIF's obligation to begin paying interim compensation was never triggered. See Stanley Smith Security v. Pace, supra; Manuel Altamirano, supra. We therefore also affirm the ALJ's order on the issue of interim compensation.

Finally, because no interim compensation was due, we further agree with the ALJ that SAIF's failure to pay interim compensation was not unreasonable.

Accordingly, on reconsideration of our April 5, 1995 order, the ALJ's order dated August 17, 1994 is affirmed.

IT IS SO ORDERED.

May 14, 1996 Cite as 48 Van Natta 1004 (1996)

In the Matter of the Compensation of
SAEDEH K. BASHI, Claimant
WCB Case No. 95-02375
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Christian and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) found that claimant was not precluded from litigating her claim for reflex sympathetic dystrophy (RSD); and (2) set aside its denial of claimant's claim for the same condition. On review, the issues are res judicata and, if claimant's claim is not barred, compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recapping the relevant facts. On January 24, 1993, claimant, who worked as a clothing salesperson, compensably injured her right hand when she jammed her fingers and hand into a wooden dress rack. On February 5, 1993, claimant sought treatment from Dr. Geddes for pain extending into the wrist, elbow and shoulder. On March 15, 1993, the insurer accepted a hand sprain.

Claimant's condition failed to resolve, so she was sent to several specialists for further evaluation. Dr. Tongue diagnosed systemic sclerosis/sclerodoma. On July 23, 1993, the insurer issued a partial denial of that condition.

On August 30, 1993, claimant sought treatment from Dr. Fraback, rheumatologist, for pain extending into her shoulders. Dr. Fraback opined that claimant's condition was right ulnar neuropathy or, possibly, RSD. On February 7, 1994, the insurer accepted claimant's right ulnar neuropathy. (Ex. 11). On February 13, 1994, Dr. Fraback advised the insurer's attorney that he considered RSD a possible, but not probable, diagnosis. (Ex. 11A).

Meanwhile, on November 30, 1993, claimant filed a request for hearing seeking, inter alia, reversal of the July 23, 1993 partial denial of systemic sclerosis/sclerodoma. The hearing convened on February 14, 1994. Since claimant had failed to timely request a hearing on the July 1993 denial, the prior ALJ dismissed claimant's hearing request as untimely. (Ex. 12A). The Board affirmed. (Ex. 14BB).

On October 26, 1994, Dr. Cline performed a neurological consultation. Initially, Dr. Cline opined that claimant's symptoms were consistent with ulnar neuropathy, but, after finding no evidence of nerve conduction abnormality, Dr. Cline opined that claimant's symptoms were consistent with RSD.

On January 11, 1995, Dr. Ochoa opined that, while claimant's clinical presentation fit the description of RSD, her condition was psychosomatic. On February 8, 1995, the insurer denied RSD on the basis that claimant's January 1993 injury was not the major contributing cause of that condition.

The insurer contends, first, that claimant is barred by claim preclusion from litigating the compensability of her RSD. Alternatively, the insurer contends that claimant failed to prove that her RSD is compensable. We disagree with both contentions.

Claim Preclusion

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

The ALJ concluded that claimant's current condition, diagnosed as RSD, (see Exs. 14C-2; 21-20; 33-1; 36-10, -11, -15, -16, -29), is not the same as the condition the insurer denied in 1993, viz., progressive systemic sclerosis/diffuse scleroderma. The insurer contends that, because claimant's current symptoms are the same as those she experienced in 1993, she has failed to establish that the two conditions are different. We disagree.

An uncontested denial bars future litigation of the denied condition, unless the denied condition has changed. Mary Morris, 44 Van Natta 1273 (1992). This bar does not, however, prevent a claimant from litigating a condition that is different from the denied condition. Margaret R. Jones, 45 Van Natta 1249 (1993).

Here, the insurer's July 1993 denial specifically identified the denied condition as "progressive systemic sclerosis, i.e. diffuse scleroderma," a systemic collagen vascular disease. (Exs. 3C, 4-1). Because the insurer denied a specific condition, claimant is barred from litigating her current condition only if it is the same as the denied condition. We review the medical evidence to ascertain whether the claimant's current condition is something other than that specific condition. See Sherry L. Rose, 46 Van Natta 293 (1994). Based on the following reasoning, we conclude that claimant's current condition is different from the previously denied condition.

Claimant's current condition was diagnosed as RSD. (Ex. 14A, 14C, 21-19 and -20, 29A-5, 33, 36-29). Each of the physicians who examined claimant, including Dr. Fraback, claimant's attending physician, and Dr. Ochoa, who examined claimant for the insurer, considered claimant's current diagnosis as something other than the denied scleroderma condition. (See Exs. 14C; 21-10 and -11; 36-10). Accordingly, we find that claimant's current condition is different from the condition the insurer denied in 1993. Thus, we conclude that claimant is not barred from litigating her current condition. We next turn to the merits of claimant's RSD claim.

Compensability

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

The ALJ concluded that claimant's RSD arose directly from her accepted January 1993 injury and that she sustained her burden to prove that the compensable injury was a material cause of her condition. The insurer, in contrast, contends that RSD was a consequence of claimant's accepted injury and that, therefore, the proper standard of proof is major contributing cause under ORS 656.005(7)(a)(A). Accordingly, we look at the medical evidence to establish whether claimant's right RSD condition is directly related to the industrial accident. If it is, then the material contributing cause standard applies. If not, then the major contributing cause standard applies. Albany General Hospital

v. Gasperino, 113 Or App 411 (1992) (the material contributing cause test applies to a condition or need for treatment that is directly caused by an industrial accident (primary consequence), whereas the major contributing cause test applies to a condition or need for treatment that is caused by a compensable injury (secondary consequence)). The major contributing cause test is not applied to conditions directly, though belatedly, related to the original compensable event. Id.

Due to the passage of time and number of diagnoses for claimant's condition, the causation issue is a complex medical question which requires expert medical evidence. Uris v. Compensation Department, 247 Or 420, 424 1967); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, the medical evidence indicates that the original injury involved the right wrist, elbow and shoulder. (See Exs. A, B, 1B, 2B, 2C). However, claimant's condition, originally accepted as a strain, failed to resolve. Dr. Fraback, claimant's treating rheumatologist, first treated claimant eight months after the injury. He diagnosed RSD on the basis of claimant's history of continuing arm discomfort, muscle atrophy, hand coolness and elimination of other diagnoses over time. (Ex. 36-10, -11). He opined that claimant's RSD arose as a direct, although belated, result of claimant's right hand injury. (Ex. 36-29, 30, 35). Moreover, Dr. Fraback also opined that claimant's injury was the major contributing cause of her RSD condition. (Ex. 36-15).

Dr. Ochoa, in contrast, opined that claimant's RSD is unrelated to her right hand injury and, instead, opined that her symptoms are pseudoneuropathic, a psychiatric conversion-somatization, possibly driven by secondary gain. (Ex. 21-22). The ALJ found that Dr. Ochoa had only 30 minutes of personal observation on which to base his opinion. The ALJ also found that no psychological testing was performed, and that Dr. Ochoa failed to explain the mechanism by which the alleged psychological condition operated to cause claimant's post-injury skin discoloration and the temperature variance compared to the non-affected extremity. Moreover, the ALJ found that Dr. Ochoa relied on the result of a test which was not performed, and found no basis for Dr. Ochoa's suggestion that "secondary gain" was involved.

We agree with the ALJ's analysis of Dr. Ochoa's opinion. Hence, as did the ALJ, we find Dr. Fraback's opinion more persuasive. Weiland v. SAIF, 64 Or App 810, 814 (1983) (we generally give great weight to the opinion of the treating physician, absent persuasive reasons to do otherwise); Somers v. SAIF, 77 Or App 259, 262 (1986) (we give greater weight to those medical opinions which are both well-reasoned and based on complete information). Consequently, we conclude that claimant's RSD condition is a primary consequence of her 1993 right hand injury and that she has proven the compensability of her claim.[1] ORS 656.005(7)(a); Albany General Hospital v. Gasperino, 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 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated September 21, 1995 is affirmed. For services on review, claimant's attorney is awarded a reasonable assessed attorney fee of $1,500, to be paid by the insurer.

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[1] Because Dr. Fraback's persuasive medical opinion also indicates that claimant's right hand injury is the major contributing cause of her RSD condition, claimant satisfies her burden of proof under either a major or material contributing cause standard.

In the Matter of the Compensation of
ROSA CAZARES, Claimant
WCB Case Nos. 95-07588 & 95-07587
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Spangler's order that affirmed Orders on Reconsideration classifying claimant's right and left arm injury claims as nondisabling. On review, the issue is claim classification. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has accepted nondisabling claims for right and left arm injuries. Determination Orders issued for each claim which declined to reclassify the claims to disabling. After claimant requested reconsideration, Orders on Reconsideration also found the claims correctly classified as nondisabling.

At hearing, claimant submitted a medical report that was generated after the Orders on Reconsideration issued. The ALJ, applying ORS 656.283(7), refused to admit the document. The ALJ further concluded that, based on the records developed during reconsideration, claimant did not prove her claims to be disabling. ORS 656.005(7)(c).

On review, claimant challenges only the ALJ's evidentiary ruling. We need not resolve that question because, even if we considered the excluded evidence, it would not alter our ultimate determination that claimant's injury claim was properly classified as nondisabling. We base this conclusion on the following reasoning.

ORS 656.005(7)(c) provides that 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." Here, there is no dispute that no temporary disability benefits were due and payable to claimant. The medical report sought to be admitted by claimant is a report signed by claimant's current physician, Dr. Poulson, stating that, "as a result of work exposure, [claimant] suffers from a chronic condition of her shoulders and upper extremities which will permanently limit or preclude her ability to engage in repetitious activities involving use of her upper extremities." With this document, claimant asserts that she can prove a reasonable expectation of permanent disability and, thus, her claims should be classified as disabling.

Notwithstanding claimant's assertions, there is countervailing medical evidence. In August 1994, Dr. Taylor, a former treating physician, although noting that claimant was permanently restricted from overhead lifting, indicated that claimant was medically stationary and had no permanent impairment. (Ex. 21). In November 1994, Dr. Sund, who treated claimant subsequent to Dr. Taylor, indicated that claimant had "significant physical limitations because of the chronic pain problem" and provided permanent work restrictions. (Ex. 2-30). Dr. Sund, however, had difficulty "deciding how much of her chronic pain problem is a direct result of work injury versus how much may be part of an underlying muscle pain syndrome such as early fibromyalgia and how much may be related to emotional and social factors that we cannot discover." (Id.) Dr. Sund further stated that the "work related injury is not the major factor in her ongoing limitations and disability." (Id.)

We find such evidence more persuasive than Dr. Poulson's opinion contained in the disputed medical report. Dr. Poulson did not begin to treat claimant until June 1995, sixteen months after claimant's injuries. (Ex. 35-1). At that time, Dr. Poulson indicated that claimant was released for regular work. (Ex. 34). Until the disputed report, Dr. Poulson had not indicated any permanent disability. (Exs. 35). Finally in light of the countervailing evidence, Dr. Poulson does not adequately explain in the disputed report why he believes claimant has a chronic condition or why such condition is related to the compensable injuries rather than the other factors named by Dr. Sund.

Accordingly, based on the evidence from Dr. Taylor and Dr. Sund, we conclude that claimant has not proven that she has, or can reasonably expect, permanent disability that was caused by the compensable injuries. Thus, we agree with the ALJ that the claims should not be reclassified from nondisabling to disabling. ORS 656.005(7)(c).

For these reasons, we find the document sought to be admitted by claimant not to be persuasive concerning claimant's permanent disability. Thus, even if we considered the disputed medical report, it would not change the result of this classification dispute. Consequently, based on this discussion, we need not reach the issue of the applicability of ORS 656.283(7). Hence, we also do not address claimant's contention that the statute is unconstitutional.

ORDER

The ALJ's order dated November 16, 1995 is affirmed.

In the Matter of the Compensation of
DONALD E. COLEMAN, Claimant
WCB Case No. 95-06756
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Kevin L. Mannix, Defense Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Martha J. Brown's order that: (1) found no entitlement to temporary disability benefits (interim compensation) for the period from January 8, 1992 until August 18, 1994; (2) declined to award a penalty or attorney fee for the SAIF Corporation's allegedly unreasonable failure to pay temporary disability for the period from April 13, 1992 until May 9, 1995; and (3) authorized SAIF to offset overpaid temporary disability against claimant's current award of temporary disability. In its brief, SAIF argues that the parties' September 22, 1994 settlement agreement resolved the time loss, penalty, and attorney fee issues. On review, the issues are the effect of the agreement, temporary disability (interim compensation), offset, 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," with the following exception and supplementation.

We do not find that the California State Compensation Insurance Fund accepted claimant's January 8, 1992 right knee injury claim "erroneously" or that it paid benefits totaling $20,850.67.

The parties' September 22, 1994 "Order Approving Settlement" resolved and settled the then-existing dispute regarding claimant's entitlement to interim compensation and related penalties and attorney fees for the period from the January 8, 1992 injury until September 22, 1994. The "Order Approving Settlement" also provided that the interim compensation due claimant (under the order) was subject to appropriate offsets.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was not entitled to interim compensation for the period from January 8, 1992 until August 18, 1994, because Dr. Poulson's September 1, 1994 letter authorizing such time loss does not retroactively authorize time loss more than 14 days prior to its issuance. See ORS 656.262(4)(f).[1] We modify, based on the following reasoning.

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[1] We adopt the ALJ's reasoning regarding claimant's substantive due process challenge to retroactive application of the statute. See Veronica M. Strackbein, 48 Van Natta 88, 90 (1996) (citing Betty S. Tee, 47 Van Natta 2396 (1995)); see also Ralph I. Pingle, 47 Van Natta 2155, 2156 n.1 (1995).

Temporary Disability (Interim Compensation): 6/30/94-8/29/94

On September 22, 1994, a prior ALJ signed (and thereby approved) a document memorializing an agreement between the parties entitled "Order Approving Settlement." (Ex. 14). The order provided, in relevant part:

> "Hearing in this bifurcated matter was scheduled for September 22, 1994. . . .
>
> "Prior to hearing, the undersigned [ALJ] was informed that the issue of claimant's entitlement to interim compensation and penalties and attorney fees had been compromised and settled. . . . The parties have agreed as follows:
>
> "1. SAIF Corporation will pay claimant interim compensation at the full temporary total disability rate for the period of June 30, 1994 through August 29, 1994, less the appropriate offsets for actual earnings and unemployment compensation received by claimant during the period at issue;
>
> "2. * * *
>
> "3. The issue of penalties and attorney fees for SAIF's alleged [sic] unreasonable failure to pay interim compensation shall be dismissed with prejudice.
>
> "The parties' agreement is hereby APPROVED and amounts specified herein are ordered paid. Claimant's request for hearing is hereby dismissed with prejudice." (Id) (Emphasis added).

By its express terms, the parties' agreement finally resolved the issues of claimant's entitlement to interim compensation and related penalties and attorney fee for the period from June 30, 1994 through August 29, 1994. Because these matters were settled by agreement, the parties are bound by the agreement. See Eugene J. Senger, 47 Van Natta 836 (1995), aff'd mem Senger v. Winston Dillard Water District, 139 Or App 325 (1996).

Temporary Disability (Interim Compensation): 1/8/92-6/29/94 & 8/30/94-9/22/94

The ALJ found that Dr. Poulson's September 1, 1994 letter (and subsequent chart notes) verified claimant's inability to work. (Exs. 13A, 13B). We agree and adopt her opinion in this regard.

The ALJ also determined that claimant was not entitled to interim compensation for periods more than 14 days before Dr. Poulson's September 1, 1994 authorization. We agree. See amended ORS 656.262(4)(f); Delores L. Holmes, 47 Van Natta 2359 (1995) (Under amended ORS 656.262(4)(f), 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); Shannon M. Oliver, 48 Van Natta 386 (1996) (ORS 656.262(4)(f)'s 14 day limit on retroactivity applies to interim compensation).

Under these circumstances, Dr. Poulson's authorization would be effective to authorize time loss beginning August 18, 1994, at the earliest. However, because the parties' agreement settled claimant's entitlement to such compensation through August 29, 1994, the ALJ's order is modified to award claimant interim compensation for the period from August 30, 1994 until May 9, 1994 (when SAIF accepted the claim and began paying benefits).[2]

Penalty

Claimant argues entitlement to a penalty for allegedly unreasonable nonpayment of temporary disability (interim compensation) for the period from April 13, 1992 (when claimant began treating with Dr. Poulson) until May 9, 1995 (when SAIF accepted the claim and started paying benefits to claimant).

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[2] In reaching this conclusion, we note that SAIF acknowledges its duty to pay temporary disability for the period from March 29, 1995 through May 9, 1995.

As a preliminary matter, we find that SAIF's nonpayment of interim compensation was not unreasonable at least until the September 22, 1994 agreement, because it had not received notice of claimant's inability to work. We further find that the above-quoted September 22, 1994 agreement expressly resolved any entitlement claimant may have had to a penalty based on nonpayment of temporary disability for the period from June 30, 1994 through August 29, 1994. (Ex. 14). Consequently, the remaining question is whether SAIF had a legitimate doubt regarding its liability for time loss for the period from August 30, 1994 until May 9, 1995, when SAIF accepted the claim and began paying benefits.

SAIF argues that it did have a legitimate doubt concerning its liability for the above time loss, based on the parties' September 22, 1994 settlement agreement and Dr. Poulson's chart notes indicating that claimant had returned to work. We disagree.

First, the parties' agreement did not address claimant's entitlement to time loss except for the period from June 30, 1994 through August 29, 1994. Second, although Dr. Poulson's chart notes indicate that claimant did return to modified work, they did not provide a basis upon which SAIF might reasonably have concluded that claimant returned to regular work. (See Exs. 4-5-13; 13A). Third, we note that SAIF concedes that claimant was entitled to temporary disability benefits beginning March 29, 1995, the date of surgery for his compensable condition (Tr. 26), and offers no explanation for its nonpayment of benefits for periods after that date.

Under these circumstances, we find that SAIF did not have a legitimate doubt regarding its liability for interim compensation for the period from August 30, 1994 until May 9, 1995. Accordingly, a penalty is warranted. See Lester v. Weyerhaeuser, 70 Or App 307, 311-312, rev den 298 Or 427 (1984) (Unexplained delay in paying compensation is unreasonable); Ernest J. Meyers, 44 Van Natta 1054, 1055-56 (1992).

Finally, we acknowledge claimant's contention that the offset issue was "premature" at hearing or, alternatively, that the ALJ's offset authorization might be misconstrued (apparently, to include offset of California benefits). However, we find that the offset issue was not "premature." See ORS 656.268(15)(a); see also Judith K. Nix, 45 Van Natta 2242 (1993). In addition, although we do not find that the ALJ's authorization might be misconstrued, we note that we have not adopted her finding regarding the amount of California benefits previously paid to claimant because it is unnecessary to resolve the issues before us.

ORDER

The ALJ's order dated October 20, 1995 is modified in part, reversed in part, and affirmed in part. That portion of the order that found claimant entitled to temporary total and/or temporary partial disability benefits from August 18, 1994, less amounts paid and subject to SAIF's offsets, until such benefits may be terminated according to law is modified. Claimant is awarded temporary disability benefits from August 30, 1994, less amounts paid and subject to SAIF's offsets, until such benefits may be terminated according to law. The ALJ's "out-of-compensation" attorney fee award is modified accordingly. That portion of the order that declined to award a penalty for SAIF's unreasonable resistance to the payment of compensation is reversed. Claimant is awarded a penalty of 25 percent of temporary disability due for the period from August 30, 1994 until May 9, 1995, payable by SAIF. The penalty shall be paid in equal portions to claimant and his attorney. The remainder of the order is affirmed.

In the Matter of the Compensation of
RITA J. WIMMER, Claimant
WCB Case No. 95-10131
ORDER OF ABATEMENT
Richard A. Sly, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

The self-insured employer requests abatement and reconsideration of our April 10, 1996 Order on Review. Specifically, the employer contends that, because claimant did not raise the issue of adaptability until her reply brief, claimant did not timely raise the issue on review.

In order to consider this matter, we withdraw our April 10, 1996 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order.

IT IS SO ORDERED.

May 14, 1996 Cite as 48 Van Natta 1011 (1996)

In the Matter of the Compensation of
LARRY K. JONES, Claimant
WCB Case No. 95-09058
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall, Christian and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that upheld the SAIF Corporation's denial of his injury or occupational disease claim for a right shoulder condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and summarize the pertinent facts as follows:

Claimant, age 50 at the time of hearing, began working for the employer in 1992. On October 4, 1994, while shoveling rocks into a ditch at work, claimant experienced the instantaneous onset of sharp pain in his right shoulder. He continued working, but experienced ongoing pain. Claimant ultimately sought treatment for his right shoulder and was diagnosed with probable right acromiclavicular impingement syndrome without evidence of rotator cuff tear.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to prove major causation. Specifically, the ALJ found the opinion of claimant's treating doctor, Dr. Ayers, insufficient because he employed a "but for" analysis in identifying claimant's shoveling activities at work as the major contributing cause of his current combined condition. The ALJ also noted that, although there were objective findings concerning the preexisting arthritis condition, there was no clear evidence of an "otherwise compensable injury" to the shoulder (see ORS 656.005(7)(a)(B)) or a pathological worsening of the preexisting disease (see ORS 656.802(2)).

Claimant contends on review that his right shoulder condition is compensable either as an injury or an occupational disease.[1] Claimant further contends that, contrary to the ALJ's determination, Dr. Ayers' opinion is complete and well-reasoned and persuasive evidence that his work activity was the major contributing cause of a pathological worsening of his preexisting asymptomatic right shoulder condition. We agree.

Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of the attending physician because of his or her opportunity to observe the claimant over an extended period of time. See Weiland v. SAIF, 64 Or App 810, 814 (1983). We find no persuasive reason not to rely on the opinion of claimant's treating physician, Dr. Ayers. Dr. Ayers, who began treating claimant in April 1995, opined that claimant's shoveling activities on October 4, 1994, as well as his continued employment activities thereafter, caused claimant's preexisting osteopathic spurs to rub against the rotator cuff resulting in inflammation of the joint and an impingement syndrome. Dr. Ayers reported that, although claimant's on-the-job injury did not cause his arthritic condition, the injury and subsequent work activities lead to a worsening of that condition with resulting inflammation, swelling, pain and stiffness.

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[1] Claimant concedes that, because of his preexisting arthritis condition, he must prove that his work activity was the major contributing cause of his combined condition under either theory. ORS 656.005(7)(a)(B), ORS 656.802(2).

Determining the "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the *primary* cause. See Dietz v. Ramuda, 130 Or App 397 (1994). At first blush, Dr. Ayers' reasoning suggests a "But for" analysis in summarizing his opinion.[2] However, Dr. Ayers also specifically evaluated the relative contribution of the different causes of claimant's condition (i.e., the preexisting arthritis, the October 4, 1994 shoveling incident and the continued work activities thereafter) before concluding that claimant's work activity was the major contributing cause of claimant's current worsened condition and need for surgery. Because Dr. Ayers' opinion goes beyond a simple "but for" analysis and addresses the different causes, we find his opinion sufficient to sustain claimant's burden under the major contributing cause standard. Thus, we conclude that claimant proved compensability.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by 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 November 17, 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 review, claimant's attorney is awarded $3,500, payable by SAIF.

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[2] Dr. Ayers agreed that "given the degenerative condition, it is at least medically probable that claimant would not be having these problems at this time if it were not for his recent employment injury." (Ex. 11-2).

Board Member Haynes dissenting.

The ALJ found that claimant failed to prove that his work activity was the major cause of his combined right shoulder condition. Because I agree with the ALJ's assessment and am not persuaded by the opinion of Dr. Ayers, I respectfully dissent.

Like the ALJ, I find Dr. Ayers' opinion insufficient to establish that claimant's work activity resulted in an "otherwise compensable injury" to his right shoulder or any "pathological worsening" of his preexisting degenerative arthritis. See ORS 656.005(7)(a)(B); 656.802(2). Relying upon a history of claimant's condition "worsening" over the months following the initial onset of pain on October 4, 1994, Dr. Ayers opined that claimant sustained an injury while shoveling rock, and that this injury and his continued work activity thereafter "set in motion a chain of events" leading to his eventual need for surgery.[1] (Ex. 11). Claimant testified, however, that his pain began suddenly on October 4 and did not generally change until he sought treatment more than four months later. (Tr. 14). Because claimant's testimony does not support the premise on which Dr. Ayers' relied, I would give Dr. Ayers' opinion little probative value. See Miller v. Granite Construction Co., 28 Or App 473, 478 (1977) (doctors' opinions based on an inaccurate history entitled to little or no weight).

Further, unlike the majority, I do not see how Dr. Ayers' analysis satisfies the standard for determining major contributing cause set forth in Dietz v. Ramuda, 130 Or App 397 (1994). Although Dr. Ayers acknowledged the existence of claimant's preexisting degenerative arthritis and found that this condition combined with claimant's work activities to cause the current condition, he did not weigh these competing causes nor explain why claimant's work activity was the primary cause. In fact, given Dr. Ayers' concession that claimant may have developed his current condition over time regardless of physical activities, I would find that he simply employed a "but for" analysis in concluding that claimant's work activity was the major cause, which is legally insufficient. See Alec E. Snyder, 47 Van Natta 838 (1995).

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[1] As the ALJ noted, Dr. Ayers' analysis seems to combine an injury theory with elements of a disease process. Dr. Ayers opined that "the shoveling activities during the on-the-job injury, as well as his continued employment activities thereafter, caused the rubbing of these spurs on the rotator cuff, resulting in both inflammation and swelling of the joint." (Ex. 11-2).

In the Matter of the Compensation of
CARL M. McLEMORE, Claimant
Own Motion No. 66-0428M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On March 14, 1996, the SAIF Corporation submitted claimant's request for medical services for his compensable 1965 facial trauma injury. SAIF recommends that the Board deny authorization of dental services, specifically, an extraction and a crown, because the requested services and claimant's current condition are not causally related to claimant's compensable 1965 injury. In addition, SAIF requests that the Board approve diagnostic services, including a record review by Dr. O'Brien and x-rays taken by Dr. Kiley, provided to determine compensability of claimant's current condition.

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

SAIF advised the Board that claimant's original medical records related to his 1965 facial injury have been destroyed. On March 19, 1996, the Board requested the parties' positions regarding the compensability of claimant's current dental services/condition. Responses from claimant and from SAIF have been received. We proceed with our review of the record.

In a January 10, 1996 letter, Dr. Kiley, claimant's treating dentist, opined that:

> "[Claimant] presented to me on December 12, 1995 with root tips of several fractured teeth on the maxillary left. At that time I extracted those. The [claimant] related to me that he had a Workman's Comp injury on January 5, 1965. His maxillary left area was traumatized. Gold crowns and bridges were placed. The [claimant] feels that the injury was ultimately responsible for the loss of his teeth there.
>
> "As I was not involved in [claimant's] continuing care over the years, I cannot say for certain if this is the case. One argument that the injury was at least contributory is that the maxillary left quadrant is in the worst shape of any quadrant. The blow of 30 years ago may have caused fractures that eventually resulted in the loss of those teeth."

Here, although Dr. Kiley examined and treated claimant, he stated that he was not involved with claimant's treatment over the years, and he clearly does not opine that the compensable injury "was ultimately responsible for the loss of his teeth there." Claimant contends that his left maxillary area was traumatized during his 1965 injury, however, Dr. Kiley opined that he "cannot say for certain if this is the case," and that the "blow of 30 years ago (claimant's compensable 1965 injury) may have caused fractures that eventually resulted in the loss of those teeth." (Emphasis added). Thus, although Dr. Kiley opined that the left maxillary quadrant is in the "worse shape of any quadrant," the record supports a conclusion that claimant's dental problems in his entire mouth were the result of extensive "decay [which] extends to bone," (see April 6, 1992 Veteran's Administration staff dental chart note) and lack of routine dental hygiene (see October 19, 1992 chart note from Veteran's Administration staff which notes that claimant "has some edema in his gingival tissues that would require improved home care & professional follow-up"). Inasmuch as Dr. Kiley expressed his opinion in terms of medical possibility rather than medical probability, we find that this opinion is of limited value in resolving the causation issue. Gormley v. SAIF, 52 Or App 1055 (1981)

Thus, we are not persuaded by Dr. Kiley's opinion that claimant's current condition may be related to his 1965 injury, nor do we find that the medical evidence in the record establishes that the requested medical services, specifically, dental services including an extraction and a crown, are causally related to the compensable injury.

Accordingly, we are unable to find that claimant's current condition is causally related to his 1965 industrial injury. Therefore, we decline to authorize payment for the requested dental services.

Finally, SAIF's request for reimbursement for diagnostic services is hereby approved. Because claimant's original records were destroyed, and since the aforementioned services were requested prior to SAIF's rejection of the claim, we find that the diagnostic services were reasonable and necessary in order to determine compensability. By this order, claimant's 1965 injury claim is reopened and closed for the payment of diagnostic services only.

IT IS SO ORDERED.

In the Matter of the Compensation of
GARY A. TOEDTEMEIER, Claimant
Own Motion No. 66-0387M
INTERIM OWN MOTION ORDER DEFERRING ACTION
Emmons, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for medical services and temporary disability compensation for his August 30, 1963 compensable low back injury. SAIF has recommended that the Board disallow the provision of the requested L3-4 surgery, contending that claimant's current low back condition is not compensably related to his original low back injury. Because we find the present record insufficiently developed to resolve the causal relationship between claimant's current low back condition and proposed L3-4 surgery and his original injury, we defer action on our decision pending receipt of further medical evidence.

Inasmuch as claimant sustained a compensable injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, the Board may exercise its own motion authority to authorize medical services and temporary disability compensation for compensable injuries occurring before January 1, 1966. ORS 656.278(1)(b).

On August 24, 1994, the Board issued its Own Motion Order, which authorized the reopening of claimant's 1963 claim for the provision of decompression surgery at L4 through S1, as well as for temporary disability compensation commencing the date claimant underwent that surgery until claimant is medically stationary. On April 3, 1995, pursuant to SAIF's request, we issued an Own Motion Order which authorized additional medical services which were reasonable and necessary and causally related to claimant's 1963 injury.

On March 16, 1995, SAIF issued a Notice of Closure in this claim. Claimant requested review of that closure, and, in a June 23, 1995 Own Motion Order Reviewing Carrier Closure, the Board set aside SAIF's March 16, 1995 closure as premature. The claim remains reopened for compensable medical services and temporary disability compensation.

On March 29, 1996, SAIF notified the Board that it had received a request for further surgery for claimant's low back. SAIF alleges that:

> "After review of his condition and review of the medical information available, it is our contention that [claimant's] industrial injury should not be responsible for the L3-4 surgery."

On April 3, 1996, we requested the parties' positions with respect to the compensability of claimant's L3-4 condition and proposed surgery. In an April 17, 1996 letter, claimant submitted all current medical information (up to April 4, 1996) to the Board. However, claimant advised that:

> "You will note that clear back in September of 1995, Dr. Todd Lewis, claimant's attending orthopedic surgeon, recommended surgery at L3-4 disc. SAIF Corporation had Dr. Fuller exam[ine claimant] on their behalf and[, in] his November 16, 1995 report, on page 5, [Dr. Fuller] suggested that disc generation may be a causative factor, but one

way to determine that is to x-ray the claimant's neck to see if there is any degenerative disc disease in that area. If there is disc disease in that area, Dr. Fuller would, therefore, surmise that there is disc degeneration in the low back. On the other hand, if there is not significant disc degeneration in the neck, then the industrial injury would be the major cause.

"On December 28, 1995, SAIF Corporation sent Dr. Fuller's report to Dr. Lewis, who indicated that he would "provide the MRI and a full cervical x-ray for Dr. Fuller to continue his review." However, that was not accomplished.

"On our instructions, [claimant] discussed this with Dr. Lewis and a cervical x-ray has been completed and it is my understanding it has been submitted by Dr. Lewis to Dr. Fuller for his evaluation. We, of course, would ask that those future records be obtained. We, also, request that we have the right to have Dr. Lewis provide his opinion on this matter with the cervical x-rays in mind, as well as [claimant's] history."

On April 29, 1996, SAIF forwarded to the Board copies of its current medical records, including a January 2, 1996 medical report, in which Dr. Fuller opined that:

"This [claimant] appears to have a lumbar scoliosis with long term degenerative disc disease at L3-4 and long term facet hypertrophy at L4-5 and L5-S1. This lumbar scoliosis may well be present on a congenital basis, [it] may possibly have resulted from the 1963 injury, or [it] may have occurred as an idiopathic finding in a 54-year-old man. At this time there is no way of discerning the main causal agent in the absence of serial x-rays."

Under these particular circumstances, we are currently unable to determine whether claimant's current condition and requested L3-4 surgery are compensably related to his 1963 injury. In particular, Dr. Fuller has apparently deferred rendering an opinion as to the causal relationship between claimant's current L3-4 disc condition and the original injury pending the outcome of the requested medical work-up. In addition, Dr. Lewis has noted that the x-rays of claimant's cervical spine were taken at SAIF's request, and that an MRI and further work-up are pending.

Accordingly, we conclude that it is appropriate to defer further action on this case pending receipt of the results of Dr. Lewis' "work-up" requested by SAIF regarding claimant's cervical status, as well as the opinions from both Drs. Lewis and Fuller. Therefore, upon its receipt of the aforementioned "work-up" and the other medical information, SAIF shall forward such material to the Board. SAIF shall also includes its written position regarding the effect this additional evidence has on the issue of whether claimant's current condition and proposed L3-4 surgery are causally related to his compensable 1963 low back injury. Claimant's written response to SAIF's submission, along with any additional evidence, must be filed within 21 days from the date of mailing of SAIF's submission. SAIF's reply, if any, will be due 14 days from the mailing date of claimant's response. Upon receipt of the aforementioned medical documentation and argument, we will proceed with our review.

In reaching this conclusion, we acknowledge our authority to refer disputes to the Hearings Division for fact finding. See OAR 438-012-0040(3). Such actions are normally taken when the disputes are directly attributable to a witness' credibility or reliability. See e.g. Ernest R. Miller, 44 Van Natta 2139 (1992) (when the insurer submitted evidence refuting claimant's contention that he was in the work force at the time of current disability, the Board referred claimant's request for own motion relief to the Hearings Division for taking of testimonial and documentary evidence concerning the issue of claimant's withdrawal from the work force). Following such a hearing the ALJ provides us with a recommendation regarding resolution of the parties' dispute. Here, the matter in dispute is not contingent on an appraisal of a witness' credibility or reliability. Rather, the issue pertains to medical opinions/observations which will eventually be offered once final examinations/studies are completed. Under such circumstances, rather than referring this matter to a hearing for further fact finding, we consider it appropriate to merely defer action until such time as the parties have presented additional medical evidence. Such a procedure will not only be more efficient, but will be less costly and time-consuming to the parties.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN R. WOODS, Claimant
Own Motion No. 95-0508M
OWN MOTION ORDER
Welch, et al, Claimant Attorneys
Liberty Northwest, Insurance Carrier

Claimant has moved the Board for an order awarding penalties for the insurer's allegedly unreasonable delay of payment of compensation pursuant to an Own Motion Order authorizing the reopening of claimant's claim for the payment of temporary disability compensation. We grant claimant's request based on the following reasoning.

FINDINGS OF FACT

On October 6, 1995, the Board received the insurer's recommendation to reopen claimant's 1978 injury claim for the payment of temporary disability compensation.

On October 10, 1995, the Board issued its Own Motion Order authorizing the payment of temporary disability benefits from the time claimant was actually hospitalized or underwent surgery (claimant underwent surgery in May 1994). Our October 10, 1995 order became final on November 9, 1995.

On or about January 4, 1996, claimant received payment of retroactive temporary disability compensation beginning the date of surgery.

In a February 14, 1996 letter, claimant noted that the Own Motion Order issued on October 10, 1995, and that the parties listed on that order were claimant, claimant's attorney, the insurer and the Department (information copy). Claimant requested that the Board advise "whether your standard practice is to mail the Order to each of those listed parties [on the order] and whether there is anything in your file that would indicate that that was not done in this particular case."

In a February 20, 1996 letter, the Board advised claimant that the parties claimant had listed were the same parties that were listed on its October 10, 1995 order. In addition, the Board reported that it is standard practice to mail a copy of any document to all parties listed on that document. Finally, the Board notified claimant that there was nothing in the record to indicate that this was not done. The insurer was copied with the Board's February 20, 1996 letter.

On March 13, 1996, claimant filed a motion seeking the assessment of a penalty, contending that the insurer "unreasonably delayed payment of compensation due as a result of the October 10, 1995 Own Motion Order." In addition, claimant advised that "[t]he appropriate time loss due was not received by claimant until approximately January 4, 1996." Claimant requested a payment of the maximum 25 percent penalty/fee in this matter.

In a March 19, 1996 letter, the Board requested the parties' positions with respect to claimant's allegations. Additionally, the parties were notified that the Board has exclusive own motion jurisdiction over this claim, which includes the authority to enforce the Board's own motion orders. See Thomas L. Abel, 45 Van Natta 1768 (1993); Darlene M. Welfl, 44 Van Natta 235 (1992); Ivan Davis, 40 Van Natta 1752 (1988); David L. Waasdorp, 38 Van Natta 81 (1986).

In an April 4, 1996 letter, the insurer notified the Board that it did not receive the October 10, 1995 order until December 11, 1995, when a copy was faxed to its office by claimant's counsel. With its letter, the insurer enclosed a copy of the faxed order bearing the fax date-stamp of December 11, 1995. The insurer contended that, although the Board had acknowledged that it was "standard practice" for the Board to mail a copy of the order to all parties, that, in this case, the only copy received by the insurer was the copy faxed to it on December 11, 1995.

In an April 15, 1996 letter, claimant alleged that it is irrelevant that the insurer did not receive the order until December 11, 1995. Claimant contended that the argument that the insurer did not receive the document is not successful to offset its failure to respond to the October 10, 1995 (mailing date) order timely.

CONCLUSIONS OF LAW AND OPINION

Under former OAR 438-12-035(3) (the administrative rule in effect on the date we issued our order authorizing reopening of claimant's 1978 injury claim), "[t]he insurer shall make the first payment of temporary disability compensation within 14 days from the date of an order of the Board reopening the claim." The insurer stated that it did not receive a copy of our October 10, 1995 order until December 11, 1995. The insurer does not contest claimant's representation that he received payment of his temporary disability award on or about January 4, 1996.

The sole issue in this case is whether claimant can establish that the insurer unreasonably delayed payment of temporary disability compensation. Under ORS 656.262(11)(a), if the insurer or self-insured employer "unreasonably delays or unreasonably refuses to pay compensation," the insurer shall be liable for an additional amount of 25 percent of the amounts then due.

It is unnecessary to determine whether the insurer first received our order prior to the time it claims. In other words, the insurer concedes that it did receive our order by December 11, 1995. Furthermore, the insurer "do[es] not dispute that claimant received the time loss due on or about January 4, 1996." Since more than 14 days elapsed between the insurer's receipt of our order and its payment of temporary disability benefits to claimant, we find its conduct to be in violation of former OAR 438-12-035(3). Inasmuch as the insurer does not offer any explanation for this delay, we conclude it unreasonably delayed the payment of temporary disability compensation then due to claimant. Therefore, under ORS 656.262(11)(a), we find that claimant is entitled to, and we are authorized to assess, a 25 percent penalty of the amounts "then due" claimant at the time of the insurer's untimely payment of temporary disability, payable in equal shares to claimant and his attorney. See Jeffrey D. Dennis, 43 Van Natta 857 (1991).

IT IS SO ORDERED.

May 15, 1996 Cite as 48 Van Natta 1017 (1996)

In the Matter of the Compensation of
BROOK BODEN, Claimant
WCB Case No. 95-08492
ORDER ON RECONSIDERATION
Bottini, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Claimant requests reconsideration of that portion of our April 17, 1996 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that affirmed an Order on Reconsideration that awarded claimant no unscheduled permanent disability for a neck injury. Specifically, "[c]laimant continues to maintain that Dr. Michael Calhoun was her actual attending physician at the time of claim closure." Claimant thus argues that Dr. Calhoun's July 20, 1995 report (Ex. 44) should be considered in evaluating the extent of her disability.

We withdraw our April 17, 1996 Order on Review. After reviewing claimant's motion in support, we continue to adhere to the findings, reasoning and conclusions reached in our prior order.

In our prior order, we explained that because the insurer has contracted with a Managed Care Organization (MCO) certified pursuant to ORS 656.260, claimant receives medical services in the manner prescribed in the contract. Amended ORS 656.245(4). Under the insurer's MCO contract, Dr. Davis was authorized as claimant's attending physician. Dr. Davis referred claimant to specialist Calhoun. As a specialist, Dr. Calhoun did not qualify as an attending physician under the MCO rules. Consequently, Dr. Davis, rather than Dr. Calhoun, was claimant's attending physician at the time of claim closure.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our April 17, 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
CONSTANCE A. ASBURY (SHAFFER), Claimant
WCB Case No. 94-15540
ORDER ON REVIEW
Patrick K. Mackin, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Spangler's order which: (1) upheld the insurer's denial of her low back injury claim; and (2) declined to award penalties or attorney fees for the insurer's allegedly unreasonable claim processing. On review, the issues are compensability, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

In September 1983, claimant underwent a non-work related decompression and fusion at L5-S1. Claimant had an excellent recovery from her surgery. After October 1983, claimant received no additional treatment for her low back for over 10 years.

In February 1994, claimant began working for the insured as a Certified Nursing Assistant. She worked without difficulty until she sustained a compensable injury to her right knee and hips/buttocks on March 20, 1994. The insurer accepted a "right hip, contusion right knee, acute strain." (Ex. 17).

While the claim was open, claimant allegedly sustained a low back injury on April 20, 1994 while transferring a patient. Claimant was seen in the emergency room on April 22nd by Dr. Brown, who observed claimant "guarding" her low back and exhibiting an antalgic gait. (Ex. 18). Dr. Brown diagnosed a lumbar strain with disc herniation. Dr. Grewe, who eventually became claimant's attending physician, reported that claimant demonstrated decreased range of motion. (Ex. 23). Dr. Grewe also noted the presence of lumbosacral spondylolisthesis and possible pseudoarthrosis of claimant's prior fusion. (Ex. 33).

Rather than processing the April 1994 injury as a separate injury, the insurer combined that claim with the March 20, 1994 injury claim for processing purposes. After several examining physicians evaluated claimant's low back condition (Drs. White, Martens and Gambee), the insurer denied claimant's low back condition, described as lumbar strain with minimal sciatic complaints, spondylolisthesis, and arthrodesis, on December 1, 1994. (Ex. 46). Claimant then requested a hearing.

Claimant alleged that the insurer's December 1994 denial was an invalid "preclosure" partial denial and that the insurer improperly consolidated her two injury claims. Although rejecting claimant's former contention, the ALJ agreed that the insurer should have processed claimant's two incidents of injury as separate claims. Analyzing the compensability of claimant's denied low back conditions as a "threshold" April 1994 injury claim, the ALJ upheld the insurer's denial. The ALJ reasoned that the record did not contain sufficient evidence of "objective findings" of a lumbar strain injury. The ALJ also determined that claimant did not prove that her April 1994 injury claim was compensable under ORS 656.005(7)(a)(B).

Finally, the ALJ rejected claimant's request for penalties or attorney fees based on her argument that the insurer had denied her April 1994 claim more than 90 days after it had been filed. Although agreeing that the insurer's denial was untimely, the ALJ did not award a penalty because, as a result of his compensability decision, there were no amounts due on which to base a penalty. In addition, the ALJ determined that he could not award an attorney fee under ORS 656.382(1) because there was no unreasonable resistance to the payment of compensation when claimant was not entitled to compensation.

On review, claimant contends that she sustained a compensable low back injury supported by "objective findings." Claimant also asserts that she is entitled to penalties and/or attorney fees for the insurer's unreasonable claim processing. We agree.

As a fact finder, it is our obligation to apply the appropriate legal standards to determine the compensability of a worker's claim. Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard v. Renalds, 132 Or App 288 (1995), and Michele K. Dibrito, 47 Van Natta 970 (1995)). The record supports a finding that claimant has spondylolisthesis that preexisted her April 20, 1994 injury. (Exs. 1, 2, 3, 7). In addition, claimant had extensive surgery in 1983. We, therefore, conclude that claimant had a preexisting back condition.

In determining whether ORS 656.005(7)(a)(B) applies, we must determine whether claimant's preexisting low back condition "combined" with her April 1994 injury to cause disability or a need for medical treatment. Based on the opinions of Drs. White and Gambee, the only physicians to directly address the issue, we find that claimant's April 1994 injury "combined" with her preexisting low back condition to cause a need for medical treatment. (Exs. 42B, 57). We, therefore, conclude that ORS 656.005(7)(a)(B) is applicable and decide the compensability issue pursuant to that statute.[1]

Dr. Grewe, claimant's attending physician, has consistently stated that claimant's April 1994 injury is the major contributing cause of her need for treatment. (Exs. 33, 41, 55, 56). We find no persuasive reasons not to defer to Dr. Grewe's opinion. See Weiland v. SAIF, 64 Or App 810 (1983). Thus, we conclude that claimant compensably injured her low back on April 20, 1994. This conclusion is further supported by other medical evidence in the record.

Dr. Gambee opined that claimant "undoubtedly" sprained her low back in April 1994. (Ex. 50-1). In a March 31, 1995 report, Dr. White also wrote that it would not be unreasonable for a nondisabling injury to be accepted. (Ex. 51). Given these opinions, solicited by the insurer, we find that claimant has satisfied her burden of proving that her April 1994 injury is the major contributing cause of her need for treatment of her low back condition under ORS 656.005(7)(a)(B).

Having resolved the causation question, we proceed to a determination of whether claimant's injury claim was supported by "objective findings." Based on the following reasoning, we answer that question in the affirmative.

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 former statute, 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 may 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 is 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).

Amended ORS 656.005(19) 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."

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[1] Amended ORS 656.005(7)(a))(B) now 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."

In Jairo J. Garcia, 48 Van Natta 235 (1996), we reviewed the legislative history behind the amendments to ORS 656.005(19). We held that the attending physician's report of the claimant's "pain," without findings that were "reproducible, measurable or observable," was insufficient to satisfy the "objective findings" requirement of ORS 656.005(7)(a) and amended 656.005(19).

Amended ORS 656.005(19) has created a more stringent standard for "objective findings." Nevertheless, we find that this record contains sufficient evidence of "objective findings" to satisfy that standard.

Dr. Grewe reported that claimant demonstrated decreased range of motion. (Ex. 23). We disagree with the insurer's contention that claimant's range of motion findings are unreliable because both the examining physicians and Dr. Grewe have noted marked pain behavior. Dr. Grewe never stated that his range of motion findings were unreliable. (Ex. 23). In fact, Dr. Grewe reported that claimant's symptoms had been "relatively consistent" throughout her treatment. (Ex. 56).

Accordingly, based on Dr. Grewe's persuasive report finding a reduced range of motion, we conclude that claimant's low back injury was supported by objective findings under amended ORS 656.005(19).[2] See Kenneth E. Smith, 48 Van Natta 572 (1995). We, therefore, reverse the ALJ's decision that claimant's injury was not supported by objective findings. Consequently, the insurer's denial is set aside.

Finally, as previously noted, the ALJ found that the insurer had untimely denied claimant's April 1994 low back injury claim. However, the ALJ did not assess a penalty because there were "no amounts due" as a result of his decision upholding the insurer's denial.

We have now determined that claimant's low back injury claim is compensable. Inasmuch as the insurer does not dispute the ALJ's finding that it untimely denied claimant's claim, a finding which the record supports, we conclude that claimant is entitled to a 25 percent penalty pursuant to ORS 656.262(11) based on compensation due as a result of this order as of the date of the denial. Wacker Siltronic Corp. v. Satcher, 91 Or App 654, 658 (1988). This penalty is to be shared equally by both claimant and her attorney.

Claimant's attorney is also entitled to an assessed fee for services at hearing and on review regarding the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the compensability issue is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record, claimant's appellate briefs and counsel's statement of services), 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 March 24, 1995 is reversed in part and affirmed in part. That portion which upheld the insurer's denial is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing in accordance with law. Claimant is awarded a 25 percent penalty to be based on compensation due as of the date of the denial (as a result of this order) and to be shared equally by claimant and his counsel. The remainder of the ALJ's order is affirmed. For services at hearing and on review, claimant's counsel is awarded an attorney fee of $3,500, payable by the insurer.

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[2] The insurer also contends that claimant's reduced range of motion is due, not to her April 1994 work incident, but rather to preexisting spondylolisthesis and arthrodesis. There is no medical evidence to support that contention, however. Moreover, claimant's lengthy period without low back treatment prior to the April 1994 incident also persuades us that her decreased range of motion is not due entirely to her preexisting conditions.

In the Matter of the Compensation of
JULIE A. GOULD, Claimant
WCB Case No. 95-00692
ORDER ON REVIEW
Olson Law Firm, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order which set aside its denial of claimant's mental disorder claim. On review, the issue is compensability.

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

The ALJ found that claimant had met her burden of proving that she sustained a compensable mental disorder under ORS 656.802(3). In reaching this conclusion, the ALJ relied on the medical opinion of a clinical psychologist, Dr. deCampos, who opined that claimant's employment was the major contributing cause of her mental disorder, diagnosed as major depression.

On review, SAIF contends that Dr. deCampos' medical opinion is insufficient to satisfy claimant's burden of proof because: (1) it relied on an inaccurate or incomplete history; (2) it was based on an unsupported conclusion that claimant was exposed to sexual harassment at work; (3) Dr. deCampos had become an advocate for claimant and had lost her objectivity; and (4) Dr. deCampos did not rebut the medical opinions of an examining physician, Dr. Parvaresh, and of claimant's attending physician, Dr. Neuberg.[1] We disagree with SAIF's contentions.

We first address SAIF's contention that Dr. deCampos did not have a complete medical history. In reaching her conclusion that claimant's work activities as a correctional officer were the major contributing cause of her mental disorder, Dr. deCampos noted that claimant had no past psychiatric history, no family history of psychiatric disturbance and no history of use of medication for mood disturbance. Dr. deCampos concluded that no other reasonable explanation ever arose for claimant's psychological distress apart from her employment. (Ex. 20).

SAIF cites, employment records in November 1991 that indicate claimant was concerned about her safety because of problems with her ex-husband. (Ex. AA-1). SAIF also cites medical records in 1992 in which it is documented that claimant exhibited signs of depression due to off-the-job stressors. (Exs. AA-3, AA-4, AA-5). SAIF renews its argument that Dr. deCampos' opinion is unpersuasive given her apparent ignorance of these medical records.

We agree with the ALJ's reasoning that these alleged off-the-job stressors are sufficiently remote in time that they do not significantly undermine the persuasiveness of Dr. deCampos' opinion. Moreover, we agree with the ALJ that there is no medical opinion that these alleged stressors were in fact stressful. After reviewing Dr. deCampos' August 7, 1995 medical report, which was based on four treatment sessions with claimant, we are also persuaded that Dr. deCampos adequately explored potential non-work related causes of claimant's psychological symptoms that caused her to file her mental disorder claim in November 1994. (Ex. 20). Accordingly, we agree with the ALJ that Dr. deCampos had a substantially accurate history on which to comment on the causation issue.

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[1] To establish the compensability of a stress-related mental condition, claimant must prove that employment conditions were the major contributing cause of her disease. ORS 656.802(2)(a). Additionally, the employment conditions producing the mental disorder must exist in a real and objective sense and must be conditions other than those 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. Furthermore, there must be a diagnosis of a mental or emotional disorder that is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the medical disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d). Claimant has the burden of proof. ORS 656.266. SAIF does not contest the ALJ's findings that there is a diagnosis of a mental disorder generally recognized in the medical community and that the employment conditions producing the mental disorder are those not generally inherent in every working situation. ORS 656.802(3)(b) and (c).

SAIF next contends that the record does not support Dr. deCampos' conclusion that claimant was subjected to ongoing sexual harassment. We disagree.

Claimant testified regarding instances of harassment directed at her by coworkers and supervisory staff. The ALJ found that claimant testified in a credible manner. Inasmuch as the ALJ's credibility finding was based on claimant's manner of testifying, we defer to that credibility finding. See Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987); Barbara J. Watson, 47 Van Natta 2183 (1995). Moreover, SAIF does not dispute the ALJ's factual findings that support Dr. deCampos' conclusion that claimant was exposed to gender-based harassment at work. For the above reasons, we conclude that the factual premise for Dr. deCampos' opinion is accurate and supported by the record.[2]

SAIF also contends that Dr. deCampos' opinion should be discounted because she became an advocate for claimant. See Willie A. Sowers, 44 Van Natta 1243 (1992). SAIF cites Dr. deCampos' statement that claimant "hopefully will have her depression determined to be related to her work" and asserts that it calls into question her ability to perform a fair evaluation of the causation issue. Once again, we disagree.

The statement cited by SAIF is contained in the portion of Dr. deCampos' February 25, 1995 evaluation entitled "History of Present and Psychosocial Issues." (Ex. 17-1). Given its location among claimant's factual statements and information recited from another medical report, this statement more likely reflects claimant's rather than Dr. deCampos' opinion. In any event, our review of Dr. deCampos' medical reports persuades us that she rendered a thorough and objective assessment of the causation issue. Moreover, there is nothing in this record to indicate that Dr. deCampos manipulated the medical record to assist claimant, as did the physician in Sowers, the case on which SAIF relies.

Finally, SAIF argues that Dr. deCampos failed to rebut the medical opinions of Dr. Parvaresh and Dr. Neuberg, both of whom issued medical reports questioning the relationship between claimant's mental disorder and her work environment. (Exs. 10, 18A). Specifically, SAIF notes that Dr. deCampos' did not address the evidence from those doctors that claimant was exaggerating her symptoms.

While Dr. deCampos did not specifically address the medical reports from Dr. Parvaresh and Dr. Neuberg, we have determined that, based on a substantially accurate history, she addressed the causation issue in an objective manner. Dr. deCampos did not report that claimant embellished her symptoms and, in fact, observed that claimant was "fully candid and straightforward." (Ex. 20-2). Given the ALJ's undisputed finding that claimant was exposed to employment conditions not generally inherent in every working situation, we find that Dr. deCampos' opinion is persuasive. The ALJ did not err in relying on that opinion, which we find more persuasive than those of Dr. Parvaresh and Dr. Neuberg.

Dr. Parvaresh concluded in his December 19, 1994 report that "At this point it is medically not probable that her job is a major contributing cause of her problem, but review of additional medical records and the investigative report should clear this issue one way or the other." (Ex. 10-1). Because it was tentative and subject to possible modification on further review, we are not persuaded by Dr. Parvaresh's opinion. There is no indication in the record that Dr. Parvaresh ever reviewed the additional documents that he mentioned in his report. For that matter, the record does not contain any follow-up report from Dr. Parvaresh.

As previously noted, Dr. Neuberg is claimant's attending physician. We generally defer to claimant's attending physician in the absence of persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, like the ALJ, we find persuasive reasons not to rely on Dr. Neuberg's opinion.

On November 15, 1994, Dr. Neuberg's initial assessment of claimant's condition was "work-related stress and depression." (Ex. 4). Dr. Neuberg subsequently opined on December 13, 1994 that if the level of stress in claimant's work environment was "extraordinary," then she "would have no

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[2] Our order is not intended to suggest that the "harassment" which formed the basis of Dr. deCampos' medical opinion necessarily would satisfy the requirements for a separate legal cause of action against the employer or any of its employees.

difficulty saying that this is a major depression whose major cause is work stress." (Ex. 8). As previously noted, the ALJ found that claimant was exposed to work conditions not generally inherent in every work situation. Given that SAIF does not dispute this finding, and given claimant's credible testimony that supports that finding, we conclude that claimant was exposed to "extraordinary" stress. Thus, Dr. Neuberg's December 13, 1994 opinion supports compensability.

We note, however, Dr. Neuberg's subsequent "check-the-box" January 5, 1995 concurrence with Dr. Parvaresh's medical report. (Ex. 12). We also note Dr. Neuberg's final medical report of March 20, 1995. (Ex. 18A). In that report, Dr. Neuberg stated that the "severity, duration, and resistance of [claimant's] symptoms in the face of passage of time and major amounts of antidepressant medication really go against the work environment stress, as well as the actions taken by her co-workers, as being the explanation for her current situation." Dr. Neuberg noted that the severity of claimant's symptoms were "basically out of proportion to the work factors."

To the extent that this report signals a retreat from her earlier opinions that claimant's psychological complaints were due to work stress, we do not find it persuasive. Although Dr. Neuberg implies that claimant's symptoms are exaggerated, she previously diagnosed "major depression." (Ex. 10A-2, 18). She also stated that, if claimant's work environment provided "extraordinary stress," then she would have no difficulty relating claimant's mental condition in major part to her employment. (Ex. 8). Given the ALJ's undisputed finding that claimant was exposed to conditions not generally inherent in every working situation, that opinion strongly supports claimant's case. Without more explanation of why claimant's symptoms are "out of proportion" to work factors and additional explanation why the factors cited in her March 1995 report "go against" a work relationship, we do not find Dr. Neuberg's revised opinion persuasive.[3]

In summary, we agree with the ALJ that claimant has sustained her burden of proof. The ALJ properly set aside SAIF's denial of her mental disorder 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 concerning the compensability issue is $1,800, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated November 1, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed fee of $1,800, payable by SAIF.

[3] We note that Dr. Deiter, a consulting physician to whom Dr. Neuberg referred claimant for a psychological evaluation, also diagnosed "major depression." (Ex. 15-3). Dr. Deiter did not report that claimant's psychological symptoms were exaggerated.

May 15, 1996 Cite as 48 Van Natta 1023 (1996)

In the Matter of the Compensation of
CHRISTOPHER J. KAUFMAN, Claimant
WCB Case No. 94-03382
ORDER ON REMAND
Floyd H. Shebley, Claimant Attorney
Roberts, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. D & D Company v. Kaufman, 139 Or App 459 (1996). The court has reversed our prior order, Christopher J. Kaufman, 47 Van Natta 433 (1995), which held that claimant's "new injury" claim for a middle and low back condition was not precluded by an approved Claim Disposition Agreement (CDA) concerning a previously accepted back claim. Concluding that the CDA unambiguously incorporated and released claimant's rights regarding "the August 12 incident" (the alleged "new injury"), the court has held that we erred in finding that the CDA did not bar claimant's "new injury" claim. Consequently, the court has reversed and remanded.

As determined by the court, claimant's "new injury" claim was barred by the parties' previously approved CDA. Under such circumstances, we affirm the Administrative Law Judge's July 7, 1994 order that reached this same conclusion.

IT IS SO ORDERED.

In the Matter of the Compensation of
TINA HOLLIDAY, Claimant
WCB Case No. 94-14593
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's injury claim for a syncopal episode (fainting spell). On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the last sentence in that section.

CONCLUSIONS OF LAW AND OPINION

In determining that claimant's fainting spell was compensable, the ALJ analyzed the question in terms of whether the conditions of claimant's employment were a material contributing cause of her syncopal episode. On review, SAIF argues that the question is not whether claimant's work was a material cause of her fainting spell, but whether the fainting spell was sufficiently work-related to be found compensable. Specifically, SAIF contends that there is no persuasive evidence that claimant fainted due to work conditions rather than to idiopathic factors. We agree and reverse the ALJ's order.

On September 10, 1994, claimant reported to work at 6:00 a.m. at a warehouse, as directed by the employer, a temporary services agency. It was the sixth time claimant had worked a 10-hour day that week. The weather was sunny and warm, but not hot. The air temperature felt warmer to claimant in the warehouse than outside. There were exhaust fans in the warehouse, and claimant did not believe that the warehouse was extraordinarily hot that day. Claimant's work involved filling orders for a retail store. Claimant did not perceive the work as particularly stressful or physically demanding.

On September 10, 1994, claimant was suffering from an upper respiratory infection (URI), for which she had been taking cold pills for several days. Claimant took a half-hour lunch break at 11:00 a.m.. At about 11:15 a.m., she took a cold pill with food. Claimant returned to work at 11:30 a.m.. Approximately 40 to 45 minutes later, she noticed her heart was pounding, her breathing was rapid, and her hands were shaking and tingling. Claimant felt herself passing out and slumped to the floor. Claimant sustained no injuries when she fell.

Claimant was taken to the emergency room, where Dr. Rovang diagnosed syncope, hyperventilation (rapid breathing), and URI. Dr. Rovang opined that the fainting episode was most likely due to hyperventilation, commonly triggered by anxiety in persons of claimant's young age. Dr. Rovang also commented that it was possible that the fainting spell was a side effect from the cold tablets claimant was taking. He advised claimant to remain off work for two days.

Claimant suffers from hypoglycemia (low blood sugar). She tries to eat every few hours to maintain her blood sugar levels. Claimant had three previous fainting episodes prior to the incident in question. However, those episodes felt different to claimant.

Claimant also is allergic to caffeine. Claimant thought the cold pill contained an amphetamine.

There is no dispute that claimant fell at work, as a result of her fainting spell.

A compensable injury is "an accidental injury * * * arising out of and in the course of employment." ORS 656.005(7)(a). An unexplained fall that occurs on the employer's premises, during working hours, while the employee is performing required duties is compensable if the employee eliminates idiopathic causes, i.e., the reason is known but is personal to claimant rather than work-related. However, if the fall is due to idiopathic causes, it is not compensable. Neither is one where it is equally possible that its cause was idiopathic or work-related. See Phil A. Livesley Co. v. Russ, 296 Or 25, 30 (1983); McAdams v. SAIF, 66 Or App 415 (1984) (where it is equally possible that a claimant's fainting spell was idiopathic as that it was work-related, claimant's burden of proof not satisfied).

Claimant's fall is not an unexplained fall. Claimant's fainting episode caused her fall. Based on the following reasoning, we are not persuaded that the fainting spell is causally related to claimant's employment.

Claimant had previous fainting episodes prior to the incident in question. At first, Dr. Rovang, was unable to determine what had caused claimant to faint. Later, claimant's counsel asked Dr. Rovang to assume that claimant had been working 10 hours per day, six days per week in a non-air conditioned warehouse, was "exhausted," and was suffering from an upper respiratory infection when she fainted. On those "facts," and without explanation, Dr. Rovang checked "yes" boxes indicating that "such working conditions could have induced sufficient [anxiety] to cause the episode of vasovagal syncope at issue," and that "it was medically probable that [claimant]'s working conditions were a material contributing cause of her episode of vasovagal syncope." Dr. Rovang did not attempt to explain the relative contributions, if any, of hypoglycemia, the cold medication, or the upper respiratory infection to claimant's fainting.

Dr. White reviewed claimant's medical records for SAIF. He attributed claimant's syncopal episode at work to her preexisting hypoglycemia or a drug reaction to the cold medication. Dr. White found no evidence that claimant's work activity, workplace, or the stresses of her job contributed to the fainting episode in any meaningful way.

Thus, there are a number of possible conditions which could have caused claimant's fainting episode. Inasmuch as Dr. Rovang did not address the potential contributions to claimant's fainting spell from the other "non-work" factors, we are more persuaded by Dr. White's conclusion that the fainting episode resulted from idiopathic factors. Consequently, claimant has failed to establish a sufficient work connection to satisfy her burden of proof. ORS 656.266; ORS 656.005(7)(a); see Phil A. Livesley Co. v. Russ, supra.

ORDER

The ALJ's order dated November 7, 1995 is affirmed in part and reversed in part. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award for prevailing over SAIF's denial is also reversed. The remainder of the order is affirmed.

May 15, 1996 Cite as 48 Van Natta 1025 (1996)

In the Matter of the Compensation of
BRIAN D. SHIPLEY, Claimant
WCB Case No. 95-04202
ORDER OF ABATEMENT
Nancy F.A. Chapman, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

On May 9, 1996, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) held that the Hearings Division lacked jurisdiction over the SAIF Corporation's "de facto" denial of claimant's cervical condition and the parties' vocational assistance dispute; (2) affirmed an Order on Reconsideration holding that claimant's lumbar injury claim was not prematurely closed and awarding claimant temporary disability compensation and 7 percent (22.4 degrees) unscheduled permanent disability; and (3) declined to assess a penalty for SAIF's allegedly unreasonable claims processing. In reaching our decision regarding one of the jurisdictional issues, we determined that claimant had not filed a "new medical condition" claim as required by amended ORS 656.262(7)(a). In making this determination, we rejected claimant's argument that the amended statute was not retroactively applicable.

On our own motion, we withdraw our May 9, 1996 order for further consideration. In particular, we intend to examine the question of whether it would be "absurd and unjust" for claimant to comply with the procedural requirements for a "new medical condition" claim when such requirements did not exist when the claim was initially advanced. See Rick A. Webb, 47 Van Natta 1550 (1995). To assist us in conducting our reconsideration, the parties are granted an opportunity to submit supplemental briefs. To be considered, each parties' brief must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

May 16, 1996 Cite as 48 Van Natta 1026 (1996)

In the Matter of the Compensation of
PEGGY S. KLIMER, Claimant
WCB Case No. 95-07542
ORDER ON REVIEW
Scott McNutt, Sr., Claimant Attorney
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Crumme''s order that set aside the SAIF Corporation's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the seventh finding of fact.

CONCLUSIONS OF LAW AND OPINION

Concluding that claimant had failed to establish that her work for SAIF's insured was the major cause of a pathological worsening of her preexisting CTS, the ALJ upheld SAIF's denial. Claimant contests the ALJ's finding that her CTS was preexisting and argues that the medical evidence is sufficient to establish that her work activities for SAIF's insured were the major contributing cause of her CTS. We need not address the preexisting condition issue, because the medical evidence otherwise fails to establish a compensable claim.

To establish a compensable occupational disease, claimant must prove that her employment conditions were the major cause of the disease. Amended ORS 656.802(2)(a). Claimant's theory is that her recent employment with SAIF's insured, and not her years of similar self-employment in the past, is the major contributing cause of her CTS.[1] She relies on the opinions of Dr. Oelke, treating internist, and Dr. Keizer, treating surgeon.

Dr. Oelke initially determined that, in light of claimant's markedly worse symptoms recently, there was a "distinct connection" between claimant's work for SAIF's insured and her CTS. (Ex. 15). Thereafter, Dr. Keizer concluded that claimant's CTS "was either caused or enhanced and aggravated by her work at [SAIF's insured]." (Ex. 17). At most, those reports suggest that claimant's work activities for SAIF's insured were the precipitating cause of her current condition. That is insufficient to satisfy amended ORS 656.802(2)(a)'s major contributing cause standard. See Dietz v. Ramuda, 130 Or App 397, 401 (1994) (precipitating cause not necessarily major cause).

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[1] SAIF refers us to several cases that hold that all employment may be used to establish the compensability of a worker's occupational disease. Because claimant's theory considers only her employment at SAIF's insured, we limit our inquiry to that employment.

We likewise reject Dr. Oelke's concurrence report stating that claimant's work activities for SAIF's insured were the major contributing cause of her CTS. (Ex. 16). That report is wholly lacking in any analytical basis; therefore, it merits no probative weight. See Marta I. Gomez, 46 Van Natta 1654 (1994) (persuasiveness of medical opinion depends on persuasiveness of the underlying foundation).

Last, we discount Dr. Oelke's deposition testimony. He stated that it is "feasible" that claimant's work at SAIF's insured was "a major contributing cause" of her CTS. (Ex. 19-9; emphasis added). At most, that testimony establishes the possibility that those work activities caused claimant's CTS. That is not enough. See Miller v. SAIF, 60 Or App 557, 561-62 (1982) (court discounted medical report couched in terms of possibilities).

For these reasons, then, neither Dr. Oelke's nor Dr. Keizer's reports are sufficient to establish that claimant's work activities for SAIF's insured were the major contributing cause of her CTS. Lacking any other evidence to support compensability under that theory, the claim fails. Accordingly, we affirm the ALJ's decision upholding SAIF's denial of the claim.

ORDER

The ALJ's order dated December 7, 1995 is affirmed.

May 16, 1996 Cite as 48 Van Natta 1027 (1996)

In the Matter of the Compensation of
KENNETH C. LANE, Claimant
WCB Case No. 95-08965
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that awarded claimant an assessed attorney fee for his counsel's services in obtaining a rescission of the insurer's "de facto" denials. On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had satisfied the notice requirements of ORS 656.262(6)(d) and was therefore entitled to an attorney fee pursuant to ORS 656.386(1) because his counsel was instrumental in obtaining the rescission of the insurer's "de facto" denials. While we agree with the ALJ that claimant satisfied the requirements of ORS 656.262(6)(d) through his letter to the employer's processing agent, we disagree that this, in itself, results in entitlement to an attorney fee pursuant to ORS 656.386(1).

Under 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." 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. 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).

We have previously interpreted the emphasized language of the statute in Michael J. Galbraith, 48 Van Natta 351 (1996). In Galbraith, the claimant asserted that he was entitled to an attorney fee pursuant to amended ORS 656.386(1) for services regarding the rescission of a "de facto" denial. We concluded that the claimant was not entitled to an assessed attorney fee on the basis that there was no evidence of unpaid compensation nor did the carrier question the causal relationship between the compensable injury and the condition which the claimant asserted had been "de facto" denied. Galbraith, supra.

Here, as in Galbraith, there is no evidence that the employer refused to pay compensation. Moreover, there is no concession by the employer that a fee should be awarded and no acknowledgment in the record that the employer questions the causal relationship between the 1980 compensable injury and the conditions which claimant asserted were "de facto" denied (L4-5 disc, depression/chronic pain syndrome, osteomyelitis/chronic infection, L-5 laminectomy, mild compression fracture of T-12, ankle fracture, pseudoarthrosis, L4-5 and L5-S1, and esophagitis).

Under such circumstances, the record does not establish that the employer refused to pay compensation on the express ground that claimant's conditions were not compensable or did not give rise to an entitlement to compensation. Therefore, we conclude that a "denied claim" has not been established and consequently, an attorney fee may not be awarded under amended ORS 656.3861(1). See Michael J. Galbraith, supra.

ORDER

The ALJ's order dated November 30, 1995 is reversed. The ALJ's award of a $1,700 assessed attorney fee is reversed.

May 16, 1996 Cite as 48 Van Natta 1028 (1996)

In the Matter of the Compensation of
WARREN N. BOWEN, Claimant
WCB Case No. 91-15616
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Julene M. Quinn (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our April 17, 1996 Order on Review which found that we retained jurisdiction under ORS 656.245(6) to resolve a dispute regarding the causal relationship between claimant's compensable right foot injury and a proposed weight loss program.

In order to consider this matter, we withdraw our April 17, 1996 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
HENRY A. TERRY, Claimant
WCB Case Nos. 93-03582 & 92-15766
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

This case is before the Board on remand from the Court of Appeals. SAIF v. Terry, 138 Or App 179 (1995). The court has reversed our order in Henry A. Terry, 46 Van Natta 1466 (1994), in which we set aside the SAIF Corporation's denial of claimant's cervical condition. Noting that we analyzed the claim under former ORS 656.005(7)(a)(B), the court has remanded for reconsideration in light of the 1995 amendments to that statute. In accordance with the court's instructions, we now proceed with our reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Before commencing our analysis, we will briefly summarize the factual and procedural background of this case. Claimant first sought treatment for a cervical condition in 1985, undergoing surgery in 1988. In December 1991, claimant sustained compensable left foot and low back injuries when he fell from a ladder. Shortly after his injury, claimant complained of neck pain. In November 1992, diagnostic studies identified a degenerative cervical condition at C5-6. SAIF denied medical services for claimant's neck condition on December 4, 1992, on the ground that his compensable injury was not the major contributing cause of his degenerative cervical condition.

Applying former ORS 656.005(7)(a)(B), the ALJ determined that the major contributing cause of claimant's "resultant condition" was his preexisting degenerative cervical condition. Therefore, the ALJ held that claimant had failed to prove the compensability of his cervical condition.

On Board review, we reversed the ALJ's order. Henry A. Terry, supra. Relying on the medical opinion of the attending physician, Dr. Newby, we found that claimant had met his burden under former ORS 656.005(7)(a)(B) of proving that his compensable injury was the major contributing cause of his need for treatment. See U-Haul of Oregon v. Burtis, 120 Or App 353 (1993). We, therefore, set aside SAIF's denial and remanded the claim for processing. SAIF petitioned for judicial review of our order.

Noting that the 1995 legislature has amended ORS 656.005(7)(a)(B), the court has reversed our order and remanded for reconsideration in light of those amendments. SAIF v. Terry, supra. Having summarized the factual and procedural background of this claim, we now proceed with our analysis.

Under former ORS 656.005(7)(a)(B), the "resultant condition" was compensable if the compensable injury was the major contributing cause of disability or the need for medical treatment. Amended ORS 656.005(7)(a)(B) now 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, and 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."

Although amended ORS 656.005(7)(a)(b) now speaks of a "combined" rather than a "resultant" condition, under either version of the statute, the compensable injury must be the major contributing cause of the claimant's need for treatment or disability. Accordingly, we find that the proper disposition of this claim on remand depends not on the applicable statute, but rather on an analysis of the medical evidence.

In Burtis, supra, the claimant experienced a compensable cervical strain injury, which was superimposed on a preexisting degenerative cervical spine disease, and which caused the preexisting condition to become symptomatic and require surgery. The employer contended that the claimant's surgery was not compensable because it was intended to ameliorate the claimant's degenerative disc disease and not the cervical strain. The court agreed with our reasoning that, under former ORS 656.005(7)(a)(B), the test did not turn upon whether the treatment was separately directed to either the compensable injury or the preexisting condition. Instead, the court affirmed our decision that the resultant condition is compensable where the medical evidence establishes that the claimant's accepted injury is the major contributing cause of the claimant's disability and need for treatment. Noting that the medical evidence established that the claimant's cervical strain made his degenerative disc disease symptomatic, resulting in the need for the surgery, the court concluded there was substantial evidence to support our finding that the injury was the major contributing cause of disability and the need for treatment.

In Alec Snyder, 47 Van Natta 838 (1995), we determined that Burtis did not set forth a rule of law that, in all cases where a work incident causes a previously asymptomatic condition to become symptomatic, the work incident shall be deemed the major contributing cause of the resultant condition. Indeed, as the Court of Appeals explained in Dietz v. Ramuda, 130 Or App 397 (1994) (a decision issued subsequent to our order in this case), an event which precipitates symptoms of a preexisting condition is not necessarily the major contributing cause of those symptoms.

In Dietz, the claimant experienced a heart attack after an extended period of smoke inhalation. The claimant had been diagnosed with preexisting, although a symptomatic, coronary artery disease. The court agreed with our application of ORS 656.005(7)(a)(B) in determining whether the work incident was the major contributing cause of the claimant's resultant condition. The court, however, rejected the claimant's argument that a work event that is the precipitating cause of a disease or injury was necessarily the major cause, explaining that, 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. 130 Or App at 401.

Here, as previously noted, we relied on Dr. Newby's opinion in determining that claimant had sustained his burden of proof under former ORS 656.005(7)(a)(B). Dr. Newby initially opined that the primary cause of claimant's ongoing neck pain was his prior cervical condition. (Ex. 43). However, in his deposition, Dr. Newby testified that the major contributing cause of claimant's symptoms was his compensable fall in December 1991 and that, therefore, the major contributing cause of his need for medical treatment was his compensable injury. (Ex. 45-22; see also Ex. 45-9). Thus, Dr. Newby's opinion is essentially that claimant's compensable injury precipitated the symptoms of his preexisting degenerative condition and, therefore, the compensable injury was the major contributing cause of his need for treatment.

While we initially determined that this opinion was sufficient to satisfy claimant's burden of proof under former ORS 656.005(7)(a)(B), the Dietz court subsequently emphasized, and we recognized in Snyder, that the fact that a work event is the precipitating cause of a disease or injury does not necessarily mean that it is the major cause. As the Dietz court noted, 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.

In this case, Dr. Newby determined that the precipitating cause was the major contributing cause without weighing the various causes of claimant's cervical condition. This is precisely the kind of analysis that the Deitz court disapproved.

Accordingly, we conclude on remand that claimant has failed to sustain his burden of proving that his medical treatment and/or disability for his cervical condition is compensable under ORS 656.005(7)(a)(B).[1] Therefore, on reconsideration of our July 14, 1994 order, the ALJ's order dated August 12, 1993 is affirmed.

IT IS SO ORDERED

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[1] We note that Dr. Tesar, an examining physician, opined that claimant's preexisting cervical condition, not his industrial injury, was the major contributing cause of his need for treatment. (Ex. 32-12). This opinion does not satisfy claimant's burden of proof, either.

Board Chair Hall dissenting.

After concluding in our initial order that this claim is compensable, the majority abruptly reverses course and now concludes that claimant has failed to satisfy his burden of proof under ORS 656.005(7)(a)(B). Because I would find that Dr. Newby's opinion satisfies the standards of Dietz v. Ramuda, 130 Or App 397 (1994), I must respectfully dissent.

Based on my reading of Dr. Newby's deposition, I submit that Dr. Newby did not simply conclude that, because claimant's injury "precipitated" his symptoms, the compensable injury was the major contributing cause. To the contrary, Dr. Newby addressed the role the preexisting pathology and the additional compensable strain/sprain played in claimant's need for medical treatment and reasonably concluded that the compensable injury was the major contributing cause of claimant's need for treatment. (Ex. 45-10,11). Because he evaluated the relative contributions of the different causes involved, Dr. Newby's testimony clearly satisfies the standards of Dietz and Alec Snyder, 47 Van Natta 838 (1995). For this reason, I would find, as we did in our initial order, that claimant's medical treatment is compensable.

May 17, 1996 Cite as 48 Van Natta 1031 (1996)

In the Matter of the Compensation of
DAVID L. ROLFE, Claimant
WCB Case No. 95-12532
ORDER OF DISMISSAL (REMANDING)
Charles D. Beshears, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has requested Board review of Administrative Law Judge (ALJ) Lipton's April 25, 1996 order. We have reviewed the request to determine whether we have jurisdiction to consider it. Since we conclude that jurisdiction rests with the Hearings Division, we withdraw our acknowledgment of SAIF's appeal and return this case to ALJ Lipton.

FINDINGS OF FACT

On April 25, 1996, ALJ Lipton issued an Opinion and Order that set aside SAIF's denial of claimant's occupational disease claim for a lumbar degenerative condition and awarded claimant's attorney a $2,000 fee.

On April 29, 1996, the Portland office of the Board received claimant's request for reconsideration, which sought an increased attorney fee award. On April 30, 1996, ALJ Lipton abated the April 25, 1996 order to consider claimant's motion, and to allow SAIF an opportunity to respond.

On May 2, 1996, the Board received SAIF's May 1, 1996 request for Board review of ALJ Lipton's order. On May 7, 1996, the Board mailed its computer-generated letter acknowledging SAIF's request for Board review of ALJ Lipton's order.

CONCLUSIONS OF LAW AND OPINION

SAIF's request for Board review of the ALJ's April 25, 1996 order was not mailed by certified mail. Thus, the request was filed on May 2, 1996, when the Board received the request. See OAR 438-005-0046(1)(b). However, on April 30, 1996, ALJ Lipton had already abated the April 25, 1996 order to consider claimant's motion for reconsideration.

Inasmuch as the ALJ's April 25, 1996 order had been abated prior to the filing of SAIF's request for Board review, jurisdiction to consider this matter remains with the Hearings Division. See Ramey S. Johnson, 40 Van Natta 370 (1988). Accordingly, SAIF's request for Board review is dismissed as premature. This matter is remanded to ALJ Lipton for further proceedings consistent with the April 30, 1996 abatement order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BARBARA J. CUNIFF, Claimant
WCB Case Nos. 95-02029 & 94-09979
ORDER DENYING RECONSIDERATION
Richard A. Sly, Claimant Attorney
Lindsay, Hart, et al, Defense Attorneys
Roberts, et al, Defense Attorneys

On April 10, 1996, the Board issued its Order On Review which reversed those portions of Administrative Law Judge (ALJ) Otto's order that had set aside May Department Stores Company's (May's) denial of claimant's "new occupational disease" claim for a left shoulder condition and had awarded a carrier-paid attorney fee. Submitting a "Disputed Claim Settlement," claimant and May seek approval of their agreement which proposes to resolve the compensability of claimant's left shoulder condition. Since the agreement pertains to issues addressed in the Board's April 10, 1996 order, we treat the parties' submission as a motion for reconsideration. Inasmuch as that order has become final, we are without authority to alter the Board's prior decision.

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 April 10, 1996 order was May 10, 1996. The parties' settlement document was hand-delivered to the Board's Portland office on May 10, 1996. Nevertheless, by the time the proposed agreement was brought to our attention, the 30-day statutory period of ORS 656.295(8) had expired. Inasmuch as the Board's April 10, 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.[1] See ORS 656.295(8); International Paper Co. v. Wright, supra; Fischer v. SAIF, supra; Donald J. Bidney, 47 Van Natta 1097 (1995). Consequently, we lack authority to consider an agreement which addresses issues arising from the ALJ's and the Board's prior orders.

Accordingly, the parties' request for reconsideration for purposes of considering their disputed claim settlement is denied.

IT IS SO ORDERED.

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[1] As we have noted on prior occasions, the Board attempts to respond to motions for reconsideration as expeditiously as possible. Darlene E. Parks, 48 Van Natta 190 (1996); 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, the parties' proposed settlement was delivered to the Board's Portland office on the 30th day following its April 10, 1996 order. Unfortunately, by the time the agreement was brought to our attention, the statutory 30-day period had already expired. Consequently, despite our stated intentions for an expeditious response to such matters, our authority to conduct reconsideration of our decision and to consider the parties' proposed agreement had elapsed by the time the settlement was presented for our review.

In the Matter of the Compensation of
DANIEL MARTUSHEV, Claimant
Own Motion No. 96-0174M
OWN MOTION ORDER ON RECONSIDERATION
Lavis Alvey, Claimant Attorneys
Saif Legal Department, Defense Attorney

On May 2, 1996, the Board received claimant's submissions regarding his employment during 1995. Because the Board issued its own motion order denying authorization of temporary disability compensation as claimant had not established he was in the work force at the time of his disability, we treat claimant's letter and attached documentation as claimant's request for reconsideration of our May 2, 1996 Own Motion Order.

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

In our prior order, we found that claimant's compensable condition worsened requiring L5-S1 surgery on January 5, 1996.

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).

On April 12, 1996, after receiving claimant's 1993 and 1994 tax returns, SAIF still opposed reopening of the claim because the 1993 and 1994 wage information did not establish that claimant was in the work force in 1995 and 1996. In our May 2, 1996 order, we found that claimant had not carried his burden of proving that he was in the work force at the time of disability, because he submitted only 1993 and 1994 wage information. Thus, we were not persuaded that claimant was in the work force in January 1996 when his compensable condition worsened requiring surgery.

Claimant currently submits work invoices from January 3, 1995 through November 25, 1995, which establish that he was gainfully employed during that time. Claimant also submitted an application for an extension of time within which to file his 1995 tax returns. In his April 30, 1996 letter, claimant advised that, because he had not yet filed his 1995 income tax returns, he was unable to provide 1995 income tax returns previously.[1]

On the current record, we are persuaded that claimant has established that he was in the work force at the time of current disability.

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.

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[1] Although the Board requests that a claimant submit to the carrier pertinent information which would establish that the claimant was in the work force at the time of disability, a current tax return is not a requisite document for proof of work. As in this case, the submission of work invoices, check stubs or wage-withholding statements which reflect dates of work during or prior to the appropriate time frame, are sufficient for our review. It appears from the record, that SAIF attached a copy of the Board's work force criteria letter to claimant's recommendation. This letter offers suggestions and alternative documentation which a claimant might submit in order to establish that he/she was in the work force at the time of disability. We require that a carrier send this letter to a claimant if it recommends that timeloss be denied because claimant was not in the work force at the time of disability. See Addendum to Bulletin 2-1994, effective January 1, 1996; OAR 438-012-0020, 438-012-0030 and 438-012-0035.

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.

In the Matter of the Compensation of
BRENDA GUZMAN, Claimant
WCB Case No. 93-11840
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to its February 29, 1996 order, the court has remanded our prior order, Brenda Guzman, 46 Van Natta 2161 (1994), which found that claimant's claim should be classified as disabling. Citing amended ORS 656.005(7)(c) and amended ORS 656.262(4)(b), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the findings of fact of the Administrative Law Judge (ALJ).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had failed to establish that her claim should be reclassified as disabling. On review, we reversed the ALJ's order. Brenda Guzman, supra. Relying on our prior decision in Sharman R. Crowell, 46 Van Natta 1728 (1994),[1] we held that because claimant was released to modified work, her claim was disabling, notwithstanding the fact that she would receive temporary partial disability (TPD) at a rate of zero.

Effective June 7, 1995, the legislature enacted Senate Bill 369, amending ORS 656.005(7)(c). The amended statute 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."

In Karren S. Maldonado, 47 Van Natta 1535 (1995), the claimant was released to, and worked, modified employment. However, she was not entitled to temporary disability. Applying amended ORS 656.005(7)(c), we held that, because no temporary disability benefits were due and payable, the claimant's claim was not disabling unless there was a reasonable expectation of permanent disability. We held that the unambiguous language of the amended statute effectively overruled our holding in Crowell. We specifically found, in light of the statutory language providing that an injury is not "disabling" if no temporary benefits are due and payable, that it was not enough that a claimant be limited to modified work. To classify a claim as disabling, we reasoned that there must also be entitlement to temporary benefits or a reasonable expectation of permanent disability. See also Clifford E. Clark, 47 Van Natta 2310 (1995).

Here, claimant was released to, and worked, modified employment. However, she was not entitled to temporary disability. Because no temporary benefits were due and payable, her claim is not disabling unless there is proof of a reasonable expectation of permanent disability. Amended ORS 656.005(7)(c).

Claimant contends, based on the opinion of his treating physician, Dr. Miller, that she has established a reasonable expectation of permanent disability. We disagree.

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[1] In Crowell, which was decided under former ORS 656.005(7)(c), we addressed the proper claim classification for a claimant who performed modified work at her regular wage and incurred no time loss. We held that the mere fact the claimant was required to do modified work meant that the claimant was temporarily and partially disabled.

The ALJ found Dr. Miller's opinion to be unpersuasive, in part because it was conclusory. We agree with the ALJ's assessment. Dr. Miller released claimant to regular work, but noted that claimant should use a wrist splint. (Ex. 8). Dr. Miller was asked, in a "check-the-box" format whether he believed that there was a substantial likelihood that claimant would have some chronic permanent impairment as a result of the injury. On December 17, 1993, not having examined claimant since July 21, 1993, Dr. Miller checked the box marked "yes," and wrote below the box that "[claimant] still had tenderness over Rt wrist ulnar aspect on palpation when seen on 7/21/93." (Ex. 11). Because we find Dr. Miller's opinion to be conclusory and lacking in explanation and analysis, we do not find it persuasive. See Moe v. Ceiling Systems, 44 Or App 429 (1980).

Dr. Farris examined claimant on behalf of SAIF. Dr. Farris found no measurable impairment. Claimant contends that Dr. Farris' opinion regarding impairment cannot be used to rate impairment without the concurrence of the attending physician. SAIF argues that, although an examining physician's opinion cannot be used to rate a worker's impairment, there is no authority which restricts the evidence that can be considered for purposes of classifying a claim. We need not determine whether Dr. Farris' report can be considered, however. Inasmuch as we have found the opinion of Dr. Miller to be unpersuasive, there is no persuasive evidence in the record of a reasonable likelihood of permanent disability. Under such circumstances, we conclude that claimant's claim was properly classified as nondisabling.[2]

Accordingly, on reconsideration, the ALJ's January 6, 1994 order is affirmed.

IT IS SO ORDERED.

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[2] Claimant also argues that amended ORS 656.005(7)(c) and (d) are unconstitutional under Article I, section 10 of the Oregon Constitution because they deny her a remedy. Specifically, claimant contends that her claim does not fit the statutory definition of either a nondisabling or a disabling claim. Noting that a nondisabling claim is one that requires medical services only, claimant asserts that, in addition to medical treatment, her claim required "the modification of employment duties." We reject claimant's contention that her claim does not fit the definition of a nondisabling claim. Because claimant's claim does not entitle her to temporary disability benefits, and because there is no reasonable expectation of permanent disability, her claim is a "nondisabling" claim as defined by the statutory scheme. Thus, her initial injury claim is one which requires medical services only and does not result in temporary or permanent disability. See Kathlene M. York, 48 Van Natta 932, 934 n. 3 (1996).

May 20, 1996 Cite as 48 Van Natta 1035 (1996)

In the Matter of the Compensation of
CHRISTOPHER L. LANDER, Claimant
WCB Case No. 95-02063
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
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) T. Lavere Johnson's order that set aside its denial of claimant's claim for a low back condition, including spondylolisthesis at L5-S1 and pelvis somatic dysfunction with acute bilateral psoas spasms. On review, the issue is compensability.

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

Claimant, age 25 at the time of hearing, has worked as a hardwood floor refinisher since age 14. At work on February 16, 1994, he experienced sharp pain in his low back and stiffness as he attempted to stand up after using an edger sander for several hours without stopping. He sought treatment and was diagnosed with a lumbosacral sprain or strain with preexisting spondylolisthesis at L5-S1.

SAIF accepted a lumbosacral strain on April 21, 1994. Claimant's pain and inability to stand up straight continued. On May 9, 1994, claimant was examined by Dr. Turner, who diagnosed claimant's condition as "cervical, thoracic, lumbar and pelvis somatic dysfunction with acute bilateral psoas spasm." On September 26, 1994, claimant made a claim for these conditions.

Claimant continued to seek treatment for pain in his lumbar and pelvis areas from Dr. Turner as well as Drs. Lee, Pentecost, Baum and Waldram. At the request of SAIF, claimant was also examined by Drs. Burr and Wilson on March 24, 1994, Drs. Smith and Friedman on December 7, 1994, and Drs. Duff and Podemski on March 14, 1995.

The ALJ found that claimant's accepted back strain combined with his preexisting spondylolisthesis to cause his continued disability and need for treatment. Relying primarily on the opinions of Drs. Turner, Lee and Baum, the ALJ determined that claimant's accepted lumbar strain injury was the major contributing cause of claimant's current condition and also that claimant's work activity on February 16, 1994 resulted in a pathological worsening of his preexisting spondylolisthesis.[1]

SAIF argues on review that the ALJ erred in concluding that claimant's preexisting spondylolisthesis is compensable under the "combined condition" analysis of ORS 656.005(7)(a)(B) and also that claimant's February 16, 1994 injury was the major contributing cause of his need for treatment of the combined condition.

The condition for which claimant now seeks compensation is the combination of his accepted lumbar strain and his preexisting spondylolisthesis, diagnosed by Dr. Turner as "somatic dysfunction of the lumbar region, lumbar strain, and a bilateral psoas muscle spasm." While we agree with SAIF that ORS 656.005(7)(a)(B) does not operate to make claimant's "preexisting" spondylolisthesis compensable, we conclude, for the reasons set forth by the ALJ, that claimant has established the compensability of his "combined condition." Therefore, to the extent claimant's pathologically worsened L5-S1 spondylolisthesis is a part of the "combined condition," it is compensable.[2]

SAIF also contends that claimant's "pelvis somatic dysfunction with acute bilateral psoas spasms" is not a separate condition, but rather an alternate description for his accepted lumbosacral strain. We disagree. Considering that the aforementioned conditions were separately described, it is evident that Dr. Turner's diagnosis covers the combination of the accepted strain and the spondylolisthesis. Therefore, we find that each is a separate compensable 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 $1,200, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 30, 1995 is affirmed. For services on review, claimant's counsel is awarded $1,200, payable by SAIF.

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[1] The ALJ further found that claimant did not establish the compensability of the cervical and thoracic conditions. Claimant does not challenge this finding on review.

[2] Like the ALJ, we are persuaded by the opinions of Drs. Turner and Baum that claimant's work activity on February 16, 1994 caused a pathological worsening of his preexisting asymptomatic spondylolisthesis at L5-S1.

In the Matter of the Compensation of
TONI L. LINTON, Claimant
WCB Case No. 95-08641
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorneys
Nancy J. Meserow, Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Thye's order that upheld the self-insured employer's partial denial of claimant's claim for a consequential thickening of the right first metacarpal joint capsule. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

Medical treatment (splinting) for claimant's compensable right wrist tendonitis condition was the major contributing cause of her thickened right first metacarpal joint capsule.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant failed to prove that medical treatment for her compensable tendonitis was the major contributing cause of her thickened right first metacarpal joint capsule (capsule) condition. In reaching this conclusion, the ALJ reasoned that claimant could not prevail simply by ruling out other possible causes or solely by deductive reasoning. See ORS 656.266.

Claimant contends that her capsule condition is a compensable consequence of her accepted right wrist tendonitis condition because it was caused in major part by splint treatment for the tendonitis condition. We agree and reverse the ALJ's order.

To prove that a consequential condition is compensable, claimant must establish that the compensable injury is its major contributing cause. See ORS 656.005(7)(a)(A). However, when "a claimant suffers a new injury as the direct result of reasonable and necessary treatment of a compensable injury, the compensable injury is the major contributing cause of the consequential condition for purposes of ORS 656.005(7)(a)(A)." Barrett Business Services v. Hames, 130 Or App 190, 193 (1994) (citations omitted).

In this case, treatment for claimant's compensable tendonitis condition included a thumb spica splint. The splint rubbed over the dorsum of claimant's right thumb, causing pain and redness. (Exs. 9, 13, 20). When Dr. Witczak performed surgery on claimant's right wrist, he noted claimant's thickened joint capsule. (Ex. 28-2). Thereafter, Dr. Witczak opined that claimant's capsule "likely became thickened as a result of splint irritation." (Ex. 30-2; see Ex. 37-1).

Dr. Button provides the only other medical evidence concerning causation. He opined that it is medically improbable that wearing a wrist brace caused the capsule thickening, because the capsule area would not be exposed to trauma or pressure from most types of braces. (Exs. 31-6, 33).

In our view, Dr. Witczak's opinion concerning causation is based on numerous opportunities to observe claimant's condition, including occasions when the splint was causing irritation, and a "hands on" opportunity during surgery. Considering Dr. Witczak's advantageous opinion as claimant's treating surgeon, we find his conclusions more persuasive than those of Dr. Button. See Argonaut Insurance Company v. Mageske, 93 Or App 698 (1988). Accordingly, based on Dr. Witczak's opinion, we find that claimant has carried her burden of proof.[1]

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[1] In reaching this conclusion, we acknowledge the employer's contentions that claimant's joint capsule condition is not compensable because it has not caused disability or a need for medical services. See ORS 656.005(7)(a). However, because medical treatment for claimant's compensable right wrist tendonitis condition involved splinting and that splinting required repeated adjustment to address irritation to the metacarpal joint, we find that Dr. Witczak did provide medical services specifically for claimant's irritated right first metacarpal joint. (See Exs. 9, 13, 20, 22).

We further acknowledge the employer's objection to the ALJ's admission of Exhibit 36 (an excerpted medical article). We need not address the objection, because we do not rely on the disputed evidence.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500 payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated November 17, 1995 is reversed in part and affirmed in part. The self-insured employer's partial denial of claimant's claim for a consequential thickening of the right first metacarpal joint capsule is set aside and the claim is remanded to it for processing according to law. For services at hearing and on review, claimant's attorney is awarded a $3,500 attorney fee, payable by the employer. The remainder of the order is affirmed.

In the Matter of the Compensation of
STEVEN M. McCARROLL, Claimant
WCB Case No. 95-06168
ORDER ON REVIEW
Bischoff, et al, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that reduced his unscheduled permanent disability award for a low back condition from 30 percent (96 degrees), as awarded by an Order on Reconsideration, to 24 percent (76.8 degrees). On review, the issue is extent of unscheduled permanent disability.

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

The only issue in dispute with regard to the extent of claimant's unscheduled permanent disability is the adaptability factor used in calculating the award.[1] Based on the record submitted on reconsideration before the Department, the ALJ found that the only job claimant performed in the five years prior to claim closure was that of a "fork lift operator," giving him a base functional capacity (BFC) of medium strength. The ALJ further found that claimant had a residual functional capacity (RFC) of light strength as a result of his permanent, injury-related restrictions. Relying on the matrix set forth in OAR 436-35-310(6), the ALJ assigned an adaptability value of 3 to claimant's disability equation.

On review, claimant contends that the ALJ erred in reevaluating claimant's BFC because neither party raised that particular issue at hearing. We disagree. SAIF requested a hearing concerning the extent of claimant's unscheduled permanent disability. More particularly, SAIF challenged the adaptability value used in the Order on Reconsideration. Under these circumstances, it was appropriate for the ALJ to reevaluate claimant's job at injury even though, at hearing, SAIF did not specifically challenge the BFC used on reconsideration. See, e.g., Lynda D. Streeter, 48 Van Natta 243 (1996) (where the claimant submitted a request for hearing objecting to extent of unscheduled permanent disability, she did not waive her right to litigate an allegedly incorrect DOT classification on review even though she did not specifically raise the issue until her request for reconsideration of the ALJ's order).

ORDER

The ALJ's order dated September 11, 1995 is affirmed.

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[1] The parties stipulated that under the applicable standards, claimant is entitled a value of 15 for impairment, 3 for skills and 0 for age and formal education.

In the Matter of the Compensation of
TERRY R. MYERS, Claimant
WCB Case No. 95-08570
ORDER ON REVIEW
Bischoff, et al, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Yeager's order that: (1) set aside its denial of claimant's medical services claim for his current cervical condition; and (2) awarded claimant's counsel an assessed attorney fee for his services at hearing. On review, the issues are compensability and attorney fees.

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

In concluding that claimant had met his burden of proof, the ALJ relied on the opinion of Dr. Hacker, claimant's attending physician. The insurer argued that Dr. Hacker had originally concurred with the opinion of the Medical Consultants, and had then changed his opinion without explanation. The ALJ concluded that, because Dr. Hacker's subsequent opinion was stated with a degree of certainty, it could not be said that Dr. Hacker had a change of opinion. Rather, the ALJ speculated that Dr. Hacker could have been in agreement with portions of the Consultants' report, such as the diagnoses and need for surgical treatment, without necessarily agreeing with its opinion on causation.

Like the ALJ, we do not find that Dr. Hacker's second report constitutes a change of opinion. Alternatively, we conclude that even if Dr. Hacker did change his opinion, claimant has proven compensability of his claim.

Although we decline to speculate why Dr. Hacker would have originally agreed with the Medical Consultants, we agree with the ALJ that Dr. Hacker's subsequent opinion establishes compensability. First, we find that Dr. Hacker's initial agreement with the Consultants' opinion was merely a "check-the-box" letter, with no additional explanation or reasoning. (Ex. 28). However, Dr. Hacker subsequently wrote a thorough, well-reasoned opinion which explained why he believed that claimant's current condition was related to the accepted injury. (Ex. 30). See Richard D. Wendler, 47 Van Natta 87 (1995) (Treating doctor's opinion accepted, despite concurrence with the one-time examiners' opinion that the claimant's condition was non-work related. The Board reasoned that little weight was given to conclusory opinions, such as "check-the-box" reports, and the treating doctor's opinions, as a whole, supported compensability). Also see Martin J. Stuehr, 46 Van Natta 1877 (1994).

Consequently, after considering Dr. Hacker's status as the physician who performed claimant's 1991 cervical surgery, see Argonaut Ins. Co. v. Mageske, 93 Or App 698 (1988), and his opinion, as a whole, we agree with the ALJ that claimant has met his burden of proof. Therefore, claimant's medical services claim is compensable.

Attorney fees

The ALJ awarded claimant's counsel an assessed attorney fee for services at hearing. On review, the insurer contends that claimant did not preserve the attorney fee issue at hearing. Furthermore, the insurer argues that claimant is not entitled to an attorney fee, as he released all rights to benefits except medical services when he entered into a Claim Disposition Agreement (CDA). We disagree with the insurer's contentions.

First, we find that claimant listed the issues on the request for hearing as "compensability," "penalties," and "attorney fees." Additionally, in opening remarks, claimant agreed that the issue was the compensability of medical services. (Tr. 2). Moreover, because the insurer denied compensability of claimant's claim, claimant is entitled to an assessed fee for prevailing over the insurer's denial. ORS 656.386(1); Richelle E. Volz, 43 Van Natta 902 (1991).

Consequently, in light of claimant's statutory entitlement to an assessed fee, we conclude that an attorney fee is a natural derivative from a compensability determination regarding a represented claimant. See Frank P. Heaton, 44 Van Natta 2104 (1992) (The claimant's attorney was entitled to an assessed attorney fee for prevailing over the insurer's denial, despite the fact that the ALJ may have neglected to award an attorney fee in his initial order).

Finally, we do not agree with the insurer's contention that the CDA, which we approved on September 10, 1992, precludes claimant from receiving an assessed attorney fee.[1] In Robert J. Egyedi, 44 Van Natta 1748 (1992), we held that a CDA which provided that the parties had settled the claimant's claim for "compensation and payment of any kind due or claimed for all past, present, and future conditions, except medical services," did not settle the claimant's entitlement to a future attorney fee. In Egyedi, we reasoned that, although the CDA settled the claim for "compensation" and "benefits" to the claimant, attorney fees were neither "compensation" nor a "benefit to [the] claimant" Moreover, we noted that the CDA did not contain an express provision which settled the attorney fee dispute, nor did it purport to settle all "issues raised or raisable" between the parties. Id at 1749.

We find the facts of this case to be similar to those presented in Egyedi, supra. The parties' CDA settled only claimant's claim for compensation and benefits other than medical services. There was no express provision stating that claimant's past, present or future attorney fee awards were being released. Accordingly, we conclude that the CDA did not preclude the ALJ from awarding an assessed attorney fee. We therefore affirm the attorney fee award.

Claimant's counsel is awarded an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,000, to be paid by the insurer. In reaching this conclusion, we have considered the complexity of the issue, the time devoted to the issue (as represented by claimant's respondent's brief), and the value of the interest involved. We note that no attorney fee may be awarded for claimant's counsel's services on the issue of attorney fees. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

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

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[1] We note that, effective June 7, 1995, the legislature amended ORS 656.236(1). The amended statute now provides, in part, that "[u]nless otherwise specified, a (claim) 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." Amended ORS 656.236(1). Consequently, the statute would appear to overrule the Egyedi holding. However, in the present case, the CDA was approved prior to the enactment of SB 369. Former ORS 656.236(1), which was in effect at the time the CDA was approved, contained no requirement regarding the preservation of attorney fee issues. Accordingly, in this case, we continue to rely on the rationale expressed in Egyedi.

May 20, 1996 Cite as 48 Van Natta 1040 (1996)

In the Matter of the Compensation of
CHERYL A. LOSLI, Claimant
WCB Case No. 95-00049
ORDER OF ABATEMENT
Pamela A. Schultz, Claimant Attorney
Wallace & Klor, Defense Attorneys

On April 19, 1996, we reversed those portions of an Administrative Law Judge's (ALJ's) order that had set aside the insurer's denial of claimant's current low back condition and awarded attorney fees under ORS 656.382(1) and 656.386(1). Asserting that portions of our decision are internally inconsistent and announcing that the parties have scheduled a mediation session to resolve their dispute, claimant seeks abatement of our decision.

In order to further consider this matter, we withdraw our April 19, 1996 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, unless the parties have chosen to pursue mediation, we shall proceed with our reconsideration.

In the event that the parties decide to proceed with mediation, our further review of this dispute will be held in abeyance pending the outcome of the mediation session. In the mean time, the parties are requested to keep us fully apprised of any future developments affecting this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
SENETRA SMITH-WAMPLER, Claimant
WCB Case No. 93-15113
ORDER ON RECONSIDERATION
Martin J. McKeown, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

On April 19, 1996, we withdrew our March 22, 1996 order which had affirmed an Administrative Law Judge's (ALJ's) order that: (1) declined to dismiss claimant's request for hearing; and (2) set aside the self-insured employer's partial denial of claimant's current left shoulder condition. We took such action to consider the employer's contentions that we had erred in declining to dismiss claimant's request for hearing and in setting aside its partial denial of claimant's current left shoulder condition. Having received claimant's response, we proceed with our reconsideration.

Citing Charles W. Roller, 38 Van Natta 50 (1986) aff'd Weyerhaeuser Company v. Roller, 85 Or App 500 (1987), the employer contends that claimant's request for hearing should be dismissed on the basis that she withdrew the request. Contrary to the employer's contention, claimant did not "withdraw" her request for hearing. Rather, claimant filed a motion to dismiss. As we previously found, the ALJ properly considered the circumstances under which claimant's "motion to dismiss" was filed and determined that claimant was moving to "dismiss" the employer's denial as precluded by *res judicata*. Such a conclusion is further confirmed by a review of the hearing transcript, where, in "mov[ing] for a dismissal," claimant's counsel asserts that the employer's denial "fails" because it did not "allege a new compensable shoulder condition." (Tr. 2 - 3).

The employer's reliance on Karen D. Maloney, 47 Van Natta 436 (1995) is similarly misplaced. In that case, we held that a withdrawal of a hearing request divests the Hearings Division of jurisdiction. Again, claimant did not "withdraw" her hearing request. Had claimant withdrawn her request for hearing, we agree that it would be inappropriate to investigate the reasons behind that withdrawal. However, where, as here, claimant filed a motion, the ALJ properly considered the underlying circumstances in determining whether the motion should be granted.

The employer also takes issue with our reliance on Mary J. McFadden, 44 Van Natta 2414 (1992), on the basis that it involved a request for Board review rather than a request for hearing. We find this distinction immaterial. Jurisdiction over a request for hearing, like a request for Board review, is dependent on a dismissal of the request, not the withdrawal of the request. In this regard, the appeal period for either a Board order or ALJ order runs from the date of the dismissal order, not the date of the withdrawal. ORS 656.289(3); 656.295(2)-(8); 656.298.

Concerning the employer's contentions regarding the compensability of claimant's current left shoulder condition, we have nothing further to add to our prior order.

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

Accordingly, as supplemented and modified herein, we adhere to and republish our March 22, 1996 order. The parties' rights of appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LISA A. HINER, Claimant
Own Motion No. 96-0080M
ORDER POSTPONING ACTION ON OWN MOTION REQUEST
Malagon, et al, Claimant Attorneys
Kevin L. Mannix, Defense Attorney

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's compensable multiple injuries.[1] Claimant's aggravation rights on her nondisabling claim expired on September 19, 1995. The employer opposed the reopening of claimant's claim on the ground that the "claimant has pending litigation in regard to our denial of an aggravation claim." In addition, the employer did not indicate in its recommendation whether claimant's current condition required surgery or hospitalization, however, it recommended that surgery or hospitalization is not reasonable and necessary because no surgery or inpatient hospitalization was proposed. Finally, the employer noted that it "denied the claimant's claim for aggravation on the basis that it was untimely (having been filed more than five years after the date of this nondisabling injury claim) and on the additional grounds that there has been no establishment of a worsening of the claimant's compensable conditions." Claimant requested a hearing with the Hearings Division regarding the reclassification of her claim as "disabling" and the employer's denial of the provision of benefits under ORS 656.273. (WCB Case No. 95-11008).

In a May 6, 1996 letter, claimant advised the Board that her "current condition does not require surgery, but does require in-patient hospitalization." In addition, claimant notified the Board that she would not submit to inpatient treatment "unless she is assured that her claim will be reopened under the Board's Own Motion authority" pursuant to ORS 656.278 for payment of temporary disability compensation. Claimant requested that the Board issue its "Own Motion Order reopening the claim for in-patient rehabilitation services and/or an Order reopening the claim for in-patient psychiatric services." Based on the following facts and reasoning, we decline to grant claimant's request at this time.

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).

On May 6, 1996, Administrative Law Judge (ALJ) Howell issued an Opinion and Order which: (1) dismissed claimant's request for a hearing regarding the reclassification of her claim to disabling; (2) upheld the employer's denial of claimant's aggravation claim; and (3) denied claimant's request for a penalty. Claimant requested Board review of ALJ Howell's order.

It is the Board's policy to postpone action until pending litigation on related issues has been resolved. Inasmuch as litigation is still pending at the Board Review level, we are unable to exercise our authority under ORS 656.278 in this case at this time. Here, the issue of whether claimant's claim is currently in own motion status (and thus, whether the Board, under ORS 656.278, has jurisdiction to review claimant's request for own motion relief) has not been finally resolved. Therefore, we defer action on this request for own motion relief pending Board review of ALJ Howell's order. After issuance of the Board's order, the parties should advise the Board of their respective positions regarding own motion relief.

IT IS SO ORDERED.

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[1] In its April 25, 1996 recommendation, the insurer noted that it has accepted the following conditions: chronic neck, shoulder girdle and right arm pain; soft tissue cervicodorsal strain injury; mild reflex sympathetic dysautonomia of the right upper extremity; muscular right thoracic outlet syndrome; myofascial pain syndrome; methadone dependence; high autonomic reactivity; intermittent sleep disorder; difficulty pacing activities; chronic low back pain; left lower extremity pain; muscular guarding and bracing; and trigger points in the anterior/posterior shoulder girdles, bilateral. The insurer agreed that claimant's current "[w]orsened conditions alleged as to [sic] fibromyalgia and psychological" are related to the compensable condition "except Obesity, Nicotine consumption and Hot flashes" conditions.

In the Matter of the Compensation of
KENNETH A. HINKLEY, Claimant
WCB Case No. 93-14894
ORDER ON REMAND
Craine & Love, Claimant Attorneys
Roberts, et al, Defense Attorneys

This case is before the Board on remand from the Court of Appeals. Sherman County E. S. D. v. Hinkley, 138 Or App 517 (1996). The court has reversed our order which affirmed the Administrative Law Judge's (ALJ's) award of temporary partial disability from June 11, 1991 through June 11, 1993. Citing Volk v. America West Airlines, 135 Or App 565 (1995), the court has remanded for reconsideration in light of the 1995 statutory amendments. In accordance with the court's mandate, we now proceed with our reconsideration.

FINDINGS OF FACT

We adopt the ALJ's "findings of fact."

CONCLUSIONS OF LAW AND OPINION

We begin by briefly summarizing the factual background of the claim. Claimant, a teacher, sustained compensable injuries to his right rib and trapezius on September 17, 1990. He subsequently developed low back pain and sciatica. After returning to his regular job on September 25, 1990, claimant became partially disabled through the end of October 1990 and totally disabled from October 31 through November 14, 1990. Claimant thereafter performed his regular duties through the end of the school year, June 6, 1991. On June 4, 1991, Dr. Czarnecki, claimant's attending physician, had advised claimant to do no bending or twisting. (Ex. 22).

Claimant did not return to teaching in the fall, but instead took a one-year leave of absence for personal reasons. On September 10, 1991, Dr. Czarnecki advised claimant to continue to avoid bending and twisting and to not lift over ten pounds. (Ex. 25).

In October 1991, claimant began a parts-exchange business. This required claimant to lift 5 to 15 pounds up to 30 times a day. Claimant occasionally lifted 50 pounds. By March 1992, claimant had not contacted the employer about returning to his teaching position for the 1992-93 school year, so the employer filled his position.

Dr. Scott examined claimant for the first time on July 12, 1993 and noted that claimant believed his condition was worsening. Based on a review of claimant's medical records and his history, Dr. Scott opined that claimant was unable to "fully perform" his duties as a teacher or a parts-exchanger from June 1992 to July 1993. (Ex. 52). Dr. Neitling examined claimant in November 1993 and concluded that claimant was able to work as a teacher, but not as a mechanic. (Ex. 64).

Claimant sought payment of temporary partial disability (TPD) from June 11, 1991 to June 11, 1993. The ALJ, in a June 1994 order, found that claimant's position as a teacher required him to bend, twist and lift up to 25 pounds. Citing Stone v. Whittier Wood Products, 116 Or App 427 (1992), rev'd on recon 124 Or App 117 (1993), rev den 318 Or 459 (1994), the ALJ held that claimant was entitled to TPD for the period claimed. The ALJ reasoned that once claimant's attending physician advised him to do no twisting or bending, claimant became entitled to TPD because he was no longer able to do his regular duties and thus sustained a proportionate loss of earning power in any kind of work.

We affirmed the ALJ's order. The court, however, has now remanded for reconsideration in light of the amendments to Oregon workers' compensation law contained in Senate Bill 369. Volk, supra. Having summarized the procedural and factual background of this case, we proceed with our analysis.

On June 4, 1991, Dr. Czarnecki, claimant's treating physician, placed work restrictions of no bending or twisting. Dr. Czarnecki'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). Therefore, claimant was entitled to TPD.[1] Alejandro R. Trevino, 48 Van Natta 399 (1996).

Because his disability was partial, claimant is entitled, at least theoretically, to TPD benefits during the period in question. Amended ORS 656.212; David L. Gooding, 47 Van Natta 1468 (1995); Ricardo Morales, 47 Van Natta 1394 (1995).[2]

In Lonnie L. Dysinger, 47 Van Natta 2282, 2283 (1995), we addressed the issue of whether amended ORS 656.212 overruled the court's holding in Stone, supra. We reasoned that, under amended ORS 656.212, the rate of TPD must be based on the proportion of payments provided for TTD which "the loss of wages bears to the wage used to calculate temporary disability pursuant to ORS 656.210." (emphasis added). We also noted ORS 656.210(2)(b)(A), which provides that "[t]he benefits of a worker who incurs an injury shall be based on the wage of the worker at the time of injury."

Accordingly, we concluded that, under amended ORS 656.212, the claimant's TPD rate must be calculated based on a comparison of his wages at modified employment with his at-injury wage. To the extent that Stone held otherwise, we determined that the Stone holding was no longer good law. Lonnie L. Dysinger, supra.[3]

Here, the record does not establish claimant's wages at modified work. Therefore, we are unable to determine the rate of claimant's temporary partial disability. Accordingly, we remand to the insurer for the calculation of claimant's temporary partial disability in accordance with amended ORS 656.212 and our decision in Dysinger.

Claimant is entitled to a reasonable attorney fee award before every prior forum for finally prevailing on the temporary disability issue. ORS 656.388(1). Since the ALJ's "out-of-compensation" attorney fee award and our prior award for services on review have not been challenged, those awards are republished. Inasmuch as, following remand, we have not disallowed or reduced compensation awarded by the ALJ, claimant's counsel is entitled to an assessed fee under ORS 656.382(2) for services before the Court of Appeals. 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 before the court concerning the temporary disability issue is $2,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's appellate brief), the complexity of the issue, and the value of the interest involved.

In conclusion, on reconsideration, we affirm the ALJ's order which found claimant entitled to temporary disability from June 11, 1991 through June 11, 1993. The claim is remanded to the insurer for processing in accordance with this order.

IT IS SO ORDERED

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[1] We have held that where a claimant is released to modified work at or above his or her regular wages, the claimant is temporarily and partially disabled, even though the actual rate of TPD may be computed to be zero. See, e.g. Kenneth W. Metzker, 45 Van Natta 1631, 1632 (1993); Valorie L. Leslie, 45 Van Natta 929 (1993), rev'd on other grounds Leslie v. U. S. Bancorp, 129 Or App 1 (1994). Consistent with those points and authorities, we conclude that claimant became entitled to TPD when Dr. Czarnecki imposed work restrictions on June 4, 1991, even though the rate of TPD may be zero.

[2] We acknowledge the insurer's argument to the court that, to the extent we relied on Dr. Scott's July 12, 1992 chart note to order payment of temporary disability, amended ORS 656.262(4)(f) limits the effectiveness of authorization of temporary disability compensation to no more than 14 days prior to its issuance. We need not address the insurer's contention, however, inasmuch as Dr. Czarnecki, claimant's attending physician, placed work restrictions on claimant on June 4, 1991 that were never removed.

[3] As our Order on Remand in Babette Stone, 46 Van Natta 1191 (1994), makes clear, Stone v. Whittier Wood Products, supra, is a case that involves the calculation of the amount of TPD to which the claimant was entitled. See also Sharman R. Crowell, 46 Van Natta 1728,1729 (1994), rev'd on other grounds Viking Industries v. Crowell, 138 Or App 703 (1996), on remand 48 Van Natta 768 (1996). There was no dispute in Stone as to whether the claimant was entitled to TPD; the only question was what the rate (zero or something else) of TPD should be. Babette Stone, supra. Therefore, the fact that the 1995 amendments to ORS 656.212 overruled the court's decision in Stone does not alter our previous conclusion that claimant is entitled to TPD.

In the Matter of the Compensation of
CONRID J. PAXTON, Claimant
WCB Case Nos. 95-00537, 94-13809 & 94-10357
ORDER ON RECONSIDERATION
Aller, Morrison, et al, 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 the Board's February 29, 1996 order that: (1) set aside RLC's denial of claimant's hearing loss claim; (2) upheld SAIF's denials, on behalf of Woolley Enterprises (SAIF/Woolley) and Sun Studs (SAIF/Sun Studs); (3) directed RLC to pay claimant's "hearings level" attorney fee award of $2,500; and (4) awarded claimant a $500 attorney fee for services on review, payable by SAIF/Sun Studs. Contending that we erroneously awarded claimant's attorney a fee for services on Board review, SAIF/Sun Studs asks us to reconsider our order. RLC requests reconsideration of the Board's order on the ground that we erroneously assigned responsibility for claimant's hearing loss claim to it. Conceding that he is not entitled to an attorney fee on review, claimant requests reconsideration of the Board's order so that we may correct our reference to the attorney fee award for services at hearing.

On March 25, 1996, we withdrew the Board's February 29, 1996 order for reconsideration. After considering the parties' requests and reviewing the record, we agree that, because claimant's attorney did not file a brief with the Board, there is no basis for awarding an attorney fee for services on review. Shirley M. Brown, 40 Van Natta 879, 882 (1988). Therefore, we withdraw the attorney fee for services on Board review awarded in the Board's prior order. Additionally, we note that the ALJ awarded a $2,800 attorney fee for services at hearing, whereas the Board's order refers to a $2,500 award. We modify the Board's order accordingly and award $2,800.

Turning to the merits of the responsibility issue, in lieu of our prior decision, we conclude that responsibility for claimant's hearing loss claim rests with SAIF/Sun Studs. On reconsideration, the parties do not dispute that initial responsibility lies with SAIF/Sun Studs, claimant's employer from 1991 forward. As the Board's order reasoned, SAIF/Sun Studs can shift responsibility to a prior carrier by showing that claimant's work exposure while one of those carriers was on the risk was the sole cause of his 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. Corp., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985). In its prior order, the Board concluded that, on the basis of Drs. Scott's and Hodgson's reports,[1] SAIF/Sun Studs had established that the sole cause of claimant's hearing loss was his work exposure before June 4, 1981. On reconsideration, we conclude otherwise.

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).

Neither physician specifically addressed whether claimant's pre-June 4, 1981 work was the sole cause of his hearing loss, or whether it was impossible for claimant's work conditions at Sun Studs to have caused that condition. Indeed, Dr. Hodgson's statement that the major portion of claimant's hearing loss was due entirely to pre-1981 work noise exposure admits, at least impliedly, that part of his

[1] In its prior order, the Board declined to rely on the reports of Dr. Ediger, because they were inconsistent, and the report of Dr. Hiatt, because it was virtually unexplained. We adhere to those conclusions.

hearing loss was due to post-1981 work noise exposure, which would include claimant's period of employment at Sun Studs.[2]

Under the circumstances, we conclude that SAIF/Sun Studs is not entitled to shift responsibility to an earlier carrier under the "sole cause/impossibility" test set forth above. Therefore, we affirm the ALJ's decision setting aside SAIF/Sun Studs denial and upholding the denials on behalf of RLC and SAIF/Woolley, and awarding a $2,800 attorney fee for services at hearing, payable by SAIF, on behalf of Sun Studs. Claimant's attorney is not entitled to a fee for services regarding his reconsideration request, because the request is limited to the attorney fee issues. See Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

Accordingly, our February 29, 1996 order is withdrawn. On reconsideration, as supplemented herein, we republish the "Findings of Fact" contained in the Board's February 29, 1996 order. In addition, in lieu of the Board's prior order, we affirm the ALJ's order which found SAIF/Sun Studs responsible for claimant's hearing loss claim, as well as a $2,800 attorney fee award. The parties' appeal rights shall run from the date of this order.

IT IS SO ORDERED.

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[2] In its brief on review, SAIF/Sun Studs argued that the ALJ had erroneously relied on Beneficiaries of Strametz v. Spectrum Motorworks, 135 Or App 67, 74, mod 138 Or App 9 (1995), where the court said, "If a claimant proves that there was Oregon employment with 'conditions of exposure * * * of a kind which could have caused the disease ,' then the last employer with those conditions will be assigned responsibility under the last injurious exposure rule." SAIF/Sun Studs argued that, because the medical evidence shows that claimant's work exposure at Sun Studs did not and could not have caused his hearing loss, Strametz is inapposite. We disagree. No physician unequivocally concluded that claimant's employment at Sun Studs could not have caused his hearing loss; moreover, Dr. Hodgson's report suggests that claimant's work at Sun Studs could have caused at least part of that condition. For those reasons, we reject SAIF/Sun Studs' attempt to distinguish this case from Strametz.

In the Matter of the Compensation of
TERRY L. SHEELEY, Claimant
WCB Case No. 94-03090
ORDER ON RECONSIDERATION
Andrew H. Josephson, Claimant Attorney
Steven T. Maher, Defense Attorney

On May 9, 1996, the Board withdrew its April 10, 1996 order that affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside the insurer's partial denials of claimant's claim for a right knee strain, right knee synovitis and patella tendinitis; and (2) found claimant's claim was prematurely closed. This action was taken in response to the insurer's announcement that the parties were negotiating a settlement of their dispute and were seeking abatement of the Board's order.

The insurer has now provided notification that the parties have been unable to reach a settlement of their dispute. Consequently, the insurer requests that the Board's prior order be republished.

In light of such circumstances, we republish the Board's April 10, 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
GREG H. BOOTH, Claimant
WCB Case No. 95-04876
ORDER ON REVIEW
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Michael Johnson's order that upheld the SAIF Corporation's denial of his occupational disease claim for his sinus and upper respiratory condition. On review, the issue is compensability.[1]

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

On review, claimant argues that SAIF's examining doctor, Dr. Montanaro, is inaccurate, as he opined that claimant had a history of chronic sinus problems. Claimant contends that his problems did not become chronic until April 1995, which was eight and a half years after he began working in an environment containing pine dust.

We do not find that Dr. Montanaro had an inaccurate history. Claimant informed Dr. Montanaro that he had always had sinus trouble, which is consistent with his testimony that he suffered from sinus infections every year since the eighth grade. Claimant underwent treatment for his sinus infections and also had nasal surgery in 1978. Finally, claimant moved to Central Oregon, in part, to control his sinus problems.

Claimant also argues that the opinions of both Dr. Cade and Dr. Conner support compensability, as they have stated that sawdust or pine dust was the probable cause of claimant's sinus and lung problems. As noted by the ALJ, however, Dr. Cade concurred with the report of Dr. Montanaro, who did not believe that claimant's condition was work related. (Ex. 14). Additionally, we do not find Dr. Conner's opinion to be persuasive. First, we find that the reference relied upon by claimant is a chartnote which contains no explanation with respect to causation. Furthermore, there is no indication that Dr. Conner was aware of claimant's past history of sinus problems. Under the circumstances, we decline to accept Dr. Conner's opinion.

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[1] We note that, following receipt of claimant's reply brief, and the completion of the briefing schedule, claimant submitted a medical report detailing a sinus procedure performed on March 11, 1996. There is no indication that a copy of claimant's submission was provided to SAIF, as required by our rules. See OAR 438-005-0046(2)(a). Consequently, we have enclosed a copy of claimant's letter and the medical report with SAIF's counsel's copy of our Order on Review.

We treat claimant's submission of the March 11, 1996 medical report as a request for remand. A compelling basis for remand exists when the evidence concerns disability, was not obtainable at the time of hearing, and is reasonably likely to affect the outcome of the case. Compton v. Weyerhaeuser Co., 301 Or 641, 646 (1986).

Here, we find that the medical report submitted by claimant concerns disability and was not obtainable at the time of hearing. However, we do not find that the report affects the outcome of this case. The report provides that claimant has "significant industrial-related nasal responses" and has had clinical and x-ray evidence of "ongoing sinusitis."

Under the circumstances, we do not find the recent medical report to assist claimant's case. SAIF does not dispute, and we do not doubt, that claimant has objective findings of a sinus/respiratory condition. However, the issue in this case is causation, and we are unable to conclude that the report's statement regarding a work-related "response" equates to a finding that work is the major contributing cause of claimant's condition. Moreover, the report also refers to an "ongoing sinusitis" condition, which is consistent with the report of Dr. Montanaro.

Accordingly, because we do not find that the March 1996 medical report would affect the outcome of this case, we decline to remand to the ALJ.

Finally, claimant argues that Dr. Montanaro's opinion is not persuasive, as Dr. Montanaro had an inaccurate understanding of claimant's work environment. Claimant argues that Dr. Montanaro believed that he worked in an environment filled with "large dust particles," while claimant argues that the particles were small and powderlike. Additionally, claimant argues that Dr. Montanaro opined that surgical masks provided "excellent" protection in such settings, while claimant found that the surgical mask he used at work did not help.

After reviewing Dr. Montanaro's opinion, we conclude that he had an accurate understanding of claimant's work environment. Although claimant does not agree with some of the adjectives used in Dr. Montanaro's opinion, we are unable to conclude that Dr. Montanaro did not have an accurate picture of claimant's work environment.

Accordingly, after considering claimant's arguments on review, we conclude that the ALJ correctly found that claimant has failed to meet his burden of proof.

ORDER

The ALJ's order dated December 15, 1995 is affirmed.

In the Matter of the Compensation of
OPAL G. CHRISTIAN, Claimant
WCB Case No. 94-13537
ORDER ON REVIEW
John Bogardus, Claimant Attorney
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen D. Brown's order that set aside its denial of claimant's right piriformis muscle tendinitis injury claim. The employer also moves to strike claimant's "cross-reply brief," on the grounds that claimant did not file a cross-appeal. On review, the issues are motion to strike and compensability.

We grant the motion, and adopt and affirm the ALJ's order, with the following factual clarifications, exception and comment.

We replace the second sentence in "Finding (1)" on page one with: Toward the end of her shift on June 28, 1994, between 2:00 a.m. and 3:00 a.m., claimant noticed a numb feeling in her left anterior thigh.

We replace the second sentence in "Finding (12)" on page four with: Dr. Casey diagnosed right hip piriformis muscle tendinitis due to work activity. Casey noted that it was also possible that, if claimant had a painful hip or back from some other causes, the piriformis muscle irritation was a secondary problem due to an abnormal gait pattern.

We delete the second complete sentence on page five in the "Opinion" section.

We turn to the employer's motion to strike. On December 15, 1995, the employer requested review. On January 22, 1996, the employer filed its "Appellant's Brief." On February 12, 1996, claimant filed her "Respondent's Brief." On February 21, 1996, the employer filed its "Reply Brief." Thereafter, on March 12, 1996, claimant filed a "Cross-Reply Brief."

Under the Board's rules, only a "Cross-Appellant" may file a "Cross-Reply" Brief. See OAR 438-011-0020(2). Here, because claimant did not cross-request Board review, she cannot be a "Cross-Appellant." Accordingly, the employer's motion to strike claimant's "Cross-Reply Brief" is granted; we do not consider it in our deliberations. See Rosalie Naer, 47 Van Natta 2033 (1995).

Claimant is entitled to an attorney fee for her counsel's 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 assessed attorney fee for claimant's counsel's services on Board review is $1,000, to be paid by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 17, 1995 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, to be paid by the self-insured employer.

In the Matter of the Compensation of
WESLEY CROWE, Claimant
WCB Case No. 95-09494
ORDER ON REVIEW
G. Joseph Gorciak III, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Podnar's order that: (1) found that it improperly terminated claimant's temporary disability; and (2) assessed a penalty for allegedly unreasonable termination of temporary disability. On review, the issues are temporary disability and penalties. We affirm.

FINDINGS OF FACT

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

The employer's description of the modified job offered to claimant provided that no lifting, carrying, or use of the right arm would be required. (Ex. 21). Based on this description, Dr. Witczak approved the job for claimant, commenting "May work job with above restrictions." (Id.)

CONCLUSIONS OF LAW AND OPINION

Termination of Temporary Disability

The ALJ found that SAIF improperly terminated claimant's temporary disability benefits because the employer's job offer to claimant did not strictly comply with the requirements set out in OAR 436-60-030(12). Specifically, the ALJ found that the offer did not specify the duration of the job offered, even though it was known. See OAR 436-60-030(12)(c). We adopt the ALJ's conclusions and reach the same result, but find additional reasoning for our conclusion.

Under ORS 656.268(3)(c), temporary total disability (TTD) may be terminated before claim closure if the "attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment." Former OAR 436-60-030(12) more specifically provides that the employer shall cease paying TTD when the injured worker "refuses or fails to begin wage earning employment prior to claim determination," under certain conditions. Those conditions include that "the attending physician has been notified by the employer or insurer of the physical tasks to be performed by the injured worker." Former OAR 436-60-030(12)(a).

Substantial compliance with the procedural requirements of the rule is insufficient to authorize a carrier to terminate TTD benefits. See Fairlawn Care Center v. Douglas, 108 Or App 698 (1991);

Safeway Stores, Inc. v. Little, 107 Or App 316 (1991); Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986).[1] Strict compliance is required. Id.

Here, the employer provided Dr. Witczak, attending physician, with a description of the physical requirements for the job which it intended to offer claimant. (Ex. 21). The description stated, inter alia, that no lifting, carrying, or use of the right arm would be required on the proposed job. (Ex. 21). Dr. Witczak approved the job for claimant, commenting "May work job with above restrictions." (Id.)

At hearing, the employer admitted that the job description approved by Dr. Witczak was inaccurate. (Tr. 46-48). Specifically, the employer conceded that it would be impossible to do the modified work expected of claimant without lifting or carrying. In light of the inaccurate job description, we do not find that claimant's attending physician was "notified by the employer or insurer of the physical tasks to be performed by the injured worker." Former OAR 436-60-030(12)(a); see Jose A. Valladeres, 48 Van Natta 142 (1996) (Where attending physician's history regarding available modified work was inaccurate, time loss authorization was unpersuasive). Therefore, we conclude that the offer did not strictly comply with the procedural requirements of former OAR 436-60-030(12), specifically subsection (c). Under these circumstances, we agree with the ALJ that SAIF improperly terminated claimant's TTD based on claimant's failure to begin the job offered.

Penalty

Caselaw unambiguously required strict compliance with the rule's requirements when SAIF terminated claimant's temporary disability in this case. Under these circumstances, we agree with the ALJ that SAIF's conduct in terminating claimant's TTD based on the employer's job offer was unreasonable. Accordingly, a penalty is appropriate.

Claimant's attorney is entitled to an assessed fee for services on review concerning 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 the temporary disability issue is $850, 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. Claimant is not entitled to an attorney fee for services devoted to the penalty issue. See Saxton v. SAIF, 80 Or App 631 (1987).

ORDER

The ALJ's order dated October 31, 1996 is affirmed. For services on review, claimant is awarded an $850 attorney fee, payable by the SAIF Corporation.

[1] The cases cited decided the "rule compliance" issue under former OAR 436-60-030(5). However, because the rule was merely renumbered in 1994 without substantive changes, the cases continue to support a conclusion that substantial compliance with the rule is insufficient to authorize termination of TTD. See Marie E. Kendall, 46 Van Natta 2520, n.1 (1994).

In the Matter of the Compensation of
RHONDA J. HENNESSEE, Claimant
WCB Case No. 95-09139
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has worked as a food service worker for the employer, a community hospital, since 1992. In May 1994, she began working as a dishwasher in the employer's kitchen. Claimant's work duties as a dishwasher included lifting items of various sizes and weights, and twisting.

Claimant had no low back problems prior to May 1994. In May or June 1994, after a couple of weeks of dishwashing duties, claimant began to feel low back soreness. After beginning full time duties in October or November 1994, claimant experienced increased low back pain along with a "pulling sensation." Claimant's low back symptoms gradually increased, along with right leg symptoms, prompting her to seek medical treatment from her family physician, Dr. Stryker, in March 1995. Claimant filed an occupational disease claim for her low back condition in April 1995.

Dr. Stryker referred claimant for a neurological consultation with Dr. Edmonds in April 1995. At the insurer's request, claimant underwent an examination by Dr. Strum, orthopedist, and Dr. Gardner, neurologist, in May 1995. The insurer denied claimant's occupational disease claim for a "lumbar strain" in July 1995.

In order to establish a compensable occupational disease claim, claimant must prove that employment conditions were the major contributing cause of her disease. ORS 656.802(2)(a). Because of the gradual development of symptoms over time and claimant's delay in seeking medical treatment, we find that the causation question is medically complex and requires expert medical opinion to resolve. Barnett v. SAIF, 122 Or App 279, 282 (1993); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). It is claimant's burden to prove that her occupational disease is compensable. ORS 656.266.

After our review of the record, we find no medical opinion indicating that claimant's work activities were the major contributing cause of her occupational disease. The examining physicians, Drs. Strum and Gardner, indicated there was no evidence that claimant's work activities actually were the major contributing cause of her condition, and they indicated that no causal relationship to any activities could be established. (Ex. 12-5). Dr. Stryker, claimant's treating physician, noted the nature of claimant's work activities, but he gave no opinion regarding the cause of claimant's low back condition. (See Ex. 1). In fact, Dr. Stryker concurred with the report of Drs. Strum and Gardner in its entirety. (Ex. 14). Dr. Edmonds, claimant's consulting neurologist, opined that, since claimant did not have a herniated disk, her back pain was exacerbated by her work, but not caused by her work. (Ex. 3-3). Dr. Edmonds concluded that there was no medical or neurological explanation for claimant's back pain. (Ex. 8).

While we do not require "magic words" to establish causation, McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986), we are unable to construe any of these opinions as indicating that claimant's work activities were the major contributing cause of her low back condition. Accordingly, we conclude that claimant has failed to carry her burden of proof.

ORDER

The ALJ's order dated November 29, 1995 is reversed. The insurer's July 7, 1995 denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
DEBRA A. HERGERT, Claimant
WCB Case No. 95-07222
ORDER OF DISMISSAL
Robert E. Martin, Claimant Attorney
Roberts, et al, Defense Attorneys

Claimant, pro se, has requested review of Administrative Law Judge (ALJ) Johnstone's March 15, 1996 order. We have reviewed this request on our own motion to determine if we have jurisdiction to consider this matter. Because the record does not establish that all parties received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On March 15, 1996, ALJ Johnstone issued an Opinion and Order. Pursuant to that order, the insurer's denials of claimant's low back and current conditions were upheld. Parties to that order were claimant, claimant's attorney, the employer, its insurer and its attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On Monday, April 15, 1996, the Board received claimant's request for Board review. Claimant's letter, which was hand-delivered to the Board's Portland office, stated that claimant "wish[ed] to APPEAL the hearing denial entered at Portland[,] Oregon on March 15, 1996." Claimant's request did not indicate that copies had been provided to the other parties to the proceeding.

On April 18, 1996, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's request for Board review. Based on the insurer's counsel's May 8, 1996 letter, counsel's receipt of this acknowledgment on April 23, 1996 constitutes the insurer'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).

Filing means the physical delivery of a thing to any permanently staffed office of the Board, or the date of mailing. OAR 438-005-0046(1)(a). If filing of a request for Board review of an ALJ's order is accomplished by mailing, it shall be presumed that the request was mailed on the date shown on a receipt for registered or certified mail bearing the stamp of the United States Postal Service showing the date of mailing. OAR 438-005-0046(1)(b). If the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the party filing establishes that the mailing was timely. Id.

The failure to timely file and serve all parties with a request for Board review requires dismissal, Mosley v. Sacred Heart Hospital, 113 Or App 234, 237 (1992); except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. See Zurich Ins. Co. v. Diversified

Risk Management, 300 Or App 47, 51 (1985); Argonaut Insurance Co. v. King, supra. 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 March 15, 1996 order was April 14, 1996, a Sunday. Therefore, the last day on which to perfect a timely appeal of the ALJ's order was Monday, April 15, 1996. Anita L. Clifton, 43 Van Natta 1921 (1991). Claimant's undated request for review was hand-delivered to the Board's Portland office on April 15, 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); 656.295(2); OAR 438-005-0046(1)(b); Anita L. Clifton, supra.

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, based on the insurer's counsel's May 8, 1996 letter, the record indicates that the insurer's first notice occurred when it received a copy of the Board's April 18, 1996 letter acknowledging claimant's request for Board review. Since April 18, 1996 is more than 30 days after the ALJ's March 15, 1996 order, such notice is untimely. John E. Bafford, 48 Van Natta 513 (1996).

Under such circumstances, we conclude that notice of claimant's request was not provided to the other parties within 30 days after the ALJ's March 15, 1996 order.[1] Consequently, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. See ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has 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 she provided notice of her request for Board review to the insurer within 30 days after the ALJ's March 15, 1996 order, she may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Since our authority to consider this order expires within 30 days after the date of this order, claimant must file her written submission as soon as possible.

May 23, 1996 Cite as 48 Van Natta 1053 (1996)

In the Matter of the Compensation of
DAVID J. INGRAM, Claimant
WCB Case No. 95-01842
ORDER ON REVIEW
Coughlin, 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) Schultz's order that set aside its denial of claimant's occupational disease claim for spondylolisthesis. On review, the issue is compensability. 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

Claimant first sought treatment for low back problems in 1981. Claimant began working for the employer in 1984 as a retail tire sales and service person. Claimant started having low back pain again in 1990 and began treating with Dr. Allen.

In 1994, claimant was diagnosed with spondylolisthesis. On November 22, 1994, claimant filed a claim for spondylolisthesis arising out of his work activity.

The ALJ found that claimant's spondylolisthesis was a long-standing preexisting condition and that claimant most likely acquired the defect developmentally when he was a teenager. The ALJ framed the issue as whether or not claimant's work activities caused an actual worsening of the preexisting condition. The ALJ concluded that the medical evidence established that claimant's preexisting spondylolisthesis condition worsened as a result of his work activity for the employer.

SAIF argues that the ALJ applied the wrong standard of proof. Rather than applying an "actual worsening" standard, SAIF contends that claimant must prove that his work activities were the major contributing cause of the combined condition and pathological worsening of the disease. See ORS 656.802(2)(b).

Claimant contends that it is speculation that his spondylolisthesis condition developed when he was a teenager and he argues that there is no evidence of any combined condition. We disagree.

Claimant first sought treatment for a low back problem in 1981, before he began working for the employer. (Tr. 9). Drs. Bishop, Naeve and Pettee reported that claimant's spondylolisthesis condition probably developed when he was a teenager as a result of rapid growth. (Exs. 9-7, 18, 22-4, 23-5). In fact, Dr. Bishop testified that there was "no doubt that the defect was pre-existent to [claimant's] work at the tire company." (Ex. 22-11). There are no contrary medical opinions. Therefore, we agree with the ALJ that claimant's spondylolisthesis was a long-standing preexisting condition.

Claimant contends that his spondylolisthesis condition has worsened as the result of the repetitive lifting he did at the employer. Because claimant's occupational disease claim is based on a worsening of a preexisting disease, he must prove that "employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." ORS 656.802(2)(b). It is no longer sufficient for claimant to prove that work conditions were the major contributing cause of the worsening of the preexisting disease; he must prove that work conditions were the major contributing cause of the "combined condition." Dan D. Cone, 47 Van Natta 2220 (1995).

Here, the "combined condition" is claimant's current spondylolisthesis condition, which resulted from the combination of claimant's preexisting spondylolisthesis and the work conditions with the employer. Claimant must prove that work conditions with the employer were the major contributing cause of the combined condition and pathological worsening of the disease. See ORS 656.802(2)(b). In addition, the worsening of the preexisting spondylolisthesis condition must be established by medical evidence supported by objective findings. ORS 656.802(2)(d).

SAIF asserts that the medical evidence shows that claimant's work activities symptomatically worsened the preexisting spondylolisthesis condition. However, SAIF argues that there is no medical evidence suggesting that claimant's work activities were the major contributing cause of his combined spondylolisthesis condition. We disagree.

Dr. Allen, chiropractor, has treated claimant's low back condition since 1990. Dr. Allen reported that claimant's spondylolisthesis condition "most definitely worsened" while he was employed by the employer. (Ex. 14). Dr. Allen believed that the major cause of the worsening of the condition was claimant's work activities. Dr. Allen explained that the kind of work claimant had to do, including forward flexion and lifting, "undoubtedly adds to the flexion deformity of the spondylolisthesis such as he has." (Id.). According to Dr. Allen, the medical research establishes that the type of activity claimant performed commonly exacerbates spondylolisthesis. Dr. Allen commented that claimant presented a classical example of nerve root impingement caused by his employment.

In a later report, Dr. Allen explained the objective evidence of claimant's condition:

> "I would offer the following objective evidence as to the worsening of [claimant's] spondylolisthesis as being one of primary increased symptomatology particularly paresthesia radiating into the lower extremity, decreased range of motion as well as the fact that he had an inability for a short period of time to heel and toe walk which is an indication of nerve root impingement directly responsible to an exacerbation of his spondylolisthesis." (Ex. 17).

Dr. Allen believed that claimant's work activity was the main reason for his condition. (Id.)

In a "check-the-box" letter, Dr. Allen agreed that claimant's spondylolisthesis had become unstable and he believed that claimant's work activities were the major cause of the development of the instability. (Ex. 20).

Although Dr. Allen referred to claimant's spondylolisthesis becoming "symptomatic," his opinion, read as a whole, establishes more than a symptomatic worsening of the disease. Dr. Allen described how claimant's work activities added to the flexion deformity of the spondylolisthesis and led to decreased range of motion. (Exs. 14, 17). Furthermore, Dr. Allen commented that claimant presented a classical example of nerve root impingement caused by his employment. (Ex. 14). Dr. Allen believed that claimant's condition "most definitely worsened" and the major cause of the worsening was claimant's work activities. (Ex. 14). Although Dr. Allen did not use "magic words," his report establishes that claimant's work activities with the employer were the major contributing cause of the combined condition and pathological worsening of the current spondylolisthesis condition.

Dr. Allen's opinion is supported by Dr. Bishop. Dr. Bishop reported that claimant's work activities had "clearly aggravated his back significantly." (Ex. 18). Dr. Bishop explained:

> "[Claimant's] history leads me to believe that his condition has clearly worsened in recent years, probably with overgrowth at his pseudoarthrosis and progressive impingement or stenosis on the underlying L5 nerve roots, which I believe is the anatomic abnormality that worsens in time with these defects." (Id.)

Dr. Bishop found an "exacerbation of symptoms in recent years" superimposed on a preexisting defect.

In a post-hearing deposition, Dr. Bishop testified that claimant's work did not cause the defect itself. (Ex. 22-8). However, Dr. Bishop believed that claimant's work activities advanced the spondylolisthesis condition. (Ex. 22-20). Dr. Bishop explained that repetitive loading, twisting and straining on a weak spot would likely lead to a recurring strain, usually followed by inflammation and sometimes overgrowth and hypertrophy. (Ex. 22-17). Dr. Bishop believed that claimant's work activities caused inflammation and hastened the development of degenerative change in claimant's spondylolisthesis condition. (Exs. 22-17, 22-18). Dr. Bishop explained that the inflammation can lead to spurring or hypertrophy, which can encroach on the nerve and cause intermittent nerve irritation. (Ex. 22-18). Dr. Bishop said that had happened with claimant. (Ex. 22-19).

Dr. Bishop testified that "repetitive trauma and overuse contributes to overgrowth at the spondylitic site and contribute to progression of slip." (Ex. 22-20). When Dr. Bishop was asked if he was just talking about claimant's back becoming symptomatic, he testified that "it's anatomic and it's real." (Ex. 22-21). Dr. Bishop explained:

> "It's an overgrowth -- a more rapid degeneration and spurring in overgrowth at the site of the defect that was previously not symptomatic. So I think there is a true worsening of a condition." (Id.)

Based on a reasonable medical probability, Dr. Bishop believed that claimant's spondylolisthesis condition advanced as a result of his work activities. (Exs. 22-20, 22-24).

Dr. Naeve, who treated claimant on one occasion, testified that claimant's work activity "very possibly" aggravated his back condition. (Ex. 23-14). On the other hand, Dr. Naeve testified that, although claimant's work had some role in the worsening, the disease itself was the major contributing cause of the disease. (Ex. 23-9).

Dr. Pettee, who examined claimant on behalf of SAIF, reported that claimant's work was not a major contributing cause of his spondylolisthesis, but caused only a "temporary aggravation of a pre-existing problem."[1] (Ex. 9-7).

When the medical evidence is divided, we tend to give greater weight to the claimant's treating physicians, absent persuasive reasons not to. Weiland v. SAIF, 64 Or App 810 (1983). In addition, we give greater weight to those opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259, 263 (1986).

Here, we see no persuasive reason not to defer to the opinion of claimant's treating physician, Dr. Allen, who had the opportunity to observe the claimant over an extended period of time and whose opinion was based on a complete understanding of the progression of claimant's condition since 1990. Dr. Allen's opinion is supported by that of Dr. Bishop. In contrast, Drs. Naeve and Pettee examined claimant on only one occasion. Based on the opinions of Drs. Allen and Bishop, we conclude that claimant's work conditions with the employer were the major contributing cause of the combined condition and pathological worsening of the disease. See ORS 656.802(2)(b). In addition, we agree with the ALJ that those opinions establish the existence of the worsening by medical evidence supported by objective findings. See ORS 656.802(2)(d).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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 December 5, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by SAIF.

[1] We note that, in a "check-the-box" letter, Dr. Bishop originally concurred with Dr. Pettee's report. (Ex. 11). Since Dr. Bishop subsequently explained in his reports and deposition that claimant's spondylolisthesis condition advanced as a result of his work activities, we assign little probative value to his concurrence with Dr. Pettee's report.

In the Matter of the Compensation of
KATHRYN D. KNIGGE, Claimant
WCB Case Nos. 94-09758 & 94-09757
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) upheld the SAIF Corporation's denial, on behalf of Jack & Jerry's Tavern (SAIF/J&J), of claimant's aggravation claim for right arm and shoulder strains; and (2) upheld the SAIF Corporation's denials, on behalf of Jopa, Inc. (SAIF/Jopa), of compensability and responsibility for the same condition. In its brief, SAIF/Jopa contends that the ALJ erred in failing to grant its motion to dismiss pursuant to ORS 656.308(2)(c). On review, the issues are compensability, responsibility, and dismissal. We affirm.

FINDINGS OF FACT

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

On August 25, 1995, SAIF/Jopa filed a motion to dismiss pursuant to ORS 656.308(2)(c). Claimant objected. On September 7, 1995, the ALJ denied the motion.

CONCLUSIONS OF LAW AND OPINION

Compensability and Responsibility

We adopt and affirm the ALJ's order, as reconsidered, with the exception of that portion of the ALJ's opinion beginning in the second paragraph with the words "The later examiners" to the end of the opinion.[1]

Dismissal

On June 7, 1994, SAIF/Jopa disclaimed responsibility for claimant's claim. On July 1, 1994, SAIF/J&J denied claimant's aggravation claim. On July 5, 1994, SAIF/Jopa denied compensability. On September 8, 1994, the Department denied a request for a ".307" order. On August 25, 1995, SAIF/Jopa filed a motion to dismiss pursuant to ORS 656.308(2)(c). Claimant objected to the motion. On September 7, 1995, the ALJ denied the motion, reasoning that, without a ".307" order, SAIF/Jopa was barred from dismissal.

On review, SAIF/Jopa contends that the ALJ erred in failing to grant its motion to dismiss pursuant to ORS 656.308(2)(c). We disagree with SAIF/Jopa's contention and affirm the ALJ, but for different reasons.

Subsequent to the ALJ's order, we issued Ernest L. Chavez, 48 Van Natta 529 (1996). In Chavez, an employer denied compensability and responsibility and an insurer denied responsibility. The claimant filed a request for hearing on the employer's denial. The ALJ found that there was no substantial evidence in the record that the claim was compensable as to the employer. The ALJ accordingly dismissed claimant's hearing request. We concluded that the dismissal procedures under ORS 656.308(2)(c) apply only to responsibility issues, and, thus, that the ALJ had no statutory authority to dismiss the claimant's hearing request.

Here, as in Chavez, SAIF/Jopa denied both compensability and responsibility. There is no evidence that it later conceded compensability.[2] Thus, compensability as well as responsibility against SAIF/Jopa was in issue at hearing. Consequently, the ALJ did not err in denying SAIF/Jopa's motion to dismiss. Chavez, supra.

ORDER

The ALJ's order dated October 11, 1995, as reconsidered November 14, 1995, is affirmed.

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[1] Because claimant has failed to establish that her current neck and arm condition resulted from the 1993 injury, we need not address whether her compensable condition has "actually worsened." See ORS 656.273(1).

[2] As we noted in Chavez, supra, if the employer had conceded that the claimant's condition was compensable, it would have been appropriate for the ALJ to consider whether the employer should be dismissed from the proceeding pursuant to ORS 656.308(2)(c). See, e.g., Castle & Cooke v. Alcantar, 112 Or App 392, 395 (1992) (A concession of compensability in relation to a ".307" order admits only that a claimant's condition resulted from a work exposure without operating to waive an employer's right to argue that the disability is not related to a work exposure in its employment).

In the Matter of the Compensation of
JAMES R. LAZENBY, Claimant
WCB Case No. 95-06321
ORDER ON REVIEW
Heiling Dodge & Associates, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Schultz' order that awarded a $2,500 attorney fee for claimant's counsel's services in obtaining the pre-hearing rescission of the SAIF Corporation's denial of claimant's occupational disease claim. Claimant contends that the ALJ's fee award is insufficient. In its brief, SAIF argues that the fee award is excessive. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact through the second full paragraph on page three of the Opinion and Order.

CONCLUSIONS OF LAW AND OPINION

Claimant requests a $6,400 attorney fee for his counsel's services in obtaining the pre-hearing rescission of SAIF's denial of claimant's occupational disease claim for a bilateral carpal tunnel syndrome (CTS) condition. In support of his request, claimant relies on his statement of services and an hourly rate of $150 per hour plus an additional $50 per hour as a contingency multiplier.

SAIF responds that no fee may be awarded under ORS 656.386(1), because it denied responsibility only. Alternatively, if a fee is awarded, SAIF argues that it should be no more than $500. We affirm the ALJ's order.

First, we find that SAIF denied compensability, as well as responsibility. The denial is titled "Disclaimer of Responsibility and Claim Denial." It asserts that claimant's work activity for SAIF's insured was not the major contributing cause of the claimed bilateral carpal tunnel syndrome condition and denies claimant's claim for benefits. It further informs claimant that SAIF had not requested designation of a paying agent pursuant to ORS 656.307. Finally, the denial included "notice of hearing" provisions consistent with a denial of compensation pursuant to OAR 438-005-0053(4). (Ex. 43).

Under these circumstances, we conclude that SAIF denied compensability of the claim and claimant is entitled to an attorney fee under ORS 656.386(1) for his counsel's services in obtaining pre-hearing rescission of that denial. See Linda K. Ennis, 46 Van Natta 1142 (1994).

After receiving the denial, claimant's attorney requested a hearing on claimant's behalf. He devoted approximately 30 hours of legal services to preparing for the hearing. His efforts included reviewing 38 exhibits submitted by SAIF, and 46 exhibits submitted by Liberty Northwest Insurance Corporation.[1] He filed several requests for hearing and amended requests for hearing before SAIF rescinded its denial.

Claimant's counsel submitted an affidavit describing his pre-hearing services regarding this matter and requested a $6,400 attorney fee, based on his regular hourly rate ($150 per hour), plus $50 per hour as a "contingency factor." The ALJ awarded a $2,500 attorney fee for claimant's attorney's services in obtaining the pre-hearing rescission of SAIF's compensability denial.

On de novo review, we consider the amount of claimant's counsel's attorney fee for services at the hearings level by applying the factors set forth in OAR 438-015-0010(4). Those factors include: (1)

[1] The ALJ described these documents as copied to claimant and received into evidence. (Opinion and Order p.1). SAIF does not dispute these numbers.

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. Because the risk of an attorney's efforts going uncompensated is already a factor which must be considered under the rule, we decline to apply a contingency multiplier in determining a reasonable attorney fee under ORS 656.386(1). See Rosalie Naer, 47 Van Natta 2033 (1995); Lois J. Schoch, 46 Van Natta 1816 (1994), aff'd mem Schoch v. Leupold & Sims, 137 Or App 633 (1995).

Based on the application of the previously enumerated factors, we conclude that $2,500 is a reasonable assessed attorney fee for claimant's counsel's services at the hearing level regarding the compensability issue. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's counsel's affidavit) and the risk that claimant's counsel might go uncompensated. Claimant's attorney is not entitled to a fee for services pertaining to post-rescission matters or those associated with the attorney fee issue. See Dotson v. Bohemia, Inc., 80 Or App 233 (1986); Martin E. Mendez-Esquibel, 45 Van Natta 959 (1993).

ORDER

The ALJ's order dated December 13, 1995 is affirmed.

May 23, 1996 Cite as 48 Van Natta 1059 (1996)

In the Matter of the Compensation of
JOSEF E. TUNISON, Claimant
WCB Case No. 94-09711
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Holtan's that: (1) upheld the insurer's denial of his injury claims for a cervical strain, cervical contusion, lumbosacral strain and thoracic strain; (2) declined to assess penalties and attorney fees for the insurer's alleged failure to accept or deny those conditions in a timely manner; and (3) affirmed the Order on Reconsideration which did not award any permanent partial disability. On review, the issues are whether the parties' stipulation precludes claimant from litigating compensability, and, alternatively, compensability, extent of permanent partial disability, penalties and attorney fees.

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

The ALJ found, based on Good Samaritan Hospital v. Stoddard, 126 Or App 69, rev den 319 Or 572 (1994), and Safeway Stores, Inc. v. Seney, 124 Or App 450 (1993), that claimant was barred from asserting the compensability of his cervical strain, cervical contusion, lumbosacral strain and thoracic strain conditions because those issues could have been raised and negotiated before approval of the parties' March 3, 1994 stipulation.

Claimant argues that the March 3, 1994 stipulation, which addressed the duration and rate of temporary disability and an accompanying penalty, does not preclude the compensability issues raised by claimant because the time loss issue did not rise out of the same group of facts as the compensability issues. We disagree.

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[1] Although the ALJ's order states that exhibits 1 through 80, 55A, 55B and 66A were admitted into evidence, exhibits 55A, 55B and 66A are not part of the record. Those exhibits were admitted at the first hearing on November 9, 1994. (Tr. 5). At the second hearing on September 6, 1995, the ALJ said that all past admitted exhibits were also in this record, some of which were renumbered. (Tr. 3). The ALJ admitted exhibits 1 though 80 into evidence. (Id.) Thus, it appears that exhibits 55A, 55B and 66A were renumbered and incorporated into exhibits 1 through 80.

The parties' March 3, 1994 stipulation provided that claimant's request for hearing "shall be dismissed with prejudice on all issues raised or raisable." (Ex. 67). When the agreement purports to resolve all issues which were raised or could have been raised, the settlement bars a subsequent claim for a condition that could have been raised before the date of the agreement. See Good Samaritan Hospital v. Stoddard, supra; Safeway Stores, Inc. v. Seney, supra.

Claimant contends that Safeway Stores, Inc. v. Seney, supra, does not apply in this case, because the insurer did not put claimant "on notice" that there was a problem with the compensability of his injury at the time of the settlement. Claimant asserts that, in Seney, the employer had denied benefits for the claimant's condition "well before the settlement was approved" and the claimant was on notice that there was a problem with the compensability of his injury.

To the extent claimant is arguing that the issues of his cervical strain, cervical contusion, lumbosacral strain and thoracic strain conditions were not "raisable" because the insurer had not issued a written denial, we disagree.

In Vicki D. Pollock, 48 Van Natta 463, 463 n.2 (1996), the claimant argued that because the aggravation claim had yet to be denied at the time the stipulation was approved, the claimant could not have forced the employer to litigate the merits of the aggravation claim. Although we acknowledged that "litigation" of the claim before the Hearings Division would not have been possible at the time of the parties' stipulation, we reasoned that "litigation" was not the proper test. In Good Samaritan Hospital v. Stoddard, supra, 126 Or App at 73, the court expressly found that a denial from the employer was not required for an issue to be raisable. Rather, the correct inquiry was whether the issue could have been negotiated before approval of the settlement. In Pollock, since the claimant's condition had been diagnosed and related to her prior work injuries before the stipulation was signed and approved, we found that the aggravation issue was ripe for negotiation and could have been raised. See also Daniel R. Loynes, 47 Van Natta 1075 (1995) (the parties' stipulation, which settled all issues "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 before the settlement agreement was approved).

Here, we agree with the ALJ that claimant's alleged cervical strain, cervical contusion, and interscapular thoracic strain, with symptoms of neck pain, upper back and left arm pain and numbness, were diagnosed by August 20, 1993 as possibly related to the accepted injury. (Exs. 36, 39). In October 1993, claimant was diagnosed with a lumbosacral strain, possibly related to the injury. (Exs. 53, 54). The ALJ pointed out that more than 90 days had passed after those conditions had been diagnosed and possibly related to the injury.

Thus, claimant's cervical strain, cervical contusion, lumbosacral strain and thoracic strain conditions had been diagnosed and related to his work injury before the stipulation was signed and approved. Therefore, those conditions were ripe for negotiation and could have been negotiated before the parties' stipulation was approved on March 3, 1994. See Good Samaritan Hospital v. Stoddard, supra. The parties' unambiguous March 3, 1994 stipulation provided that claimant's request for hearing "shall be dismissed with prejudice on all issues raised or raisable." (Ex. 67). Since the compensability of claimant's cervical strain, cervical contusion, lumbosacral strain and thoracic strain conditions could have been raised, the stipulation resolved those claims when all other issues were dismissed with prejudice. See Good Samaritan Hospital v. Stoddard, supra; Safeway Stores, Inc. v. Seney, supra. Consequently, we conclude that claimant is precluded by the stipulation from litigating the compensability of his claims for the cervical strain, cervical contusion, lumbosacral strain and thoracic strain.[2]

ORDER

The ALJ's order dated December 13, 1995 is affirmed.

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[2] In light of our conclusion, we need not address claimant's arguments concerning the compensability of the cervical strain, cervical contusion, lumbosacral strain and thoracic strain conditions, the extent of disability of any new compensable conditions or penalties and attorney fees.

In the Matter of the Compensation of
JAMES W. VULLO, Claimant
WCB Case No. 95-05199
ORDER ON REVIEW
Gatti, Gatti, et al, Claimant Attorneys
Tooze, Shenker, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Kekauoha's order that declined to award a penalty and attorney fee for an allegedly unreasonable "de facto" denial of a right wrist condition. On review, the issues are penalties and attorney fees.

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

On December 14, 1994, the self-insured employer accepted a claim for right carpal tunnel syndrome (CTS). On May 1, 1995, claimant filed a request for hearing alleging that the employer "de facto" denied a claim for right wrist strain/sprain, right elbow strain/sprain and acute tenosynovitis of the right wrist. On June 28, 1995, the employer's attorney wrote to claimant's attorney announcing that the additional conditions were being accepted. Asserting that the hearing request was the employer's first notice of the conditions, its attorney contended that no attorney fee was warranted. On July 24, 1995, the employer issued its formal notice of acceptance of the conditions listed in claimant's request for hearing.

The ALJ concluded that claimant was not entitled to a penalty under ORS 656.262(11)(a) or attorney fee under ORS 656.386(1) because the employer did not "de facto" deny claimant's right wrist condition. Claimant challenges this conclusion, asserting that there was an unreasonable "de facto" denial and, because the employer rescinded the denial before hearing by accepting the additional conditions, he should be awarded a penalty and attorney fee. We disagree with claimant's contentions.

For the following reasons, we agree with the ALJ that claimant is not entitled to an attorney fee for the alleged "de facto" denial. Under amended ORS 656.386(1), which is applicable in this case, a claimant's attorney is entitled to an attorney fee "in cases involving denied claims" where the attorney is instrumental in obtaining a rescission of the denial.[1] A "denied claim" is defined 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 compensation." We held in Michael J. Galbraith, 48 Van Natta 351 (1996) that there was no "denied claim" under amended ORS 656.386(1) where the carrier paid all benefits for the compensable condition and did not expressly contend that the allegedly "de facto" denied condition was not compensable. Cf. Guillermo Rivera, 47 Van Natta 1723 (1995) (finding a "denied claim" where the employer questioned the causation of the "de facto" denied condition).[2]

In this case, as in Michael J. Galbraith, supra, there is no contention that any benefits for the additional conditions listed in the hearing request have been unpaid. In addition, the record does not establish that the employer refused to pay compensation on the express ground that the additional conditions were not compensable or did not give rise to an entitlement to compensation. Under such circumstances, we conclude that a "denied claim" has not been established and no attorney fee may be awarded under amended ORS 656.386(1). See Jerry L. Jones, 48 Van Natta 833 (1996).

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[1] In reaching this conclusion, we reject claimant's assertion that the amendments to ORS 656.386(1) are not retroactively applicable because they affect a procedural time limitation. See Gayle J. Williams, 48 Van Natta 892 (1996).

[2] The employer asserts that claimant is precluded from asserting a "de facto" denial because he did not satisfy amended ORS 656.262(6)(d), which requires that the worker "first communicate in writing" to the carrier any objections to a notice of acceptance before alleging a "de facto" denial at a hearing. We need not resolve that question because, for the reasons expressed in this decision, there is no "denied claim" upon which to award an attorney fee under ORS 656.386(1).

Finally, because no benefits have gone unpaid, there are no amounts "then due" upon which to base a penalty under ORS 656.262(11)(a) and no unreasonable resistance to the payment of compensation under ORS 656.382(1). See Jerry L. Jones, supra.

ORDER

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

May 23, 1996 Cite as 48 Van Natta 1062 (1996)

In the Matter of the Compensation of
THOMAS A. WEAVER, Claimant
WCB Case No. 95-10856
ORDER ON REVIEW
Lavis, Alvey, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Herman's order that upheld the insurer's denial of claimant's aggravation claim for a right knee injury. On review, the issue is aggravation.

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

The record contains two medical opinions which address whether claimant's compensable right knee condition has worsened. Dr. Farris, examining physician, opined that there was no objective evidence of any worsening of claimant's right knee condition.

Dr. Benz, claimant's attending physician, opined that claimant had sustained "a substantial worsening of his knee problem" since claim closure. Dr. Benz noted that claimant complained of increased pain in the knee medially and laterally. The ALJ noted that all of Dr. Benz' other examination findings, such as limping, giveway weakness and severe valgus instability, were already present at the time of claim closure. The ALJ also noted that reconstructive surgery was also considered and rejected by claimant prior to claim closure. The ALJ concluded that the increased pain complaints noted by Dr. Benz were insufficient on their own to constitute "objective findings" under amended ORS 656.005(19). We agree.

Amended ORS 656.005(19)[1], defines "objective findings" in support of medical evidence as verifiable indications of injury or disease. The definition 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), we concluded that a physician's indication that the worker experiences pain is no longer sufficient to constitute "objective findings" under amended ORS 656.005(19).

Here, in support of his conclusion that claimant's condition had actually worsened, Dr. Benz relied on the fact that claimant "seemed to complain more of medial than lateral pain." As we have previously stated, Dr. Benz' other examination findings were present prior to claim closure. Thus, the only new finding was increased pain. Because Dr. Benz relied solely on claimant's subjective complaints of increased pain to support his conclusion that claimant's condition had worsened, we agree with the ALJ that there are no "objective findings" of a worsening. Jairo J. Garcia, supra.

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[1] Amended ORS 656.005(19) 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."

Because the record contains no "medical evidence of an actual worsening of the compensable condition supported by objective findings" as required by ORS 656.273(1), we agree with the ALJ that claimant has failed to establish a compensable aggravation claim.

ORDER

The ALJ's order dated January 19, 1996 is affirmed.

In the Matter of the Compensation of
BETTY V. WEST, Claimant
WCB Case No. 95-01628
ORDER ON REVIEW
Hollander,et al, Claimant Attorneys
VavRosky, et al, 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 claimant's left arm condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant asserts that the ALJ erred by concluding that the medical evidence failed to establish that claimant's left arm condition[1] was a compensable consequence of an accepted right arm condition. We disagree.

Claimant asserts that, as a consequence of her compensable right arm condition, she overused her left arm, which resulted in the development of her left arm condition and need for surgery. To prevail on that theory, claimant must establish that her compensable right arm condition is the major contributing cause of her left arm condition. ORS 656.005(7)(a)(A). She has not met that burden.

Three physicians rendered opinions regarding the cause of claimant's left arm condition. No one attributed that condition, in major part, to claimant's compensable right arm condition, or to her compensatory left arm activities.

Dr. Franks, treating neurosurgeon, initially stated that claimant's left arm condition was not work-related. (Ex. 4). He later reiterated that opinion, implicating claimant's amyotropic lateral sclerosis (ALS) as a cause of her left arm problems. (Ex. 11). Dr. Kirschner, consulting neurologist, agreed that claimant's left arm condition was not caused, in major or material part, by her work activities; Dr. Franks concurred. (Exs. 12-2, 13). Franks subsequently issued another report, again concluding that claimant's left arm condition was not caused, in major part, by work activity. (Ex. 17). Dr. Button, hand surgeon, performed a records review, and concluded that it was not medically reasonable that claimant's increased left hand use following her right arm condition resulted in her left arm condition. (Ex. 18-1).

In deposition, Dr. Franks identified three causes of claimant's left arm problems: ALS, compensatory left arm work and non-work activities and an anatomic predisposition to develop left arm

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[1] The left arm condition has been diagnosed as radial nerve palsy and/or posterior interosseous nerve syndrome.

problems. (Exs. 20-8, -14, -15). Franks agreed that claimant's work activities accelerated her left arm condition (id. at 16), but was unable to say that those activities were the major cause of that condition. (See id. at 13, 20).

This evidence is insufficient to establish a compensable claim under ORS 656.005(7)(a)(A). Although Franks said, at one point, that claimant's work activities were a major cause of her left arm condition, (id. at 17, -20), in view of the other potential causes of claimant's condition, Franks' initial reports, and the countervailing reports of Drs. Kirschner and Button, we conclude that that statement fails to carry claimant's burden of proof.[2] See, e.g., Arnold D. Schaffer, 47 Van Natta 1667, 1669-70 (1995) (in light of claimant's non-medically stationary off-work injury, Board held that medical opinion stating that work injury was a major contributing cause of claimant's need for treatment did not establish compensable claim under ORS 656.005(7)(a)(B)).

Claimant asserts that, because ALS is not amenable to surgical treatment, and because that condition was not diagnosed until after she treated for her left arm condition, the ALS was not, and could not have been, a cause of her left arm condition. We need not address those assertions, because, aside from the ALS issue, there is insufficient evidence to establish that claimant's right arm condition was the major cause of her left arm condition.

Accordingly, for these reasons, we agree with the ALJ that claimant's left arm condition is not compensable. Therefore, we affirm the ALJ's decision upholding the employer's denial of that condition.

ORDER

The ALJ's order dated December 18, 1995 is affirmed.

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[2] In reaching this conclusion, we note that Dr. Franks was unable to state whether claimant's compensatory activities were more or less than half the cause of her left arm problems. (Ex. 20-20; see also id. at 27). That supports our conclusion that, by characterizing those activities as a major cause, Franks was not necessarily identifying the primary cause of claimant's left arm condition.

In the Matter of the Compensation of
ROGER C. ATCHLEY, JR., Claimant
WCB Case No. 95-13677
ORDER ON REVIEW
Swanson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Podnar's order that declined to award temporary disability compensation from September 18, 1995 through January 5, 1996. On review, the issue is temporary disability.

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

Claimant sustained a compensable injury on May 7, 1993. A Notice of Closure issued on July 7, 1994, finding claimant medically stationary as of June 9, 1994. On January 3, 1995, claimant began an authorized training program (ATP), and the insurer reinstituted payment of temporary total disability (TTD) benefits. Claimant completed the ATP on September 18, 1995, and the insurer suspended payment of TTD benefits at that time.

A Determination Order (DO) issued on January 5, 1996, reclosing the claim. Noting that claimant had completed the ATP, the DO awarded temporary disability from January 3 through September 18, 1995. The DO also affirmed the June 9, 1994 medically stationary date. Claimant requested a hearing, contending that the insurer was required to continue payment of temporary disability benefits until termination was authorized by ORS 656.268(9). The ALJ assessed a 25 percent penalty for the insurer's unreasonable suspension of TTD benefits (from which the insurer does not appeal). However, citing Lebanon Plywood v. Seiber, 113 Or App 651 (1992), the ALJ declined to award further permanent disability.

On review, claimant argues that assessing a 25 percent penalty, rather than requiring the insurer to pay the entire amount procedurally due, rewards the insurer for its unreasonable refusal to pay TTD benefits. The court addressed this same issue in Lebanon Plywood v. Seiber, supra. Noting that the claimant's substantive entitlement to temporary disability benefits did not extend beyond his medically stationary date, the court held that the Board could not, as a means of preventing the insurer from "reap[ing] any advantage from" its claim processing violation, impose an "overpayment" on the insurer by requiring the insurer to pay ("procedural") temporary disability benefits until claim closure. Instead, the court explained that if an insurer unreasonably refuses to pay temporary disability benefits, "it is subject to penalties, which is the appropriate way to induce compliance." Id. at 654.

In that the present case concerns this same kind of claim processing violation, Lebanon Plywood v. Seiber, supra, controls. While it was unreasonable for the insurer not to have continued payment of TTD benefits until claim closure, under Seiber, we are prevented from ordering the insurer to pay any additional TTD benefits beyond those awarded under the DO. Compare Anodizing, Inc. v. Heath, 129 Or App 352 (1994) (concluding that no administrative overpayment results where a claimant is statutorily entitled, under ORS 656.313, to the temporary disability benefits in question, regardless of the outcome of the eventual decision concerning the merits).

ORDER

The ALJ's order dated January 29, 1996 is affirmed.

In the Matter of the Compensation of
DAVID L. BARNHART, Claimant
WCB Case No. 95-10280
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) decreased claimant's unscheduled permanent disability award from 36 percent (115.2 degrees), as awarded by an Order on Reconsideration, to 21 percent (67.2 degrees); and (2) eliminated a penalty awarded on reconsideration pursuant to ORS 656.268(4)(g). On review, the issues are extent of unscheduled permanent disability and penalties. We modify in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and summarize the pertinent facts as follows:

Claimant compensably injured his back on October 31, 1994. The SAIF Corporation issued a Notice of Closure on June 13, 1995, which awarded 7 percent scheduled permanent disability for claimant's left leg and 21 percent (67.2 degrees) unscheduled permanent disability for the low back.

Claimant requested reconsideration of the Notice of Closure, challenging, among other things, the adaptability value used in rating the extent of his unscheduled permanent disability. A September 7, 1995 Order on Reconsideration increased claimant's total unscheduled permanent disability award to 36 percent (115.2 degrees) and awarded claimant a penalty of $1,503.65 pursuant to ORS 656.268(4)(g). The insurer requested a hearing, arguing that claimant's unscheduled permanent disability award should be reduced to 21 percent, as set forth in the Notice of Closure.

CONCLUSIONS OF LAW AND OPINION

Extent of Unscheduled Permanent Disability

The parties stipulate that claimant's unscheduled impairment value is 21 percent, that claimant's total age and education value is 5, and that claimant's residual functional capacity (RFC) is medium strength. Therefore, the dispute in this matter concerns claimant's base functional capacity (BFC) under OAR 436-35-310.

The ALJ found that, in the five years prior to the Notice of Closure, the most physically demanding jobs that claimant performed were operating feller bunchers and skidders in logging operations. The ALJ further found that the DOT Codes which most accurately described claimant's job duties are "tree shear operator" (DOT 454.683-010) for the feller buncher jobs and "logging tractor operator" (DOT 929.663-010) for the skidder jobs. Because the DOT assigns a medium strength factor to both tree shear operator and logging tractor operator, the ALJ determined that claimant's BFC under OAR 436-35-310(4) was medium strength.

Claimant argues on review that his BFC should be heavy strength because he was working for a two man logging operation which imposed greater physical requirements than those contemplated in the DOT Code descriptions for tree shear operators and logging tractor operator. This contention notwithstanding, the record submitted on reconsideration before the Department does not establish that claimant's job at injury had the heavy strength demands of a timber faller or all-round logger (DOT Code 454.684.018). Claimant advised SAIF's investigator that he worked as a "skidder operator," and that his specific job was to operate a John Deere 648 tractor, and occasionally service and fuel up the machine. (Ex. 12-6). Claimant did not indicate that he used an ax or chain saw to manually fall trees. Similarly, when a job analysis was conducted in August 1995, claimant's employer described claimant's duties at injury as that of a skidder operator, and did not identify any heavy strength activities. (Ex. 12). Further, in completing his work history for SAIF, claimant consistently reported that he worked as a filler buncher and skidder and did not list axes or chain saws as machinery, tools or equipment used on the job. Accordingly, on this record, we agree with the ALJ that claimant's BFC is medium.

Applying OAR 436-35-280(1)(a) and 436-35-310(6), the ALJ determined that a BFC of medium and an RFC of medium results in an adaptability value of 0. Subsequent to the ALJ's order, however, the Court of Appeals held that a former Director's rule, which also gave a 0 adaptability value in certain circumstances, was invalid because it was inconsistent with ORS 656.726(3)(f)(A). Carroll v. Boise Cascade Corp., 138 Or App 610 (January 24, 1996). In Joe R. Ray, 48 Van Natta 325 (1996), we held the rules applicable in this case were similarly invalid. See also Phillips v. Hammond, 139 Or App 507 (1996). Therefore, we may no longer rely on those adaptability rules in determining the extent of claimant's unscheduled disability. Instead, because age, education, and skill factors must be considered under the standards, we assign claimant an adaptability factor of 1, as in Joe R. Ray, supra.

The total value of claimant's age, education and skills (5) is multiplied by the adaptability factor (1) for a total of 5. OAR 436-35-280(6). When this value is added to the value for impairment (21), the result is 26. OAR 436-35-280(7). Therefore, claimant's total unscheduled permanent disability award is 26 percent (83.20 degrees).

Penalty

Because the Department, on reconsideration of the Notice of Closure, increased claimant's permanent disability compensation by more than 25 percent and found claimant to be more than 20 percent permanently disabled, the Order on Reconsideration awarded claimant a 25 percent penalty pursuant to ORS 656.268(4)(g). The ALJ, however, eliminated that penalty based on the finding that claimant's permanent disability award should be reduced to the 21 percent awarded in the Notice of Closure. Claimant seeks the reinstatement of the penalty award on review.

ORS 656.268(4)(g) provides for the assessment of a penalty "[i]f, 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 paid to the worker for either a scheduled or unscheduled permanent disability and if the worker is found upon reconsideration to be at least 20 percent permanently disabled." In SAIF v. Cline, 135 Or App 155 (1995), the court held that only a worker who receives a total sum of 64 degrees of permanent scheduled and/or unscheduled disability is considered to be "at least 20 percent permanently disabled" for purposes of former ORS 656.268(4)(g).

Although claimant in this case is at least 20 percent permanently disabled, we have determined that the Order on Reconsideration's increased award of 36 percent permanent partial disability should be reduced to 26 percent. Therefore, there is no longer an increase of 25 percent or more in the compensation paid pursuant to the Notice of Closure (21 percent), and no penalty is warranted under ORS 656.268(4)(g).[1]

Attorney Fee

Because our order results in increased compensation from that awarded by the ALJ's order, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation (5 percent unscheduled permanent disability) created by this order, not to exceed $3,800. ORS 656.386(2); OAR 438-015-0055(1). In the event that this increased permanent disability award has already been paid to claimant in connection with the Order on Reconsideration, claimant's attorney may 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).

ORDER

The ALJ's order dated January 11, 1996 is modified in part and affirmed in part. In addition to the ALJ's award of 21 percent unscheduled permanent disability, claimant is awarded 5 percent for a total unscheduled permanent disability award of 26 percent (83.20 degrees). Claimant's attorney is awarded an attorney fee equal to 25 percent of the increased compensation created by this order, not to exceed $3,800. In the event 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.

[1] 25 percent of 21 is 5.25. This order only increases claimant's unscheduled permanent disability award by 5 percent.

In the Matter of the Compensation of
LAURA L. BLUEFOX, Claimant
WCB Case No. 95-00263
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The self-insured employer requests review of Administrative Law Judge (ALJ) McKean's order that set aside its denial of claimant's occupational disease claim for a mental disorder. Claimant cross-requests review, asking the Board to correct the ALJ's attorney fee award. On review, the issues are compensability and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the following exception.

We change the references to "Mary Snedher" in the second paragraph on page 2 to "Mary Snedker."

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt the ALJ's conclusions on the compensability issue, with the following changes and supplementation.

On page 5, we delete the citation to Kathleen M. Payne, 42 Van Natta 1900 (1990).

The employer argues that claimant's version of the facts is confused and often exaggerated and cannot be relied upon except when independently corroborated. According to the employer, any expert opinion about the cause of claimant's mental disorder that relies on claimant's history is suspect. We disagree.

The ALJ commented that claimant was nervous, excited, emotional, disorganized, and at times unresponsive. Nevertheless, based on claimant's attitude and demeanor, the ALJ found her testimony to be credible. The ALJ further found that the substantive parts of claimant's testimony were corroborated by other witnesses and documentary evidence.

Although not statutorily required, the Board generally defers to the ALJ's determination of credibility. See Erck v. Brown Oldsmobile, 311 Or 519, 526 (1991). 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's analysis and conclusions. We agree that claimant is a credible witness and an accurate historian. Furthermore, we disagree with the employer's assertion that the medical opinions are unreliable because they are based on claimant's history.

Next, the employer argues that claimant did not prove that her work was the major contributing cause of her mental disorder. According to the employer, the opinions of Dr. Berman and Dr. Hughes are not persuasive because they were based on the assumption that a "precipitating cause" is necessarily a "major contributing cause." We disagree.

Dr. Hughes, psychiatrist, examined claimant on behalf of the employer. Dr. Hughes discussed claimant's mental history and identified preexisting personality characteristics. Dr. Hughes said that it was significant to note that claimant's job performance was seemingly acceptable or uncompromised through July 1994. (Ex. 5-4). Dr. Hughes commented that subsequent events reportedly contributed to claimant's physical and emotional deterioration. Dr. Hughes concluded:

> "In the absence of information or history material which would support previous disabling function, it is my belief that [claimant's] employment must be considered a major contributing factor in terms of the present clinical picture. While I do not have an internal report to review as would relate to the present clinical profile, it is reasonable to conclude that any individual exposed to similar threatening environmental work problems would become anxious, fearful, physically compromised, and depressed given similar circumstances." (Ex. 5-6).

Dr. Hughes later qualified his opinion to say that, if claimant's history was not accurate, it is "reasonable to conclude then that her subjective complaints relate to delusional function and/or paranoia, at least on a possible basis." (Ex. 5A). Inasmuch as we have concluded that claimant's history was accurate, we assign little probative weight to Dr. Hughes' subsequent qualified opinion.

The employer asserts that Dr. Berman's opinion "completely discounts" claimant's preexisting personality disorder and her prior stressors. The employer relies on Dr. Berman's comment that "[u]sing the classic 'egg shell' logic, [claimant's] pre-incident history and vulnerabilities simply do not matter." (Ex. 7).

When taken out of context, Dr. Berman's comments that claimant's pre-incident history does not matter indicate that he inappropriately discounted claimant's preexisting condition. However, we conclude that, when read as a whole, Dr. Berman's report establishes that he properly evaluated the relative contribution of the various causes of claimant's mental disorder.

As claimant's treating psychologist, Dr. Berman had the most extensive contact with claimant and was well aware of claimant's preexisting problems. Dr. Berman acknowledged that claimant had experienced "substantive prior major stressors," some of which could be characterized as traumatic. (Ex. 7). Dr. Berman commented that "the literature does recognize the cumulative impact of such events/burdens." (Id.)

Dr. Berman had reviewed Dr. Hughes' reports and found Dr. Hughes' symptom description to be accurate. Dr. Berman commented:

> "[Claimant] is likely anxious, depressed, vigilant and quite concerned. [Dr. Hughes] notes that she describes at least her depression and TMJ as beginning after her (purported) work stressors. He does not, however, cite any other life stressors, relationship concerns, financial crises, major losses, new illnesses, etc. In other words, it would appear that her symptom constellation dates and stems from the onset of her work concerns." (Id.)

Dr. Berman went on to state that his conclusion was confirmed by Dr. Hughes' "third finding," in which Dr. Hughes concluded that claimant's employment was a major contributing factor in her mental disorder. Dr. Hughes' "third finding" also included his comments that any individual exposed to similar work problems would become anxious, fearful, physically compromised, and depressed given similar circumstances.

Dr. Berman reported that, despite claimant's difficult history, "she was by all reports functioning well in the period preceding the events in question." (Id.) Dr. Berman explained:

> "[Claimant] managed well the stresses leading up to the work-caused relocation, seemed to settle into a new life in a new state and at some remove (sic) from her previous support system, and appears to have initially transitioned well into her new work environment. Given that she reports that she was stressed by work-related events, that no one has pointed to other proximal stressors that might have caused her distress, and that she was apparently asymptomatic prior to those events, then symptoms that she now presents are presumably the responsibility of her employer. Using the classic 'egg shell' logic, her pre-incident history and vulnerabilities simply do not matter. She functioned well, then was distressed by work-related events, and now does not function well." (Id.)

We conclude that, when read as a whole, Dr. Berman's report indicates that he properly evaluated the relative contribution of the causes of claimant's mental disorder. Dr. Berman clearly acknowledged claimant's preexisting condition and pointed out that no one had identified any other proximal stressors that might have caused her distress. Although Dr. Berman did not use "magic words," he concluded that claimant's mental disorder was caused by her work conditions.

We conclude that the reports of Drs. Berman and Hughes establish, by clear and convincing evidence, that claimant's employment conditions were the major contributing cause of her combined condition and pathological worsening of her disease. Therefore, we agree with the ALJ that claimant's mental disorder is compensable.

Attorney Fees

Finally, we modify the "order" portion of the ALJ's order to award claimant an attorney fee of $3,000, rather than $2,500.[1] In reaching this conclusion, we note that the ALJ attempted to correct this error in a corrected Opinion and Order. However, the ALJ no longer had jurisdiction over the case because a request for Board review had already been filed. 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 $3,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (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 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 November 13, 1995 is affirmed in part and modified in part. In lieu of the ALJ's $2,500 attorney fee award, claimant's attorney is awarded $3,000, to be paid by the self-insured employer. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the employer.

[1] Board Chair Hall does not advocate second-guessing an ALJ's attorney-fee award, absent compelling reasons to do so. See Paul R. Huddleston, 48 Van Natta 4 (1996) (Board Member Hall dissenting); Patricia L. Row, 46 Van Natta 1794 (1994) (Board Member Hall dissenting). Here, however, it appears that the ALJ was trying to make the same change in the attorney fee award, which appears to be a clerical error. Board Chair Hall agrees that, under these circumstances, it is appropriate to change the amount of the ALJ's attorney fee award.

May 28, 1996 Cite as 48 Van Natta 1070 (1996)

In the Matter of the Compensation of
SHARON HANNAH, Claimant
WCB Case No. 95-10373
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Christian and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Daughtry's order that set aside its denial of claimant's occupational disease claim for left carpal tunnel syndrome (CTS). On review, the issue is compensability.

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

Claimant, age 51, works stocking grocery store shelves for a snack food company. Wrist-intensive activities occupy about 85 percent of her work time. In June 1995, claimant began waking up with numbness in her left hand, involving the thumb, index and middle fingers. In July 1995, claimant sought treatment from Dr. Bassinger, who diagnosed left CTS.

In August 1995, claimant was examined by Dr. Radecki, who opined that her CTS was the result of idiopathic factors, namely, her age, increased wrist ratio and heredity. (Ex. 5).

In contrast, Dr. Bassinger, who acknowledged claimant's wrist squareness and hereditary as factors in the development of her CTS, opined that the major cause of claimant's condition arose from the repetitious flexion/extension and gripping required by her job. He further opined that the factors delineated by Dr. Radecki were only minor factors in the development of claimant's CTS. (Ex. 11).

When medical evidence is divided, we generally give greater weight to the conclusions of a claimant's treating physician, unless there are persuasive reasons not to do so. Weiland v. SAIF, 64 Or App 810 (1983). The ALJ relied on Dr. Bassinger's analysis of claimant's condition because he was her treating physician. Bassinger had examined claimant a number of times and had a better opportunity to evaluate her condition than Dr. Radecki, who examined claimant only once. As did the ALJ, we find Dr. Bassinger's opinion more persuasive than that of Dr. Radecki. Weiland v. SAIF, supra; Somers v. SAIF, 77 Or App 259 (1986). Consequently, claimant has carried her burden to prove that her work is the major contributing cause of her occupational disease claim for CTS. See ORS 656.802(1)(a)(C), (2)(a).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the 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 December 20, 1995 is affirmed. For services on review, claimant's attorney is awarded a $1,000 attorney fee, payable by the insurer.

May 28, 1996 Cite as 48 Van Natta 1071 (1996)

In the Matter of the Compensation of
DENNIS G. HANSEN, Claimant
WCB Case No. 94-08198
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Cobb & Woodworth, Defense Attorneys

Reviewed by Board Members Christian and Hall.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Poland's order that found claimant entitled to temporary disability benefits from December 3, 1992 through January 28, 1994. On review, the issue is temporary disability benefits.

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

Claimant compensably injured his low back in 1986 while working at the employer's plywood mill. His claim was closed with an award of 15 percent unscheduled permanent disability. In September 1992, claimant left his job with the employer to enter a training program as a laboratory technician under the Trade Readjustment Act (TRA), a federal retraining program. Claimant received a federal wage subsidy through the state unemployment benefit system and became a full-time student at Portland Community College. Claimant's low back condition worsened while he was retraining and, on December 3, 1992, claimant underwent disk surgery. He took time off from the program because of the surgery. The employer reopened claimant's injury claim, but paid no temporary disability benefits.

On review, the employer contends that claimant had withdrawn from the work force at the time of his disability because he had quit his job in order to enter the retraining program. We disagree.

A claimant is deemed to be in the work force if the claimant, although not employed at the time, is willing to work and is making reasonable efforts to obtain employment at the time of aggravation. Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser, 299 Or 290 (1985); Joyce E. Mitts, 42 Van Natta 333 (1990); Gilbert R. Brown, 43 Van Natta 585 (1991).

In this case, claimant's inability to work was due to his injury and ensuing surgery, and not due to his voluntary withdrawal from the work force. Although claimant was not employed at the time he became disabled, he was enrolled in a federal vocational retraining program and was planning to obtain a paying job in his new field as soon as his retraining was completed. Moreover, claimant received wage replacement benefits during the training program. Accordingly, we conclude that claimant was a member of the work force at the time of his hospitalization for surgery. Dawkins v. Pacific Motor Trucking, supra. Accordingly, claimant is entitled to temporary disability benefits beginning December 3, 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 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,500, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated November 22, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,500, to be paid by the self-insured employer.

May 28, 1996 Cite as 48 Van Natta 1072 (1996)

In the Matter of the Compensation of
WILLIAM M. HECK, Claimant
WCB Case No. 95-01844
ORDER ON REVIEW
Thomas A. Coleman, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Johnstone's order that: (1) found that claimant's claim was not prematurely closed; (2) declined to award temporary disability benefits; and (3) declined to assess penalties and attorney fees for the SAIF Corporation's allegedly unreasonable claim processing. On review, the issues are premature claim closure, entitlement to temporary disability benefits, penalties, and attorney fees.

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

Premature Closure

On review, claimant renews his contention that his claim was improperly closed because his alleged attending physician was not asked to respond to an insurer-arranged medical examiner Binder's November 9, 1994 report opining that claimant was medically stationary.[1] Nothing restricts

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[1] Claimant also asserts that ORS 656.245(4)(a), the statute that placed claimant under the provisions of a contract between SAIF and a managed care organization (MCO), violates his "equal protection" rights under Article I, section 20 of the Oregon Constitution. ORS 656.245 concerns medical treatment and is not relevant to the issue of premature closure. Thus, we need not address claimant's constitutional challenge on review.

Were we to address claimant's contention, however, we would find that the class of claimants who are required to be treated within an MCO is created wholly by statute. Groups created by virtue of a challenged statute are not considered to be classes for the purposes of Article I, section 20. Sealey v. Hicks, 309 Or 387, 397 (1990). Accordingly, we would reject claimant's "equal protection" argument.

consideration of opinions regarding medically stationary status to those opinions rendered by attending physicians. Charlotte A. O'Neal, 47 Van Natta 1994 (1995); see Patricia M. Knupp, 46 Van Natta 2406 (1994); Francisco Villagrana, 45 Van Natta 1504 (1993). As did the ALJ, we find that the persuasive medical evidence establishes that claimant was medically stationary on October 27, 1994.

Penalties and Attorney Fees

Finding that SAIF properly closed claimant's claim, the ALJ concluded that there was no basis for an award of penalties and fees. On review, claimant also contends that he is entitled to a penalty for unreasonable claims processing because he could not recall receiving notification from SAIF advising him that he was required to treat within an MCO for his compensable conditions.

Because we have affirmed the ALJ on the merits, there are no amounts due upon which to assess a penalty. See SAIF v. Condon, 119 Or App 194, rev den 317 Or 162 (1993) (no basis for ORS 656.382(1) penalty where all compensation due has been paid). Therefore, on this additional basis, we decline to award penalties and attorney fees for SAIF's processing of this claim.

ORDER

The ALJ's order dated November 9, 1995 is affirmed.

In the Matter of the Compensation of
TERRY HICKMAN, Claimant
WCB Case No. 95-08942
ORDER ON REVIEW
Schneider, et al, Claiman Attorneys
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order that upheld the SAIF Corporation's denial, on behalf of the Department of Administrative Services, Inmate Injury Fund, of his injury claim for neck strain and right rib contusions. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

On July 14, 1995, SAIF, on behalf of the Department of Administrative Services, Inmate Injury Fund, issued a denial of claimant's claim which stated, in material part:

> "[Y]our claim is not compensable under the provisions of ORS 655.505 to 655.550 for the following reason(s): The alleged injuries occurring as a result of inmate conduct, unrelated to work assignment, or in order to maintain premises security, is not compensable." (Ex. 9).

In opening statement at the hearing, SAIF's attorney stated, "The defense is that this injury arose as a result of violation of work rules. And also that there was some negligence on the part of the claimant here." (Tr. 8).

We also adopt the first sentence of the ALJ's findings of ultimate fact, but we do not adopt the second sentence of the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

On April 15, 1995, claimant sustained an injury to his neck and right ribs during the course of his employment at a correctional institution when his supervisor choked him and struck him in the ribs, thinking that claimant was assaulting him.

SAIF, on behalf of the Department of Administrative Services, Inmate Injury Fund, denied the claim on the basis that claimant's alleged injuries were unrelated to his work assignment, or were incurred in order to maintain premises security. (Ex. 9). More specifically, at hearing, SAIF asserted that claimant's injury arose as a result of his willful violation of a work rule that forbids disturbances. (Tr. 8; see also Opinion and Order at 3).

The ALJ determined that claimant was not involved in a disturbance. Therefore, the ALJ found that claimant did not violate a work rule, and that his injuries were not the result of a willful violation of work rules.

The ALJ then turned to the question of whether claimant had established a "compensable injury" as defined in ORS chapter 656. See former ORS 655.505(3).[1] After reviewing the medical evidence, the ALJ concluded that claimant had failed to meet his burden of proof because claimant failed to establish the existence of an injury by medical evidence supported by objective findings. ORS 656.005(7)(a). Accordingly, the ALJ upheld SAIF's denial.

On review, claimant contends that the ALJ erred in deciding an issue that was not raised by the parties. Specifically, claimant contends that the ALJ erred in requiring claimant to prove the existence of his injury by medical evidence supported by objective findings, when SAIF did not dispute the existence of the injury. We agree with claimant.

A carrier is bound by the express language of its denial. Tattoo v. Barrett Business Service, 118 Or App 348, 351-52 (1993); see also Larry R. Burnside, 47 Van Natta 2040 (1995). Here, the basis for SAIF's denial was that claimant's injuries occurred as a result of inmate conduct unrelated to his work assignment, or in the course of maintaining premises security. No issue regarding the existence of the injuries, or whether there was medical evidence supported by objective findings to establish the existence of the injuries, was expressly raised by the denial.

Nevertheless, parties to a workers' compensation proceeding may, by agreement, try an issue that is outside the express terms of the denial. See Weyerhaeuser Co. v. Bryant, 102 Or App 423, 435 (1990); Ronald A. Krasneski, 47 Van Natta 852 (1995); Judith M. Morley, 46 Van Natta 882, 883, on recon 46 Van Natta 938 (1994).

Here, in opening statement, SAIF's counsel specified that SAIF's defense to the claim was that the injury arose as a result of claimant's violation of work rules. (Tr. 8). The claim was litigated on that basis. (See generally Tr.12-71). SAIF did not raise, nor did the parties agree to litigate, an issue regarding whether there is medical evidence supported by objective findings to establish the existence of claimant's injuries. Accordingly, we find that the only basis on which the claim was litigated was that identified by SAIF in its opening statement at hearing. That is, the parties litigated the issue of whether claimant's injuries occurred as a result of his violation of work rules. We do not find that the parties agreed to litigate, either expressly or impliedly, the issue of whether there is medical evidence supported by objective findings to establish claimant's injuries.

Moreover, we find that to allow SAIF to raise a new defense after the close of the evidentiary hearing would prejudice claimant if the case were resolved on that basis. To decide the case on a different basis than was litigated at the hearing would be fundamentally unfair, and we decline to do so.

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[1] ORS 655.505 was amended by the 1995 legislature. Or Laws 1995, ch 384, § 18 (HB 2903, § 18). The amendments to chapter 655, pertaining to inmate injury claims, became effective June 30, 1996. However, the Act does not provide for retroactive application of the amendments. We have previously held that the amendments to ORS 655.525 applied only to injuries occurring on or after June 30, 1995. Freddy Vasquez, 47 Van Natta 2182, 2183 & n.4 (1995) (holding that the Board and Hearings Division had jurisdiction to decide an inmate injury claim where the injury occurred prior to June 30, 1995). Here, claimant was injured before June 30, 1995. The parties and the ALJ litigated and decided this case under the former law. No one contends that the 1995 amendments to ORS chapter 655 apply to this case. Accordingly, we apply the provisions of former ORS chapter 655.

See Sean W. Miller, 45 Van Natta 2337 (1993), citing Greg S. Meier, 45 Van Natta 922, on recon 45 Van Natta 1015 (1993) (Board declined to consider a carrier's challenge to a claim based on insufficiency of medical evidence when the carrier had only contested the claim on "not arising out of employment" grounds at the hearing); Linda R. Burrow, 44 Van Natta 71 (1992) (Where hearing was based on denial of causal relationship, Board declined to consider a new "course and scope" defense on review). See also Mavis v. SAIF, 45 Or App 1059 (1980).

The ALJ's scope of review is limited to the issues raised by the parties. Saedeh K. Bashi, 46 Van Natta 2253 (1994). Here, we find that the sole compensability issue was whether claimant's injuries occurred as a result of his violation of work rules. The issue of the sufficiency of medical evidence, supported by objective findings, to establish the existence of claimant's injuries was not raised either in SAIF's denial or at hearing, nor did the parties agree to litigate that issue.[2] Accordingly, we hold that a "lack of objective findings" issue was not raised or litigated at the hearing.

Inasmuch as we have determined that SAIF did not raise the issue of causation, or the sufficiency of the medical evidence to establish the existence of an injury supported by objective findings, the sole issue is whether claimant's injuries occurred as a result of a willful violation of work rules. See Larry R. Burnside, supra. On this question, we adopt and affirm the ALJ's order finding that claimant did not violate a work rule, and that his injuries were not the result of a willful violation of work rules. Thus, we conclude that claimant established the compensability of his neck and rib injuries.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,000, 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 November 27, 1995 is reversed. The SAIF Corporation's July 14, 1995 denial, on behalf of the Department of Administrative Services, Inmate Injury Fund, is set aside, and the claim is remanded to SAIF for processing in accordance with law. Claimant's attorney is awarded $3,000 for services at hearing and on Board review, to be paid by SAIF.

[2] Because we do not have a transcript of the closing argument at hearing, we are unable to determine whether the issue was raised in closing argument. However, even if the issue was raised in closing argument, we would still decline to address it. We have consistently held that we will not consider an issue raised for the first time during closing argument. Lawrence E. Millsap, 47 Van Natta 2112 (1995); Larry L. Schutte, 45 Van Natta 2085 (1993). We decline to do so here.

May 28, 1996 Cite as 48 Van Natta 1075 (1996)

In the Matter of the Compensation of
SCOTT J. MALONEY, Claimant
WCB Case Nos. 95-09774 & 95-02568
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's right carpal tunnel syndrome (CTS) condition; (2) affirmed an Order on Reconsideration that found a claim for right wrist strain was prematurely closed; (3) found claimant entitled to additional temporary disability; and (4) assessed a penalty for the insurer's allegedly unreasonable claims processing. On review, the issues are compensability, premature claim closure, temporary disability, and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant has an accepted claim for a right wrist strain resulting from a November 21, 1994 work injury. Claimant subsequently was diagnosed with right CTS. Relying on the opinion of the treating orthopedic surgeon, Dr. Matteri, the ALJ concluded that claimant proved the condition compensable. We agree with the ALJ that Dr. Matteri provided the most persuasive opinion.

On November 23, 1994, claimant was examined by Dr. Abraham, M.D., at a hospital emergency room. (Ex. 2). Claimant did not seek treatment again until he saw Dr. Matteri on March 7, 1995, for numbness and tingling in his right wrist. (Ex. 5). After a nerve conduction study, Dr. Matteri diagnosed right CTS. (Ex. 6).

In May 1995, claimant was evaluated by examining hand surgeon, Dr. Jewell. Although acknowledging that injuries could cause CTS, Dr. Jewell found that the November 1994 minor wrist strain was not sufficiently significant to either cause an acute CTS or worsen a preexisting CTS. (Ex. 12). Dr. Jewell further explained that, if claimant experienced an acute CTS from the November 1994 incident, he would expect more significant abnormalities in view of the length of time claimant alleged he had been symptomatic. (Id.) Dr. Abraham concurred with Dr. Jewell's report. (Ex. 11).

Dr. Matteri found that, "based on the fact that [claimant] was nonsymptomatic before that injury * * * his carpal tunnel symptoms are the direct result of the injury." (Ex. 10). During a deposition, Dr. Matteri explained that CTS "frequently follows traumatic occurrences" and that he had based his opinion on the history that claimant had been asymptomatic before the injury, then experienced progressively worsening symptoms following the injury. (Ex. 13-10). Dr. Matteri also noted that claimant's CTS symptoms were consistent with the injury since he was not experiencing any symptoms in the left wrist. (Id. at 18).

Absent persuasive reasons to the contrary, we defer to the treating physician's opinion. Weiland v. SAIF, 64 Or App 810 (1983). We rely on Dr. Matteri's opinion. Dr. Matteri provided a well-reasoned opinion based on an accurate history. Although Dr. Jewell's opinion also was well-reasoned, it cannot overcome that of Dr. Matteri as the treating physician. Based on Dr. Matteri's opinion, claimant proved the compensability of his right CTS. ORS 656.005(7)(a)(A).

Premature Claim Closure

We adopt and affirm the ALJ's order concerning this issue.

Temporary Disability

The ALJ awarded temporary disability for the period of August 7, 1995 (the date of the Order on Reconsideration which set aside a July 13, 1995 Notice of Closure) through the date of hearing. The insurer objects to this conclusion, arguing that claimant is not entitled to such benefits because no physician authorized time loss for that period of time.

Temporary disability is not due and payable "for any period of time not authorized by the attending physician." ORS 656.262(4)(f). Here, we find that Dr. Matteri did authorize temporary disability benefits when he stated in a "pre-closure" March 7, 1995 chartnote that claimant "is limited in what he can do at this time" and was "not able to use his right hand or wrist for repetitive movement or lifting." (Ex. 5-2). Dr. Matteri did not provide a work status report to the employer because claimant was not employed at that time. (Id.) A couple of months later, Dr. Matteri reviewed, and did not disagree with, examining physician Dr. Jewell's report that claimant was capable of gainful employment. (Exs. 10, 11-5). Dr. Jewell's report also indicated that claim closure was appropriate. (Ex. 11-5).

We interpret such evidence as indicating that claimant was temporarily disabled. Thus, we conclude that Dr. Matteri authorized time loss temporary disability benefits for the period of time indicated by the ALJ. See ORS 656.262(4)(f).

Penalties

We adopt and affirm 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 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability, premature closure, and temporary disability issues is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review regarding the penalty issue. Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated October 25, 1995 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, payable by the insurer.

May 28, 1996 Cite as 48 Van Natta 1077 (1996)

In the Matter of the Compensation of
RITA J. WIMMER, Claimant
WCB Case No. 95-10131
ORDER ON RECONSIDERATION
Richard A. Sly, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

On May 10, 1996, we abated our April 10, 1996 order that increased claimant's unscheduled permanent disability award from 8 percent (25.6 degrees), as awarded by Order on Reconsideration (OOR), to 12 percent (38.4 degrees). We took this action to consider the self-insured employer's motion for reconsideration. Having received claimant's response, we proceed with our reconsideration.

On reconsideration, the employer contends that we should not have addressed the issue of adaptability, as claimant did not raise the issue until her reply brief. We disagree.

First, the OOR made findings with respect to claimant's base functional capacity (BFC) and her residual functional capacity (RFC). The OOR found that, because claimant's RFC was greater than the BFC, the "values for age, education and adaptability" were given a neutral value of zero, pursuant to the Department's rule. Under the circumstances, we conclude that claimant's adaptability was at issue on reconsideration.

Additionally, as explained in our prior order, where claimant raised the issue of extent of permanent disability at hearing, we are unable to find that claimant's position at hearing precludes her from raising the adaptability value argument on review. See Elmer F. Knauss, 47 Van Natta 826 (1995).

Finally, the employer argues that claimant was required to raise the adaptability issue in her opening brief. The employer also argues that claimant should have relied on the court's decision in Carroll v. Cascade Corporation, 138 Or App 610 (1996), in her opening brief, as the court had issued its decision prior to claimant's filing of her brief.

Again, we conclude that, because claimant raised the issue of extent of permanent disability at the time of hearing, she had not waived the issue of an adaptability factor by focusing on the impairment issue. Knauss, supra. Furthermore, because we are required to apply the standards on review, ORS 656.295(5), and the Carroll case provided for a value for adaptability (whereas the Director's rule had previously provided no basis for such an award), our award of a value for adaptability is consistent with the directive set forth in the statute.

Claimant's attorney is entitled to an attorney fee for services on reconsideration. 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 reconsideration is $150, to be paid by the employer.

On reconsideration, as supplemented herein, we adhere to and republish our April 10, 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
SPENCER L. YOUNCE, Claimant
WCB Case No. 95-01509
ORDER ON REVIEW
Roger D. Wallingford, Claimant Attorney
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

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

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

We agree with the ALJ that Dr. Schmidt's opinion regarding causation should be discounted. However, we reach this conclusion based on the following reasoning.

Claimant had cervical degeneration which preexisted the September 7, 1994 work incident. (Exs. 4, 6, 8, 9, 11, 14, 16). Because the preexisting condition contributes to his current cervical problems, claimant is subject to the major contributing cause standard under ORS 656.005(7)(a)(B). (See id).

Accordingly, in order to carry his burden, claimant must establish that the work incident contributed more to his current disability and need for treatment than all other factors combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 298, 309-310 (1983). In evaluating the medical evidence concerning causation, we consider all potential contributors to claimant's current condition, not just the precipitating cause. See Dietz v. Ramuda, 130 Or App 397 (1994).

Here, although Dr. Schmidt opined that claimant's need for cervical surgery is related to the September 7, 1994 work incident (because claimant was previously asymptomatic), he did not evaluate the effect of the preexisting degeneration upon claimant's combined condition. On the other hand, Dr. Brett, treating surgeon, did consider and personally observe, claimant's cervical condition. Accordingly, based on Dr. Brett's opinion that claimant's preexisting degeneration was the "major contributing factor," we agree with the ALJ that claimant has not carried his burden. See Argonaut Insurance Co. v. Mageske, 93 Or App 698 (1988).

ORDER

The ALJ's order dated November 7, 1995 is affirmed.

In the Matter of the Compensation of
THOMAS H. KONSCHUH, Claimant
WCB Case No. 94-14779
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that found that claimant was a subject worker. On review, the issue is subjectivity. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following exceptions and corrections.

Generally, if a customer had a problem or complaint with the installation of the carpet, Great Floors & More (Great Floors) would refer the customer to the installer to have the problem corrected. If the customer could not reach the installer, then Great Floors would call the installer to try to get it repaired. Occasionally, if Great Floors had to have a different installer repair or replace the carpet, then Great Floors would pay the installer. If there was a defect in the carpet or other product defect, then Great Floors was responsible for replacing the carpet.

We also do not adopt the ALJ's findings that claimant notified the store manager the next day after his alleged injury.

CONCLUSIONS OF LAW AND OPINION

Great Floors is in the business of selling floor coverings. As a service to the customer, it schedules an installer to install the floor covering. Great Floors displays a price list for installation (the price is based on the market rate) and keeps six or seven calendars for installers. (Tr. 38, 41). Claimant was on the calendar for installers who did not request work every day. Scheduling is based on customer needs and installer availability. Great Floors refers approximately 60 percent of its customers to installers. The remainder of the customers do not use its referral service. (Tr. 57). Great Floors receives no income from these referrals. (Tr. 42).

The ALJ found that, pursuant to the "right to control" test, claimant was a worker under amended ORS 656.005(30). In reaching this conclusion, the ALJ found that Great Floors had hired claimant to install floor coverings, that Great Floors was essentially claimant's only employer, that Great Floors had control over the what, when and cost of each job, and that Great Floors fixed any problems that resulted from claimant's work. We disagree with the ALJ's findings and reverse.

When deciding whether a person comes under the workers' compensation law, the first inquiry is whether the person is a "worker" under ORS 656.005(30) and the judicially created "right to control" test and, if so, whether the worker is "nonsubject" under one of the exceptions in ORS 656.027. S-W Floor Cover Shop v. Natl. Council on Comp. Ins., 318 Or 614, 630- 31 (1994). If the relationship between the parties cannot be established by the "right to control" test, it is permissible to apply the "nature of the work" test. Id. at 622 n 6.

The factors to be considered under the "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). None of those factors is dispositive; rather, they are to be viewed in their totality. Cy Investment, Inc. v. Natl. Council on Comp. Ins., 128 Or App 579, 583 (1994).

The Right to, or the Exercise of, Control

Under this factor, the pertinent consideration is the employer's control over the method of performance, as opposed to control over the result to be reached. Cy Investment, Inc. v. Natl. Council on Comp. Ins., supra. Citing Larson, the court in Reforestation General v. Natl. Council on Comp. Ins., 127 Or App 153 167-68 (1994) explained:

> "An owner, who wants to get work done without becoming an employer, is entitled to as much control of the details of the work as is necessary to ensure that he gets the end result from the contractor that he bargained for."

Here, as part of its referral service, the end result that Great Floors expected was to have carpet installed for the customer. To help ensure this result, Great Floors provided a cost estimate to the customer and scheduled when claimant worked. See Reforestation General v. Natl. Council on Comp. Ins., supra (no right to control where control did not extend beyond the details of the desired result).

In addition, Great Floors had no control over how long claimant took on a job. Claimant could refuse to accept a job for any reason. Claimant could also indicate the days he was unavailable for work. (Tr. 48). Claimant's flexibility in setting his schedule is not indicative of employee status. Alan E. Nix, 47 Van Natta 2082, 2083 (1995) (under "the right to, or exercise of, control" factor, the claimant's ability to set his own schedule did not indicate he was an employee).

Further, Great Floors did not control how claimant installed floor coverings nor had it ever supervised claimant's work at a job site. Rather, claimant exercised control over the manner and means of installing floor coverings. If a customer was dissatisfied with the installation, claimant was responsible for correcting the problem.[1] See Collins v. Anderson, 40 Or App 765, 769 (1979) (an independent contractor is ordinarily responsible for any defects in workmanship).

Finally, although claimant primarily performed work for Great Floors and had done installation work for Great Floors for four or five years, Great Floors did not prevent claimant from working for other entities. The fact that claimant did install carpet for other people indicates that he was not an employee. Alan E. Nix, supra (horse rider who exercised horses for people other than alleged employer was a factor in finding the claimant not an employee).

Under the circumstances, we are not persuaded that Great Floors controlled the means and methods of claimant's performance.

Method of Payment and the Furnishing of Equipment

The second and third factors, "the method of payment" and "the furnishing of equipment" indicate independent contractor status. Great Floors provided the customer an estimate of the cost to install the floor covering based upon the amount to be installed. However, claimant could negotiate a different price with the customer if additional labor was required. (For example, for moving heavy furniture, repairing the floor, etc.) Claimant could also refuse the job if the price was not acceptable. Claimant was paid by the customer and not by Great Floors.

Claimant provided his own tools,[2] installation materials, and transportation, including a van. Claimant did not receive reimbursement for transportation.

The Right to Fire

In Henn v. SAIF, 60 Or App 587, 593 (1983), the court stated that "[a]n unqualified right to fire, indicative of an employer-employe relationship, must be distinguished from the right to terminate the contract of an independent contractor for bona fide reasons of dissatisfaction. The exercise of such a right is still consistent with the idea that a satisfactory end result is all that is aimed for by the contract." Id. at 593.

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[1] When Great Floors became increasingly dissatisfied with claimant's work, rather than having claimant do his own repairs, it paid for different installers to replace carpet claimant had not installed properly. Great Floors' ability to replace claimant because of unsatisfactory work is consistent with principles of the right to control the quality of work and the right to fire for bona fide reasons of dissatisfaction. See Reforestation General v. Natl. Council on Comp. Ins., supra (a hiring party's control over the quality of work does not automatically convert the independent contractor relationship into an employment relationship) and Henn v. SAIF, infra.

[2] Mr. Gilbert, the owner of Great Floors, testified that when claimant was terminated as a salesman, he paid claimant $500 "to go become an independent carpet installer." (Tr. 36). Claimant bought many of his tools with the money. (Tr. 30-31). Great Floors otherwise provided no tools to claimant. Because the $500 payment could be construed either as severance pay or as part of furnishing of equipment, we do not find that this fact alone renders the furnishing of equipment factor inconclusive. Moreover, the totality of the right to control factors weigh in favor of independent contractor status.

Here, Great Floors had no right to fire claimant before completion of a particular job. However, Great Floors' ability to stop sending referrals to claimant at any time approaches the right to fire. See Cy Investment, Inc. v. Natl. Council on Comp. Ins., supra. Yet, Great Floors did not stop referring business to claimant until it became dissatisfied with claimant's work. Great Floors could not monetarily reprimand claimant for unsatisfactory work. Compare Salem Decorating v. Natl. Council on Comp. Ins., 116 Or App 166, 172 (1992) (employer's ability to withhold installer's pay until unsatisfactory installation remedied indicated an unqualified right to fire). Furthermore, no evidence was offered on whether Great Floors could discharge claimant for other than unsatisfactory work. Such is insufficient to show that Great Floors retained an absolute right to fire claimant.

Based on the above factors, we conclude that the right to control test conclusively establishes that claimant is not a worker subject to workers' compensation coverage. Therefore, we need not apply the "nature of the work" test.

ORDER

The ALJ's order dated September 15, 1995 is reversed. The insurer's October 28, 1994 denial is reinstated and upheld. The ALJ's assessed attorney fee of $3,000 is also reversed.

May 29, 1996 Cite as 48 Van Natta 1081 (1996)

In the Matter of the Compensation of
FARADZH SAADIYAYEV, Claimant
WCB Case No. 95-08257
ORDER ON REVIEW
Hollander, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Hall and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Martha Brown's order which set aside its termination of claimant's temporary total disability (TTD) benefits. Claimant cross-requests review, seeking penalties and/or attorney fees for the insurer's allegedly unreasonable conduct. On review, the issues are temporary disability, 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

Unilateral Termination of Temporary Disability

We adopt and affirm the ALJ's conclusions concerning the insurer's unilateral termination of TTD benefits.

Penalties and Attorney Fees

At hearing, claimant did not request a penalty and attorney fee for the insurer's allegedly unreasonable termination of temporary disability benefits. However, claimant had raised the penalty and attorney fees issues in his motion for a show cause order. Accordingly, those issues were properly raised and should have been considered by the ALJ. See Liberty Northwest v. Alonzo, 105 Or App 458 (1991); Connie G. Johnson, 47 Van Natta 1984, 1987 (1995).

The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the employer had a legitimate doubt as to its liability. International Paper Co. v. Huntley, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available. Brown v. Argonaut Insurance Company, 93 Or App 588 (1988).

The insurer contends that its bona fide job offer and claimant's failure to respond to the offer gave the insurer legitimate doubt as to its liability. The insurer essentially argues that it had substantially complied with the procedural requirements of former OAR 436-60-030(5). However, substantial compliance with the administrative rule is insufficient to authorize a carrier to terminate TTD benefits. Fairlawn Care Center v. Douglas, 108 Or App 698 (1991); Safeway Stores, Inc. v. Little, 107 Or App 316 (1991); Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986).

Here, on April 7, 1995, the employer sent claimant a written job offer for modified work to start on April 3, 1995. At that time, it was unaware of the typographical error in the letter regarding the job's starting date. The employer learned of its error after it had terminated claimant's temporary disability pursuant to ORS 656.268(3) and after claimant was fired for reasons unrelated to the claim.

Thus, although the employer believed that it had complied with the procedural requirements of ORS 656.268(3), the employer cannot profit by its own error and failure to strictly comply with statutory and administrative obligations. See Deanna L. Klock, 47 Van Natta 2229, 2231 (1995) (carrier's conduct unreasonable where no evidence that the strict administrative requirements for unilateral termination of temporary disability benefits had been met); see also Nix v. SAIF, 80 Or App 656, 660 (1986) (unreasonable conduct by employer is legally attributable to its insurer).

Accordingly, we conclude that the insurer's conduct was unreasonable and that a 25 percent penalty shall be assessed based upon the amounts then due as of the date of the hearing as a result of the ALJ's order. Claimant's attorney shall receive one-half of this penalty in lieu of an attorney fee. Amended ORS 656.262(11)(a). Inasmuch as there is compensation on which to base a penalty, and because the unreasonable resistance is the same conduct for which a penalty is assessed under ORS 656.262(11), claimant is not entitled to a separate attorney fee under ORS 656.382(1). 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).

Claimant's attorney is also entitled to an assessed fee for services on review concerning 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 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.

ORDER

The ALJ's order dated August 29, 1995 is affirmed in part and reversed in part. That portion of the ALJ's order that failed to assess a penalty is reversed. A penalty is assessed equal to 25 percent of the temporary disability benefits due and owing as of the August 16, 1995 hearing, as a result of the ALJ's order, to be equally divided between claimant and his attorney. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded a $900 attorney fee, payable by the insurer.

May 29, 1996 Cite as 48 Van Natta 1082 (1996)

In the Matter of the Compensation of
MARILYNN A. WHEELER, Claimant
WCB Case No. 94-10789
ORDER ON REVIEW
Craine & Love, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order which dismissed her aggravation claim for a bilateral wrist and forearm condition. On review, the issue is dismissal and, if dismissal was not proper, aggravation. We reverse the ALJ's dismissal order and uphold the insurer's denial.

FINDINGS OF FACT

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

The insurer accepted claimant's September 1989 injury claim for bilateral wrist tendinitis. (See Ex. 29).

Claimant did not have elbow symptoms associated with her 1989 claim. (Tr. 10). Claimant's elbow symptoms developed gradually during her employment in North Dakota. (Tr. 14-15).

CONCLUSIONS OF LAW AND OPINION

Claimant, a reporter, writer and editor for the employer, a news agency, has an accepted bilateral wrist tendonitis claim from 1989 in Oregon. In 1990, she was transferred to North Dakota. Her wrist and forearm symptoms became worse, and in 1994 claimant sought treatment in North Dakota for bilateral wrist and forearm conditions. Her condition was diagnosed as bilateral fibrositis and lateral epicondylitis. (Exs. 23-1, -2; 27).

On August 15, 1994, the insurer denied compensability of claimant's Oregon aggravation claim. (Ex. 29). Claimant filed a workers' compensation claim in North Dakota. On April 6, 1995, the North Dakota claim was dismissed on the ground that it was untimely filed. (Ex. 33). Claimant appealed that decision. (Ex. 34). The North Dakota claim is currently being held in abeyance pending a decision on the Oregon claim. (Ex. 34).

The ALJ dismissed claimant's aggravation claim without prejudice, reasoning that since there was no final determination of the North Dakota claim yet, under Miville v. SAIF, 76 Or App 603 (1985), claimant's Oregon aggravation claim was presently barred. We disagree.

In Miville, the claimant sustained a compensable back injury in Oregon. Subsequently, he sustained back injuries while working out-of-state. Thereafter, he returned to Oregon and sought compensation for his back condition as an aggravation of his original Oregon injury. The Oregon carrier denied the aggravation claim. We upheld the denial on the ground that the out-of-state injuries had contributed independently to the present worsened condition, thereby relieving the Oregon carrier of liability.

The Court of Appeals disagreed. The court reasoned that the policy decision adopted in Grable v. Weyerhaeuser Co., 291 Or 387 (1982), should apply in the circumstances presented in Miville, where a worker with a compensable injury suffers a subsequent on-the-job, but out-of-state injury to the same body part. The Miville court defined the policy adopted in Grable thus: "[A] worker who suffers what would ordinarily be a noncompensable off-the-job injury should not go uncompensated if an earlier compensable on-the-job injury remains a material contributing cause of the disability." Miville, supra, 76 Or App at 606. Where a compensable injury is followed by an out-of-state, work-related injury, the Miville court concluded that the Grable rationale should apply, provided that the claimant has claimed, but not been awarded, workers' compensation benefits in the other state. 76 Or App at 607. Accordingly, the Miville rule can be stated thus: When subsequent out-of-state employment independently contributes to a condition for which workers' compensation benefits are sought in Oregon, the original Oregon employer remains responsible if the initial Oregon injury continues to materially contribute to that condition, provided that the worker has filed a claim for benefits in the foreign jurisdiction where the second injury occurred, and the claim has been rejected. See Olson v. EBI Co., 78 Or App 261 (1986); Don L. Siler, 43 Van Natta 254, 255 (1991).

Subsequently, the rule in Miville has been articulated as both a substantive rule setting forth the standard under which an Oregon aggravation claim will be found compensable following an intervening, out-of-state injury, as well as a procedural rule requiring a claimant to first file and obtain a final determination of his claim in the foreign jurisdiction. See SAIF v. Scott, 111 Or App 99, 104 (1992) (stating that Miville requires a worker with an accepted Oregon claim who suffers a worsening while working out-of-state to file a claim concerning the worsened condition in the other state); Progress Quarries v. Vaandering, 80 Or App 160, 165 (1986) (Miville provides that a worker can recover in Oregon if he has filed a claim in the other state and has been denied recovery); Don L. Siler, supra; Duane C. Leafdahl, 43 Van Natta 1 (1991); Charles P. Boddy, 42 Van Natta 2481, 2482 (1990).

As a condition precedent to application of the Miville rule, the claimant must prove that the condition for which benefits are sought in Oregon is compensably related to an accepted Oregon injury.[1] See Olson v. EBI Co., supra, 78 Or App at 264; Don L. Siler, supra. Absent such proof, there is no entitlement to compensation in Oregon, and it is unnecessary to delay a determination of the Oregon claim pending the final determination of the out-of-state claim. In other words, consideration of whether an out-of-state claim has been filed and finally determined only becomes relevant if the evidence establishes that the disputed condition is compensably related to an accepted Oregon claim.

Hence, in this case, we must first determine whether claimant's condition is compensably related to the accepted 1989 claim with the insurer. Therefore, we reinstate claimant's hearing request and proceed to the merits of claimant's aggravation claim.

The 1995 legislature amended the aggravation statute, ORS 656.273(1). Or Laws 1995, ch 332 § 31 (SB 369, § 31). The first portion of the statute now provides:

> "After the last award or arrangement of compensation, an injured worker is entitled to additional compensation for worsened conditions resulting from the original injury. A worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings." (Emphasis supplied to identify new language).

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).

We held in Gloria T. Olson, supra, that the unambiguous language of amended ORS 656.273(1) modified the court's holding in Jocelyn, supra, by specifically defining the elements of proof which establish a "worsened condition resulting from the original injury." We held that amended ORS 656.273(1) requires proof of two distinct elements in order to establish a "worsened condition resulting from the original injury": (1) "actual worsening;" and (2) a compensable condition.

In Olson, the claimant had an accepted right shoulder strain, but her worsened condition was a right rotator cuff tear, which was not accepted. We held that since the claimant's worsened condition was not a compensable condition, she had to first establish that the right rotator cuff tear was a compensable condition under ORS 656.005(7)(a). In Olson, we found that the claimant's original, compensable injury had combined with a preexisting condition resulting in the current, "combined" condition of a right rotator cuff tear. Therefore, we held that the claimant had to establish the compensability of her worsened condition under ORS 656.005(7)(a)(B). In holding that ORS 656.005(7)(a)(B) applies to aggravation claims, we noted that, unlike the statute addressed in Jocelyn, supra, which did not refer to the term "compensable injury" or otherwise reference ORS 656.005(7)(a)(B), amended ORS 656.273(1) specifically refers to "compensable condition" in the aggravation statute. Thus, since the claimant's compensable shoulder 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. We begin with a determination of whether claimant's worsened condition is a compensable condition. Claimant's accepted condition is bilateral wrist tendinitis. (See Exs. 5, 29). The worsened condition has been diagnosed as bilateral fibrositis and lateral epicondylitis. (Exs. 23, 27). Neither of the latter conditions has been accepted. Specifically, we note that claimant had no elbow symptoms associated with her accepted 1989 Oregon claim. (Tr. 10). Rather, her elbow symptoms developed in 1993-94 while she was working in North Dakota. Claimant's elbow symptoms were the primary focus of the treatment she received in North Dakota in 1994 and 1995. Accordingly, we hold that claimant must first establish the compensability of her fibrositis and lateral epicondylitis conditions under ORS 656.005(7)(a).

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[1] Under the law in effect at the time of the Miville decision, a compensable relationship was established by proof that the condition was materially related to the Oregon injury. Under current law, the standard of proof for establishing compensability may be either material contributing cause or major contributing cause, depending on the facts of the particular case. See ORS 656.005(7)(a).

Our next task is to determine which provisions of the workers' compensation law, specifically ORS 656.005(7)(a), are applicable. Hewlett-Packard Co. v. Renalds, 132 Or App 288, 292 (1995) (quoting Dibrito v. SAIF, 319 Or 244, 248 (1994); see also Michelle K. Dibrito, 47 Van Natta 970 (1995). It is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim.

Claimant's fibrositis and lateral epicondylitis conditions developed some three years after her bilateral wrist tendinitis claim was closed in 1990. The medical evidence indicates that claimant's wrist and elbow conditions in 1994 were related to her accepted Oregon condition. (Exs. 26, 28-9, 30). Dr. Opgrande, claimant's treating physician in North Dakota, indicated that her 1994 conditions were an aggravation or reinjury of her previous condition. (Exs. 26, 28-9; see also Ex. 25-3). He also opined that claimant's current condition had been made worse by her ongoing work activities. (Ex. 30). There is no evidence that the 1994 conditions were directly caused by claimant's 1989 injury. Neither is there evidence that a preexisting condition is involved.

Under such circumstances, we conclude that the compensability of claimant's fibrositis and lateral epicondylitis conditions is most appropriately analyzed as a consequential condition under ORS 656.005(7)(a)(A).[2] See Albany General Hospital v. Gasperino, 113 Or App 411 (1992) (distinguishing between a compensable injury, which is directly caused by an industrial accident, and a consequential condition, which is caused in turn by the compensable injury). Accordingly, in order to establish the compensability of her bilateral fibrositis and lateral epicondylitis conditions, claimant must prove that her compensable 1989 work injury is the major contributing cause of those conditions. ORS 656.005(7)(a)(A).

Because claimant's conditions developed some three years after closure of her original claim, and because subsequent work activities apparently contributed to the development of those conditions, we find that the causation issue is medically complex. Therefore, we require expert medical opinion to resolve the causation issue. Barnett v. SAIF, 122 Or App 279, 282 (1993); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985).

Here, as we discussed above, the only medical opinions in the record concerning the cause of claimant's fibrositis and lateral epicondylitis conditions indicate that the conditions are "related" to claimant's 1990 wrist condition. (Exs. 26, 28-9, 30). Dr. Opgrande opined that claimant's 1994 conditions were an aggravation or reinjury of her previous condition. (Exs. 26, 28-9; see also Ex. 25-3). Dr. Opgrande further indicated that claimant's current condition had been made worse by her ongoing work activities. (Ex. 30).

However, there is no medical opinion that establishes that the compensable 1989 injury is the major contributing cause of the current condition. We acknowledge that "magic words" are not required to establish major contributing cause and the compensability of a claim. McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986). Nevertheless, considering claimant's potential exposure in North Dakota and the length of time that has transpired since closure of her Oregon claim, we find that a more complete and direct medical opinion than provided here is required to meet the statutory standard. Therefore, since claimant failed to establish that her 1989 injury was the major contributing cause of her fibrositis and lateral epicondylitis conditions, we conclude that claimant has failed to establish the compensability of those conditions. ORS 656.005(7)(a)(A).

Since we have found that claimant's worsened condition is not a "compensable condition" under ORS 656.273(1), we need not proceed further in our aggravation analysis. Furthermore, we need not address the question of whether claimant's subsequent employment exposure in North Dakota amounted to "an injury not occurring within the course and scope of employment," within the meaning of ORS 656.273(1).[3] See John I. Jett, 46 Van Natta 33 (1994). Accordingly, we conclude that claimant has failed to establish the compensability of her aggravation claim.

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[2] ORS 656.005(7)(a)(A) provides that "[n]o injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

[3] The above-quoted language is from ORS 656.273(1), which provides, in pertinent part: "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."

ORDER

The ALJ's order dated July 10, 1995, as amended July 20, 1995 is reversed. Claimant's hearing request is reinstated. The insurer's August 15, 1994 denial is upheld.

Board Chair Hall concurring in part and dissenting in part.

I concur with the majority's methodology in analyzing the aggravation claim under amended ORS 656.273(1). However, because I disagree with the result reached by the majority, I respectfully dissent from the majority's conclusion.

I agree that claimant must establish the compensability of her aggravation claim under amended ORS 656.273(1). In order to do so, I agree that claimant must first establish that her current, worsened condition is a compensable condition. Gloria T. Olson, 47 Van Natta 2348 (1995). Thus, I agree that it is claimant's burden to establish, first, that her compensable 1989 injury is the major contributing cause of her current, worsened condition. ORS 656.005(7)(a)(A). However, I disagree with the majority's approach in evaluating the medical evidence.

The majority concluded that, since there was no expert medical opinion stating that the 1989 injury was the "major contributing cause" of claimant's current condition, claimant failed to prove the compensability of her current condition. The majority acknowledges the court's admonition that "magic words" are not required to establish medical causation. McClendon v. Nabisco Brands, Inc., supra, 77 Or App at 417. Yet that is precisely what the majority requires of claimant to prove her claim. Because it did not find the magic words "major contributing cause" in the medical record, the majority concluded that claimant failed to carry her burden of proof. I believe the majority erred.

In McClendon, the court described the proper approach in evaluating medical causation opinions. Instead of looking for "magic words," the court considered the medical expert's language and whether it "sufficiently strongly suggest[ed]" that claimant's work activity was the major cause of her disability. It then juxtaposed the medical opinion with other evidence in the record bearing on whether work activities were the major cause of claimant's disability. Thus, the court considered the meaning of the medical expert's language, not merely the presence or absence of "magic words." The court then considered the medical opinion in the context of the entire record in deciding whether the claimant had satisfied her burden of proof. Id.

After evaluating the medical opinions consistent with the court's directive in McClendon, I conclude that claimant carried her burden of proving that the 1989 injury was the major contributing cause of her worsened condition. Dr. Opgrande, claimant's treating physician in North Dakota, opined that her current condition was related to her compensable 1989 injury. Although he noted that claimant's condition had been worsened by her ongoing work activities, he described claimant's current condition as an aggravation or reinjury of her previous condition. Dr. Dean, who saw claimant in consultation on referral from Dr. Opgrande, also believed that claimant's current condition was an exacerbation of her compensable 1989 injury. (Ex. 25-3). There are no contrary medical opinions. There is no medical evidence that attributes claimant's current condition to any cause other than her compensable 1989 injury. Thus, I would conclude that the medical evidence sufficiently strongly suggests that the compensable 1989 work injury was the major contributing cause of claimant's current condition.

Moreover, considering the medical evidence in the context of the entire record, I note that claimant's testimony is consistent with the medical opinions attributing the cause of her current condition to the compensable 1989 Oregon claim. Claimant testified that the symptoms from her Oregon condition never completely resolved. (Tr. 7, 21). She testified that the flare-up of symptoms she experienced while working in North Dakota was the "same thing" she experienced in Oregon, only worse. (Tr. 12, 30). In fact, when she discussed her situation with the North Dakota workers' compensation staff, she described her current condition as a flare-up of the "same thing" she had in Oregon. (Tr. 33, 35). Claimant also testified that she engaged in no off-work activities that irritated her arms. (Tr. 32). In fact, she testified that she has been unable to knit since her arm problems started in 1989. (Tr. 33). Thus, I would conclude, based on the record as a whole, considering the meaning of the medical evidence as well as its context, that claimant carried her burden of proving that her compensable 1989 injury was the major contributing cause of her current condition.

Alternatively, I would remand this case to the ALJ for further evidence taking. We may remand 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). We have previously found a compelling reason to remand where the provisions of Senate Bill 369 changed the legal standard and the record was devoid of evidence on that standard. See Carmen C. Neill, 47 Van Natta 2371 (1995) (case remanded because record devoid of evidence of "actual worsening"); Helen M. Callander, 47 Van Natta 1626 (1995) (same); see also 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); Betty S. Tee, 45 Van Natta 289 (1993) (Board remanded to ALJ in light of Supreme Court's intervening definition of relevant statutory term).

Here, the hearing was held on April 14, 1995. Thus, the record was developed prior to June 7, 1995, the effective date of Senate Bill 369. At the time the record was developed in this case, the relevant standard for proving an aggravation under former ORS 656.273(1) was material contributing cause. In other words, claimant's burden was to prove that her compensable 1989 injury was a material contributing cause of her worsened condition. Iocelyn v. Wampler Werth Farms, 132 Or App 165 (1994), rev den 320 Or 587 (1995) (decision issued December 28, 1994, and review denied March 7, 1995). That standard was also consistent with the rule in Miville, which held that the original Oregon employer remained responsible if the initial Oregon injury (when followed by out-of-state exposure) materially contributed to a subsequent, worsened condition. Thus, at the time the record was developed in this case, the relevant standard was material contributing cause. Therefore, since the relevant legal standard changed after the hearing was held and the record was developed in this case, I would remand for the taking of further evidence pertaining to the major contributing cause standard. Cf. Robert A. Wentz, (unpublished order) (February 13, 1996) (remand denied where hearing was convened after SB 369 became effective).

Accordingly, I respectfully concur in part and dissent in part.

May 29, 1996 Cite as 48 Van Natta 1087 (1996)

In the Matter of the Compensation of
MICHAEL L. WOFFORD, Claimant
WCB Case No. 94-04772
ORDER ON REMAND
Coons, Cole, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

This case is before the Board on remand from the Court of Appeals. Roseburg Forest Products v. Wofford, 138 Or App 560 (1996). The court has reversed our prior order which affirmed an Administrative Law Judge's (ALJ's) order that relied on Williams v. Gates, McDonald & Co., 300 Or 278 (1985) to uphold the compensability of medical treatment for a non-work related preexisting condition as a prelude to treatment of a compensable condition. Citing ORS 656.225, the court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

In August 1991, claimant's bilateral carpal tunnel condition (CTS) was found compensable by a prior ALJ's order. In April 1993, the prior ALJ's order was affirmed by an earlier Board order. On May 26, 1993, a Notice of Closure closed the disabling injury claim.

In April 1993, Dr. Richards examined claimant for a fungal infection on his left hand and feet. (See Ex. 31-1). Dr. Richards treated the fungal condition with a topical ointment, without success. In May 1993, Dr. Richards prescribed an oral medication, which claimant did not purchase because it was too expensive. (Ex. 28).

On August 9, 1993, claimant returned to Dr. Hayes, treating physician for the CTS. Dr. Hayes recommended bilateral carpal tunnel release surgeries. On November 1, 1993, Dr. Hayes performed the surgery on claimant's right hand. (Ex. 25). On November 2, 1993, claimant's claim was reopened as a disabling aggravation. (Ex. 26).

Due to claimant's left hand fungal condition, Dr. Hayes would not operate until the condition resolved. Thereafter, claimant obtained the oral medication to treat the fungal condition. The condition of the left hand cleared within a few months.

On February 18, 1994, the self-insured employer denied compensability of the fungal condition, and medical treatment for the condition. Claimant requested a hearing, contesting the medical services portion of the denial. Relying on Williams v. Gates, McDonald & Co., supra, the ALJ found the medical treatment compensable. On Board review, we adopted and affirmed the ALJ's order. The employer appealed, and the court has remanded for reconsideration in light of ORS 656.225. We proceed with our reconsideration.

As a preliminary matter, we note that claimant has requested oral argument. The employer opposes the request. We will not ordinarily entertain oral argument. OAR 438-011-0015(2). However, we may allow oral argument where the case presents an issue of first impression which could have a substantial impact on the workers' compensation system. See OAR 438-011-0031(2); Raymond L. Mackey, 47 Van Natta 1 (1995); Jeffrey B. Trevitts, 46 Van Natta 1767 (1994); Ruben G. Rothe, 44 Van Natta 369 (1992). Discretion to grant such requests rests solely with the Board. OAR 438-011-0031(3).

Here, through their appellate briefs and supplemental briefs on remand, the parties have fully addressed the impact of ORS 656.225 on the issue before the Board. Inasmuch as the parties' positions regarding the issue have been thoroughly defined and briefed, we are not persuaded that oral argument would assist us in reaching our decision. Accordingly, we decline to grant the request for oral argument. See OAR 438-011-0031(3); Glen D. Roles, 45 Van Natta 282, n. 2 at 283 (1993).

The ALJ relied on Dr. Hayes' opinion and found that treatment for the fungal condition was necessary before claimant's left carpal tunnel surgery could proceed. Thus, the ALJ concluded that treatment for the left hand fungal condition was compensable. See Williams v. Gates, McDonald Co., supra.

In Williams, the Court found that surgery for a noncompensable condition was necessary before the claimant could undergo surgery for a compensable disc condition. The Court held that, if 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. Therefore, in Williams, the surgery related to the noncompensable condition was compensable because it was required for total medical treatment necessitated by the compensable injury.

To begin, the employer contends that we lack authority to consider this dispute under ORS 656.245(6) and ORS 656.704(3). Specifically, because it is not contesting the compensability of claimant's accepted left carpal tunnel syndrome, and because claimant is not alleging the compensability of his fungal condition, the employer argues that this dispute does not concern "the compensability of the underlying claim."

We have consistently ruled that we retain jurisdiction over a medical treatment dispute where the issue concerns whether treatment for a worker's condition was causally related to the compensable injury. See Arthur R. Morris, 48 Van Natta 349 (1996); Richard L. Wheeler, 47 Van Natta 2011 (1995). Here, as previously noted, claimant is not asserting that his left fungal condition is compensable. Nevertheless, he is contending that the treatment for that condition is compensable. In other words, the parties' dispute pertains to the compensability of claimant's medical services claim. Under such circumstances, we retain jurisdiction to resolve this compensability dispute.

Having resolved the jurisdiction issue, we proceed to a resolution of the merits of this dispute.

Subsequent to our prior order, the legislature amended ORS Chapter 656, adding ORS 656.225, which states in pertinent 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.

" * * * *

"(3) In medical service claims, the medical service is prescribed to treat a change in the preexisting condition as specified in subsection (1) * * *, and not merely as an incident to the treatment of a compensable injury or occupational disease."

The employer argues that ORS 656.225 overrules Williams. We agree. We find that the relevant portions of the statute are clear and unambiguous.[1]

Accordingly, in this medical services claim, in order to find the treatment of the fungal condition compensable, the treatment must have been prescribed to treat a change in the preexisting fungal condition, and not merely as an incident to the treatment of claimant's CTS. See ORS 656.225(3).

Claimant argues that the fungal condition is not a preexisting condition. We disagree.

ORS 656.005(24) defines preexisting condition, in part, 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 * * * a claim for worsening pursuant to ORS 656.273." (Emphasis added).

In April 1993, claimant first sought treatment from Dr. Richards for a fungal infection, similar to athlete's foot, on his feet and left hand. (Ex. 28). On May 26, 1993, a Notice of Closure closed claimant's bilateral CTS claim. On May 28, 1993, Dr. Richards recommended an oral medication, rather than the previously prescribed topical ointment. Dr. Richards subsequently stated that this fungal condition was unrelated to claimant's accepted CTS. (Ex. 31-1).

Dr. Hayes performed right carpal tunnel surgery on November 1, 1993, but informed claimant that it would not be appropriate to perform the left CTS surgery until the fungal condition cleared up. Thereafter, claimant returned to Dr. Richards and obtained the oral medication in order to proceed with the left hand carpal tunnel surgery. Following the surgery, claimant's accepted CTS claim was reopened pursuant to ORS 656.273.

Based on the aforementioned medical evidence, we find that the fungal condition is a disease or other condition that contributed to or predisposed claimant to disability or a need for treatment and that preceded claimant's claim for worsening pursuant to ORS 656.273. Consequently, we conclude that the fungal condition constitutes a preexisting condition as defined in ORS 656.005(24).

Furthermore, we conclude that the prescribed medication was solely directed to the preexisting fungal condition. On November 18, 1993, when claimant returned to Dr. Richards, he wanted to fill a previously unfilled prescription for the fungal condition, because Dr. Hayes would not perform left carpal tunnel surgery until claimant's hands were cleared. (Ex. 28). The medical record does not attribute the need for the medication to any reason other than claimant's fungal condition.

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[1] Although the language of the statute is clear, the legislative history further supports our reading of the statute. Testifying before the Senate Labor Committee, Jerry Keene, a workers' compensation attorney, stated:

"Section 3 [codified as ORS 656.225] was intended as an omnibus statute to guide the determination of initial and ongoing compensability decisions in claims involving preexisting conditions in all contexts. * * * Subsection 1(c) [now subsection 3] overrules Williams vs. Gates/McDonald and Van Blokland vs. OHSU to the extent that those cases render employers liable for the treatment of preexisting conditions on the theory that they are necessary in order to further or accommodate the treatment of a compensable condition." (Minutes of the Senate Labor and Government Operations Committee, Tape 19A, February 1, 1995).

Finally, the record also contains no evidence, and claimant does not contend, that his compensable CTS constituted the major contributing cause of a pathological worsening of his fungal condition. See ORS 656.225(1). Likewise, the record does not establish that the medication was prescribed to treat a change in the preexisting fungal condition; rather, the record indicates that the medication was prescribed merely as an incident to the treatment of the CTS. See ORS 656.225(3).

Accordingly, on reconsideration we conclude that claimant's fungal medication treatment is not compensable. Therefore, in lieu of our March 15, 1995 order, we reverse the ALJ's order dated September 28, 1994 which found the employer responsible for the treatment and awarded a $2,250 attorney fee.

IT IS SO ORDERED.

May 30, 1996 Cite as 48 Van Natta 1090 (1996)

In the Matter of the Compensation of
JERRY E. BISHOP, Claimant
WCB Case No. 94-14311
ORDER ON REVIEW
David C. Force, Claimant Attorney
David O. Horne, Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that declined to award interim compensation. On review, the issue is interim compensation. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ALJ's finding of ultimate fact. Instead, we make the following finding of ultimate fact: An attending physician has not authorized temporary disability compensation for claimant.

CONCLUSIONS OF LAW AND OPINION

Claimant, a partner in an engineering business, made a claim through his employer for a work-related psychological condition, indicating that December 20, 1991 was his last date of work. (Ex. 4). The claim was made in June 1992. At that time, claimant was represented by an attorney who was also handling matters related to his ownership interest in the firm.

The insurer issued a denial dated October 19, 1992, which was mailed to claimant's attorney but not to claimant. (Exs. 9, 10). Claimant first became aware of the denial in December 1993 when he became dissatisfied with his legal representation and obtained his file from the law firm. Claimant did not request a hearing from the denial, but instead, stipulated that his condition was not compensable.

In the present matter, claimant contends that he is entitled to interim compensation from December 20, 1991 to the present, arguing that the October 1992 denial was invalid because it was not sent to claimant and, therefore, was not effective to terminate claimant's right to interim compensation. The ALJ found that the denial was effective to terminate interim compensation and held that claimant was not entitled to the relief he sought. We agree that claimant is not entitled to interim compensation, but we do so based on the following reasoning.

Before the enactment of Senate Bill 369, a claimant was entitled to receive interim compensation for disability from the date the employer had notice or knowledge of a claim until the claim was accepted or denied. See ORS 656.262(2); former ORS 656.262(4)(a); Bono v. SAIF, 298 Or 405 (1984); Jones v. Emanuel Hospital, 280 Or 147 (1977). A claimant was entitled to interim compensation when he or she had left work due to the alleged work injury, whether or not the claim was eventually found to be compensable. Bono v. SAIF, supra, 298 Or at 410; RSG Forest Products v. Jensen, 127 Or App 247, 250 (1994).

In 1995, the legislature amended ORS 656.262(4). Amended ORS 656.262(4)(a) now 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."

The amended statutes 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, 135 Or App 565 (1995). Since there is no specific exception to the retroactive application of amended ORS 656.262(4)(a), we must apply the new law. See Or Laws 1995, ch 332, § 66 (SB 369, § 66); Shanon M. Oliver, 48 Van Natta 386 (1996).

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. Although the parties stipulated that "at all times relevant and material hereto the Claimant was incapable of returning to his employment with the subject Employer," there is no evidence of authorization by an attending physician of the payment of temporary disability compensation. The responsibility to authorize temporary disability compensation cannot be delegated. See Nenita Stockie, 48 Van Natta 299 (1996). Thus, the parties' stipulation is insufficient to satisfy the requirements of ORS 656.262(4)(a). Therefore, we conclude that claimant is not entitled to interim compensation. See Shanon M. Oliver, supra (interim compensation must be authorized by an attending physician under amended ORS 656.262(4)).

Since we find that claimant's right to interim compensation never started, because interim compensation was never authorized by an attending physician, it is unnecessary to reach the question of whether the October 1992 denial was effective to terminate interim compensation. Accordingly, based on the aforementioned reasoning, we affirm the ALJ's order denying claimant's claim for interim compensation.

ORDER

The ALJ's order dated September 5, 1995, as reconsidered November 29, 1995 and amended on reconsideration December 4, 1995, is affirmed.

May 30, 1996 Cite as 48 Van Natta 1091 (1996)

In the Matter of the Compensation of
GRACE E. CASSIDY, Claimant
WCB Case No. 93-14898
ORDER ON RECONSIDERATION
Coons, Cole, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of our March 27, 1996 Order on Review that affirmed the Administrative Law Judge (ALJ's) order which upheld the self-insured employer's denial of claimant's occupational disease claim for a psychological condition. In order to consider claimant's contentions, we abated our prior order. Having now received the self-insured employer's response, we proceed with our reconsideration.

On reconsideration, claimant argues that the report of Ms. Kellow, a licensed social worker, establishes that work was the major contributing cause of claimant's combined condition. In support of her argument, claimant relies upon several portions of Ms. Kellow's report, as set forth in Exhibit 36. Claimant points out that Ms. Kellow noted that claimant's condition had "dramatically worsen[ed]" and the stressor at the employer's store "caused her to so decompensate." Claimant argues that her combined condition involves panic disorder, with features of nightmares, reduced energy, reduced interest, apathy, helplessness, and powerlessness.

After considering claimant's arguments, we continue to adhere to our prior conclusion. As we explained in our order, although Ms. Kellow did describe a work incident which caused stress for claimant, Ms. Kellow also identified numerous nonwork-related psychosocial stressors that have

contributed to claimant's condition. In addition to claimant's work incident stressor, Ms. Kellow identified claimant's husband's "life-threatening" drinking problem, separation, filing for divorce, and memories of childhood incest. (Ex. 36-3). However, Ms. Kellow did not assess the relative contribution of the different causes, as required by Dietz v. Ramuda, 130 Or App 397 (1994). Thus, although we agree with claimant that Ms. Kellow found one of claimant's stressors to be the work incident, we are unable to construe Ms. Kellow's report as finding that work is the major contributing cause of claimant's condition.

Accordingly, we withdraw our March 27, 1996 order. On reconsideration, as supplemented herein, we adhere to and republish our March 27, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

May 30, 1996 Cite as 48 Van Natta 1092 (1996)

In the Matter of the Compensation of
DEAN J. EVANS, Claimant
WCB Case No. 95-06031
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members en banc.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Myzak's order that: (1) excluded a post-reconsideration medical report regarding the extent of claimant's unscheduled permanent disability; and (2) affirmed a May 1995 Order on Reconsideration that did not award claimant unscheduled permanent disability benefits. The self-insured employer moves to strike part of claimant's appellant's brief as irrelevant. On review, the issues are motion to strike, evidence and extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

The excluded evidence is an attending physician's "post-reconsideration" medical report about the extent of claimant's permanent disability.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The employer moves to strike that part of claimant's appellant's brief that incorporates the respondent's supplemental brief in Joe R. Ray, 48 Van Natta 325 (1996).[1] The employer asserts that, because the issues in Ray are not identical to the issues in this case, we should strike the reference to the Ray brief as irrelevant. We disagree.

Claimant relies on the arguments submitted in Ray to support his assertion that the ALJ erred by excluding the "post-reconsideration" medical report in this case. We are aware of no legal prohibition to a litigant relying on arguments developed in another case to support his or her position in a similar case. Because the issues in both cases are similar, the arguments in Ray are not irrelevant here. Accordingly, we deny the motion to strike.[2]

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[1] The claimants in this and the Ray case had the same attorney on review.

[2] In his rely brief, claimant objects to the employer's offer of the appellant's and amicus briefs in Joe R. Ray, supra, in opposition to claimant's offer of the respondent's supplemental brief in that case. Although the employer did not submit those briefs in this case, we are well aware of the arguments set forth in them. Accordingly, we have considered all the arguments raised in the Ray case in analyzing this matter.

Evidence

Citing ORS 656.268(7)(g) and 656.283(7), the ALJ excluded an attending physician's "post-reconsideration" medical report from the hearing record.[3] Claimant asserts that the retroactive 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. We disagree.

Amended ORS 656.283(7) provides, in part, that "[e]vidence 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[.]" That statute went into effect on June 7, 1995, which was subsequent to the May 4, 1995 Order on Reconsideration, but prior to the September 15, 1995 closure of the hearing record. Therefore, the statute applies here. See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

Under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent partial disability. Id. However, amended ORS 656.283(7) does not apply to exclude evidence that was previously and properly admitted at hearing, i.e., evidence submitted at hearing prior to June 7, 1995, the effective date of amended ORS 656.283(7). Id.

In Joe R. Ray, supra, we held that, under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process, and not made a part of the reconsideration record, is inadmissible at a subsequent hearing about the extent of an injured worker's permanent partial disability.[4] Nevertheless, in light of the court's decision in Plummer, that holding has been overruled to the extent that evidence concerning the extent of an injured worker's permanent partial disability that was properly admitted at hearing can be considered on review.

However, where a hearing concerning the extent of permanent partial disability was held after June 7, 1995, the prohibition on subsequent evidence set forth in amended ORS 656.283(7) is applicable. Thus, we continue to adhere to our holding in Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995.

Here, the matter was submitted on the record which closed on September 15, 1995. Because the proffered medical report was not submitted during the reconsideration process and was not made a part of the reconsideration record, the ALJ properly excluded it from the record. Joe R. Ray, supra.

Finally, claimant asserts the same constitutional arguments here as did the claimant in Joe R. Ray. We rejected them in Ray, and we do so again. In doing so, we note that, in Ray, the focus was on the claimant's right to present "post-reconsideration" testimony, whereas here, the issue concerns claimant's right to present "post-reconsideration" written evidence. That difference is unimportant: Both cases involve the exclusion of "post-reconsideration" evidence. Accordingly, for the reasons stated in our decision in Ray, we conclude that the application of amended ORS 656.283(7) to this case did not violate claimant's procedural due process rights.

We also note that claimant's due process arguments do not expressly encompass amended ORS 656.268(7)(g). Therefore, we do not consider that issue, except to note that it is highly unlikely that amended ORS 656.283(7), which excludes all post-reconsideration evidence, would survive such a constitutional challenge, while amended ORS 656.268(7)(g), which only excludes post-reconsideration medical evidence,[5] would not.

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[3] No one requested the appointment of a medical arbiter.

[4] Although a signatory to this order for purposes of *stare decisis*, Chair Hall continues to believe, for the reasons set forth in his concurrence/dissent in Joe R. Ray, supra, that amended ORS 656.283(7) should not be applied to those cases where the reconsideration record was developed prior to June 7, 1995.

[5] Amended ORS 656.268(7)(g) provides that, "[a]fter reconsideration, no subsequent medical evidence is admissible before the department, the Workers' Compensation Board or the courts for purposes of making findings of impairment on the claim closure."

In sum, we reject claimant's due process arguments. Therefore, we conclude that the ALJ did not err by excluding the "post-reconsideration" medical report.

Extent of Unscheduled Disability

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

ORDER

The ALJ's order dated October 16, 1995 is affirmed.

May 30, 1996 Cite as 48 Van Natta 1094 (1996)

In the Matter of the Compensation of
CHARLES L. GRANTHAM, Claimant
WCB Case No. 95-04939
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board en banc.[1]

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

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

The ALJ found that the preponderance of the evidence established that claimant's preexisting degenerative disc disease combined with a February 1995 work injury, and that the preexisting disease was the major contributing cause of the combined condition. Therefore, the ALJ concluded that, under ORS 656.005(7)(a)(B), claimant failed to establish the compensability of his current low back condition.

On review, claimant contends that he initially sustained a lumbar strain as a result of the February 1995 injury which should be found compensable even if the Board finds that, after the strain resolved, the "combined" condition was no longer caused in major part by the February 1995 injury. In other words, claimant contends that the "combined condition" analysis under ORS 656.005(7)(a)(B) does not apply to the initial injury he sustained in February 1995, but applies only to claimant's condition after the initial strain resolved.

In Tektronix, Inc. v. Nazari, 117 Or App 409 (1992), on recon 120 Or App 590, rev den 318 Or 27 (1993), which was decided under former ORS 656.005(7)(a)(B), the court rejected the "two-step" analysis proposed by claimant 117 Or App at 412. In Nazari, the court explained that former ORS 656.005(7)(a)(B) was applicable in the context of an initial injury claim, if the injury combined with a preexisting condition to cause or prolong disability or the need for treatment. The court explained the appropriate analysis:

> "If, in an initial claim, there is disability or a need for treatment as a result of the injury alone, then the claim is compensable if the injury is a material contributing cause of the disability or need for treatment. If, in an initial claim, the disability or need for treatment is due to the combination of the injury and a preexisting, noncompensable condition, then the injury is compensable only if it is the major contributing cause of the disability or need for treatment."

Nazari, supra, 120 Or App at 594.

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[1] Board Member Moller has recused himself from this case. OAR 438-011-0023. Consequently, he has not participated in the Board's review.

The current version of ORS 656.005(7)(a)(B) now provides that if "an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause" of the disability or need for treatment of the combined condition. Amended ORS 656.005(7)(a)(B). Under the facts of this case, we find that the Nazari analysis remains viable under the amended statute.

Here, the medical evidence establishes that the February 1995 work injury combined with claimant's preexisting degenerative disc disease at the outset. Only Dr. Fuller, who examined claimant at SAIF's request, suggested that claimant may have initially sustained a "pulled muscle in the lumbar spine," but he opined that it was more likely that claimant experienced a flare-up of his underlying condition. (Ex. 14-5). Dr. Fuller further opined that claimant's preexisting degenerative condition combined with the February 1995 injury, explaining that the "severe discopathy at L5 failed to meet the challenge of his work activities of 2/3/95 causing a flare of lumbar symptoms which continues." (Id.). There is no other medical evidence that even suggests that claimant initially sustained a lumbar strain as a result of the February 1995 injury that did not combine at the outset with his preexisting condition. Accordingly, we conclude that the ALJ properly analyzed compensability of this claim under ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated October 3, 1995 is affirmed.

Chair Hall specially concurring.

Although I agree with the reasoning and conclusion expressed in the lead opinion, I write separately to address another aspect of amended ORS 656.005(7)(a)(B).

Where, as here, the medical evidence establishes that a work injury combines from the outset with a preexisting condition, I concur with the lead opinion's determination that the Nazari decision remains viable under amended ORS 656.005(7)(a)(B). Nevertheless, I would further note that amended ORS 656.005(7)(a)(B) now speaks of an otherwise compensable injury combining at any time with a preexisting condition. Thus, under the amended statute, it is conceivable that a preexisting condition could combine with a compensable injury at a later time, rather than at the outset as in Nazari. Should such a circumstance arise, the Nazari analysis would not apply until "combination" occured.

In conclusion, I submit that, in applying amended ORS 656.005(7)(a)(B) and Nazari, it is first necessary to determine whether a compensable injury has combined with a preexisting condition, and, if so, whether that combination occurred at the outset of the claim or at a later time. Here, since the medical evidence establishes that claimant's otherwise compensable injury combined at the outset with his preexisting condition, I concur with my fellow members' conclusion that the Nazari analysis is appropriate under amended ORS 656.005(7)(a)(B).

In the Matter of the Compensation of
HARRIET E. HARVEY, Claimant
WCB Case Nos. 95-08046, 95-07590 & 95-06634
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
Wallace & Klor, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Christian, Hall and Haynes.

Fireman's Fund Insurance Co. requests review of those portions of Administrative Law Judge (ALJ) Otto's order which: (1) set aside its compensability and responsibility denials of claimant's occupational disease claim for left carpal tunnel syndrome (CTS); and (2) upheld Liberty Northwest Insurance Corporation's denial of compensability and responsibility for the same condition. On review, the issues are compensability and responsibility.

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 $900, payable by Fireman's Fund Insurance Co. 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 26, 1995 is affirmed. For services on Board review, claimant's counsel is awarded an assessed attorney fee of $900, payable by Fireman's Fund Insurance Co.

Board Member Haynes dissenting.

Because I find the history of claimant's carpal tunnel complaints and the multitude of medical opinions important factors in the determination of this issue, I set out the chronology of claimant's history and treatment.

In 1986, claimant began working for Security Pacific Bank as a proof operator. Her primary job duty was putting individual checks into a canceling machine while, at the same time, recording the amount of the check with a ten-key pad. The checks were put into the machine with the left hand, and the right hand operated the ten-key. Claimant processed from 1800 to 2500 checks per hour.

In early February 1991, claimant sought treatment from Dr. Beeson, chiropractor. (Ex. 1). He diagnosed CTS, cervico brachial syndrome, and myofascitis. He noted that the conditions involved the right wrist, elbow and neck. On February 8, 1991, claimant saw Dr. Nelson, on referral from Dr. Beeson, for "painful discomfort and weakness in the right upper extremity including the hand." (Ex. 3-1). Dr. Nelson was claimant's primary treating physician. (See Ex. 7-1). He noted a positive Tinel's sign over the median nerve at the right wrist, and a positive Phalen's test on the right. (Ex. 3-3).

In March 1991, claimant saw Dr. Aversano for nerve conduction studies. (Ex. 5). On physical examination, he noted a very positive Tinel's sign on the right, mildly positive on the left. (Ex. 5-2). He diagnosed CTS, mild electrically, moderate clinically in the right hand, and tendinitis, right elbow and wrist. (Id). He made no diagnosis of left CTS. (See also Ex. 9).

On March 18, 1991, Liberty accepted right carpal tunnel syndrome. (Ex. 6). On May 31, 1991, Liberty also accepted right cervico brachial syndrome and myofascitis. (Ex. 12).

On May 9, 1991, claimant was examined by the Medical Consultants Northwest. The physicians obtained a description of claimant's work activities, and a history of her right upper extremity and neck problems. They specifically noted that claimant had never had symptoms in the left arm. (Ex. 10-2). On examination, they noted no tenderness on the left of either the ulnar or median nerve. (Ex. 10-5).

On July 29, 1991, claimant was examined by the Orthopaedic Consultants. (Ex. 15). They reported that claimant had "no left arm symptoms at all despite the fact that she explains she uses her left arm in rapid repetitive motion as part of her ordinary job activity." (Ex. 15-3).

Claimant continued with conservative treatment for her right CTS by Drs. Nelson and Aversano through 1991. (Exs. 14, 16, 17, 19, 20). On February 27, 1992, claimant returned to Dr. Nelson for a closing examination. Although Dr. Nelson noted a direct relationship with the demands of claimant's work and the use of her upper extremities, he did not refer to any left arm complaints. (Ex. 21-1).

On June 16, 1992, Dr. Barth, medical arbiter, examined claimant. Median nerve testing on the left was negative, as was ulnar nerve testing at the elbow. (Ex. 23-3).

On July 1, 1992, Bank of America bought Security Pacific Bank. Fireman's Fund provided coverage for Bank of America. Claimant was laid off in February 1993. She has not been employed since she was laid off. (Tr. 32).

Between June 1992 and November 1993, claimant did not see a physician for upper extremity complaints. In November 1993, claimant sought treatment from Dr. Goldberg, family physician, complaining of a great deal of pain in the right upper extremity, face, neck and shoulder. (Ex. 26). Claimant reported that her right upper extremity, hand and neck had been bothering her since September 1993. Dr. Goldberg treated claimant until December 1993, but did not address left CTS.

On January 13, 1994, claimant first sought treatment from Dr. Long, on referral from Dr. Beeson, D.C. (Ex. 27). Claimant's current symptoms focused on intense right upper extremity pain. (Ex. 27-3). Nevertheless, Dr. Long, also obtained a history of numbness in the left hand and forearm. He diagnosed bilateral CTS, right much greater than left. (Ex. 27-4).

On January 18, 1994, claimant saw Dr. Hill on referral from Dr. Long. Dr. Hill also diagnosed bilateral CTS, more severe on the right side. He recommended a release of the ligament on the right side. (Ex. 28).

On March 28, 1994, Dr. Button examined claimant. He diagnosed possible right CTS, based on Dr. Aversano's testing. (Ex. 30-4). He also related claimant's CTS to obesity, and diagnosed functional overlay and symptom magnification. (Ex. 30-5).

On April 26, 1994, Dr. Long reviewed claimant's upper extremity history in a report to claimant's counsel. Dr. Long's report again focused on claimant's right upper extremity symptoms. (Ex. 32-2).

On May 3, 1994, Dr. Hill performed a sectioning of the right transverse carpal ligament. He noted that the ligament "was extremely thick, and when the ligament was incised, the tunnel contents, nerve and tendons bulged out quite impressively * * *." (Ex. 33).

Follow-up reports by Dr. Long after claimant's right carpal tunnel release surgery did not address claimant's left CTS. (Exs. 35, 37). Moreover, Dr. Long did not note tenderness over the left volar wrist, as he had in the past. (Ex. 35-2; compare Exs. 27-4, 31-3). Additionally, on August 23, 1994, although Dr. Long noted that claimant had been doing rather heavy physical work on a sustained basis, Long did not report left CTS symptoms. (Ex. 37-1).

Finally, on September 26, 1994, claimant returned to Dr. Beeson. (Ex. 38). She reported that her right CTS had been greatly relieved with surgery, but that now her left hand was giving her pain. Claimant described the pain as constant and, at times unbearable. (Id).

On January 19, 1995, Dr. Hill performed a resection of the left transverse carpal tunnel. (Ex. 42). He again noted that the ligament was quite thick and the contents were quite compressed.

On May 15, 1995, claimant was examined by the Medical Consultants Northwest. (Ex. 49). They did not relate claimant's left hand symptoms to her work. Furthermore, they noted that claimant's thickened transverse carpal ligament, as described by Dr. Hill in his operative reports, was a result of claimant's anatomic development, not the result of work. (Ex. 49-10).

The ALJ found that claimant was a credible witness. However, based on the significant inconsistencies between claimant's testimony and the contemporaneous medical records, I do not agree with the ALJ's credibility finding. Specifically, although claimant saw at least seven physicians between February 1991 and June 1992 for treatment of her accepted right CTS, not one of the physicians' reports mentions left CTS complaints. Furthermore, nearly a year passed between the time claimant was laid off from her work at the bank and the time she sought treatment from Dr. Long who, on the first visit, briefly referred to left CTS.

The ALJ relied on three reports, Exhibits 4, 5, and 11, in support of his conclusion that claimant was experiencing left hand CTS symptoms before she was laid off. I do not find that the reports support such a conclusion.

In March 1991, Dr. Erickson reported that claimant was having trouble with her wrists, in the plural, but his report addressed only claimant's right wrist. (Ex. 4). In May 1991, Dr. Nelson noted symptoms "in the hands with any significant use of the upper extremities." (Ex. 11). Again, although Dr. Nelson's report references hands and upper extremities, in the plural, the examination is specific to the right side.

Finally, in March 1991, Dr. Nelson referred claimant to Dr. Aversano for nerve conduction studies. (Ex. 5). On physical examination, comparing the left and right wrists, Dr. Aversano noted very positive Tinels's sign on the right, and mildly positive on the left. (Ex. 5-2). Nevertheless, the remainder of his report, including the nerve conduction studies, focused only on the right side, and did not report left side complaints. Furthermore, other contemporaneous medical examinations in May and July 1991 report no left arm or hand symptoms. (See Exs. 10-2, 3; 15).

In conclusion, I find that the evidence shows that claimant did not seek treatment for left CTS until January 1994, nearly a year after she had ceased working for the employer. Furthermore, when claimant did seek treatment in 1994, Dr. Long's mention of left CTS symptoms was merely incidental to intense right hand symptoms. (Ex. 27-3).

In light of the overwhelming evidence to the contrary, I do not believe that Exhibits 4,5 and 11 would withstand the court's substantial evidence review to support the ALJ's conclusion that claimant's work activities were the major contributing cause of left CTS. Therefore, I would reverse the ALJ's order which found the claim compensable.

Accordingly, I respectfully dissent.

In the Matter of the Compensation of
JOB G. LOPEZ, Claimant
WCB Case No. 93-08872
Emmons, Kropp, et al, Claimant Attorneys
Steve Cotton (Saif), Defense Attorney
ORDER ON REMAND

This matter is before the Board on remand from the Court of Appeals. SAIF v. Lopez, 139 Or App 322 (1996). In our prior order, Job G. Lopez, 47 Van Natta 193 (1995), we affirmed the Administrative Law Judge's (ALJ's)[1] order finding that the Hearings Division had jurisdiction over a Managed Care Organization (MCO) proposed medical services dispute. In addition, we reversed the ALJ's decision on the merits of the medical services issue and found that the proposed low back surgery was reasonable and necessary treatment. Citing Newell v. SAIF, 134 Or App 625, aff'd on recon 136 Or App 280 (1995), the court has remanded for reconsideration. SAIF v. Lopez, supra.

FINDINGS OF FACT

We republish the "Findings of Fact" from our previous order.

CONCLUSIONS OF LAW AND OPINION

We first summarize the relevant facts of this case. Claimant compensably injured his low back in October 1988 and, as a result of that injury, underwent two low back surgeries in 1989. The SAIF Corporation accepted the claim, which was closed by Determination Order in June 1990.

Claimant continued to have symptoms in his back and legs, and eventually came under the care of Dr. Grewe, a neurosurgeon and a member of CareMark Comp, a MCO. Dr. Grewe recommended L4-5 spinal fusion surgery. CareMark Comp disapproved the surgery request on the basis that surgery was not medically necessary or appropriate. Dr. Grewe appealed the disapproval and both CareMark Comp's Medical Advisory Council and its Medical Management Committee upheld the disapproval.

Dr. Grewe appealed the disapproval of surgery to the Director. On July 21, 1993, the Director issued a Proposed and Final Order Concerning a Bona Fide Medical Services Dispute under ORS 656.327, upholding CareMark's disapproval and concluding that the proposed surgery was not appropriate for claimant's condition.

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[1] Formerly referred to as "Referee."

On July 29, 1993, claimant requested a hearing to contest the Director's order. At hearing, SAIF moved for dismissal of the hearing request for lack of jurisdiction. The ALJ denied the motion, but concluded that claimant had failed to establish that the requested L4-5 spinal fusion surgery was either reasonable or necessary.

On review of the ALJ's order, we rejected SAIF's assertion that, under former ORS 656.260, the MCO statute, and former ORS 656.704(3), the Director had exclusive jurisdiction over a MCO proposed medical services dispute. Job G. Lopez, 47 Van Natta at 194-200. Rather, we concluded that, in the MCO context, where jurisdiction lies depends on the type of medical services 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 the dispute involved a proposed surgery, the Hearings Division had exclusive jurisdiction to review the matter. 47 Van Natta at 201-02. On the merits, we found the proposed surgery reasonable and necessary.

SAIF requested judicial review. Citing Newell v. SAIF, supra, the court remanded the matter for reconsideration. SAIF v. Lopez, supra. We proceed with our reconsideration.

Subsequent to our order, the legislature amended ORS 656.327(1)(a), 656.260(6), and 656.704(3). Amended ORS 656.704(3) now provides, in relevant part:

> "For purposes of determining the respective authority of the director and the board to conduct hearings, investigations and other proceedings under this chapter, and for determining the procedure for the conduct and review thereof, matters concerning a claim under this chapter are those matters in which a worker's right to receive compensation, or the amount thereof, are directly in issue. However, such matters do not include any disputes arising under ORS 656.245, 656.248, 656.260, 656.327 * * * " (Emphasis added).
>
> Amended ORS 656.327(1)(a) now 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, 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." (Emphasis added).

Amended ORS 656.260(6) now provides, in relevant part: "Any 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." (Emphasis added).

Except as provided otherwise, the amendments of Senate Bill 369 (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. Newell v. SAIF, supra; Volk v. America West Airlines, 135 Or App 565, 572-73 (1995). Here, the Board's decision was appealed; however, because the court remanded for reconsideration, the Board's decision was not finally resolved on appeal. In addition, amended ORS 656.327(1)(a), 656.327(2), 656.260(6), and 656.704(3) are not among the exceptions to this general retroactivity rule, see SB 369, § 66 (listing exceptions to general retroactivity provision). Therefore, the amended versions of the statutes apply here.

In Newell v. SAIF, 136 Or App at 283, the court held that amended ORS 656.327(1)(a) and 656.704(3) provide that the director has exclusive jurisdiction to review proposed medical treatment. Because the treatment here concerns a proposed medical treatment, the Director has exclusive jurisdiction over this medical services issue.

Furthermore, in Ronald R. Streit, Sr., 47 Van Natta 1577 (1995), 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. 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 proposed medical services dispute. Accordingly, exclusive jurisdiction of this dispute lies with the Director, not the Hearings Division. Amended ORS 656.327(1)(a); 656.260(6); 656.704(3); Newell v. SAIF, supra; Ronald R. Streit, Sr., supra; Ronald M. Ross, 48 Van Natta 293 (1996).

Consequently, on reconsideration of our prior order, we vacate the ALJ's November 10, 1993 order. Claimant's request for hearing is dismissed for lack of jurisdiction.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT MENDEZ, Claimant
WCB Case No. 95-07954
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Galton's order that: (1) found that the doctrine of res judicata precluded its partial denial of claimant's current condition and medical services claim; and (2) in the alternative, set aside the denial on the merits. On review, the issues are res judicata and, if the denial is not barred by res judicata, compensability.

We adopt and affirm the ALJ's order with the following supplementation addressing the insurer's argument on review that claim preclusion does not apply to bar its June 1995 partial denial.

On October 19, 1990, claimant sustained a compensable low back injury, which the insurer accepted as a disabling L3-4 herniated disc. On December 17, 1990, claimant underwent a right L3-4 discectomy and medial foraminotomy as a result of the compensable injury. On March 6, 1992, the Board approved a Claim Disposition Agreement (CDA) between the parties. Under the CDA, claimant retained "his right to medical services for the compensable injury." (Ex. 53-3). On February 7, 1995, the insurer issued a partial denial of claimant's "current condition" and claim for medical benefits, alleging that claimant's "current condition" was no longer related to the compensable low back injury. (Ex. 91). By a Stipulated Settlement approved May 9, 1995, the insurer rescinded its February 7, 1995 partial denial. (Ex. 108). On June 27, 1995, the insurer issued another partial denial of claimant's "current condition" and claim for medical benefits, alleging that claimant's "current condition" was no longer related to the compensable low back injury. (Ex. 114). This June 27, 1995 denial is the subject of the current litigation.

On review, the insurer argues that, contrary to the ALJ's holding, its June 1995 denial is not barred by claim preclusion because it was "not possible to litigate the issue of claimant's current condition as of June, 1995 in a settlement that [was] finalized one month earlier in May, 1995." (Appellant's Brief, page 3). The fallacy of this argument is that there was no change in claimant's current condition in the interval between the May 1995 Stipulation and the June 1995 denial. Therefore, we agree with the ALJ that the insurer's June 1995 denial is barred by claim preclusion.

"Claim preclusion" precludes a plaintiff who has prosecuted one action against a defendant through to a final judgment from prosecuting another action against the same defendant where the claim in the second action is based on the same factual transaction that was at issue in the first, and where the plaintiff seeks a remedy additional or alternative to the one sought in the first, and is of such a nature as could have been joined in the first action. Drews v. EBI Companies, 310 Or 134, 140 (1990) (citing Rennie v. Freeway Transport, 294 Or 319, 323 (1982)). Claim preclusion does not require actual litigation, only the opportunity to litigate. Furthermore, the May 1995 Stipulation was negotiated, based on a weighing of choices and the exercise of judgment as to the most beneficial outcome for each party. See Fimbres v. Gibbons Supply Co., 122 Or App 467, 471 (1993). Once approved by an ALJ, it has the finality and effect of a judgment. Id.

Thus, the May 1995 Stipulation represents a final judgment that claimant's current condition and medical services are compensable as of the date of that stipulation. In addition, the insurer may not relitigate the same claim or claims which arise from the same transaction or series of transactions. Drews, supra. Thus, the question is whether claimant's condition has changed so as to create a new set of operative facts that previously could not have been litigated at the time of the May 1995 Stipulation. Cf., Liberty Northwest Ins. Corp. v. Bird, 99 Or App 560 (1989) (when a claimant reasserts a claim for medical services after being previously denied, the question is whether his condition has changed so as to have created a new set of operative facts that previously could not have been litigated). Based on the following reasoning, we conclude that claimant's condition did not so change.

Prior to the May 1995 Stipulation: (1) an April 1995 MRI indicated degenerative changes in claimant's spine, as did the interpretation of this MRI by Dr. Toffler, claimant's treating physician; (2) Drs. Martens and Watson, examining physicians, and Dr. Toffler diagnosed chronic back pain, with Dr. Toffler, at one point, relating claimant's current exacerbated back pain to current work activities; (3) Dr. Toffler also diagnosed and treated claimant's depression, with some indication that it was related to claimant's back pain; and (4) Dr. Rohrer, consulting neurosurgeon, recommended treatment at a pain center and noted that surgery probably would not benefit claimant, and Dr. Toffler concurred with Dr. Rohrer. Subsequent to the stipulation, all of these same conditions persisted, with the neurosurgical consultations clarifying that surgical intervention was not recommended, although pain center treatment was. In short, there was no change in claimant's current condition following the May 1995 Stipulation.

Given this record, we find that there was no change in the set of operative facts existing after the May 1995 Stipulation that could not have been litigated at the time of the May 1995 Stipulation. The fact that the insurer did not seek a specific causation opinion from Dr. Toffler prior to entering into the May 1995 Stipulation does not present a new set of operative facts when the insurer sought Dr. Toffler's causation opinion after entering that stipulation. Accordingly, we find that claim preclusion bars the insurer's June 1995 partial 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 $1,000, payable by the insurer directly to claimant's attorney. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 6, 1995 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,000, to be paid by the insurer directly to claimant's attorney.

Board Member Haynes specially concurring.

I agree with the lead opinion that the doctrine of claim preclusion precludes the insurer's June 27, 1995 partial denial of claimant's current condition and medical services claim. Thus, the matter is decided on the basis of claim preclusion and there is no need to alternatively address the compensability of claimant's current condition on the merits. For this reason, I would not address the compensability of claimant's current condition, nor would I adopt the ALJ's alternative reasoning and conclusions "on the merits."

Furthermore, I note that in making his alternative finding on the merits that claimant's current condition is compensable, the ALJ included the statement that "[i]f claimant indeed has DDD [degenerative disc disease], it is a direct and proximate result of this injury." (Opinion and Order, page 6). However, the record contains no medical evidence relating any degenerative disc disease to the compensable injury. Instead, the ALJ appears to have substituted his own "medical judgment" in making this statement. Because this statement is not supported by the medical record, I would not adopt it. Moreover, because there is no need to address the merits of the compensability issue, I would not adopt any of the ALJ's reasoning and conclusions on that issue. As the supplementation in the lead opinion illustrates, the insurer is precluded from issuing its June 27, 1995 partial denial.

In the Matter of the Compensation of
JESUS MUNOZ, Claimant
WCB Case No. 94-04199
ORDER ON RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Bonnie V. Laux (Saif), Defense Attorney

Claimant requests reconsideration of our May 1, 1996 Order on Review that: (1) reduced claimant's scheduled permanent disability for loss of use and function of the left foot (ankle) from 17 percent (22.95 degrees), as awarded by an Order on Reconsideration, to 16 percent (21.6 degrees); and (2) declined to award claimant's attorney an assessed fee under ORS 656.382(2).

Contending that we erred in determining the combined value of claimant's 15 percent impairment for inability to stand and walk for greater than two hours and 2 percent impairment for decreased range of motion, claimant seeks reconsideration of our order.

Upon review of the table for determining the combined value of impairments, we agree with claimant's contention. The appropriate combined value for claimant's impairment is 17 percent. We consequently affirm the Order on Reconsideration awarding claimant 17 percent (22.95 degrees) scheduled permanent disability for the loss of use and function his left foot (ankle).

Because we have increased the Administrative Law Judge's (ALJ's) award of 2 percent scheduled permanent disability to 17 percent, this order results in increased compensation. Therefore, claimant's attorney is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by our order (15 percent scheduled permanent disability for the left foot), not to exceed $3,800, payable directly to claimant's attorney. ORS 656.386(2). This attorney fee award is in lieu of our prior "out-of-compensation" attorney fee award.

The SAIF Corporation initiated the request for hearing, challenging the Order on Reconsideration's 17 percent scheduled permanent disability award. Consequently, because the compensation awarded to claimant has not been disallowed or reduced, claimant's attorney is entitled to a reasonable attorney fee. ORS 656.382(2).

Claimant seeks an insurer-paid fee of $2,550 for her counsel's services at hearing and on review. In Patricia L. McVay, 48 Van Natta 317 (1996), we recently addressed the issue of whether an insurer-paid attorney fee under ORS 656.382(2) is appropriate for services at both hearing and on review, where, as here, an ALJ, in response to a carrier's hearing request, reduces the amount awarded by an Order on Reconsideration and, on Board review of a claimant's appeal, we reinstate (or increase) the Order on Reconsideration award. We concluded that the claimant was entitled to an insurer-paid attorney fee award, but only for services at the hearings level.

We reasoned that, although the insurer was initially successful in its quest for a reduction of permanent disability awards granted by an Order on Reconsideration, it was ultimately unsuccessful by virtue of our order, and, since our order replaced that of the ALJ, it necessarily followed that the claimant was entitled to an insurer-paid fee for her counsel's services at the hearings level. Moreover, because claimant's attorney was already receiving a fee for efforts on claimant's request for Board review of the ALJ's order 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) (as is the case here as well), it followed that the claimant's counsel was not entitled to an insurer-paid attorney fee for such efforts on Board review. Consistent with the McVay rationale, we hold that claimant's entitlement to an insurer-paid attorney fee award is limited to his counsel's services at the hearings level.

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 an 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 the certified reconsideration record, obtained by SAIF. The hearing lasted 40 minutes, consisting of 7 pages of hearing transcript. No witnesses testified at 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.[1] That statement, which seeks a total attorney fee award of $2,300, sets forth a total of 13.1 hours for attorney services at the hearings and Board levels.

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. The value of the interest to claimant is high, in that the entire permanent disability award granted to him 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 award might have gone uncompensated.

After consideration of the aforementioned factors, 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 award is $1,300, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's counsel's statement of services), 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 on Board review.

Accordingly, our May 1, 1996 order is withdrawn. On reconsideration, as modified and supplemented herein, we republish our May 1, 1996 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] Claimant also requests an additional $250 for preparing the motion requesting reconsideration. For the same reasons outlined in Patricia L. McVay, supra, we decline to award an assessed fee for such services on reconsideration.

May 30, 1996 Cite as 48 Van Natta 1103 (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 ON RECONSIDERATION
Coons, Cole, et al, Claimant Attorneys
Brian L. Pocock, Defense Attorney
Lundeen, et al, Defense Attorneys
Mannix, Nielsen, et al, Defense Attorneys
Cowling, Heysell, et al, Defense Attorneys

On March 6, 1996, we abated 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. We took this action to consider claimant's motion for reconsideration. Having received a response from Douglas County Forest Products/Liberty and claimant's reply, we proceed with our reconsideration.

Claimant requests that we change our apparent factual finding that he "has not yet appealed" the March 31, 1994 denial issued by Douglas County Forest Products/Liberty. On page 3 of our order discussing Douglas County Forest Products/Liberty's argument that claimant's hearing request regarding its denial was not timely, we said:

> "Douglas County Forest Products/Liberty issued a denial on March 31, 1994. Claimant had not yet appealed that denial, although his attorney filed a request for hearing for a 'de facto' denial on September 8, 1994."

We change the second sentence quoted above to read as follows:

> "As of the December 8, 1994 hearing in this case, claimant had not yet filed a specific request for hearing referring to the March 31, 1994 denial, although his attorney had filed a request for hearing for a 'de facto' denial on September 8, 1994."

Claimant also asks us to reconsider our interpretation of the Disputed Claim Settlement (DCS) with WRP, Inc. According to claimant, he asserted his entire employment exposure as causative of his compensable hearing loss. Claimant argues that the DCS did not evidence an "agreement" by claimant that the work with WRP did not contribute to some extent to his hearing loss or that he elected to prove actual causation against the remaining employers.

After considering claimant's contentions, we agree with claimant that the DCS with WRP, Inc., did not indicate an election to prove actual causation against the remaining employers. Nevertheless, we adhere to our conclusion that claimant cannot rely on his employment with WRP, Inc. for purposes of proving compensability of his bilateral hearing loss claim.[1]

Claimant agreed in the DCS 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.

By agreeing that he would have "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," we conclude that the DCS evidences an agreement by claimant that he could not rely on his employment with WRP, Inc. for purposes of proving compensability of his bilateral hearing loss claim. Compare Bennett v. Liberty Northwest Insurance Corp., 128 Or App 71 (1994) (DCS terms did not preclude the claimant from relying on the "DCS" employment for purposes of proving compensability).

In our previous order, we addressed claimant's argument that, because Huffman and Wright Logging/Liberty, Douglas County Forest Products/Liberty, Parkway Ford/Liberty and Murphy Plywood Company/Liberty all allegedly failed to timely comply with former ORS 656.308(2), none of those carriers could deny responsibility. We found that claimant had continued to pursue his claims against those carriers and the carriers' alleged violations did not preclude claimant from pursuing the claim with other carriers. See Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994).

On reconsideration, claimant argues that our decision permits the violations of former ORS 656.308(2) and he asserts that the carriers' untimely disclaimers did not require him to pursue the claim with other carriers or risk going uncompensated.

We agree with claimant that he was not required to pursue the compensability of his claim against the other carriers. In our order, we distinguished this case from Donald A. James, 46 Van Natta 1898 (1994). In James, as in this case, the claimant was not required to pursue the compensability of the claim against all carriers. However, the claimant in James moved for dismissal of all carriers 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 carriers. The other carriers joined the claimant's motion for dismissal. We concluded that, since the claimant was no longer asserting a claim against the other carriers, the remaining carrier was precluded from attempting to shift responsibility for the claimant's condition to another carrier.

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[1] In our prior order, we noted that claimant apparently only worked for WRP, Inc. for eight days, from "10/10-10/18/88." (Ex. A).

In our prior order, we noted that, in contrast to Donald A. James, supra, claimant in this case did not move to dismiss all other carriers. Rather, he has continued to pursue his claims against Huffman and Wright Logging/Liberty, Douglas County Forest Products/Liberty, Parkway Ford/Liberty and Murphy Plywood Company/Liberty. On reconsideration, we continue to adhere to our conclusion that, even if we assume, without deciding, that those carriers all failed to comply with former ORS 656.308(2), claimant has continued to pursue 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.

Next, claimant takes issue with our finding 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." Claimant contends that we failed to note that Parkway Ford/Liberty's disclaimer was issued on November 22, 1994, but the claim was made with Parkway Ford/Liberty on May 23, 1994. Claimant asserts that he was under no obligation to suffer further litigation delay because of this untimely disclaimer. According to claimant, Douglas County Forest Products/Liberty would still be precluded from denying responsibility, because Parkway Ford/Liberty's disclaimer would only benefit it, not another adverse party.

Once again, claimant is arguing about the alleged failure of some carriers to timely comply with former ORS 656.308(2). As we mentioned in our previous order and earlier in this order, even if we assumed, without deciding, that those carriers failed to timely comply with former ORS 656.308(2), that alleged violation did not preclude claimant from pursuing the claim with other carriers, and claimant chose to do so. By commenting in our prior order that the disclaimer from Parkway Ford/Liberty had notified claimant of a potential claim against Douglas County Forest Products/Lumbermen's Underwriting Alliance, we were merely pointing out that claimant had notice that another carrier was potentially involved in the claim. Claimant apparently chose, for whatever reason, not to file a claim against Douglas County Forest Products/Lumbermen's Underwriting Alliance and it was not a party to the hearing.

On reconsideration, claimant contends that he did, in fact, present a claim for all employment at Douglas County Forest Products. Claimant argues that there is not an adequate evidentiary basis to infer that he willingly relinquished a known right against an earlier Douglas County Forest Products insurer. We disagree.

Waiver is "the intentional relinquishment of a known right." Wright Schuchart Harbor v. Johnson, 133 Or App 680, 685 (1995) (quoting Drews v. EBI Companies, 310 Or 134, 150 (1990)). Waiver must be plainly and unequivocally manifested, either "in terms or by such conduct as clearly indicates an intention to renounce a known privilege or power." Id. at 685-86 (quoting Great American Ins. v. General Ins., 257 Or 62, 72 (1970)). A waiver may be explicit or implied from a party's conduct. Id. at 686.

Claimant asserts that there is no evidence in the record that Lumbermen's Underwriting Alliance was an insurer of Douglas County Forest Products or that Liberty did not insure Douglas County Forest Products for all periods of claimant's employment. We are not inclined to address this argument because claimant did not raise this argument at hearing or on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). In any event, for the following reasons, we conclude that the record preponderates in favor of a finding that Lumbermen's Underwriting Alliance did insure Douglas County Forest Products during a portion of claimant's employment with Douglas County Forest Products.

Claimant did not explicitly waive a claim against an earlier Douglas County Forest Products insurer, Lumbermen's Underwriting Alliance. Nevertheless, a waiver may be implied from a party's conduct. Id. at 686. We look to the "totality of the circumstances" to determine if claimant actually intended to waive his right to assert a claim against Douglas County Forest Products/Lumbermen's Underwriting Alliance before the hearings in this case.[2] See id. at 688; Connie M. Johnson, 47 Van Natta 2191 (1995), on recon 48 Van Natta 239 (1996).

[2] We emphasize that we are only addressing whether claimant waived his right to assert a claim against Douglas County Forest Products/Lumbermen's Underwriting Alliance in this particular proceeding.

The record establishes that claimant had notice that Douglas County Forest Products was insured by two different carriers. As we discussed earlier and in our previous order, Parkway Ford/Liberty notified claimant of a potential claim against Douglas County Forest Products/Lumbermen's Underwriting Alliance. (Ex. 51). Moreover, it is clear from Exhibit A that claimant was aware that Douglas County Forest Products had two carriers. Exhibit A is a form prepared by claimant's counsel entitled "Jon Norstadt Claims." (Tr. 4 - 12/8/94 hearing). Exhibit A refers to, among other things, "Douglas Co. Forest Prod.," date of employment "(1) 8/15/86-3/87 (2) 10/16/91-3/16/92." Beside "(2)" in the adjacent column, Exhibit A lists "LNW." There is no carrier listed for "(1)."

Although claimant had notice that Douglas County Forest Products was insured by two different carriers, claimant's claim filed with Douglas County Forest Products was expressly limited to a claim for a specific period of employment. In our previous order, we addressed claimant's argument that Douglas County Forest Products was joined as a party. We disagreed with claimant, reasoning that 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 had 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).

In our previous order, we concluded that, by referring to a particular period of exposure, claimant's "claim" was limited to that exposure. There was 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. We adhere to that conclusion on reconsideration.

In summary, based on the "totality of circumstances," we conclude that claimant implicitly waived a claim in this particular proceeding against an earlier Douglas County Forest Products insurer, Lumbermen's Underwriting Alliance. See Connie M. Johnson, supra. The record establishes that claimant had notice that Douglas County Forest Products was insured by two different carriers. Notwithstanding that notice, claimant's claim with Douglas County Forest Products was limited to a claim for a specific period of employment, i.e., the time period when Douglas County Forest Products was insured by Liberty Northwest. Under these circumstances, we conclude that, by his conduct, claimant implicitly waived his right to file a claim against Douglas County Forest Products/ Lumbermen's Underwriting Alliance before the hearings in this particular case.

Alternatively, claimant argues that, since he was not given notice by Douglas County Forest Products/Liberty of the possible existence of an earlier insurer, a remand to the ALJ is appropriate to permit joinder of Douglas County Forest Products/Lumbermen's Underwriting Alliance, following the processing of an amended claim.[3]

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).

We find no compelling reason to remand. First, since claimant has not previously requested remand, we are not inclined to consider such a request for the first time on reconsideration. See Betty S. Tee, 48 Van Natta 67 (1996). Second, claimant's request for remand is premised on his assertion that he was not given notice by Douglas County Forest Products/Liberty of the possible existence of an earlier insurer. Although claimant was not notified by Douglas County Forest Products/Liberty of another potential carrier, claimant did have notice from at least one other source that Douglas County Forest Products was insured by two different carriers. Finally, claimant is not merely asking for remand to present additional evidence. Rather, claimant requests remand to permit joinder of another carrier and presumably to litigate his claim against Douglas County Forest Products/Lumbermen's Underwriting Alliance. We conclude that such circumstances do not establish good cause or any other compelling basis to justify remand. See generally Bruce W. Archer, 47 Van Natta 2119 (1995).

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[3] In claimant's motion for reconsideration, he included two documents dated March 1, 1996, Exhibits 200 and 201. Since those documents were not part of the record on review, we do not consider them.

On reconsideration, as supplemented herein, we republish our February 7, 1996 Order on Review in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Board Chair Hall dissenting.

On reconsideration, the majority adheres to its original decision. After further reflection, I believe that some of claimant's arguments on reconsideration are well-taken. For the following reasons, I respectfully dissent.

To begin, I disagree with the majority's conclusion that claimant cannot rely on his employment with WRP, Inc. for purposes of proving compensability. In Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71 (1994), the claimant entered into a DCS with Caterpillar, that provided, in part:

> "[Caterpillar] denied this claim on March 12, 1991, for the reason that claimant's condition did not arise out of or in the course and scope of his employment, and further, that he has untimely filed the claim. There being a bona fide dispute and the parties wishing to resolve this matter on a disputed claim basis, and both having evidence to respect [sic] their respective positions;
>
> "IT IS HEREBY STIPULATED AND AGREED that this matter be compromised and settled, * * * by [Caterpillar's insurer] paying and claimant accepting, the sum of $7,500 in full and final settlement of his claim. In consideration for this payment, claimant agrees that his claim shall remain in its denied status and that he shall take no workers' compensation benefits on account thereof." 128 Or App at 73-74.

The court held:

> "The DCS does not, by its terms, evidence an agreement by claimant that work at Caterpillar did not contribute in any way to claimant's loss of hearing; nor does it by its terms indicate an election to prove actual causation as against Siltec. There is nothing in the DCS with Caterpillar that shows an election to prove actual causation against Siltec." Id. at 78.

The intent and effect of the DCS language in Bennett is the same as the DCS language in this case. Here, claimant agreed in the DCS 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. As in Bennett, the DCS in the present case does not foreclose claimant from relying upon his employment with WRP to prove compensability.

In any event, the issue is not claimant's actual entitlement to file a claim with WRP, Inc., but the ability to use the WRP employment under the last injurious exposure rule. This situation is similar to cases allowing consideration of out-of-state employment to prove compensability under the last injurious exposure rule, even though the claimant cannot legally recover Oregon benefits from the out-of-state employer. See Silveira v. Larch Enterprises, 133 Or App 297 (1995).

The majority also concludes that, by referring to a particular period of exposure in the letter to Douglas County Forest Products, claimant's "claim" is limited to that exposure. I believe that the majority reads the "claim" too narrowly.

A claimant's claim is with the employer, not with any particular carrier. A claimant is required to give notice of the occupational disease claim to the employer. See ORS 656.265; ORS 656.807. ORS 656.265(2) provides, in part: "The notice need not be in any particular form. However, it shall be in writing and shall apprise the employer when and where and how an injury has occurred to a worker."

Here, claimant sent a letter to Douglas County Forest Products on March 7, 1994, enclosing a copy of a SAIF disclaimer for the same claim. Claimant's letter stated:

"Please accept this letter as notice of claim for occupational disease (for hearing loss) which SAIF Corporation is requiring Jon Norstadt file with Douglas County Forest Products. Enclosed you will find a copy of SAIF Corporation's disclaimer letter dated 2/17/94. That letter gives the claim number, etc.

"Please submit to the comp carrier insuring you for the period of exposure stated in the enclosed letter from SAIF." (Ex. 19).

SAIF's February 17, 1994 disclaimer referred 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).

Under ORS 656.262(3), Douglas County Forest Products was required to give notice of any claims to its insurer(s). ORS 656.262(3) provides, in part:

"Employers shall, immediately and not later than five days after notice or knowledge of any claims or accidents which may result in a compensable injury claim, report the same to their insurer. The report shall include:

"(a) The date, time, cause and nature of the accident and injuries.
(b) Whether the accident arose out of and in the course of employment.
(c) Whether the employer recommends or opposes acceptance of the claim, and the reasons therefor.
(d) The name and address of any health insurance provider for the injured worker.
(e) Any other details the insurer may require."[1]

Since claimant notified Douglas County Forest Products of a claim for an occupational disease, Douglas County Forest Products was required to notify its insurers[2] of a claim "which may result in a compensable injury claim" in order to satisfy ORS 656.262(3). Because claimant's claim was for an occupational disease, the claim could have resulted in a compensable claim in connection with any of claimant's employment exposure with Douglas County Forest Products. Therefore, Douglas County Forest Products was required to report the claim to both of its insurers. The fact that claimant referred to the period of exposure stated in SAIF's disclaimer does not limit claimant's claim to that time period because Douglas County Forest Products was required under ORS 656.262(3) to report to its insurers any claim "which may result in a compensable injury claim." (Emphasis added).

Furthermore, it is apparent that Douglas County Forest Products, based on its own disclaimer, understood the claim to be for all of claimant's employment exposure at Douglas County Forest Products. The March 31, 1994 disclaimer from Liberty Northwest Insurance Corporation, on behalf of Douglas County Forest Products, provided, in part:

"It is alleged that this [bilateral hearing loss] condition is the result of your work exposure while employed with Douglas County Forest Products.

"* * * * *

"It is our position that your bilateral hearing loss did not arise out of or in the course and scope of your employment duties while working for Douglas County Forest Products. It is also our position that your Douglas County Forest Products employment did not materially contribute to your condition.

"Listed below are the names and addresses of each employer, and its insurer, as well as the possible dates of injury or occupational exposure, which may be responsible for your current condition: * * *" (Ex. 26B).

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[1] Although ORS 656.262(3) refers to a "compensable injury claim," ORS 656.804 provides that an occupational disease is considered an "injury" for employees of employers who have come under this chapter.

[2] Douglas County Forest Products was insured by two different insurers during claimant's employment.

Liberty, on behalf of Douglas County Forest Products, did not notify claimant that another insurer of Douglas County Forest Products could be responsible for his hearing loss claim, i.e., Liberty did not disclaim against the other insurer of Douglas County Forest Products.

In summary, claimant fulfilled his statutory obligation of filing his claim with the employer, Douglas County Forest Products. The fact that Douglas County Forest Products chose not to notify its other insurer, Lumbermen's Underwriting Alliance, of the occupational disease claim does not negate the fact that Douglas County Forest Products itself had notice of the claim. The employer on the risk when claimant first sought treatment in 1986 was Douglas County Forest Products. The evidence demonstrates that Douglas County Forest Products is responsible for claimant's bilateral hearing loss condition.

For the same reasons, I disagree with the majority's conclusion that claimant implicitly "waived" a claim against the other Douglas County Forest Products insurer, Lumbermen's Underwriting Alliance.

May 30, 1996 Cite as 48 Van Natta 1109 (1996)

In the Matter of the Compensation of
KAREN J. WHITE, Claimant
WCB Case Nos. 95-05495, 95-05023 & 95-05494
ORDER ON REVIEW
Parker, et al, Claimant Attorneys
Moscato, Byerly, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its denial of compensability and responsibility, on behalf of the Oregon Symphony Association (Symphony), for claimant's bilateral shoulder calcific tendinitis; (2) upheld its responsibility denial, on behalf of A & N Management, Inc. (A & N), for the same condition; and (3) upheld its responsibility denial, on behalf of Portland Opera Association, Inc. (Opera), for the same condition. Claimant filed a cross-request for review in case the issue of compensability was raised. Since the compensability issue was not contested by the parties, claimant did not submit a brief. On review, the issue is responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

We begin by briefly recapping the relevant facts. Claimant is a violinist who has been playing professionally for 25 years. Claimant contracts with several employers throughout the year to perform as a musician in various concerts, ballets and operas. These contracts include required rehearsals.

In 1992, claimant experienced left elbow soreness for which she sought treatment from a chiropractor, Dr. West, in September of that year. Dr. West diagnosed left medial epicondylitis. (Ex. 5). Claimant filed a workers' compensation claim against the Opera that was settled by Disputed Claim Settlement in July 1993. (Ex. 14A).

From September 24, 1994 to November 12, 1994, claimant performed with the Opera. On September 26, 1994, claimant returned to Dr. West, complaining of elbow symptoms. Dr. West diagnosed mild lateral epicondylitis, although it appeared that claimant was having some shoulder and arm discomfort. (Ex. 15-1, 2).

From December 9, 1994 to December 24, 1994, and again on December 30 and 31, claimant performed for A & N. Claimant contracted to perform with the Symphony beginning January 16, 1995.

When claimant pulled her violin out of its case to practice during the second week of January 1995, she noticed right shoulder blade and shoulder cap soreness. On January 9, 1995, claimant sought treatment from Dr. West for her right shoulder soreness. (Ex. 17). Dr. West's treatment was ineffective, so claimant was referred to Dr. Heitsch on January 16, 1995. Dr. Heitsch diagnosed bilateral calcific bursitis/tendinitis and supraspinatus syndrome. (Ex. 19).

On January 17 and 18, 1995, claimant performed in two and one-half hour daily rehearsals for the Symphony. When she tried to rehearse with the Symphony on January 19, 1995, she was unable to lift her bow to the strings. On January 20, 1995, claimant returned to Dr. Heitsch, who again diagnosed bilateral calcific bursitis/tendinitis, prescribed physical therapy and authorized temporary disability. (Exs. 20, 21).

In May 1995, SAIF issued a series of denials of compensability and responsibility on behalf of A & N, the Opera and the Symphony. Claimant appealed those denials.

The ALJ first concluded that claimant had proven by a preponderance of the evidence that her work activities as a violinist were the major contributing cause of her bilateral shoulder condition. The ALJ, thus, determined that claimant's bilateral shoulder calcific tendinitis was compensable.

Reasoning that ORS 656.308(1) was inapplicable because there was no accepted claim for claimant's shoulder condition, the ALJ applied the last injurious exposure rule (LIER) to assign initial responsibility for claimant's right shoulder claim to A & N, claimant's last employer prior to her seeking medical treatment for her bilateral shoulder condition on January 9, 1995. Then, citing Strametz v. Spectrum Motorwerks, 135 Or App 67 (1995), the ALJ shifted responsibility forward to the Symphony, concluding that employment conditions there were of a kind which could have caused claimant's shoulder condition.

On review, compensability is not disputed. The only issue is responsibility. The Symphony contests the ALJ's responsibility determination for claimant's shoulder condition. We agree that the Symphony is not responsible for claimant's condition.

The LIER provides that, where 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); Meyer v. SAIF, 71 Or App 371, 373 (1984), rev den 299 Or 203 (1985).[1] 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). The dispositive date is the date the claimant first sought treatment for symptoms of the compensable condition, even if the condition was not correctly diagnosed until later. SAIF v. Kelly, 130 Or App 185, 188 (1994).

In the Fall of 1994, claimant testified that she would awaken with a "very deep ache" on the outside of the right arm. (Tr. 15). Claimant sought care from a chiropractor, Dr. West, on September 26, 1994. (Ex. 15-1). Claimant complained of some right shoulder/arm discomfort, although Dr. West diagnosed mild lateral epicondylitis. (Ex. 15-2). Claimant explained that she had Dr. West treat her muscles between the shoulder and neck with ultrasound because her muscles tightened with violin playing. (Tr. 43).

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[1] The Opera contends that LIER should not be applied here, because actual causation lies with either Symphony or A & N. We disagree. The only medical evidence that the Opera cites to support its argument is from an examining physician, Dr. Duff, who opined that claimant's employment was not the major contributing cause of her shoulder condition, but that, if it was, the Symphony would "presumably" be responsible because it provided the majority of claimant's work hours. (Ex. 29-4). However, we do not find Dr. Duff's unexplained opinion persuasive. Accordingly, we do not find that actual causation has been established and conclude that LIER is applicable.

In January 1995, claimant experienced new pain in the front of her right shoulder and shoulder blade and underneath her arm for which she sought treatment from Dr. West on January 9, 1995. (Ex. 17-1; Tr. 16, 22, 41). Claimant began her work with the Oregon Symphony as scheduled on or about January 17, 1995. She played the rehearsals in pain for two days. On the third day she was unable to lift her bow to the strings. (Tr. 21). On January 16 and 20, 1995, she sought treatment from Dr. Heitsch, M.D., who diagnosed claimant's condition as bilateral calcific tendinitis.[2] (Ex. 19, 20, 21).

Given the appearance of new and different symptoms in January 1995 resulting in the diagnosis of bilateral calcific tendinitis, we conclude that claimant first sought treatment for this condition on January 9, 1995. Thus, the ALJ appropriately assigned initial responsibility for claimant's bilateral shoulder condition to A & N, the last employment prior to her seeking medical treatment for her condition.[3]

The Symphony argues that responsibility for claimant's condition should not shift from A & N to the Symphony. We agree.

In Strametz, the claimant suffered from mesothelioma, a cancerous lung condition caused by exposure to asbestos. The medical evidence indicated that mesothelioma has a latency period of at least ten years. The claimant had been exposed to asbestos over a period of many years while serving in the Navy and while working as an auto mechanic; however, he did not begin working in Oregon until 1984. The claimant filed a claim against his Oregon employers and settled with all of them but the most recent two. Both employers denied the claim. Because of the lengthy latency period, we found that it was impossible for any Oregon employment to have caused claimant's mesothelioma. Therefore, we determined that claimant's lung condition was not compensable. William A. Strametz, 45 Van Natta 1150 (1993).

Responding to the employers' arguments that the claimant's lung condition was not compensable because their employment could not have actually caused the condition, the Court of Appeals stated that whether the exposure at an employer was or was not the actual cause is irrelevant. Instead, the court reasoned that all a claimant must show to establish a compensable claim is that employment conditions at an Oregon employer could have caused the disease. Strametz, supra, 135 Or app at 71.

Although the evidence in Strametz showed that, due to the latency period for the development of mesothelioma, conditions of employment could not have contributed to the claimant's disease, the court emphasized, citing Meyer v. SAIF, supra, that an employer is responsible if the conditions at its employment were of a kind that could have caused the same disease at a future date. Strametz, supra, 135 Or App at 73. The court then remanded to the Board for a determination of whether the remaining employers were responsible for the claim because conditions at those employments were of a kind which could have caused the claimant's disease.

Here, the ALJ interpreted the court's decision in Strametz as allowing a presumptively responsible employer to shift responsibility forward to a subsequent employer on the basis that the subsequent employment "could have" caused the disease. However, we do not interpret Strametz as overturning the long-settled rules for shifting responsibility forward to a subsequent employer, which require actual contribution from the subsequent employment. See, e.g., Bracke v. Baza'r, 293 Or 239, 250 (1982) ("A recurrence of symptoms which does not affect the extent of a continuing underlying disease does not shift liability for the disabling disease to a subsequent employer"); Timm v. Maley, 134 Or 245, 249 (1995) (Substantial evidence supported the Board's findings that the claimant's condition actually worsened and that her employment with the subsequent employer independently contributed to the worsening).

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[2] Subsequently, when claimant began physical therapy for her right arm, she experienced pain on the shoulder cap of her left arm. (Tr. 23).

[3] A & N asserts that the Opera is initially responsible for claimant's shoulder condition, because claimant first sought treatment for her condition in September 1994, while she was working for the Opera. We disagree. The medical evidence does not relate claimant's symptoms in September 1994 to her bilateral calcific tendinitis condition. Moreover, claimant credibly testified that her pain in January 1995 was different from that in the Fall of 1994. Under these circumstances, we find that claimant did not seek medical treatment for her shoulder condition until January 9, 1995.

In other words, the "potential contribution" standard of LIER is used to establish compensability and presumptive responsibility in the first instance. However, evidence of actual contribution from a subsequent employment is necessary in order to shift responsibility forward after an initial assignment of responsibility under LIER has been made. Inasmuch as the court did not overrule Timm or any other similar decision, and because Strametz was not a case where an initial assignment of responsibility had been made under LIER, we find that it is distinguishable from this case and, therefore, not controlling. Accordingly, we apply the "actual contribution" standard to determine the responsible employer in this case.

Because A & N is presumptively responsible for claimant's bilateral shoulder condition, it can shift responsibility to the Symphony if employment conditions at the Symphony contributed to the cause of, aggravated or exacerbated 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 actually contribute to a worsening of the condition). A claimant must experience more than a mere increase in symptoms. Timm v. Maley, supra, 134 Or App at 249.

As previously noted, Dr. West initially treated claimant for her shoulder condition on January 9, 1995. (Ex. 17-1). Dr. Heitsch later removed claimant from work on January 20, 1995 and prescribed 8-12 weeks of physical therapy. (Ex. 19). However, neither Dr. West nor Dr. Heitsch discussed the difference between claimant's condition on January 9, 1995 and her condition on January 20, 1995, or whether claimant's approximately 5 hours of violin playing for the Symphony actually contributed to a worsening of her shoulder condition.

Three physicians addressed causation issues: Drs. Duff, Fuller and Puziss. Dr. Duff opined that claimant's work conditions contributed to a "symptomatic flare-up" of a preexisting condition, but that there was nothing to indicate a change in the underlying pathology of claimant's shoulder condition. (Ex. 29-3, 4). Dr. Fuller, another examining physician, also opined that there was no change in underlying pathology based on his comparison of x-rays taken in January 1995 and in April 1995. (Ex. 45-5).

Dr. Puziss examined claimant on referral from claimant's counsel. Dr. Puziss stated that claimant "had an exacerbation of her right shoulder pain in approximately January, 1995, causing her to lose time from work." He further stated that "[I]t is because of [claimant's] overuse of the shoulder * * * that caused the flare-up of symptoms and probably she did have a subacromial bursitis that was treated..." (Ex. 48-4).

None of the above physicians opined that claimant's brief employment for the Symphony in January 1995 actually contributed to a worsening of claimant's underlying shoulder condition. At most, Dr. Puziss confirmed that claimant experienced a flare-up of symptoms, which is not sufficient to shift responsibility forward to the Symphony. Timm v. Maley, supra.

Inasmuch as A & N is presumptively responsible for claimant's bilateral shoulder condition, it has the burden of proof. Renee M. Willshire, 47 Van Natta 1339, 1341 (1995). On this record, we conclude that A & N has failed to show that claimant's employment conditions at the Symphony in January 1995 actually contributed to a worsening of her underlying shoulder condition. Accordingly, we conclude that A & N is responsible for claimant's bilateral shoulder condition and reverse the ALJ's decision assigning responsibility to the Symphony.

ORDER

The ALJ's order dated October 25, 1995 is reversed in part and affirmed in part. A & N/SAIF Corporation's denial of responsibility is set aside and the claim is remanded to SAIF for processing on behalf of A & N. The SAIF Corporation's denial of responsibility on behalf of Oregon Symphony is reinstated and upheld. The ALJ's assessed fee award of $2,800 shall be paid by SAIF on behalf of A & N, rather than the Oregon Symphony. The remainder of the order is affirmed.

In the Matter of the Compensation of
ROBERT B. CHAMBERS, Claimant
WCB Case No. 95-02781
ORDER ON REVIEW
Bischoff, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Odell's order which set aside its partial denial of claimant's occupational disease claim for a low back condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following clarification. Claimant's job rotation from shear, the saws and the burn table was sometimes longer or shorter than once every 90 days. (Tr. 57-58).

CONCLUSIONS OF LAW AND OPINION

Applying the major contributing cause standard, the ALJ determined that the cause of claimant's low back condition was his work activities. In so doing, the ALJ found persuasive the medical opinion of Dr. Miller, attending physician. On review, the insurer contends that Dr. Miller's opinion is based on an inaccurate history of claimant's work activities and is therefore not persuasive.

On review, the parties do not dispute the application of the "major contributing cause" standard; therefore, we apply the same standard. Further, absent persuasive reasons to do otherwise, we generally defer to a claimant's attending physician. See Weiland v. SAIF, 64 Or App 810 (1983). Finally, in resolving a complex medical causation issue, such as that 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).

Claimant testified that operating the shear machine was the most physically demanding machine he operated. (Tr. 58). The shear machine required him to maneuver metal plates into the machine which were then cut into pieces which weighed from thirty to three hundred pounds. (Tr. 63). Claimant stated that he was constantly bending over and picking up the cut pieces of metal. (Tr. 70). Claimant testified that there was a straddle crane which could be used to move the cut metal. However, claimant stated that he would often manually lift and stack the cut metal pieces because the crane could not always be used to lift the cut pieces of metal.

Mr. Erickson, co-worker, testified that a shear operator was always pushing, pulling, bending, stooping and lifting nine hours a day six days a week. (Tr. 13). He stated that a shear operator had to lift 80 to 100 pounds pieces metal off the floor and stack them on pallets repetitively. (Tr. 15-17). Mr. Erickson considered the job of a shear machine operator as a very physically demanding job.

Dave Schmidt, employer's supervisor, testified that the job of a shear machine operator was a "physically intensive job" requiring frequent pushing, pulling and some strenuous lifting. (Tr. 113). A "Physical Job Analysis" prepared by Mr. Schmidt reported that claimant used a crane for carrying objects of 50 pounds or more. (Ex. 38A). The job analysis described claimant's job as a shear operator as requiring "bending from waist, squatting to lift steel" and twisting to move parts. Id.

Dr. Miller, in a letter from claimant's attorney summarizing their telephone conversation, stated that claimant's work involving repetitive heavy lifting was the major contributing cause of his low back condition. (Ex. 49). Dr. Miller relied on a history (provided by claimant's attorney) that claimant did heavy work that required frequent lifting of 50 pounds and occasional lifting of 100 pounds. Dr. Miller also believed that claimant often lifted heavy pieces of metal because there was only one crane to service five machines.

On deposition, Dr. Miller stated that, even though Dr. Woolpert believed that certain occupations caused degenerative disc disease, this does not mean that other occupations do not also

cause degenerative disc disease. (Ex. 52-25). When asked to describe claimant's work, Dr. Miller stated that claimant took large sheets of metal off a pile and, due to the unavailability of a crane, claimant "often" had to do the lifting by himself. (Ex. 52-23). Dr. Miller went on to state that, "although [claimant's] job description is supposed to include up to a certain amount of lifting, he actually frequently had to lift quite a bit more than that." Id. Dr. Miller stated he understood that claimant would lean over, lift heavy sheets of metal onto the machine, and then stack them on a pile. (Ex. 52-24). Dr. Miller did not know that claimant would rotate to other types of machinery.

Dr. Woolpert, who examined claimant on behalf of the insurer, opined that repetitive heavy lifting can accelerate degenerative disc disease. (Ex. 46). However, (based on the employer's job analysis) Dr. Woolpert reported that claimant's job did not require heavy lifting and, therefore, Dr. Woolpert believed that claimant's degenerative disc disease was due to idiopathic factors. Dr. Woolpert (relying on medical journals) stated that persons doing some lifting and some bending had less degenerative disc disease in respect to persons who do heavy lifting. Id.

Here, although the insurer argues that Dr. Miller has an inaccurate history, we are not persuaded that there is any substantive contradiction between the history of claimant's job duties (as reported by claimant, Mr. Erickson and Mr. Schmidt) and the history which Dr. Miller relied upon to base his opinion. Dr. Miller's opinion was based on the fact that claimant often lifted "relatively heavy sheets of metal." Based on the testimony of Mr. Erickson and Mr. Schmidt, claimant's work required him to repetitively bend and lift objects between 50 and 100 pounds, activity which is consistent with heavy work. Further, although there may have been a crane at the shear machine, we find that the crane (based on the testimony of Mr. Schmidt and claimant) was not always able to assist the operator in picking up the pieces of metal. Therefore, claimant's work activities often required him to pick up heavy pieces of metal repetitively. Consequently, we find no persuasive reason to discount the opinion of Dr. Miller.

In contrast, we decline to rely on the opinion of Dr. Woolpert because it is based on an inaccurate history of claimant's job activities. Specifically, Dr. Woolpert believed that claimant may have never lifted objects over 50 pounds. However, we have found that claimant did lift heavy objects repetitively. Further, while Dr. Woolpert believed that persons engaged in some lifting and some bending actually were at less risk of having degenerative disc disease, he agreed that heavy lifting could accelerate the disease. Therefore, in light of our finding that claimant repetitively lifted heavy objects, we find Dr. Woolpert's opinion consistent with Dr. Miller's in this regard. Accordingly, we find that claimant has proven that his job activities were the major contributing cause of his low back condition.

Finally, we address the insurer's contention that the ALJ found claimant's low back condition was a compensable consequence of claimant's accepted cervical claim. Specifically, the insurer asserts that by contesting the partial denial of March 2, 1995, claimant is alleging that his low back condition was a consequence of his accepted cervical condition. We disagree.

On March 2, 1995, the insurer issued a partial denial which continued to accept responsibility for claimant's C6-7 disc herniation while denying claimant's degenerative disc disease of the lumbar spine on the basis that his "work activities" were not the major contributing cause.

Here, we find that the denial of March 2, 1995 denied claimant's low back condition as a noncompensable occupational disease claim. Specifically, the insurer stated in its denial that claimant's "work activities" were not the major contributing cause of his low back condition. At hearing, claimant did not allege that his low back condition was a consequence of his cervical disc herniation. Further, the parties litigated claimant's claim on the basis of an occupational disease claim. Therefore, we find that the ALJ's order, as amended on October 23, 1995, properly set aside the insurer's March 2, 1995 denial of claimant's low back condition.

Inasmuch as claimant did not timely submit his respondent's 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 October 10, 1995, as amended October 23, 1995, is affirmed.

In the Matter of the Compensation of
GARY E. FRAZIER, Claimant
WCB Case No. 94-06685
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Zimmerman, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's claim for right carpal tunnel syndrome (CTS) and trigger finger conditions of the right middle fingers. In addition, in its brief, the insurer argues that the Board erred in its prior order, as reconsidered, which vacated the ALJ's earlier dismissal order regarding this claim and remanded the claim to the ALJ for hearing. On review, the issues are dismissal and compensability.

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

We previously decided that, because claimant's failure to appear at the second insurer-arranged medical examination (IME) was justifiable, there was no basis to dismiss his hearing request on the grounds that he unjustifiably delayed the hearing more than 60 days pursuant to former OAR 438-06-071(1). Therefore, we vacated the ALJ's dismissal order, reinstated claimant's hearing request, and remanded the matter to the ALJ for hearing. Gary E. Frazier, 47 Van Natta 1313, on recon 47 Van Natta 1401, on recon 47 Van Natta 1508 (1995). At hearing, the insurer preserved the earlier issue regarding its motion for dismissal. (Tr. 3). On review, the insurer renews its arguments that claimant's hearing request should be dismissed. The insurer's arguments were addressed in our prior orders, including its arguments regarding the applicability of amended ORS 656.325(1)(a). We stand by our decision that dismissal is not appropriate under the facts of this case. Gary E. Frazier, supra.

We also agree with the ALJ's reasoning and conclusions that claimant meets his burden of proving the compensability of the right hand trigger finger condition and the right CTS condition, whether that burden is identified as material or major contributing cause. In this regard, we rely on the opinion of claimant's long-time treating physician, Dr. Thayer, who opined that claimant's work activities with the employer were the major cause of the right trigger finger and right CTS conditions. (Exs. 44, 54). The insurer argues that Dr. Thayer's opinion is not based on an accurate understanding of claimant's work activities. Therefore, the insurer argues, Dr. Thayer's opinion is not persuasive. We disagree.

From claimant's description of his work activities, Dr. Thayer understood that claimant worked as a welder, and that claimant's work involved heavy hand use, with repeated forceful gripping with the right hand. (Exs. 44, 54). Claimant's testimony that his work activities were hand intensive, involving welding, grinding, and drilling, supports Dr. Thayer's understanding of those work activities. (Tr. 6-11, 23-26). In addition, although the testimony of claimant's supervisor, Mr. Dofelmier, revealed some dispute regarding the details of claimant's work, Mr. Dofelmier agreed that claimant's job involved welding, grinding, and drilling during the time he worked for the employer. (Tr. 30). On this record, we find that Dr. Thayer had an accurate understanding of claimant's work activities.

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

ORDER

The ALJ's order dated November 2, 1995 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

In the Matter of the Compensation of
CHARLOTTE F. JOSEPH, Claimant
WCB Case No. 93-03996
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that: (1) postponed the hearing; (2) admitted certain disputed medical reports and testimony; and (3) declined to grant permanent total disability. On review, the issues are postponement, evidence, and permanent total disability. We affirm.

FINDINGS OF FACT

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

In January 1990, claimant sustained a compensable injury. In January 1991, claimant underwent an employer-arranged examination with Dr. Kho and Dr. Perry. In February 1992, claimant was examined by Dr. Parvaresh, psychiatrist, at the employer's request. In April 1992, Drs. Perry and Brown examined claimant on behalf of the employer.

A Determination Order of October 15, 1992 awarded claimant 57 percent unscheduled permanent disability. An Order on Reconsideration dated March 31, 1993 affirmed.

In April 1993, claimant requested a hearing. The employer then scheduled claimant to be separately examined by Dr. Farris and Oregon Health Sciences University (OHSU) on May 25, 1993; by Dr. Brown on May 26, 1993; and by Dr. Binder on May 27, 1993. Claimant attended only the examination by Dr. Farris.

The ALJ granted the employer's motion to postpone the hearing. In making this ruling, the ALJ found that the employer was entitled to require claimant to complete the previously scheduled examinations. The employer scheduled claimant for examinations with OHSU on July 27, 1993; Dr. Brown on July 28, 1993; and Dr. Binder on July 29, 1993. Claimant attended all the examinations but did not complete the evaluation with Dr. Binder.

The employer moved to dismiss. The ALJ denied the motion and the employer scheduled claimant to be tested at OHSU on February 24, 1994, and examined by Dr. Binder on February 25, 1994. Claimant attended and completed the examinations.

The hearing, which first convened on June 29 and June 30, 1994, was postponed. It then was continued until September 28 and concluded on September 29, 1994. At the hearing, claimant objected to the admission of all reports generated from the employer-arranged examinations conducted during and after May 1993. The ALJ, based on his prior ruling that claimant could be required to attend the examinations, overruled the objection and admitted all the reports.

Without objection, several persons, including claimant, testified during the hearing on claimant's and the employer's behalf.

CONCLUSIONS OF LAW AND OPINION

Postponement/Evidence

On review, claimant continues to assert that the employer lacked authority under ORS 656.325(1)(a)[1] to require her attendance at the employer-arranged examinations during and after May

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[1] ORS 656.325(1)(a) provides, in relevant part:

"Any worker entitled to receive compensation under this chapter is required, if requested by the * * * insurer or self-insured employer, to submit to a medical examination * * *. However, no more than three examinations may be requested after notification to and authorization by the director. If the worker refuses to submit to any such examination, * * * the right of the worker to compensation shall be suspended with the consent of the director until the examination has taken place, and no compensation shall be payable during or for account of such period."

1993. Claimant argues that, consequently, the ALJ erred in postponing the hearing and admitting the reports generated from the examinations.

We first note that, subsequent to the ALJ's order, the legislature amended ORS 656.283(7) to provide, 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 court recently considered the statute in Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996). The court first found that the "unmistakable import" of the statute was that "any evidence, including a claimant's testimony concerning the notice of closure or reconsideration order... is inadmissible at a subsequent hearing concerning the extent of the injured worker's permanent disability if not submitted at reconsideration and not made a part of the reconsideration record." Id. at 231. The court further found, however, that the statute "does not apply" because it "purports to bar from admission at hearing evidence not previously offered on reconsideration" without making any provision "concerning the review of evidence previously and properly admitted." Id. Because, in Plummer, the claimant's testimony was admissible when it was offered and considered by the ALJ and the Board, the court concluded that the admission of the testimony "was not error" and "there is no basis for correcting the Board's action[.]" Id.

The hearing in this case took place before the legislature amended ORS 656.283(7). Thus, no party challenged the admission of any documentary or testimonial evidence based on the statute. Hence, unless not properly admitted, we find no error in the ALJ's consideration of evidence that was not submitted during reconsideration. Precision Castparts Corp. v. Plummer, supra.

As discussed above, relying on ORS 656.325(1)(a), claimant does assert that some medical reports were not properly admitted and that the ALJ improperly postponed the hearing. We need not resolve that contention because, even if we agree with claimant's argument and refused to consider any of the disputed medical evidence, as explained below, we would hold that claimant was not permanently and totally disabled based on the remaining portions of the record.

Permanent Total Disability

Permanent total disability is the loss of use or function of any scheduled or unscheduled portion of the body which "permanently incapacitates the worker from regularly performing work at a gainful and suitable occupation." ORS 656.206(1)(a). According to claimant, she is permanently and totally disabled based on physical incapacity. In making this assertion, claimant relies on opinions from Dr. Byers, as well as Dr. Jacobson, Dr. Gross, and Dr. Harris.

Dr. Jacobson, internal medicine specialist, began treating claimant in September 1992. Dr. Jacobson reported that claimant "is completely and totally disabled secondary to ongoing cerebellar ataxia secondary to cerebellar abscess with resection." (Ex. 101A-1). Dr. Gross first saw claimant in April 1990 and apparently treated her for cadiovascular problems. Dr. Gross also indicated that claimant was "totally disabled at this point, not only from her back and balance problems but also from her [sic] cadiovascular standpoint." (Ex. 102-1). In this regard, Dr. Gross described claimant in July 1993 as "fidgety, frustrated, unable to reliably perform tasks of a repetitive nature from day to day, or even hour to hour or minute to minute." (Id.)

Dr. Byers, a physical medicine specialist who treated claimant until May 1992, stated that claimant could perform "very little work" due to her balance dysfunction. (Ex. 102A-18). Dr. Byers described claimant as able only to walk slowly and carefully with a cane and stated that she avoided crowds, rapid movement, and visual disturbances because such stimuli altered her stability; Dr. Byers also stated that claimant could only ride in a car if she avoided looking at the scenery. (Id. at 18, 20).

At hearing, Dr. Harris, neuropsychologist, testified on claimant's behalf. Dr. Harris evaluated claimant in March 1991, which included testing, and then saw claimant briefly in June 1994 before the

hearing. (Tr. 17 (Day 1)). According to Dr. Harris, claimant could not normally integrate sensory information, which in turn caused disequilibrium. (Id. at 26). Specifically, Dr. Harris stated that claimant experienced constant feelings of movement, nausea, headache, and ringing in the ears; such feelings were worsened with sudden movement or perceptually complex situations, producing vision blurring and overloaded concentration. (Id. at 27). Dr. Harris thought that claimant could work no more than two hours per day, with breaks every 30 minutes, located away from people and bright lights. (Id. at 31-32).

Finally, Bruce McLean, a vocational rehabilitation consultant, also testified at the hearing. Based on a February 1991 physical capacities evaluation (PCE), Mr. McLean found that claimant was not employable. (Id. at 70). The PCE indicated that claimant could work two to four hours if sitting but a maximum of one hour is standing or walking. (Ex. 55). The document further found that "most areas of limitation are due to equilibrium loss/dizziness, ie: any bend or squat, standing, walking, climbing & repetitive body motion." (Id.)

In rebuttal of such evidence, at hearing the employer provided testimony and videotape from two investigators who performed surveillance on claimant for the periods December 20, 1991 through December 21, 1991; February 4, 1992 through February 8, 1992; February 17, 1992 through February 18, 1992; April 10, 1992 through April 12, 1992; May 21, 1993; May 25, 1993 through May 30, 1993; June 1, 1993; June 3, 1993; July 27, 1993; and June 1, 1994. The investigators saw claimant at home and performing such activities as driving, grocery shopping, shopping in a mall, eating in restaurants, attending medical examinations, and camping. Claimant was observed walking over various ground surfaces, including gravel and stairs, in differing weather situations, including rain. Except when she attended some examinations scheduled by the employer, claimant walked in a normal manner, either carrying her cane or only superficially using it; when observed at home, claimant did not use her cane at all. Claimant also was seen walking a distance of three city blocks and strolling through a large mall, exhibiting no difficulty with balance or direction.

Claimant also exhibited the ability to drive for some period of time; in a couple instances, claimant drove without stopping for two hours. Claimant also was observed driving on the freeway at a speed of 70 m.p.h., as well as residential areas. In no instance did claimant exhibit confusion or hesitation; most of the time, claimant was accompanied by a companion who rode as a passenger. Claimant additionally showed the ability to sit in a restaurant for a period of one and a half hours.

Claimant's behavior in May 1993 when she attended an examination in Portland is particularly telling. After attending the first examination, claimant walked three blocks to a car in a normal manner, at one point walking down 15 steps. (Tr. 108). She then rode as a passenger to another appointment; she was transported into, and later left, the building by wheelchair. (Id. at 109-10). Claimant and her companion then went to a hotel, walking up 10 steps rather than using the handicap entrance; claimant did not use her cane. (Id. at 110-11). Claimant then went to another appointment at OHSU, again transported by wheelchair into the building. (Id. at 112). Claimant subsequently was admitted into the hospital and spent the night there. (Id. at 113). The next morning, claimant left the hospital by wheelchair and an orderly assisted her into the car. (Id.) When claimant arrived at the hotel, she again used the stairs to enter rather than the elevator reserved for handicapped people. (Id. at 114).

Claimant checked out of the hotel the next morning, carrying items down the steps into the car; before departing, claimant used a camcorder to videotape the hotel, panning the camera to the top of the building then turning to record the car. (Id. at 116-17). Claimant then drove herself and her companion, not stopping for two hours until reaching a rest stop. (Id. at 118-19). Claimant's companion then drove for a period; claimant completed the trip by driving another hour and a half. (Id. at 121).

The next day, claimant and her companion spent an hour loading up an RV; each walked between the house and the vehicle carrying items and stepping on various ground surfaces, as well as negotiating around large boulders. (Id. at 122-23). A couple times, claimant bent over a toolbox to choose items; claimant caught her foot on the box but quickly recovered in a normal manner. (Id. at 124). Throughout this time, claimant walked briskly without using her cane. (Id. at 125).

Claimant then drove the RV for two hours, stopping at a gas station. (Id. at 127). Claimant continued to sit in the vehicle, then drove another hour and a half along a windy, narrow road to a campground. (Id. at 127-28). Claimant spent at least two nights in the area. (Id. at 128).

We find such evidence sufficiently shows that the physicians providing opinions of claimant's permanent and total disability did not have accurate information regarding her actual condition or impairment. Contrary to the physicians' understanding of claimant's condition, during surveillance, claimant showed no evidence of disequilibrium, used her cane minimally or not at all, walked briskly and without hesitation, and could drive and sit for greater periods of time. As an example that claimant's condition was not as she reported or demonstrated to medical providers, we note claimant's behavior in May 1993, outlined above. Within one day of having been admitted into the hospital (ostensibly because the testing caused heart problems (Ex. 99)), claimant was able to check out of the hotel, return (driving for a total period of three hours), and the next day load up an RV and drive another long distance to go camping.

Thus, we conclude that the medical opinions supporting permanent total disability are not persuasive. Somers v. SAIF, 77 Or App 259 (1986). Lacking such medical evidence, claimant failed to prove that she is permanently totally disabled. ORS 656.206(1)(a).

ORDER

The ALJ's order dated November 1, 1994 is affirmed.

May 21, 1996 Cite as 48 Van Natta 1119 (1996)

In the Matter of the Compensation of
RAYMOND C. MANN, Claimant
WCB Case Nos. 95-09104 & 95-08364
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Scheminske, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Yeager's order that: (1) set aside its denial of claimant's "new injury" claim for his current low back condition; and (2) upheld Argonaut Insurance Company's denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility.

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

On review, SAIF contends that the ALJ erred in concluding that claimant had established compensability. Specifically, SAIF argues that there is no medical evidence which supports a finding that claimant's work activities at its insured were the major contributing cause of the combined condition. SAIF contends that the opinion of Dr. Collada, who opined that claimant's current condition was caused in major part by his compensable 1989 injury and his work activities in 1995, does not meet claimant's burden of proof. We disagree.

Where a claimant chooses to rely on the last injurious exposure rule of proof (as opposed to actual causation), he may show that the claimed condition is work-related in general, rather than related to a particular insurer or employer. See e.g. Joseph E. Kelly, 45 Van Natta 313 on recon 45 Van Natta 775 (1993); Spurlock v. International Paper Co., 89 Or App 461, 464 (1988). Consequently, we agree with the ALJ's conclusion that the opinion of Dr. Collada, claimant's treating neurosurgeon, establishes compensability, as Dr. Collada has reported that claimant's employment, in general, is the major contributing cause of his combined condition.

SAIF further contends that the ALJ erred in applying the last injurious exposure rule. SAIF argues that the case is governed by ORS 656.308(1). ORS 656.308(1) applies if a worker sustains a "new compensable injury" involving the same condition as that previously processed as part of an accepted claim. SAIF v. Yokum, 132 Or App 18 (1994). SAIF contends that, because Dr. Collada opined that the 1989 compensable injury contributed to claimant's current condition, then claimant's current condition must be the "same condition" for purposes of applying ORS 656.308(1).

We agree with the ALJ that claimant's current herniated disc condition at L4-5 is not the same condition as the 1989 low back strain which was accepted by Argonaut. SAIF argues that it is clear that claimant's herniated disc was in existence at the time the 1989 claim was accepted. However, claimant was injured in July 1989, and a lumbosacral strain was diagnosed. (Ex. 1A). Argonaut accepted the low back strain by checking a box on the 801 form, and it was not until March 30, 1990 that an MRI revealed a disc bulge at L4-5. Additionally, although Dr. Collada has related claimant's disc bulge, at least in part, to the 1989 injury, it has not been shown that claimant's current herniated disc bulge at L4-5 is the "same condition as that previously processed" as part of the compensable low back strain. Accordingly, we conclude that the ALJ properly applied the last injurious exposure rule.

Claimant's counsel is entitled to an attorney 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, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 5, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
MARION C. NICKELL, Claimant
WCB Case No. 95-08891
ORDER ON REVIEW
Whitehead & Klosterman, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Factory Home Services, Inc. (Factory), a noncomplying employer, requests review of Administrative Law Judge (ALJ) Nichol's order that dismissed Factory's request for hearing on the ground that there was no matter concerning a claim raised by the hearing request. On review, the issue is jurisdiction.

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

On review, Factory contends that the ALJ had jurisdiction over this matter, as its request for hearing involved a "matter concerning a claim." ORS 656.708. We disagree, and we adopt the ALJ's Conclusions of Law and Opinion on that issue. See e.g. Lloyd v. EBI, 96 Or App 591 (1989) (Reimbursement issue between insurer and paying agent was not a matter concerning a claim, where the worker had already received his compensation and was no longer a party to the dispute). See also EBI v. Kemper Group, 92 Or App 319 (1988).

Factory also disagrees with the ALJ's "alternative" finding that, even if the Hearings Division had jurisdiction, Factory would be precluded from raising its issue at hearing. Because we agree with the ALJ that this matter did not concern a claim, we do not find it necessary to adopt the ALJ's alternative finding, or to discuss that issue on review.

ORDER

The ALJ's order dated November 9, 1995, as reconsidered December 13, 1995, is affirmed.

In the Matter of the Compensation of
JOHN F. CASSIDY, Claimant
WCB Case Nos. 93-07111, 93-00760, 93-07110 & 93-00761
ORDER ON REMAND
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Priscilla M. Taylor, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Albertsons, Inc., v. Cassidy, 139 Or App 115 (1996). In our prior order, we set aside Albertson's "back-up" denial and found it responsible for claimant's low back condition. John F. Cassidy, 46 Van Natta 2254 (1994). Citing amended ORS 656.262(6)(a), the court has reversed and remanded for reconsideration of the effectiveness of Albertsons' "back-up" denial.

FINDINGS OF FACT

We adopt the Administrative Law Judge's (ALJ's) findings of fact with the following addition. On February 26, 1993, Albertsons issued a "back-up" denial of claimant's claim.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back in August 1992 while working for Fred Meyer. Fred Meyer accepted claimant's claim for a low back strain. In November 1992, claimant again injured his low back while working for Albertsons. Albertsons accepted claimant's low back strain in December 1992. On February 26, 1993, Albertsons issued a "back-up" denial of claimant's claim on the ground that it had received evidence that claimant did not sustain a new compensable injury at Albertsons.

The ALJ assigned responsibility for claimant's low back condition to Fred Meyer. The ALJ did not address the propriety of the "back-up" denial issued by Albertsons, reasoning that the issuance of an order under former ORS 656.307 rendered the "back-up" denial issue moot.

On review, we concluded that, because the case involved issues of compensability, our review was de novo in spite of the issuance of an order under former ORS 656.307. Reviewing de novo, we concluded that Albertsons had not established by "clear and convincing" evidence that claimant's low back condition was not compensable. See former ORS 656.262(6). Consequently, we set aside Albertsons' "back-up" denial of claimant's "strained back" and found that responsibility for claimant's low back condition remained with Albertsons by virtue of its acceptance of claimant's claim. John F. Cassidy, supra.

The court has remanded for reconsideration of the effectiveness of Albertsons' "back-up" denial in light of amended ORS 656.262(6)(a). In accordance with the court's mandate, we proceed with our reconsideration.

Under former ORS 656.262(6), if a carrier accepted a claim in good faith, but later obtained evidence that the claimant was not compensable or the paying agent was not responsible for the claim, the carrier, at any time up to two years from the date of acceptance, could revoke the acceptance and issue a formal notice of claim denial. However, if the worker requested a hearing on the denial, the carrier was required to prove by clear and convincing evidence that the claim was not compensable or that the paying agent was not responsible for the claim.

Amended ORS 656.262(6)(a) provides, in relevant part:

> "If the insurer or self-insured employer accepts a claim in good faith * * * and later obtains evidence that the claim is not compensable or evidence that the insurer or self-insured employer is not responsible for the claim, the insurer or self-insured employer may revoke the claim acceptance and issue a formal notice of claim denial, if such revocation of acceptance and denial is issued no later than two years after the date of the initial acceptance. If the worker requests a hearing on such revocation of 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 insurer or self-insured employer is not responsible for the claim." (Emphasis added).

Under the amended statute, a carrier need only establish by a preponderance of the evidence that the claim is not compensable or that it is not responsible for the claim.[1] Based on the following reasoning, we conclude that Albertsons has not satisfied the requisite (amended) statutory standard to support its "back-up" denial.

Two physicians address the causation of claimant's low back condition. Dr. Peterson, an orthopedist, examined claimant on behalf of Albertsons. Dr. Peterson opined that the November 29, 1992 injury at Albertsons was not a new, independent injury, but was merely an exacerbation of the August 1992 Fred Meyer injury. Dr. Peterson based his opinion on his understanding that claimant never made a complete recovery from his August 1992 injury and never experienced a symptom-free interval after August 11, 1992. Dr. Peterson also believed that the November 1992 incident was a relatively trivial event in which claimant lifted a 20 pound weight. Dr. Peterson opined that the November 29, 1992 "Albertsons" incident was the major contributing cause of claimant's disability and need for treatment for one month after the November 1992 injury. Thereafter, Dr. Peterson believed that the August 11, 1992 injury was the major, if not the sole, cause of claimant's need for treatment.

Dr. Berkeley, a neurologist who treated claimant for the Albertsons injury, also gave an opinion regarding the cause of claimant's low back condition. Dr. Berkeley believed that the November 1992 Albertsons incident was an acute exacerbation of an already existing condition related to the August 11, 1992 injury. Dr. Berkeley later elaborated on his opinion by explaining that claimant's condition was probably caused by three factors: his preexisting degenerative disc disease, the August 11, 1992 lifting incident at Fred Meyer and the November 28, 1992 lifting incident at Albertsons. Dr. Berkeley believed that the November 1992 lifting incident at Albertsons was chronologically the major cause of claimant's disability and need for treatment after November 28, 1992.

At his deposition, Dr. Berkeley explained that claimant had a long-standing degenerative condition that preexisted both the Fred Meyer and Albertsons injuries. Dr. Berkeley opined that even if claimant had not recovered 100 percent from the Fred Meyer incident, the Albertsons incident was the major contributing cause of the disability and need for treatment after November 28, 1992. Dr. Berkeley disagreed with Dr. Peterson's opinion that the lifting incident at Albertsons would not be capable of producing an independent injury. Dr. Berkeley explained that it was the body mechanics used which would cause the injury rather than the amount of weight lifted.

Dr. Dougan, a physician who treated claimant for the Fred Meyer injury, but did not treat claimant after the Albertsons injury, opined that the August 1992 Fred Meyer injury was not the major contributing cause of the need for treatment and disability since claimant's condition from the August 1992 injury was much improved and appeared to be resolving the last time Dr. Dougan saw claimant.

After reviewing the record, we are more persuaded by the opinion of Dr. Berkeley. Dr. Berkeley believed that both injuries, as well as the preexisting condition, contributed to claimant's low back condition. However, Dr. Berkeley opined that the November 1992 injury was the major contributing cause of claimant's disability and need for treatment after November 28, 1992. Moreover, even Dr. Peterson agrees that the November 1992 incident was the major contributing cause of the disability and need for treatment, at least for a period of time, after the November 1992 injury.

Under such circumstances, we conclude, based on the greater weight of the evidence, that Albertsons has not established that claimant's claim is not compensable or that it is not responsible. Consequently, after conducting our reconsideration, we continue to conclude that Albertsons' "back-up" denial is improper and that Albertsons remains responsible for claimant's low back condition.[2]

Accordingly, on reconsideration, as supplemented herein, we republish our October 27, 1994 order.

IT IS SO ORDERED.

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[1] The term "preponderance of the evidence" means the greater weight of evidence. Riley Hill General Contractor v. Tandy Corp., 303 Or 390, 394 (1987). "Clear and convincing" means that the truth of the fact asserted is "highly probable." Id at 407.

[2] Because we have found, based on a preponderance of the evidence, that Albertsons has not established that it is not responsible for claimant's claim, we need not address the issue regarding whether Albertsons "back-up" denial was based on later obtained evidence.

In the Matter of the Compensation of
JOYCE J. CHALMERS, Claimant
WCB Case No. 94-07061
ORDER ON REVIEW (REMANDING)
Scott McNutt, Sr., Claimant Attorney
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that: (1) declined to reopen the record to admit an exhibit; (2) set aside the insurer's denial of claimant's coccygodynia, on the ground that the denial was premature; (3) assessed a penalty for the insurer's allegedly unreasonable denial; and (4) awarded an assessed fee pursuant to ORS 656.386(1). On review, the issues are evidence, premature denial, and penalties. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Reasoning that the parties had agreed on the record that the premature denial issue was in controversy, the ALJ proceeded to address the issue, concluding that the insurer's denial of claimant's coccygodynia was premature. The insurer asserts that, because claimant did not raise the issue of an allegedly premature denial, the ALJ exceeded his authority by addressing it. We agree.

An ALJ's review at hearing is limited to issues that the parties raised. Nikki Burbach, 46 Van Natta 265, 268 (1994). In Patricia L. Serpa, 47 Van Natta 747, 748 (1995), we held that an ALJ should not have addressed a "pre-closure" denial issue because the claimant could have raised it at hearing. Because the claimant did not do so, we concluded that the ALJ should have instead addressed the compensability of the claimant's condition. Id.

Here, claimant raised compensability, penalties and attorney fees as issues to be decided at hearing. (Tr. 1). Although there was some discussion between the ALJ and defense counsel regarding a "premature denial," claimant did not join in that discussion. (Tr. 2 - 7). Furthermore, the issue was not among those specifically framed by the parties. Under such circumstances, the ALJ should not have addressed the denial based on a "premature" theory. Rather, the ALJ should have limited his review to the issues that claimant raised.

Finally, although the ALJ admitted exhibits and testimony was given concerning the compensability issue, he did not reach the merits. Therefore, the ALJ did not render findings concerning claimant's credibility as a witness or evaluate the evidence about the compensability issue. Under the circumstances, we consider the current record to be insufficiently developed. Patricia L. Serpa, supra, 47 Van Natta at 748; see ORS 656.295(5).

Accordingly, we remand this matter to ALJ Livesley for reconsideration. The ALJ shall determine whether claimant's coccygodynia is compensable on the merits, including, if appropriate, any findings about claimant's credibility. The ALJ shall also address the remaining issues raised at hearing. The ALJ shall proceed in any manner that he determines will achieve substantial justice; he shall then issue a final, appealable order.

Accordingly, the ALJ's order dated May 9, 1995, as republished on October 24, 1995, is vacated. This matter is remanded to ALJ Livesley for further proceedings consistent with this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DANNY R. FULLER, Claimant
WCB Case No. 93-12935
SECOND ORDER ON RECONSIDERATION
Schneider, Hooton, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On May 7, 1996, we abated our April 9, 1996 Order on Reconsideration, which republished our February 2, 1996 Order on Review. In our original order, we reversed an Administrative Law Judge's (ALJ's) order which: (1) set aside the insurer's denial of claimant's aggravation/current condition claim for an upper neck condition; (2) set aside the insurer's partial denial of claimant's right shoulder impingement syndrome; and (3) assessed a penalty for an allegedly unreasonable denial. Citing the court's recent decision in Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), claimant seeks reconsideration of the legal analysis and factual findings reached in our prior decisions.

Having now received the insurer's response to claimant's motion, we proceed with our reconsideration.

Cervical condition

The ALJ set aside the insurer's denial of claimant's aggravation/current condition claim for an upper neck condition. In reaching his conclusion, the ALJ relied on Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994), rev den 320 Or 507 (1995).[1]

In Messmer I, an employer failed to appeal a Determination Order which had awarded permanent disability based, in part, on the effects of surgery for a noncompensable degenerative disease. The court held that, although an employer's payment of compensation, by itself, did not constitute acceptance of the degenerative condition, the employer's failure to challenge the award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that the condition was not part of the compensable claim. In Messmer I, the court reasoned that the result was not that the degenerative condition had been accepted, it was that the employer was barred by claim preclusion from denying that it was part of the compensable claim. Id. at 258.

Consequently, in light of Messmer I, the ALJ concluded that, because the insurer did not contest a Determination Order which included an award for stenosis, the insurer could not subsequently deny the compensability of that condition.

On review, we applied amended ORS 656.262(10) retroactively to claimant's claim. In doing so, we relied on our decision in Craig L. Hiatt, 47 Van Natta 2287 (1995). In Hiatt, we found that the clear language of the amended statute provided that payment of a Determination Order did not preclude an insurer from subsequently contesting the compensability of a condition rated therein. Accordingly, in light of our decision in Hiatt, we found that the insurer was not precluded from contesting the compensability of the denied condition. Furthermore, on the merits of the case, we found that claimant failed to prove the compensability of his current condition.

Subsequent to our order on review and our first order on reconsideration, the court issued its decision in Deluxe Cabinet Works v. Messmer, supra (Messmer II). In Messmer II, the court concluded that the amended statute did not require a change in the result of the case. The court found that, if the legislature had intended to enact a statute that had the effect of overruling the court's prior decision, it had failed to do so. Specifically, the court concluded that the amended statute said nothing about the preclusive consequences of an employer's failure to appeal a determination order. Rather, the court reasoned that the statute, as amended, provides only that payment of permanent disability benefits does not preclude an employer from subsequently contesting compensability. Accordingly, the court held that, because the legislature had not successfully changed the law, the court could not rewrite the statute to give effect to what the legislature may have intended. Consequently, the court determined that amended ORS 656.262(10) did not effectively overrule its prior decision in Messmer I. Deluxe Cabinet Works v. Messmer, supra.

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[1] For the sake of clarity, we refer to the court's first decision as Messmer I. We refer to the court's most recent decision as Messmer II.

On reconsideration, the insurer concedes that Messmer II controls this case. We agree with the insurer's concession, as we find that, in the present case, the insurer failed to contest the Determination Order which awarded permanent disability benefits for claimant's surgery and foraminal stenosis. Therefore, pursuant to the court's recent decision in Messmer II, the insurer is now precluded from denying claimant's forminal stenosis. Thus, on reconsideration, we affirm that portion of the ALJ's order which set aside the insurer's denial of claimant's stenosis condition.

Impingement syndrome

The ALJ also set aside the insurer's partial denial of claimant's right shoulder impingement syndrome. On review, and in our first reconsideration order, we found that, because the impingement syndrome was not an accepted condition, claimant was required to first establish compensability of the condition. After reviewing the medical evidence, we concluded that, under either a standard of material or major contributing cause, claimant had failed to meet his burden of proof.

On reconsideration, claimant argues that we should rely on the opinion of Dr. Gerry, who saw claimant on two occasions, rather than on the opinion of Dr. Waller, claimant's treating and operating physician. For the reasons set forth in our prior orders, we continue to adhere to our decision that claimant has failed to prove compensability of his shoulder impingement syndrome.

Claimant's attorney is entitled to an assessed fee for services on review and reconsideration concerning the stenosis 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 and reconsideration is $1,200, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's appellant's briefs and motion on reconsideration), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. We note that no attorney fee is available for the portions of claimant's counsel's appellate briefs devoted to the impingement syndrome issue.

Accordingly, on reconsideration, as modified and supplemented herein, we republish our February 2, 1996 order, as reconsidered April 9, 1996, effective this date. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 4, 1996 Cite as 48 Van Natta 1125 (1996)

In the Matter of the Compensation of
DENNIS C. GROSS, Claimant
Own Motion No. 92-0461M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Ransom & Gilbertson, Claimant Attorneys
Mitchell, Lang & Smith, Defense Attorneys

Claimant requests review of the self-insured employer's May 3, 1994 Notice of Closure, which closed his claim with an award of temporary disability compensation from September 14, 1992 through February 27, 1994. The employer declared claimant medically stationary as of February 28, 1994. Claimant contends that he is entitled to additional benefits as he was not medically stationary when the employer closed his claim. Specifically, claimant contends that, because his physician recommended additional surgery for the compensable condition, and diagnosed a severe depression condition prior to claim closure, his claim was prematurely closed. We affirm the employer's Notice of Closure.

FINDINGS OF FACT

On August 12, 1982, claimant sustained a compensable injury to his right foot. On September 4, 1992, the Board authorized the reopening of claimant's claim for the payment of temporary disability compensation commencing the date claimant underwent the proposed right digital neuroma excision of the right fourth intermetatarsal space. Dr. Puziss performed that surgery on September 14, 1992.

Claimant entered a pain center on January 4, 1994. On February 28, 1994, Dr. Jensen, claimant's program physician at the pain center, declared claimant medically stationary. In a March 30, 1994 chart note, Dr. Puziss opined that claimant had a possible recurrent right tarsal tunnel syndrome, chronic and severe situational depression and anxiety, chronic pain syndrome and drug and alcohol dependence. Dr. Puziss referred claimant to a neurologist, Dr. Grimm, and, on April 12, 1994, Dr. Grimm recommended a right tarsal tunnel exploration and release. Dr. Puziss requested authorization to perform the right tarsal tunnel release, and referred claimant to a psychiatrist, Dr. Kolilis.

On May 3, 1994, the employer closed the claim, declaring claimant medically stationary as of February 28, 1994. On June 27, 1994, claimant requested review of the claim closure. On July 22, 1994, the employer denied claimant's current psychological condition. On August 19, 1994, the employer denied the reasonableness and necessity of the right foot tarsal tunnel release surgery proposed by Dr. Puziss. Claimant requested a hearing regarding the denials (WCB Case No. 94-09087). On September 2, 1994, the Board issued its order postponing action on review of the closure, and referred the own motion matter for a consolidated hearing with the pending litigation. In postponing action on our review, we reasoned that, if the proposed surgery was found to be reasonable and necessary for claimant's compensable injury, and/or if claimant's psychological condition was determined to be compensable to this claim, the decision could affect our review of the employer's closure.

By Opinion and Order dated March 13, 1995, Administrative Law Judge (ALJ) Bethlahmy upheld the employer's denials. Claimant requested Board review of the ALJ's order. On October 30, 1995, the Board affirmed that portion of the ALJ's order which upheld the employer's July 22, 1994 denial of claimant's psychological condition, but vacated that portion of the order concerning the propriety of medical services and penalties/attorney fees in this claim. Claimant requested review of the appropriateness of the proposed medical services with the Director.

On November 25, 1995, the Medical Review Unit of the Workers' Compensation Division issued a Proposed and Final Order Concerning a Medical Services Dispute. In that order, the Director found that the proposed surgery was not reasonable and necessary. That order was not appealed. Therefore, it has been finally determined that the surgery proposed by Dr. Puziss (right tarsal tunnel release and excision of multiple Morton's neuromas from claimant's right foot), is not reasonable and necessary for the compensable injury.

CONCLUSIONS OF LAW AND OPINION

A claim may not be closed unless the claimant's condition is medically stationary. See OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. Berliner v. Weyerhaeuser Corp., 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the May 3, 1994 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. See ORS 656.268(1); Sullivan v. Argonaut Ins. Co., 73 Or App 694 (1985); Alvarez v. GAB Business Services, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. Harmon v. SAIF, 54 Or App 121, 125 (1981); Austin v. SAIF, 48 Or App 7, 12, (1980).

In order to close a claim, all compensable conditions must be medically stationary. Rogers v. Tri-Met, 75 Or App 470 (1985). In determining whether a claim was properly closed, medical evidence that becomes available post-closure may be considered as 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). When a claimant's medically stationary status is contingent upon the claimant undergoing a recommended surgery, the claim is prematurely closed if the record establishes that the recommended surgery is reasonable and necessary for claimant's compensable condition and it would materially improve claimant's compensable condition. Bill H. Davis, 47 Van Natta 219 (1995); Richard Uhing, 48 Van Natta 465 (1996).

Claimant contends that he was not medically stationary at the time of claim closure because Dr. Puziss recommended the tarsal tunnel decompression and associated nerve blocks. In addition, claimant contends that he was in need of psychological treatment when his claim was closed, and thus, was not medically stationary relative to that condition.

In a June 22, 1993 letter, Dr. Puziss opined that any further surgical procedure to claimant's foot "would be quite unpredictable in its result." Dr. Puziss recommended that claimant undergo pain center treatment, but that, following the pain program, claimant "could become medically stationary, depending on the treatment outcome." In addition, Dr. Puziss opined that:

> "Since the pain center may have something to offer [claimant,] he is not medically stationary, but if they had nothing to offer him, then he would be stationary at that point."

Claimant was scheduled to attend the pain clinic twice weekly beginning January 4, 1994. However, the record indicates that, between January 4, 1994 and February 11, 1994, claimant attended only four sessions, many times not showing up for appointments with no explanation. Because he did not comply with the program contract, he was declared medically stationary by Dr. Jensen on February 28, 1994.

As noted previously, on April 12, 1994, Dr. Grimm recommended a right tarsal tunnel release. Dr. Puziss agreed with the recommendation and requested authorization to perform that surgery prior to claim closure. Here, however, the proposed surgery which claimant contends establishes that he was not medically stationary at claim closure, has subsequently been found to be unreasonable and unnecessary for claimant's compensable injury. Scheuning v. J.R. Simplot & Co., supra; Bill H. Davis, supra; Richard Uhing, supra. Claimant's contention that the recommended surgery proved he was not medically stationary at claim closure is rebutted by the final determination that the proposed surgery was not reasonable and necessary. See also Everett G. Wells, 48 Van Natta 959 (1996), (because the Director ordered that the proposed surgery was appropriate treatment for claimant's compensable condition, the Board found that claimant's proposed surgery would likely improve claimant's current condition, and thus, established a "worsening" of the compensable injury); Henry Williams, 48 Van Natta 408 (1996), (the Board affirmed a carrier's claim closure where the claimant's physician opined that the proposed surgery was not a medical necessity at claim closure). Therefore, based on the inappropriateness of the proposed surgery and thus, the lack of evidence that the proposed surgery would materially improve claimant's compensable condition, we are not persuaded that claimant's medically stationary status was contingent upon undergoing that surgery.

Notwithstanding the inappropriateness of the proposed surgery, Dr. Puziss' June 23, 1993 opinion that, if the pain center had nothing to offer claimant, "then [claimant] would be stationary at that point," and Dr. Jensen's February 28, 1994 opinion that claimant was medically stationary on that date, further persuade us that claimant was medically stationary when the claim was closed.

Finally, because the ALJ found, and the Board affirmed, that claimant's depression (psychological) condition was not a compensable portion of his claim, we find that claimant was medically stationary with respect to all compensable conditions on May 3, 1994, the date of claim closure. Rogers v. Tri-Met, supra.

On this 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. Berliner v. Weyerhaeuser Corp., supra. Therefore, we conclude that the employer's closure was proper.

Accordingly, we affirm the employer's May 3, 1994 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
LOUIS L. HARON, Claimant
Own Motion No. 66-0195M
OWN MOTION ORDER REFERRING FOR FACT FINDING HEARING
Floyd H. Shebley, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for medical services for his April 13, 1960 back injury. Claimant's claim is currently reopened for temporary disability benefits and medical benefits. SAIF has recommended that the Board deny the provision of the current requested medical services, specifically, the placement of an osteostimulator into claimant's spine, contending that further surgery and the placement of the osteostimulator is "not medically reasonable and necessary treatment." In addition, SAIF asks the Board to disallow medical treatment for claimant's depression, contending that "[t]he depression should no longer be considered a compensable part of his claim for the injury of 1960."

Inasmuch as claimant sustained a compensable injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. William A. Newell, 35 Van Natta 629 (1983). However, the Board may exercise its own motion authority to authorize medical services and temporary disability compensation for compensable injuries occurring before January 1, 1966. ORS 656.278(1)(b). No worsening of the pre-1966 injury is required to qualify for such authorization. Gerald S. Gaage, 42 Van Natta 2722 (1990); Donald B. Karstetter, 42 Van Natta 156 (1990).

The Board last reopened claimant's claim on July 27, 1989 for lumbar surgery and temporary disability compensation. According to the record, claimant has undergone approximately nine surgeries to his back, the most recent occurred in July 1993 for removal of L3-4 Steffe plates. At that time, Dr. Misko, claimant's treating surgeon, opined that the lumbar fusion at L3-4 was solid.

In a July 26, 1994 letter, Dr. Nash, claimant's treating surgeon, opined that he felt there was instability at L3-4 due to pseudoarthrosis, and that claimant was developing signs of right L3-4 foraminal stenosis. He recommended an osteostimulator and stated that this was the only option other than a repeat surgical fusion. In an October 24, 1994 radiology report, Dr. Greene, consulting radiologist, opined that there was a solid-appearing fusion from L4 to the sacrum. Dr. Greene noted that "[m]otion is present above L4, but no abnormal motion is seen." In a December 7, 1994 radiology report which interpreted Dr. Greene's x-rays and chartnotes, Dr. Arkless, consulting radiologist, opined that:

> "At first determination there would truly seem to be motion at the L3-4 level on these flexion-extension views, but if we carefully superimpose L4 on the two views, we see that there is no motion here."

On May 22, 1995, SAIF submitted claimant's request for the osteostimulator for claimant's low back injury. SAIF recommended that the Board deny the provision of the requested medical services, as not reasonable and necessary for the compensable back injury. Because the record was insufficient to determine whether we should authorize payment of the requested medical services, we requested the parties to submit their positions and any supporting medical evidence regarding the compensability of the requested medical services. Neither SAIF nor claimant responded.

On July 6, 1995, SAIF submitted an additional report from Dr. Davies, examining clinical psychologist, regarding claimant's compensable depression condition. SAIF requested that the Board issue an order disallowing further treatment for that condition, contending that "Dr. Davies states that [claimant's] depression is no longer caused in major part by his industrial injury."

After considering SAIF's submittals, we remain unable to determine whether we should authorize payment of the requested medical services based on the current record. In particular, Dr. Reimer, examining neurologist, opined in an April 4, 1995 Independent Medical Examination (IME) that:

> "[w]hether pseudoarthrosis exists or not, this panel feels [claimant] is medically stationary. We do not feel that further efforts directed toward treatment are medically indicated and may, in fact, have a deleterious and negative effect on this man."

The only report from Dr. Nash, subsequent to his July 26, 1994 recommendation for the osteostimulator, is a check-the-box response to SAIF in which he indicated that he did not agree with Dr. Arkless' opinion, and he opined that "[t]he [claimant] has clinical evidence of pseudoarthrosis L3/4 and L3/4 foraminal stenosis."

In addition, SAIF's request that we disallow continuing medical services for claimant's depression condition is supported only by a check-the-box response from Dr. Davies. In that letter, Dr. Davies was asked: "In your opinion, does the injury of 1960 remain the major contributing cause of the depression and need for treatment of same?" Dr. Davies simply wrote "no," and signed and dated the response. However, in his April 4, 1995 report, Dr. Davies noted that claimant was a poor candidate for any surgical procedure, but recommended that claimant undergo "aggressive treatment of this depressive disease. This would be primarily through medications. I do not feel that psychological counseling is necessary." In that report, Dr. Davies does not render his opinion with respect to compensability of claimant's current depression condition.

Under these circumstances, we conclude that this is an appropriate matter for referral to the Hearings Division for an evidentiary hearing. See OAR 438-12-040.

Accordingly, this matter is referred to the Hearings Division with instructions to assign an Administrative Law Judge (ALJ) to perform the fact finding hearing. At the hearing, the assigned ALJ shall take evidence on the issues of whether the current request for medical treatment is reasonable and necessary for the compensable back injury, and whether the work injury is causally related to claimant's need for continuing treatment for depression.

This hearing may be conducted in any manner that the ALJ determines will achieve substantial justice. ORS 656.283(7). Following the hearing, the ALJ shall issue a recommendation to the Board within 30 days. In that recommendation, the ALJ shall make findings of fact on whether the current request for surgical implant of the osteostimulator is reasonable and necessary for claimant's compensable back condition, and whether the work injury is causally related to claimant's need for medical treatment for depression. Based on those findings of fact, the ALJ shall recommend to the Board whether it should order the claim reopened under own motion jurisdiction for payment of medical services. Following the hearing and closure of the record, we shall implement a briefing schedule, and, upon its completion, proceed with our review.

IT IS SO ORDERED.

June 4, 1996 Cite as 48 Van Natta 1129 (1996)

In the Matter of the Compensation of
LYNDA S. SAYLOR, Claimant
WCB Case No. 95-08223
ORDER ON REVIEW
Jon C. Correll, Claimant Attorney
Dennis Ulsted (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Odell's order which upheld the SAIF Corporation's denial of her right lateral epicondylitis injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant was employed as a Certified Nurse Assistant. On March 23, 1995, she was assisting a resident with "toileting." The resident is a large woman who suffers from Alzheimer's disease, and is sometimes combative. As claimant extended her hands to the patient to steady her, the patient yanked against claimant's hands. The actions caused pain in claimant's right shoulder.

Claimant went home from work early, and later that evening was examined by Dr. Lambros at an urgent care center. (Ex. 1). On March 25, 1995, claimant filed a right arm injury claim, attributing her injury to the work incident. (Ex. 2).

On May 18, 1995, claimant was examined by Dr. Matteri, orthopedist. He obtained a history consistent with claimant's description of the work incident. (Ex. 3).

On September 26, 1995, Dr. Lambros stated that, given the straightforward history he obtained from claimant, he "had no qualms about saying that it is medically probable that [claimant's] work activity is the major contributing cause to her condition." (Ex. 6).

We are mindful of the conflicting testimonial evidence in the record. Nevertheless, we find claimants testimony and the medical evidence in the record (specifically Exs. 3 & 6) support a conclusion that claimant's work activities were a material contributing cause of her right lateral epicondylitis. Consequently, claimant has established the compensability of her injury claim. See ORS 656.005(7)(a); 656.266; Mark N. Wiedle, 43 Van Natta 855 (1991). Accordingly, we reverse the ALJ's order and set aside SAIF's denial.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,200, 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 November 16, 1995, as reconsidered November 28, 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 Board review, claimant's counsel is awarded an assessed attorney fee of $3,200, payable by SAIF.

In the Matter of the Compensation of
ANN K. BIAS, Claimant
WCB Case No. 95-08960
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) excluded claimant's hearing testimony regarding the extent of her permanent disability; and (2) affirmed an Order on Reconsideration that had awarded claimant 25 percent (80 degrees) unscheduled permanent disability. On review, the issues are evidence and extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Evidence

Claimant asserts that the ALJ erred in excluding her hearing testimony regarding the extent of her disability pursuant to amended ORS 656.283(7). We disagree.

Amended ORS 656.283(7) provides, in part, that "[e]vidence 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." That statute went into effect on June 7, 1995, shortly before the issuance of the July 31, 1995 Order on Reconsideration. Therefore, the amended statute applies to this case. See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

Under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process, is inadmissible at a subsequent hearing about the extent of an injured worker's permanent partial disability. Id. However, amended ORS 656.283(7) does not apply to exclude evidence that was previously and properly admitted at hearing, i.e., evidence submitted prior to June 7, 1995, the effective date of amended ORS 656.283(7). Id.

In Joe R. Ray, 48 Van Natta 325 (1996), we held that under amended ORS 656.283(7), evidence that was not submitted during the reconsideration process and not made a part of the reconsideration record, is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent partial disability.[1] Nevertheless, in light of the court's decision in Plummer, that holding has been overruled to the extent that evidence concerning the extent of an injured worker's permanent partial disability, that was properly admitted, can be considered on review.

However, where a hearing concerning extent of permanent disability was held after June 7, 1995, the prohibition on subsequent evidence set forth in amended ORS 656.283(7) is applicable. Thus, we continue to adhere to our holding in Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995. Dean J. Evans, 48 Van Natta 1092 (1996).

Here, the hearing was held on October 30, 1995. Because claimant's hearing testimony was not submitted during the reconsideration process, we conclude that the ALJ did not err by excluding claimant's hearing testimony.

Extent of Unscheduled Permanent Disability

We adopt and affirm the ALJ's analysis regarding this issue, with the following modification.

On review, claimant contends that, even based on the written record, she has proven that the value for adaptability should be increased. Claimant argues that she previously worked as a store clerk, which has a DOT that defines the strength requirements of that job as "heavy." Claimant also contends that she returned to a light job, and because she has lifting restrictions, she should be considered in the "sedentary" or "light/sedentary" category. We disagree.

First, we conclude that the ALJ properly identified the job description and DOT (#299.367-014) which most accurately describes claimant's prior work as a store clerk. Furthermore, because the DOT determines strength rating, and the appropriate DOT in this case provides for a strength rating of "light," we conclude that the ALJ correctly found that claimant's Base Functional Capacity (BFC) is "light." See OAR 436-35-310(4)(a); Marlin D. Rossback, 46 Van Natta 2371 (1994).

Claimant next contends that she is capable of working only in the sedentary/light category. Although claimant acknowledges that she returned to "light" work, she argues that she has restrictions on reaching, pushing, and pulling more than five pounds, which would bring her within the definition of "sedentary/light." See OAR 436-35-310(3)(e).

Here, claimant relies on Exhibit 12-1 to establish her restrictions. In that report, claimant's treating doctor, Dr. Sedgwick, reported that claimant's only limitation was that she could not do "any type of activities requiring her to deal with over five pounds in an overhead position." After reviewing Dr. Sedgwick's report, we conclude that it can only be construed to include one restriction involving overhead activity. In other words, we are unable to construe the doctor's statement to also restrict claimant from pushing or pulling. Consequently, because the definition of "restrictions" in the Department's rule requires that claimant have at least one other restriction in addition to reaching, we agree with the ALJ that claimant's RFC is "light." OAR 436-35-310(3)(l)(A); 436-35-310(3)(b).

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[1] Although a signatory to this order for purposes of *stare decisis*, Chair Hall continues to believe, for the reasons set forth in his concurrence/dissent in Joe R. Ray, supra, that amended ORS 656.283(7) should not be applied to those cases where the reconsideration record was developed before June 7, 1995.

Finally, the ALJ concluded that, in view of claimant's light base and residual functional capacities, her adaptability value was zero pursuant to former OAR 436-35-280(1) (WCD Admin. Order No. 93-056).[2] Subsequent to the ALJ's order, the Court of Appeals determined that a former standard giving a zero adaptability value in certain circumstances was inconsistent with ORS 656.214(5)[3] and 656.726(3)(f)(A).[4] 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 previously applied the Carroll decision to former OAR 436-35-280(1). Joe R. Ray, supra. We noted that, under former OAR 436-35-310(2), adaptability is determined by comparing a worker's base functional capacity (BFC) to his or her RFC at the time of becoming medically stationary. We also noted that, if a worker's RFC is equal to or greater than his or her BFC, under former OAR 436-35-280(1)(a), the factor for adaptability, age and education is to be given a neutral value of zero. 48 Van Natta at 334.

In Ray, because the claimant's RFC was equal to his BFC, his adaptability factor under former OAR 436-35-280(1)(a) was zero. Moreover, because that factor was used as a multiplier, former OAR 436-35-280(6), the claimant was not allowed a value for age, education, or skills. In light of Carroll, however, we concluded that former OAR 436-35-280(1) was inconsistent with ORS 656.726(3)(f)(A). 48 Van Natta at 335. Therefore, we declined to apply the rule. Rather, we found that, pursuant to former OAR 436-35-280(7),[5] the value for the age, education and skills factor should be added to the impairment value to determine the amount of unscheduled permanent disability. That analysis essentially resulted in assigning a value of one to the adaptability factor. Id. at 335.

This case is governed by the same rules as those that were at issue in Joe R. Ray. Here, as in Ray, claimant's BFC and RFC are equal. Consequently, under former OAR 436-35-280(1)(a), claimant's adaptability value is zero. Because such an analysis is contrary to the Carroll holding, we reach a different conclusion. Pursuant to Carroll and Ray, we assign a value of 1 to claimant's adaptability factor. Id. at 335.

Here, on review, SAIF agrees that claimant is entitled to a value of 1 for formal education, and 2 for the SVP factor. Assembling those factors, we add the age (0) and education (1), and SVP (2) together for a total of 3. That total is multiplied by claimant's adaptability value of 1, for a product of 3. When added to claimant's impairment value of 25, the total is 28 percent (89.6 degrees) unscheduled permanent disability. We modify the ALJ's order accordingly.

ORDER

The ALJ's order dated November 29, 1995 is modified. In addition to the ALJ's and Order on Reconsideration's award of 25 percent (80 degrees) unscheduled permanent disability, claimant is awarded 3 percent (9.6 degrees) unscheduled permanent disability, for a total of 28 percent (89.6 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 attorney.

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[2] All citations to the administrative rules are to Workers' Compensation Department Administrative Order No. 93-056.

[3] 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)."

[4] ORS 656.726(3)(f)(A) provides that "[t]he 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."

[5] Former OAR 436-35-280(7) requires that one add to the worker's impairment value the amount equal to the adaptability value multiplied by the value for the other societal factors.

In the Matter of the Compensation of
CAMILLA R. BLANCO, Claimant
WCB Case No. 95-10109
ORDER ON REVIEW
Shelley K. Edling, Claimant Attorney
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Herman's order that set aside its denial of claimant's occupational disease claim for a left leg condition. On review, the issue is compensability.

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

We have previously held that, under amended ORS 656.802(2), when an occupational disease claim is based on the worsening of a preexisting disease, the claimant must prove not only that employment conditions were the major contributing cause of the pathological worsening of the disease, but also that employment conditions were the major contributing cause of the "combined condition" itself. ORS 656.802(2)(b); Dan D. Cone, 47 Van Natta 2220, on recon 47 Van Natta 2343 (1995).

We disagree with the employer's contention that the medical evidence does not establish that claimant's work activities between July 10 and July 24, 1995 were the major contributing cause of the disability or the need for treatment of the combined condition under ORS 656.005(7)(a)(B).[1]

The "combined condition" in this case is the new fibial fracture and the increased tibial angulation. Claimant's attending physician, Dr. Buuck, opined that the work activities between July 10 and July 24, 1995 were the major contributing cause of the fibula fracture and increased tibial angulation.

The employer asserts that, because Dr. Buuck also noted that the preexisting tibia fracture would have still required "some immobilization," Dr. Buuck's opinion does not support a conclusion that claimant's work activities after July 24, 1995 were the major contributing cause of the disability of the combined condition. We disagree with the employer's interpretation of Dr. Buuck's opinion.

There is no contention that claimant's preexisting fracture is compensable. Rather, claimant asserts that her "combined condition," a new fibula fracture and increased tibial angulation, were caused by her work activities between July 10 and July 24, 1995. We interpret Dr. Buuck's opinion that the new fibula fracture and increased tibial angulation were caused in major part by her work activities between July 10 and July 24, 1995, to mean that the work activities were the major contributing cause of the disability and need for treatment of the combined condition. This conclusion is further supported by the circumstances which followed claimant's July 1995 work activities. Although claimant's preexisting fracture would have required "some immobilization," claimant had been performing her regular duties before her new fibula fracture and increased tibial angulation. After the July 1995 onset of the new conditions, claimant was taken completely off work. Under such circumstances, we are persuaded that claimant's work activities were the major contributing cause of the disability of the combined condition, as well as the need for treatment of the combined condition.

The employer also contends that the opinion of Dr. Marble, examining physician, supports the conclusion that claimant's preexisting condition (tibia fracture) was the major contributing cause of her disability and need for treatment. Even assuming that Dr. Marble's opinion can be interpreted in such a manner, we find no reason in this case not to rely on the opinion of Dr. Buuck, claimant's treating physician. Weiland v. SAIF, 64 Or App 810, 814 (1983).

The employer next contends that claimant's injury fell outside the course and scope of her employment because she violated her supervisor's admonition to use her crutches at work. Claimant testified that she found it impossible to perform her job duties as a teller using the crutches.

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[1] Whether claimant's claim is analyzed as an injury or as an occupational disease, the burden of proof is the same, i.e., claimant would have to establish that her work between July 10 and July 24, 1995 was the major contributing cause of the disability or need for treatment of the combined condition. See ORS 656.005(7)(a)(B).

One objective of the Workers Compensation Law is to provide treatment and benefits to injured workers, regardless of fault. ORS 656.012(2)(a). A violation of an employment rule does not render a claim per se noncompensable. Andrews v. Tektronix, 323 Or 154, at 166 (1996). Rather, the compensability determination is made by evaluating all of the factors that are pertinent to the question of work-connectedness, and weighing those factors in light of the policy underlying the Workers' Compensation Act. Id.

Here, claimant's injuries occurred while she was performing her regular work duties. Thus, although she did not use her crutches while performing her usual work duties, we find that the connection between the injury and the employment is sufficient to warrant compensation. Rogers v. SAIF, 289 Or 633, 642 (1980). Accordingly, we agree with the ALJ that claimant's failure to use her crutches does not remove her from the course and scope of employment and that claimant was within the boundaries of her ultimate work when she sustained her injuries.

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 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 December 11, 1995 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the employer.

Board Member Haynes specially concurring.

I write separately to express my concerns regarding the claimant's failure in this case to follow her employer's specific directions to use her crutches at work. Although I find claimant's conduct troubling, the present state of the law is that an employee's disregard of an employer's instruction is but one of many factors to be considered in the overall calculation of work-connectedness. Andrews v. Tektronix, Inc., 323 Or 154, at 165 (1996). Considering the facts of this case, I do not believe that claimant's failure to use her crutches while performing her regular work duties takes her out of the course and scope of her employment.

Given the current state of the law, the ALJ's demeanor-based credibility finding and the medical evidence in this case, I am left without any latitude to dissent.

In the Matter of the Compensation of
LAURELL R. BROWNSON, Claimant
WCB Case No. 95-01640
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Judy Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome, bilateral ulnar tunnel syndrome, and bilateral overuse syndrome with tendinitis of the wrist. On review, the issue is compensability.

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

To prove compensability of an occupational disease, claimant must show that her work exposure was the major contributing cause of her bilateral hand and arm condition. See ORS 656.802(2). In light of claimant's work and off work activities and her family history of arthritis, which may indicate a connective tissue disorder as the cause of her symptoms, we conclude that expert medical evidence is necessary to establish causation. Uris v. Compensation Department, 247 Or 420, 427 (1967); Barnett v. SAIF, 122 Or App 279, 282 (1993) (when a case involves a medically complex condition, there must be expert medical evidence establishing causation.). Medical opinions based on incomplete or inaccurate information are not afforded persuasive force. See Somers v. SAIF, 77 Or App 259, 263 (1986); Miller v. Granite Construction Co., 28 Or App 473, 476 (1977).

On December 14, 1994, Dr. Dickerman, neurologist, examined claimant on behalf of SAIF and performed nerve conduction tests. (Exs. 7, 11, 13, 14). Dr. Dickerman opined that the nerve tests were normal, without evidence of an entrapment syndrome of the median, ulnar or radial nerves. (Exs. 7-8, 7-10-13). He diagnosed right forearm and wrist flexor tendinitis, of unknown etiology. With regard to the etiology of claimant's symptoms, Dr. Dickerman reviewed claimant's job analysis with her and opined that, although the job required the use of claimant's hands, it was quite varied and without significant and continued repetitive use of the hands associated with the development of overuse syndromes or entrapment syndromes. (Exs. 7-2, -8).

In addition, Dr. Dickerman opined that claimant's symptoms were not related to any work activities because those symptoms worsened after claimant went to half-time status on September 25, 1994, and was taken off work on October 31, 1994. (Exs. 7-2, -3, -8, -9, 14-10-11). Dr. Dickerman noted that Dr. Maukonen, consulting neurologist, reported the same history of claimant's symptoms worsening after being taken off work. (Exs. 14-11, 9BA-1). Dr. Dickerman also opined that, with claimant's family history of arthritis and her mottled skin hue during examination, claimant may have a connective tissue disorder that could explain her symptoms. (Exs. 7-9, 11, 14-11-12). In his deposition, Dr. Dickerman noted that the gripping and vibration of motorcycle handles during claimant's off-work activities could also cause tendinitis, although he needed more information as to the amount of riding claimant did. (Ex. 7-29-30).

Dr. Lichtenstein, treating M.D., concurred with most of Dr. Dickerman's December 14, 1994 report. (Ex. 9A). However, Dr. Lichtenstein opined that the temporal relationship between the development of symptoms and the reported increased pace and volume of manual tasks at work made a work relationship likely. Id. In addition, Dr. Lichtenstein noted that development of tenosynovitis does not require the same repetitive tasks but can occur with constant use of the same anatomical part performing varied tasks. Id. Dr. Lichtenstein also noted that failure to improve after stopping work is not rare. Id. Finally, Dr. Lichtenstein agreed with claimant's attorney's statement that, assuming claimant had no off-work repetitive high use of her hands, her employment was the major contributing cause of her current disability and need for treatment. (Ex. 16).

Dr. Dickerman disagreed with Dr. Liechtenstein's opinion that claimant's work required constant use of the same anatomical part. (Ex. 11-1). Dr. Dickerman opined that claimant's job was significantly varied so that the work not only required no repetitive type of activity, it also did not require persistent use of the same anatomical part. Id. In addition, Dr. Dickerman disagreed with Dr. Liechtenstein's assessment regarding claimant's failure to improve after stopping work. Dr. Dickerman noted that claimant reported increased symptoms after work was reduced to half-time and when she was taken off work. He also noted that, although failure to improve in the short term may occur after discontinuing work, it was not medically reasonable that one would fail to improve after discontinuing work if the condition were related to persistent use of certain muscles in work. Id.

On February 10, 1995, based on his clinical examination of claimant, Dr. Worland diagnosed carpal tunnel syndrome and ulnar nerve compression. (Ex. 9B). Dr. Worland referred claimant to Dr. Maukonen for nerve conduction tests, which showed no evidence of any nerve entrapment. (Ex. 9BA). On February 27, 1995, Dr. Worland performed surgery for right carpal tunnel syndrome and right ulnar nerve compression. (Exs. 9B, 9C, 9D). Dr. Worland initially opined that claimant's employment could have been the major cause of her carpal tunnel syndrome. (Ex. 12A). Subsequently, Dr. Worland opined that the onset of claimant's problems with her hands were "temporarily related to the repetitive type of work" claimant was doing, with the symptoms she developed occurring due to the repetitive work she was performing at the time. (Ex. 15). Dr. Worland noted that he had problems reviewing claimant's history in the past due to inconsistencies; however, after reviewing claimant's history again, he was able to "support her industrial claim with greater than 50% likelihood." Id.

When medical evidence is divided, we tend to give greater weight to the claimant's treating physicians, absent persuasive reasons not to. Weiland v. SAIF, 64, Or App 810 (1983). Here, we find persuasive reasons not to rely on the opinions of Drs. Lichtenstein and Worland. In the first place, both physicians appear to rely on a temporal relationship in reaching their causation opinions. A temporal relationship, in and of itself, is not sufficient to meet claimant's burden of proof. See Allie v. SAIF, 79 Or App 284 (1986). Second, neither physician appears to have an accurate history of claimant's work and off-work activities. Claimant testified that she did not tell either Dr. Lichtenstein or Dr. Worland about her off-work activities driving all terrain vehicles, nor did she go over the job analysis with them. (Tr. 23-24, 27-28). In contrast, Dr. Dickerman went over the job analysis with claimant and had a clear understanding of claimant's job activities. In addition, neither Dr. Lichtenstein nor Dr. Worland considered the possibility of a connective tissue disorder given claimant's family history of arthritis, a potential causative factor raised by Dr. Dickerman. Therefore, we do not find the opinions of Drs. Lichtenstein and Worland persuasive.

Accordingly, we find that claimant has not met her burden of proving that her work activities were the major contributing cause of her bilateral hand and arm conditions. See, e.g., Pamela A. Burt, 46 Van Natta 415 (1994) (Finding a doctor's opinion not sufficient to meet the claimant's burden of proof where there was no indication that the doctor was aware of, and therefore, was precluded from considering, other activities that could have contributed to the claimant's condition).

ORDER

The ALJ's order dated December 6, 1995 is affirmed.

June 5, 1996 Cite as 48 Van Natta 1136 (1996)

In the Matter of the Compensation of
ARLAN F. CAYA, Deceased, Claimant
WCB Case Nos. 95-00769, 95-03569, 95-03568, 95-03567 & 95-03566
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) set aside its denial of claimant's occupational disease claim for peritoneal mesothelioma; and (2) upheld Liberty Northwest Insurance Corporation's (Liberty's) denial of claimant's occupational disease claim for the same condition. On review, the issue is responsibility. We affirm.

FINDINGS OF FACT

Claimant worked for E. J. Bartells from 1964 to 1988. SAIF was on the risk from 1964 to 1986 (Bartells/SAIF), while Liberty was on the risk from 1986 to April 1988 (Bartells/Liberty). Claimant worked for Thermal Services, Inc. (TSI) from April 1988 until 1990, when he retired. TSI is insured by SAIF (TSI/SAIF).

Claimant installed insulation products for thirty years before his retirement. Until the mid-1970's, claimant's work involved direct asbestos exposure. Claimant testified that he was exposed to asbestos while working for Bartells and TSI. (Tr. I-12, -19, -20, -23, -25, -29-32).

Bartells/Liberty and TSI/SAIF conceded that claimant's peritoneal mesothelioma was compensable and that one of them was responsible for the condition.

CONCLUSIONS OF LAW AND OPINION

Citing Beneficiaries of Strametz v. Spectrum Motorwerks, 135 Or App 67, mod 138 Or App 9 (1995), the ALJ found that the dispositive issue was when claimant was last exposed to asbestos. The ALJ found that claimant's asbestos exposure was the same at Bartells and TSI. The ALJ concluded that, since TSI was the last Oregon employment where the conditions were of a kind that could have caused the mesothelioma, TSI/SAIF was responsible for claimant's condition.

SAIF argues that claimant's employment conditions at TSI were not of a type that could have caused claimant's disease. We disagree.

Claimant testified that he came into direct contact with asbestos dust while working at TSI and he said that some of the job sites were in Oregon. (Tr. I-30, -31). Claimant said that he was exposed to bags of asbestos waste that had ripped open while being deposited in dumpsters. (Tr. I-24-26, -31). Claimant was exposed to the airborne asbestos when he walked by the dumpsters on the docks. (Tr. I-25, -26).

Claimant also testified that, after asbestos abatement crews had removed asbestos, asbestos products were still present in the workplace. (Tr. I-12). Claimant said that he worked in areas at TSI where dust and asbestos fibers were present. (Id.) While he was working at TSI, claimant inhaled asbestos fibers when there was leftover asbestos dust on ships after the debris had been removed. (Tr. I-32). Claimant said that his exposure to asbestos during the last couple of years at Bartells and his exposure at TSI was about the same. (Tr. I-29-30).

SAIF contends that, although claimant believed that he inhaled asbestos fibers from shipyard dumpsters while working at TSI, that belief is not supported by the evidence. SAIF relies on the testimony of Mike McLermore, safety manager for Cascade General,[1] to establish that claimant mistakenly believed that ordinary dumpsters contained asbestos. McLermore testified that asbestos waste was double-bagged in a bright yellow bags marked "asbestos." (Tr. II-97). The yellow bags were deposited in a containment box on the pier that had a lid and locks. (Id. at 98). In contrast, the regular dumpsters did not have lids. (Id. at 99). McLermore did not believe the asbestos waste could be a source of contamination. (Id. at 98).

According to SAIF, because claimant testified that "there was always a dumpster full of it [asbestos] sitting around," (Tr. I-23), he was apparently talking about dumpsters without lids and SAIF asserts that claimant "mistakenly" believed that ordinary dumpsters contained asbestos. We disagree.

On cross-examination, SAIF's counsel asked claimant whether the dumpsters he was referring to were filled with both asbestos and general debris. (Tr. I-25). Claimant disagreed. (Id.) Furthermore, William Ingram, claimant's supervisor at TSI, testified that the asbestos debris was put into specially marked dumpsters that did not have lids. (Tr. II-35). We are not persuaded by SAIF's contention that claimant mistakenly believed that ordinary dumpsters contained asbestos.

SAIF also argues that claimant's belief that asbestos fibers were left on the ships after the asbestos abatement crews finished removing the asbestos was not supported by the record.[2] SAIF relies on the testimony of Ingram and McLermore that the abaters used monitors to check the area for asbestos fibers and no one was allowed into the area until they receive a clearance report. (Tr. II-35, -96). However, McLermore testified that, despite all safety precautions, it was not possible to guarantee the elimination of all asbestos from a work area. (Tr. II-109). McLermore agreed that it was not uncommon for an abatement crew to be called back after completing abatement to clean up additional asbestos. (Tr. II-114-115). Ingram also testified that, on job sites in which asbestos abatement had been done, there were times that abaters had to be called back in to clean up additional asbestos. (Tr. II-46-47). In addition, one of the owners of TSI testified that it was possible that claimant had been exposed to asbestos at TSI, although he believed that it was highly unlikely. (Tr. II-147).

We conclude that a preponderance of the evidence establishes that claimant was exposed to asbestos during his employment at both Bartells[3] and TSI. The next question is which carrier is responsible for claimant's condition.

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[1] McLermore testified that Cascade General was involved in ship repair and part of its business was to monitor what the asbestos abatement crews were doing. (Tr. II-92-93).

[2] We note that, although SAIF relies on claimant's testimony that the "only" place at TSI where he inhaled asbestos was in passing the shipyard dumpsters, (Tr. I-26-27), SAIF acknowledged that claimant subsequently testified that he had been exposed to asbestos dust which was left after the asbestos abaters finished removing asbestos on the ships. (Tr. I-32).

[3] Claimant testified that, while he was working at Bartells, the asbestos abatement crews were not always successful in removing all the asbestos and he would ask the crews to clean up the asbestos. (Tr. I-17-20). Claimant inhaled some of the dust before the crews could get there. (Tr. I-19). Claimant also said that he saw small chunks of "mud" or "block" containing asbestos while working for Bartells/Liberty. (Tr. I-20). Claimant also saw little piles of dust that he believed contained asbestos. (Id.)

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 peritoneal mesothelioma 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).

The last injurious exposure 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, 241 (1984). The "onset of disability" is the triggering date for determining the last potentially causal employment. Bracke v. Baza'r, 293 Or 239, 248 (1982). The "onset of disability" is the date on which a claimant first seeks treatment for, or becomes disabled by, the compensable condition. Timm v. Maley, 125 Or App 396, 401 (1993), rev den 319 Or 81 (1994).

Here, claimant first sought treatment for mesothelioma after he retired from TSI. Under the last injurious exposure rule, the last employment providing potentially causal conditions is deemed to have caused the occupational disease. See Boise Cascade Corp. v. Starbuck, supra, 296 Or at 241. Since TSI is the last employment that potentially caused claimant's condition, we assign initial responsibility for the mesothelioma to TSI/SAIF.

TSI/SAIF can shift responsibility to Bartells/Liberty or Bartells/SAIF, the prior carriers, by showing that claimant's work exposure while either of those carriers was on the risk was the sole cause of his mesothelioma, or that it was impossible for conditions while TSI/SAIF 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).

TSI/SAIF has failed to carry that burden. As we have discussed, the preponderance of evidence establishes that claimant had at least some exposure to asbestos at TSI. That evidence precludes TSI/SAIF from prevailing on the "sole cause" or "impossibility" theories. Accordingly, we conclude that TSI/SAIF remains responsible for claimant's peritoneal mesothelioma.

TSI/SAIF asserts that, because most of claimant's work involved maritime duties governed by the Longshoremen's and Harbor Workers' Compensation Act (LHWCA), claimant was not a subject Oregon worker and, therefore, it is not responsible for claimant's mesothelioma. We disagree.

Oregon Workers' Compensation law provides that if a current state claim is covered by federal workers' compensation law, claimant is a non-subject worker for purposes of Oregon law. ORS 656.027(4); Mann v. SAIF, 91 Or App 715 (1988). To avoid responsibility under the LHWCA theory, TSI/SAIF must establish that the LHWCA provides compensation for claimant's condition. See Kenneth R. Barker, 42 Van Natta 2419, 2420 (1990). Since TSI/SAIF has not done so, we reject that assertion. In any event, we do not consider claimant's LHWCA employment for purposes of determining responsibility. See Richard W. Branchcomb, 48 Van Natta 16 (1996) (the claimant's LHWCA employment could not be considered in determining responsibility under the last injurious exposure rule).

Finally, TSI/SAIF asserts that, because only five percent of claimant's work for TSI was subject Oregon employment, "it would be pure speculation to conclude that any such [asbestos] exposure occurred during claimant's subject Oregon employment." (TSI/SAIF's Appellant's Brief at 4). As we discussed earlier, to prevail on the LHWCA theory as a responsibility defense, it was incumbent on TSI/SAIF to establish that the laws relating to claimant's non-Oregon employment provided compensation for claimant's condition. TSI/SAIF has not done that.

Furthermore, claimant testified that he came into direct contact with asbestos dust while working at TSI and he said that some of the job sites were in Oregon. (Tr. I-30, -31). In any event, even if claimant's employment with TSI/SAIF was not the actual cause of the perioneal mesothelioma, that factor is not dispositive in determining initial responsibility for claimant's occupational disease claim. See Beneficiaries of Strametz v. Spectrum Motorwerks, supra (all the 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).

After considering the factors set forth in OAR 438-015-0010(4), claimant's attorney is awarded $1,000 for services on Board review, to be paid by SAIF. In reaching this conclusion, we have particularly considered the complexity of the issues, the time devoted to the case (as represented by claimant's respondent's brief and counsel's statement of services), and the value of the interest involved.

ORDER

The ALJ's order dated November 20, 1995 is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
MANUEL G. GARCIA, Claimant
WCB Case No. 95-09040
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Thye's order that awarded 13 percent (41.6 degrees) unscheduled permanent disability for claimant's cervical condition, whereas an Order on Reconsideration had awarded none. Claimant cross-requests review, seeking additional unscheduled permanent disability. On review, the issue is extent of permanent disability. We reverse.

FINDINGS OF FACT

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

A December 27, 1994 Opinion and Order in WCB Case No. 94-11218 finally determined that claimant's then current C5-6 and C6-7 disc condition was not compensable.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's C5-6 and C6-7 disc protrusion condition is not compensable, but concluded that claimant is entitled to a 13 percent unscheduled permanent disability award for his cervical condition. We agree in part and disagree in part.

The Supreme Court has set out the elements of issue preclusion as follows: "'If a claim is litigated to a final judgment, the decision on a particular issue or determinative fact is conclusive in a later or different action between the same parties if the determination was essential to the judgment.'" Drews v. EBI, 310 Or 134, 139-140 (1990) (quoting North Clackamas School Dist. v. White, 305 Or 48, 53 (1988)).

In this case, the parties are the same as were involved in a prior proceeding. The compensability of claimant's C5-6 and C6-7 disc protrusion condition was raised and litigated at the prior hearing. The prior ALJ upheld the insurer's partial denial of claimant's C5-6 and C6-7 disc condition. (Ex. 55). The parties agree that the December 27, 1994 Opinion and Order became final without appeal. (Tr. 1).

We conclude that the prior proceeding established that claimant's C5-6 and C6-7 disc protrusion condition was not compensable as a matter of law. Because we find no evidence that claimant's current C5-6 and C6-7 disc protrusion condition differs from the condition he had at the time of the prior hearing, we further conclude that claimant's current C5-6 and C6-7 disc condition is not compensable.

The ALJ found claimant entitled to 13 percent unscheduled permanent disability, based on the medical arbiter's cervical impairment findings. We reverse.

To be entitled to permanent disability compensation for his cervical impairment, claimant must establish that the impairment is due to his compensable injury. ORS 656.214(2). 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 construe the findings as showing that the impairment is due to the compensable injury. See Kim E. Danboise, 47 Van Natta 2163, 2164 (1995). However, where the medical arbiter related the claimant's impairment to causes other than the compensable injury, the medical arbiter's opinion is not considered persuasive evidence of injury-related impairment. Julie A. Widby, 46 Van Natta 1065 (1994); see Christine M. Hasvold, 47 Van Natta 979, 980 (1995).

Here, Dr. Gancher, medical arbiter, expressly stated that he was "unable to disassociate [claimant's] accepted cervical sprain from radiographic abnormalities; he seems to have evidence of cervical radiculopathy. . . ." (Ex. 57-3). Because Dr. Gancher could not distinguish between claimant's strain-related findings and those findings related to the noncompensable disc condition, his report does not constitute persuasive evidence of injury-related impairment. We further find the opinion of Dr. Ushman, treating physician, insufficient to establish injury-related impairment. See Ex. 50; see also Exs. 40-3, 44-3-4. Under these circumstances, we are unable to find claimant entitled to a permanent disability award. See ORS 656.266; 656.726(3)(f)(A)&(B);[1] see Shelley A. Patee, 48 Van Natta 388, 389-90 (1996).

ORDER

The ALJ's order dated December 12, 1995 is reversed. The Order on Reconsideration is affirmed. The ALJ's attorney fee award is reversed.

[1] We acknowledge claimant's evidentiary and constitutional arguments regarding proposed non-impairment factors. However, because we conclude herein that claimant has not proven injury-related impairment, he is not entitled to a permanent disability award and we do not reach those arguments.

In the Matter of the Compensation of
NANCY J. JONER, Claimant
WCB Case No. 95-09124
ORDER ON REVIEW
Doblie & Associates, Claimant Attorneys
VavRosky, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order which upheld the self-insured employer's denial of her low back aggravation claim. In her brief, claimant requests that we assess penalties and attorney fees because of the employer's allegedly unreasonable claim processing. On review, the issues are aggravation, penalties and attorney fees. We affirm.

FINDINGS OF FACT

Claimant, a melt helper at a steel mill, sustained a low back injury on February 3, 1991 shoveling "mill scale." The employer accepted the claim as a nondisabling low back strain for which claimant received conservative treatment. Claimant was placed on light duty for several weeks and then returned to regular work. Although the possibility of a herniated disc at L3-4 was raised, the presence of such a condition was not confirmed. (Exs. 16, 17).

Claimant sustained a second low back injury on May 14, 1992 lifting a large metal object at work. The employer also accepted this claim as a nondisabling low back strain. (Ex. 28C). Subsequent to June 2, 1992, at which time Dr. Guyer, claimant's attending physician, noted that her examination was "completely unremarkable" and that her low back strain was "rapidly resolving," claimant did not receive medical treatment for her low back until March 25, 1994. (Exs. 28, 31). At that time, claimant complained of low back and right hip pain of unknown cause. (Ex. 31).

In mid-1994, claimant became pregnant. Claimant gained 70 pounds during her pregnancy and continued to work, albeit with difficulty, until February 13, 1995, when she was placed on pregnancy leave. (Ex. 32D). Claimant gave birth on March 6, 1995.

On April 12, 1995, an unknown physician's chart note reads: "cleaning stalls [and] pulled up wheelbarrow D mid T -> arms." (Ex. 33). The next day, a physician's assistant at Kaiser reported that claimant was experiencing "low back pain across the hip, around front [and] down back [and] sides of legs." (Ex. 35). The "assessment" by the physician's assistant was "low back pain." An April 19, 1995 CT scan revealed a slight L4-5 disc protrusion. (Ex. 37).

Claimant came under the care of Dr. Wagner, who diagnosed a low back strain with a possible herniated L4-5 disc. (Ex. 39). Claimant also obtained a neurosurgical consultation from Dr. Amstutz, who diagnosed L4-5 disc disease with some L5-S1 radicular symptoms. (Ex. 40). Dr. Amstutz opined that claimant's work activities in 1991 were the major contributing cause of her low back condition. Id.

Claimant was subsequently evaluated on June 20, 1995 by examining physicians, Drs. Gambee and Rich, who attributed claimant's low back condition to her pregnancy and weight gain. (Ex. 43-7). Dr. Wagner concurred with this report and agreed that the majority of claimant's problem was related to pregnancy and weight gain. (Ex. 46). Thereafter, on July 17, 1995, the employer denied reopening of the claim. (Ex. 47). Claimant requested a hearing, contesting the denial.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the employer's denial of claimant's low back aggravation claim, finding that claimant had failed to sustain her burden of proving that her compensable low back injury of February 3, 1991 was the major contributing cause of her need for treatment in April 1995. In reaching this conclusion, the ALJ determined that claimant was not a credible witness based on alleged inconsistencies in the record.

On review, claimant contends that the ALJ erred in finding that she was an non-credible witness and that, regardless of whether we concur with the ALJ's credibility assessment, a statement by Dr. Wagner in a deposition, as well as the opinion of Dr. Amstutz, establish that her current low back condition is causally related to either her compensable nondisabling low back injury of February 3, 1991 or to the subsequent nondisabling low back injury in May 1992.[1] See Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984); Anthony P. Thexton, 47 Van Natta 1000, 1000 (1995) (claim can be compensable even if claimant not credible). We conclude that claimant's aggravation claim is not compensable, but our reasoning differs from the ALJ's.

At the outset, we address the credibility issue. The employer alleges that the ALJ's credibility finding was supported by documentary evidence of alleged back injuries and treatment prior to May 1990, which claimant either minimized or failed to disclose. The employer also cites documentary and lay evidence of alleged off-the-job injuries in 1994 and 1995. Claimant responds that most of the employer's credibility evidence is collateral to the compensability issue and that the employer has distorted the record.

We need not resolve the credibility issue, however. Regardless of whether or not claimant was a credible witness, the medical evidence does not prove that claimant's current low back condition is compensable.

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[1] The ALJ applied a major contributing cause standard in determining the compensability of claimant's aggravation claim. On review, the employer appears to concede that a material causation standard is applicable. Claimant does not mention the appropriate burden of proof. In Gloria T. Olson, 47 Van Natta 2348 (1995), we held that amended ORS 656.005(7)(a)(B) was applicable in aggravation claims. See also Paul D. Rutter, 48 Van Natta 119 (1996). In Olson, the claimant's compensable injury had 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. In this case, there is no evidence that claimant's compensable injury "combined" with a preexisting condition. Therefore, amended ORS 656.005(7)(a)(B) may not be applicable. However, we need not decide whether the appropriate legal standard is material or major contributing cause because we conclude that claimant has failed to sustain her burden of proof under either standard.

Dr. Wagner agreed with the medical report submitted by examining physicians, Drs. Gambee and Rich, who concluded that claimant's low back condition in 1995 was not related in major or material part to her compensable injury in 1991, but rather was related to claimant's pregnancy and related weight gain. (Exs. 43-7, 46). We generally defer to the opinion of the attending physician absent persuasive reasons to do otherwise. See Weiland v. SAIF, 64 Or App 810 (1983)

In Dr. Wagner's deposition, claimant's counsel reviewed medical records pertaining to claimant's 1991 and 1992 injuries. These records showed that claimant experienced lower extremity complaints in 1991 and 1992 as she had in 1995, and that the possibility of a herniated disc had also been raised in 1991.

In response to a question posed by claimant's counsel, Dr. Wagner opined: "You would think, given the history that we've covered so far, that, yes, the work activity [in 1991 and 1992] would be the main cause of her back pain." (Ex. 53-27). However, upon further direct examination by the employer's counsel, Dr. Wagner reiterated his agreement with the medical report of Drs. Gambee and Rich and related claimant's exacerbation of pain in 1995 to off-the-job activities. (Ex. 53-32, 34). While there is no requirement that a physician use "magic words," see McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986), we are not persuaded that Dr. Wagner's unexplained, one-sentence response satisfies claimant's burden of proof, given the medical evidence elsewhere in the record from Dr. Wagner that negates a causal connection between claimant's prior compensable injuries and her current low back condition.[2]

In conclusion, we agree with the ALJ that claimant failed to satisfy her burden of proving a compensable aggravation claim. Accordingly, we affirm the ALJ's decision upholding the employer's denial.[3]

ORDER

The ALJ's order dated December 8, 1995 is affirmed.

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[2] Dr. Amstutz opined on May 18, 1995 that claimant's heavy work activities in 1991 were the major contributing cause of her current low back condition. (Ex. 40-1). Dr. Amstutz, however, did not analyze the affect of the two-year period in which claimant did not seek medical treatment for her low back condition, nor did he consider the impact of claimant's pregnancy and weight gain on her low back condition. See Somers v. SAIF, 77 Or App 259 (1986) (greatest weight given to well-reasoned medical opinions). Moreover, Dr. Amstutz's May 18, 1995 opinion is conclusory. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Marta I. Gomez, 46 Van Natta 1654 (1994) (least weight given to conclusory, poorly analyzed opinions). Finally, on August 8, 1995, Dr. Amstutz acknowledged that claimant's claim had been denied, but stated that he did not have further information to contribute. (Ex. 48A). Given the deficiencies in Dr. Amstutz's May 18, 1995 opinion, and his failure to explain his opinion further in August 1995, we find that Dr. Amstutz's chart notes do not satisfy claimant's burden of proof.

[3] Claimant requests an award of penalties and/or attorney fees for the employer's allegedly unreasonable claim processing. However, this issue was not raised at hearing. Therefore, we do not address it on review. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991) (Board can refuse to address issue raised for the first time on review).

In the Matter of the Compensation of
RODNEY D. SULLIVAN, Claimant
Own Motion No. 96-0269M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's compensable comminuted medial tibial plateau fracture with peroneal nerve palsy, left knee and closed-head injury. Claimant's aggravation rights expired on March 16, 1993. SAIF opposes authorization of temporary disability compensation, contending that it is unknown whether claimant has withdrawn from the work force.

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

On February 29, 1996, Dr. Shaw, claimant's treating physician, recommended that claimant undergo a lateral wedge osteotomy (through the triple arthrodesis) to correct a varus deformity. 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).

SAIF advises that it is unclear whether claimant was in the work force at the time of the current disability. Claimant forwarded 1994 Profit and Loss From Business forms as proof that he remained in the work force at the time of disability. In his May 21, 1996 letter, claimant advised that he is self-employed and "[o]ur 95 taxes is on an extension[. It] should be done before Aug. [1996]." Here, claimant has not submitted information which would establish that he was in the work force during the relevant time frame.[1] Claimant has the burden of proof on this issue, and must provide persuasive evidence that he was working during the period in question.

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

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

IT IS SO ORDERED.

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[1] Although the Board requests that a claimant submit to the carrier pertinent information which would establish that the claimant was in the work force at the time of disability, a current tax return is not a requisite document for proof of work. Daniel Martushev, 48 Van Natta 1033 (1996). The submission of work invoices, check stubs or wage-withholding statements which reflect dates of work during or prior to the appropriate time frame, are sufficient for our review. Pursuant to the Board's Addendum to Bulletin 2-1994, effective January 1, 1996, the carrier is required to mail to claimant the Board's work force criteria letter. That letter offers suggestions and alternative documentation which a claimant might submit in order to establish that he/she was in the work force at the time of disability. From the record, it is not evident that SAIF has done so. Therefore, we enclose a copy of that letter to claimant with this order. OAR 438-012-0020; 438-012-0030; 438-012-0035.

In the Matter of the Compensation of
JAMES I. WEATHERS, Claimant
WCB Case No. 93-09767
ORDER ON REVIEW
Victor Calzaretta, Claimant Attorney
Lester R. Huntsinger (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its denial of claimant's occupational disease claim for a mental disorder; and (2) assessed a penalty and attorney fee for its allegedly unreasonable denial. On review, the issues are compensability, penalties and attorney fees.

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

Claimant, who lives in Salem, worked as a corrections officer in the employer's Salem correctional facility from September 1982 until he sustained a compensable back injury in August 1988. Claimant received vocational training, and in May 1990, began a period of trial service as a corrections counselor in the same facility. Claimant "underfilled" that position until he could meet the minimum qualifications for the job.

In May 1992, the employer determined that, in order to meet anticipated changes in the State's post-prison release program, it would have to transfer two corrections counselor positions from its facility in Salem to its facility in Portland. The employer requested volunteers to transfer to Portland. When none were forthcoming, the employer notified its employees, via their public employees union, that, pursuant to its contract with the union, transfer of personnel to staff the relocated positions would be based on inverse seniority. In the interim (based on inverse seniority), two corrections counselors were temporarily transferred to Portland. Claimant was not one of the two.

Claimant received excellent performance evaluations and, in July 1992, he was reclassified as a corrections counselor, retroactive to May 1992. On several occasions over the next year, claimant was advised that the total time performing the counselor job (including the two years underfilling that position) would be credited in calculating seniority. Then, in April 1993, the employer sought the union's opinion concerning calculating seniority. A representative for the union replied that underfill time should not be considered. The employer thereafter revised its seniority list and, on July 19, 1993, notified claimant that he was slated for permanent transfer to the Portland facility effective July 20, 1993.

Claimant became depressed by what he perceived as an unreasonable last minute decision to transfer him to Portland, and he sought treatment from Dr. Mead, psychiatrist. Claimant had previously treated with Dr. Mead from March 1991 to December 1992. Dr. Mead opined that claimant's earlier condition had essentially resolved, and concluded that the unreasonableness of the July 1993 transfer was a new incident causing a major depressive episode. After considering and eliminating other possible stressors, Dr. Mead opined that the prospect of unreasonable transfer was the major cause of claimant's mental disorder in July 1993. There is no contrary medical opinion.

The ALJ found that SAIF had conceded that claimant had been diagnosed with a mental disorder which is generally recognized in the medical or psychological community, and that there was no apparent dispute concerning whether the employment conditions producing claimant's mental disorder existed in a real and objective sense. The ALJ further found that Dr. Mead's opinion established by clear and convincing evidence that claimant's mental condition arose out of his employment. Finally, the ALJ concluded that the employment conditions producing claimant's mental disorder were conditions other than conditions generally inherent in every working situation or reasonable business decision. See ORS 656.802(3).

We address only this latter issue on review. Because we find, as did the ALJ, that the employer's actions were unreasonable, those actions are not excluded under ORS 656.802(3)(b) and may be considered in the analysis of the compensability of the claim.

The parties agree that claimant's depression was related to the transfer. They further agree that the dispositive issue is whether the employer acted reasonably in making its determination to transfer claimant. Therefore, as urged by the parties, we look to the union contract between them to determine whether this transfer was reasonable. There is no provision in the parties' contract which addresses the situation where an employee is transferred from one job site to another, yet remains in the same bargaining unit. Recognizing that the contract was silent on this point, the employer had previously advised the union and its employees that it would base its transfer selections on the well-established tradition of inverse seniority.

The only section of the contract that specifies how seniority is to be calculated is found in Article 44. That section explicitly states that an employee in an underfill position is credited with working in the higher position to which he is eventually reclassified. Factoring in the two years claimant underfilled the corrections counselor position, claimant had sufficient seniority not to be transferred to Portland. Not counting those two years, however, claimant was one of the two least senior corrections counselors and could be transferred. It was the non-credit for the two years underfilling the counselor position which led to claimant's lower seniority rating and involuntary transfer, and ultimately, according to Dr. Mead and conceded by SAIF, claimant's depression.

Consequently, we conclude that, in light of the plain language of Article 44, the employer's actions in not crediting claimant with the total time he performed the counselor job (including the two years underfilling that position), were in violation of its legal contract and, thus, unreasonable. See Susan L. Kozlowski, 47 Van Natta 1683 (1995) (employer's illegal action of summarily demoting a claimant in retaliation for claiming her earned pay held not to be a condition generally inherent in every working situation).

We distinguish this case from Robert J. Douglass, 48 Van Natta 374 (1996). There, the claimant contended 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." We found that while the claimant's transfer may have been unexpected or unwanted from his standpoint, the record did not support a finding that the employer acted unreasonably or outside the course of ordinary business in making this decision. Rather, we found that the claimant was transferred out of concern that he might reinjure himself, having been found asleep on the job and exhibiting slower reaction times. Under those circumstances, we concluded that the actions taken by the employer were not unusual and constituted conditions generally inherent in every working situation.

Here, by contrast, the employer's actions in calculating seniority contrary to its union contract were unusual and not generally inherent in every working situation. We thus find that the manner in which the employer acted in making its determination to transfer claimant was unreasonable. Consequently, we conclude that claimant has established, by clear and convincing evidence, that work-related stressors, not otherwise excluded by statute, were the major contributing cause of his mental disorder. We therefore affirm the ALJ's order setting aside SAIF's denial.

Claimant is entitled to an attorney fee for his counsel's 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 assessed attorney fee for claimant's counsel's services on Board review is $1,500, to be paid 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 November 30, 1995 is affirmed. For services on Board review, claimant's counsel is awarded $1,500, to be paid by the SAIF Corporation.

In the Matter of the Compensation of
DONNA M. ZAVATSKY, Claimant
WCB Case No. 95-07644
ORDER ON REVIEW
Coughlin, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

The SAIF Corporation requests, and claimant cross-requests, review of that portion of Administrative Law Judge (ALJ) Thye's order that increased claimant's unscheduled permanent disability benefits for a right shoulder injury from 12 percent (38.4 degrees), as awarded by an Order on Reconsideration, to 27 percent (86.4 degrees). On review, the issue is extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the sentence, "Claimant began working for employer on December 20, 1993, as both an office clerk (same DOT as prior clerk work) and an auto parts clerk, which has an SVP of 3 and a strength of heavy. DOT 222.367-042. Claimant lifted up to 50 lbs. maximum and up to 30 lbs. regularly on the job with the employer." (Opinion and Order at 2).

CONCLUSIONS OF LAW AND OPINION

Adaptability

On the basis of the written record and hearing testimony, the ALJ concluded that claimant's base functional capacity (BFC) was heavy. Consequently, in view of the parties' stipulation that claimant's residual functional capacity (RFC) was sedentary, the ALJ held that claimant's adaptability value was 6. SAIF contests the ALJ's conclusion, contending that hearing testimony was inadmissible under amended ORS 656.283(7). We agree.

Two "pre-reconsideration" documents describe claimant's at-injury job. One, a Work, Injury and Pain worksheet completed by claimant, describes her job duties as doing daily tills, preparing deposits, filing and separating invoices and making deliveries in a pick-up truck as needed. (Ex. 14). It also states that claimant lifted and carried parts weighing between one and twenty pounds 10 to 30 times each day. (Id.) The other, a Job Analysis Worksheet, states that claimant's primary job duties involved separating and filing invoices and performing other office work. (Ex. 20-1). It also states that, approximately 20 to 30 percent of the time, claimant used a vehicle to deliver small parts to dealers and shops, and that the job required no lifting over 10 pounds. (Id.) At hearing, claimant testified that she sometimes lifts boxes weighing up to 50 pounds and that she often lifts boxes weighing 25 to 30 pounds. (Tr. 6-8).

Amended ORS 656.283(7) provides, in part, that "[e]vidence 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[.]" That statute went into effect on June 7, 1995, shortly before the issuance of the June 19, 1995 Order on Reconsideration. Therefore, the amended statute applies to this case. See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

Under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process is inadmissible at a subsequent hearing about the extent of an injured worker's permanent partial disability. Id. However, amended ORS 656.283(7) does not apply to exclude evidence that was previously and properly admitted at hearing, i.e., evidence submitted prior to June 7, 1995, the effective date of amended ORS 656.283(7). Id.

In Joe R. Ray, 48 Van Natta 325 (1996), we held that under amended ORS 656.283(7), evidence that was not submitted during the reconsideration process and not made a part of the reconsideration record, is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent partial disability.[1] Nevertheless, in light of the court's decision in Plummer, that holding has been

[1] Although a signatory to this order for purposes of *stare decisis*, Chair Hall continues to believe, for the reasons set forth in his concurrence/dissent in Joe R. Ray, supra, that amended ORS 656.283(7) should not be applied to those cases where the reconsideration record was developed before June 7, 1995.

overruled to the extent that evidence concerning the extent of an injured worker's permanent partial disability that was properly admitted at hearing can be considered on review.

However, where a hearing concerning extent of permanent partial disability was held after June 7, 1995, the prohibition on subsequent evidence set forth in amended ORS 656.283(7) is applicable. Thus, we continue to adhere to our holding in Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995. See Dean J. Evans, 48 Van Natta 1092 (1996).

Here, the hearing was held on September 18, 1995. Because claimant's hearing testimony was not submitted during the reconsideration process and was not made a part of the reconsideration record, it is inadmissible at a hearing about the extent of her permanent partial disability. Joe R. Ray, supra. Therefore, we analyze the adaptability issue without considering that testimony.[2]

Turning to the merits, the dispute here concerns claimant's BFC, which is "[t]he highest strength category assigned in the DOT [Dictionary of Occupational Titles] for the most physically demanding job that the worker has successfully performed in the five years prior to determination." OAR 436-35-310(4)(a). The parties agree that claimant's BFC should be based on her at-injury job as a clerical assistant/delivery driver for SAIF's insured, a retail automobile parts business. The controversy centers around the proper occupational title to assign to that job.

Claimant asserts that the ALJ properly assigned "Auto Parts Clerk," DOT # 22.376-042, to her at-injury job. We disagree. That is a heavy strength position in which a worker receives, stores, issues and inventories auto parts. Claimant's at-injury job as a clerical assistant/delivery driver did not generally involve those duties.

SAIF asserts that two other DOT titles more accurately describe claimant's at-injury job: "Deliverer, Outside," DOT # 230.663-010, and "Deliverer, Merchandise (retail trade)," DOT # 299.477-010. The former, a light strength position, involves the delivery of messages, telegrams, documents, packages and other items to business establishments. The latter, a medium strength position, includes the delivery by light truck of merchandise from a retail store to customers.

On this record, we conclude that the "Deliverer, Merchandise (retail trade)" title most accurately describes claimant's at-injury job. Claimant spent between 20 to 30 percent of her time delivering auto parts weighing up to 20 pounds for her employer, a retail auto parts business; she used a pick-up truck to make the deliveries. That work is more like the merchandise deliverer title, which involves the delivery of medium-weight merchandise, than the outside deliverer title, which involves the delivery of light-weight documents and other objects. Because the merchandise deliverer title describes a medium strength position, claimant's BFC is medium. OAR 436-35-310(4)(a). Moreover, because claimant's RFC is sedentary, her adaptability factor is 5. OAR 436-35-310(6). We modify the ALJ's order accordingly.

Impairment

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

We 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 (5) equals 20. OAR 436-35-280(6). Finally, we add that sum to claimant's impairment value (3), for a total of 23 percent unscheduled permanent disability. OAR 436-35-280(7). We modify the ALJ's order accordingly.

ORDER

The ALJ's order dated October 12, 1995 is modified. In lieu of the ALJ's award, and in addition to the Order on Reconsideration award of 12 percent (38.4 degrees), claimant is awarded 11 percent (35.2 degrees), for a total award of 23 percent (73.6 degrees) unscheduled permanent partial disability. We modify the ALJ's "out-of-compensation" attorney fee accordingly.

[2] The parties do not dispute the admissibility of the written exhibits. Therefore, we will consider them in analyzing claimant's adaptability.

In the Matter of the Compensation of
DONNA J. SPENCER, Claimant
WCB Case No. 94-14252
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Martha Brown's order that: (1) affirmed the Order on Reconsideration's award of 4 percent (6 degrees) scheduled permanent disability for loss of use or function of the right forearm (wrist); (2) declined to remand the claim to the Director for further evidence regarding the extent of scheduled permanent disability; (3) declined to decide the issue of rate of scheduled permanent disability; and (4) dismissed for lack of jurisdiction claimant's hearing request regarding entitlement to vocational assistance. On review, the issues are evidence, remand, extent of scheduled permanent disability, rate of scheduled permanent disability, and jurisdiction.

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

On review, claimant argues that the ALJ erred in declining to permit claimant to testify at hearing regarding the extent of her disability. We disagree.

Amended ORS 656.283(7) provides, in part, that "[e]vidence 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[.]" That statute went into effect on June 7, 1995, which was subsequent to the November 17, 1994 Order on Reconsideration but prior to the November 2, 1995 record closure for this hearing. Therefore, the statute applies here. See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

Under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent partial disability. Id. However, amended ORS 656.283(7) does not apply to exclude evidence that was previously and properly admitted at hearing, i.e., evidence submitted prior to June 7, 1995, the effective date of amended ORS 656.283(7). Id.

In Joe R. Ray, supra, we held that, under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process, is inadmissible at a subsequent hearing about the extent of an injured worker's permanent partial disability.[1] Nevertheless, in light of the court's decision in Plummer, that holding has been overruled to the extent that evidence concerning the extent of an injured worker's permanent partial disability that was properly admitted can be considered on review.

However, where a hearing concerning the extent of permanent partial disability was held after June 7, 1995, the prohibition on subsequent evidence set forth in amended ORS 656.283(7) is applicable. Thus, we continue to adhere to our holding in Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995. Dean J. Evans, 48 Van Natta 1092 (1996).

Here, the matter was submitted on the record which closed on November 2, 1995. Because the proffered testimony regarding extent of disability was not submitted during the reconsideration process, the ALJ properly excluded it from the record. Joe R. Ray, supra. Furthermore, we agree with the ALJ's alternative reasoning that medical evidence is required to establish a chronic condition award and the medical evidence in this record does not meet claimant's burden of proof. OAR 436-35-005(5); William K. Nesvold, 43 Van Natta 2767 (1991).

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[1] Although a signatory to this order for purposes of *stare decisis*, Chair Hall continues to believe, for the reasons set forth in his concurrence/dissent in Joe R. Ray, supra, that amended ORS 656.283(7) should not be applied to those cases where the reconsideration record was developed prior to June 7, 1995.

Claimant also argues that the ALJ erred in finding that the issue of rate of scheduled permanent disability was not ripe for determination. We agree with the ALJ's reasoning and conclusion. See Hamlin v. Salem Area Transit, 137 Or App 497 (1995) (where a Board order provided that the carrier must pay an additional award of a certain percent of permanent partial disability, the court declined to address the claimant's argument as to the rate at which the award should be paid, holding that the rate at which that award must be paid was not properly before the court); David J. Aronson, 47 Van Natta 1948 (1995).

Additionally, claimant makes several arguments in support of her contention that the Hearings Division and the Board have jurisdiction to review the vocational assistance administrative order issued by the Director. In Danell L. Sweisberger, 48 Van Natta 441 (1996), we rejected these same arguments and held that amended ORS 656.283(2)(c) divests the Board and Hearings Division of all jurisdiction, without exception, to review vocational assistance administrative orders issued by the Director. We continue to reject these arguments for the reasons explained in Sweisberger, supra.

ORDER

The ALJ's order dated December 4, 1995 is affirmed.

June 5, 1996 Cite as 48 Van Natta 1149 (1996)

In the Matter of the Compensation of
STEVEN D. WINDSOR, Claimant
WCB Case Nos. 95-03437 & 95-03436
ORDER OF ABATEMENT
Parker, Bush & Lane, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Claimant, for the second time, requests reconsideration of our May 7, 1996 Second Order on Reconsideration. In making the request, claimant submits a report from Dr. Mandiberg dated June 3, 1996, stating that, based on treatment provided to claimant following the hearing, he now agrees that claimant's cervical condition was caused by a January 1993 injury.

In order to further consider this matter, we withdraw our May 7, 1996 order. The SAIF Corporation is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order. Thereafter, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
DENNIS L. SYLVESTER, Claimant
WCB Case No. 95-09823
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorneys
Williams, Zografos, et al, Defense Attorneys

Reviewed by Board Members Hall and Moller.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that awarded 39 percent (124.8 degrees) unscheduled permanent disability for claimant's low back strain condition, whereas an Order on Reconsideration had awarded none. On review, the issue is extent of unscheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted lumbar strain claim with the employer. He also has long-standing preexisting low back degeneration. A Determination Order awarded 39 percent unscheduled permanent disability for claimant's low back strain condition. An Order on Reconsideration decreased claimant's permanent disability to zero. The ALJ modified the Order on Reconsideration, finding claimant entitled to 39 percent unscheduled permanent disability.[1]

The employer challenges this conclusion, asserting that the medical evidence fails to establish that claimant's impairment is injury-related and, therefore, claimant is not entitled to permanent disability. We agree.

With the exception of the medical arbiter, only the attending physician at the time of claim closure may make findings concerning a worker's impairment. See ORS 656.245(3)(b)(B); Koitzsch v. Liberty Northwest Ins. Corp., 125 Or App 666 (1994).[2]

The ALJ found the opinion of Dr. Jackson, treating physician, more persuasive than that of the medical arbiter regarding claimant's impairment. Although the ALJ applied the correct legal analysis, we disagree with her conclusions regarding the persuasiveness of the medical evidence, based on the following reasoning.

It is undisputed that claimant had significant low back degeneration which preexisted his August 3, 1994 strain injury at work. (Exs. 15-1-3,16, 24). Claimant began treating with Dr. Jackson, family practitioner, on December 7, 1994. Dr. Jackson ordered a lumbar MRI which confirmed claimant's multilevel degenerative disease. (Ex. 27). On March 20, 1995, Dr. Jackson performed a closing examination and erroneously noted that claimant had experienced no previous back injuries.[3] (Ex. 36). Although Dr. Jackson acknowledged claimant's MRI findings of multi-level low back degeneration, he concluded that claimant was medically stationary "with permanent impairment from the chronic lumbar strain[.]" (Id).

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[1] At hearing, claimant was the only party registering dissatisfaction with the reconsideration order. Because claimant was the dissatisfied party, he had the burden of establishing that the standards had been incorrectly applied, i.e., that the reconsideration order incorrectly failed to relate claimant's impairment to the compensable injury. See ORS 656.283(7); David J. Schafer, 46 Van Natta 2298, 2299 (1994).

[2] However, impairment findings from a physician other than the attending physician may be used if those findings are ratified by the attending physician. See OAR 436-35-007(8); Roseburg Forest Products v. Owen, 127 Or App 442 (1994). In this case, there are no such ratified findings.

[3] This history is inconsistent with claimant's back injuries in the late 1960's and in 1989. (Ex. 16-2).

Dr. Peterson performed an arbiter's examination on June 20, 1995. (Exs. 46, 48). Considering the nature of claimant's strain injury, his preexisting disc degeneration, and the fact that claimant's range of motion had worsened since Dr. Farris' September 1994 examination (see Ex. 16), Dr. Peterson concluded that claimant's current impairment was related to his preexisting degeneration, rather than his work injury.

Dr. Peterson expressly considered the nature of claimant's strain injury, his preexisting condition and his symptoms since the injury. Dr. Jackson did not. Under these circumstances, we find Dr. Peterson's opinion regarding the etiology of claimant's current impairment the most persuasive. See Somers v. SAIF, 77 Or App 259 (1986). Based on that opinion, we conclude that claimant is not entitled to a permanent disability award because he has not established injury-related impairment. See ORS 656.214(5); 656.726(3)(f)(A)&(B).

ORDER

The ALJ's order dated December 15, 1995 is reversed. The Order on Reconsideration is affirmed. The ALJ's attorney fee award is reversed.

June 7, 1996 Cite as 48 Van Natta 1151 (1996)

In the Matter of the Compensation of
ROBERT W. FLEMING, Claimant
WCB Case No. 95-09529
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Poland's order that set aside its partial denial of claimant's thoracic and lumbar disc conditions. On review, the issues are res judicata and, if the claim is not precluded, compensability.

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

Claim preclusion bars future litigation not only on every claim included in the pleadings, but on every claim that could have been alleged under the same aggregate of operative facts. Million v. SAIF, 45 Or App 1097, rev den, 289 Or 337 (1980). 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).

Finding that the present claim regarding compensability of claimant's current thoracic and lumbar condition involves different operative facts, the ALJ concluded that a prior proceeding and order have no preclusive effect on the present litigation. We agree.

"The res judicata effect [of a] denial is limited to the conditions denied as they existed on or before the date of the denial." Sharon E. Mack, 42 Van Natta 1562, 1564 (1990); George W. Jordan, 41 Van Natta 2072, 2073 (1989). Here, the issues litigated before ALJ Baker in June 1995 concerned compensability of a psychological condition and foot condition. Subsequent to the June 1995 hearing, based on a report received from record reviewer Dr. Young on July 5, 1995, the insurer denied claimant's current thoracic and lumbar condition on July 7, 1995. Thus, this claim is not the same claim which was litigated before the prior ALJ.

Inasmuch as claimant did not have an opportunity to litigate the thoracic and lumbar disc compensability issue in the prior proceeding, claimant is not precluded from bringing an action on the insurer's July 1995 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 the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief, his counsel's statement of services, and the insurer's response), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated December 15, 1995 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the insurer.

In the Matter of the Compensation of
SPENCER L. METCALF, Claimant
WCB Case No. 95-02724
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Spangler's order that upheld the SAIF Corporation's denial of his occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issues are compensability and, if the claim is compensable, responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the facts. Claimant, 50 years old at the time of hearing, has worked in various physically demanding jobs since 1974. In the early 1980's, he worked as a hod carrier for C & L Masonry. In 1983, he filed a claim for bilateral CTS, which C & L's insurer denied. From August to December 1984, claimant worked for Haughton Logging Company as a knot bumper. In 1985, he again filed a claim for bilateral CTS, which Haughton's insurer denied. There is no evidence that claimant appealed either denial, and the denials became final by operation of law.

Claimant first received treatment for CTS in November 1984 from Dr. Kendrick. (Ex. 1-1). Nerve conduction studies at that time revealed mild bilateral CTS. (Ex. 2).

After several other jobs, claimant began working for the current employer in 1990 as a custodian. Claimant's bilateral wrist and arm symptoms increased. In April 1992, he was taken off work due to right wrist tendonitis. (Ex. 14). Claimant's claim for that condition was denied, and the dispute was resolved in March 1993 by a Disputed Claim Settlement (DCS). (Exs. 19, 21).

Claimant continued in his employment, and his arm and wrist symptoms increased. In November 1994, repeat nerve conduction studies revealed moderately severe bilateral CTS. (Ex. 22-3). Consequently, claimant underwent a right carpal tunnel release in January 1995, performed by Dr. Johnson, and a left carpal tunnel release in February 1995, performed by Dr. Sulkosky. (Exs. 26, 36).

In January 1995, claimant filed a claim against his present employer for bilateral CTS. On January 30, 1995, SAIF disclaimed responsibility for claimant's condition and, on February 17, 1995, denied compensability of the occupational disease claim as well. (Exs. 33, 39). Claimant requested a hearing.

At hearing, the ALJ determined that claimant failed to prove the compensability of his bilateral CTS condition as an occupational disease. Reasoning that claimant had to establish the compensability of his occupational disease claim under ORS 656.802(2)(b), because he had a bilateral CTS condition that preexisted his exposure with the current employer, the ALJ concluded that the medical evidence failed to establish, within reasonable medical probability, that claimant's work activities since 1990, with the current employer, were the major contributing cause of his current CTS condition. In doing so, the ALJ rejected claimant's argument that compensability of his occupational disease should be established using the "last injurious exposure rule" of proof, taking into consideration all claimant's potentially contributory work exposures.

We agree with the result reached by the ALJ, that is, that claimant failed to prove the compensability of his occupational disease claim, but we do so based on the following reasoning.

Since this is an occupational disease claim, it is claimant's burden to prove that employment conditions were the major contributing cause of his bilateral CTS.[1] ORS 656.802(2)(a); 656.266. Because of the number of potential causes of claimant's condition, as well as the long period of time between the alleged onset of symptoms and claimant's filing of this claim, we find that the causation question is medically complex. Therefore, we require expert medical opinion to resolve the causation question. Barnett v. SAIF, 122 Or App 279, 282-83 (1993); Kassahn v. Publishers Paper Co., 76 Or App 105, 109 (1985). In order to be sufficient to carry claimant's burden, medical opinion must be expressed in terms of reasonable medical probability. In other words, claimant must prove more than the mere possibility of a causal connection. Gormley v. SAIF, 52 Or App 1055, 1059-60 (1981).

After our review of the record, we conclude that claimant failed to carry his burden of proof, because we find no medical opinion that establishes with reasonable medical probability that claimant's work activities were the major contributing cause of his bilateral CTS.

Claimant first obtained treatment for bilateral CTS in November 1984 from Dr. Kendrick. In July 1985, Dr. Kendrick opined that claimant's work activity prior to November 1984 (carrying hod) was responsible for the onset of symptoms. (Ex. 1-3). Dr. Kendrick did not continue to treat claimant, and he did not render an opinion regarding the cause of claimant's symptoms in 1994.

Between 1989 and 1991, claimant received chiropractic treatment from Dr. Hiskey for neck and upper back problems, including complaints of bilateral arm numbness. (Ex. 8 at 1-3).

In 1992, Dr. Johnson treated claimant for a painful right wrist condition that was diagnosed as tendinitis. (Exs. 7-1, 14, 18). Dr. Hiskey also provided treatment for claimant's right wrist tendinitis, which he related to claimant's work activities as a janitor. (Ex. 18). However, Dr. Hiskey did not indicate whether claimant's work activities were the major contributing cause of his tendinitis, nor did he continue to treat claimant after 1993. (See Ex. 8-6).

In 1994, Dr. Johnson again saw claimant for bilateral hand and arm pain and numbness. He diagnosed bilateral CTS. (Ex. 7-3). In November 1994, Dr. Ireland saw claimant in consultation and confirmed the diagnosis of bilateral CTS of moderate severity. (Ex. 22-3). Dr. Johnson performed a right carpal tunnel release on January 4, 1995. (Ex. 26). However, neither Dr. Johnson nor Dr. Ireland offered an opinion regarding the cause of claimant's bilateral CTS condition.

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[1] Although claimant acknowledges that he must prove that employment conditions were the major contributing cause of his disease, he also argues, relying on Runft v. SAIF, 303 Or 493, 498 (1987), that he need only prove that his employment conditions with the current employer were of the type that could have caused his symptoms. (Appellant's Brief at 5-6). Apparently, claimant seeks to rely on the "last injurious exposure rule" to prove the compensability of his occupational disease. We observe that the rule of proof aspect of the last injurious exposure rule allows consideration of all employments in determining whether employment conditions were the major contributing cause of an occupational disease. Silveira v. Larch Enterprises, 133 Or App 297, 300-01 (1995); Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71, 74-76 (1994). However, the rule does not eliminate the claimant's burden to prove compensability of an occupational disease in the first instance; that is, the claimant must still prove that employment conditions were the major contributing cause of the disease. Id. Here, we conclude that claimant has failed to establish the necessary employment connection. See Bennett v. Liberty Northwest Ins. Corp., supra, 128 Or App at 75-76 (1994).

In January 1995, claimant began treating with Dr. Sulkosky. (Exs. 30, 31). In February 1995, Dr. Sulkosky performed a left carpal tunnel release. (Ex. 36). Dr. Sulkosky noted that claimant had indications of CTS in 1984, and that he has a case for "possible slow progression" of his CTS. He added that claimant has experienced increased symptoms with his current work activities as a custodian. (Ex. 41A). Dr. Sulkosky further opined that there is a "probability" that work activities as a custodian increased claimant's symptoms, as evidenced by worsened nerve conduction studies. However, he qualified his opinion by adding:

> "Obviously, anything that I say regarding this would be pure supposition and speculation, as I discussed with you on the phone the other day. I would think that the patient has had progression from 1984 to the present, and even if he had mild carpal tunnel back then, the only way that we could document that it was work activity related would be to have nerve conductions which were worse sometime in the interim, and then when he stopped the work have them get better with time, which has not happened." (Emphasis in original).

(Ex. 42-1). Moreover, Dr. Sulkosky initially concurred with the report of Drs. Rich and Neumann who examined claimant at SAIF's request and opined that his symptoms were not work-related. (Ex. 41). Thus, we find that Dr. Sulkosky's opinion regarding the cause of claimant's current CTS condition is unclear, equivocal and speculative, and we do not find it persuasive. In addition, since Dr. Sulkosky does not express an opinion regarding the cause of claimant's current CTS condition in terms of reasonable medical probability, it is insufficient to carry claimant's burden of proof. Gormley v. SAIF, supra.

Finally, Drs. Rich and Neumann opined that claimant has had CTS since 1984, which has progressed in severity over the years. They explained that CTS, once established, tends to be a chronic and progressive condition, and that claimant's symptoms would have increased over the years due to the natural progression of the condition. They did not believe claimant's work activities as a custodian were responsible for either the onset of the condition or its pathological worsening. (Ex. 37-5).

Considering the medical evidence as a whole in this case, we find no persuasive opinion that establishes, with reasonable medical probability, that claimant's work activities were the major contributing cause of his bilateral CTS condition in 1994. We would reach this conclusion even if we were to consider all claimant's work activities since approximately 1984. Therefore, it is unnecessary to determine which specific time periods of employment can be considered in this case, nor is it necessary to determine whether a "preexisting condition" is involved in this case. In addition, since we have found that claimant's current occupational disease claim is not compensable, it is unnecessary to determine responsibility.

ORDER

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

In the Matter of the Compensation of
SCOTT J. MALONEY, Claimant
WCB Case Nos. 95-09774 & 95-02568
ORDER OF ABATEMENT
Malagon, Moore, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

On May 28, 1996, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) set aside the insurer's denial of claimant's right carpal tunnel syndrome (CTS) condition; (2) affirmed an Order on Reconsideration that found a claim for right wrist strain was prematurely closed; (3) found claimant entitled to additional temporary disability; and (4) assessed a penalty for the insurer's allegedly unreasonable claims processing. Announcing that the parties have reached a settlement of their disputes, the insurer seeks abatement of our decision so that we may retain jurisdiction to consider their forthcoming agreement.

Based on the representations contained in the insurer's announcement, we withdraw our May 28, 1996 order. On receipt of the parties' proposed settlement, we will proceed with our reconsideration. In the meantime, the parties are requested to keep the Board fully apprised of any further developments in this case.

IT IS SO ORDERED.

June 7, 1996 Cite as 48 Van Natta 1155 (1996)

In the Matter of the Compensation of
KEVIN M. ROTTER, Claimant
WCB Case No. 95-09240
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Scott Terrall & Associates, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Bethlahmy's order that awarded claimant 5 percent (0.5 degrees) scheduled permanent disability award for loss of use or function of the right ring finger, whereas an Order on Reconsideration had awarded no permanent disability. In addition, the employer contends that the ALJ erred in admitting claimant's testimony into the record. On review, the issues are evidence and the extent of scheduled permanent disability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant, a bus driver, compensably injured his right ring finger when he caught his finger on the spoke of the steering wheel and bent it back. On August 31, 1993, Dr. Nathan performed a trigger release on claimant's finger. Claimant subsequently developed a small nodule at the incisional site.

Relying on claimant's testimony as well as on the medical opinions from claimant's treating physician, Dr. Nathan, and from the medical arbiter, Dr. Dinneen, the ALJ found claimant entitled to 5 percent scheduled chronic condition impairment. We disagree and reverse.

Subsequent to the ALJ's order, in Joe R. Ray, 48 Van Natta 325 (1996), we held that amended ORS 656.283(7) retroactively applied to exclude any evidence, including at-hearing testimony, which was not submitted at the reconsideration proceeding.[1] Accordingly, on review, we do not consider claimant's testimony.

The employer challenges the ALJ's award of 5 percent scheduled permanent disability for a chronic and permanent condition limiting repetitive use of claimant's right ring finger. We agree with the employer's contention and reverse.

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[1] In Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996), the Court of Appeals overruled Joe R. Ray to the extent we held that ORS 656.283(7) applies retroactively to cases in which "post-reconsideration" evidence was properly admitted under the former law. In this case, however, both the Department's reconsideration process and the hearing took place after the June 7, 1995 enactment of SB 369. Therefore, the prohibition against admission of "post-reconsideration" evidence set forth in amended ORS 656.283(7) is applicable here. See Dean J. Evans, 48 Van Natta 1092 (1996) (adhering to the holding of Joe R. Ray where the hearing was held after June 7, 1995).

Former OAR 436-35-010(6) provides that a "worker may be entitled to scheduled chronic condition impairment when a preponderance of medical opinion establishes that the worker is unable to repetitively use a body part due to a chronic and permanent medical condition[.]" The rule requires medical evidence 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. 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. Donald E. Lowry, 45 Van Natta 749, on recon 45 Van Natta 1452 (1993).

Dr. Nathan performed a closing examination on October 19, 1994. He reported that claimant had some hypertrophy of the palmar fascia in the area of the surgical scar and that the tissue was "non dolor," i.e., not painful. (Ex. 18). Dr. Nathan's examination was otherwise normal. He declared claimant medically stationary without evidence of permanent impairment.

Dr. Dinneen, medical arbiter, examined claimant on August 5, 1995. His examination was also normal. Dr. Dinneen concluded:

> "[t]here is no objective evidence of any inability to repetitively use the right hand. [Claimant] does have a prominence and likely would have some symptoms with repetitive gripping, etc., and so history would be consistent with, at least, slight decreased ability to repetitively use the right hand, based on the accepted condition." (Ex. 20).

We find Dr. Dinneen's statement analogous to the medical evidence in Rae Holzapfel, 45 Van Natta 1748 (1993) aff'd mem Holzapfel v. M. Duane Rawlins, Inc., 127 Or App 208 (1994). In Holzapfel, the doctors' recommendations that the claimant avoid repetitive strenuous work with her hands in order to prevent an increase in symptoms was insufficient to establish a permanent and chronic impairment of the wrists.

Here, we find a lack of objective medical findings of claimant's impairment and of an inability to repetitively use his hand. Consequently, Dr. Dinneen's opinion, based on claimant's subjective history, that claimant will likely experience symptoms with repetitive use, is insufficient to establish a permanent and chronic condition. Accordingly, we conclude that the preponderance of the medical opinion fails to establish that claimant is unable to repetitively use his right ring finger/hand due to a chronic and permanent condition. Consequently, claimant is not entitled to an award of scheduled permanent disability.

ORDER

The ALJ's order dated December 14, 1995 is reversed. The August 7, 1995 Order on Reconsideration, which awarded claimant no permanent disability, is affirmed. The ALJ's out-of-compensation attorney fee award is also reversed.

In the Matter of the Compensation of
GEORGIA COLE, Applicant
WCB Case No. CV-95008
FINDINGS OF FACT, CONCLUSIONS AND PROPOSED ORDER (CRIME VICTIMS ACT)
Mary Campbell, Assistant Attorney General

Pursuant to notice, a telephonic hearing was conducted and concluded by Celia M. Fitzwater, special hearings officer, on April 16, 1996, in Salem, Oregon. Applicant, Georgia Cole, participated and was not represented by counsel. The Department of Justice Crime Victims' Compensation Fund (Department) was represented by Mary Campbell, Assistant Attorney General. The hearing was recorded by the Department after both parties agreed to this procedure. Exhibits 1 through 30 were admitted into evidence. The record closed April 16, 1996. Doug Yerke participated as a witness for the Department. Also present as an observer was Kristin Preston, Assistant Attorney General.

Applicant has requested review by the Workers' Compensation Board of the Department's Order on Reconsideration dated December 11, 1995. By its order, the Department denied applicant's claim for compensation as a victim of a crime under ORS 656.147.005 to 147.375. The Department based its denial on the finding that applicant did not prove she was a victim of a crime.

FINDINGS OF FACT

In February 1994, applicant worked in a temporary position for a bank located in downtown Portland.

On February 24, 1994, applicant presented to a hospital emergency room and was examined by Dr. Ralston. The chartnote states that applicant "apparently tripped on a brick step downtown two days ago" and she "fell face forward, with her back arched and arms extending, striking her right knee, her right hand, and apparently somehow bracing herself with her right knee as well." (Ex. 24-8). Dr. Ralston diagnosed "multiple soft tissue injuries." (Id. at 9).

On December 27, 1994, applicant again presented to the emergency room with right knee complaints and was examined by Dr. Meyer. According to the chartnote, applicant stated that "she fell on February 22 in the PGE building." (Ex. 24-6). Dr. Meyer diagnosed right knee contusion. (Id.)

On February 3, 1995, applicant saw Dr. Satterfield. The chartnote states that applicant "had an injury in February 1994, a trip and fall injury in the PGE building." (Ex. 22-2).

On March 11, 1995, applicant once more sought treatment at the emergency room. The chartnote provides that applicant "apparently has a history of falling at work at the Portland Gas and Electric Company" and she "fell and hit her knee with multiple soft tissue injuries." (Ex. 24-4).

As of the date of hearing, applicant continued to seek treatment for right knee pain.

CONCLUSIONS OF LAW AND OPINION

A person is eligible for crime victims' compensation if he or she "is a victim * * * of a compensable crime that resulted in a compensable loss of more than $100." ORS 147.015(1). "Victim" is defined as a person "killed or injured in this state as a result of a compensable crime perpetrated or attempted against that person." ORS 147.005(12)(a)(A). "Compensable crime" in part means "an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state." ORS 147.005(4). The standard for review in this case is de novo on the entire record. ORS 147.155(5).

After reviewing the medical reports of applicant's treatment, the Department denied applicant's claim on the basis that claimant's injury did not result from having been the victim of a compensable crime.

Applicant testified that, on February 22, 1994, she was walking in downtown Portland during the lunch hour. Applicant also testified that she remembers only being thrown into the street and landing face-down. Applicant explained that, because she suffers from amnesia, she does not remember anything more about the incident. According to applicant's testimony, however, she has had several

"flashbacks" about the event when she has "seen" a man pointing a gun at her face and holding her arm. Applicant believes that, on February 22, 1994, two men attempted to rob her and that she was then pushed to the ground. In making this assertion, applicant relies on her "flashbacks" and her belief that the severity of her symptoms could not have been caused merely by tripping and falling.

Applicant's testimony is not supported by the medical evidence. The reports of applicant's treatment on February 24, 1994, December 27, 1994, February 3, 1995, and March 11, 1995 all provide a history that applicant tripped and fell face-down. Applicant asserted that the histories contained in the reports were not provided by her because, having amnesia, she has no memory of the event.

Given the consistency of the histories in the reports, the fact that applicant was examined by numerous physicians, and the close temporal relationship between the examinations and the February 1994 event, I do not accept applicant's assertion that she was not the source of the information concerning the history of her injury. Furthermore, applicant's testimony is not supported by corroborating evidence. For instance, applicant did not provide any testimonial or documentary evidence from those persons who she claims have direct or indirect knowledge that she was the victim of a robbery and assault.

The only evidence that applicant was the victim of a compensable injury is from her testimony. Such testimony, however, is not even based on applicant's memory, but rather on "flashbacks" and her belief that her injuries are too severe to have been caused by tripping and falling. In that respect, applicant's own testimony has no firm foundation. Moreover, applicant's testimony is disputed by the medical reports showing a history of having only tripped and fell.

For all these reasons, I find that applicant did not prove that a "compensable crime" occurred when she was injured on February 22, 1994. Consequently, I conclude that applicant is not eligible for crime victims' compensation. ORS 147.015(1).

PROPOSED ORDER

I recommend that the July 25, 1995 Findings of Fact, Conclusions and Order of the Department of Justice, as reconsidered September 20, 1995 and December 11, 1995, be affirmed.

In the Matter of the Compensation of
LOUIS L. HARON, Claimant
Own Motion No. 66-0195M
OWN MOTION ORDER
Floyd H. Shebley, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for medical services for his compensable April 13, 1960 back injury. SAIF recommended that the Board deny the provision of the current requested medical services, specifically, the placement of an osteostimulator into claimant's spine, contending that further surgery and the placement of the osteostimulator is "not medically reasonable and necessary treatment." In addition, SAIF asks the Board to disallow medical treatment for claimant's depression, contending that "[t]he depression should no longer be considered a compensable part of his claim for the injury of 1960."

On October 4, 1995, the Board referred this case to the Hearings Division for a fact finding hearing on the issues of: (1) whether the request for surgical implantation of an osteostimulator (to establish a solid fusion at the L3-4 level) is reasonable and necessary medical treatment for claimant's compensable back condition; and (2) whether the compensable injury is causally related to claimant's need for continuing treatment for depression.

The fact finding hearing was held before Administrative Law Judge (ALJ) Lipton on December 22, 1995. On March 26, 1996, ALJ Lipton issued a recommendation that: (1) Dr. Nash's request to surgically implant an osteostimulator or to fuse claimant's spine at L3-4 be denied on the grounds that the L3-4 fusion is solid and the recommended surgery is therefore neither reasonable nor necessary; and (2) the compensable 1960 injury remains the major contributing cause of claimant's major depression and treatment thereof.

Following the receipt of ALJ Lipton's recommendation, the Board established a briefing schedule to allow the parties an opportunity to respond to the recommendation. The parties' responses have been received, and we proceed with our review of the record.

FINDINGS OF FACT

We adopt the findings of fact as set forth in the ALJ's recommendation.

CONCLUSIONS OF LAW AND OPINION

We adopt as our reasoning and conclusions on these issues the ALJ's discussion and conclusions as set forth in his recommendation to the Board, with the following supplementation.

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

Proposed Low Back Surgeries

In our order referring for evidentiary hearing, we defined the proposed medical treatment as the implantation of an osteostimulator. By letter dated December 15, 1995, Dr. Nash also recommended a multiple level foraminal decompression and stabilization at L3-4. That recommendation was considered at hearing.

We conclude, as did the ALJ, that the surgeries proposed by Dr. Nash are not supported by evidence or clinical findings as being reasonable and necessary for claimant's compensable injury. On the contrary, all other physicians who examined claimant opined either that the proposed surgeries would not improve claimant's condition because the fusion at L3-4 was solid, or that the surgeries might even have a negative effect on claimant's condition.

Accordingly, based on the medical record, we decline to authorize the requested medical services, specifically, the proposed osteostimulator implant or the fusion surgery at L3-4, as being neither reasonable nor necessary treatment for claimant's compensable condition.

Psychological Condition and Need for Treatment

We also agree with the ALJ's reliance on the opinion of Dr. Fleming, claimant's longtime treating psychologist. Despite his retirement, Dr. Fleming maintained contact with claimant, and provided a reasoned opinion explaining that claimant continues to have a psychological/depression condition that is related to the 1960 injury. Although Dr. Fleming has not treated claimant since 1993, he has supported his opinion that the cause of claimant's depression continues to be the 1960 injury with objective and subjective data.

Dr. Davies, who examined claimant at SAIF's request on April 4, 1995, diagnosed a pain disorder and, like Dr. Fleming, also diagnosed moderate to severe depression. Despite recommending that the depression be aggressively treated, Dr. Davies opined in a one-word response to an inquiry from SAIF, that the 1960 injury is not the major contributing cause of claimant's depression and need for treatment. Because Dr. Davies only examined claimant one time, we do not rely on his one-word conclusory analysis because it does not explain what has changed since the condition was initially diagnosed by Dr. Fleming such that the compensable injury would no longer be the major contributing cause of claimant's condition. Moe v. Ceiling Systems, 44 Or App 429 (1980).

On the other hand, Dr. Klecan, the psychiatrist who examined claimant for SAIF, opined that claimant does not suffer from major depression. Instead, Dr. Klecan opined that claimant is merely unhappy because of the limitations and physical handicaps resulting from the compensable injury. Dr. Klecan's discussion regarding whether or not claimant suffers from major depression is not relevant to our inquiry in this case. SAIF does not contend that claimant does not have a psychological condition. Rather, SAIF contends that claimant's current psychological condition is no longer related to his industrial injury. In addition, Dr. Klecan, like Dr. Davies, examined claimant only one time, and his opinion should be weighed accordingly. Finally, although Dr. Klecan does not believe that claimant suffers from depression, he does relate the condition he views as claimant's unhappiness to the physical handicaps resulting from the compensable injury.

Therefore, the record supports Dr. Fleming's opinion that claimant's psychological condition continues to be causally related to claimant's 1960 injury. Accordingly, we are persuaded that claimant's depression/psychological condition continues to be caused by his 1960 injury.

Therefore, we authorize the provision of medical treatment for claimant's depression/psychological condition. Claimant's claim shall remain reopened to provide medical services that are found to be reasonable and necessary and causally related to the compensable injury pursuant to our order of February 12, 1993 and our order of this date. Authorization for these medical services shall continue on an ongoing basis for an indefinite period of time until there is a material change in treatment or other circumstance. After those medical services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT E. CARPER, Claimant
Own Motion No. 94-0718M
OWN MOTION ORDER
Schiro & Baron, Claimant Attorneys
Saif Legal Department, Defense Attorney

On April 10, 1995, the Board issued its Own Motion Order Referring for Consolidated Hearing in this matter. We took this action because litigation on related issues was pending before the Hearings Division. (WCB Case No. 95-01564).

On April 10, 1996, Administrative Law Judge (ALJ) Otto approved a "Stipulation and Order," which resolved the parties' dispute pending before the Hearings Division. Pursuant to that order, the SAIF Corporation agreed to accept claimant's current arachnoid cyst in the area of T6 to T9, along with syringomyelia in the lower thoracic area conditions.

Because the status of claimant's request for own motion reopening remained unclear, on April 26, 1996, the Board requested the parties' positions regarding whether claimant's compensable condition had worsened requiring surgery and whether claimant was in the work force at the time of disability. We have received the parties' responses, and proceed with our review of the record.

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 November 19, 1994, Dr. Frank, claimant's neurosurgeon, recommended surgery at the location of T8 through T10. On December 1, 1994, Dr. Frank performed that surgery, and placed a plural shunt in the subarachnoid area. Thus, we conclude that claimant's compensable condition worsened requiring surgery.

However, in order to be entitled to temporary disability compensation, claimant must have been in the work force at the time of disability. Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990). There is no evidence that claimant was actually employed at the time of disability. Therefore, in order to prevail, claimant must prove that he is willing to work and either: (1) he was making reasonable efforts to obtain work; or (2) reasonable efforts to obtain work would have been futile because of the compensable injury. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Cutright v. Weyerhaeuser Company, 229 Or 290 (1985). Claimant has the burden of proving that he was in the work force at the time of disability.

SAIF contends that claimant was not in the work force at the time of the current disability because he is "retired and drawing Social Security." Claimant responded that he is not retired, but he is receiving social security benefits. Claimant further contends that:

"A social security recipient's eligibility can be re-evaluated at anytime by the Social Security Administration and if [claimant] is no longer disabled, his social security benefits will cease. This is the program under which [claimant] is being paid.

"If the treatment provided by SAIF Corporation restores his ability to compete in the workplace, [claimant] will again be in the work force."

Pursuant to Dawkins, supra, "[a] claimant who is not employed, is not willing to be employed, or, although willing to be employed, is not making reasonable efforts to find employment (unless such efforts would be futile because of the work-related injury) has withdrawn from the work force." Konnie Sprueill, 45 Van Natta 541 (1993). A claimant's eligibility for social security benefits indicates that he is disabled from work due to one or a number of medical conditions. However, the provision of social security benefits does not automatically establish that a claimant is disabled from work because of a compensable injury. Therefore, a claimant's entitlement to social security benefits is not determinative evidence regarding whether he is disabled due to the compensable injury, unless the claimant can establish the entitlement to disability benefits is due to the compensable condition. See Kenneth C. Felton, 48 Van Natta 725 (1996).

Here, claimant merely asserts that he is receiving Social Security Disability benefits, he provides no evidence as to whether his entitlement to these benefits is due to the compensable back conditions or some noncompensable condition. Under these circumstances, claimant has not established that he was unable to work at the time of disability because of a compensable injury. Furthermore, receipt of Social Security Disability benefits does not establish claimant's willingness to work. Dawkins, supra.

Finally, claimant underwent surgery in December 1994. Claimant argues that if the treatment provided by SAIF restores his ability to compete in the workplace, "[claimant] will again be in the work force." However, claimant must establish that he was in the work force at the time of disability. Weyerhaeuser v. Kepford, supra.

Accordingly, we are not persuaded that claimant has carried his burden of proving that he was in the work force at the time of disability. Therefore, claimant's request for temporary disability compensation is denied. 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.

June 11, 1996 Cite as 48 Van Natta 1161 (1996)

In the Matter of the Compensation of
GARY W. BENSON, Claimant
WCB Case No. 95-09331
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that upheld the insurer's partial denial of his low back condition, including degenerative spondylosis and transitional vertebrae at the L5 level. On review, the issue is compensability.

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

Claimant, age 43 at the time of hearing, was working as a drywall painter when, on May 22, 1995, he compensably injured his left shoulder and low back. The insurer accepted a disabling lumbosacral strain and left shoulder contusion.

Claimant's low back symptoms persisted. A June 12, 1995 x-ray of claimant's lumbosacral spine showed joint space narrowing, degenerative changes and a transitional vertebrae at the L5 level. A June 15, 1995 CT scan of the lumbar spine similarly showed degenerative changes and an osteophyte spur on the left at L5-S1.

Claimant's treating doctor, Dr. Peacock, referred claimant to Dr. Tahir for a neurosurgery consultation. On July 19, 1995, Dr. Tahir opined that claimant's ongoing symptoms were not related to the on-the-job incident, but rather due to "a gradually progressively developing narrow lateral spinal canal recess which is a bony canal." Dr. Tahir recommended surgery.

On August 2, 1995, claimant was examined by Drs. Laycoe and Watson at the insurer's request. After considering the reports and findings of Dr. Peacock and Dr. Tahir, Drs. Laycoe and Watson opined that claimant's current need for treatment was due to his preexisting condition, and was neither caused nor worsened by claimant's May 25, 1995 work incident.

On August 8, 1995, the insurer issued a partial denial, asserting that claimant's ongoing disability and need for treatment were directly related to his preexisting degenerative spondylosis and transitional vertebrae at L5, and that the May 22, 1995 industrial injury did not cause or worsen this condition.

On October 2, 1995, claimant was examined by Dr. Hill at his attorney's request. Acknowledging that claimant had preexisting degenerative changes in his spine, Dr. Hill nevertheless concluded that claimant's current condition was caused in major part by the May 22, 1995 work injury. Dr. Hill reported that the work injury caused greater disability than would have been anticipated but for the injury.

Applying ORS 656.005(7)(a)(B) and 656.005(24), the ALJ found that claimant failed to establish by a preponderance of the evidence that his work injury of May 22, 1995 was the major contributing cause of his ongoing low back problems. Specifically, the ALJ determined that because Dr. Hill failed to explain how or why claimant's work injury worsened his preexisting condition, and did not weigh the relative contribution of the preexisting condition and the work-related incident, his opinion was not persuasive enough to outweigh the contrary opinions of Drs. Tahir, Peacock, Watson and Laycoe.

On review, claimant contends that Dr. Hill's opinion is sufficient to sustain his burden of proof under ORS 656.005(7)(a)(B). We disagree, and adopt and affirm the ALJ's reasoning and conclusion on this issue.

Alternatively, claimant argues that the major contributing cause standard set forth in ORS 656.005(7)(a)(B) violates the Americans With Disabilities Act ("ADA"), the Age Discrimination and Employment Act ("ADEA") and Article I, Section 10 of the Oregon Constitution. We address each contention in turn.

42 U.S.C. § 12112(a) prohibits employers from discriminating against an individual because of that individual's "disability." 42 U.S.C. § 12132 similarly protects individuals with a disability from discrimination by a public entity. For purposes of the ADA, the term "disability" is defined as "(A) a physical or mental impairment that substantially limits one or more of the major life activities of [an] individual; (B) a record of such impairment; or (C) being regarded as having such an impairment." 42 U.S.C. § 12102(2).

Claimant contends that, because ORS 656.005(7)(a)(B) imposes a major causation standard when a claimant has a preexisting condition which combines with a compensable injury to cause or prolong disability or need for treatment, the statute unlawfully discriminates against claimants with preexisting conditions. Claimant's argument assumes that a "preexisting condition" under the Workers' Compensation Act[1] is the equivalent of a "disability" under the ADA.

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[1] A "preexisting condition" is defined in ORS 656.005(24) 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 any initial claim for an injury or occupational disease, or that precedes a claim for worsening pursuant to ORS 656.273."

We have previously held that we lack jurisdiction to consider a claimant's ADA challenge to the worker's compensation statutes. Sandra J. Way, 45 Van Natta 876 (1993), aff'd on other grounds Way v. Fred Meyer, Inc., 126 Or App 343 (1994). We have also refused to consider a similar ADA challenge because the argument was insufficiently developed for our review. Jim M. Greene, 47 Van Natta 2245 (1995).

We continue to hold, for the reasons expressed in Sandra J. Way, supra, that the Board is not the proper forum for claimant's ADA challenge. We note, however, that even if we had jurisdiction to consider claimant's ADA arguments, we would find the evidence insufficiently developed in this case. Indeed, the record lacks sufficient evidence to establish even the first element of a prima facie case of discrimination under the ADA, i.e., that claimant is "an individual with a disability" under the terms of the Act.[2]

Claimant next asserts that the Workers' Compensation Act runs afoul of the ADEA because it imposes the "major contributing cause" standard on claimants who suffer from a preexisting degenerative condition. Specifically, claimant argues that his preexisting degenerative low back condition developed as part of the aging process, and that but for his age, he would not have the preexisting condition with which his compensable injury combined. Claimant reasons that, if he were younger, he would not have to prove that his work injury was the major contributing cause under ORS 656.005(7)(a).

29 U.S.C. § 623(a) provides that it is unlawful for an employer to discriminate against any individual because of such individual's age. We conclude, for the reasons articulated in Sandra J. Way, supra, that we similarly lack jurisdiction to consider claimant's ADEA challenge. As with the ADA, the Equal Employment Opportunity Commission (EEOC) is the agency responsible for investigating and enforcing the provisions of the ADEA. See 29 U.S.C. § 626. To the extent claimant contends the ADEA preempts ORS 656.005(7)(a)(B) or that his employer unlawfully discriminated against him by relying on this statute, we find that claimant's complaint falls within the jurisdiction of the EEOC and/or the courts, but not the Board.

Moreover, even if the Board was the proper forum for an ADEA challenge, the record would not support claimant's contention. Although claimant asserts that his preexisting condition is related to his age, he offers no persuasive evidence that his age was the determinative factor in his employer's decision to deny him benefits.[3]

Lastly, claimant argues that the "major contributing cause" standard, applied in conjunction with the exclusive remedy provision of amended ORS 656.018, effectively deprives him of a remedy for his current low back condition in violation of Article I, Section 10 of the Oregon Constitution. As we did in Jim M. Greene, supra, we decline to consider this constitutional challenge because claimant has not demonstrated that he has been injured by operation of amended ORS 656.018. Instead, we continue to adhere to the fundamental rule that a case shall not be decided upon constitutional grounds unless absolutely necessary to determination of the issue before it. See, e.g., Jackson v. Fred Meyer, Inc., 139 Or App 222 (1996) (declining to consider Article I, Section 10 challenge to amended ORS 656.018(1)).

ORDER

The ALJ's order dated December 26, 1995 is affirmed.

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[2] Although claimant asserts he has satisfied the ADA's definition of disability, there is no persuasive evidence to support this assertion. Indeed, there is no medical evidence indicating that claimant's preexisting asymptomatic low back condition is a physical impairment that substantially limits a major life activity, such as working. See 42 U.S.C. § 12102(2). For example, in order to show that he is substantially limited in the major life activity of working, claimant must prove that he is "significantly restricted in ability to perform either a class of jobs or a broad range of jobs in various classes as compared to the average person with comparable training, skills and abilities. The inability to perform a single, particular job does not constitute a substantial limitation in the major life activity of working." 29 C.F.R. § 1630.2(j)(3)(i).

[3] Liability under the ADEA depends on whether the employee's age actually motivated the employer's conduct. If the employer's action is motivated by factors other than the worker's age, even if the motivating factor is correlated with age, there will be no ADEA violation. See Hazen Paper Co. v. Biggins, 113 S.Ct. 1701 (1993) (employer's termination of employee to prevent his pension benefits from vesting does not violate ADEA, because an employee's age and years of service are analytically distinct).

In the Matter of the Compensation of
PATRICIA A. BROWN, Claimant
WCB Case No. 94-15271
ORDER ON REVIEW (REMANDING)
Strooband & Ousey, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Michael V. Johnson's order that: (1) reversed a temporary disability award granted by an Order on Reconsideration; (2) declined to direct the insurer to pay temporary disability benefits pursuant to an appealed Determination Order; (3) declined to assess penalties for allegedly unreasonable claims processing; and (4) declined to remand the claim to the Director for the appointment of a medical arbiter and the issuance of another Order on Reconsideration. On review, the issues are claims processing, temporary disability benefits, penalties and remand. We vacate the ALJ's order and remand to the Hearings Division.

We briefly summarize the pertinent facts of the case. In the spring of 1994, claimant experienced a reaction to a tuberculosis test which had been required by the employer. A chest x-ray was normal, but claimant continued to have a lesion on her right forearm at the site of the original injection. Claimant filed a claim and the insurer accepted a "skin irritation" condition.

Claimant treated with Dr. Young, who was unsure whether claimant's continuing skin irritation was due to a reaction or to self-inflicted injury. Dr. Young released claimant to modified work in July 1994.

Claimant subsequently began to treat with Dr. Pons, who reviewed claimant's medical records and also questioned whether claimant's skin lesion was due to the tuberculosis test or to self-inflicted injury. Dr. Pons ultimately reported that claimant had no disability related to her wound.

On November 17, 1994, a Determination Order issued which awarded claimant temporary partial disability from May 22, 1994 through November 8, 1994.

On December 20, 1994, claimant requested a hearing, seeking payment of the temporary disability benefits awarded by the November 1994 Determination Order.

In February 1995, the insurer requested Department reconsideration of the Determination Order, and claimant filed a cross-request. Claimant's cross-request for reconsideration raised the issue of permanent disability and requested a medical arbiter exam.

On March 6, 1995, the insurer filed a supplemental hearing request, listing the issues as the Determination Order, an "Order on Reconsideration 2/28/95," scheduled permanent disability, unscheduled permanent disability, premature claim closure, and extent of temporary disability.

A March 7, 1995 Order on Reconsideration awarded claimant temporary partial disability from May 22, 1994 through October 3, 1994. The Order on Reconsideration also found that claimant's request for a medical arbiter was not timely and, therefore, no arbiter had been appointed. The Order on Reconsideration awarded no permanent disability.

A March 8, 1995 hearing was convened concerning claimant's request for enforcement of the Determination Order award of temporary disability benefits. Both claimant and the insurer raised issues concerning the March 7, 1995 Order on Reconsideration. The insurer contended that claimant was not entitled to an award of permanent disability, and claimant argued that the matter should be remanded back to the Department for an arbiter exam.

In light of the new issues which had arisen from the reconsideration order, and claimant's request to obtain the deposition of Dr. Pons, the hearing was continued, following claimant's testimony.

On March 9, 1995, the Department issued an order which abated and withdrew the March 7, 1995 Order on Reconsideration. Determining that claimant's request for the appointment of a medical arbiter had been timely, the Department abated its March 7, 1995 order and continued its reconsideration proceeding. Thereafter, the Department issued a "Notice of Postponement of Reconsideration Proceeding," in order for a medical arbiter to be appointed.

On March 27, 1995, the insurer wrote to the Department and contended that the Department had lost jurisdiction over the Order on Reconsideration when the parties requested a hearing. On March 29, 1995, the Department responded, and agreed with the insurer that, because a hearing had been requested, the Department lost jurisdiction over the matter and the order of abatement was void. See OAR 436-30-008.

On May 2, 1995, Dr. Pons' deposition was taken.

Following receipt of Dr. Pons' deposition and the parties' closing argument, the record was closed. The ALJ's order issued November 13, 1995. Finding that claimant had self-inflicted her injury, and therefore, had no disability, the ALJ declined to direct the insurer to pay temporary disability benefits pursuant to the November 1994 Determination Order. Consequently, the award of temporary disability benefits was reversed. The ALJ also declined to remand to the Director for the appointment of a medical arbiter and the issuance of another Order on Reconsideration.

On review, claimant contends that the ALJ erred in failing to remand this claim to the Department for appointment of a medical arbiter. Claimant also disagrees with the ALJ's finding that she intentionally produced an injury which prolong her recovery and, therefore, his conclusion that claimant was not entitled to temporary disability benefits.

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 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).

We conclude that remand to the ALJ is appropriate in this case. Here, the insurer's request for reconsideration was received by the Department on February 13, 1995. Claimant's cross-request was received by the Department on February 21, 1995. Accordingly, because of the legal holiday ("Presidents' Birthday") which fell during the interim, claimant's cross-request for reconsideration was valid, as it was timely received on the sixth working date from the insurer's request. See OAR 436-30-165(1)(c) (Cross-request for reconsideration must be received within 6 working days of the original reconsideration request). Therefore, by declining to appoint an arbiter, the Department violated its own rule. The Department subsequently acknowledged its error in its March 9, 1995 "Order Abating and Withdrawing."

Consequently, we conclude that because the statute mandates the appointment of an arbiter and since claimant's request for reconsideration (and the accompanying request for an arbiter) was timely, the Department is required to appoint an arbiter. ORS 656.283(7); OAR 436-30-050(6)(c). Accordingly, we remand to the ALJ to await the Department's appointment and scheduling of a medical arbiter exam.

In reaching this conclusion, we do not mean to imply that the Department has jurisdiction to amend its initial Order on Reconsideration. See OAR 436-030-0008(1)(b). Rather, the medical arbiter report is admissible, "even if the report is not prepared in time for use in the reconsideration proceeding." Amended ORS 656.268(6)(e). Here, the record establishes that a request for a medical arbiter examination was timely and properly filed and the Department (the only entity statutorily authorized to appoint an arbiter) neglected to schedule that examination before issuance of an Order on Reconsideration. Under such circumstances, we find it consistent with the statutory scheme to conclude that the Department retains authority to appoint a medical arbiter and schedule the examination.[1] To

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[1] We also find that our prior decision, Joyce A. Crump, 47 Van Natta 1516 (1995), supports our conclusion in the present case. In Crump, the claimant was scheduled for a medical arbiter's exam, which she did not attend. An Order on Reconsideration issued, and claimant requested a hearing. Subsequent to the claimant's request for hearing, the Department rescheduled the claimant's medical arbiter exam and the exam was performed.

The employer argued that, once the claimant requested a hearing, the Department lost jurisdiction to order the medical arbiter's exam. However, we disagreed, as we found that the claimant had been referred by the Director for the arbiter exam prior to the request for hearing, and regardless of the fact that the exam was not performed until after the hearing request, the Department still had jurisdiction to "refer" the claimant for an arbiter's exam.

Here, as in Crump, the Director failed to schedule the arbiter exam. Because the Director retains that authority, we find it appropriate to remand to the ALJ for completion of the exam and the submission of the report.

do otherwise would preclude a party from obtaining the statutory relief which she timely requested. Likewise, consistent with ORS 656.268(6)(e), the post-reconsideration medical arbiter report may be considered at hearing. See e.g. Linda M. Cross, 45 Van Natta 2130 (1993) (Relying on former ORS 656.268(6)(a), Board held that a medical arbiter report could be received as evidence at a hearing, even if the report was not prepared in time for use in the reconsideration proceeding).

In light of the fact that the parties raised the issue of permanent disability at hearing, we conclude that a medical arbiter's report is likely to affect the outcome in this case. Therefore, the matter is remanded to the ALJ to await the Department's appointment of an arbiter and the parties' submission of the arbiter's report.

Finally, we note that, although claimant requests remand to the Department for appointment of a medical arbiter, we are not authorized to take such an action. See Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993). In any event, the result sought by claimant, which is the appointment of a medical arbiter, will not be changed by our decision to remand to the ALJ, rather than the Department. See e.g. Linda M. Cross, supra (Where the claimant was entitled to a medical arbiter and none had been appointed due to a finding of premature closure, following a reversal of the premature closure issue, the extent issue was deferred until the Department conducted a medical arbiter exam).

Accordingly, the ALJ's order dated November 13, 1995 is vacated. This matter is remanded to ALJ Michael Johnson to await the parties' submission of the medical arbiter's report. The ALJ shall then proceed to resolve the remaining issues and issue a final, appealable order.[2] In conducting these further proceedings, the ALJ may proceed in any manner, consistent with our order, that will achieve substantial justice. Thereafter, the ALJ shall issue a final, appealable order.

IT IS SO ORDERED.

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[2] In light of our decision to remand regarding the Order on Reconsideration, we do not address claimant's other contentions on review. However, on remand, the parties and the ALJ may wish to consider the effect, if any, that the following holdings may have on the remaining issues: Anodizing, Inc. v. Heath, 129 Or App 356 (1994); Pascual Zaragoza, 45 Van Natta 1221 (1993).

In the Matter of the Compensation of
BRIAN D. HOLSEY, Claimant
WCB Case No. 95-08294
ORDER ON REVIEW
Ernest Jenks, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order which: (1) upheld the SAIF Corporation's denial of claimant's aggravation claim for a low back condition; (2) upheld SAIF's denial of a L4-5 disc herniation; and (3) declined to assess SAIF a penalty for allegedly unreasonable claims processing. On review, the issues are compensability, aggravation and penalties.

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

The ALJ found that claimant failed to prove that his accepted L5-S1 disc herniation had compensably worsened. In so doing, the ALJ declined to rely on the opinion of Dr. Berkeley because it was not well-reasoned and based on an inaccurate history. Further, the ALJ determined that claimant's current L4-5 condition was not a compensable consequence of claimant's accepted condition.

On review, claimant asserts that the opinion of Dr. Berkeley supports the compensability of his aggravation and current condition claims. According to claimant, Dr. Berkeley's opinion is well reasoned and based on an accurate history.

To establish a compensable aggravation, claimant must show an actual worsening resulting from the original injury. ORS 656.273(1)[1]; Gloria T. Olson, 47 Van Natta 2348 (1995). An aggravation has two components: (1) "actual worsening"; and (2) a compensable condition. 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. ORS 656.273(8).

In July 1990 claimant sought medical treatment for pain in his low back and left leg. (Ex. 1). Claimant filed a workers' compensation claim which was accepted for a disc herniation at L5-S1. (Exs 7; 10). According to Dr. Berkeley, treating physician, claimant's worsened condition is degenerative changes at both L5-S1 and L4-5. (Exs. 20; 21). The degenerative changes are not accepted conditions. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish the degenerative changes are compensable conditions. See Gloria Olson, supra.

On April 28, 1995, claimant was examined by Dr. Berkeley for bilateral pain in his legs, right worse than left. (Ex. 14). Dr. Berkeley related claimant's reduced neurological findings (i.e. decreased ranges of motion) to degenerative changes due to claimant's 1990 surgery, foraminal stenosis bilaterally at L4-5 and L5-S1 due to facet disease and subligamentous disc bulge at L4-5. (Ex. 20). He stated that claimant's heavy work activities since 1994 was a contributing factor of claimant's current aggravation. (Ex. 21). Dr. Berkeley opined that claimant's compensable injury and surgery in 1990 were the major contributing cause of claimant's current condition at L4-5 and L5-S1. Id. Dr. Berkeley disagreed with the examiner's report. (Exs. 20; 21).

In June 1995, Drs. Wilson and Tesar, who performed an insurer-arranged examination, opined that claimant's L4-5 and L5-S1 conditions were due to nonorganic factors (i.e. relationship with his employer). (Ex. 18). The examiners did not believe that surgical intervention was necessary.

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, we are unpersuaded by the opinion of claimant's treating physician, Dr. Berkeley, because of its conclusory nature. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Although, Dr. Berkeley explained how claimant's reduced neurological findings were related to degenerative changes, he offered little explanation as to how claimant's 1990 injury led to the various degenerative changes which have resulted in claimant's current conditions. As such, we decline to rely on the opinion of Dr. Berkeley. See Moe v. Ceiling Systems, supra.

Inasmuch as Dr. Berkeley's opinion is the only one which relates claimant's degenerative changes to the original injury in 1990, and because we have determined that his opinion is unpersuasive, we find that claimant has failed to establish that his L4-5 condition is a compensable consequence of his compensable condition or that his accepted L5-S2 disc condition has actually worsened. In conclusion, we affirm the ALJ's decision upholding SAIF's denial.

ORDER

The ALJ's order dated November 8, 1995 is affirmed.

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[1] 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).

In the Matter of the Compensation of
ESTHER L. MACE, Claimant
WCB Case Nos. 95-11711, 95-11710, 95-11709 & 94-11339
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's occupational disease claim for a low back condition. On review, the issue is compensability. We 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 found that claimant proved that her work activities and prior accepted injuries with the employer were the major contributing cause of a worsening of claimant's degenerative lumbar disc disease.

The employer argues that claimant failed to carry her burden of establishing a compensable occupational disease under ORS 656.802. Specifically, the employer contends that, because claimant had a back injury in 1988[1] which resulted in disability, she must prove that traumatic work activities --since closure of the 1988 claim-- caused a worsening of her preexisting degenerative back condition.[2] We disagree.

Amended ORS 656.802(2) provides:

"(a) The worker must prove that employment conditions were the major contributing cause of the disease.

"(b) If the occupational disease claim is based on the worsening of a preexisting disease or condition pursuant to ORS 656.005(7), the worker must prove that employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease.

"(c) Occupational diseases shall be subject to all of the same limitations and exclusions as accidental injuries under ORS 656.005(7).

"(d) Existence of an occupational disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings.

"(e) Preexisting conditions shall be deemed causes in determining major contributing cause under this section."[3]

Under the statute, when an occupational disease claim is based on the worsening of a preexisting disease, the claimant must prove that employment conditions were the major contributing cause of the combined condition and a pathological worsening of the disease. ORS 656.802(2)(b).

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[1] Claimant has accepted claims with the employer for a 1978 and 1988 low back strains. (Exs. 2, 8).

[2] In this regard, the employer cites Dan D. Cone, 47 Van Natta 2220 (1995).

[3] Amended ORS 656.005(24) defines "preexisting condition" 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...."

Here, however, there is no evidence that claimant had low back degeneration which preexisted her work exposure with the employer which began in the early 1970's. Under such circumstances, we have previously held that claimant need not carry the additional statutory burden associated with a preexisting condition in order to prove a compensable disease claim. 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 prove that his work exposure was the major contributing cause of a combined condition and worsening of a preexisting condition).

The employer's reliance on Dan D. Cone, 47 Van Natta 2220, 2221 n.1 (1995), is misplaced, because that case is distinguishable.[4] There, the claimant's occupational disease claim rested on a theory that repetitive traumatic work activities after a 1985 work injury, caused a worsening of the injury-related condition. Because the claim was based on a worsening of a preexisting condition, claimant did need to prove that "employment conditions were the major contributing cause of the combined condition and pathological worsening of the disease." Amended ORS 656.802(2)(b).

Here, in contrast, claimant contends that repetitive work activities during her 20-odd years of employment with the employer were the major contributing cause of her current low back degenerative condition. The medical evidence supports her contention. Unlike Cone, claimant's claim in the present case does not rest on a worsening of a preexisting condition. Moreover, this claimant did not have a preexisting condition "at the onset" of this, her initial occupational disease claim. See ORS 656.005(24). Under these circumstances, Cone does not control and claimant need only establish that her work activities for the employer were the major contributing cause of her low back degenerative condition. ORS 656.802(2); Charlene A. Dieringer, 48 Van Natta 20, 21 (1996); Delbert D. Shuck, Sr., supra.

We agree with the ALJ that claimant has carried her burden of proof, based on the opinions of Drs. Grimm and Grewe. These opinions, read together, indicate that claimant's low back degeneration exceeds that expected for someone her age. (See Ex. 35-42). Further, specifically considering claimant's long history of repetitive work activities (involving her low back), Drs. Grimm and Grewe persuasively explained[5] how such activities "loaded" claimant's low back and contributed to her degenerative condition more than did other causes. (Exs. 31-4, 35-7, 35-24, see Ex. 35-42-44). Because the contrary opinions fail to adequately address claimant's long work history of repetitive activities, we find them less persuasive. Accordingly, based on the opinions of Drs. Grimm and Grewe, we agree with the ALJ that claimant has carried her burden.

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

ORDER

The ALJ's order dated October 12, 1995, as amended October 19, 1996 and October 26, 1996, is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, payable by the self-insured employer.

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[4] See also Stacy v. Corrections Division, 131 Or App (1994) (Claimant failed to prove a "new" occupational disease since his prior accepted disease claim, where the medical evidence did not establish that the work exposure since the prior claim was the major cause of his subsequent condition); Thomas Tobin, 47 Van Natta 1974 (1995) (Claimant failed to prove the compensability of his current condition, because the medical evidence did not establish that work activities after his accepted strain injury were its major cause).

[5] To the extent that Dr. Grewe changed his opinion concerning causation, we find that this is also well-explained. (See Exs. 30, 33-4).

In the Matter of the Compensation of
CATHY M. MONTGOMERY, Claimant
WCB Case No. 95-04223
ORDER ON REVIEW
Robert G. Dolton, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) increased claimant's unscheduled permanent disability award for a back injury from 7 percent (22.4 degrees), as awarded by an Order on Reconsideration, to 8 percent (25.6 degrees); and (2) declined to consider "post-reconsideration" evidence regarding the extent of permanent disability issue, including claimant's testimony at hearing. On review, the issues are evidence and extent of unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidence

At hearing, the ALJ allowed claimant to testify regarding the extent of her permanent disability and allowed claimant to submit Exhibit 24A, a May 2, 1994 statement from Dr. Grewe, attending physician, stating that claimant should avoid strenuous activity at work. Exhibit 24A was not part of the reconsideration record. (Tr. 21-22). The ALJ took the admissibility of such evidence under advisement. In her order, the ALJ relied solely on Exhibits 1 through 45 in deciding the extent issue, without considering claimant's testimony or Exhibit 24A. For the following reasons, we find that Exhibit 24A and claimant's testimony regarding the extent issue are not admissible.

Amended ORS 656.283(7) provides, in part, that "[e]vidence 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[.]" That statute went into effect on June 7, 1995, which was subsequent to the April 4, 1995 Order on Reconsideration but prior to October 13, 1995 record closure. Therefore, the statute applies here. See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

Under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process and not made a part of the reconsideration record, is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent partial disability. Id. at 231. However, amended ORS 656.283(7) does not apply to exclude evidence that was previously and properly admitted at hearing, i.e., evidence submitted prior to June 7, 1995, the effective date of amended ORS 656.283(7). Id.

In Joe R. Ray, 48 Van Natta 325, on recon 48 Van Natta 458 (1996), we held that, under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process, and not made a part of the reconsideration record, is inadmissible at a subsequent hearing about the extent of an injured worker's permanent partial disability.[1] [2] Nevertheless, in light of the court's decision in Plummer, that holding has been overruled to the extent that evidence concerning the extent of an injured worker's permanent partial disability that was properly admitted at hearing, can be considered on review.

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[1] We note that, in Joe R. Ray, we also rejected the argument that claimant makes on review that the limitation on evidence in amended ORS 656.283(7) applies only to medical evidence. 48 Van Natta at 327 n.2.

[2] Although a signatory to this order for purposes of *stare decisis*, Chair Hall continues to believe, for the reasons set forth in his concurrence/dissent in Joe R. Ray, supra, that amended ORS 656.283(7) should not be applied to those cases where the reconsideration record was developed prior to June 7, 1995.

However, where a hearing concerning the extent of permanent partial disability was held after June 7, 1995, the prohibition on subsequent evidence set forth in amended ORS 656.283(7) is applicable. Thus, we continue to adhere to our holding in Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995. Dean J. Evans, 48 Van Natta 1092 (1996).

Here, the matter was submitted on the record which closed on October 13, 1995. Because Exhibit 24A and claimant's testimony were not submitted during the reconsideration process and were not made a part of the reconsideration record, such evidence is not admissible and the ALJ properly declined to consider it. Joe R. Ray, supra.

Claimant asserts that, for the reasons stated in ALJ Howell's order in Joshua V. Sol, WCB Case Nos. 93-03236 and 92-06831, the application of amended ORS 656.283(7) to this case violates her procedural due process rights. We rejected similar arguments in Joe R. Ray, 48 Van Natta at 329-33, and continue to do so.

Finally, claimant argues that the issue of job classification and adaptability are issues that "arise out of" the reconsideration order. Claimant contends that "[e]vidence about such issues is specifically allowed by [amended] ORS 656.283(7)." (Appellant's Brief, page 7). We disagree with claimant's contention that amended ORS 656.283(7) allows "post-reconsideration" evidence.

Amended ORS 656.283(7) provides, in relevant 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.**" (Added words are in bold face type; emphasis added).

Amended ORS 656.268(8) provides:

> "**No 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.**" (Added words are in bold face type; emphasis added).

The quoted section of amended ORS 656.283(7) differentiates between evidence that can be admitted at hearing and issues that can be raised at hearing. Although new evidence is not admissible in a "post-reconsideration" hearing, issues may be raised if the issues "arise[] out of the reconsideration order itself." Similarly, amended ORS 656.268(8) provides that "issues arising out of the reconsideration order may be addressed and resolved at hearing." (Emphasis added).

By their terms, amended ORS 656.283(7) and amended ORS 656.268(8) allow a party to raise new issues that "arise out of the reconsideration order." Even if we assume, without deciding, that claimant's issue arose out of the reconsideration order itself, the statutes do not allow for the introduction of any new evidence. Therefore, we conclude that neither amended ORS 656.283(7) nor amended ORS 656.268(8) allow claimant to present evidence that was not submitted at reconsideration at a subsequent extent of permanent disability hearing. Thus, even if the evidence offered by claimant "arose out of the reconsideration order," it is not admissible.

Accordingly, we affirm the ALJ's decision not to consider claimant's hearing testimony or Exhibit 24A.

Extent of Unscheduled Permanent Disability

The extent of claimant's permanent disability is determined by an application of the "standards." Claimant became medically stationary on September 26, 1994 and her claim was closed on December 6, 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). These are the standards the ALJ applied.

We adopt the ALJ's reasoning and conclusions that claimant is entitled to 8 percent impairment for her compensable cervical, thoracic, and lumbar strains.

Regarding the adaptability factor, under the applicable standards, adaptability is measured by comparing base functional capacity (BFC) to the worker's residual functional capacity (RCF) 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 ALJ determined that the heaviest job that claimant performed in the past five years was her at-injury job as a waitress. (DOT # 311.477-030). That job is assigned a strength of light. Claimant argues that her testimony regarding her at-injury waitressing job establishes that this job included medium work and, as such, should be classified as a "bus person" job, which has a strength category of medium. (DOT # 311.677-018). However, as discussed above, claimant's testimony is not admissible; therefore, we may not consider it in determining the adaptability issue. In addition, claimant's written description of her at-injury work duties are encompassed in the DOT description of waitress duties. (DOT 311.477-030; Ex. 31-2). There is no persuasive admissible evidence that waitress is not the appropriate DOT job description for claimant's at-injury job. Accordingly, we agree with the ALJ that claimant's BFC is light.

Moreover, we agree with the ALJ that, because claimant returned to work as a waitress, her RFC is also light. OAR 436-35-280(1)(a) provides for an adaptability value of zero when a worker's RFC is equal to or greater than her BFC. Applying OAR 436-35-280(1)(a), the ALJ determined that claimant's adaptability value was zero; therefore, claimant was not entitled to social and vocational factors in rating her claim.

However, the Court of Appeals has determined that Director's rules which give a zero adaptability value when a worker had returned to regular work conflict with ORS 656.214(5) and 656.726(3)(f)(A) and are, therefore, invalid. Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996). In Joe R. Ray, supra, we applied the reasoning used by the Carroll court in concluding that OAR 436-35-280(1) was inconsistent with ORS 656.726(3)(f)(A). Therefore, we concluded that that rule cannot be used in determining the extent of a worker's unscheduled permanent disability.[3] 48 Van Natta at 335.

Rather, we found 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. Joe R. Ray, supra. We concluded that this analysis was essentially the same as assigning an adaptability value of one. Because the claimant's social and vocational factors would be considered under this analysis, we considered this formula to be consistent with the Director's standards, as altered by the court's holding in Carroll, and applied this formula to determine the claimant's entitlement to unscheduled permanent disability. Id.

Applying this formula here, the value of claimant's age (0),[4] formal education (0),[5] and skills (3)[6] are added for a total of 3, which is multiplied by the adaptability value of (1) for a total of 3. OAR 436-35-280(6). When this value is added to the value for impairment (8), the result is 11. OAR 436-35-280(7). Therefore, claimant's unscheduled permanent disability is 11 percent.

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[3] We note that in Joe R. Ray, as in the present case, WCD Admin. Orders Nos. 6-1992 and 93-056 were the applicable rules. Thus, Ray analyzed the rules that apply to the claim before us. In addition, here, as in Ray, amended ORS 656.726(3)(f)(D) is not applicable because that statute applies only to claims that become medically stationary on or after June 7, 1995, the effective date of the Act. Or Laws, ch 332, § 66(4) (SB 369, § 66(4)).

[4] Claimant was under 40 at the time of determination; therefore, the value for age is zero. OAR 436-35-290(2).

[5] Claimant has completed 14 years of school and has a high school diploma; therefore, the value for formal education is zero. OAR 436-35-300(2)(a).

[6] Claimant's skills value is the highest Specific Vocational Preparation (SVP) of any job that claimant met in the five years prior to the determination. OAR 436-35-300(3)(b). Claimant's job with the highest SVP in the last five years before determination is waitress, which has a SVP of 3. (DOT # 311.477-030). This translates to a skill value of 3. OAR 436-35-300(4).

Our order results in increased compensation over that awarded by the ALJ and, in effect, reinstates the 11 percent award made by the Notice of Closure. Therefore, claimant's attorney is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation created by our order. See ORS 656.386(2). However, the total "out-of-compensation" attorney fee granted by the ALJ's order and this order shall not exceed $3,800. See OAR 438-015-0055(1). In the event that all or part of 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, 136 Or App (1995).

ORDER

The ALJ's order dated November 14, 1995, as corrected November 22, 1995, is modified. In addition to the ALJ and Order on Reconsideration's awards totaling 8 percent (25.6 degrees), claimant is awarded unscheduled permanent disability of 3 percent (9.6 degrees), for a total award to date of 11 percent (35.2 degrees) unscheduled permanent disability for a back injury. Claimant's attorney is awarded 25 percent of the additional compensation created by this order. However, the total "out-of-compensation" attorney fee granted by the ALJ's order and this order shall not to exceed $3,800. In the event 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, supra.

June 11, 1996 Cite as 48 Van Natta 1173 (1996)

In the Matter of the Compensation of
JOSE A. PASTOR, Claimant
WCB Case No. 95-10249
ORDER ON REVIEW
Willner & Associates, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Lipton's order that set aside its denial of claimant's injury claim for broken dentures. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On May 8, 1995, claimant amputated the tip of his finger at work. The employer accepted the claim. On June 30, 1995, while calling his treating physician's office for a refill of a prescription, claimant stated that his dentures had cracked "due to the stress of injury." (Ex. 3). Claimant was referred to his primary care physician, Dr. Leon, who recorded a history that claimant clenched his teeth at the time of amputation and felt his denture break. (Ex. 4A).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant broke his upper dentures at the time of the May 8, 1995 accident. In reaching this conclusion, the ALJ relied on claimant's testimony that, when his finger was amputated, he clenched his jaws, thereby cracking his dentures. The ALJ also found adequate evidence of medical causation from Dr. Leon. On review, the employer asserts that Dr. Leon's statements are insufficient to establish that the May 8, 1995 accident was a material contributing cause of the broken dentures. Therefore, the employer argues, the claim should fail.

We find that there is insufficient medical evidence supporting causation. Only Dr. Leon addressed the issue of medical causation. Acknowledging that he lacked expertise in dentistry, he indicated that he could not render an opinion whether claimant could break his dentures by clenching his mouth. (Exs. 10-2, 11). Dr. Leon also stated that absent other evidence in his records, he "had to believe" what claimant told him concerning the broken dentures. (Ex. 11).

Eric Young, denturist, who provided claimant with a cost estimate for denture replacement, also offered no opinion as to medical causation. (Ex. 9).

Medical evidence is not always required in order to establish causation. Specifically, expert medical evidence is not required if: (1) the situation is not complicated; (2) symptoms appear immediately; (3) the worker promptly reports the occurrence to a superior and consults with a physician; (4) the worker previously was free from disability of the kind involved; and (5) there is an absence of expert testimony that the alleged precipitating event could not have caused the injury. Barnett v. SAIF, 122 Or App 279, 283 (1993) (citing Uris v. Compensation Department, 247 Or App 420 (1967)).

Here, although claimant immediately reported and sought treatment for his amputated finger, he did not report his broken dentures until nearly two months after the injury. Thus, he did not promptly report the occurrence to a superior or to a medical provider.[1] Given the nature of claimant's hand injury, it would not be surprising if claimant did not report his broken dentures immediately following the accident. However, a delay of nearly two months is more problematic. Furthermore, given the concession from Dr. Leon, a medical doctor, that he lacks the expertise to decide causation, we find the situation to be complicated. In other words, if Dr. Leon, a thoracic and vascular surgeon, (Ex. 4A), considered his expertise inadequate to determine whether claimant could break his dentures as he described, we consider the situation to be sufficiently complicated to require expert evidence of causation.

Based on these factors, we find that medical expert evidence establishing causation is necessary. Because there is only claimant's testimony that his dentures cracked at the time of his injury, and thus the accident caused the dentures to break, we find insufficient proof to carry claimant's burden of proof.

ORDER

The ALJ's order dated December 29, 1995 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

[1] Claimant's former wife testified that, shortly after the accident, claimant told her he had cracked his teeth; she further testified that, when claimant removed his dentures later that night, it came out in two pieces. (Tr. 9). We do not find such testimony responsive to the apparent considerations underlying the Uris factors of a prompt reporting to a "superior" and a timely medical consultation.

In the Matter of the Compensation of
VICTOR ROBLES, Claimant
WCB Case No. 95-02233
ORDER ON REVIEW
Malagon, Moore, et al, 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) Nichols' order that: (1) declined to address his entitlement to temporary disability benefits; and (2) declined to assess a penalty for the insurer's allegedly unreasonable claim processing. In its brief, the insurer challenges that portion of the ALJ's order that awarded an assessed attorney fee for its allegedly unreasonable claim processing. On review, the issues are temporary disability benefits, penalties and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the "Findings of Fact" as set forth in the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Benefits

Citing Lebanon Plywood v. Seiber, 113 Or App 561 (1992), the ALJ found that it was "premature" to address claimant's entitlement to a specific period of temporary disability benefits or to determine the degree of claimant's temporary disability (total or partial), reasoning that such issues should first be raised with the Department pursuant to ORS 656.268. We disagree.

In his January 4, 1995 order, ALJ Michael Johnson found that claimant's claim had been prematurely closed and therefore set aside the prior February 8, 1994 Determination Order, as well as the September 7, 1994 Order on Reconsideration and remanded the claim to the insurer for processing. On April 28, 1995, the insurer issued a Notice of Closure, awarding claimant temporary partial and temporary total disability from August 8, 1993 to January 27, 1995, the date the insurer found claimant medically stationary. On June 23, 1995, the Board affirmed ALJ Johnson's order.

Pursuant to ORS 656.313(1)(a)(A), a carrier has a statutory obligation to pay temporary disability benefits that accrue from the date of an appealed reconsideration order. Moreover, the carrier is required to pay the temporary disability benefits that accrue during the pendency of the appeal, regardless of the outcome of the appeal. Anodizing, Inc. v. Heath, 129 Or App 356 (1994); Pascual Zaragosa, 45 Van Natta 1221, 1223 (1993), aff'd mem Zaragoza v. Liberty Northwest Insurance Corp., 126 Or App 544 (1994); Roseburg Forest Products v. McDonald, 116 Or App 448 (1992).

Here, once the insurer appealed ALJ Johnson's order, it was required to resume paying claimant temporary disability benefits accruing from the date of the order until such time as the claim was closed under ORS 656.268. ORS 656.313(1)(a)(A). Notwithstanding the insurer's appeal, ALJ Johnson's order was effective and enforceable when it issued. See Theodore W. Lincicum, 40 Van Natta 1953, 1955 (1988), aff'd mem Astoria Oil Service v. Lincicum, 100 Or App 100 (1990). Thus, the inquiry becomes whether any temporary disability benefits accrued following ALJ Johnson's order.

By virtue of ALJ Johnson's January 4, 1995 order, claimant's claim was ordered reopened. At that time, Dr. Mata, who had become claimant's treating physician in January 1994, had only released claimant to modified work and the insurer had not "reoffered" any modified employment to claimant nor had it submitted any potential modified employment opportunities to Dr. Mata for his approval. (Ex. 98). Because claimant was released to only modified work at the time ALJ Johnson's order issued, temporary partial disability benefits accrued from that date until claim closure.[1] Although it did close claimant's claim on April 28, 1995, the claim closure did not relieve the insurer of its obligation to pay benefits from the date of ALJ Johnson's order until it closed claimant's claim on April 28, 1995. See Anthony N. Bard, 47 Van Natta 2016 (1995) (Pursuant to ORS 656.313, a carrier is obligated to pay benefits awarded by prior ALJ order even though underlying claim ultimately determined not compensable). Accordingly, claimant is entitled to temporary partial disability benefits from January 4, 1995 through April 28, 1995.

Because our award of temporary disability benefits is granted pursuant to ORS 656.313(1)(a)(A), those amounts cannot be recouped from future awards of compensation. ORS 656.313(2). Consequently, our award does not create an overpayment that is prohibited by Lebanon Plywood v. Seiber, supra. See Anodizing, Inc. v. Heath, supra.

Penalties

The ALJ found that the insurer's failure to pay temporary disability benefits after January 4, 1995 was unreasonable. We agree with and adopt the ALJ's conclusions and reasoning in this regard. However, the ALJ did not award a penalty finding no amounts on which to base a penalty. Rather, the ALJ awarded an attorney fee pursuant to ORS 656.382(1). We modify.

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[1] In December 1993, Dr. Poulson had approved a modified job offer submitted by the employer. (Ex. 46, 47). However, at the time of Dr. Poulson's approval, claimant's compensable injury did not include the L5-S1 disc condition or the L5-S1 degenerative arthropathy and osteoarthritis which were found compensable in subsequent litigations. While it is unclear whether or not claimant took the offered job, this fact is not relevant to claimant's entitlement to temporary disability benefits as of January 1994 at which time he was treating with Dr. Mata who had not approved any modified job offers.

Inasmuch as we have herein found that claimant is entitled to temporary partial disability benefits from January 4, 1995 through April 28, 1995, there are amounts "then due" on which to base a penalty under ORS 656.262(11)(a). Accordingly, we assess a penalty equal to 25 percent of the temporary disability compensation due between January 4, 1995 and April 28, 1995, to be paid in equal shares to claimant and his counsel. Because we have awarded a penalty for the insurer's failure to pay temporary disability benefits and there is no separate basis for awarding an attorney fee under ORS 656.382(1), we reverse the ALJ's award of a $750 assessed attorney fee. See Martinez v. Dallas Nursing Home, 114 Or App 453 (1992).

ORDER

The ALJ's order dated July 27, 1995 is reversed. Claimant is awarded temporary partial disability benefits from January 4, 1995 through April 28, 1995. Claimant's counsel is awarded 25 percent of the increased compensation created by this order, not to exceed $1,050, payable directly to claimant's attorney. The insurer is assessed a penalty equal to 25 percent of the temporary disability compensation due between January 4, 1995 and April 28, 1995 as a result of this order, to be paid in equal shares to claimant and his attorney. The ALJ's $750 insurer-paid attorney fee is reversed.

June 11, 1996 Cite as 48 Van Natta 1176 (1996)

In the Matter of the Compensation of
RODNEY D. SULLIVAN, Claimant
Own Motion No. 96-0269M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

The Board received claimant's May 30, 1996 letter addressed to a claims examiner at the SAIF Corporation. Because the letter to the claims examiner was routed to the Board, we enclose copies of claimant's letter and attached submissions with SAIF's copy of this order. Inasmuch as claimant submitted new information regarding the work force issue, we treat claimant's submission as a request for reconsideration of our June 5, 1996 Own Motion Order in which we declined to reopen his 1985 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. On reconsideration, we issue the following order in place of our June 5, 1996 order.

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

In our previous order, we found that, on February 29, 1996, Dr. Shaw recommended that claimant undergo a lateral wedge osteotomy (through the triple arthrodesis) to correct a varus deformity. Thus, we concluded that claimant's compensable condition had 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).

SAIF contended that it was unknown whether claimant was in the work force at the time of disability because tax information claimant submitted indicated "the 1995 year as being inactive." Claimant contends that he is self-employed and has filed for an extension of time in which to file his 1995 taxes. Claimant previously submitted his 1994 tax returns as proof that he was in the work force at the time of disability.

In our June 5, 1996 order, we advised claimant that, although the 1994 tax return did not meet the criterion for proof of work during the relevant time period, claimant could submit other documents which might establish that he was in the work force at the time of disability. We explained that the submission of work invoices, check stubs or wage-withholding statements which reflect dates of work during or prior to the appropriate time frame, are sufficient for our review.

Attached to his May 30, 1996 letter to SAIF, claimant submitted check stubs and receipts for 1995. A November 2, 1995 invoice in the amount of $947.00 establishes that claimant was working until at least November 2, 1995. Claimant also explained that he indicated on an "S Corporation" form that he was "inactive" during the 1995 tax year. Claimant stated that the term "inactive" related to his desire to become unincorporated, and did not mean that his work status was inactive. On the current record (based on the aforementioned check stubs/receipts and claimant's unrebutted explanation for the term "inactive"), we find that claimant has established that he was working at the time of disability.

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

IT IS SO ORDERED.

June 12, 1996 Cite as 48 Van Natta 1177 (1996)

In the Matter of the Compensation of
JERRY E. BISHOP, Claimant
WCB Case No. 94-14311
ORDER OF ABATEMENT
David C. Force, Claimant Attorney
David O. Horne, Defense Attorney

On May 30, 1996, we affirmed an Administrative Law Judge's (ALJ's) order that declined to award interim compensation. Relying on amended ORS 656.262(4)(a), Shanon M. Oliver, 48 Van Natta 386 (1996), and Nenita Stockie, 48 Van Natta 299 (1996), we found that the parties' stipulation that "claimant was incapable of returning to his employment" did not constitute an authorization by an attending physician for the payment of temporary disability. Contending that we resolved this dispute based on an issue not "raised" by the parties, i.e., the adequacy of the stipulation for purposes of authorizing interim compensation, claimant asks that this matter be remanded for the introduction of additional evidence regarding whether claimant's attending physician authorized temporary disability.

In order to further consider claimant's motion, we withdraw our May 30, 1996 order. The insurer is granted an opportunity to respond. To be considered, the insurer's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARY E. CORDEIRO, Claimant
WCB Case No. 93-04146
ORDER ON REVIEW
Nancy F.A. Chapman, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Johnstone's order that dismissed for lack of jurisdiction claimant's requests for hearing from: (1) a March 30, 1993 Order on Reconsideration; and (2) a December 1, 1994 Order Denying Request for Reconsideration. In addition, claimant requests that, if we find the Hearings Division has jurisdiction, we grant her request for permanent total disability. On review, the issues are jurisdiction and permanent total disability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. The March 30, 1993 Order on Reconsideration found claimant not permanently totally disabled. (Ex. 186).

The May 25, 1994 Determination Order that issued after claimant's authorized training program (ATP) ended determined that claimant's condition was medically stationary on March 15, 1994. (Ex. 250).

Dr. Thomas, M.D., has been claimant's treating physician since December 1987 and has performed surgery on claimant's compensable right wrist condition. On March 15, 1994, Dr. Thomas found claimant medically stationary regarding her right wrist condition. (Ex. 231). On April 5, 1994, Dr. Strum, orthopedist, examined claimant on behalf of the self-insured employer and found claimant medically stationary regarding her right wrist condition. (Ex. 236-6). Dr. Thomas agreed with Dr. Strum's report. (Ex. 239).

Claimant's ATP terminated in April 1994. (Exs. 243, 244). Claimant's compensable right wrist condition was medically stationary at that time. (Exs. 231, 236, 239).

Claimant's left wrist/hand condition has been found not compensable. (Exs. 254, 266).

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts. Claimant has an accepted right wrist injury claim, with a date of injury of September 1, 1986. (Exs. 6, 16). On October 22, 1992, the claim was closed by a Determination Order that awarded claimant various periods of temporary disability and 58 percent scheduled permanent disability for loss of use or function of the right wrist/forearm. (Ex. 168). Claimant requested reconsideration, alleging, inter alia, that she was permanently totally disabled. (Ex. 177). On March 30, 1993, an Order on Reconsideration issued which: (1) found claimant not permanently totally disabled; (2) increased the scheduled permanent disability award to 70 percent for loss of use or function of the right wrist/forearm; and (3) affirmed the October 22, 1992 Determination Order in all other respects. (Ex. 186).

Claimant requested a hearing regarding the March 30, 1993 Order on Reconsideration, raising, among other issues, the issue of permanent total disability. The case was assigned WCB Case No. 93-04146 and scheduled for hearing. Subsequently, claimant's claim was reopened due to claimant's participation in an ATP. As a result, on October 26, 1993, prior to the scheduled hearing date, ALJ Quillinan issued an Order Deferring Hearing. This deferral order provided that the hearing request in WCB Case No. 93-04146 was deferred and a hearing date would be assigned when the claim was re-closed. Subsequently, a hearing was rescheduled; however, on February 24, 1994, prior to the scheduled hearing date, ALJ Schultz issued another Order Deferring Hearing, again advising that a hearing date would be assigned when the claim was re-closed.

Following the termination of the ATP, a Determination Order issued on May 25, 1994, which awarded additional temporary disability and increased the scheduled permanent disability award to 82 percent for loss of use or function of the right wrist/forearm. (Ex. 250). On November 2, 1994, claimant requested reconsideration. (Ex. 255). On December 1, 1994, the Department issued an Order Denying Request for Reconsideration, finding that, pursuant to Weyerhaeuser Co. v. Purdy, 130 Or App 322 (1994), the Department did not have jurisdiction to reconsider the May 25, 1994 "post-ATP" Determination Order. (Ex. 262). On December 6, 1994, claimant filed a request for hearing challenging, inter alia, the December 1, 1994 Order Denying Request for Reconsideration.

Jurisdiction Regarding the May 25, 1994 "Post-ATP" Determination Order

The ALJ reasoned that former ORS 656.268(6)(b) and former 656.268(9) applied to claimant's claim. The ALJ further reasoned that claimant did not timely request a hearing on the "post-ATP" Determination Order under either statute. In this regard, the ALJ reasoned that former ORS 656.268(6)(b) allowed a party disagreeing with an Order on Reconsideration to request a hearing pursuant to ORS 656.283. However, the ALJ reasoned that, because the Department did not issue an Order on Reconsideration, but instead issued an Order Denying Request for Reconsideration, claimant's request for a hearing on the Order Denying Request for Reconsideration did not confer jurisdiction in the Hearings Division pursuant to former ORS 656.268(6)(b). Furthermore, because claimant did not timely request a hearing on the "post-ATP" Determination Order under former ORS 656.268(9), the Hearings Division did not attain jurisdiction under that statute either. Therefore, the ALJ concluded that the Hearings Division did not have jurisdiction over the "post-ATP" Determination Order. While we agree with the ALJ that the Hearings Division did not have jurisdiction over the "post-ATP" Determination Order, we reach this conclusion based on the following reasoning.

Subsequent to the ALJ's order, we decided Richard La France, 48 Van Natta 427 (1996), which we find directly on point. In La France, the claimant had requested reconsideration of a February 1992 Determination Order. The resulting Order on Reconsideration issued in October 1992, and the claimant requested a hearing. Subsequently, the claimant entered an ATP and the hearing on the October 1992 Order on Reconsideration was deferred by an Order Deferring Hearing. Following the conclusion of the ATP, a Determination Order issued in April 1994. The claimant sought reconsideration. The Department issued an Order Denying Reconsideration, finding that, under Weyerhaeuser Co. v. Purdy, supra, the Department did not have jurisdiction to reconsider the "post-ATP" Determination Order. The claimant requested a hearing challenging the Order Denying Reconsideration. This request for hearing was filed more than 180 days from the mailing date of the "post-ATP" Determination Order.

We held that since the claimant had not timely requested a hearing within 180 days from the date the "post-ATP" Determination Order was mailed, the Hearings Division did not have jurisdiction over the "post-ATP" Determination Order. In doing so, we determined that the amendments made by Senate Bill 369 (SB 369) to ORS 656.268(8) and (9) did not apply to the claimant's claim. In making this determination, we found that SB 369, § 66(4) provided that the amendments to ORS 656.268(9) applied only to claims that became medically stationary on or after June 7, 1995, the effective date of the Act. SB 369, §§ 66(4), 69. Because the claimant's condition became medically stationary before June 7, 1995, we determined that former ORS 656.268(8) and (9) applied to the claimant's claim.[1] 48 Van Natta at 428.

Next, we noted that, pursuant to Weyerhaeuser Co. V. Purdy, supra, under former ORS 656.268(8) and (9), a claimant was not required to request reconsideration of a "post-ATP" Determination Order. Instead, the participation in an ATP program triggered a review process under former ORS 656.268(8) and (9) that was separate from the reconsideration process. 130 Or App at 325. Under former ORS 656.268(8) and (9), the method for appeal of a "post-ATP" Determination Order was by timely request of a hearing within 180 days from the date the "post-ATP" Determination Order was mailed. Weyerhaeuser Co. v. Purdy, supra; Richard La France, supra at 428-29. Finally, applying these requirements to the facts in La France, we determined that, because the claimant did not request a

[1] The amendments to ORS 656.268(8) and (9), in part: (1) created a new ORS 656.268(8); (2) renumbered former ORS 656.268(8) as amended ORS 656.268(9); and (3) deleted former ORS 656.268(9). In La France, we found the reference to ORS 656.268(9) in SB 369, § 66(4) applied 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). 48 Van Natta 428. Thus, we found that former ORS 656.268(8) and (9) applied to the claimant's claim.

hearing within 180 days following the issuance of the "post-ATP" Determination Order, the Hearings Division did not have jurisdiction over the "post-ATP" Determination Order, which had become final by operation of law. 48 Van Natta at 429.

Here, claimant became medically stationary on March 15, 1994, well before the June 7, 1995 effective date of Senate Bill 369. (Ex. 250). Thus, former ORS 656.268(8) and (9) apply to claimant's claim. Richard La France, supra. Under former ORS 656.268(8) and (9), the method for appealing a "post-ATP" Determination Order was by timely request of a hearing within 180 days from the mailing date of the "post-ATP" Determination Order. Id.

The ALJ found that claimant had only requested a hearing on the December 1, 1994 Order Denying Request for Reconsideration, without ever requesting a hearing on the May 25, 1994 "post-ATP" Determination Order itself. Claimant argues that her request for hearing on the Order Denying Reconsideration necessarily included a request for hearing on the underlying May 25, 1994 "post-ATP" Determination Order. We need not decide that issue because, even considering claimant's December 6, 1994 request for a hearing on the Order Denying Reconsideration as a request for hearing on the May 25, 1994 "post-ATP" Determination Order, we find that request was untimely because it was made more than 180 days after the mailing date of the May 25, 1994 "post-ATP" Determination Order.[2]

Therefore, the Hearings Division does not have jurisdiction over the "post-ATP" Determination Order. Accordingly, the May 25, 1994 "post-ATP" Determination Order has become final by operation of law.

Jurisdiction Regarding the March 30, 1993 "Pre-ATP" Order on Reconsideration

Because the "post-ATP" Determination Order redetermined claimant's current extent of disability and that "post-ATP" Determination Order was not correctly appealed and had become final by operation of law, the ALJ determined that claimant was precluded from litigating the extent issue pursuant to the prior hearing request. Therefore, the ALJ dismissed claimant's hearing request regarding the March 30, 1993 Order on Reconsideration. While we find that the Hearings Division retains jurisdiction over the March 30, 1993 Order on Reconsideration and, therefore, claimant's hearing request regarding that order should not have been dismissed, we agree with the ALJ regarding the ultimate effect of the subsequent "post-ATP" Determination Order.

In La France, applying Minor v. Delta Truck Lines, 43 Or App 29 (1979), and David E. Sakrisson, 45 Van Natta 1069 (1993), we determined that the Hearings Division retained jurisdiction over a "pre-ATP" Order on Reconsideration. There, as here, the claimant's hearing request regarding the "pre-ATP" Order on Reconsideration was deferred pending completion of the ATP, an action permitted by former OAR 438-06-105(1). In addition, there, as here, the ALJ's deferral order stated that a hearing would be rescheduled when the claim was closed. Therefore, even if the 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 concluded that any such failure did not affect the claimant's right to a hearing on the "pre-ATP" order. Thus, because the claimant had preserved his appeal from the "pre-ATP" Order on Reconsideration, we concluded that the Hearings Division had jurisdiction over the issue of extent of disability regarding the "pre-ATP" Order on Reconsideration. 48 Van Natta at 429-30.

As in La France, here, claimant preserved her appeal from the "pre-ATP" Order on Reconsideration. Therefore, under the reasoning in La France, the Hearings Division has jurisdiction over the issue of extent of disability regarding the March 30, 1993 "pre-ATP" Order on Reconsideration.

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[2] Claimant argues that the period of time from her November 2, 1994 request for reconsideration of the "post-ATP" Determination Order until the Order Denying Reconsideration was issued on December 1, 1994 should not be included in determining the timeliness of her hearing request. Former ORS 656.268(6)(b) provided that "[t]he time from the request for reconsideration until the reconsideration is made shall not be counted in any limitation on the time allowed for the request for hearing." Former ORS 656.268(6)(b) was one of the statutes governing the reconsideration process. However, as explained above, under the facts of this case, the method for requesting a hearing on the "post-ATP" Determination Order is separate from the reconsideration process and requires a request for a hearing within 180 days from the mailing date of the "post-ATP" Determination Order. Because the reconsideration process does not apply here, it follows that the running of the time to request a hearing is not stayed during any "reconsideration process."

Permanent Total Disability

At hearing and on review, claimant argues that she is entitled to an award of permanent total disability. Because the ALJ dismissed claimant's hearing request regarding the "pre-ATP" Order on Reconsideration, he did not address claimant's arguments regarding the permanent total disability issue, although the record was fully developed regarding that issue. As explained above, we find that the Hearings Division had jurisdiction over the "pre-ATP" Order on Reconsideration. Therefore, we address the permanent total disability issue.

In La France, supra, we determined that, under the statutory scheme, although we retained jurisdiction of the "pre-ATP" Order on Reconsideration via the Deferral Order, the "post-ATP" Determination Order remained the final determination of the claimant's disability to date. Therefore, we determined that the claimant was not entitled to additional permanent disability regarding his appeal of the "pre-ATP" Order on Reconsideration. 48 Van Natta at 431.

Here, for the same reasons, claimant is not entitled to permanent total disability regarding her appeal of the "pre-ATP" Order on Reconsideration. In other words, the "post-ATP" Determination Order award of 82 percent scheduled permanent disability for loss of use or function of the right wrist/forearm remains the final determination of claimant's disability to date.

ORDER

The ALJ's order dated January 10, 1996 is reversed in part and affirmed in part. That portion of the order that dismissed claimant's hearing request on the March 30, 1993 Order on Reconsideration is reversed. Claimant's hearing request on the March 30, 1993 Order on Reconsideration is reinstated. Claimant is not entitled to permanent total disability. The remainder of the ALJ's order is affirmed.

June 12, 1996 Cite as 48 Van Natta 1181 (1996)

In the Matter of the Compensation of
JODY CROMPTON, Claimant
WCB Case Nos. 95-06699 & 95-03643
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Garrett, Hemann, 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) Michael V. Johnson's order that set aside its denial of medical services for claimant's carpal tunnel syndrome. On review, the issue is compensability. We affirm the order insofar as it set aside the medical services denial, but vacate it insofar as it upheld the employer's aggravation denial.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. Claimant first sought medical treatment for her bilateral carpal tunnel syndrome condition on October 27, 1989. (Ex. 1). Claimant stated on her 801 form that the date of injury was September 30, 1989. (Ex. 2). In its April 16, 1990 notice of acceptance, the employer accepted September 30, 1989 as the date of injury. (Ex. 5).

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the relevant facts. In April 1990, the employer accepted right carpal tunnel syndrome, with a date of injury of September 30, 1989. (Ex. 5). The claim was classified as nondisabling. Id. On February 27, 1995, the employer issued a denial concerning the compensability of claimant's "current condition" of "bilateral carpal tunnel syndrome for [sic] injury date of 12-22-94." On August 23, 1995, the employer, referring to the September 30, 1989 injury date and "without waiving further questions of compensability," issued a denial of claimant's "aggravation claim." On August 24, 1995, the employer provided an amended notice accepting bilateral carpal tunnel syndrome as part of the September 30, 1989 nondisabling injury claim. (Ex. 14).

At hearing, claimant withdrew her request for hearing concerning the February 27, 1995 denial, conceding that it was "accurate." (Tr. 2). In his order, the ALJ upheld the February 27, 1995 denial. With regard to the August 23, 1995 denial, the ALJ upheld it concerning the aggravation claim, but set it aside concerning medical services. We address each aspect of the August 23, 1995 denial separately.

August 23, 1995 Denial - Aggravation

Although acknowledging that claimant's aggravation rights had expired before she filed the 1994 new occupational disease claim, the ALJ upheld the employer's August 23, 1995 denial to the extent that it denied an aggravation claim. For the following reasons, we find that the ALJ did not have jurisdiction to address the "aggravation" denial.

As a preliminary matter, we acknowledge that neither party raises the issue of the validity of the August 23, 1995 "aggravation" denial. However, the Board has de novo review authority and is free to make any disposition of the case it deems appropriate, including reaching issues that were before the ALJ but not raised by the parties on review. See ORS 656.295(5), (6); Destael v. Nicolai Co., 80 Or App 596 (1986); Miller v. SAIF, 78 Or App 158 (1986); Neely v. SAIF, 43 Or App 319, 323, rev den, 288 Or 493 (1979). Accordingly, inasmuch as the "aggravation" issue was before the ALJ, we are free to address it on review. Finally, and most importantly, jurisdictional issues such as this are not dependent on whether a party has raised the issue. See Southwest Forest Industries v. Anders, 299 Or 205 (1985). In other words, the issue of jurisdiction is always raisable, even by the decision-making body itself. Id.

ORS 656.273(4)(b) provides that a claim for aggravation of a nondisabling injury must be made within five years after the date of injury.[1] For purposes of determining aggravation rights, the "date of injury" in occupational disease claims is either the date of disability or the date when medical treatment is first sought. Papen v. Willamina Lumber Company, 123 Or App 249 (1993); Donald G. Stacy, 45 Van Natta 2360 (1993), aff'd Stacy v. Corrections Division, 131 Or App 610 (1994). ORS 656.278(1)(a) confers exclusive jurisdiction on the Board in its own motion capacity for "aggravation" claims filed after the five year period has expired. Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988).

Here, whether claimant's nondisabling carpal tunnel syndrome condition is considered an injury or an occupational disease claim, claimant's aggravation rights expired before her "worsening" claim arose in December 1994, when she returned for treatment with Dr. Button and filed the 801 form alleging a "new injury." In this regard, if the nondisabling carpal tunnel syndrome is considered an injury claim, as indicated by the September 30, 1989 "date of injury" on the 801 form and the notice of acceptance, claimant's aggravation rights expired on September 30, 1994, five years after the September 30, 1989 "date of injury." ORS 656.273(4)(b). If considered an occupational disease claim, claimant's aggravation rights expired on October 27, 1994, five years after the date of her first treatment for the condition on October 27, 1989. (Ex. 1). Papen v. Willamina Lumber Company, supra; Donald G. Stacy, supra; Stacy v. Corrections Division, supra. Thus, either way, claimant's aggravation rights had expired before her "worsening" claim arose in December 1994.

Consequently, because claimant's aggravation rights expired before she made her claim for a worsening, the Board has exclusive own motion jurisdiction over any "aggravation" claim. See Miltenberger v. Howard's Plumbing, supra; Carl C. Clayton, 47 Van Natta 1069 (1995). Therefore, the Hearings Division did not have jurisdiction over the "aggravation" claim. Accordingly, we reverse that portion of the ALJ's order that purported to uphold the "aggravation" denial. Claimant's request for hearing related to the August 23, 1995 aggravation denial is dismissed.

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[1] Aggravation rights are governed by ORS 656.273(4), which provides:

"(a) The claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268.

(b) If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury."

August 23, 1995 Denial - Compensability of Medical Services

We adopt the ALJ's reasoning and conclusions regarding the compensability of the medical services claim, with the following supplementation. As noted above, because claimant's aggravation rights have expired, the Board has exclusive jurisdiction over reopening this claim for the benefits allowed pursuant to ORS 656.278. However, the Board's own motion jurisdiction does not extend to issues of compensability. Instead, the Hearings Division has initial jurisdiction over compensability issues. ORS 656.283(1). Therefore, the ALJ had jurisdiction to determine the compensability of the medical services related to the 1989 carpal tunnel syndrome claim.

On review, the employer argues that, because the ALJ dismissed the request for hearing from the February 27, 1995 denial, such action "precluded the ALJ from making an adverse decision on the compensability of the claimant's treatment, since the February 27, 1995 denial expressly denied the compensability of that treatment."

We agree with the ALJ that the action taken with the February 27, 1995 denial did not affect claimant's ability to challenge the August 23, 1995 denial. In particular, the February denial concerned a claim based on a December 22, 1994 date of injury. Thus, the claim was for a "new injury" and involved initial compensability under ORS 656.005(7)(a) or 656.802. The scope of the August denial, on the other hand, included claimant's 1989 claim and compensability of medical services under ORS 656.245. Because the two denials concerned different claims and causation issues, we conclude that claimant's concession of "accuracy" involving the February denial has no impact on claimant's ability to challenge the August 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 regarding the medical service issue is $1,000, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated October 10, 1995 is affirmed in part and vacated in part. That portion of the ALJ's order that purported to uphold the self-insured employer's August 23, 1995 aggravation denial is vacated. Claimant's request for hearing related to the August 23, 1995 aggravation denial is dismissed. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the self-insured employer.

June 12, 1996 Cite as 48 Van Natta 1183 (1996)

In the Matter of the Compensation of
JODY CROMPTON, Claimant
Own Motion No. 95-0287M
OWN MOTION ORDER
Carney, et al, Claimant Attorneys

The self-insured employer initially submitted claimant's request for temporary disability compensation for her compensable bilateral carpal tunnel syndrome condition. Claimant's aggravation rights on that claim expired on September 30, 1994.

In April 1990, the employer accepted right carpal tunnel syndrome, with a date of injury of September 30, 1989. The claim was classified as nondisabling. On February 27, 1995, the employer issued a denial concerning the compensability of claimant's "current condition" of "bilateral carpal tunnel syndrome for [sic] injury date of 12-22-94." On August 23, 1995, the employer, referring to the September 30, 1989 injury date and "without waiving further questions of compensability," issued a denial of claimant's "aggravation claim." On August 24, 1995, the employer provided an amended notice accepting bilateral carpal tunnel syndrome as part of the September 30, 1989 nondisabling claim.

Claimant requested hearings regarding the February 27, 1995 and August 23, 1995 denials. (WCB Case Nos. 95-03643, 95-06699). These hearings were consolidated. The Board postponed action on the own motion matter pending resolution of that litigation.

By Opinion and Order dated October 10, 1995, Administrative Law Judge (ALJ) Michael V. Johnson upheld the February 27, 1995 denial regarding the December 22, 1994 "new injury" claim. In addition, although noting that the aggravation rights on the 1989 bilateral carpal tunnel syndrome claim had expired, the ALJ upheld the August 23, 1995 denial insofar as it denied an aggravation claim but set it aside insofar as it denied medical services relating to the 1989 claim. The employer requested Board review of ALJ Johnson's order. By an order issued on today's date, the Board affirmed the ALJ's order in part and vacated it in part. Specifically, the Board vacated that portion of the ALJ's order that upheld the August 23, 1995 aggravation denial, finding that, because claimant's 1989 claim was in the Board's own motion jurisdiction, the Hearings Division did not have jurisdiction over any "aggravation" relating to that claim. The Board affirmed the remainder of the ALJ's order, including the ALJ's decision setting aside the employer's denial of medical services relating to the 1989 claim.

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

On April 13, 1995, claimant underwent a right carpal tunnel release. Pursuant to the ALJ and Board orders discussed above, this medical treatment is compensably related to the 1989 carpal tunnel syndrome condition. However, the employer argues that this surgery does not represent a "worsening" of the compensable condition. In this regard, the employer contends that there is no "valid aggravation upon which the Board may exercise its own motion jurisdiction" because the ALJ upheld the employer's August 23, 1995 "aggravation" denial. Furthermore, the employer notes that ORS 656.273(1)(b) provides that a worsening is not established by "[i]npatient treatment of the worker at a hospital for the worker's condition from the original injury." We disagree with the employer's arguments and its reliance on ORS 656.273.

The employer's reliance on the ALJ decision upholding its August 23, 1995 "aggravation" denial is misplaced. As noted above, on today's date, the Board vacated that portion of the ALJ's decision, finding that the ALJ did not have jurisdiction to address any "aggravation" claim relating to the 1989 claim. In this regard, ORS 656.273(4)(b) provides that a claim for aggravation of a nondisabling injury must be made within five years after the date of injury. ORS 656.278(1)(a) confers exclusive jurisdiction on the Board in its own motion capacity for "aggravation" claims filed after the five year period has expired.

Here, claimant's aggravation rights expired on September 30, 1994, five years after the date of her September 30, 1989 nondisabling bilateral carpal tunnel syndrome claim. Claimant's "worsening" claim arose in December 1994, when she returned for treatment with Dr. Button and filed the 801 form alleging a "new injury."[1] Thus, the "worsening" claim arose after claimant's aggravation rights on the 1989 claim expired. Consequently, the Board has exclusive own motion jurisdiction over this claim. ORS 656.278; Miltenberger v. Howard's Plumbing, 93 Or App 475, 477 (1988).

Because claimant's 1989 carpal tunnel syndrome claim is in the exclusive jurisdiction of the Board's own motion authority, claimant's entitlement to benefits regarding that claim is governed by ORS 656.278. Pursuant to ORS 656.278(1)(a), we may reopen a claim for additional temporary disability compensation under our own motion authority when we find that "[t]here is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization." Thus, pursuant to ORS 656.278(1)(a), a "worsening" of an own motion claim is defined as requiring inpatient or outpatient surgery or other treatment requiring hospitalization. Tamera Frolander, 45 Van Natta 968 (1993); Fred E. Smith, 42 Van Natta 1538 (1990).

We realize that this is contrary to ORS 656.273(1)(b), which provides that a worsening is not established by "[i]npatient treatment of the worker at a hospital for the worker's condition from the original injury." However, because claimant's 1989 carpal tunnel syndrome claim is controlled by ORS 656.278, the provisions of ORS 656.273 do not apply to claimant's claim.

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[1] As noted above, the employer's denial of this claim for a "new injury" has been upheld.

Finally, we note that the employer cites Diana M. Wright, 44 Van Natta 123 (1992), in support of its argument that there "must be a worsened condition, ie. [sic] an aggravation claim, in order for the Board to exercise its own motion jurisdiction." In the first place, if there was an "aggravation claim," that is, a "worsening" claim made prior to the expiration of a worker's aggravation rights, by definition, that claim would not be within the Board's own motion jurisdiction, as discussed above. Second, in Wright, we denied the claimant's request for own motion relief because she failed to establish that she required surgery or hospitalization for treatment, as required by ORS 656.278(1)(a). Here, there is no question that claimant underwent surgery for her compensable carpal tunnel syndrome condition in April 1995. Thus, Wright does not support the employer's argument.

On this record, we are persuaded that claimant's compensable carpal tunnel syndrome condition worsened requiring surgery. Accordingly, we authorize the reopening of claimant's 1989 claim to provide temporary disability compensation beginning April 13, 1995, the date claimant underwent the right carpal tunnel release surgery. When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the employer directly to claimant's attorney. OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

June 12, 1996 Cite as 48 Van Natta 1185 (1996)

In the Matter of the Compensation of
DEBORAH L. EGLE, Claimant
WCB Case Nos. 95-08986 & 95-05920
ORDER ON REVIEW
Brothers, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

K-Mart, a self-insured employer, requests review of Administrative Law Judge (ALJ) Nichols' order that: (1) refused to admit a medical report; (2) set aside its denial of compensability and responsibility of claimant's bilateral carpal tunnel syndrome (CTS); and (3) upheld the responsibility denial of Wal-Mart, also a self-insured employer, for the same condition. On review, the issues are evidence, compensability and responsibility.

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

At hearing, the ALJ refused to admit a report from Dr. Nathan, examining orthopedic surgeon. The ALJ did so because Dr. Nathan based his report on a video that the ALJ found did not accurately depict claimant's work activities. According to the employer, the "question of whether or not Dr. Nathan's opinion is based on a correct assumption is not a question of admissibility" but rather goes to "how much weight should be accorded the opinion."

Dr. Nathan did not personally examine or speak with claimant and relied on the videotape to determine whether claimant's work activities caused her condition. During cross-examination, claimant testified that some of the activities noted by Dr. Nathan were not accurate. We find that, because Dr. Nathan relied on a videotape that was not personal to claimant and contained at least some inaccuracies, he did not provide a persuasive opinion. Thus, even if the report is admissible, it is given little or no weight and does not change the outcome of this case. Consequently, we need not resolve the question of whether it was an abuse of discretion for the ALJ to exclude Dr. Nathan's opinion from the record.

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

ORDER

The ALJ's order dated November 29, 1995 is affirmed. For services on Board review, Claimant's attorney is awarded $1,200, to be paid by K-Mart.

June 12, 1996 Cite as 48 Van Natta 1186 (1996)

In the Matter of the Compensation of
MARLIN M. FISHER, Deceased, Claimant
WCB Case No. 95-06466
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant's beneficiary requests review of that portion of Administrative Law Judge (ALJ) McKean's order that affirmed an Order on Reconsideration that did not grant additional unscheduled permanent disability beyond the 22 percent (70.4 degrees) claimant had been previously awarded by a prior reconsideration order. On review, the issue is extent of unscheduled permanent disability.

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

Before he filed a request for hearing, decedent died from causes unrelated to the compensable conditions. He leaves a surviving spouse.

Under ORS 656.218(4), if a worker dies before filing a request for hearing, the persons described in ORS 656.218(5) "shall be entitled to file a request for hearing and to pursue the matter to final determination as to all issues presented by the request for hearing." In order for the beneficiaries to recover such benefits, however, the deceased worker must have been entitled to the benefits. ORS 656.218(1).

On review, we find, as did the ALJ, that the medical evidence does not support the conclusion that claimant's compensable conditions were medically stationary at the time of his death. Inasmuch as claimant's conditions were not medically stationary, it would be speculative for us to determine claimant's capacity to return to work or the extent of his permanent impairment attributable to his compensable conditions. See OAR 436-035-0007(17). Consequently, claimant (and, therefore, his beneficiaries) is not entitled to recover permanent disability in excess of that awarded by a prior reconsideration order.

ORDER

The ALJ's order dated January 26, 1996 is affirmed.

In the Matter of the Compensation of
MITCHEL A. HANSON, Claimant
WCB Case No. 95-05699
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order which upheld the insurer's denial of his current 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 applied ORS 656.005(7)(a)(B) and found that claimant had failed to prove that his compensable 1991 low back injury was the major contributing cause of his L3-4, L4-5 disc protrusions and L5 neuropathy which required surgery. In reaching this conclusion, the ALJ rejected the opinions of Drs. Brett, Goldberg and Noren, all of whom opined that claimant's 1991 injury was the major contributing cause of his current low back condition. (Exs. 186, 187, 190). The ALJ determined that the opinions of these physicians were based on an inaccurate history that claimant had never had back problems before his May 1991 injury and that none of the physicians discussed the significance of claimant's preexisting back problems or of his left leg symptoms after an injury in 1989.

On review, the parties agree that ORS 656.005(7)(a)(B) is applicable and requires that claimant prove that his compensable 1991 injury is the major contributing cause of his disability and need for treatment of the "combined condition." See Rickey C. Amburgy, 48 Van Natta 106 (1996). Claimant contends that the ALJ incorrectly determined that Drs. Brett, Goldberg and Noren based their opinions on an inaccurate history. Claimant cites portions of the record that he alleges indicates that each doctor was aware of claimant's prior accepted injury in 1989 and that Dr. Noren was also aware of claimant's back problems beginning in 1983.[1] Moreover, claimant notes that the ALJ did not discuss the medical report of examining physicians, Drs. Snodgrass and Duff, who also concluded that claimant's 1991 injury was the major contributing cause of his current low back condition. (Ex. 188). Claimant contends that the opinions of these physicians are more persuasive than that of the examining physician, Dr. Marble, who opined in medical reports and hearing testimony that preexisting degenerative and congenital conditions are the major contributing cause of claimant's current low back condition. (Exs. 185a, 189A; Trs. 74-5). We disagree with claimant's contentions.

While it appears that Drs. Goldberg, Noren and Brett had access to information regarding claimant's prior back injury in 1989, the fact remains that each doctor failed to acknowledge or discuss the significance, if any, of claimant's previous injury in 1989 or the evidence in the record suggesting that claimant had several low back injuries prior to 1989. (Exs. A-I, 6-1, 20-1). Therefore, we agree with the ALJ that those opinions of Drs. Brett, Goldberg, and Noren are not persuasive. See Somers v. SAIF, 77 Or App 259 (1986) (greatest weight given to well-reasoned medical opinions). With respect to the medical report of Drs. Duff and Snodgrass, they, too, failed to discuss claimant's back problems prior to 1991. Moreover, they did not provide sufficient reasoning for their opinion that claimant's 1991 is the major contributing cause of his current low back condition. See Moe v. Ceiling Systems, 44 Or App 429, 433 (1980); Gloria T. Olson, 47 Van Natta 2348, 2351 (1995). For these reasons, we find that the medical report of Drs. Duff and Snodgrass also fails to satisfy claimant's burden of proof.

Finally, based on our de novo review of the record, we conclude that Dr. Marble's medical reports and testimony are persuasive evidence that claimant's current low back condition is caused in major part by preexisting degenerative and congenital conditions. Accordingly, we affirm the ALJ's decision to uphold the insurer's denial under ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated December 20, 1995 is affirmed.

[1] At hearing and on review, claimant has made no allegation that the insurer is responsible for his current low back condition under the 1989 claim or that his current condition is compensably related to that injury. (Tr. 25).

In the Matter of the Compensation of
RUTH M. REYES, Claimant
WCB Case No. 95-06309
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Stoel, Rives, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Myzak's 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 alleged failure to timely accept or deny the claim. On review, the issues are compensability and penalties.

We adopt and affirm with the following exception and supplementation. We do not adopt the ALJ's statement that Dr. Stringham, claimant's treating physician, explained his change of opinion.

The insurer argues that the ALJ did not make a demeanor credibility finding and that claimant is not credible. We disagree. The ALJ found claimant credible, stating that "[c]laimant is a very candid, forthright, straightforward, and credible witness." (Opinion and Order, page 2). Although the ALJ did not explicitly state that her credibility finding was based on claimant's demeanor, her description of claimant's testimony establishes that she was, in fact, making a demeanor credibility finding. We defer to the ALJ's demeanor-based credibility finding. See International Paper Co. v. McElroy, 101 Or App 61 (1990).

On January 2, 1995, Dr. Stringham examined claimant regarding her neck and left shoulder pain and diagnosed "[l]eft trapezius myofascitis, etiology uncertain." (Ex. 6). He opined that claimant's January 1, 1995 work activities were not the major contributing cause of claimant's left shoulder pain. (Ex. 6). He noted that, although claimant had the onset of neck and left shoulder pain while at work, there was no specific event. (Ex. 6-2). He stated that claimant's condition could be a spontaneous event or related to her preexisting injuries, which he had identified as a November 1991 whiplash injury and a July 1994 incident where claimant was beaten up by a female neighbor. (Ex. 6).

On January 9, 1995, Dr. Stringham examined claimant and diagnosed left trapezius strain, left shoulder strain, and left scapula strain. (Ex. 9). He stated that claimant's symptoms were not resolving and noted that "[t]he onset was at work when putting some stock away. Therefore, declaring it as an on-the-job injury seems appropriate at this time." Id.

In response to a February 20, 1995 letter from the insurer's claims examiner, Dr. Stringham stated that he had changed his mind regarding the cause of claimant's left shoulder condition "after seeing [claimant] on 1/2/95, 1/5/95 and 1/9/95." (Ex. 13). He noted that, on January 9, 1995, he deemed the left shoulder condition to be work related; however, he also noted that he had "some reservation about this position for the reasons noted on 1/2/95." Id. In addition, in a March 20, 1995 chart note, Dr. Stringham opined that "psychophysiologic factors are playing a significant role." (Ex. 18a).

In letters to claimant's attorney dated August 6 and August 27, 1995, Dr. Stringham stated that claimant's work activity on January 1, 1995 was the major contributing cause of claimant's left shoulder conditions, diagnosed as left trapezius strain, left shoulder strain, and left scapula strain. (Exs. 27, 28).

Dr. Stringham does not explain his change of opinion. While we agree with the ALJ that claimant need only establish that the work activity is a material contributing cause of her shoulder condition, given Dr. Stringham's inconsistent opinions, we are unable to find that his opinions meet that standard. No other medical evidence supports compensability of claimant's left shoulder claim. Accordingly, we find that claimant has failed to establish that her left shoulder condition is compensable. ORS 656.266.

ORDER

The ALJ's order dated January 8, 1996 is affirmed.

In the Matter of the Compensation of
STEVEN R. ROMANIELLO, Claimant
WCB Case Nos. 94-01060 & 93-12066
ORDER ON REVIEW (REMANDING)
Welch, Bruun, et al, Claimant Attorneys
Zimmerman, Rice, et al, Defense Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Thye's order that: (1) found that claimant's March 1993 lumbar strain injury claim, accepted by EBI Companies (on behalf of Devine-Willamette), was not prematurely closed; (2) declined to assess a penalty and attorney fee against EBI for allegedly unreasonable claim processing; (3) affirmed an Order on Reconsideration that awarded claimant no unscheduled permanent disability for his accepted lumbar strain condition; (4) upheld Liberty Northwest Insurance Corporation's denial (on behalf of Garibaldi Hardwoods) of claimant's July 1993 low back injury claim; and (5) declined to assess a penalty and attorney fee against Liberty for an allegedly unreasonable denial. On review, the issues are premature closure, extent of unscheduled permanent disability, compensability, penalties and attorney fees. We affirm in part and vacate and remand in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction, exception, and supplementation. We correct the fifth sentence of the fourth paragraph of the findings of facts to reflect that claimant was referred to Dr. Schmidt by his father.

We do not adopt the first two sentences of the "Findings of Ultimate Fact."

On May 20, 1993, EBI administratively closed claimant's disabling low back strain claim. (Exs. 7, 9).

CONCLUSIONS OF LAW AND OPINION

We begin with a brief summary of the relevant facts. On March 23, 1993, claimant was an employee of Devine-Willamette, a temporary services agency insured by EBI. On that date, claimant was injured while working at Garibaldi Hardwoods' mill pulling green chain. Garibaldi Hardwoods is insured by Liberty. On March 24, 1993, claimant was taken off work by an emergency room physician. Subsequently, he came under the care of Dr. Robinson, who prescribed physical therapy and restricted claimant to light work. On April 5, 1993, Dr. Robinson found that claimant's pain symptoms had improved. Dr. Robinson ordered physical therapy for two more weeks and light duty for one more week, with full duty thereafter if claimant continued to improve. Claimant did not seek further care from Dr. Robinson.

Claimant continued pulling green chain with somewhat lighter wood despite continuous low back pain and occasional left leg pain. On April 23, 1993, EBI notified claimant that he should return to his doctor if he was still having problems. EBI advised:

> "If we do not hear from you or your doctor within two weeks from the date of this letter, we will assume that you have recovered to the point where your physical condition is the same as it was before you were injured, and we will proceed to close your claim." (Ex. 7).

Claimant did not return to Dr. Robinson after the April 5, 1993 visit. On May 20, 1993, EBI issued both a claim acceptance of a disabling low back strain and a Notice of Closure, which awarded temporary but no permanent disability and declared claimant medically stationary May 17, 1993. This Notice of Closure was an administrative closure based on a presumption of medically stationary status due to claimant's failure to seek further medical treatment.

Claimant continued performing moderately heavy green chain work until he was hired directly by Garibaldi Hardwoods prior to May 20, 1993, and promoted to a millwright supervisor. This was generally lighter work; however, it required a lot of overtime and included cleanup work, which could be heavy. On July 7, 1993, claimant experienced increased low back pain while cutting knots with a chain saw and throwing the pieces into the chipper. Claimant sought medical treatment for these increased symptoms. On July 8, 1993, claimant filed a new injury claim with Garibaldi Hardwoods. On October 5, 1993, Liberty denied this claim. Claimant requested a hearing on this denial, raising the issues of compensability of a new injury claim and penalties and attorney fees for an allegedly unreasonable denial.

On October 26, 1993, claimant requested reconsideration of EBI's May 20, 1993 Notice of Closure. A January 19, 1994 Order on Reconsideration modified the temporary disability award, but otherwise affirmed the Notice of Closure. Claimant requested a hearing, raising the issues of premature closure, extent of unscheduled permanent disability, and penalties and attorney fees for allegedly unreasonable claims processing.

Liberty Claim - Compensability of a New Injury and Penalties and Attorney Fees

The ALJ found that claimant failed to establish a compensable new injury claim with Liberty's insured. On that basis, the ALJ found that Liberty's compensability denial was appropriate; therefore, claimant was not entitled to an award of penalties or attorney fees. We adopt the ALJ's reasoning and conclusions regarding these issues.

EBI Claim - Premature Closure, Extent of Unscheduled Permanent Disability, and Penalties and Attorney Fees

On May 20, 1993, pursuant to former OAR 436-30-035(7)[1] (WCD Admin. Order 5-1992), EBI administratively closed claimant's low back strain claim, declaring claimant medically stationary as of May 17, 1993. On review, the parties dispute the sufficiency of the notice of administrative closure given by EBI and the propriety of EBI's claim closure. Claimant contends that EBI's notice was insufficient and its claim closure was improper; and EBI contends that its notice was sufficient and its closure was proper. For the following reasons, we find the record insufficiently developed to determine whether claim closure was proper.

ORS 656.268(1) provides the standards under which a claim may be closed. Subsequent to the ALJ's order, the Legislature amended ORS 656.268(1). Amended ORS 656.268(1) provides, in relevant part:

> "(1) One purpose of this chapter is to restore the injured worker as soon as possible and as near as possible to a condition of self support and maintenance as an able-bodied worker. Claims shall not be closed if the worker's condition has not become medically stationary unless:
>
> "* * * * *
>
> "(b) Without the approval of the attending physician, the worker fails to seek medical treatment for a period of 30 days or the worker fails to attend a closing examination, unless the worker affirmatively establishes that such failure is attributable to reasons beyond the worker's control."

---

[1] Former OAR 436-30-035(7) provided that a worker would be presumed to be medically stationary when the worker had not sought medical treatment in excess of 28 days, unless so instructed by the attending physician, provided that the carrier had notified the worker that claim closure would occur due to the worker's failure to seek medical treatment. Pursuant to Paniagua v. Liberty Northwest Insurance Corporation, 122 Or App 288 (1993), and Bertha Paniagua, 46 Van Natta 55 (1994), the notice given by the carrier had to be in strict compliance with former OAR 436-30-035 in order for the medically stationary presumption to apply.

Under former ORS 656.268(1), a claim could not be closed if the worker's condition was not medically stationary. However, under amended ORS 656.268(1)(b), a claim can be closed without the worker's condition being medically stationary where the worker fails to seek medical treatment for 30 days without the attending physician's approval, and the worker fails to affirmatively establish that such failure was beyond his or her control.

In Mark E. Cooper, 47 Van Natta 2223 (1995), we determined that amended ORS 656.268(1)(b) applied retroactively to a worker's claim where the time to appeal the Board's decision had not expired. See Volk v. America West Airlines, 135 Or App 565 (1995). However, we also determined that application of amended ORS 656.268(1)(b) did not necessarily result in a finding that the claim closure was proper. 47 Van Natta at 2225. We found that the Paniagua court did not overrule the fundamental premise that the merits of a premature closure issue remained irrespective of a proper procedural closure. id. at 2224 n.3. On the other hand, we found that Paniagua required that the procedural closure issue be addressed before review of the merits of the premature closure issue could proceed. Id.

In addressing the procedural closure issue, we noted that, although amended ORS 656.268(1)(b) allows for claim closure where the worker is not medically stationary when the worker fails to seek medical treatment for 30 days without the attending physician's approval, it does not allow for such closure where the worker affirmatively establishes that such failure was beyond his or her control. Because the legal standard had changed while Board review of the case was pending and the record was devoid of evidence regarding whether the claimant's failure to seek medical treatment was attributable to reasons beyond his control, we found the record insufficiently developed. id. at 2225. Therefore, we remanded the matter for further development of the record regarding whether the claimant's failure to seek treatment was for reasons beyond his control.

Here, for the reasons explained in Cooper, we find that amended ORS 656.268(1)(b) applies to claimant's claim. Also, as in Cooper, the legal standard has changed, i.e., amended ORS 656.268(1)(b) went into effect after this record was developed and while Board review of the matter was pending. Finally, the record is essentially devoid of evidence regarding whether claimant's failure to seek medical treatment was attributable to reasons beyond his control.

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, 79 Or App 416, 420 (1986). Under the circumstances, we consider the record to be incompletely and insufficiently developed to determine whether claimant's failure to seek medical treatment was for reasons beyond his control. Moreover, because the legal standard changed after the record was developed and while Board review was pending, we find there is a compelling reason to remand this matter for the parties' submission of additional evidence regarding whether claimant's failure to seek medical treatment was for reasons beyond his control. Mark E. Cooper, supra.

Finally, because the penalty and attorney fee issue and extent of unscheduled permanent disability issue depend on the decision regarding the propriety of the procedural closure and the merits of the premature closure issue, we cannot proceed to address those issues. Consequently, those matters are also remanded to the ALJ to await submission of the aforementioned additional evidence regarding the premature closure issue.

Accordingly the ALJ's May 17, 1995 order is affirmed in part and vacated in part. Those portions of the ALJ's order regarding claimant's low back injury claim with EBI Companies which found the claim was not prematurely closed, affirmed the Order on Reconsideration that awarded no unscheduled permanent disability, and declined to award penalties and attorney fees for allegedly unreasonable claim processing are vacated. These matters are remanded to ALJ Thye for further proceedings consistent with this order, which 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 EBI claim on the issues of premature closure, extent of unscheduled permanent disability, and penalties and attorney fees. The remainder of the ALJ's order is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DEBORAH A. ROSENBAUM, Claimant
WCB Case No. 95-06163
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) upheld the insurer's partial denial of claimant's consequential condition claim for fibromyalgia; and (2) found that claimant's injury claim was not prematurely closed. On review, the issues are compensability and, if compensable, premature closure. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, with the following exception and clarification.

We do not adopt the ALJ's findings of ultimate fact.

The Determination Order issued on December 23, 1994, rather than on December 23, 1995.

CONCLUSIONS OF LAW AND OPINION

Compensability

The ALJ upheld the insurer's denial of claimant's consequential fibromyalgia condition under ORS 656.005(7)(a)(A). The ALJ reasoned that, because no doctor discussed compensability in terms of major causation, claimant had failed to sustain her burden of proof. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992).

On review, claimant concedes that she must prove major causation under ORS 656.005(7)(a)(A). Citing McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986), however, claimant asserts that the opinion of her treating physician, Dr. Beckwith, as supported by fibromyalgia specialist, Dr. Krohn, is sufficient to satisfy her burden of proof. We agree.

Claimant has treated with Dr. Beckwith since March 1993 for her compensable September 1992 right wrist/forearm injury. In February 1994, Dr. Beckwith diagnosed chronic wrist sprain and "current fibromyalgia." Before claimant's claim was closed by Determination Order on December 23, 1994, Dr. Beckwith referred claimant to Dr. Krohn at the Oregon Health Sciences University for evaluation. In January 1995, Dr. Krohn confirmed the diagnosis of fibromyalgia. In a March 17, 1995 letter to claimant's counsel, Dr. Beckwith opined that claimant's "fibromyalgia is a consequence of her work injury of 9-17-92."

Dr. Beckwith's causation opinion is reinforced by fibromyalgia specialist Krohn. In a August 25, 1995 concurrence letter to the insurer's counsel, Dr. Krohn stated that claimant's condition may represent a post-injury fibromyalgia. Dr. Krohn explained that an injury such as claimant's may change the mechanical use of the arm to protect the injured area, causing myofascial pain and leading to fibromyalgia. Then, in a September 13, 1995 concurrence letter to claimant's counsel, Dr. Krohn further stated that he "believe[d] a physician who has had a long-standing doctor-patient relationship is in the best position to comment upon causation questions." Dr. Krohn then "defer[red] to Dr. Beckwith's opinion regarding the relationship of [claimant]'s fibromyalgia to her work injury of September 17, 1992." Drs. Beckwith and Krohn's reports are uncontroverted.

Although Dr. Beckwith's did not expressly state that claimant's compensable injury was the "major contributing cause" of her fibromyalgia, in the absence of any evidence to the contrary, and in light of Dr. Krohn's deference to Dr. Beckwith's opinion, we interpret Dr. Beckwith's opinion as supporting a conclusion that claimant's original compensable injury is the major contributing cause of her consequential fibromyalgia condition. See Liberty Northwest Ins. Corp. v. Cross, 109 Or App 109 (1991) (No incantation of "magic words" or statutory language is required); McClendon v. Nabisco Brands, Inc., supra. Based on this record, we therefore find that the medical evidence can be reasonably interpreted as establishing major causation, thus satisfying claimant's burden of proof. Accordingly, we reverse the ALJ's order upholding the insurer's consequential condition denial.

Premature Closure

A claimant must be medically stationary from all compensable conditions resulting from an accepted disabling injury before the claim may be properly closed. See Nordstrom, Inc. v. Gaul, 108 Or App 237 (1991); Rogers v. Tri-Met, 75 Or App 470 (1985). Conditions that result from an accepted disabling injury include denied conditions that are found related after litigation. See Lynda J. Zeller, 47 Van Natta 1926 (1995) (construing amended ORS 656.268(4)(a)). An injured worker is considered medically stationary when no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Whether or not claimant was medically stationary is primarily a medical question. Harmon v. SAIF, 54 Or App 121, 125, rev den 292 Or 232 (1981).

Finding that claimant's claim was not prematurely closed on the basis of "noninclusion" of the denied fibromyalgia condition, the ALJ declined to set aside the December 1994 Determination Order and May 1995 Order on Reconsideration. Inasmuch as we have herein found that claimant's fibromyalgia condition is a compensable component of the accepted disabling injury, we consider her fibromyalgia condition on review.

At the time the claim was closed, Dr. Beckwith concurred with the opinion of insurer-arranged medical examiner Coletti that claimant's right wrist/forearm strain was medically stationary. Even though claimant's strain was medically stationary in December 1994, claim closure would nonetheless be premature if claimant's fibromyalgia condition was not yet medically stationary when the Determination Order issued on December 23, 1994. Both of the compensable conditions arose out of the same industrial injury, and should, therefore, be processed to closure together. See Rogers v. Tri-Met, supra. 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); Lynda J. Zeller, supra.

Here, the record does not establish that claimant's fibromyalgia condition was medically stationary in December 1994. In October 1994, Dr. Beckwith referred claimant to Dr. Krohn. In his January 1995 report, Dr. Krohn recommended medication and physical therapy to improve claimant's fibromyalgia condition. Dr. Beckwith thereafter reexamined claimant, and advised her to follow the "intensive" treatment plan prescribed by Dr. Krohn.

No doctor stated that claimant's fibromyalgia condition was stationary at or prior to claim closure. Under these circumstances, we conclude that the December 23, 1994 Determination Order prematurely closed claimant's claim as it did not consider her fibromyalgia condition which was not medically stationary.

Claimant is entitled to an assessed attorney fee for services at hearing and on review for prevailing over the insurer's denial of claimant's consequential condition claim for fibromyalgia. 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 $3,000, 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 brief), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated.

Inasmuch as we found that claimant's injury claim was prematurely closed, claimant's attorney is also entitled to an out-of-compensation attorney fee equal to 25 percent of any increased compensation created by this order, not to exceed $3,800, payable directly to claimant's counsel. ORS 656.386(2); OAR 438-015-0055(1).

ORDER

The ALJ's order dated November 17, 1995 is reversed in part and affirmed in part. The insurer's denial of claimant's consequential condition claim for fibromyalgia is set aside. The December 23, 1994 Determination Order and the May 18, 1995 Order on Reconsideration are set aside as premature. The claim is remanded to the insurer for further processing according to law. For services at hearing and on review concerning the compensability issue, claimant's attorney is awarded an assessed attorney fee of $3,000, payable by the insurer. Claimant's attorney is also awarded 25 percent of any increased temporary disability benefits created by this order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
CECIL L. WILMARTH, JR., Claimant
WCB Case No. 94-06524
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Odell's order that: (1) declined to admit Exhibit 35, a "post-medical arbiter/post-reconsideration order" report from Dr. Hansen, claimant's attending physician; and (2) affirmed an Order on Reconsideration's award of no unscheduled permanent disability for a shoulder condition. The self-insured employer requests review of that portion the ALJ's order that awarded 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the right arm, whereas an Order on Reconsideration awarded no scheduled permanent disability. On review, the issues are evidence and permanent disability (scheduled and unscheduled).

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

The ALJ declined to admit Exhibit 35 into the hearing record. Exhibit 35 is an August 15, 1995 report from Dr. Hansen, attending physician, issued after the February 11, 1995 medical arbiter's report and the March 10, 1995 Order on Reconsideration. The ALJ found that Exhibit 35 was inadmissible under both former ORS 656.268(7) and amended ORS 656.283(7). We agree.

Amended ORS 656.283(7) provides, in part, that "[e]vidence 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[.]" That statute went into effect on June 7, 1995, which was subsequent to the March 10, 1995 Order on Reconsideration but prior to the August 17, 1995 record closure. Therefore, the statute applies here. See Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996).

Under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process, is inadmissible at a subsequent hearing concerning the extent of an injured worker's permanent partial disability. Id. at 231. However, amended ORS 656.283(7) does not apply to exclude evidence that was previously and properly admitted at hearing, i.e., evidence submitted prior to June 7, 1995, the effective date of amended ORS 656.283(7). Id.

In Joe R. Ray, supra, we held that, under amended ORS 656.283(7), evidence that is not submitted during the reconsideration process, and not made a part of the reconsideration record, is inadmissible at a subsequent hearing about the extent of an injured worker's permanent partial disability.[1] Nevertheless, in light of the court's decision in Plummer, that holding has been overruled to the extent that evidence concerning the extent of an injured worker's permanent partial disability that was properly admitted can be considered on review.

However, where a hearing concerning the extent of permanent partial disability was held after June 7, 1995, the prohibition on subsequent evidence set forth in amended ORS 656.283(7) is applicable. Thus, we continue to adhere to our holding in Joe R. Ray, supra, in those cases where the hearing was held after June 7, 1995. Dean J. Evans, 48 Van Natta 1092 (1996).

Here, the matter was submitted on the record which closed on August 17, 1995. Because the proffered medical report was not submitted during the reconsideration process and was not made a part of the reconsideration record, the ALJ properly excluded it from the record. Joe R. Ray, supra.

At hearing and on review, claimant argues that Exhibit 35 is admissible under amended ORS 656.268(8), as evidence addressing an issue arising out of the reconsideration order. In this regard, claimant argues that the reconsideration order raised the "issue" of whether a preponderance of the medical evidence established a different impairment than the medical arbiter's finding of no impairment. Claimant asserts that Exhibit 35 is admissible as evidence addressing that "new issue". We agree with the ALJ that amended ORS 656.268(8) does not apply to the facts of this case.

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[1] Although a signatory to this order for purposes of *stare decisis*, Chair Hall continues to believe, for the reasons set forth in his concurrence/dissent in Joe R. Ray, supra, that amended ORS 656.283(7) should not be applied to those cases where the reconsideration record was developed prior to June 7, 1995.

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."[2] Here, the issue on reconsideration was extent of scheduled and unscheduled permanent disability. (Ex. 34A-3). The fact that the reconsideration order found the medical evidence insufficient to establish entitlement to a permanent disability award does not raise a new issue. If we accepted claimant's argument that such a finding raised a new issue which permitted admission of "post-reconsideration" evidence pursuant to amended ORS 656.268(8), the effect would be to eviscerate the provisions of amended ORS 656.268(8) and amended ORS 656.283(7) that explicitly limit the admissibility of post-reconsideration evidence. Therefore, because no new issue arose out of the reconsideration order, amended ORS 656.268(8) does not apply to this case. Accordingly, for these reasons, as well as those addressed by the ALJ, we find that the ALJ properly excluded Exhibit 35.

Finally, claimant argues that Dr. Woolpert's opinion supports a finding of an unscheduled chronic condition impairment. However, Dr. Woolpert served as neither a medical arbiter nor the attending physician in this case. In addition, the attending physician did not ratify Dr. Woolpert's opinion. Therefore, we may not rely on Woolpert's opinion in rating disability. ORS 656.245(2)(b)(B); ORS 656.268(7); Roseburg Forest Products v. Owen, 129 Or App 442 (1994); Alex J. Como, 44 Van Natta 221 (1992). Consequently, we concur with the ALJ's decision to affirm that portion of the Order on Reconsideration that did not award unscheduled permanent disability.

Finally, claimant is not entitled to an attorney fee on Board review, because he filed no brief responding to the employer's cross-appeal and presented no argument on the scheduled permanent disability issue. See Shirley M. Brown, 40 Van Natta 879 (1988).

ORDER

The ALJ's order dated September 14, 1995 is affirmed.

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[2] We note that amended ORS 656.283(7) also provides that issues not raised at the reconsideration proceeding may not be raised at hearing "unless the issue arises out of the reconsideration order itself." However, as discussed in the body of our order, because no new issue was raised by the reconsideration order itself, this exception in amended ORS 656.283(7) does not apply to the facts of the present case.

June 12, 1996 Cite as 48 Van Natta 1195 (1996)

In the Matter of the Compensation of
ERIC E. SMITH, Deceased, Claimant
WCB Case No. 93-13695
ORDER DENYING RECONSIDERATION
Welch, Bruun, et al, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Claimant requests reconsideration of our December 7, 1995 Order on Review that reversed an Administrative Law Judge's (ALJ's) order setting aside the SAIF Corporation's denial of claimant death claim. SAIF's response in opposition to claimant's request has been received.

Prior to the request, claimant petitioned the Court of Appeals for judicial review of our Order on Review. ORS 656.295(8). Furthermore, the 30-day period within which to withdraw and reconsider our order has expired. Thus, jurisdiction of this matter rests with the court. ORS 656.295(8), 656.298(1). Claimant asks that we exercise our authority to withdraw the appealed order for purposes of reconsideration. See ORS 183.482(6); ORAP 4.35; Glen D. Roles, 43 Van Natta 278 (1991). Claimant requests that we do so in order to reconsider our decision in light of Andrews v. Tektronix, Inc., 323 Or 154 (May 9, 1996), which issued subsequent to our order.

Because this matter presently is before the court, the parties may present their respective positions before that forum concerning Andrews and its effect on this case. Consequently, we find that judicial and administrative efficiency is best served by declining the request to withdraw our order for reconsideration. Carole A. VanLanen, 45 Van Natta 178 (1993).

Accordingly, claimant's motion for reconsideration is denied. The issuance of this order neither "stays" our prior order nor extends the time for seeking review. International Paper Company v. Wright, 80 Or App 444 (1986).

IT IS SO ORDERED.

In the Matter of the Compensation
DEAN J. EVANS, Claimant
WCB Case No. 95-06031
ORDER ON RECONSIDERATION
Coons, Cole, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys

On May 30, 1996, we affirmed an Administrative Law Judge's (ALJ's) order that: (1) excluded a post-reconsideration medical report regarding the extent of claimant's unscheduled permanent disability; and (2) affirmed a May 1995 Order on Reconsideration that did not award claimant unscheduled permanent disability benefits. Relying on ORS 656.712(1), claimant contends that our order was invalid because our en banc decision did not include two members "with background and understanding as to the concerns of employees." Based on the following reason, we disagree with claimant's assertion.

Because of former Member Gunn's April 11, 1996 departure, the Board is presently composed of four members. Nevertheless, such a vacancy does not invalidate the Board's decision making capacity. To the contrary, ORS 656.718(2) expressly provides that "[n]o vacancy shall impair the right of the remaining members to exercise all the powers of the Board." Moreover, in the exercise of the Board's decision making authority, when sitting en banc, the concurrence of a majority of the members participating is necessary for a decision. ORS 656.718(3).

In light of the aforementioned statutory scheme, it is apparent that ORS 656.712 addresses the composition of the Board's membership and the qualifications for appointment to such positions. On the other hand, ORS 656.718 concerns the exercise of the Board's decision making authority whether reviewing in panels, en banc, or with a vacancy in the membership.

Here, as previously noted, all current members of the Board participated in the review of this case. For the reasons expressed in our order, all members concurred in that decision. Under such circumstances, our en banc decision is valid. See ORS 656.718(2), (3).[1]

Accordingly, our May 30, 1996 order is withdrawn. On reconsideration, as supplemented herein, we republish our May 30, 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] Assuming for the sake of argument that the Board's current composition precludes the issuance of an en banc order, we would still retain authority to render a decision. Not only does ORS 656.718(2) provide such authority, but section (3) also permits the Board to decide individual cases by a majority of the members sitting in a panel. Here, since all four members sitting in this panel reached the same decision, our order would also be statutorily valid on this alternative ground.

In the Matter of the Compensation of
ROGER L. WOLFF, Claimant
WCB Case No. 93-06586
ORDER ON REMAND
William H. Skalak, Claimant Attorneys
Judy C. Lucas (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. SAIF v. Wolff, 138 Or App 393 (1996). In our prior order, we held that the SAIF Corporation was barred by claim preclusion from denying that claimant's left knee osteochondritis dessicans was part of his accepted 1980 left knee injury claim and, therefore, that his current left knee condition was compensable. Roger L. Wolff, 46 Van Natta 2302 (1995). The court has remanded the case for reconsideration in light of the 1995 amendments to the Workers' Compensation Act. Or Laws 1995, Chapter 332 (SB 369).

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

Claimant injured his left knee at work in November and December 1980. X-rays revealed osteochondritis dessicans. (Ex. 2). SAIF accepted a left knee contusion. (Ex. 4).

In April 1981, claimant sought treatment for left knee pain, which he related to the work injury. (Ex. 5). Dr. Thomas, treating surgeon, diagnosed a loose bony fragment that was likely the result of osteochondritis dessicans. Thomas surgically repaired the knee. (Exs. 9, 10). SAIF paid claimant compensation, including medical expenses, related to his left knee condition.

Claimant's left knee claim was closed by an October 1981 Determination Order that awarded him 10 percent scheduled permanent disability. (Ex. 13). The Determination Order listed osteochondritis as one of claimant's conditions. (Id. at 2). SAIF paid claimant benefits pursuant to, and did not appeal, the Determination Order.

In 1993, claimant again experienced left knee pain. (Ex. 27). SAIF denied Dr. Thomas' request for authorization to perform another surgery on claimant's left knee. (See Ex. 30).

Claimant requested a hearing. The ALJ concluded that the major cause of claimant's current knee condition and need for treatment was the 1980 work injuries and the residuals of his two knee surgeries.

SAIF requested Board review. On review, SAIF asserted that, because claimant's osteochondritis dessicans preexisted his 1980 work exposure, this case should be analyzed under ORS 656.005(7)(a)(B) and that, under that statute, the claim fails.

We did not address that issue in our prior order. Roger L. Wolff, supra. Rather, relying on Messmer v. Deluxe Cabinet Works, 130 Or App 254, rev den 320 Or 507 (1995), we concluded that SAIF was barred by claim preclusion from denying that claimant's osteochondritis dessicans was part of his 1980 claim.[1] In Messmer I, an employer failed to appeal a Determination Order which had awarded permanent disability based, in part, on the effects of surgery for a noncompensable degenerative disease. The court held that, although an employer's payment of compensation, by itself, did not constitute acceptance of the degenerative condition, the employer's failure to challenge the award on the basis that it included an award for a noncompensable condition precluded the employer from contending later that the condition was not part of the compensable claim. In Messmer I, the court reasoned that the result was not that the degenerative condition had been accepted, it was that the employer was barred by claim preclusion from denying that it was part of the compensable claim. Id at 258.

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[1] For the sake of clarity, we refer to the court's first decision as Messmer I. We refer to the court's most recent decision as Messmer II.

Consequently, applying the court's holding in Messmer I, we found that, as a result of SAIF's failure to challenge the 1981 Determination Order, it was precluded from denying the dessicans condition. Accordingly, we affirmed the ALJ's conclusion that claimant's current left knee condition was compensable. Roger L. Wolff, supra, 46 Van Natta at 2304.

SAIF 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 remanded this case for our reconsideration in light of the amendments.

Subsequent to this matter being remanded to the Board, the court reexamined the Messmer case a second time, and issued its decision in Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) (Messmer II). In its decision, the court found that, if the legislature had intended to enact a statute that had the effect of overruling the court's prior decision, it had failed to do so. Specifically, the court held that the amended statute said nothing about the preclusive consequences of an employer's failure to appeal a determination order. Rather, the court noted that the amended statute provides only that payment of permanent disability benefits does not preclude an employer from subsequently contesting compensability. Accordingly, the court held that, because the legislature had not successfully changed the law, the court could not rewrite the statute to give effect to what the legislature may have intended. Consequently, the court concluded that the amended statute, ORS 656.262(10), did not effectively overrule its prior decision in Messmer I. Deluxe Cabinet Works v. Messmer, supra.

In light of the court's most recent ruling in Messmer II, we continue to adhere to the reasoning expressed in our prior order which relied on the court's initial decision in Messmer I. Roger L. Wolff, supra.

Claimant has finally prevailed after remand with respect to the compensability 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 attorney fee of $3,300 for prevailing over SAIF's denial. ORS 656.386(1). On review, we awarded a $1,000 fee, payable by SAIF. 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 on remand before the Board is $2,000, payable by SAIF. 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 issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated.

Accordingly, on reconsideration, as supplemented herein, we republish our October 31, 1994 order in its entirety. For services before the court and Board on remand, claimant's counsel is awarded an attorney fee of $2,000, to be paid by the SAIF Corporation. This attorney fee is in addition to the $4,300 granted by the ALJ's order and our prior order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JUAN M. DELGADO, Claimant
WCB Case No. 95-10317
ORDER ON REVIEW
Corey B. Smith, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that reduced claimant's unscheduled permanent disability for a low back injury from 23 percent (73.6 degrees), as awarded by an Order on Reconsideration, to zero. Submitting an admittedly untimely filed

respondent's brief, the self-insured employer seeks its admission due to extraordinary circumstances beyond its control. See OAR 438-011-0030. On review, the issues are the employer's procedural motion and extent of unscheduled permanent disability.

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

The employer acknowledges that its respondent's brief was untimely filed. However, the employer contends that the appellant's brief had been misidentified by claimant and was not discovered by the employer until after its respondent's brief was due. Consequently, the employer argues that it has shown extraordinary circumstances beyond its control, sufficient to justify an extension and consideration of its brief on review. Claimant takes no position on the employer's motion.

In light of claimant's position, we conclude that the employer has shown extraordinary circumstances to explain its untimely filing. Consequently, the employer's request for an extension is granted and its respondent's brief and claimant's reply brief are considered on review.

ORDER

The ALJ's order dated February 2, 1996 is affirmed.

In the Matter of the Compensation of
EMILY M. BOWMAN, Claimant
WCB Case No. 95-09511
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Yeager's order that assessed a $1,600 attorney fee under ORS 656.386(1) based on its pre-hearing acceptance of claimant's "new medical condition" claim for a right plantar fascitis condition. On review, the issue is attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded $1,600 in attorney fees for claimant's counsel's services in obtaining pre-hearing acceptances of claimant's claims for low back strain and right foot plantar fascitis conditions. We reach the same result, based on the following reasoning.

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." A "denied claim" is defined in the statute 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 compensation."

Here, claimant filed claims for a right foot and ankle sprain on January 15, 1993, for a low back strain on March 29, 1993, and for right plantar fascitis on October 8, 1993.[1] (Exs. 3, 7). On March 29, 1993, the insurer accepted "right ankle sprain; right foot sprain." (Ex. 4). On August 21, 1995, claimant requested a hearing regarding the insurer's failure to respond to the low back and fascitis claims. The

[1] All claims were related to claimant's January 13, 1993 work incident.

same day, by letter, claimant asked the insurer to accept the claims. (Ex. 11). On September 22, 1995, the insurer responded to claimant's request for hearing by denying (among other things) that claimant sustained a work-related injury or occupational disease. However, on October 17, 1995, the insurer amended its March 29, 1993 acceptance to include acceptance of the low back strain and right foot plantar fascitis conditions. (Ex. 12).

We find that the insurer's response to claimant's request for hearing (which denied that claimant had sustained a work-related injury or occupational disease) meant that the unaccepted claims were "denied" within the meaning of ORS 656.386(1) (i.e., the insurer answered claimant's request for hearing by denying her allegations on the express ground that these condition are not compensable).[2] Because these claims were only accepted after claimant requested a hearing, we further find that claimant's attorney was instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge and claimant is therefore entitled to an attorney fee under ORS 656.386(1).

After considering the insurer's objection to the amount of the ALJ's attorney fee award, claimant's response, and the factors of OAR 438-015-0010(4), we conclude that $1,600 was a reasonable assessed fee for claimant's counsel's services in obtaining pre-hearing acceptance of the claims for low back and right foot plantar fascitis conditions. Finally, we note that claimant is not entitled to an attorney fee for services on review regarding the attorney fee issues. Dotson v. Bohemia, 80 Or App 233 (1986).

ORDER

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

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[2] We find this case distinguishable from Michael J. Galbraith, 48 Van Natta 351 (1996). In Galbraith, the carrier responded to the claimant's request for hearing by asserting that the worker was "entitled to no relief." Because there was no refusal to pay compensation on the express ground that the condition was not compensable or that claimant was not otherwise entitled to compensation, there was no "denied claim" as required by ORS 656.386(1). Here, in contrast, the carrier's response to the request for hearing expressly denied that claimant had sustained a work-related injury or disease. Because the carrier's response in this case constitutes a refusal to pay compensation on the express ground that the condition is not compensable, it is a "denied claim" within the meaning of ORS 656.386(1).

In the Matter of the Compensation of
JULIE A. GOULD, Claimant
WCB Case No. 95-00692
ORDER OF ABATEMENT
Olson Law Firm, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

The SAIF Corporation requests reconsideration of our May 16, 1996 Order on Review, which affirmed the Administrative Law Judge's (ALJ's) that set aside SAIF's denial of claimant's mental disorder claim. Submitting "new evidence" which it asserts was unobtainable at the August 1995 hearing and allegedly supports a conclusion that claimant misled medical experts and the ALJ, SAIF asks that this matter be remanded for the admission of this additional evidence.

In order to further consider this matter, we withdraw our May 16, 1996 order. In addition, we implement the following supplemental briefing schedule. Claimant's supplemental response must be filed within 14 days from the date of this order. SAIF's supplemental reply must be filed within 14 days from the date of mailing of claimant's response. Thereafter, we shall take this matter under advisement. In submitting their respective positions, the parties are requested to address the effect, if any, the following Board decisions has on this case. Jeffrey M. Fisher, 46 Van Natta 729 (1994); Sonja M. Dairy, 46 Van Natta 534 (1994); Robert D. Blanchfield, 44 Van Natta 2139, on recon 44 Van Natta 2276 (1992); Jose L. Cervantes, 41 Van Natta 2419 (1989).

IT IS SO ORDERED.

In the Matter of the Compensation of
LANA M. LILLIE, Claimant
WCB Case No. 95-03980
ORDER ON REVIEW
Estell & Smith, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Michael V. Johnson's order which set aside its denial of claimant's right index finger 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

As part of a planned move to smaller office space, the employer asked claimant, an office manager/bookkeeper, whether she would be willing to perform her duties at home. Claimant agreed to do so and made arrangements to convert her laundry room to an in-home office. Claimant testified that, on the morning of February 27, 1995, after moving office equipment from her van into the laundry room, she vigorously closed the door between the laundry room and the garage. She further testified that, as a result of this incident, she accidentally slammed her right index finger in the door, sustaining her injury.

On March 3, 1995, claimant filled out a form 801, indicating that she injured her finger moving a file cabinet. (Ex. 2). The insurer denied the claim on March 29, 1995, based on information from the employer that claimant had injured her finger while carrying groceries into her house. (Ex. 7). Claimant appealed the denial.

The ALJ concluded that claimant had failed to sustain her burden of proving that she was moving office furniture at the time of injury. The ALJ nevertheless determined that claimant's injury was compensable, even if it occurred while carrying groceries. The ALJ reasoned that the employer had requested that claimant set up a home office and that, as a result of that request, it had assumed the risk that claimant would engage in some brief non-work related activities. The ALJ noted that claimant's injury occurred in the part of the house dedicated to storing the employer's office equipment and where claimant would be performing her duties.

On review, the insurer contends that claimant's injury is not compensable under Norpac Foods, Inc. v. Gilmore, 318 Or App 363 (1994). We agree.

At the outset, we address the issue of whether claimant proved that she sustained her injury while moving office furniture, as she testified, or whether it occurred while she was carrying groceries, as the employer's witnesses testified. Based on our de novo review of the record, we agree with the ALJ that claimant failed to prove that her injury occurred while moving office furniture. We, therefore, conclude that claimant's injury occurred while carrying groceries. Accordingly, we address, as did the ALJ, the issue of whether claimant's injury is compensable even if she was carrying groceries at the time of injury. For the following reasons, we find that claimant's injury would not be compensable under those circumstances.

To establish the compensability of an injury, claimant must prove 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, supra, 318 Or at 366. 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. Id.

We first consider the issue of whether claimant's injury occurred in the course of her employment. Claimant was being paid a salary at the time of her injury, which occurred during work hours. (Ex. 2). In addition, the alleged injury took place at or near the area of claimant's house to be devoted to her employment duties. Accordingly, there are factors that suggest that claimant was in the course of her employment at the time of injury.

However, claimant's injury must also "arise out of" her employment. In determining whether a causal connection existed between the injury and the employment, we consider whether the conditions of claimant's employment put her in a position to be injured. Henderson v. S. D. Deacon Corp., 127 Or App 333, 338-39 (1994); Donna M. Wilson, 47 Van Natta 2160, 2161 (1995). Here, we have found that claimant's injury occurred while she was carrying groceries. Other than the fact that the injury occurred on or near an area to be devoted to claimant's work activities, we find no risk connected with claimant's employment. There is no contention, nor is there any evidence, that claimant's injury occurred as a result of any employer-created hazard. Compare Ron M. Mattioli, 47 Van Natta 801 (1995) (injury occurring on employer's premises which arose from a premises hazard (vending machine) held compensable) with Cheryl T. Torko, 48 Van Natta 227 (1996) (injury did not arise from a hazard over which the employer had control; injury not compensable). Claimant was also engaged in a personal mission (bringing groceries into her home) at the time of injury. Under these circumstances, we conclude that the conditions of claimant's employment did not put her in a position to be injured.[1] Henderson v. S. D. Deacon Corp., supra.

Accordingly, we find that claimant's injury did not result from an act which was an ordinary risk of, or incidental to, her employment and, therefore, did not "arise out of" her employment. Claimant has failed to establish that the injury was sufficiently related to her employment to be compensable. Therefore, the ALJ's decision to set aside the insurer's denial is reversed.

ORDER

The ALJ's order dated December 7, 1995 is reversed in part and affirmed in part. That portion which set aside the insurer's denial is reversed. The insurer's denial is reinstated and upheld. The ALJ's assessed fee award is also reversed. The remainder of the order is affirmed.

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[1] In Eileen B. Palmer, 45 Van Natta 1686 (1993), we found that an injury which occurred in the claimant's garage was compensable. However, in contrast to this case, the claimant in Palmer was engaged in the employment activity of removing the employer's file box from the trunk of the employer's car in order to perform a required inventory. In finding the claim compensable, we applied the factors contained in Mellis v. McEwen, Hanna, Grisvold, 74 Or App 571, 575, rev den 300 Or 249 (1985). The Court of Appeals subsequently held in First Interstate Bank of Oregon v. Clark, 133 Or App 712, 717 (1995), that the Mellis test should no longer be used as an independent and dispositive test of work connection. Instead, we must consider the "totality of the circumstances" to determine if the claimant has shown a sufficient work connection. While the claimant in Palmer was clearly engaged in employment activity when she injured herself in her garage, claimant here was not so engaged. Considering the "totality of circumstances" surrounding claimant's injury, we are not persuaded that her injury arose out her employment.

In the Matter of the Compensation of
ADAM PARSONS, Claimant
WCB Case No. CV 96001
CRIME VICTIM ORDER
Kristin Preston, Department of Justice

Britt Parsons (hereafter referred to as "applicant"), has requested Board review of the Department of Justice's January 26, 1996 Order on Reconsideration. By its order, the Department denied applicant's claim, on behalf of his minor son, Adam, for compensation as a victim of a crime under ORS 147.005 to 147.375. The Department based its denial on a finding that applicant's son substantially provoked his assailant.

Following our receipt of the request for Board review, applicant was advised that he was entitled to present his case to a hearing officer. To exercise his right to a hearing, applicant was instructed to notify the Board within 15 days from the date the Department mailed him a copy of its record. The Department mailed a copy of its record to applicant on March 1, 1996. Having received no hearing request within the requisite time period, we have conducted our review based solely on the record.

FINDINGS OF FACT

On June 23, 1995, applicant's 11 year old son, Adam, was in an elementary school parking lot smoking cigarettes with four other children who were approximately the same age. A witness who was not involved in the fight described the incident as follows: Kirkpatrick, a teenage boy, approached Adam and the children and requested and was given a cigarette. A verbal argument then ensued between Adam and Kirkpatrick which resulted in Kirkpatrick picking Adam up and throwing him to the ground. Adam, who was unhurt, got up, approached Kirkpatrick and began kicking and punching him. In retaliation, Kirkpatrick picked Adam up again and threw him to the ground causing Adam's head to hit the pavement. Kirkpatrick then left the area.

The Medford Police Department was called and investigated the incident. Kirkpatrick told the investigating officer that Adam began the fight by flicking a cigarette at his face. Kirkpatrick admitted shoving Adam away from him. When Adam came at him kicking and punching, Kirkpatrick stated that he again pushed Adam away causing him to fall.

Adam told the police officer only that he had been thrown down by an older male.

Applicant told the investigating officer that this may be a lesson for his son as his son is frequently involved in fights.

CONCLUSIONS OF LAW AND OPINION

The standard of review for cases appealed to the Board under ORS Chapter 147 is de novo on the entire record. ORS 147.155(5); Jill M. Gabriel, 35 Van Natta 1224, 1226 (1983).

A person is eligible for crime victims' compensation if the person is a victim of a "compensable crime." ORS 147.015(1). A "compensable crime" is an intentional, knowing or reckless act that results in serious bodily injury or death of another person and which, if committed by a person of full legal capacity, would be punishable as a crime in this state." ORS 147.005(4). Eligibility for benefits is based in part on a finding that injury to the victim "was not substantially attributable to the wrongful act of the victim or substantial provocation of the assailant of the victim." ORS 147.015(5). "Substantial provocation" is "a voluntary act from which there can be a reasonable inference that, had the act not occurred, the crime likely would not have occurred." OAR 137-76-010(8).

Applicant has sought Board review of the Department's Order on Reconsideration denying crime victims benefits for Adam. He asserts that Adam was protecting his friend's little brother when his injuries occurred. Applicant also states that he does not understand how a 17 year old can be provoked by an 11 year old.

Adam did not tell the police officer investigating the incident that he was protecting another child. Instead, Adam stated only that he had been thrown down by an older male. Kirkpatrick told the investigating officer that Adam began the altercation by flicking a cigarette at his face. When Adam came at him kicking and punching, Kirkpatrick stated that he again pushed Adam away causing him to fall.

The police officer investigating the incident interviewed an uninvolved witness. Given the differing versions of the incident provided by applicant and Kirkpatrick, we primarily rely on the statement of the uninvolved witness. That witness indicated that, after being thrown to the ground the first time, Adam, who was uninjured, approached Kirkpatrick and began kicking and punching him. In retaliation, Kirkpatrick threw Adam to the ground. There is no mention in the witness' statement or in the police report of Adam protecting any other person.

In light of such circumstances, we draw the following conclusions. Applicant does not contest Kirkpatrick's statement that the altercations began when Adam flicked a cigarette in Kirkpatrick's face. Such evidence indicates that Adam either initiated, or at least substantially provoked the altercation. Moreover, after being thrown to the ground the first time, Adam had an opportunity to withdraw from the fight and did not do so. Instead, he approached Kirkpatrick and began kicking and punching him.

Consequently, we hold that Adam substantially provoked his assailant. This version of the altercation is consistent with applicant's statement to the investigating officer that Adam was frequently involved in fights. Finally, based on the uninvolved witness' description of the incident, we are unpersuaded by applicant's assertions that Adam was protecting another child when he was injured.

Based on our de novo review, we conclude that Adam is ineligible for crime victims' compensation.

ORDER

The Department's January 10, 1996 "Determination Order and Notice," as reconsidered on January 26, 1996, is affirmed.

In the Matter of the Compensation of
HAZEL C. BISHOP, Claimant
Own Motion No. 94-0678M
OWN MOTION ORDER
Emmons, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests that the Board authorize the payment of temporary disability compensation for her compensable low back injury, commencing the date she enters the hospital for surgery. In addition, claimant requests an extraordinary approved attorney fee for claimant's attorney's services in obtaining additional temporary disability compensation (TTD). See OAR 438-015-0080.

FINDINGS OF FACT

The SAIF Corporation initially submitted claimant's request for temporary disability compensation for claimant's compensable 1982 lumbosacral strain/sprain injury. Claimant's aggravation rights expired on April 14, 1988, thus, the claim is currently in "own motion" status. SAIF opposed reopening the claim on the grounds that: (1) claimant's request for lumbar laminectomy/foraminotomy, L4-5 facet ablation surgery was not reasonable and necessary treatment for her compensable condition; (2) claimant had not sustained a worsening of the compensable injury; and (3) claimant was not in the work force at the time of her current disability. Claimant requested a hearing with the Hearings Division. (WCB Case No. 94-10974).

On November 16, 1994, the Board consolidated the own motion matter with the hearing pending the outcome of that litigation. Following the hearing, on November 8, 1995, Administrative Law Judge (ALJ) Crumme' issued an Opinion and Order which dismissed claimant's request for hearing, concluding that the Director, rather than the Hearings Division, had jurisdiction over denials of the reasonableness and necessity of proposed surgery and managed care organization (MCO) disputes.[1] In a separate Own Motion Recommendation, the ALJ made Findings of Fact and Ultimate Findings of Fact and Conclusions of Law regarding the work force issue. In that document, the ALJ recommended, should the Director find the proposed surgery reasonable and necessary, that the Board find claimant was in the work force at the time of disability, and that she be entitled to temporary disability compensation commencing the date of surgery.

Claimant appealed the medical services dispute to the Director. See amended ORS 656.260; temporary OAR 436-010-0008(4) (effective December 4, 1995). On May 29, 1996, the Director issued a Proposed and Final Order Concerning a Medical Services Dispute (MTX96-144), which ordered that the surgical ablation of the right L4-5 lumbar facet joint is appropriate for claimant's diagnosis and current condition.

In a June 4, 1996 letter, claimant requested that the Board "exercise its Own Motion Jurisdiction, [by] entering an Order finding that the claimant was in the work force at the time her compensable condition worsened pending surgery and ordering the payment of temporary total disability benefits from the date of surgery until [claimant is] medically stable." In addition, noting that claimant's attorney had expended numerous hours in obtaining additional benefits for claimant, claimant requested that the Board allow an attorney fee payable out of claimant's compensation, not to exceed the statutory administrative rule maximum for services in this matter.

On June 6, 1996, SAIF recommended that the Board authorize the reopening of claimant's claim for the payment of temporary disability compensation.

CONCLUSIONS OF LAW AND OPINION

Temporary Disability Compensation

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

Here, the proposed surgery has finally been determined reasonable and necessary, and SAIF no longer contests claimant's request to reopen her claim for the payment of temporary disability compensation. See amended ORS 656.260, 656.278, and 656.327. Thus, we conclude that claimant's compensable injury has worsened requiring surgery. In addition, in a June 6, 1996 letter, SAIF noted that "[t]he Fact Finding order from the ALJ has been issued indicating that the worker was in the work force at the time of worsening." Therefore, because SAIF recommends that the Board "reopen this Own Motion claim for the appropriate benefits," we are persuaded that SAIF is not disputing that claimant was in the work force at the time of disability. See Weyerhaeuser v. Kepford, 100 Or App 410, 414 (1990); Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989).

Accordingly, we authorize the reopening of claimant's 1982 industrial injury claim to provide temporary disability compensation beginning the date she is hospitalized for the proposed surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

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[1] In his November 8, 1995 Opinion and Order, the ALJ noted that the jurisdiction question in this cased initially concerned whether the Hearings Division had jurisdiction under former ORS 656.260 regarding proposed treatment denials where the worker is subject to a managed care organization. While the hearing was pending, however, ORS chapter 436 was substantially amended by Or Laws 1995, ch 332, effective June 7, 1995. The ALJ, citing Or Laws 1995, ch 332, §66; Volk v. America West Airlines, 135 Or App 565 (1995) concluded that those amendments applied to the medical services issue in WCB Case No. 94-10974. Thus, the ALJ found that the Director, rather than the Hearings Division had jurisdiction over the denials of reasonableness and necessity of proposed treatment (ORS 656.327(1)(a)) and over medical services denials where the worker is subject to a managed care organization (ORS 656.245(6); ORS 656.260(6)). Based on these findings, the ALJ dismissed the hearing.

Approved Attorney Fee

Concerning an approved attorney fee for claimant's attorney's services, claimant asserts that:

"[T]he Board [should] allow an attorney fee payable out of claimant's compensation, not to exceed the statutory administrative rule maximum for [claimant's attorney's] services in this matter. Enclosed is a copy of our retainer agreement.

"Concerning the fee, [claimant's attorney has] expended numerous hours on this matter, both before the Board and with the Director, relative to these issues on behalf of [claimant]."

OAR 438-015-0080 provides that:

"If an attorney is instrumental in obtaining increased disability compensation, the Board shall approve a reasonable attorney fee, not to exceed $1,050, payable out of the increased compensation. The Board may allow a fee in excess of $1,050 upon a finding that extraordinary services have been rendered."

OAR 438-015-0010 provides that attorney fees for an attorney representing a claimant shall be authorized only if an executed retainer agreement has been filed with the Administrative Law Judge or Board. Here, claimant's attorney has filed such a document with the Board. The retainer agreement was signed by claimant on June 4, 1996. That retainer agreement provides, in pertinent part, that, if claimant's attorney is instrumental in obtaining compensation for claimant, claimant pay to claimant's attorney, "if the compensation is for temporary disability, [the amount of] 25% of the [additional] compensation up to $1,050." In addition, the agreement provides that "[a] greater amount may be petitioned for if extraordinary services warrant."

Here, although SAIF has finally recommended that claimant's 1982 claim be reopened, the record establishes that claimant's attorney was instrumental in obtaining the additional temporary disability benefits available to claimant under the Board's own motion authority. See e.g. Marvin Crafts, 48 Van Natta 724 (1996) (approved attorney fee granted where carrier rescinded a Notice of Closure as premature, because the claimant's attorney was instrumental in obtaining the closure rescission and additional benefits for claimant).

Here, as in Crafts, the record establishes that claimant's attorney represented claimant's interest in obtaining additional temporary disability compensation both at hearing (concerning the "work force" issue) and during the Director's review (regarding the surgery issue). Notwithstanding such services, applicable law neither authorizes the ALJ nor the Director to award attorney fees.

Nonetheless, it is undisputed that, if claimant's surgery had not ultimately been approved by the Director as reasonable and necessary for her compensable injury through her attorney's efforts, claimant would not be entitled to temporary disability compensation under ORS 656.278. Likewise, claimant's counsel's efforts were important in resolving the issue of whether claimant was in the work force at the time of disability. Thus, it follows that the only benefits which the Board might approve under ORS 656.278 (temporary disability benefits) were directly dependent upon the resolution of these issues. Therefore, we conclude that we have the authority to approve an extraordinary out-of-compensation attorney fee for claimant's attorney's efforts.

Because it is paid out of compensation, an extraordinary attorney fee reduces the amount of compensation that is ultimately received by the claimant. For that reason, it is essential that the forum awarding the additional benefits have a sufficiently developed record on the issue of whether extraordinary circumstances exist to justify a higher fee. Darrell R. Evans, 45 Van Natta 2211 (1993).

Here, documents in the record indicate that, pursuant to stipulation, the hearing was continued until October 14, 1995 to allow the parties to file additional evidence, and at least 33 exhibits were submitted during the year-long hearing proceedings. Furthermore, based on the ALJ's recommendation, we conclude that claimant's attorney submitted sufficient documentation to support claimant's position

that she was in the work force at the time of disability.[2] This documentation ultimately resulted in the ALJ's recommendation that TTD be awarded if the surgery was found to be reasonable and necessary. Additionally, documents in the record, as well as the Director's order, substantiate that claimant's attorney actively represented claimant during the Director's review by requesting pertinent information and documentation from the managed care organization in order that claimant and her treating physician might address the concerns of the MCO in that forum. Finally, claimant's increased temporary disability compensation is a direct result of claimant's attorney's efforts on her behalf through nearly two years of litigation.

Under such circumstances, we find extraordinary circumstances sufficient to warrant an attorney fee in excess of the standard "out-of-compensation" attorney fee schedule for Own Motion claims. See OAR 438-015-0080. In reaching this conclusion, we have considered the factors set forth in OAR 438-015-0010(4). In particular, we have relied on the time expended to resolve the issue (as represented in the record, including the ALJ's order/recommendation and the Director's order), the complexity of the issue, the value of the interest involved, the nature of the proceedings and the risk that claimant's counsel's efforts might go uncompensated.

Accordingly, upon finding that extraordinary services have been rendered in obtaining additional temporary disability benefits for claimant, 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 $3,000, payable by SAIF directly to claimant's attorney. See OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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[2] The ALJ was persuaded by the evidence submitted during the hearing proceedings that "after claimant was laid off in January 1994, she continued to look for other employment." ALJ Crumme' further concluded that "[i]t then became futile to continue to look for work after [claimant's] attending physician, Dr. Nagel, authorized time loss, effective May 23, 1994, based on her low back condition." See November 8, 1995 Own Motion Recommendation. Included in his Own Motion Recommendation, the ALJ cited the following exhibits which he considered in making his recommendation that claimant was in the work force at the time of disability: (1) Ex. 25-2, document verifying that claimant was last employed at a microfiche company from 1989 until she was laid off on or about January 4, 1994; (2) Ex. 25-6, document verifying that claimant received unemployment insurance benefits and sought other employment; (3) Ex. 16, Dr. Nagel's time loss authorization from May 23, 1994 through August 23, 1994.

In the Matter of the Compensation of
DENNIS E. CAMPBELL, Claimant
WCB Case No. 95-08269
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

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

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

SAIF argues that claimant had a preexisting, asymptomatic compression neuropathy of the median nerves. We disagree.

On May 3, 1995, claimant was examined by Dr. Eliason for bilateral hand numbness. Dr. Eliason diagnosed "[p]ossible carpal tunnel syndrome, left greater than right vs. diabetic neuropathy." (Ex. 5). Dr. Eliason referred claimant for nerve conduction studies to help differentiate the diagnosis. The nerve conduction studies showed that claimant had severe bilateral carpal tunnel syndrome. (Ex. 6). Dr. Eliason subsequently referred claimant to Dr. Collada.

On May 30, 1995, Dr. Collada examined claimant and reported that the electrical studies "showed a pattern very classic for median nerve entrapment and no clear pattern to go along with a neuropathy." (Ex. 8). Dr. Collada recommended a bilateral carpal tunnel release.

SAIF relies on the opinions of Drs. Brooks and Duff to prove that claimant had a preexisting, asymptomatic compression neuropathy of the median nerves. On July 7, 1995, Drs. Brooks and Duff opined that, because of the severity of the electrical changes, claimant had asymptomatic compression neuropathy of the median nerves that probably went back several years, before claimant began to work for the employer.[1] (Ex. 11-5). However, Drs. Brooks and Duff acknowledged that they had no prior documentation of the neuropathy. (Id.) In a deposition, Dr. Brooks testified that he could not rule out the possibility that the progression of median neuropathy was rapid. (Ex. 17-15). Likewise, Dr. Duff testified that it was possible, but unlikely, that claimant might have had normal electrial studies before he started working for the employer. (Ex. 18-30).

In response, Dr. Collada reported that the "severity of electrical studies does not * * * qualify as a way of dating the onset of clinically significant median nerve entrapment at the carpal tunnel region." (Ex. 16). Dr. Collada commented that there was no way to determine whether there was a preexisting carpal tunnel narrowing. (Id.)

When the medical evidence is divided, we tend to give greater weight to 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 defer to Dr. Collada's opinion. Dr. Collada concluded that the electrical studies showed no clear pattern of neuropathy, (Ex. 8), and he did not agree with Drs. Brooks and Duff that the severity of the electrical studies proved that claimant had preexisting neuropathy. (Ex. 16). Moreover, both Drs. Brooks and Duff acknowledged that it was possible that claimant did not have median neuropathy before he began working for the employer. Based on Dr. Collada's report, we are persuaded that claimant did not have preexisting median neuropathy. Consequently, we find that claimant's occupational disease claim is not based on the worsening of a preexisting disease or condition. Therefore, claimant need not establish that his work activities were the major contributing cause of a combined condition and pathological worsening of a preexisting disease. See ORS 656.802(2)(b).

We agree with the ALJ's reasoning and conclusion that claimant has established that his employment conditions were the major contributing cause of his bilateral carpal tunnel syndrome.

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 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 February 12, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the SAIF Corporation.

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[1] Dr. Duff subsequently testified that he deferred to Dr. Brooks on this issue. (Ex. 18-29, -35).

In the Matter of the Compensation of
NORMA J. DETROIT, Claimant
WCB Case Nos. 95-09793 & 95-09792
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

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

We adopt and affirm the ALJ's order with the following changes and supplementation. We do not adopt the ALJ's conclusion that Dr. Newby's opinion was incomplete in failing to analyze the effects of smoking.

Claimant argues that the ALJ improperly discounted the opinion of Dr. Newby, who concluded that claimant's October 11, 1994 injury was the major contributing cause of her disability and need for treatment. We disagree.

On April 11, 1995, claimant filed a claim for an injury sustained on October 11, 1994. (Ex. 16). On the same date, Dr. Newby reported that claimant "returns for follow-up after a long absence continuing to have low back pain intermittently but has been progressive over the last few months." (Ex. 15). Dr. Newby diagnosed "low back pain, etiology unclear." (Id.) Dr. Newby did not mention the October 11, 1994 incident.

On May 23, 1995, Dr. Newby reported that claimant suffered "an acute injury due to the incident on 11/11/94 [sic]." (Ex. 26). Dr. Newby commented that claimant's L4-5 stenosis had been developing for a long period of time. Dr. Newby accepted claimant's claim that she had been asymptomatic until the October 1994 incident, and he said that "although the stenosis was preexisting the incident was the factor that caused the onset of pain." (Id.) Dr. Newby concluded that the injury was responsible for greater than 50 percent of claimant's disability or need for treatment. (Id.)

On October 3, 1995, Dr. Newby commented that claimant had "degenerative bony hypertrophy of her L4-5 facets," and he believed that the October 11, 1994 injury was the "result of her irritating the L5 nerve roots in the lateral recesses at L4-5 to produce symptoms of back and leg pain." (Ex. 31). Dr. Newby reported that claimant's exposure to "chronic vibration predisposed her to premature degenerative changes at the L4-5 level, which lead [sic] to her lateral recess stenosis." (Id.)

Absent persuasive reasons to the contrary, we generally defer to the opinion of the treating physician. Weiland v. SAIF, 64 Or App 810 (1983). We give the most weight to medical opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

Here, we agree with that ALJ that there are persuasive reasons not to defer to the opinion of claimant's treating physician, Dr. Newby. Dr. Newby's reports indicated that he treated the October 11, 1994 injury as the precipitating or triggering cause of claimant's symptoms. However, the precipitating cause is not necessarily the major contributing cause of the symptoms. Dietz v. Ramuda, 130 Or App 397 (1994), rev dismissed 321 Or 416 (1995). 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. Id.

Dr. Newby's pre- and post-operative reports indicate that surgery was performed specifically to address the lateral recess stenosis at L4-5. (Exs. 24, 25). Although Dr. Newby reported that claimant's exposure to "chronic vibration predisposed her to premature degenerative changes at the L4-5 level, which lead [sic] to her lateral recess stenosis," (Ex. 31), Dr. Newby did not indicate whether claimant's October 11, 1994 work incident caused the lateral recess stenosis. Dr. Newby's reports on causation do not provide any reasoning regarding the relative contribution of the preexisting degenerative condition and the October 11, 1994 incident to determine which was the primary cause of claimant's disability and need for treatment. See Dietz v. Ramuda, supra.

In sum, we are not persuaded by Dr. Newby's opinion because it is conclusory.[1] Consequently, we agree with the ALJ that claimant has not established that the October 11, 1994 injury was the major contributing cause of her disability and need for treatment.

ORDER

The ALJ's order dated January 10, 1996 is affirmed.

[1] Board Member Haynes also finds Dr. Newby's opinion unpersuasive for additional reasons. Although Dr. Newby's May 23, 1995 report described the "11/11/94" incident as an "acute injury," (Ex. 26), none of Dr. Newby's reports explained the details of how claimant was actually injured at work. In fact, in his April 11, 1995 report, Dr. Newby diagnosed "low back pain, etiology unclear." (Ex. 15). (Board Member Haynes notes that claimant described the details of the October 11, 1994 incident on the "827" form that was apparently signed by Dr. Newby.) Moreover, Dr. Newby did not explain why, if the October 1994 injury was acute, claimant did not seek treatment until April 11, 1995.

In the Matter of the Compensation of
GERALD D. McCLUNE, Claimant
WCB Case No. 95-01952
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Schwabe, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Poland's order which: (1) upheld the self-insured employer's "de facto" denial of claimant's occupational disease claim for degenerative arthritic disc disease; and (2) declined to remand the claim for reclosure/rating of permanent disability. Claimant also contends that he is entitled to an attorney fee pursuant to ORS 656.386(1) for obtaining acceptance of lumbar disc bulges and a lumbosacral strain at the hearing. On review, the issues are compensability, remand, and attorney fees.

We adopt and affirm the ALJ's order with the following supplementation regarding claimant's entitlement to an assessed attorney fee under ORS 656.386(1).

Claimant contends that he is entitled to an assessed attorney fee under ORS 656.386(1) because of the insurer's agreement at hearing to amend its acceptance to include a lumbosacral strain and right L3-4 and L4-5 disc protrusions. (Tr. 2). We are not inclined to address this issue inasmuch as it was not raised at hearing. See Stevenson v. Blue Cross of Oregon, 108 Or App 247, 252 (1991); Shanon M. Oliver, 48 Van Natta 386, 388 (1996). However, even if this issue were properly raised, we would decline claimant's request for an attorney fee.

We find that the employer did not refuse to pay compensation on the express ground that the injury or condition was not compensable or otherwise did not give rise to an entitlement to compensation. Amended ORS 656.386(1). Accordingly, we conclude that, even assuming that this issue was properly raised, claimant would not be entitled to an attorney fee under ORS 656.386(1).

ORDER

The ALJ's order dated February 2, 1996 is affirmed.

In the Matter of the Compensation of
BONNIE D. ROGERS, Claimant
WCB Case No. 95-05681
ORDER ON REVIEW
Aller & Morrison, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's left knee injury claim; and (2) awarded a 5 percent penalty for an alleged discovery violation. On review, claimant moves to dismiss the employer's request for review on the ground that no timely appellant's brief was filed. The employer moves for acceptance of its appellant's brief on the ground that the brief was untimely due to extraordinary circumstances beyond its control. See OAR 438-011-0020(2); OAR 438-011-0030. On review, the issues are the procedural motions, compensability, and penalties and attorney fees. We deny the motion to dismiss. The employer's appellant's brief is accepted and considered on review. The ALJ's order is affirmed.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Motion to dismiss

Claimant requests dismissal of the employer's request for Board review, on the ground that the employer did not timely file an appellant's brief.

We have previously held that the filing of briefs is not jurisdictional. OAR 438-011-0020(1); Bonnie A. Heisler, 39 Van Natta 812 (1987). Accordingly, claimant's motion to dismiss is denied.

Untimely brief

Claimant opposes the acceptance of the employer's brief on the ground that the brief was untimely filed. Ordinarily, an untimely brief will be rejected in the absence of extraordinary circumstances beyond the party's control. Lester E. Saunders, 46 Van Natta 1153 (1994); OAR 438-011-0030.

Here, the employer has explained that its untimely filing was due to the illness of its paralegal. We find these circumstances distinguishable from a mere "calendaring error," which we have previously found does not constitute extraordinary circumstances. Saunders, supra. Consequently, we grant the extension and accept the employer's brief, as we find that the facts in this case constitute circumstances beyond the employer's control. See OAR 438-011-0030.

Compensability

On review, the employer argues that the ALJ's order is "overbroad" as it directed the employer to accept claimant's left knee injury and "combined condition." The employer argues that ALJ's order should be modified to reflect compensability of only a left knee sprain and synovitis.

We disagree with the employer's contention that the ALJ did not find a combined condition. (O & O P.5). Here, the medical evidence establishes that claimant's strain/sprain and synovitis "combined" with his degenerative condition. Based on such evidence, the ALJ correctly designated the employer's responsibility for claimant's condition, and cited ORS 656.005(7)(a)(B), which provides that the combined condition is compensable so long as and to the extent that the otherwise compensable injury is the major cause of the disability or need for treatment of the combined condition.. Accordingly, so long as the compensable injury remains the major cause of the need for treatment, the employer will also be responsible for claimant's "combined condition."

Consequently, we adopt the ALJ's conclusions and opinion on the issue of compensability.

Penalties/untimely discovery

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

Attorney fees/ Board review

Claimant's attorney is entitled to an attorney fee for services on review. ORS 656.382(2). After considering the factors recited in OAR 438-015-0010(4), we find that a reasonable attorney fee for such services regarding the compensability issue is $850, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We note that no attorney fee is available for claimant's counsel's services on review concerning the penalty issue Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated January 25, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $850, to be paid by the self-insured employer.

In the Matter of the Compensation of
SHIRLEE A. ODEN, Claimant
WCB Case No. 95-10157
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) T. Lavere Johnson's order that dismissed her request for hearing. On review, the issue is the propriety of the ALJ's dismissal order.

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

We agree with the ALJ's reasoning that claimant's "Motion to Withdraw" her prior withdrawal of her hearing request should be treated as a motion for postponement. Pursuant to OAR 438-006-0081, hearings "shall not be postponed except by order of an ALJ upon a finding of extraordinary circumstances beyond the control of the party...requesting the postponement." For the reasons stated in the ALJ's order, we agree that claimant has failed to show "extraordinary circumstances" beyond her control, sufficient to justify a postponement. Accordingly, the ALJ's order is affirmed.

ORDER

The ALJ's order dated January 18, 1996 is affirmed.

In the Matter of the Compensation of
DONNA E. TANNER, Claimant
WCB Case Nos. 94-14511 & 94-12207
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Stoel, Rives, et al, Defense Attorneys
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

The SAIF Corporation, on behalf of Kenton Station, requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome; and (2) upheld SAIF/Yorgo's Tavern's denial of claimant's claim for the same condition. In her brief, claimant contests the ALJ's $1,400 attorney fee award. On review, the issues are compensability, responsibility and attorney fees. We affirm in part and modify in part.

We adopt and affirm that portion of the ALJ's order which found SAIF (Kenton Station) responsible for claimant's bilateral carpal tunnel syndrome. We add the following supplementation.

The ALJ concluded that claimant had established compensability of her bilateral carpal tunnel syndrome as an occupational disease. The ALJ further concluded that SAIF/Kenton Station was responsible for that condition. On review, SAIF/Kenton Station argues that the ALJ erred in finding the opinion of claimant's attending physician and surgeon, Dr. Van Allen, more persuasive than the opinions of examining physicians, Radecki and White. We disagree.

We generally defer to the conclusions of a treating physician, unless there are persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810, 814 (1983). Here, we find no persuasive reasons not to rely on the opinion of claimant's physician and surgeon, Dr. Van Allen. Accordingly, on this basis, we agree with the ALJ that claimant has established compensability of her bilateral carpal tunnel syndrome.[1]

Claimant seeks an increase in the $1,400 attorney fee awarded by the ALJ. Based on the following reasoning, we modify the ALJ's attorney fee award.

OAR 438-015-0010(4) sets out the following factors to be considered in determining a reasonable attorney fee: (a) the time devoted to the case; (b) the complexity of the issue(s) involved; (c) the value of the interest involved; (d) the skill of the attorneys; (e) the nature of the proceedings; (f) the benefit secured for the represented party; (g) the risk in a particular case that an attorney's efforts may go uncompensated; and (h) the assertion of frivolous issues or defenses.

Our review of the record reveals the following information. The hearing regarding the carrier's denials lasted approximately three hours and claimant called one witness. Claimant's attorney obtained a medical report from Dr. Van Allen which supported claimant's claim. Claimant's attorney submitted no statement of services regarding the amount of time spent on the case. The legal, factual and medical issues involved in the case were of a complexity level not unlike those generally presented for ALJ/Board resolution.

The value of the compensability issue is substantial in that claimant required surgery. Likewise, the benefit secured is significant in that claimant's medical bills will be paid and she will be compensated for any disability related to her compensable condition. Finally, with a risk of going uncompensated for such services, claimant's counsel persuasively and successfully advocated claimant's position at hearing, resulting in a beneficial result.

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[1] Because of our disposition of this case, we find it unnecessary to address claimant's argument that ORS 656.005(24) is contrary to, and preempted by, the Americans with Disabilities Act (ADA).

After conducting our review, and considering the factors set forth in the aforementioned rule, we find that a reasonable attorney fee for claimant's counsel's services at the hearing level is $2,500, to be paid by SAIF/Kenton Station.[2] In reaching this conclusion, we have particularly considered the complexity of the denial issue, the time devoted to the issue (as represented by the hearing record), the nature of the proceedings, the benefit secured for claimant, and the risk that claimant's counsel might go uncompensated.

Finally, claimant's attorney is also entitled to an attorney fee award 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 denial issue is $1,750, payable by SAIF, on behalf of Kenton Station. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's attorney's statement of services, including SAIF's objections), the complexity of the issue, and the value of the interest involved. In determining a fee, we have not considered claimant's counsel's services in defending the ALJ's attorney fee award. See Saxton v. SAIF, 80 Or App 631 (1986).

ORDER

The ALJ's order dated June 23, 1995 is affirmed in part and modified in part. In lieu of the ALJ's attorney fee award, claimant's counsel is awarded $2,500, to be paid by SAIF/Kenton Station. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,750, payable by SAIF on behalf of Kenton Station.

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[2] As explained in his dissenting opinion in Paul R. Huddleston, 48 Van Natta 4 (1996), considering an ALJ's close proximity to the litigants and their counsel, Chair Hall refrains from second-guessing an ALJ's attorney fee award absent compelling reasons. Here, he finds those compelling reasons. His reasons for this conclusion are as follows.

In setting a reasonable attorney fee award, the court has instructed the Board to consider the factors prescribed in OAR 438-015-0010(4) and provide an explanation for our award that is "detailed enough to inform [the court] that [we] considered all of the factors and had a reasonable basis for the award." Higgins v. Schramm Plastics, 112 Or App 563 (1992). As the reviewing body for ALJ's orders, he submits that the Board can ask no less from the ALJ.

In this particular case, the ALJ's order merely states that claimant's $1,400 award has been granted"[p]ursuant to OAR 438-15-010(4)." Lacking an explanation which is sufficiently detailed to determine that the factors of the rule have been considered and that there is a reasonable basis for the attorney fee award, Chair Hall concludes that there is a compelling reason to examine claimant's attorney fee award. Moreover, for the reasons expressed in this decision, he finds that the ALJ's determination of a reasonable award was inadequate.

In the Matter of the Compensation of
ROBERT B. TATE, Claimant
WCB Case No. 95-03068
ORDER ON REVIEW
Ernest M. Jenks, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Bethlahmy's order which: (1) found that claimant's L3-4 and L5-S1 disc conditions were not compensable; and (2) declined to assess penalties and attorney fees for allegedly unreasonable claims processing. 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

Claimant compensably injured his low back on March 15, 1994. The SAIF Corporation accepted the claim for a L4-5 disc herniation. Claimant's treating doctor, Dr. Miller, performed surgery consisting of a laminectomy at L4-5 with removal of a protruding disc, laminectomy at L3-4 with exploration of the L3-4 disc, and decompression of the L4 and L5 nerve roots. Dr. Miller found no herniation of the L3-4 disc. SAIF paid all medical bills related to the surgery.

On review, SAIF does not contest the compensability of the surgery at the L3-4 level as diagnostic medical services. Claimant, however, objects to the ALJ's conclusion that the L3-4 disc bulge itself is not compensable. We agree with the ALJ's decision.[1]

Dr. Miller, neurosurgeon, first saw claimant on May 9, 1994. Dr. Miller's review of an April 1994 MRI demonstrated degenerative disc disease (DDD) from L3 to S1 with a fairly significant midline bulge at L4-5. (Ex. 4A). After claimant failed to improve with conservative treatment, Dr. Miller recommended a CT scan and myelogram. These studies revealed a lesion at L3-4 and L4-5 levels compressing the L4 and L5 nerve roots. Dr. Miller opined that these findings were related to claimant's compensable March 1994 injury. He recommended removal of the discs to decompress the L4 and L5 nerve roots. After surgery revealed that the L3-4 disc was not herniated, Dr. Miller opined that he could not determine whether the L3-4 disc bulge preexisted the March 1994 injury or was caused by the injury.

At SAIF's request, Dr. White performed a records review on July 19, 1994. Based primarily on Dr. Miller's reports that claimant had a significant L4-5 disc bulge, Dr. White opined that only the L4-5 disc herniation resulted from claimant's March 1994 injury. He concluded that claimant's preexisting DDD did not precipitate the need for treatment.

Dr. Scheinberg, orthopedist, and Dr. Williams, neurosurgeon, who examined claimant at SAIF's request, also opined that claimant's preexisting DDD was not the major contributing cause of claimant's low back pain and need for treatment. They explained that claimant's injury worsened the underlying condition causing a minor disc rupture at L4-5 with progressive extrusion. The doctors, however, did not render an opinion on the cause of the L3-4 disc bulge.

Based on the above, we find that the medical evidence is insufficient to establish that the L3-4 disc bulge is either causally related to claimant's compensable injury or to his accepted L4-5 disc condition. See Albany General Hospital v. Gasperino, 113 Or App 411 (1992). Accordingly, claimant has failed to carry his burden of proof.

Lastly, Dr. Miller opined that the L5-S1 disc bulge was not related to the March 1994 injury. His opinion is supported by Dr. White. Consequently, claimant also failed to establish compensability of the L5-S1 disc condition. Albany General Hospital v. Gasperino, supra.

Penalties and Attorney Fees

Claimant seeks penalties and attorney fees for SAIF's alleged failure to process the L3-4 and L5-S1 disc conditions within 90 days. We agree with the ALJ that penalties and attorney fees are not warranted.

Because SAIF did not accept or deny claimant's L3-4 and L5-S1 disc claims within 90 days, a penalty may be assessed under ORS 656.262(11), if there were amounts then due between the date when the acceptance or denial should have been issued and the date of the denial. Jeffrey D. Dennis, 43 Van Natta 857 (1991). However, because SAIF has paid for claimant's diagnostic surgery, including for the L3-4 disc, and because we have found the L5-S1 condition not compensable, there are not amounts then due upon which to base a penalty. Likewise, there has been no unreasonable resistance to the payment of compensation. Consequently, an attorney fee under ORS 656.382(1) is not justified.

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[1] Claimant contends that the March 1994 injury was the major contributing cause of his need for treatment related to the L3-4 and L5-S1 disc conditions. Prior to Senate Bill 369, if the prescribed medical services constituted an integral part of the total medical treatment for the condition due to the compensable injury, the medical services were compensable. See Williams v. Gates, McDonald & Co., 300 Or 278 (1995). The viability of the Williams' rationale was questioned in Roseburg Forest Products v. Wofford, 138 Or App 560 (1996) (remanded for reconsideration in light of ORS 656.225), on remand Michael L. Wofford, 48 Van Natta 1087 (1996). Here, we need not consider the applicability of Wofford or ORS 656.225 since the compensability of the L3-4 surgery is not at issue.

Claimant also seeks a penalty for SAIF's allegedly unreasonable denial of the L3-4 disc condition. The ALJ found that SAIF reasonably relied on Dr. White's report in accepting only the L4-5 disc condition.

The reasonableness of a denial is determined on the basis of whether the employer had a "legitimate doubt" about its liability for a claim based on information available at the time of the denial. See Brown v. Argonaut Insurance Company, 93 Or App 588, 591 (1988).

Dr. Miller had initially only implicated the L4-5 disc as the cause of claimant's symptoms. Radiographic studies had revealed degenerative disc disease from L3 to the sacrum, particularly at the L3-4 disc level. Dr. White agreed with Dr. Miller that the disc herniation at L4-5 was the lesion responsible for claimant's symptoms and need for surgery. Dr. White, therefore, recommended acceptance of only the L4-5 disc. We, therefore, agree with the ALJ that SAIF's acceptance of only the L4-5 disc condition was reasonable. Accordingly, neither penalties nor attorney fees are warranted.

ORDER

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

In the Matter of the Compensation of
LISA M. BEAN, Claimant
WCB Case No. 95-07812
ORDER ON REVIEW
Jensen, Fadeley, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Hall, Christian and Haynes.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's injury claim. On review, the issue is whether claimant's injury arose out of and occurred in the course of her employment.

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

On June 6, 1995, claimant parked in her usual space in the employer's parking lot. As claimant walked across the lot toward her company truck, she was struck by a vehicle driven by another employee and knocked to the ground. Claimant was treated in the emergency room for bruises, neck and low back strains, and a broken nose.

The parties stipulated at hearing that the employer owned and maintained the parking lot, thus establishing that claimant's injury occurred "in the course of" her employment. See Norpac Foods, Inc., v. Gilmore, 318 Or 363 (1994). The ALJ reasoned that, because walking through the employer's parking lot exposed claimant to the risk of the unpredictable driving behavior of other employees, claimant's conditions of employment "put her in a position to be injured," such that her injuries also "arose out of" her employment. See Henderson v. S. D. Deacon Corp., 127 Or App 333, 338-39 (1994).

On review, SAIF argues only that claimant's injury did not arise out of her employment. Consequently, the issue before us is whether claimant has established that there was a sufficient causal connection between the injury and her employment to conclude that her injury arose out of her employment. We hold that she has.

Subsequent to the ALJ's order, the court issued its opinion in SAIF v. Marin, 139 Or App 518 (1996). The court reversed our order in Ramon M. Marin, 46 Van Natta 1691 (1994), which had held that the claimant's injury arose out of the course and scope of his employment. While in his employer's parking lot after his normal work day, the claimant was unable to start his truck. After his supervisor agreed to jump start the truck, the supervisor's wife moved her car closer to the claimant's truck. While doing so, the car struck the employer's flower box which struck the claimant. Reasoning that the flower box was a hazard associated with the parking lot over which the employer exercised control, we concluded that the causal connection between the claimant's injuries and his employment was sufficient to establish that his injuries "arose out of" his employment.

The court disagreed. First, the court found no evidence that the flower box, by itself, presented any risk of harm. Second, rather than focusing only on the instrumentality over which the employer had control (the flower box), the court determined that we should have considered whether the totality of the events that gave rise to the claimant's injury was causally related to his employment.

Reasoning that the nature of the risk of harm to the claimant could neither be characterized as personal nor directly employment-related, the court concluded that the risk of the claimant being injured by the flower box while jump starting his car in the parking lot was more properly denominated a "neutral risk." The court cited Larson, 1 Workmen's Compensation Law, Section 7.30, 3-13 (1995). Consequently, the court stated that the claimant's injury was compensable only if his work conditions caused him to be in a position to be injured by the flower box.

The court explained that where an employee drives to work and parks in the parking lot, it is generally necessary for the employee to walk to and from the parking lot while entering and leaving work. Thus, "in a general sense," the court viewed walking through an employer-controlled parking lot as a condition of the employee's employment. Specifically, the court remarked that "we might conclude that (the claimant's) conditions of employment caused him to be in a position to be injured by the flower box if the flower box had tipped over on him or if it had been pushed into him by another vehicle as he was walking to or from the parking lot." However, the court reasoned that the claimant's injury was not precipitated simply by walking through the parking lot to his car, but rather was attributable to the "jump starting" efforts and the circumstances that followed. Under those circumstances, the court held that the claimant's activities were sufficiently removed from his normal ingress and egress to and from work to break the causal connection between his normal employment conditions and his injury.

Here, in contrast, claimant's injury occurred under circumstances the Marin court has suggested are sufficient to find the requisite causal connection.[1] Claimant arrived at work and parked in the employer-controlled parking lot. When struck by a co-worker's vehicle, she was simply walking through the parking lot to enter her immediate work area. There is no evidence that claimant engaged in any activity that removed her from normal ingress to work.[2]

In accordance with the Marin rationale, this situation presents a "neutral risk;" i.e., neither personal nor directly employment-related. Considering that claimant was walking to her work site after parking in the employer-controlled parking lot when she was struck by a co-worker's vehicle, we conclude the sufficient causal connection required by the Norpac and Marin holdings has been satisfied. Consequently, since we are persuaded that claimant's injuries "arose of of" her employment, we hold that her claim is compensable.[3]

In reaching this conclusion, we are not merely basing our compensability determination on the fact that the injury occurred in the employer-controlled parking lot. Such reasoning would be contrary to the Norpac rationale. Rather, since claimant's injury arose from a co-worker's vehicle in that same employer-controlled parking lot while claimant was merely attempting to reach her work site, we find that a sufficient causal connection between claimant's injury and her work has been established.

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[1] We recognize that the Marin court's statements are dicta and not controlling. Nevertheless, the court's rationale provides further guidance to us in evaluating the "arising out of" (causal connection) prong of the Norpac analysis.

[2] See Larson, 1 Workmen's Compensation Law, Section 15.42(b), 4 -101 (1995) (injuries incurred in employer-controlled parking lots are given the same status as those that occur on the main premises; viz., they are compensable to the same degree they would be compensable on the main premises).

[3] Cheryl T. Torko, 48 Van Natta 227 (1996) (head/neck injury sustained after walking into a mirror on another employee's vehicle not compensable, as it did not arise from an employer-controlled hazard), and Margaret Scott, 47 Van Natta 938 (1995) (eye injury sustained after walking into a pillar in the employer's parking lot not compensable, as it did not arise from a hazard over which the employer had control), relied upon by SAIF, were decided before SAIF v. Marin, supra. In light of the court's holding in Marin, the reasoning expressed in Torko and Scott would appear to be in question.

Claimant is entitled to an attorney fee for her counsel's 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 assessed attorney fee for claimant's counsel's services on Board review is $1,000, to be paid 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 October 20, 1995 is affirmed. For services on Board review, claimant's counsel is awarded $1,000, to be paid by the SAIF Corporation.

Board Member Haynes dissenting.

I do not agree with the majority's conclusion that claimant's injury occurred in the course and scope of her employment. Consequently, for the following reasons, I dissent from the majority opinion.

First, I disagree with the majority's reliance on the court's decision in Marin, supra. Although the court discussed an example of a claimant injured during "normal ingress and egress" to and from work, those were not facts before the court in Marin. Consequently, any discussion of such facts equates to dicta and should not be relied on to reach a decision in this case.

Additionally, it is important to note that the court suggested only that walking through a parking lot after work "could be viewed as a condition of claimant's employment." Id at 525. (Emphasis added). Consequently, the majority's interpretation of the court's statement as a holding that such conditions of employment would be found within the course and scope of employment is not entirely accurate.

Moreover, an analysis which inquires merely whether claimant was walking through an employer-owned parking lot when injured disregards the Court's holding in Norpac Foods, Inc., v. Gilmore, supra. In Norpac, the Court indicated that injuries occurring in employer-controlled parking lots were not "per se" compensable. In Norpac, the Court held that "the mere fact that an injury occurs in a parking lot that is owned and maintained by an employer when an employee is going to and coming from the employee's regular place of employment does not, in and of itself, establish compensability . . . Claimant's injury must also 'arise out of' the employment, i.e., some causal connection must be demonstrated." Id at 369.

Here, the majority's analysis addresses the "time, place, and circumstances of the injury," as it is uncontroverted that the accident occurred in the employer's parking lot while claimant was on her way to work. However, the majority's failure to address the required causal connection between the injury and claimant's employment ignores the Court's directive in Norpac. The majority has failed to identify a hazard associated with the parking lot, such as poor design or excessive speeding, over which the employer exercised control. Consequently, the only "causal connection" demonstrated in this case is the fact that the employer owned the parking lot. According to the Norpac Court, that is not sufficient.

Finally, I believe that, if a remedy exists for this claimant, it does not lie within the workers' compensation system. Because the majority's decision is inconsistent with caselaw, and because it effectively penalizes the employer for providing a parking lot for its workers, I respectfully dissent.

In the Matter of the Compensation of
ELIZABETH B. BERNTSEN, Claimant
WCB Case No. 94-15614
ORDER ON REVIEW
Schneider, Hooton, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board en banc.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Johnstone's order that: (1) set aside its denial of claimant's mid back condition as invalid; (2) awarded an assessed attorney fee of $3,500 for prevailing against the insurer's denial; and (3) awarded a penalty for the insurer's allegedly unreasonable classification of claimant's condition. The insurer also contends that the order should be modified to uphold its denial of claimant's low back problems and to clarify the time loss issue. 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 except for the ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. Claimant experienced mid to upper back pain in April 1994 due to an uncomfortable work station. Claimant left work on April 7, 1994 because of back pain. On April 11, 1994, she sought treatment from Dr. Miller, who diagnosed "thoracic level back strain." (Ex. 2). On May 23, 1994, the insurer accepted a nondisabling mid back strain. (Ex. 6).

Claimant continued to have back pain from April to October 1994. On October 27, 1994, Dr. Puziss diagnosed dorsal lumbar muscle strain. (Ex. 7).

On December 13, 1994, the insurer denied the claim for current treatment of claimant's mid and low back condition on the ground that insufficient evidence existed that her current back condition was the result of her April 1994 injury. (Ex. 10). Claimant requested a hearing.

On April 10, 1995, claimant requested reclassification of her back condition as disabling. A Determination Order issued on May 10, 1995, ordering the claim classified as "disabling." (Ex. 12).

At hearing, claimant challenged the insurer's denial of her mid back condition, but did not contest its denial of her low back condition. Claimant argued that the denial was a procedurally invalid preclosure denial. The insurer contended that its current condition denial was valid under ORS 656.262(6) and ORS 656.262(7).

The ALJ found that there was no evidence that claimant's April 1994 mid-back strain combined with a preexisting condition. The ALJ reasoned that neither ORS 656.262(6)(c) nor ORS 656.262(7)(b) applied since those statutes applied to combined or consequential conditions. Relying on Roller v. Weyerhaeuser Co., 67 Or App 583, mod 68 Or App 743, rev den 297 Or 124 (1984), the ALJ concluded that the insurer's denial of claimant's mid back condition was procedurally improper and invalid.

The insurer argues that its denial was valid, under both the former law and the 1995 amendments. The insurer contends that the ALJ erred by concluding that the claim was still open when the denial was issued on December 13, 1994. According to the insurer, the claim was still classified as nondisabling at the time the denial issued and, when issued, it was appropriate.

We are not persuaded by the insurer's argument. The fact remains that, at the time of the hearing, a Determination Order had issued and ordered the claim reclassified as "disabling." (Ex. 12). Thus, the insurer's denial issued before closure of claimant's disabling injury claim, and, therefore, the insurer's denial was a preclosure denial of claimant's current back condition. The question remains whether the denial was valid.

The parties do not dispute that ORS 656.262(6)(c) and ORS 656.262(7)(b) apply retroactively in general. See Volk v. America West Airlines, 115 Or App 565, 572-73 (1995) (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). In fact, section 66(5)(b) of Senate Bill 369 specifically provides that the amendment to ORS 656.262(6) creating new paragraph (c) applies to all claims without regard to any previous order or closure. Or Laws 1995, ch 332, § 66(5)(b). Nevertheless, claimant argues that ORS 656.262(6)(c) and ORS 656.262(7)(b) do not apply to the facts in this case.

Before the effective date of Senate Bill 369, an insurer could not deny further responsibility for any condition arising from the accepted claim while the claim was in open status and before the extent of the accepted condition had been determined pursuant to the statutory procedures for claim closure. In United Airlines, Inc. v. Brown, 127 Or App 253, rev den 319 Or 572 (1994), the court affirmed a Board order which held that a carrier's "resultant condition" denial under ORS 656.005(7)(a)(B) did not entitle the carrier to discontinue a claimant's temporary disability on an open claim. The carrier argued that the claimant's preexisting degenerative disease was the major contributing cause of her disability, and, therefore, its denial was procedurally valid. The court disagreed, finding nothing in the text or context of ORS 656.005(7)(a)(B) to suggest that the legislature intended that provision to provide a carrier with the procedural authority to deny an accepted claim. Consequently, the court held that if a carrier concludes that the compensable injury is no longer the major contributing cause of the disability or need for treatment, the appropriate procedure is claim closure under ORS 656.268. See also Sheridan v. Johnson Creek Market, 127 Or App 259 (1994).

In 1995, the legislature added ORS 656.262(6)(c) and ORS 656.262(7)(b). ORS 656.262(6)(c) provides:

> "An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

ORS 656.262(7)(b) provides: "Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

In Marianne L. Sheridan, 48 Van Natta 908 (1996) (on remand), we held that a carrier's "pre-closure" denial was appropriate under amended ORS 656.262(7)(b). Prior to closure of her accepted right elbow chipped bone injury claim, the carrier issued a denial of the claimant's current elbow condition on the basis that the injury was no longer the major contributing cause of that condition. Relying on amended ORS 656.262(7)(b), we determined that, since the carrier's denial was based on the presence of a preexisting elbow condition and the provisions of ORS 656.005(7)(a)(B), it was procedurally proper, even though it was issued prior to a valid claim closure. Turning to the merits of the carrier's denial, we were persuaded by the opinion of the claimant's former treating surgeon that her compensable elbow injury "combined" with the preexisting loose body to cause her disability and need for treatment. Moreover, based on the surgeon's opinion, we concluded that the preexisting loose body or related cartilage damage / arthritic changes (rather than the compensable injury) were responsible for the claimant's current right elbow condition.

Here, the insurer denied the claim for current treatment and disability in connection with claimant's mid and low back condition on the ground that insufficient evidence existed that her current back condition was the result of her April 1994 injury. (Ex. 10). Unlike in Marianne L. Sheridan, supra, the insurer's denial was not based on the presence of a preexisting condition or the provisions of ORS 656.005(7)(a)(B). Therefore, we must decide whether ORS 656.262(6)(c) and ORS 656.262(7)(b) apply to the denial in this case, which was not based on a combined or consequential condition.

In interpreting ORS 656.262(6)(c) and ORS 656.262(7)(b), we must begin with an examination of the text and context of the statutes. PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993). The context includes other statutes relating to the same subject matter. Id. at 611. If those sources do not reveal legislative intent, we resort to legislative history and other extrinsic aids. Id. at 611-12.

ORS 656.262(6)(c) provides that a carrier's acceptance of a "combined or consequential condition" shall not preclude the carrier from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition. By its terms, ORS 656.262(6)(c) applies only to situations involving a "combined or consequential condition." Under ORS 656.005(7)(a)(B), a "combined condition" exists when a compensable injury combines with a preexisting condition to cause or prolong disability or a need for treatment. A "combined condition" is compensable "only if, so long as and to the extent that the otherwise compensable injury remains the major contributing cause" of the disability or need for treatment of the combined condition. Under ORS 656.005(7)(a)(A), a "consequential condition" exists when an injury or disease is a consequence of a compensable injury.

In contrast, ORS 656.262(7)(b) applies only to situations involving a "combined condition." ORS 656.262(7)(b) provides that, after acceptance, 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.

Thus, the unambiguous language of ORS 656.262(6)(c) indicates that it applies only to situations involving a "combined or consequential condition." See James M. King, 47 Van Natta 1563 (1995) (since the claimant's coronary artery disease did not combine with any other preexisting condition or disease, ORS 656.262(6)(c) did not apply); Ronald L. Ledbetter, 47 Van Natta 1461 (1995) (same with regard to the claimant's osteomyelitis condition). Similarly, ORS 656.262(7)(b) applies only to combined conditions.[1] Therefore, ORS 656.262(6)(c) and ORS 656.262(7)(b) do not apply to denials that were not based on either combined or consequential conditions.

Although we need not consider the legislative history, it supports the conclusion that ORS 656.262(6)(c) applies only to situations involving a combined or consequential condition. On February 1, 1995, Jerry Keene, a workers' compensation insurance defense attorney and drafter of some of Senate Bill 369's text, testified before the Senate Labor and Government Operations Committee:

> "Subsection 6 C [of ORS 656.262] overturns Sheridan v. Johnson Creek and United Airlines v. Brown and allows for an insurer to issue a denial on open claims involving resultant conditions where the work injury component of the claim is no longer the major contributing cause of the resultant condition." Tape Recording, Senate Labor and Government Operations Committee, February 1, 1995, Tape 19, side A.

Both United Airlines, Inc. v. Brown, supra, and Sheridan v. Johnson Creek Market, supra, involved "resultant condition" denials under ORS 656.005(7)(a)(B). We note that the 1995 legislature changed the term "resultant condition" in amended ORS 656.005(7)(a)(B) to "combined condition." The legislative history for ORS 656.262(6)(c) evinces an intent to legislatively overrule United Airlines, Inc. v. Brown, supra, and Sheridan v. Johnson Creek Market, supra. However, there is no indication from the plain language of ORS 656.262(6)(c) or the legislative history that the statute was intended to apply to cases that did not involve either a combined or consequential condition. There is no indication that the legislature intended to legislatively overrule Roller v. Weyerhaeuser Co., supra, or to apply the statute to accepted conditions that are not "combined" or "consequential." Therefore, we agree with the ALJ that, for cases that do not involve combined or consequential conditions, Roller v. Weyerhaeuser Co., supra, remains good law. Since the insurer's denial in this case was not based on the presence of a preexisting condition or the provisions of ORS 656.005(7)(a)(B), ORS 656.262(6)(c) and ORS 656.262(7)(b) do not apply.

Furthermore, we reject the insurer's argument that the ALJ erred by concluding that there was no evidence of a combined condition. Dr. Miller examined claimant on April 11, 1994 and diagnosed thoracic level back strain. (Ex. 2). On May 5, 1994, Dr. Miller reported that he had obtained no history of any preexisting pathology that would have contributed to claimant's need for treatment. (Ex. 5). Dr. Miller concluded that the major contributing cause of claimant's need for care was the back strain she sustained at work.

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[1] We note that ORS 656.262(6)(c) refers to both combined and consequential conditions and ORS 656.262(7)(b) refers only to combined conditions. Since this case does not involve either a combined or consequential condition, it is not necessary for us to address that distinction.

Claimant was examined by Dr. Puziss on October 27, 1994. Dr. Puziss reported that claimant had noticed pain in April 1994 when she was doing data entry and would sit in the secretary's chair. (Ex. 7). Dr. Puziss reported that claimant had pain and stiffness in the upper to lower back without radiation into extremities. Dr. Puziss diagnosed a dorsal lumbar muscle strain. Dr. Puziss commented that claimant "has had some mid to lower back pains since early 1980's that always resolved with exercise." (Id.) Dr. Puziss noted that an x-ray showed "scoliosis with mild Grade I rotation concave to the right." (Id.)

According to the insurer, a later report from Dr. Puziss "clearly shows" that claimant's condition combined with preexisting problems. In a "check-the-box" letter from claimant's attorney, Dr. Puziss was asked whether he believed that claimant's April 8, 1994 injury was the major contributing cause of the dorsal lumbar muscle strain. (Ex. 11A). Dr. Puziss commented that he did "not know the major contributing cause of her dorsal strain." (Id.)

We do not agree with the insurer that Dr. Puziss' comment that he did not know the major contributing cause of claimant's dorsal strain establishes that claimant had preexisting problems that combined with her current injury. To the contrary, Dr. Puziss commented in an earlier report that claimant had had some back pains since the early 1980's, but they had always resolved. If anything, Dr. Puziss' earlier comment that claimant's previous back pains had always resolved indicates that any preexisting conditions did not combine with her work injury to cause her current disability or need for treatment. Furthermore, although Dr. Puziss commented that the x-rays showed scoliosis, there is no indication from his report that the scoliosis combined with the work injury.

Dr. Miller is the only physician who commented as to whether claimant had a preexisting condition that combined with her work injury. (Ex. 5). We are persuaded by Dr. Miller's report that claimant had no preexisting pathology that contributed to her need for treatment. Dr. Miller's report is also supported by Dr. Puziss' report that claimant's preexisting back pains had always resolved with exercise. We agree with the ALJ that claimant's April 1994 injury did not combine with a preexisting condition to cause her current disability or need for treatment. Therefore, we agree with the ALJ's conclusion that neither ORS 656.262(6)(c) nor ORS 656.262(7)(b) apply to this case.

The next question is whether Roller applies to the facts in this case. In Roller, the carrier was found responsible for the claimant's diabetes condition. Subsequently, it attempted to deny future responsibility for the same condition before determining the extent of the claimant's disability. The court held that a carrier may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of the accepted condition has been determined pursuant to the statutory procedures for claim closure. The court found that to permit a carrier to attempt to terminate future responsibility for an accepted claim by means of a preclosure partial denial was "tantamount to authorizing it to bypass a hearing on the extent of a claimant's disability and could preempt the resolution of an issue that is involved in determining the extent of disability." Id. at 586.

In contrast, there is no prohibition against issuing a preclosure partial denial of a condition separate from the accepted condition. Johnson v. Spectra Physics, 303 Or 49, 57- 58 (1987); Tattoo v. Barrett Business Service, 118 Or App 348, 353-54 (1993) (carrier may issue a partial denial of an unrelated condition while an accepted claim is in open status). See also ORS 656.262(7)(a) (carrier may issue a denial of a new medical condition).

In Zora A. Ransom, 46 Van Natta 1287 (1994), the employer issued a denial of the claimant's current low back strain condition two days prior to the claim closure. Because the medical evidence from the claimant's attending physician "unequivocally" indicated that the claimant's current low back strain condition was not related to the accepted low back strain, we upheld the employer's preclosure denial.

Here, unlike Ransom, the medical evidence indicates that claimant is seeking treatment for the same condition as her accepted condition. As we mentioned earlier, claimant experienced mid to upper back pain in April 1994 due to an uncomfortable work station. On April 11, 1994, she sought treatment from Dr. Miller, who diagnosed "thoracic level back strain." In claimant's "801" form, she described pain spreading up her back and pain in her neck and shoulders. (Ex. 3). The insurer accepted a nondisabling mid back strain. (Ex. 6).

After claimant's April 1994 injury, she continued to have problems in the same area and she attributed the pain to her April 1994 injury. (Tr. 13, 14). Claimant's pain varied from about an inch above the waist up through the shoulder, but it had a tendency to settle in the mid-back area. (Id.)

On October 27, 1994, she sought treatment from Dr. Puziss, who reported that claimant had noticed pain in April 1994 when she was doing data entry and would sit in the secretary's chair. (Ex. 7). Dr. Puziss reported that claimant had pain and stiffness in the upper to lower back without radiation into extremities. According to Dr. Puziss' report, claimant had tried different jobs but had to quit because of pain. Dr. Puziss diagnosed a dorsal lumbar muscle strain.

Based on the medical reports and claimant's testimony, we conclude that claimant's current mid back condition is the same condition as the accepted mid back condition. Claimant is not seeking treatment for a new injury or condition different from her accepted claim, nor does the medical evidence establish the existence of a new or different condition requiring medical treatment. See Elsa S. Wang, 48 Van Natta 444, 445 n1 (1996); Elva M. McBride, 46 Van Natta 2206 (1994).

The insurer denied the claim for current treatment of claimant's mid and low back condition on the ground that insufficient evidence existed that her current back condition was the result of her April 1994 injury. Based on Roller v. Weyerhaeuser Co., supra, a carrier may not deny further responsibility for any condition arising from the accepted claim while the claim is in open status and before the extent of the accepted condition has been determined pursuant to the statutory procedures for claim closure. Since claimant's current mid back condition is the same condition as the accepted mid back condition and her claim is not yet closed, we conclude that the insurer's December 13, 1994 partial denial with respect to claimant's mid back condition was an invalid preclosure denial of an accepted condition and must be set aside.

Denial of Low Back Condition

Although the ALJ found that claimant did not contest the insurer's denial of claimant's low back condition, the ALJ did not uphold the portion of the insurer's denial concerning the low back condition. On review, claimant does not dispute the ALJ's finding that she did not contest the insurer's denial of the low back condition. Under these circumstances, we agree with the insurer that the ALJ's order should be modified to uphold the insurer's denial of claimant's low back condition.

Penalty for Unreasonable Classification

The ALJ found that the insurer's classification of claimant's claim as nondisabling was unreasonable and assessed a penalty. The insurer argues that the classification was not unreasonable. Based on the information available to the insurer when it issued the May 23, 1994 acceptance and nondisabling classification, we agree.[2]

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).

The issue in this case is whether the insurer's nondisabling classification was unreasonable at the time of the classification, i.e., on May 23, 1994. ORS 656.005(7)(c) provides that an injury is not disabling if no temporary disability benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury.

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[2] Our review is solely confined to the issue of whether, based on the information available at the time, the insurer's claim processing decision to classify claimant's injury claim as nondisabling was unreasonable. Thus, in conducting our review, we are neither authorized to determine whether claimant's injury claim was subsequently properly found to be disabling or to address claimant's entitlement to temporary disability.

Here, when claimant saw Dr. Miller on April 11, 1994, his report indicated that claimant was to remain off work until the next visit, which was scheduled for April 15, 1994. (Ex. 2). In a letter to the insurer dated May 5, 1994, Dr. Miller commented that he had allowed claimant to be off duty for four days, but he explained later events:[3]

> "In the interim, the work place faxed a note to our office stating that there would be very light duty available and, upon review of that, the physician on duty felt that this work description would be applicable for the patient. The patient was quite upset to hear about this and returned to the clinic on 4/14/94 for re-examination by Dr. Herbst. In his notes on that date, it is obvious that the patient was extremely upset and argumentative and felt that return to work was unreasonable. His examination notes reveal no marked objective evidence of injury. She was indeed released to light duty as well as recommendation for physical therapy. She was asked to return to clinic on 4/21/94, however, she failed to keep that appointment. I have, therefore, no follow-up for you after the 4/14 date." (Ex. 5).

The insurer accepted a nondisabling mid back strain on May 23, 1994. (Ex. 6).

Given the equivocal nature of Dr. Miller's report, we conclude that at the time it accepted claimant's claim as nondisabling, the insurer had a legitimate doubt with regard to whether temporary disability benefits were due and payable. This is particularly true in light of ORS 656.210(3) which provides that no temporary disability benefits are due the first three calendar days after a worker leaves work as the result of the compensable injury unless the worker is totally disabled for 14 consecutive days. Under these circumstances, the insurer's classification of claimant's claim as nondisabling was not unreasonable. Consequently, a penalty is not warranted.

Attorney Fee

The ALJ awarded claimant an assessed fee of $3,500 for prevailing against the insurer's denial. The insurer argues that the attorney fee was excessive, particularly since claimant did not prevail over the insurer's denial of claimant's low back condition. We find the ALJ's award to be reasonable.

After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing regarding the compensability of claimant's mid back condition is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), 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 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the compensability of claimant's mid back 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 and request for fees therein), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee award for services devoted to the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233, rev den 302 Or 35 (1986).

ORDER

The ALJ's order dated October 20, 1995, as corrected November 8, 1995, is reversed in part and affirmed in part. That portion of the ALJ's order assessing a penalty for the insurer's unreasonable claim misclassification is reversed. The portion of the insurer's denial concerning claimant's low back condition is reinstated and upheld. The remainder of the ALJ's order is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the insurer.

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[3] We note that claimant testified that the employer called her on April 13, 1994 and told her she was released to work. (Tr. 11). Claimant also testified that she saw a physician the following day who released her to light work. (Tr. 16, 17).

Board Chair Hall concurring in part and dissenting in part.

I agree with the majority's decision except for the portion of the order that declines to assess a penalty for an unreasonable classification of the claim. Accordingly, I dissent from that portion of the majority's decision.

I agree with the ALJ that claimant is entitled to a penalty for the unreasonable classification of the claim as nondisabling. Dr. Miller's April 11, 1994 report stated that claimant was to remain off work until the next visit, which was scheduled for April 15, 1994. (Ex. 2). There is no evidence in the record that claimant was released to return to work. Although there is hearsay evidence that Dr. Herbst found claimant capable of performing a light duty job, there is no evidence that Dr. Herbst actually released claimant to light duty work. ORS 656.262(4)(f) provides, in part: "Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability * * *." Here, there is no evidence that claimant's attending physician ceased to authorize temporary disability. The second-hand reference to Dr. Herbst's alleged authorization in Dr. Miller's May 5, 1994 report is not sufficient to negate or call into doubt Dr. Miller's April 11, 1994 authorization for time loss.

Moreover, there is no evidence in the record that, at the time of the claim classification, the employer ever actually offered claimant light duty work. Even if claimant was entitled to temporary partial disability as a result of a release to modified work, the claim should have been classified as disabling.

In light of Dr. Miller's time loss authorization, claimant's claim should have originally been classified as disabling. In the absence of a release for work and an offer of light duty employment consistent with the work release, the insurer was required to begin the payment of temporary disability compensation. The insurer did not do so, and despite its obligations, reported the claim as nondisabling. The insurer did not have a legitimate doubt with regard to whether temporary disability benefits were due and payable. Therefore, the insurer's misclassification of the claim was unreasonable and a 25 percent penalty is appropriate. ORS 656.262(11)(a).

For these reasons, I respectfully dissent from that portion of the decision which declines to assess a penalty for an unreasonable classification of the claim.

June 19, 1996 Cite as 48 Van Natta 1225 (1996)

In the Matter of the Compensation of
CHARLES L. CARSLEY, Claimant
WCB Case Nos. 95-03850 & 95-03849
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Hartford Insurance Company[1] requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) set aside its denial of claimant's occupational disease claim for his right carpal tunnel condition; (2) upheld the SAIF Corporation's denial of claimant's claim for the same condition; and (3) awarded claimant an assessed attorney fee, payable by Hartford. On review, the issues are compensability, responsibility and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

We adopt the ALJ's Conclusions of Law and Opinion on the issues of compensability and responsibility. We add the following supplementation.

[1] In the ALJ's Opinion and Order, Hartford is referred to as "Twin City."

On review, Hartford first argues that the ALJ erred in finding that claimant's symptoms first began after he started working for Volt, Hartford's insured. Hartford points out that, at the time he was examined by Dr. Tesar, claimant informed Tesar that his carpal tunnel symptoms may have begun prior to his employment with Volt. (Ex. 11-7). At hearing, however, claimant testified that his symptoms first began after he started working for Volt (Payless). (Tr. 21). In light of the ALJ's finding regarding claimant's credibility, which we accept, we conclude that claimant's symptoms first began while claimant was working for Hartford's insured.

Hartford also contends that the ALJ erred in relying on the opinion of Dr. Strukel, SAIF's expert. Hartford argues that it supplied the ALJ with several cases which support the proposition that one week of work cannot be the major contributing cause of a carpal tunnel syndrome condition.

We reject Hartford's argument concerning the medical evidence. First, we have adopted the ALJ's order, which provides several reasons for finding Dr. Strukel's opinion to be the most persuasive medical opinion in the record. Moreover, the cases cited by Hartford do not establish legal precedent that a brief work exposure cannot ever be the cause of a carpal tunnel syndrome. Rather, such cases only discuss the persuasiveness of specific medical opinions that were rendered on facts and a record regarding a particular worker. Therefore, we do not find such cases to be of assistance in determining either legal or medical causation in this case. See e.g. Giesbrecht v. SAIF, 58 Or App 218 (1982) (Contribution of one expert's opinion to the preponderance of evidence in one workers' compensation case has no bearing on relative weight in another case concerning the same disease).

Finally, Hartford argues that if the claim is compensable, the assessed attorney fee should be split between itself and SAIF, as both denied compensability. Hartford disagrees with the ALJ's finding that its March 14, 1995 denial was a denial of both compensability and responsibility. However, regardless of whether the March 14, 1995 denial solely denied responsibility, Hartford denied compensability at the time of hearing and continues to contest compensability on review. Specifically, in its Appellant's Brief Hartford states that it did not "at hearing or now concede compensability." App. Brief, pg. 2.

Consequently, because of the fact that Hartford did not concede compensability, claimant's compensation was at risk at the time of hearing. Accordingly, we conclude that the ALJ correctly assessed the attorney fee solely against Hartford, who was found responsible for the claim. See e.g. Rita R. Lovelace, 47 Van Natta 167 (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 regarding the denial issue is $1,000, payable by Hartford. In reaching this conclusion, we have particularly considered the time devoted to the issues (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved. Claimant is not entitled to an attorney fee for services on review regarding the attorney fee issue. Dotson v. Bohemia, Inc., 80 Or App 233 (1986).

ORDER

The ALJ's order dated November 14, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,000, to be paid by Hartford.

Board Chair Hall dissenting in part.

I agree with the majority's opinion with respect to the issues of compensability, responsibility and attorney fees. In affirming the order of the ALJ, however, the majority also affirms that portion of the ALJ's order which upheld SAIF's denial in its entirety.

On review, Hartford correctly notes that, in this case, SAIF issued denials of both compensability and responsibility. Claimant has prevailed on the issue of compensability. Only that portion of SAIF's denial which denied responsibility should be upheld. Therefore, for our order to be accurate and consistent with the finding and conclusions within the opinion and order (which we have adopted), both Hartford and SAIF's denials of compensability should be set aside.

I raise this concern with the majority's opinion as I can see no valid reason to reject Hartford's request that the ALJ's order be modified for the sake of consistency. Furthermore, I believe that, for purposes of future litigation, it is important that the ALJ's order and the Board's order accurately reflect the fact that claimant prevailed over Hartford and SAIF's denials of compensability. For these reasons, I respectfully dissent from the majority's opinion.

In the Matter of the Compensation of
DANNY B. CONNER, Claimant
WCB Case No. 94-01980
ORDER ON REMAND
James L. Edmunson, Claimant Attorney
Zimmerman, Rice, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Conner v. Connecticut Indemnity Co., 139 Or App 421 (1996). In our prior order, Danny B. Conner, 47 Van Natta (1995), we reversed that portion of the Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's degenerative lumbar disc disease. The court has remanded for reconsideration in light of amended ORS 656.005(7)(a)(B) and 656.005(24).

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

In January 1993, claimant injured his back. The insurer accepted a claim for lumbar contusion. In January 1994, the insurer partially denied compensability of degenerative disc disease.

Applying former ORS 656.005(7)(a)(B), the ALJ set aside the insurer's denial. On review, we agreed with the application of former ORS 656.005(7)(a)(B). Danny B. Conner, supra. Based on medical opinion, the Board further concluded that claimant had carried his burden with regard to his condition before April 18, 1994, but had not proved compensability of his need for treatment after that date. Id. Thus, we reinstated and upheld the insurer's denial for treatment after April 18, 1994.

Noting that the parties agree that the case is governed by ORS 656.005(7)(a)(B), the court found that "the Board's determination of the compensability of claimant's degenerative condition" could be affected by amended ORS 656.005(7)(a)(B)[1] and 656.005(24).[2] Conner v. Connecticut Indemnity Co., supra. Thus, the court remanded for reconsideration in light of the statutes. Id. Pursuant to the court's mandate, we now proceed with our reconsideration.

Claimant has an accepted claim for lumbar contusion as a result of a January 1993 work injury. Claimant also has degenerative disc disease that preexisted the January 1993 injury. Inasmuch as the degenerative condition is a "disease" that preceded the compensable injury, it qualifies as a "preexisting condition." Amended ORS 656.005(24). Under amended ORS 656.005(7)(a)(B), when the compensable injury combines with a preexisting condition, the claimant must prove that the compensable injury is the major contributing cause of the "combined condition." Charles L. Grantham, 48 Van Natta 1094 (1996).

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[1] 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."

[2] ORS 656.005(24) defines "preexisting condition" 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, or that precedes a claim for worsening pursuant to ORS 656.273."

We continue to find that, at least initially, claimant's compensable lumbar strain combined with his preexisting degenerative disc disease. (Exs. 27, 28-2, 39-1, 40-4, 41). Thus, in order to prove compensability, claimant must show that the compensable injury is the major contributing cause of the "combined condition." We continue to conclude that claimant carried his burden of proof, at least with regard to his treatment through April 8, 1994,[3] since Dr. Parsons, claimant's treating physician, indicated that claimant's need for treatment and disability was in major part caused by the industrial injury. (Ex. 39-1).

The record, however, also shows that, by April 8, 1994, claimant's compensable lumbar strain had resolved and claimant's continuing symptoms were due only to the preexisting degenerative disc disease. (Exs. 35, 39-1, 41). Under amended ORS 656.005(7)(a)(B), the "combined condition" is compensable "so long as" the compensable injury is the major contributing cause of the "combined condition." Based on the evidence that claimant's compensable injury had resolved, it appears that there was no "combined condition" after April 8, 1994. Furthermore, even assuming the continuing existence of a "combined condition," there is insufficient proof that the compensable injury was the major contributing cause.

Consequently, we continue to conclude that claimant proved compensability of his condition through April 8, 1994. Amended ORS 656.005(7)(a)(B). Therefore, on remand, as supplemented herein, we republish our April 15, 1995 order.

IT IS SO ORDERED.

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[3] Our previous order incorrectly referred to a date of April 18, 1994.

In the Matter of the Compensation of
IVAN E. DAME, Claimant
WCB Case No. 94-11031
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 that portion of Administrative Law Judge (ALJ) Poland's order that affirmed an Order on Reconsideration that had awarded claimant no temporary disability benefits beyond his medically stationary date. On review, the issue is temporary disability.

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

Claimant asserts that, based on arguments that we rejected in Soledad Flores, 43 Van Natta 2504 (1991), and Jimmy G. Clark, 45 Van Natta 2308 (1993), he is entitled to temporary disability compensation through the date of claim closure. Relying on PGE v. Bureau of Labor and Industries, 317 Or 606 (1993), claimant asserts that, in Flores, we improperly considered the legislative history to interpret former ORS 656.268's provisions regarding a worker's entitlement to continued temporary disability payments. We disagree.

In PGE v. Bureau of Labor and Industries, supra, the court said that, if, but only if, the legislature's intent is not clear from a statute's text and context will it consider legislative history. 317 Or at 611. Here, claimant has presented no analysis to establish that the text and context of the provisions of former ORS 656.268 at issue in Flores clearly revealed the legislature's intent. Lacking such analysis, we decline to revisit our holding in that case or in Jimmy G. Clark, supra, which was based on Flores.

Next, claimant asserts that ORS 656.268(3)(d)[1] eliminates the distinction between procedural and substantive entitlement to temporary disability benefits. Therefore, he asserts, he is entitled to temporary disability payments through the date of claim closure. We disagree.

Since claimant's claim is closed, the issue in this case is his substantive entitlement to temporary disability benefits. Substantive entitlement to temporary disability benefits, which is codified by ORS 656.210 and developed by case law, provides that temporary disability benefits are due for those periods during which the worker was disabled due to the compensable injury, prior to becoming medically stationary. See SAIF v. Taylor, 126 Or App 658 (1994); Lebanon Plywood v. Seiber, supra, 113 Or App at 653-54; Dorothy E. Bruce, 48 Van Natta 518, 519 (1996); Esther C. Albertson, 44 Van Natta 2058, 2059, aff'd Albertson v. Astoria Seafood Corporation, 116 Or App 241 (1992); Soledad Flores, supra. ORS 656.210 was not amended in 1990, nor was it amended in any way material to this analysis in 1995.[2] Therefore, we conclude that neither the 1990 nor the 1995 amendments to the Workers' Compensation Law had any effect on the principle that a worker is substantively entitled to temporary disability benefits only until the medically stationary date.

We also reject claimant's argument that ORS 656.268(3)(d), added by the legislature in 1995, requires a different result. ORS 656.268 addresses a claimant's entitlement to temporary disability compensation during an open claim; that is, his entitlement to procedural temporary disability compensation. Fazzolari v. United Beer Distributors, 91 Or App 592, 595 (1988); see also Thomas M. Aldrich, supra (holding that the 1990 version of ORS 656.268(3) applies to procedural entitlement to temporary disability benefits); Soledad Flores, supra, 43 Van Natta at 2506-08 (holding that 1990 amendments to ORS 656.268 did not eliminate distinction between procedural and substantive entitlement to temporary disability benefits).

The 1990 amendments to ORS 656.268, which in ORS 656.268(3) identified the specific conditions under which temporary disability benefits could be terminated while the claim remained open, did not eliminate the distinction between procedural and substantive entitlement to temporary disability benefits. See Jimmie G. Clark, supra, 45 Van Natta at 2309 n.1; Soledad Flores, supra. The 1995 legislature added ORS 656.268(3)(d), which merely provides another avenue for terminating procedural temporary disability benefits during an open claim. The legislative history cited by claimant in his opening brief indicates as much.[3] Thus, we find nothing in the 1995 amendments to ORS 656.268 that indicates an intention to eliminate the distinction between substantive and procedural entitlement to temporary disability benefits, and we conclude that amended ORS 656.268 continues to address a claimant's entitlement to procedural temporary disability benefits.

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[1] In his brief, claimant refers to ORS 656.268(3)(e), a nonexistent statute. Counsel for the self-insured employer consulted with claimant's counsel, who said that he had meant to refer to ORS 656.268(3)(d). (Employer's Respondents' Brief at 3 n 1). ORS 656.268(3)(d) provides that "[t]emporary 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 any other provisions of this chapter."

[2] The 1995 amendments to ORS 656.210 pertain to the rate of temporary disability compensation and the "three-day waiting period" prior to a worker's receipt of temporary disability benefits. Amended ORS 656.210(2), (3).

[3] Claimant cited Representative Mannix's remarks to the Senate Committee on Labor and Government, January 30, 1995, Tape 15B at approx. 210:

> "REP. MANNIX 656.268, sub (3)(e): Restates the conditions for terminating time loss or temporary disability. The reform bill in 1990 permitted the payment of benefits to be disallowed at claim closure. It didn't provide a procedural mechanism for those payments to be terminated at the time the conditions occurred. What happens, then, is you end up, procedurally, having to still pay the benefits. And later, when you close the claim, oh, gee, we knew all along we were overpaying; we had to overpay; we couldn't stop. This says, no, if you are aware that the event has occurred that allows you to eliminate the entitlement of temporary disability compensation, take the action at that time. Don't incur what is, in many cases, an automatic overpayment." (Appellant's Brief at 7-8).

Here, however, the issue is claimant's entitlement to substantive temporary disability benefits. ORS 656.268 does not pertain to that determination.[4] Therefore, we conclude that ORS 656.268(3)(d), added by the legislature in 1995, has no effect on the distinction between procedural and substantive entitlement to temporary disability benefits, nor does it require or authorize the payment of temporary disability benefits beyond the medically stationary date. In light of such circumstances, we concur with the ALJ's conclusion that claimant is not entitled to additional temporary disability benefits.

ORDER

The ALJ's order dated December 6, 1995 is affirmed.

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[4] ORS 656.268(2)(a) provides that, when an injured worker's condition resulting from an accepted disabling injury has become medically stationary, the carrier shall notify the Department and request examination of the claim. This examination includes a determination of any "further compensation." Id. Such a provision further confirms our conclusion that ORS 656.268 pertains to a carrier's "pre-closure" claim processing obligations regarding the payment of temporary disability subject to a final determination of a claimant's substantive right to such benefits following claim closure. See ORS 656.268(13).

In the Matter of the Compensation of
RANDY L. DARE, Claimant
WCB Case No. 95-09119
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board en banc.

The insurer requests review of Administrative Law Judge (ALJ) Odell's order that directed it to pay claimant's scheduled permanent disability award at the rate of $347.51 per degree. On review, the issue is rate of scheduled permanent disability. We affirm.

FINDINGS OF FACT

Claimant was compensably injured on February 25, 1987. A February 19, 1988 Determination Order issued awarded 5 percent scheduled permanent disability for his left forearm (wrist).

On January 25, 1989, a further Determination Order issued which awarded claimant additional permanent disability, for a total award of 42 percent for the left forearm (wrist) and 5 percent for the right forearm (wrist).

Pursuant to a September 3, 1992 Notice of Closure (NOC), claimant was subsequently awarded a total of 23 percent scheduled permanent disability for his right arm (forearm).

Following completion of an authorized training program, the claim was again closed by an April 26, 1995 NOC. Claimant was awarded a total of 34 percent scheduled permanent disability for his right arm and 26 percent for his left arm. Payment of the additional permanent disability was made at the rate of $125 per degree.

On May 11, 1995, the insurer issued another NOC which corrected the dollar amount of compensation due to claimant.

On July 17, 1995, claimant appealed the NOC and contested the rate at which his scheduled award was paid.

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that the 1995 amendments to ORS 656.214(2) applied to the case and, consequently, the April 26, 1995 increased scheduled permanent disability award should be paid at the rate of $347.51. We agree.

Prior to the enactment of SB 369, the law provided that scheduled permanent disability awards were to be paid at the rate of $305 per degree. Former ORS 656.214(2). The law applied to permanent disability awards for injuries occurring on or after May 7, 1990. SAIF v. Herron, 114 Or App 64 (1992). For injuries prior to May 7, 1990, permanent disability awards were paid at the rate in effect at the time of the worker's injury. Id at 74. Here, because claimant was injured in 1987, all of his permanent disability awards have been paid at the rate of $125 per degree, which was the rate in effect at the time of his injury.

Pursuant to SB 369, ORS 656.214(2) was amended to provide that:

> "When permanent partial disability results from an injury, the criteria for the rating of disability shall be the permanent loss of use or function of the injured member due to the industrial injury. The worker shall receive $347.51 for each degree . . . ."

The court has held that the new law applies retroactively, unless a specific exception has been provided. See Volk v. America West Airlines, 135 Or App 565 (1995). Section 66 of SB 369, the retroactivity section addressed by the court in Volk, provides:

> "Notwithstanding any other provision of law, this Act applies to all claims or causes of action existing or arising on or after the effective date of this Act, **regardless of the date of injury** or the date a claim is presented, and this Act is intended to be fully retroactive unless a specific exception is stated in this Act." (Emphasis added). Or Laws 1995, ch 332, § 66.

The insurer argues that ORS 656.202(2) offers a specific exception to the general rule of retroactive application of SB 369. The statute provides:

> "**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).

First, we note that the legislature carved out numerous exceptions to the general retroactivity provision of SB 369. Those exceptions provide for various operative and/or applicability dates for the affected amendments. Furthermore, in providing for the payment rate of permanent disability benefits, the legislature retained section 2, chapter. 745 of Oregon Laws 1991. With respect to scheduled permanent disability awards, this section provides, in part:

> Sec. 2 (1) "**Notwithstanding the method of calculating permanent partial disability benefit amounts provided in ORS 656.214(2), for injuries occurring during the period beginning January 1, 1992, and ending December 31, 1995**, the worker shall receive an amount equal to 71 percent of the average weekly wage times the number of degrees stated against the disability as provided in ORS 656.214(2) to (4)."
>
> "* * * * *
>
> "(3) Benefits referred to in this section shall be paid **on the basis of the benefit amount in effect on the date of injury**." (Emphasis supplied).

Consequently, the aforementioned section provides an example of an exception to the increased rate set forth in ORS 656.214(2), with respect to benefits paid for injuries occurring during the period beginning January 1, 1992 through December 31, 1995. That section is not applicable in this case, however, as claimant's injury occurred in 1987. Moreover, we find no specific exception that would exempt injuries occurring in 1987 from the retroactive application of SB 369, and the increased rate found in ORS 656.214(2).

The insurer argues that a separate statute, ORS 656.202(2), provides an exception to the retroactive application of amended ORS 656.214(2). We are unable to construe the statute in such a manner. As explained by the ALJ, ORS 656.202(2) mandates application of the law at the time of injury only where not "otherwise provided by law." However, amended ORS 656.214(2) does otherwise provide for the payment of benefits at the rate of $347.51.

Additionally, the insurer's interpretation of the statutory scheme would essentially require us to give effect to one statute over another, while ignoring the general retroactivity provision of SB 369 and the court's holding in Volk, supra. The insurer has not provided us with any authority for construing the statutory scheme in such a fashion.[1]

The insurer also argues that retroactive application of amended ORS 656.214(2) is contrary to the court's decision in SAIF v. Herron, supra. Although the insurer concedes that Herron addressed a different retroactivity provision, the insurer contends that the prior provision contained a reference to ORS 656.202. Because the court in Herron found that the legislature intended the date of injury rule of ORS 656.202 to apply to the 1990 amendment to ORS 656.214(2), the insurer argues that we should do so here. We disagree.

First, we note that the court in Herron resorted to an inquiry into the legislature's intent as it concluded that the 1990 retroactivity provision could be read in more than one way. However, the insurer has not argued that the applicable statutes in this case are unclear, nor do we find them to be ambiguous. Consequently, it is unnecessary to consider the legislative history as an aid in determining the intent of the legislature. See Satterfield v. Satterfield, 292 Or 780, 782 (1992).

Alternatively, even if the statute or statutes in this case are ambiguous, the insurer has not apprised of us any legislative history which would support its argument that the 1995 law providing for a higher rate of permanent disability was not intended to be applied retroactively. By contrast, in Herron, the court relied on several statements from legislators which indicated that the increase in scheduled permanent disability was to apply only to injuries occurring after the effective date of the Act. 114 Or App at 64. Moreover, our own inquiry into the legislative history of SB 369 does not reveal an intent to except the higher rate of permanent disability from the general retroactivity provisions of the new law.

Finally, as the ALJ pointed out, the retroactivity provision of the 1990 law is distinguishable from the current law. The 1990 retroactivity provision did make reference to ORS 656.214(2) and 656.202. However, as we have found above, the general retroactivity provision of the new law does not specifically refer to or except amended ORS 656.214(2) from its retroactive application.

Under the circumstances, we agree with the ALJ that the new law, ORS 656.214(2), provides for claimant's increased scheduled permanent disability benefits to be paid at the rate of $347.51 per degree. Accordingly, the ALJ's order is affirmed.

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

ORDER

The ALJ's order dated January 19, 1996 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $750, to be paid by the insurer.

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[1] The insurer argues that the Department's temporary rule, OAR 436-35-007(20) (renumbered OAR 436-35-007(28)), is helpful insofar "it demonstrates the director's understanding that pre-June 7, 1995 closures of 1987 injuries are subject to the statutory mandate of ORS 656.202(2)..." The Department's rule provides that:

> "ORS 656.214 provides the degree values to be given for permanent partial disability awarded pursuant to ORS 656.268. For injuries sustained prior to January 1, 1992, the dollar values per degree established in ORS 656.214, Section 17, chapter 332, Oregon Laws 1995 shall apply to any initial or additional permanent partial disability awarded on or after June 7, 1995. The dollar values per degree do not apply to any portion of a permanent partial disability award that is final by operation of law." OAR 436-35-007(28).

After reviewing the rule, we agree with claimant that the rule could also be construed to support claimant's position, as the rule does provide for certain awards to be paid at the higher rate, notwithstanding the date of injury. In any event, we conclude that, to the extent to which the rule may be inconsistent with the statute, it is not valid.

In the Matter of the Compensation of
WILLIAM L. FISCHBACH, Claimant
WCB Case Nos. 95-09551 & 94-06340
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller, Christian and Hall.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Stephen D. Brown's order that: (1) awarded claimant 3 percent (5.76 degrees) scheduled permanent disability for loss of use or function of the right arm, whereas an Order on Reconsideration had awarded none; and (2) awarded 5 percent (9.6 degrees) scheduled permanent disability for loss of use or function of the left arm, whereas another Order on Reconsideration had awarded no scheduled permanent disability. Claimant cross-requests review, contending that he is entitled to an additional unscheduled permanent disability award for his low back condition beyond the 25 percent (73.6 degrees) award granted by the Order on Reconsideration and the ALJ's order. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, and briefly summarize the pertinent facts as follows:

On November 25, 1991, claimant compensably injured his right elbow, right shoulder and low back when he fell off a ladder at work. He underwent right rotator cuff repair surgery in June 1992. Then, on June 11, 1993, claimant compensably injured his left shoulder. He had left shoulder surgery on March 8, 1994.

On April 22, 1994, Dr. Fitzsimmons performed an arbiter's examination in connection with the reconsideration of claimant's first claim, for the right elbow, right shoulder and low back injuries. A May 10, 1994 Order on Reconsideration awarded claimant a total of 23 percent (73.6 degrees) unscheduled permanent disability for the right shoulder and low back conditions, and no scheduled permanent disability.

In the second claim, a January 11, 1995 Determination Order awarded claimant 7 percent unscheduled permanent disability for his left shoulder condition. On reconsideration, the left shoulder award was increased 1 percent for a total of 8 percent unscheduled permanent disability, based on the findings of Dr. Smith's July 7, 1995 arbiter's examination.

Claimant's requests for hearing on the two reconsideration orders were consolidated.

CONCLUSIONS OF LAW AND OPINION

Scheduled Disability - Right Elbow

Relying on Dr. Fitzsimmons' notation that claimant's recent left shoulder surgery "inactivates the ability to use the left arm as a comparison tool," (Ex. 14-3) the ALJ measured claimant's right elbow flexion (140 degrees) against the hypothetical normal elbow flexion (150 degrees) and determined that claimant was entitled to a scheduled award of 3 percent for impairment of the right elbow. See former OAR 436-35-100(1).

On review, the insurer contends that there is no persuasive medical evidence establishing that claimant's subsequent left shoulder injury affected the movement in his left elbow joint, and therefore the ALJ erred in failing to evaluate claimant's right elbow impairment by comparing it to the contralateral elbow joint, as required by former OAR 436-35-007(16).[1] We agree.

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[1] This rule provides, in pertinent part: "The range of motion or laxity in the injured joint shall be compared to the contralateral joint except when the contralateral joint has a history of injury or disease. In such a case, the injured joint impairment shall be valued proportionally to the full motion of the contralateral joint, unless the contralateral joint motion exceeds the normals established under these rules. * * * When the contralateral joint does have a history of injury or disease, the injured joint shall be valued based upon the ranges of motion established under these rules."

In evaluating claimant's shoulders in connection with the reconsideration of claimant's right-sided injury claim, Dr. Fitzsimmons set forth claimant's right shoulder ranges of motion without recording left shoulder ranges of motion for comparison. It was in this context that Dr. Fitzsimmons reported that "the recent surgery on the left side inactivates the ability to use the left arm as a comparison tool." In evaluating claimant's elbows, however, Dr. Fitzsimmons specifically noted that claimant had "no complaints at all." Dr. Fitzsimmons set forth range of motion findings for both elbow joints and concluded that claimant had no loss of motion in his right elbow. He also reported that claimant's right elbow contusion had cleared.

After considering the pertinent medical evidence, we conclude there is no evidence of injury or disease to claimant's left elbow so as to preclude a comparison of that joint to the injured right elbow under former OAR 436-35-007(16). Since Dr. Fitzsimmons found no loss of motion in claimant's right elbow as compared to the uninjured contralateral joint, claimant is not entitled to a scheduled permanent disability award for the right arm. Consequently, we reverse the ALJ's 3 percent award.

Unscheduled Disability - Low Back

We adopt and affirm that portion of the ALJ's order finding that claimant has not established that he is entitled to an additional unscheduled permanent disability award for decreased lumbar range of motion.

Scheduled Disability - Left Arm

Based on Dr. Smith's report that claimant was limited in the repetitive use of his left arm in an overhead position, the ALJ found that claimant was entitled to a 5 percent scheduled permanent disability award for a chronic condition in his left arm, in addition to the 8 percent unscheduled permanent disability awarded on reconsideration for his left shoulder condition. In so finding, the ALJ relied upon Foster v. SAIF, 259 Or 86 (1971), and Alvena Peterson, 47 Van Natta 1331 (1995), which hold that a claimant is entitled to separate permanent disability awards where an injury to an unscheduled body part, such as a shoulder, also produces a loss of use or function to a scheduled body part, such as the arm.

The insurer argues on review that this case is distinguishable from SAIF v. Foster and Alvena Peterson because, here, claimant's inability to repeatedly use his arm overhead is simply a positional problem created by his left shoulder impairment, and not a separate condition of the left arm. We agree and reverse the ALJ's 5 percent award.

The medical arbiter did not report any arm symptoms flowing from claimant's left shoulder injury. Rather, the arbiter explained that claimant experienced uncomfortable snapping in the left shoulder with awkward motions and difficulty using his left arm overhead because of easy shoulder fatiguability. Because Dr. Smith did not identify any symptoms causing loss of function to claimant's left arm, we conclude that claimant is not entitled to a separate scheduled disability award for a chronic condition of a scheduled member.[2] See also Olds v. Superior Fast Freight, 36 Or App 673 (1978) (referred pain to legs from low back gives rise to entitlement to scheduled permanent disability).

ORDER

The ALJ's order dated December 13, 1995 is affirmed in part and reversed in part. Those portions of the order that awarded claimant 3 percent (5.76 degrees) scheduled permanent disability for loss of use or function of the right elbow and an "out-of-compensation" attorney fee are reversed. Those portions of the order that awarded a 5 percent (9.6 degrees) scheduled permanent disability award for loss of use or function of the left arm and an "out of compensation" attorney fee are also reversed. The remainder of the order is affirmed.

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[2] Because claimant's left shoulder injury left him with limited use of his left shoulder in an overhead position, he may well have a chronic condition of the left shoulder. The disability standards provide, however, that "[w]here the total unscheduled impairment within a body area is equal to or in excess of 5 percent, the worker is not entitled to any unscheduled chronic condition impairment." Former OAR 436-35-320(5)(a). Under this rule, claimant is not entitled to an unscheduled chronic condition award because his total unscheduled impairment for left shoulder is 8 percent.

Board Chair Hall dissenting in part.

Because I believe that claimant is entitled to a scheduled award for loss of use of his left arm, I respectfully dissent. The majority finds that this case is distinguishable from Foster v. SAIF, 259 Or 86 (1971) and Alvena Peterson, 47 Van Natta 1331 (1995) because claimant has not shown that he has symptoms, such as referred pain, originating from his left shoulder and extending into the left arm. The majority reasons that claimant cannot repetitively use his left arm overhead only because that arm is attached to the injured shoulder, which cannot take the repetitive use.

In Foster, the court held that "two awards should continue to be made in the situation where an injury to an unscheduled portion of the body results in disability to both scheduled and unscheduled portions." 259 Or at 91. Unlike the majority, I do not read this rule as being limited to those cases where the "disability" to the scheduled body part is referred pain from the injured unscheduled body part. While the Foster analysis is generally applied in such cases, I believe it is equally applicable to the situation where, as here, the injury to an unscheduled body part results in a loss of use of a scheduled body part. Indeed, in this case, even if claimant is not experiencing referred symptoms in his left arm because of his shoulder injury, he is still unable to repetitively use that arm in certain situations. Since scheduled permanent partial disability awards are measured by loss of use (see ORS 656.214), and claimant has established that the injury to his left shoulder has resulted in a loss of repetitive use of his left arm in an overhead position, I would affirm the ALJ's 5 percent award.

June 19, 1996 Cite as 48 Van Natta 1235 (1996)

In the Matter of the Compensation of
DEBBIE I. JENSEN, Claimant
WCB Case No. 95-05637
ORDER ON REVIEW
Goldberg & Mechanic, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Martha J. Brown's order that directed the employer to pay claimant temporary disability benefits from January 6, 1995 to January 10, 1995. Claimant contends that she is entitled to temporary disability benefits from July 30, 1993. On review, the issue is temporary disability. We modify.

FINDINGS OF FACT

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

In December 1993, Dr. Long prescribed physical therapy for claimant, which she attended in December 1993 and January 1994. (Ex. 25-1).

In April 1994, claimant returned to Dr. Long for continued treatment for her bilateral upper extremity problems. (Ex. 12; see also Ex. 14-2).

On November 9, 1994, Dr. Long advised that claimant had been unable to perform her regular work duties on the bacon line since May 1993 when she was first evaluated by Dr. Miller. (Ex. 17A-2).

Following her second carpal tunnel surgery in February 1995, claimant returned to Dr. Long for follow-up treatment. Dr. Long prescribed physical therapy. (Exs. 22, 23-2).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that Dr. Hill was claimant's attending physician, and that he first authorized temporary disability on January 20, 1995, retroactive to May 17, 1994 until further notice. The ALJ further found that, pursuant to amended ORS 656.262(4)(f), Dr. Hill's authorization was effective to retroactively authorize temporary disability benefits only 14 days prior to the issuance of the authorization on January 20, 1995. Thus, the ALJ concluded that claimant was entitled to temporary disability benefits from January 6, 1995 until January 10, 1995.[1]

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[1] The employer began paying temporary disability benefits on January 10, 1995. (Tr. 2).

We disagree with the ALJ's finding that only Dr. Hill was claimant's attending physician.[2] Instead, we find that, at least by November 1994, Dr. Long was claimant's attending physician. However, we agree with the ALJ that, pursuant to amended ORS 656.262(4)(f), the attending physician's time loss authorization is effective to retroactively authorize temporary disability only 14 days prior to its issuance. Accordingly, we conclude that claimant is entitled to temporary disability from October 26, 1994 to January 10, 1995, based on the following reasoning.

An "attending physician" is the physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b). Whether a physician qualifies as an "attending physician" is a question of fact. See Sharon A. Gambrel, 46 Van Natta 1881, 1884 n.2 (1994); Paula J. Gilman, 44 Van Natta 2539 (1992).

Here, claimant initially treated with Dr. Miller, who referred her to various specialists, including physiatrist Dr. Gambee. Claimant last treated with Dr. Gambee in September 1993. (Exs. 8, 9, 13).

In December 1993, claimant saw Dr. Long who evaluated her and prescribed physical therapy treatment. (Exs. 10, 25-1). When advised by the employer that she should return to "your doctor" if she needed further treatment, claimant returned to Dr. Long. (Ex. 12). Claimant returned to Dr. Long in April 1994, at which time Dr. Long referred her to Dr. Hill for a neurosurgical consultation. (Ex. 23-1). Dr. Button, who examined claimant at the employer's request in April 1994, noted that claimant was continuing under Dr. Long's care. (Ex. 14-2).

Dr. Hill performed bilateral carpal tunnel surgery in January and February 1995. (Exs. 18, 20). Dr. Hill authorized temporary disability due to the surgeries, but deferred to Dr. Long on the question of whether claimant had been disabled since May 1993. (Exs. 19, 21-2). Following her surgeries, claimant returned to Dr. Long for follow-up treatment, including physical therapy. (Exs. 22, 23-2). Under such circumstances, considering that Dr. Long treated claimant before and after her surgeries and referred her to Dr. Hill for a surgical consultation, and that claimant apparently regarded Dr. Long as her treating physician, we find that Dr. Long was primarily responsible for the treatment of claimant's compensable condition. Accordingly, we conclude that Dr. Long was claimant's attending physician at least by November 1994.

During an open claim, a claimant is entitled to procedural temporary disability only for those periods of time for which an attending physician has authorized temporary disability.[3] Amended ORS 656.262(4)(a), (f). In addition, amended ORS 656.262(4)(f) provides that an attending physician's authorization of temporary disability is effective to retroactively authorize temporary disability only 14 days prior to its issuance. See Delores L. Holmes, 47 Van Natta 2359, 2361 (1995).

The new law applies retroactively, unless a specific exception provides otherwise. Volk v. America West Airlines, 135 Or App 565 (1995). Here, we agree with the ALJ's determination that no specific exception applies. Or Laws 1995, ch 332, § 66 (SB 369, § 66); Delores L. Holmes, supra (retroactively applying amended ORS 656.262(4)(f)).

However, claimant contends, citing Section 66(6) of SB 369,[4] that amended ORS 656.262(4)(f) should not be applied retroactively because it involves a procedural time limitation. Alternatively, claimant contends that the statute should not be applied retroactively because such application would

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[2] We acknowledge that at the time of her carpal tunnel surgeries on January 10, 1995 and February 27, 1995, and during the interim period, Dr. Hill was primarily responsible for treating claimant's compensable condition. He also authorized temporary disability benefits during this period. (Ex. 19). Therefore, we agree with the ALJ that Dr. Hill served as claimant's attending physician during this time period.

[3] Claimant contends that her entitlement to temporary disability depends on whether the record as a whole establishes that she was disabled during the time in question. Entitlement to substantive temporary disability upon claim closure is determined by evidence in the record as a whole and is not dependent upon an attending physician's authorization. See SAIF v. Taylor, 126 Or App 658 (1994); Dorothy E. Bruce, 48 Van Natta 518 (1996); Shanon M. Oliver, 48 Van Natta 386 (1996); Esther C. Albertson, 44 Van Natta 2058 (1992). However, the issue in this case concerns entitlement to procedural temporary disability, since the claim remains open. Accordingly, claimant's entitlement to temporary disability depends upon the attending physician's authorization.

[4] Section 66(6) 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."

produce an absurd and unjust result. Finally, claimant contends that retroactive application of the statute is unconstitutional. We address claimant's arguments in turn.

First, we disagree that ORS 656.262(4)(f) involves a procedural time limitation that renders it exempt from retroactive application under Section 66(6).[5] In Motel 6 v. McMasters, 135 Or App 583 (1995) (addressing amended ORS 656.308(2), which pertains to time limits for filing responsibility denials/disclaimers), and Guardado v. J.R. Simplot Co., 137 Or App 95 (1995) (addressing amended ORS 656.268(5)(b), which involves the time for requesting reconsideration from a Determination Order), the court did not apply the amended statutes because they involved procedural time limitations. See also Roger Eli, 47 Van Natta 1938 (1995) (addressing amended ORS 656.319(1), which pertains to the time for requesting a hearing). These cases all clearly involved the method of enforcing a right or obtaining redress. See Long v. Storms, 52 Or App 685, 687 (1981) (Generally, substantive law creates, defines and regulates rights, while procedural law prescribes the method of enforcing a right or obtaining redress for its invasion). Specifically, these cases involved time limitations for filing petitions for enforcement or redress of claims-related rights.

By contrast, we find that the time limitation of ORS 656.262(4)(f) on the retroactive effectiveness of an attending physician's temporary disability authorization is in the nature of a substantive provision, defining and regulating the circumstances under which temporary disability can be obtained during an open claim. Accordingly, we conclude that the retroactivity exemption for procedural time limitations in Section 66(6) does not apply to ORS 656.262(4)(f). See Alda S. Carbajal, 47 Van Natta 1596, 1598, n.2 (1995) (Amended ORS 656.262(4)(g), which establishes a time limitation on the effectiveness of temporary disability authorizations by chiropractors and certain other medical providers, does not involve a "procedural time limitation" within the meaning of Section 66(6)).

Moreover, Section 66(6) specifically provides that the amendments in SB 369 will not "extend or shorten" procedural time limitations. Prior to SB 369, there was no time limit pertaining to the retroactive effectiveness of an attending physician's temporary disability authorization. See former ORS 656.262(4). Thus, the imposition of a 14-day time limit by SB 369 does not "extend or shorten" a procedural time limit, since there was no prior applicable time limit. Therefore, we question whether Section 66(6), by its terms, would apply to ORS 656.262(4)(f). Accordingly, we conclude that ORS 656.262(4)(f) is not exempt from the general retroactive application of SB 369.

Next, we disagree that retroactive application of ORS 656.262(4)(f) would produce an absurd and unjust result. Within very limited circumstances, we have previously held that a departure from the literal construction and clear intent of a statute was justified when such construction would produce an "absurd or unjust" result and would clearly be inconsistent with the purposes and policies of the workers' compensation law. Specifically, we have refused to apply a statute retroactively when to do so would have required compliance with procedures that were not even in existence at the time compliance would have been required. See Betty S. Tee, 47 Van Natta 2396, 2400 n.5 (1995) (reconsideration process not in existence when Determination Order issued; ORS 656.283(7) not applied retroactively); Rick A. Webb, 47 Van Natta 1550, 1551 (1995) (Director's aggravation claim form not in existence at the time claimant filed his aggravation claim; no retroactive application of ORS 656.273(3)); Ida M. Walker, 43 Van Natta 1402 (1991) (chiropractor would have had to comply with a law not even in existence at the time treatment was rendered; no retroactive application of former ORS 656.245).

Here, however, we do not find that retroactive application of ORS 656.262(4)(f) would create an absurd or unjust result. The statute now provides that an attending physician's temporary disability authorization is effective to retroactively authorize temporary disability only 14 days prior to its issuance, whereas prior to the passage of SB 369, there was no time limit on the retroactive authorization of

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[5] The employer contends that claimant cannot raise this argument on review because she failed to raise it at hearing. We disagree. Our review is confined to the issues presented at hearing. See Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991). Here, the issue raised at hearing was claimant's entitlement to temporary disability benefits from July 30, 1993 through January 9, 1995. Necessarily encompassed within that issue, and argued by the parties at hearing, is the question of whether amended ORS 656.262(4)(f) applies retroactively to this case. Thus, the issue of retroactive application of ORS 656.262(4)(f) was raised at hearing and preserved for our consideration on review. Claimant's contention that Section 66(6) provides an exception to retroactive application in this case is no more than an alternative argument concerning the same issue that was raised at hearing. Accordingly, we address claimant's argument concerning the applicability of Section 66(6).

temporary disability. Compare former ORS 656.262(4). Nevertheless, prior to SB 369, an attending physician's authorization was still required for a claimant to obtain temporary disability during an open claim. See former OAR 436-30-036(1).

Thus, SB 369 did not create an entirely new procedure for obtaining temporary disability compensation that did not exist at the time of claimant's disability. Under the former law, claimant was required to obtain an attending physician's authorization for temporary disability compensation, and nothing prevented claimant from obtaining a contemporaneous authorization. Unlike the situation where a party would be required to perform the impossible, such as comply with procedures not yet in existence, claimant here could have obtained contemporaneous authorization for temporary disability for the period in issue. Thus, we reject claimant's argument that retroactive application of ORS 656.262(4)(f) would cause an absurd or unjust result in this case.

Finally, we disagree that retroactive application of ORS 656.262(4)(f) violates the Oregon and United States Constitutions.[6] Specifically, claimant contends that retroactive application would deprive her of a protected property interest in the receipt of temporary disability benefits without due process of law. In addition, claimant contends that retroactive application would absolutely deprive her of a remedy for the period of time she was out of work and uncompensated as a result of a condition that was subsequently found compensable. Based on the following discussion, we conclude that retroactive application of ORS 656.262(4)(f) is not unconstitutional.

With regard to claimant's "due process" argument, we adopt and affirm the ALJ's discussion of that argument, and we offer the following supplementation. Since claimant's entitlement to temporary disability benefits prior to January 10, 1995, has not yet been finally resolved, claimant has no vested right to temporary disability benefits for that period. Therefore, retroactive application of amended ORS 656.262(4) will not deprive claimant of any vested rights in her receipt of temporary disability benefits. See Liberty Northwest Ins. Corp. v. Yon, 137 Or App 413, 417 (1995) (in ongoing medical services dispute, court held that 1995 amendments to Workers' Compensation Law did not deprive claimant of any rights that had vested by virtue of a final determination of the case); Kathleen M. Butler, 47 Van Natta 2202, 2204 (1995) and cases cited therein.

Claimant also contends that the retroactive application of ORS 656.262(4)(f) will deprive her of a remedy, contrary to Article I, section 10 of the Oregon Constitution, for the period that she was disabled from working due to a condition that has been found compensable. We disagree.

Workers' compensation law, and the benefits provided therein, is an exclusively legislative plan. See State ex rel Huntington v. Sulmonetti, 276 Or 967, 972 (1976). The legislature may impose limits on the bringing of a workers' compensation claim without infringing on a claimant's constitutional rights. See State ex rel Borisoff v. Workers' Comp. Board, 104 Or App 603, 607 (1990). In Borisoff, the court rejected an Article I, section 10 argument that the legislature's elimination of the Board's own motion review of permanent disability awards deprived claimants of a remedy by due course of law. Citing prior decisions, the court explained that "it is a permissible legislative function 'to balance the possibility of outlawing legitimate claims against the public need that at some definite time there be an end to potential litigation.'" Borisoff, supra, 104 Or App at 607.

Here, as in Borisoff, the legislature has chosen to impose a limitation on the entitlement to temporary disability benefits during an open claim, making such benefits for all injured workers contingent upon the attending physician's contemporaneous authorization of temporary disability. ORS 656.262(4)(f). The legislature is entitled to do so. Sulmonetti, supra, 276 Or at 972; Borisoff, supra. Likewise, the legislature is entitled to impose the limitation retroactively to cases already in litigation. See Whipple v. Howser, 291 Or 475, 480 (1981); Sulmonetti, supra; Thus, we conclude that retroactive application of ORS 656.262(4)(f) does not violate Article I, section 10 of the Oregon Constitution. Accordingly, we conclude that retroactive application of ORS 656.262(4)(f) is not unconstitutional.

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[6] Specifically, claimant relies on Article I, section 10 of the Oregon Constitution, which provides, in part: "[E]very man shall have remedy by due course of law for injury done him in his person, property, or reputation." Claimant also cites the 14th Amendment to the U.S. Constitution, which provides in relevant part: "[N]or shall any State deprive any person of life, liberty, or property, without due process of law[.]"

We turn now to the application of amended ORS 656.262(4)(f) in this case. We find that claimant's attending physician, Dr. Long, first authorized temporary disability on November 9, 1994. (Ex. 17A-2). He authorized temporary disability retroactive to May 1993. (Id.). However, pursuant to amended ORS 656.262(4)(f), the attending physician's authorization is effective to retroactively authorize temporary disability only 14 days prior to its issuance. Accordingly, we conclude that claimant is entitled to temporary disability from October 26, 1994 to January 10, 1995.

ORDER

The ALJ's order dated October 13, 1995 is modified. In addition to the ALJ's order awarding temporary disability benefits from January 6, 1995 to January 10, 1995, the employer is directed to pay claimant temporary disability benefits from October 26, 1994 through January 5, 1995. Claimant's counsel is awarded an out-of-compensation attorney fee in the amount of 25 percent of the increased compensation created by this order (payable directly to claimant's attorney), provided that the total of the fees approved by the ALJ and the Board shall not exceed $3,800.

Board Chair Hall dissenting.

I disagree with the majority's retroactive application of amended ORS 656.262(4)(f) to the facts of this case. Retroactive application of a procedural requirement to deny benefits, when the requirement was not in existence during the period of time for which benefits are sought, is an absurd and unjust result. For this reason, I respectfully dissent.

Like the majority, I find that in November 1994 claimant's then-attending physician, Dr. Long, authorized time loss retroactive to May 1993. At that time, there was no limit on the period of retroactive time loss which could be authorized by the attending physician. Thus, under the law in effect at the time of Dr. Long's authorization, claimant was entitled to time loss retroactive to May 1993.

Yet, the majority retroactively applies amended ORS 656.262(4)(f), which did not take effect until June 1995, to limit the legal effect of Dr. Long's retroactive time-loss authorization to the 14 day period prior to his authorization. By imposing the 14 day limitation in amended ORS 656.262(4)(f) to time-loss authorization which preceded the effective date of the amended statute, the majority is, in effect, imposing a form requirement on claimant and his doctor with which neither could have complied at the time of the authorization. How could they have complied with a requirement which did not exist?

This case is similar to Rick A. Webb, 47 Van Natta 1550 (1995), where we declined to retroactively apply new form and format requirements to an aggravation claim which had been filed at a time when no such requirements were in existence. There, we concluded it would be absurd and unjust to expect the claimant to comply with procedural requirements which were not yet in existence. Id. at 1551.

The majority tries to distinguish Webb, explaining that claimant could still have obtained contemporaneous authorization of time loss for the period in question. The majority overlooks the fact that contemporaneous time-loss authorization was not required under the former law. Retroactive authorization was sufficient at the time. How could claimant have known that such authorization would not be sufficient under a law not yet in existence? The answer is he could not.

The result of the majority's decision is absurd and unjust to claimant. Because I would not apply amended ORS 656.262(4)(f) retroactively, and would order the employer to pay benefits retroactive to May 1993, I respectfully dissent.

In the Matter of the Compensation of
RICHARD C. LECKBERG, Claimant
WCB Case No. 94-15476
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Michael O. Whitty (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to its May 13, 1996 order, the court has dismissed judicial review of our prior order which affirmed an Administrative Law Judge's (ALJ's) order that affirmed an Order on Reconsideration awarding claimant 9 percent (28.8 degrees) unscheduled permanent disability for a low back condition. Citing Petkovich v. Safeway Stores, Inc., 139 Or App 154 (1996), and Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996), the court has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," and summarize the pertinent facts as follows:

Claimant compensably injured his low back in March 1994 when he slipped and fell at work. He was released to return to his regular work as a sales representative on August 30, 1994. On October 17, 1994, the SAIF Corporation issued a Notice of Closure which awarded claimant 9 percent unscheduled permanent disability. Relying on the closing examination of claimant's treating doctor, SAIF did not award claimant an impairment value for flexion. In addition, claimant was given an adaptability value of zero because he returned to his regular job without restrictions.

A December 14, 1994 Order on Reconsideration affirmed the October 17, 1994 Notice of Closure in all respects. Claimant requested a hearing, challenging his impairment and adaptability values.

CONCLUSIONS OF LAW AND OPINION

Impairment

The ALJ found that claimant was not entitled to an impairment rating based on his lumbar flexion measurement because his attending physician found that his flexion did not satisfy the straight leg raising (SLR) validity test. We subsequently affirmed the ALJ's opinion on review. On reconsideration, we adhere to our determination on this issue.

Adaptability

Relying on the Board's decision in Therese L. Petkovich, 46 Van Natta 1038 (1994), the ALJ further determined that an adaptability value of zero was a valid modification of the factors of age, education and adaptability under the standards. See former OAR 436-35-280(1) (giving the neutral value of zero when the worker's wage earning capacity is not affected). The ALJ therefore affirmed the Order on Reconsideration awarding claimant 9 percent unscheduled permanent disability. We similarly affirmed the ALJ's order on this issue.

While the matter was pending before the court on judicial review, claimant moved to remand the case to the Board for reconsideration in light of Petkovich v. Safeway Stores, Inc., supra, and Carroll v. Boise Cascade Corp., supra. The court granted the motion and dismissed judicial review.

In Petkovich and Carroll, the court held that former OAR 436-35-310(2), which gave a zero adaptability value when a worker had returned to work, conflicted with ORS 656.214(5) and 656.726(3)(f)(A), and was, therefore, invalid. In Carroll, the court explained that using a multiplier of zero to artificially reduce a claimant's age, education and adaptability factors because of a worker's return to regular work was contrary to the statutory requirement that extent of disability be calculated on the basis of loss of earning capacity, rather than earnings.

We have previously applied the Carroll decision to former OAR 436-35-280(1) (WCD Admin. Order No. 93-056). Joe R. Ray, 48 Van Natta 325 (1996). In Ray, because the claimant's residual functional capacity (RFC) was equal to his base functional capacity (BFC), his adaptability factor under

former OAR 436-35-280(1)(a) was zero. Moreover, because that factor was used as a multiplier, former OAR 436-35-280(6), the claimant was not allowed a value for age, education, or skills. In light of Carroll, however, we concluded that former OAR 436-35-280(1) was inconsistent with ORS 656.726(3)(f)(A). Joe R. Ray, supra. We therefore declined to apply the rule. Rather, we found that the value for the age, education and skills factor should be added to the impairment value to determine the amount of the unscheduled permanent disability award. That analysis essentially resulted in assigning a value of 1 to the adaptability factor.

This case is governed by the same rules as those that were at issue in Joe R. Ray. Here, as in Ray, claimant's BFC and RFC are equal because he was released to regular work by his treating physician. Consequently, under former OAR 436-35-280(1), claimant's adaptability value is zero. Because that analysis is inconsistent with Carroll, Petkovich and Joe R. Ray, we must reevaluate the extent of claimant's unscheduled permanent disability award.

As we did in Joe R. Ray, supra, we assign a value of 1 to claimant's adaptability factor, so that we can add the values for claimant's age, education and skills to his impairment value to determine the amount of his awards. In assembling the factors, the total value for claimant's age (1), and education and skills (2) is multiplied by the adaptability factor of 1, for a total of 3. This value is added to the impairment factor of 9, for a total award of 12 percent unscheduled permanent disability.

Accordingly, on reconsideration, the ALJ's order dated April 12, 1995 is modified. In addition to the 9 percent (28.8 degrees) unscheduled permanent disability for a low back condition awarded by the Order on Reconsideration, claimant is granted 3 percent (9.6 degrees) unscheduled permanent disability for a total award of 12 percent (38.4 degrees) unscheduled permanent disability. Claimant's attorney is awarded 25 percent of this increased compensation, not to exceed $3,800, payable directly to claimant's counsel.

IT IS SO ORDERED.

June 19, 1996 Cite as 48 Van Natta 1241 (1996)

In the Matter of the Compensation of
DUANE B. MEEKER, Claimant
WCB Case No. 93-01214
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Meeker v. Cornell MFG., 139 Or App 132 (1996). The court has reversed our prior order which affirmed an Administrative Law Judge's order that awarded 8 percent (25.6 degrees) unscheduled permanent disability. Citing Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996), the court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable low back occupational disease. In January 1990, claimant returned to his regular work as a warehouseman. His claim was closed by a May 1992 Determination Order that awarded 5 percent unscheduled permanent disability. An Order on Reconsideration increased the award to 8 percent, based only on claimant's impairment. (Ex. 8).

Pursuant to WCD Admin. Order No. 93-056, the ALJ applied the standards effective March 1992 (WCD Admin. Order No. 6-1992) to determine the extent of claimant's disability. Those standards stated that no values were to be given for age, education, or adaptability for workers who had returned to their usual and customary work. Therefore, the ALJ affirmed the Order on Reconsideration which awarded 8 percent unscheduled permanent disability for impairment only. On review, we affirmed the ALJ's order.

In reversing our prior order, the court cited Carroll v. Boise Cascade Corp., 138 Or App 610 (1996). The court, in Carroll, relied on England v. Thunderbird, 315 Or 633 (1993). In England, the Court held that former OAR 436-35-290(2)(a), former OAR 436-35-300(2)(a), and former OAR 436-35-310(2)(a), which held that no values are given for age, education, or adaptability for workers who have returned to their usual and customary work, were inconsistent with former ORS 656.214, which provided that "[e]arning 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." Furthermore, in Carroll, the Court of Appeals also held that OAR 436-35-310(2), which gave a zero adaptability value when a worker had returned to work, conflicted with ORS 656.214(5) and 656.726(3)(f)(A), and was, therefore, invalid. Carroll v. Boise Cascade Corporation, supra.

We recently applied the Carroll decision to former OAR 436-35-280(1) (WCD Admin. Order No. 93-056). Joe R. Ray, 48 Van Natta 325 (1996). In Ray, because the claimant's residual functional capacity (RFC) was equal to his base functional capacity (BFC), his adaptability factor under the former OAR 436-35-280(1)(a) was zero. Moreover, because that factor was used as a multiplier, former OAR 436-35-280(6), the claimant was not allowed a value for age, education, or skills. In light of Carroll, however, we concluded that former OAR 436-35-280(1) was inconsistent with ORS 656.726(3)(f)(A). Joe R. Ray, supra. Therefore, we declined to apply the rule. Rather, we found that the value for the age, education and skills factor should be added to the impairment value to determine the amount of the unscheduled permanent disability award. That analysis essentially resulted in assigning a value of 1 to the adaptability factor.

This case is governed by the same rules as those that were at issue in Joe R. Ray. Here, as in Ray, claimant's BFC and RFC are equal. Consequently, under former OAR 436-35-280(1)(a), claimant's adaptability value is zero. That analysis is inconsistent with Carroll and Ray. Consequently, in accordance with Ray, we add the value for claimant's age, education and skills factor to his impairment value to determine the amount of his unscheduled permanent disability award. In other words, we assign a value of 1 to claimant's adaptability factor. Joe R. Ray, supra.

Because the factors for age and education must be applied, we assign claimant an adaptability factor of 1. See Donna J. England, 45 Van Natta 1480 (1993); Carroll v. Boise Cascade Corporation, supra; Joe R. Ray, supra; see also Jerry S. Quillen, 48 Van Natta 526 (1996) (Board declined to apply a similarly invalid rule in determining extent of unscheduled permanent disability).

Assembling the factors, the total value for claimant's age (1), and education and skills (5) is multiplied by the adaptability factor 1, for a total of 6. This value is added to the value 8 for impairment, for a total of 14 percent unscheduled permanent disability.

Accordingly, on reconsideration, the ALJ's order dated July 15, 1993, as amended March 7, 1994, is reversed. In addition to the 8 percent (25.6 degrees) unscheduled permanent disability granted by the Order on Reconsideration, claimant is awarded 6 percent (19.2 degrees) unscheduled permanent disability for a total award of 14 percent (44.8 degrees) unscheduled permanent disability.

IT IS SO ORDERED.

In the Matter of the Compensation of
CONRID J. PAXTON, Claimant
WCB Case Nos. 95-00537, 94-13809 & 94-10357
SECOND ORDER ON RECONSIDERATION
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), requests reconsideration of our May 22, 1996 order on reconsideration that: (1) set aside its denial of claimant's hearing loss claim; (2) upheld RLC's denial and SAIF's denial, on behalf of Woolley Enterprises of claimant's claim for the same condition; and (3) directed SAIF/Sun Studs to pay claimant's "hearings level" attorney fee award of $2,500.

On reconsideration, SAIF/Sun Studs agrees with our statement of the responsibility law applicable in this case, i.e., that initial responsibility lies with SAIF/Sun Studs, who can shift responsibility to a prior carrier by showing that claimant's work exposure while one of those carriers was on the risk was the sole cause of his hearing loss condition, or that it was impossible for conditions while SAIF/Sun Studs was on the risk to have caused that condition. FMC Corp. v. Liberty Mutual Ins. Corp., 70 Or App 370, 374, mod 73 Or App 223, rev den 299 Or 203 (1985). However, SAIF/Sun Studs takes issue with our statement that no doctor in this case addressed whether claimant's pre-June 4, 1981 work (which preceded claimant's employment with Sun Studs commencing October 1991) was the sole cause of claimant's hearing loss.

SAIF argues that Dr. Hodgson reported that the sole cause of claimant's occupational hearing loss was noise exposure prior to June 4, 1981. (Ex. 10A-5). Nevertheless, as explained in our prior order, Dr. Hodgson also reported that the "major contributing factor" to the current level of hearing loss is occupational noise exposure prior to June 4, 1981. SAIF contends that Dr. Hodgson's statement cannot be construed to mean that the remainder of claimant's condition is attributable to industrial exposure (which would include claimant's work at Sun Studs) subsequent to June 4, 1981.

SAIF points out that Dr. Hodgson reported that the "major portion of the hearing loss is due to occupational noise exposure, though, as mentioned above, this is due entirely to occupational noise exposure prior to 1981." (Ex.10A-5). SAIF argues that Dr. Hodgson's opinion must be construed to mean that all of claimant's industrial hearing loss occurred prior to 1981.

We conclude that, if SAIF's interpretation of Dr. Hodgson's opinion is accepted, then Dr. Hodgson's opinion is inconsistent. That is, Dr. Hodgson found that claimant's current condition consisted of only "possible" contribution from degenerative changes, and it was "unlikely" that claimant's hearing loss was due to avocational activities. (Ex. 10A-5). Accordingly, Dr. Hodgson's opinion that claimant's pre-1981 occupational noise exposure was the major contributing factor to claimant's current hearing loss, when read in conjunction with his statement regarding nonwork contributors, could be construed to mean that post-1981 work exposure could have partially contributed to claimant's current condition. As SAIF/Sun Studs has the burden of proof in this respect, we find that SAIF's argument that all of claimant's industrial noise exposure occurred prior to 1981 is inconsistent with Dr. Hodgson's quantification of claimant's condition in terms of the "major" contributing cause.

Accordingly, SAIF's argument does not persuade us that claimant's work prior to his employment with Sun Studs was the sole cause of his hearing loss condition, or that it was impossible for conditions while SAIF/Sun Studs was on the risk to have caused that condition. See Floyd B. Talley, Jr., 48 Van Natta 222, fn. 11 (1996). Consequently, we adhere to our prior decision.

Therefore, we withdraw our prior orders. On reconsideration, as supplemented herein, we republish our May 22, 1996 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
RALPH R. TAYLOR, Claimant
WCB Case No. 94-04508
ORDER ON REMAND
Pozzi, Wilson, et al, Claimant Attorneys
David O. Horne, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Taylor v. Joseph Ryerson & Son, 139 Or App 133 (1996). The court has reversed our prior order which affirmed an Administrative Law Judge's order that awarded 18 percent (57.6 degrees) unscheduled permanent disability. Citing Carroll v. Boise Cascade Corporation, 138 Or App 610 (1996), the court has remanded for reconsideration.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

On April 9, 1993, claimant injured his low back. He underwent surgery in late April 1993. (Ex. 13). On December 15, 1993, the insurer accepted claimant's low back "injury/disease" condition. (Ex. 22). Claimant had returned to his regular work as of August 1993.

Claimant's claim was closed by a January 3, 1994 Determination Order which awarded 18 percent unscheduled permanent disability, based solely on his impairment. (Ex. 23). An Order on Reconsideration affirmed the unscheduled disability award. (Ex. 25). Claimant requested a hearing.

At hearing, the ALJ, relying on former OAR 436-35-290(2), former OAR 436-35-300(2), and former OAR 436-35-310(2), concluded that no values are given for age, education, or adaptability for workers who have returned to their usual and customary work. Therefore, the ALJ affirmed the Order on Reconsideration's unscheduled permanent disability award based solely on impairment. Subsequently, on review, we affirmed the ALJ's order. Claimant petitioned for judicial review.

In reversing our prior order, the court cited Carroll v. Boise Cascade Corp., 138 Or App 610, (1996). The court, in Carroll, relied on England v. Thunderbird, 315 Or 633 (1993). In England, the Court held that former OAR 436-35-290(2)(a), former OAR 436-35-300(2)(a), and former OAR 436-35-310(2)(a), which held that no values are given for age, education, or adaptability for workers who have returned to their usual and customary work, were inconsistent with former ORS 656.214, which provided that "[e]arning 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." Furthermore, in Carroll, the Court of Appeals also held that OAR 436-35-310(2), which gave a zero adaptability value when a worker had returned to work, conflicted with ORS 656.214(5) and 656.726(3)(f)(A), and was, therefore, invalid.

We recently applied the Carroll decision to former OAR 436-35-280(1) (WCD Admin. Order No. 93-056). Joe R. Ray, 48 Van Natta 325 (1996). In Ray, because the claimant's residual functional capacity (RFC) was equal to his base functional capacity (BFC), his adaptability factor under the former OAR 436-35-280(1)(a) was zero. Moreover, because that factor was used as a multiplier, former OAR 436-35-280(6), the claimant was not allowed a value for age, education, or skills. In light of Carroll, however, we concluded that former OAR 436-35-280(1) was inconsistent with ORS 656.726(3)(f)(A). Joe R. Ray, supra. Therefore, we declined to apply the rule. Rather, we found that the value for the age, education and skills factor should be added to the impairment value to determine the amount of the unscheduled permanent disability award. That analysis essentially resulted in assigning a value of 1 to the adaptability factor.

This case is governed by the same rules as those that were at issue in Joe R. Ray. Here, as in Ray, claimant's BFC and RFC are equal. Consequently, under former OAR 436-35-280(1)(a), claimant's adaptability value is zero. That analysis is inconsistent with Carroll and Ray. Consequently, in accordance with Ray, we add the value for claimant's age, education and skills factor to his impairment value to determine the amount of his unscheduled permanent disability award. In other words, we assign a value of 1 to claimant's adaptability factor.

Accordingly, because the factors for age and education must be applied, we assign claimant an adaptability factor of 1. See Donna J. England, 45 Van Natta 1480 (1993); Carroll v. Boise Cascade Corporation, supra; Joe R. Ray, supra; see also Jerry S. Quillen, 48 Van Natta 526 (1996) (Board declined to apply a similarly invalid rule in determining extent of unscheduled permanent disability).

Assembling the factors, the total value for claimant's age (1), and education and skills (3) is multiplied by the adaptability factor 1, for a total of 4. This value is added to the value 18 for impairment, for a total of 22 percent unscheduled permanent disability.

Accordingly, on reconsideration, the ALJ's order dated July 15, 1994 is reversed. In addition to the 18 percent unscheduled permanent disability awarded by the Order on Reconsideration, claimant is granted 4 percent (12.8 degrees) unscheduled permanent disability for a total award of 22 percent (70.4 degrees) unscheduled permanent disability.

IT IS SO ORDERED.

June 19, 1996 Cite as 48 Van Natta 1245 (1996)

In the Matter of the Compensation of
CHRIS L. THORNBURG, Claimant
WCB Case No. 95-05374
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that found that claimant had established the compensability of medical services[1] for the osteochondral lesion of the right ankle. 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 parties agree that claimant had two conditions that preexisted his December 12, 1992 right ankle injury: an osteochondral lesion (also referred to as "osteochondritis dissecans") on the medial aspect of the talus, and an os fibulare, or bone fragment, off the tip of the fibula. At hearing, claimant's attorney acknowledged that neither preexisting condition was compensable; claimant's attorney also acknowledged that the proposed surgery for the os fibulare was not compensable. (Tr. 2; closing arguments at 9). Thus, the only issue was the compensability of the proposed surgery for the osteochondral lesion.

The ALJ reasoned that ORS 656.005(7)(a)(B) did not apply because claimant's preexisting ankle condition did not combine with anything as a result of the compensable injury. The ALJ concluded that the proposed surgery for the osteochondral lesion was compensable.

The employer argues that claimant's compensable injury combined with claimant's preexisting conditions to cause the need for surgery and, therefore, ORS 656.005(7)(a)(B) applies.[2]

The parties agree that claimant had an osteochondral lesion and an os fibulare that preexisted his December 12, 1992 right ankle injury. Based on the following reasoning, we find that claimant's need for surgery arose from a combined condition.

---

[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) (under ORS 656.245(6), the Board retains jurisdiction to determine whether a claimant's condition is causally related to the compensable injury).

[2] We note that claimant also contended in closing argument that ORS 656.005(7)(a)(B) applied to the case. (Closing arguments at 8).

On March 23, 1993, Dr. Sampson requested authorization for surgery to remove the osteochondral fragment and the os subfibulare at the same time. (Ex. 14). In a concurrence letter from the employer's attorney, Dr. Sampson agreed that there were two procedures involved in the surgery: removal or correction of the osteochondritis and the os fibularis, and a synovectomy to remove the inflamed tissue surrounding these structures. (Ex. 20). Dr. Sampson said it was impossible to tell whether the synovectomy was related to the sprain or the osteochondral problem, although he agreed that, without the preexisting conditions, it was unlikely that claimant would have developed the synovitis, and it was likely that the sprain itself would have resolved without surgical intervention. (Id.)

Dr. Donahoo examined claimant on behalf of the employer. (Ex. 15). Dr. Donahoo reported that claimant's preexisting conditions were causing claimant to have continued symptoms, (Ex. 15-8), and he agreed that claimant's degenerative joint disease in the right ankle could be causing symptoms and probably was part of the symptom complex. (Id.) Dr. Donahoo also reported that claimant's sprain injury itself was "likely not sufficient to have caused this osteochondral lesion." (Ex. 17-2).

Since Dr. Sampson indicated that the proposed surgery was necessary to remove the preexisting osteochondral fragment and the inflamed tissue surrounding both preexisting conditions, we interpret his opinion to mean that claimant's current condition was a combination of his preexisting ankle conditions and the work injury. Furthermore, Dr. Sampson indicated that it was unlikely that claimant would have developed synovitis without the preexisting conditions. Dr. Donahoo agreed that claimant's preexisting conditions were causing claimant's continued symptoms. Thus, based on the opinions of Drs. Sampson and Donahoo, we find that claimant's current need for surgery is due to the combination of claimant's compensable right ankle injury with the preexisting ankle conditions. Amended ORS 656.005(7)(a)(B). Therefore, since this is a "combined condition," the employer is obligated to provide only those medical services "directed to medical conditions caused in major part by the injury." Amended ORS 656.245(1)(a).

Claimant relies on Dr. Sampson's opinion to establish compensability of the proposed surgery. At deposition, Dr. Sampson was asked whether 51 percent or more of the reason for surgery was based on the work trauma. Dr. Sampson responded:

> "Well, that's a good question, and I'm having a hard time answering it. Certainly the majority of his disease, in my opinion, was preexisting. And it's much like the straw that broke the camel's back, it wasn't a very big straw, and it sure had nothing to do with the 97 million others that were already there, but it was the one that caused the problem.
>
> "And it's sort of like that with this ankle, this ankle was -- was actually pretty beaten up before this injury, but after the injury he did have a significant amount of pain that, in my opinion, requires a surgery to get well.
>
> "So if that's a longabout answer, I -- I guess the answer is yes." (Ex. 24-9, -10).

Later in the deposition, Dr. Sampson agreed that the "vast majority of [claimant's] problems were preexisting to the injury in December of '92." (Ex. 24-13). As we mentioned earlier, Dr. Sampson also indicated that, without the preexisting conditions, it was unlikely that claimant would have developed the synovitis that required surgery, and it was likely that the sprain itself would have resolved without surgical intervention. (Ex. 20).

Claimant relies on the portion of Dr. Sampson's testimony in which he answered "yes" to whether 51 percent or more of the reason for surgery was based on the work trauma. However, Dr. Sampson's answer is inconsistent with his other comments that the majority of claimant's problems were preexisting. (Ex. 24-9, -13). Dr. Sampson's testimony and reports are, at best, inconsistent and confusing. Dr. Sampson's opinion is not sufficient to establish that claimant's need for surgery was caused in major part by his December 1992 work injury.

Claimant also relies on Dr. Donahoo's opinion. Dr. Donahoo reported that, if claimant was "asymptomatic, as he states he was, and totally functional without symptoms, even though he had a pre-existing lesion and has now become non-functioning and symptomatic with documented synovitis (that is, objective evidence of inflammation), then the injury of December 12, 1992 would be the major contributing cause." (Ex. 15-10).

In a later report, Dr. Donahoo further discussed claimant's preexisting conditions, particularly the osteochondral lesion. (Ex. 17). Dr. Donahoo indicated that the lesion might have been affected by the injury, in that the injury might have torn loose a small loose body or cartilage overlying the lesion. (Id.) Dr. Donahoo believed that whether or not the loose body was formed at the time of the work injury was primarily a question of claimant's history, i.e., whether claimant had previous complaints. (Id).

Claimant testified that he could not recall any previous twisting injuries to his right ankle. (Tr. 5). The reports from Drs. Sampson and Donahoo indicated that claimant had not been symptomatic for approximately ten years before the injury. (Exs. 8, 15).

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's reasoning and conclusion that claimant was a credible witness.

Based on Dr. Donahoo's report, we are persuaded that claimant's proposed surgery for the osteochondral lesion is "directed to medical conditions caused in major part by the injury." Amended ORS 656.245(1)(a). Accordingly, we affirm the ALJ's decision to set aside the employer's March 10, 1995 partial denial of claimant's proposed surgery for the osteochondral lesion.

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

ORDER

The ALJ's order dated February 2, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the self-insured employer.

In the Matter of the Compensation of
KERMENT C. VERNER, Deceased, Claimant
WCB Case No. 93-10270
ORDER ON REMAND
Malagon, Moore, et al, Claimant Attorneys
Employer Defense Counsel, Defense Attorneys

This matter is before the Board on remand from the Court of Appeals. Liberty Northwest Ins. Corp. v. Verner, 139 Or App 165 (1996). On remand from the Supreme Court, 322 Or 214 (1996), the Court of Appeals has reconsidered its previous decision, 135 Or App 551 (1995), and reversed our prior order that adopted and affirmed the Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of a claim for death benefits filed by decedent's surviving spouse. Kerment C. Verner, 46 Van Natta 1608 (1994). Reasoning that our prior order lacked substantial evidence to support a compensability finding, the Court of Appeals has remanded for reconsideration.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the ultimate findings of fact, with the following supplementation. In the second paragraph of the findings of fact on page 1, we change the second sentence to reflect that claimant's work shift began at 6 a.m., rather than 5 a.m. (Tr. 82).

We repeat the ALJ's findings of fact for ease of reference:

"Decedent, 49 at death, began working for the employer, a nickel ore processing plant, in September 1992. The employer processed nickel ore. At the time of decedent's hire, he underwent a physical examination by Dr. McAndrew, a physician. He was in good health. He had a stomach ulcer, however, which he had treated with Tagamet. Ex. 1-1. In December 1992, he returned to McAndrew with complaints of fatigue, sleep apnea, and acid peptic symptoms. McAndrew prescribed Tagamet. Ex. 1-2.

On March 31, 1993, decedent awoke at 3:45 a.m. to get ready for work. He normally worked the day shift, which began at 6 a.m. At 4:45 a.m. he ate breakfast with his wife, Mrs. Barcy Verner. His meal consisted of one cup of coffee, one bowl of oatmeal, and two pieces of whole wheat toast. He appeared fine before he left for work. He was even upbeat inasmuch as he was scheduled for an upcoming vacation. He showed no signs of flu symptoms.

Decedent arrived at work and started his shift at either 5 or 6 a.m. (Lawson's testimony). He had previously worked as a sampler, but over the last two weeks had started training as a process operator. Consequently, he worked inside a large tubular dryer. Ex. 8A. Ore was fed into the dryer, dried and pushed out.

It was warm inside the dryer -- approximately 80 to 85 degrees. It was warmer at the entrance, 110 to 115 degrees, and cooler at the exit, 60 to 65 degrees. A ventilating fan drew air into the dryer to help reduce the heat.

Decedent was a good worker. He prided himself in his work and never complained. He and the crew were inside the dryer to remove the lifters. The lifters were bolted to the inside of the dryer. They were 48 inches long and weighed 80 to 100 pounds. Ex. 8B.

On the morning of March 31st, decedent removed some of the lifters by himself. (Lawson's testimony). He had to carry each one approximately 20 feet. Also, a leaky propane hose was causing an unpleasant odor. The workers complained about the smell. (Lawson's testimony).

At 7:15 a.m., Scott Lawson, decedent's supervisor, pulled the crew out of the dryer. The workers wore cloth masks over their faces, while inside the dryer. When decedent stepped out the exit end at 7:15 and took off his mask, he complained to Lawson about his chest hurting. Although it was 60 to 65 degrees at the exit, it was "chilly" given the level of heat inside the dryer. (Lawson's testimony).

The work decedent performed on March 31st was different than his usual work. First, it was warm inside the dryer -- warmer than he was used to. Second, there was more lifting and walking involved. He was removing the lifters and walking back and forth over them. (Lawson's testimony).

After a 30 minute break, decedent and his co-workers returned to work inside the dryer. Within 45 minutes, they had become thirsty. Decedent complained of indigestion and a sick stomach. He wanted to sit down. Lawson observed that decedent looked a little weak and was sweating. Consequently, Lawson left the work site to purchase some sport drinks at a nearby convenience store. He was gone for approximately 25 minutes.

After Lawson returned, decedent and the crew members took the sport drinks inside the dryer. Decedent drank some of a sports drink. Shortly thereafter, he became nauseous and stated that he was going to vomit. He complained of gas pain and indigestion. After sitting down inside the dryer for 10 minutes, he did not feel any better, and asked to leave the dryer. After Lawson said okay, he did. (Lawson's testimony).

A few minutes later, Lawson exited the dryer and observed decedent throw up twice. It appeared to Lawson that claimant's vomit had food particles in it. By that time decedent had been in the dryer for at least two and one-half hours. The two then walked over to the water treatment plant. Once there, decedent threw up again. From what Lawson was observing (nausea and sweating) and hearing (complaints of weakness), he thought that decedent might be suffering a little heat stress, or possibly a minor heart attack. As a result, he took decedent to the office and told Mr. Drew Emmett,[1] the port superintendent, that decedent was sick. (Lawson's testimony).

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[1] Although the ALJ's Opinion and Order referred to "Mr. Drew Smith," the ALJ changed the name to "Mr. Drew Emmett" in the Order on Reconsideration. For that reason, all of the references to "Smith" have been changed to "Emmett."

Once there, decedent complained of indigestion and later stated that he had ate fried weiners for breakfast. His face was flushed and he appeared sick. Emmett suggested that he go home. Decedent declined, however, and asked to take an early lunch. Emmett approved. At that point, which was about 10:30 or 11 a.m., decedent went to his car and sat in it. He did not eat his lunch, however.

Shortly thereafter, Emmett went to check on decedent. He was standing at his car with both hands on it. Emmett had already been told by the crew members that decedent had vomited earlier that morning. As Emmett approached, he observed decedent vomiting.

Near that time, Lawson also returned to check on decedent. Decedent told him that he was feeling better, but was going to get some more antacid.

At approximately 11 or 11:30 a.m., decedent returned to the office. Emmett asked him how he felt. Decedent stated: "I feel like shit, but I'm here." Again declining Emmett's offer to go home, decedent was assigned to monitor truck traffic in the yard. He did so unsupervised. It was light duty and merely required decedent to carry a clipboard and to write down the arrival and departure times of the trucks.

Decedent was last seen alive at approximately 12:30 p.m. Shortly thereafter, he was found seated partially reclined, half-way up a tower stairwell. Medics were called, but could not revive him. He was pronounced dead.

Decedent's body was then transported to the office of the Coos County Coroner, Dr. Bassett. Bassett briefly examined decedent and then contacted Mrs. Verner, who indicated that she wanted decedent cremated without an autopsy. Consequently, an autopsy was not performed and decedent was cremated.

At the hearing, expert medical testimony was provided by Dr. Archie Hamilton, a forensic pathologist for Clark County, Washington."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that the decedent's period of work exposure was approximately two and one-half hours before he began to get sick, and analyzed the case as an injury claim. The ALJ found that, since there was no persuasive evidence that decedent had a preexisting condition that combined with his work exposure, ORS 656.005(7)(a)(B) did not apply. The ALJ found the claim compensable based on Dr. Hamilton's opinion. We adopted and affirmed the ALJ's order. Kerment C. Verner, supra.

The Court of Appeals reversed our order, 135 Or App 551 (1995), concluding that our determination that decedent's death was caused by work conditions was not supported by substantial evidence. Citing Garcia v. Boise Cascade Corp., 309 Or 292 (1990), the Supreme Court vacated the Court of Appeals' decision. On remand from the Supreme Court, the Court of Appeals continued to conclude that there was an absence of substantial evidence to support part of the basis for the expert's opinion. The court remanded for us to explain the relationship between the facts and our ultimate conclusion on the compensability of the claim.

Subsequent to the ALJ's order in this case, the Legislature amended ORS 656.005(7)(a)(B). 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 656.005(7)(a)(B) 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 656.005(7)(a)(B) applies 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." Here, we agree with the ALJ that there was no persuasive evidence that decedent's March 31, 1993 work "injury" combined with a preexisting condition. Absent persuasive evidence that decedent had a "combined condition," claimant need only establish that decedent's work activities was a material contributing cause of his 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).

Under ORS 656.295(6), we may affirm, reverse, modify or supplement the order of the Administrative Law Judge or make such disposition of the case as we determine to be appropriate. On reconsideration, we agree with the Court of Appeals that the conclusion in the ALJ's order that decedent's work was "performed inside a dryer with a temperature of 80 to 85 degrees" (Opinion and Order at 4), is inconsistent with finding Dr. Hamilton's testimony persuasive. Thus, for the following reasons, we disagree with the ALJ's conclusion that decedent's work was performed inside a dryer with a temperature of 80 to 85 degrees. Nevertheless, on reconsideration, again based on the foregoing reasoning, we hold that the claim is compensable.

The issue in this case is medical causation. Dr. Hamilton, forensic pathologist, testified that a combination of an unpleasant odor, heavy physical exertion and 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 ALJ found, among other things:

> "It was warm inside the dryer -- approximately 80 to 85 degrees. It was warmer at the entrance, 110 to 115 degrees, and cooler at the exit, 60 to 65 degrees. A ventilating fan drew air into the dryer to help reduce the heat." (Opinion and Order at 2).

Decedent's supervisor testified that on March 31, 1993, the day of decedent's death, decedent was assigned to work at the dryer, removing lifters. (Tr. 31). The lifters inside the dryer weighed approximately 80 to 100 pounds. (Tr. 35). The crew was carrying the lifters as far as 20 feet. (Tr. 60). On some occasions, it was necessary to "pack" the lifters as far as half the length of the dryer. (Tr. 59). The supervisor recalled decedent carrying the lifters by himself on March 31, 1993. (Tr. 60).

Decedent's supervisor was asked about the temperature in the dryer that morning and he responded:

> "A. Depending on where you're at in the dryer, when [claimant] started complaining about being nauseous that area was, I'd say, approximately around 80 -- 85 degrees. And then as you went back it's a little warmer.
>
> "Q. So one end of it was 80 to 85 degrees, and the other end is a different temperature?
>
> "A. We were basically in the middle of the dryer. So the feed end where we have the refractory was quite a bit warmer. And the discharge end was quite a bit cooler.
>
> "Q. How warm was it at the feeder end?
>
> "A. I would say around 100 -- maybe a little higher.
>
> "Q. How much higher?
>
> "A. 110 -- around there -- 105 -- 110.
>
> "Q. 110 -- and do you have any idea what the humidity was like there?"
>
> "A. I have no idea what it was like." (Tr. 37-38).

Decedent's supervisor was asked if he recalled his prior statements to Mr. Bedock[2] concerning the temperature in the dryer:

> "Q. I'll read this to you and see if this helps your recall. Mr. Bedock says, 'Average temperature, would it be fair to say, probably was 110, because when they started it was hotter?' You answered 'Yeah, it was probably a little hotter.' Does that sound accurate to you?

---

[2] Mr. Bedock was claimant's attorney's investigator. (Tr. 49).

"A. Depending on where they're at in the dryer, yes.

"Q. It's 110 degrees Fahrenheit?

"A. Correct." (Tr. 51).

On cross-examination, decedent's supervisor was asked about the temperature:

"Q. Now, Mr. Johnson was asking you about a statement that you have previously, and you indicated the temperature was 110 degrees or so. Previously you had told us that the temperature at the far end of the dryer was 100 to 110, and where you were somewhere around 80 degrees?

"A. That's all approximately, you know, estimated from where -- my point of view. It's -- I didn't have any kind of a thermometer or anything on me. So it's --

"Q. How it felt to your body?

"A. Yeah, how it felt to me. It could have felt hotter to other people in there.

"Q. And when you were talking about the temperature to Mike Bedock as being 110 degrees were you meaning at the far end of the dryer?

"A. Yeah. At the far end. It would change, you know, from the front all the way to the back, and it -- it's at the -- what we call the feed end of the dryer. It was up around 110 -- maybe even a little hotter up there -- and then cooled off as you're coming toward your discharge end. So depending on where you were at and where you were working right there, it would depend on what the temperature was." (Tr. 60-61).

The supervisor testified that the temperature at the "discharge" end would have been around 60 to 70 degrees. (Id.)

Based on the decedent's supervisor's testimony, we find that the temperature where decedent was working on March 31, 1993 ranged from 60 to 110 degrees or higher, depending on the part of the dryer where decedent was working. The supervisor testified that when claimant started complaining about being nauseous, that area was approximately 80 to 85 degrees. (Tr. 37). However, the supervisor testified that the temperature would change depending on where the person was in the dryer. (Tr. 37, 51, 61). Decedent was involved in removing lifters, which weighed approximately 80 to 100 pounds, and carrying them as far as 20 feet by himself. On some occasions, it was necessary to "pack" the lifters as far as half the length of the dryer. (Tr. 59). Therefore, decedent was not in a stationary location, but was exposed to the temperature variations in the dryer. (Tr. 35).

In addition, claimant was engaged in work which involved heavy exertion. Decedent's supervisor testified that the work claimant was doing on March 31, 1993 was different from his usual work because it was "quite a bit different in the temperature, plus the physical part is different than what we usually do." (Tr. 44). The supervisor said that it was a lot more physical than usual and decedent usually worked in a cooler environment. (Id.)

Dr. Hamilton testified that the cause of death was due to "heat, nausea, vomiting, odors, which led to cardiovascular accident by -- possibly by hyponatremia [deficiency of sodium in the blood] and certainly hypokalemia [abnormally low potassium level in the blood], with cardiac collapse and death." (Tr. 97). Dr. Hamilton explained that the combination of the propane odor and the stress and the heat led to decedent's physical stress, which led to weakening, to nausea, to vomiting, cardiovascular collapse and death. (Tr. 104). Dr. Hamilton's opinion on the causes of decedent's death was based on "more than a reasonable medical probability." (Tr. 103).

In regard to the temperature in the dryer, Dr. Hamilton testified that his conclusion on the cause of death was based on information that the heat was excessive, which led to stress, weakness, nausea, vomiting, collapse and death. (Tr. 126). Dr. Hamilton and the insurer's attorney engaged in the following colloquy:

"Q. Let's talk about just one of those items, that being heat. Your conclusion is that the temperature was 110 degrees, correct?

"A. That's what was testified to, yes.

"Q. No. You pointed to Mr. Johnson [claimant's attorney.] That's what Mr. Johnson told you, wasn't it?

"A. No, sir. In the -- in the deposition that was given to Mist -- by -- or the statement given by the supervisor that sat here in the morning, he -- he stated in his testimony this morning it was 110 degrees or maybe a little bit higher.

"Q. Did you hear him say that that was --

"A. Yes.

"Q. At the far end of the dryer where they were working?

"A. I -- yes. And then he said that the other end was 80 degrees, possibly becoming cooler near the outlet. We also at that time -- I believe Mr. Johnson asked him what the humidity was in there, which is --

"Q. And what did he say, Doctor?

"A. He said he didn't know. Because it's just as vital or as important to determine what the humidity is as it is the temperature.

"Q. Let's focus on what I think the rest of us heard the testimony, and that was that the temperature where Mr. Verner was working was approximately 80 degrees. In your opinion, is that excessive heat?

"A. That -- no -- 80 degrees is not excessive.

"Q. All right. Thank you very much.

"A. Unless the humidity is exceedingly high.

"Q. And you don't know what the humidity was, do you?

"A. No, I don't. But I heard the man testify that the temperature was over 110 degrees up where he was working." (Tr. 126-27).

The insurer's attorney later returned to the "temperature" issue:

"Q. What information did you have as it related to work activities prior to the time that you came here?

"A. I had the records of that morning, of -- of the fact that the excessive high temperature that was given in the deposition by the man when he stated that the temperature could be 110 degrees or higher where this man was working. That impressed me.

"Q. So you --

"A. Yes.

"Q. Let me just --

"A. Yes.

"Q. Clarify that. And that was the statement that Mr. Johnson's attorney took of Scott Lawson?

"A. Yes, sir. And that's what the man said here this morning, too, and his testimony was the temperature was 110 degrees in some area, and probably even higher, as I remember.

"Q. And you still remember that as being 110 and not 80 where Mr. Verner was working?

"A. There's -- there's some discrepancy into what he said here this morning versus what he said in his deposition, I believe. I believe in his deposition he was somewhat more -- had a greater tendency to use the 110, rather than the cooling temperature. And I believe that. I mean--

"Q. And you relied on the deposition that's not before us today, correct?

"A. I relied on the fact that there was hyperthermia at 100 -- I mean that there was excessive temperature, that he testified this morning that -- that there was at least 110 degrees in the area where the man worked and sometimes maybe even higher. I heard that. I believe I did." (Tr. 163-64).

It is obvious from the two colloquies between Dr. Hamilton and the insurer's attorney that they did not agree on the testimony of decedent's supervisor. The insurer's attorney believed that the supervisor had testified that the temperature where decedent was working was approximately 80 degrees. On the other hand, Dr. Hamilton believed that the supervisor testified that the temperature was 110 degrees or maybe a little bit higher.

We find that Dr. Hamilton's recollection of decedent's supervisor's testimony was consistent with decedent's supervisor's testimony. Decedent's supervisor testified that the temperature where decedent was working on March 31, 1993 ranged from 60 to 110 degrees or higher, depending on the part of the dryer where decedent was working. Although the supervisor testified that when claimant started complaining about being nauseous, that area was approximately 80 to 85 degrees, (Tr. 37), the supervisor testified that the temperature would change depending on where the person was in the dryer. (Tr. 61, 51, 37). Because decedent was removing lifters and carrying them, he was exposed to the temperature variations in the dryer. (Tr. 35). Based on the decedent's supervisor's testimony, we conclude that Dr. Hamilton's opinion was based on an accurate assumption that decedent was exposed to temperatures of 110 degrees or higher on March 31, 1993.

The other medical opinions did not establish a cause of death. Dr. Bassett reported that the immediate cause of decedent's death was "undetermined, natural." (Ex. 2). Dr. Wilson reported that same conclusion. (Ex. 2A). Dr. Romm reported that, based on the evidence available, he could not establish a cause of death with medical probability. (Ex. 7).

When the medical evidence is divided, we give the most weight to opinions that are both well-reasoned and based on accurate and complete histories. Somers v. SAIF, 77 Or App 259 (1986). Dr. Hamilton testified that a combination of an unpleasant odor, heavy physical exertion and 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. We are persuaded that Dr. Hamilton had an accurate and complete history of the events leading to decedent's death. Moreover, we find that his opinion on the cause of decedent's death is well-explained and well-reasoned. We conclude that claimant has established that decedent's work activities, including the physical exertion and excessive heat, were a material contributing cause of decedent's death. ORS 656.005(7)(a).

Claimant has finally prevailed after remand with respect to the compensability 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 $4,000 for prevailing over the insurer's denial. ORS 656.386(1). On review, we awarded a $1,500 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 Supreme Court and before the Court of Appeals.

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 Supreme Court and Court of Appeals is $4,000, 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.

Accordingly, on reconsideration, and as supplemented and modified herein, the ALJ's order dated December 20, 1993, as reconsidered January 10, 1994, is affirmed. For services before the courts and before the Board on remand, claimant's counsel is awarded $4,000, to be paid by the insurer. This attorney fee is in addition to the $5,500 granted by the ALJ's order and our prior order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN L. BJERKVIG, Claimant
WCB Case No. 95-10165
ORDER ON REVIEW
Malagon, et al, Claimant Attorneys
David J. Lefkowitz, Defense Attorney

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the self-insured employer's denial of claimant's occupational disease claim for a psychological condition. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant began working for the employer as a police officer in 1985. In December 1993, he was appointed temporary police chief.

On December 17, 1994, claimant learned that he would not be asked to serve as permanent police chief. He left work and did not return.

On December 19, 1994, claimant sought medical treatment for stress and hypertension. Dr. Herscher, family physician, authorized time loss pending cardiac testing. Following normal test results, claimant was released to return to work. He did not do so.

In February 1995, the employer's city council voted not to appoint claimant to be permanent police chief. Instead, the employer advertised the position publicly and hired one of thirteen applicants. Claimant did not apply.

Claimant first sought treatment from Dr. Brown, treating psychiatrist, on May 23, 1995 on referral by his workers' compensation attorney. He filed a claim for a psychological condition on that date.

Claimant reported stress and stress-related symptoms associated with citizen complaints to the police department; with learning that he would not be hired as permanent police chief; and with concern over loss of political support for himself as chief of police. He also reported feeling anxiety associated with his long-standing hypertension condition, which is not work-related.

CONCLUSIONS OF LAW AND OPINION

Based on the opinion of Dr. Turco, examining psychiatrist, the ALJ found that claimant's mental condition did not amount to "a diagnosis of a mental disorder or emotional disorder which is generally recognized in the medical or psychological community" as required by ORS 656.802(3)(c). The ALJ also found that claimant failed to prove that compensable stressors contributed more to claimant's psychological problems than did other causes. Consequently, the ALJ concluded that claimant failed to prove his occupational disease claim.

We need not determine whether claimant has a "diagnosis of a mental disorder" within the meaning of ORS 656.802. Even if he does, we agree with the ALJ that claimant failed to establish that work-related stressors were the major contributing cause of his disability and need for treatment. ORS 656.802(2)(a).[1]

Claimant argues that his compensable stressors include citizen complaints and loss of support (allegedly resulting from the new mayor's allegations against claimant at a city council meeting which claimant did not attend). (Tr. 8, 13-16, 18, 20-21). In addition, claimant acknowledges that his health problems, particularly hypertension, contribute to his stress and disability. (Tr. 20-21, 24-25). Claimant's hypertension is not work-related. (Exs. 6, 9).

The only medical evidence supporting the claim is provided by Dr. Brown, who opined that work stressors were the major contributing cause of claimant's depression. (Ex. 12). Dr. Brown explained that the recent history of the city's police department "is in part reflected by the destabilization of the previous chief of police that the patient replaced. It is also documented that police work is one of the highest rated occupations in terms of the development of depression." (Ex. 12-4-5). We decline to rely on Dr. Brown's conclusion, for the following reasons.

First, to the extent that Dr. Brown's opinion is general, rather than specific to claimant, it is not persuasive. See Sherman v. Western Employers Insurance, 87 Or App 602 (1987). Second, insofar as Dr. Brown believes that claimant's depression is related to replacing a previously "destabilized" police chief, we cannot say that his history is accurate because it is unsupported elsewhere in the record. Third, because claimant's non-work-related hypertension is a significant "off-work" stressor, and Dr. Brown failed to evaluate its relative contribution to claimant's psychological problems[2], we do not find that Dr. Brown's opinion persuasively supports a conclusion that legally-cognizable work-related factors contribute more to claimant's psychological disability and need for treatment than all other causes. See Dietz v. Ramuda, 130 Or App 397 (1994). On this record, we therefore agree with the ALJ that claimant has not carried his burden under ORS 656.802.

ORDER

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

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[1] We adopt the portion of the ALJ's "Conclusions of Law and Reasoning" entitled "Applicable Law."

[2] Dr. Turco, examining psychiatrist, noted that both hypertension itself and medication for treating hypertension can produce depression. (Ex. 10-1)

In the Matter of the Compensation of
ROSA M. CHAPINA, Claimant
WCB Case No. 95-11735
ORDER ON REVIEW
Rodolfo A. Camacho, Claimant Attorney
Garrett, Hemann, et al., Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order which reduced the award of scheduled permanent disability granted by an Order on Reconsideration from 12 percent (18 degrees) to zero. On review, the issue is scheduled permanent disability.

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

In setting aside the Order on Reconsideration's award of permanent disability, the ALJ relied on the medical opinion of claimant's attending physician, Dr. Pribnow, who opined that claimant had no permanent impairment due to her compensable left wrist condition. (Exs. 11, 15, 16). On review, claimant contends that the ALJ should have, instead, deferred to the impairment findings of Dr. Wilson, the medical arbiter. (Ex. 17). We disagree.

In evaluating claimant's permanent disability, we do not automatically rely on a medical arbiter's opinion in evaluating permanent impairment. See Charlene L. Vinci, 47 Van Natta 1919, 1920 (1995). Instead, impairment is established by a preponderance of medical evidence. ORS 656.726(3)(f)(B); Roseburg Forest Products v. Owen, 129 Or App 442 (1995). Therefore, we rely on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment. See Carlos S. Cobian, 45 Van Natta 1582 (1993).

For the reasons cited by the ALJ, we agree, that the medical opinion of claimant's attending physician, Dr. Pribnow, is more persuasive than that of the medical arbiter, Dr. Wilson. Accordingly, we conclude that a preponderance of the medical evidence establishes that claimant has no permanent impairment as a result of her compensable wrist condition. It follows that the ALJ correctly set aside the award of permanent disability in the Order On Reconsideration.

ORDER

The ALJ's order dated February 5, 1996 is affirmed.

In the Matter of the Compensation of
NATHAN L. HANSON, Claimant
WCB Case No. 95-09017
ORDER ON REVIEW
Coons, Cole, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Livesley's order that upheld the insurer's denial of his injury claim for bilateral inguinal hernias. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the ALJ's third ultimate finding of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant had failed to establish compensability of his indirect bilateral inguinal hernias under ORS 656.005(7)(a)(B). Claimant does not dispute that the hernias preexisted the work incident and agrees that the compensability of his bilateral indirect hernias should be analyzed under ORS 656.005(7)(a)(B). However, claimant argues that the ALJ should have relied on the medical opinion of his attending physician and surgeon, Dr. Hoversten, to find the hernias compensable.

The ALJ found Dr. Hoversten's opinion unpersuasive on the ground that he had an unexplained change of opinion. After reviewing the record, we do not agree with the ALJ's conclusion that Dr. Hoversten's opinion is unpersuasive.

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."

Dr. Hoversten opined that claimant's hernias were most probably related to his work-related activities (lifting heavy timbers at work). At his deposition, Dr. Hoversten explained that sliding of intra-abdominal contents in and out of the preexisting hernia sac causes the symptoms of the hernia. Initially, Dr. Hoversten indicated that he could not state to a medical probability that the work incident caused the preexisting hernia to be symptomatic. However, Dr. Hoversten stated that claimant's history and his findings at surgery were consistent with the scenario that increased abdominal pressure from

lifting caused or allowed the preexisting hernia sac to dilate and accept intra-abdominal contents. Dr. Hoversten also agreed with the statement that it was medically probable that the lifting incident at work and the preexisting hernia sac combined such that the work incident constituted the major contributing cause of the development of the condition and need for surgery. Dr. Hoversten further opined that the "single biggest cause" of claimant's hernias was his lengthy period of working at very strenuous physical activity.

After reviewing the totality of Dr. Hoversten's deposition testimony, we find the ultimate opinion expressed by Dr. Hoversten, concerning the cause of the need for treatment of the hernia condition, to be well reasoned and persuasive. We are persuaded that Dr. Hoversten believed that it was medically probable that the preexisting hernia sac combined with the lifting incident and that the lifting incident at work was the major contributing cause of claimant's need for treatment for the hernia condition.[1]

Dr. Blumberg, a general surgeon, also addressed the cause of the hernia condition. Dr. Blumberg indicated that claimant's hernias were preexisting and that the preexisting hernia defect was the major contributing cause of claimant's need for treatment. Dr. Blumberg did not address whether the preexisting defect combined with the work incident or whether the work incident was the major contributing cause of the disability or need for treatment of any such combined condition. Under such circumstances, we find the opinion of the treating physician and surgeon, Dr. Hoversten, to be more persuasive than that of Dr. Blumberg.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's 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 February 14, 1996 is reversed. The insurer's denial is set aside and the claim remanded to the insurer for processing according to law. For services at hearing and on review, claimant's counsel is awarded $3,500, payable by the insurer.

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[1] Amended ORS 656.005(7)(a)(B) provides that the combined condition is compensable if the compensable injury is the major contributing cause of the disability of the combined condition or the need for treatment of the combined condition. Here, although there is no dispute that claimant's hernias were preexisting, the persuasive medical evidence establishes that the work-related lifting was the major contributing cause of the need for treatment of the combined hernia condition. Under such circumstances, the statute has been satisfied.

In the Matter of the Compensation of
ROGER A. LONGBOTHAM, Claimant
WCB Case No. 95-11778
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Peterson'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 affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, except for the "Ultimate Findings of Facts."

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial of claimant's bilateral upper extremity condition based on a finding that claimant failed to establish that he has or had bilateral carpal tunnel syndrome (CTS).

The parties agree that the issue is compensability of the condition, regardless of the accuracy or certainty of its diagnosis.

Claimant bears the burden of proving that his work activities were the major contributing cause of his bilateral upper extremity condition. ORS 656.802. A finding of major causation requires that work-related causes contribute more to the claimed condition than all other causes, explanation, or exposures combined. See McGarrah v. SAIF, 296 Or 145, 146 (1983); Dethlefs v. Hyster Co., 295 Or 298 (1983).

Claimant argues that the repetitive hand intensive work activities which he performed for the employer from September 1991 through December 1991 are the major contributing cause of his current upper extremity condition. The only medical evidence supporting the claim is contained in two "check-the-box" opinions from Dr. Boyd, attending physician. (Exs. 9, 11).

Dr. Boyd initially concurred with an insurer-arranged examiners' opinion which found no clinical or laboratory evidence that claimant "sustained a carpal tunnel condition, or any other pathology of his upper extremities, as a result of his four month's employment [with the insured]." (Exs. 7-5, 9). Three months later, Dr. Boyd concurred with the statement: "The major contributing cause of [claimant's] upper extremity symptom complex, whether it is borne out to be carpal tunnel or some other condition, in my opinion, would be the repetitive use of his arms while at work, which began while working for [the insured] for four months in 1991." (Ex. 11). We are unable to find that Dr. Boyd's opinion regarding causation persuasively supports this claim, for the following reasons.

First, although Dr. Boyd expressly acknowledged the possible causal contribution of claimant's 40 pound weight gain (since working for the employer in 1991), there is no indication that Dr. Boyd considered it in reaching his ultimate conclusion concerning causation. (See Ex. 10). In addition, although claimant performed additional repetitive activities involving his upper extremities during the 4 years after he stopped working for the employer, there is no indication that Dr. Boyd considered this potential contributor either. (See Ex. 7-4). In fact, there is no indication that Dr. Boyd considered or evaluated the relative contributions of any causes other than the 1991 work exposure in forming his opinions. Because a finding of major causation requires a comparison of off-work and work-related causes and Dr. Boyd performed no such analysis, we find his conclusions insufficiently supported. See Dietz v. Ramuda, 130 Or App 397 (1994). Moreover, because Dr. Boyd changed his opinion substantially without explanation, we find his conclusion inadequately explained on this basis as well. See Moe v. Ceiling Systems, 44 Or App 429 (1980). Under these circumstances, we agree with the ALJ that the claim fails.

ORDER

The ALJ's order dated January 31, 1996 is affirmed.

In the Matter of the Compensation of
DONALD J. BOIES, Claimant
WCB Case Nos. 95-07781 & 95-04236
ORDER ON REVIEW
Emmons, Kropp, et al, Claimant Attorneys
Cummins, Goodman, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The SAIF Corporation, on behalf of Oregon Metallurgical Corporation (OREMET), requests review of those portions of Administrative Law Judge (ALJ) Martha Brown's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for bilateral hearing loss; and (2) upheld the self-insured employer's (Boise Cascade Corporation) denial of an occupational disease claim for the same condition. In his brief, claimant contends that the ALJ's attorney fee award was inadequate. On review, the issues are responsibility and attorney fees. We affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant began work for Boise Cascade in 1965 as an electrician. He worked in the vicinity of noisy paper machines. After noticing diminished hearing, claimant underwent an audiogram in March 1982, which revealed a binaural hearing loss of 20.8 percent. (Ex. 22). Claimant left his employment with Boise Cascade later that year and subsequently worked in Montana as an electrician for a power company.

Claimant began working in March 1985 as an electrician for SAIF's insured, OREMET. During his first four years at OREMET, claimant worked at various locations in the plant, including near hydraulic pumps and large grinders. Claimant wore hearing protection and only removed his ear plugs to communicate.

After 1989, claimant was assigned to the melting department where large electric furnaces and a hydraulic vacuum created significant noise. Claimant worked in that department from 1989 to the present.

After claimant filed an occupational disease claim for hearing loss against OREMET on January 31, 1995, SAIF referred claimant to an audiologist, Loyal Ediger, Ph.D., on March 13, 1995. Dr. Ediger reported that claimant had a severe, bilateral, high-frequency sensorineural hearing loss. (Ex. 17-4). SAIF denied responsibility for claimant's bilateral hearing loss and indicated that it had requested designation of a paying agent under ORS 656.307. (Ex. 18-1).

Claimant then filed a claim for his hearing loss against Boise Cascade on April 1, 1995. Boise Cascade denied the claim on June 28, 1995. (Ex. 22A).

At hearing, the parties agreed that the only issue was responsibility. The ALJ reasoned that, because claimant's bilateral hearing loss condition had never been accepted, ORS 656.308 was not applicable. Concluding that responsibility should be determined under the last injurious exposure rule of Boise Cascade Corp. v. Starbuck, 296 Or App 238 (1984), the ALJ determined that claimant's employment with OREMET was of a kind that could have caused his hearing loss. The ALJ, therefore, assigned responsibility to SAIF.

On review, SAIF contends that the ALJ erred in assigning it responsibility for claimant's hearing loss because claimant's employment activities at Boise Cascade actually caused his hearing loss. We disagree with SAIF's contention.

Generally, in cases where there is no accepted condition, ORS 656.308 does not apply and responsibility is determined under the last injurious exposure rule. SAIF v. Yokum, 132 Or App 18, 24 (1994); Bennett v. Liberty Northwest Ins. Corp., 128 Or App 71, 75 n. 1 (1994). SAIF is correct, however, that, where actual causation is established with respect to a specific employer, it is not

necessary to rely on judicially created rules of assigning responsibility in cases of successive employment exposures. See Runft v. SAIF, 303 Or 493, 501-02 (1987); Eva R. Billings, 45 Van Natta 2142 (1993). However, we disagree with SAIF that the medical evidence establishes that claimant's employment at Boise Cascade actually caused his hearing loss. We reach this conclusion for the following reasons.

Because of claimant's multiple work exposures, the causation issue presents a complex medical question requiring competent medical evidence. Uris v. Compensation Department, 247 Or 420 (1967). There are only two medical opinions that address the causation issue: those of Dr. Springate, an examining otolaryngologist, and Dr. Ediger, the audiologist.

Dr. Springate opined that, without more information, such as a pre-employment audiogram and noise level readings at Boise Cascade, he could not determine the percentage of claimant's hearing loss due to noise exposure at Boise Cascade, or to exposure in the military, in social activities, or at OREMET, SAIF's insured. (Ex. 21-2). Dr. Ediger, however, was provided with claimant's March 1982 audiogram. Dr. Ediger opined that, based on a comparison of this audiogram with one completed in March 1995, claimant's employment at OREMET did not cause or contribute to his hearing loss. (Ex. 22-1). Dr. Springate concurred with this report. (Ex. 23).

Thus, the medical evidence establishes that claimant's employment at OREMET did not cause or contribute to his hearing loss. However, neither Dr. Ediger nor Dr. Springate opined that claimant's Boise Cascade employment was the major contributing cause of his hearing loss. Accordingly, we conclude that actual causation has not been established with respect to Boise Cascade.

Since actual causation has not been established, we find that the ALJ properly resorted to the last injurious exposure rule to determine responsibility. Under that rule, if a worker establishes that disability was caused by a 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). The "onset of disability" is the triggering date for initial assignment of responsibility. See Bracke v. Baza'r, 293 Or 239 (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). Audiometric tests obtained pursuant to OSHA requirements do not constitute medical treatment for purposes of determining the onset of disability. Norman L. Selthon, 45 Van Natta 2358, 2359 (1993).

SAIF argues that claimant first sought treatment during his employment for Boise Cascade and, therefore, that initial responsibility should be assigned to Boise Cascade. SAIF further contends that, in order to shift responsibility to SAIF, Boise Cascade must prove that claimant's work exposure at SAIF's insured actually contributed to a worsening of claimant's hearing loss. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992).

In support of its argument that claimant initially sought medical treatment during his employment at Boise Cascade, SAIF cites records indicating that, while employed by Boise Cascade, claimant had audiometric tests, was advised to consult a doctor regarding his hearing loss, and purchased a hearing aid. (Exs. A, 1A-G, 17-3, 20-2). However, there is no evidence in this record that claimant sought medical treatment for his hearing loss while employed at Boise Cascade. Moreover, hearing loss tests do not constitute medical treatment sufficient to establish the onset of disability. Cf. Norman L. Selthon, supra.

Instead, we treat Dr. Ediger's March 13, 1995 examination to evaluate claimant's hearing loss as the triggering event for the onset of disability. See Gregory A. Wilson, 45 Van Natta 235 (1993) (date of first medical evaluation was triggering date where the claimant missed no work and otherwise sought no medical treatment for his hearing loss). Since this occurred during claimant's OREMET employment, responsibility is initially assigned to SAIF.

To escape responsibility for claimant's hearing loss condition, SAIF must show that claimant's work exposure for Boise Cascade was the sole cause of claimant's hearing loss condition, or that it was impossible for employment conditions at SAIF's insured 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). As discussed above, SAIF cannot show that claimant's work exposure while Boise Cascade was on the risk was the sole cause of claimant's hearing loss. We, therefore, address the "impossibility" prong of the "FMC Corp." test.

The ALJ applied Strametz v. Spectrum Motorwerks, Inc., 135 Or App 67, mod 138 Or App 9 (1995), in determining that SAIF was responsible for claimant's hearing loss condition. In Strametz, the court held that the last employer with employment conditions of a kind that could have caused the claimant's mesothelioma should be assigned responsibility, even if that specific employment could not have been the actual cause of the condition. However, Strametz was not a case that concerned the shifting of responsibility after an initial assignment of responsibility had been made under LIER. Therefore, it did not overturn the well-settled rules for shifting responsibility after an initial assignment of responsibility had been made under LIER. See Karen J. White, 48 Van Natta 1109 (May 30, 1996). Thus, we determine responsibility in this case without regard to Strametz.

Dr. Ediger initially reported that, since claimant did not receive a baseline hearing test when he started at OREMET, he could not determine whether or not claimant's hearing might have declined because of noise exposure from 1985 to 1989 (when claimant was working for OREMET). (Ex. 17-5). However, he felt that it was unlikely. After reviewing claimant's hearing tests from 1982 to 1995, Dr. Ediger opined that claimant's work at OREMET did not cause or contribute to his hearing loss because the decline in claimant's hearing did not exceed the amount related to presbycusis and because claimant's binaural hearing loss in 1982, when he left Boise Cascade, was 20.8 percent and his hearing loss in 1995 was 20.25 percent. (Exs. 17, 22).

Dr. Springate noted that claimant's 1970 audiogram showed a significant bilateral high frequency hearing loss and that claimant's hearing loss had gradually progressed since then. (Ex. 20-3). Dr. Springate later opined that it was difficult to state when the greatest hearing loss occurred without more information such as audiograms and noise level readings. (Ex. 21). However, based on inquiries from SAIF's counsel concerning the role of presbycusis, Dr. Springate subsequently agreed with Dr. Ediger that claimant's hearing loss since 1982 was related to presbycusis rather than to industrial or non-industrial noise exposure, and that, therefore, work from 1982 to 1995 (which includes claimant's OREMET employment) did not contribute to his hearing loss. (Ex. 23).

Accordingly, the medical evidence establishes that claimant's employment at OREMET did not actually cause or contribute to claimant's hearing loss. However, the fact that an employment did not actually contribute to the causation of a disease is insufficient to shift responsibility from the presumptively responsible employer to an earlier one. Cf. Floyd B. Talley, Jr., 48 Van Natta 222, 225 (1996) (medical evidence that earlier work exposure was the major contributing cause of hearing loss insufficient to establish that it was impossible for subsequent noise exposure to have contributed). The pivotal issue is not whether the conditions of the last employment actually caused the disease, but whether it was impossible for those conditions to have contributed to claimant's condition. FMC Corp., supra. However, there is no medical evidence that directly addresses this issue.

Inasmuch as we have determined that SAIF is presumptively responsible for claimant's hearing loss, it has the burden of proof. FMC Corp., supra. Therefore, because the medical evidence does not establish that another employment exposure was the sole cause of claimant's condition or that it was impossible for claimant's OREMET employment to have contributed to his hearing loss, we conclude that SAIF has failed to satisfy its burden of proof. Accordingly, we agree with the ALJ that SAIF is responsible for claimant's hearing loss.

Attorney Fees

Citing amended ORS 656.308(2)(d), the ALJ awarded a $1,000 attorney fee to claimant's counsel for active and meaningful participation on the responsibility issue. Claimant contends that amended ORS 656.308(2)(d) does not apply because the responsibility case was not governed by ORS 656.308. Therefore, claimant asserts that his attorney fee should not be subject to the $1,000 limitation of ORS 656.308(2)(d). Claimant further contends that, should we decide that ORS 656.308(2)(d) applies, he is entitled to a fee for obtaining pre-hearing concessions of compensability from OREMET and Boise

Cascade. We disagree with claimant's first contention, but agree that claimant is entitled to an attorney fee under ORS 656.386(1).

We first address claimant's contention regarding ORS 656.308(2)(d). That statute applies when a claimant finally prevails against a "responsibility denial." There is nothing in the statute that limits the attorney fee under ORS 656.308(2)(d) to responsibility cases under ORS 656.308. Claimant need only prevail against a "responsibility denial." Claimant has done so in this case. Accordingly, we conclude that the ALJ properly limited claimant's attorney fee on the responsibility issue to $1,000. Moreover, the $1,000 cap is cumulative and applies to services both at hearing and on review. Tammy Locke, 48 Van Natta 250 (1996). Therefore, claimant's total attorney fee for services rendered at hearing and on Board review regarding the responsibility issue is $1,000, to be paid by SAIF.[1]

We next address claimant's entitlement to an attorney fee under ORS 656.386(1). As previously noted, SAIF issued a disclaimer of responsibility and a claim denial on March 24, 1995. (Ex. 18). Although it contained notice of hearing provisions and stated that it was a "denial of your claim for benefits," SAIF's denial letter stated that a paying agent had been requested pursuant to ORS 656.307 and that SAIF was disclaiming "responsibility." In its response to claimant's hearing request, SAIF merely requested that the denial be upheld.

On the other hand, Boise Cascade's denial, issued on June 28, 1995, does not state that responsibility only was being denied or disclaimed or that a paying agent was being requested. (Ex. 22A). The denial does contain notice of hearing provisions. Although the stated basis for the denial was the last injurious exposure rule, Boise Cascade's response to claimant's hearing request denied that claimant had sustained a work-related injury or occupational disease.

In James D. Lollar, 47 Van Natta 740 (1995), a carrier's denial stated: "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." The denial indicated that the carrier had requested a "307" order. The document also contained "notice of hearing" provisions and stated that it was a denial of the claim for benefits. Relying on James McGougan, 46 Van Natta 1639 (1994), we concluded that the carrier's denial in Lollar did not raise a compensability issue.[2]

In McGougan, we held that, while the carrier's denial did contain notice of hearing provisions and stated that it was a denial of benefits, it also contained express language conceding compensability and specifically denying responsibility only. Under such circumstances, we found that the carrier's denial did not raise an issue of compensability.

Here, we conclude that SAIF's denial did not raise a compensability issue. SAIF specifically disclaimed responsibility and indicated that it had requested a paying agent. Although SAIF's denial letter contained notice of hearing provisions and was a denial of a claim for benefits, we conclude that it did not raise an issue of compensability in light of its express disclaimer of responsibility.

However, we find that Boise Cascade's denial did raise an issue of compensability. Boise Cascade denied claimant's claim relying on the last injurious exposure rule, but its denial contained notice of hearing provisions and did not indicate that a "307" order had been requested. Most importantly, in its response to claimant's hearing request, Boise Cascade specifically contended that

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[1] The record consisted of 23 exhibits and the hearing lasted one hour and 10 ten minutes. Only one witness (claimant) testified. Claimant's brief was 10 pages long, with approximately one page devoted to his entitlement to a greater attorney fee. Under these circumstances, we do not find "extraordinary circumstances" under ORS 656.308(2)(d) which would justify an attorney fee greater than $1,000. Cf. Tammy Locke, supra.

[2] On reconsideration, we concluded that the claimant was not entitled to an attorney fee award pursuant to ORS 656.386(1) because the issue was not timely raised. In particular, we found nothing in the record to indicate that the claimant's attorney contended that SAIF's denial raised compensability issues or that he sought an attorney fee for obtaining rescission of a compensability denial prior to hearing. James D. Lollar, 47 Van Natta 878 (1995). In this case, claimant did not argue the issue of an attorney fee under ORS 656.386(1) at hearing. However, in his request for hearing, claimant's attorney contended that Boise Cascade's denial raised compensability issues and requested an attorney fee. Issues raised in pleadings are ripe for resolution, even if they are not raised or argued at hearing. See Liberty Northwest v. Alonzo, 105 Or App 458, 460 (1991); Connie G. Johnson, 47 Van Natta 1984, 1987 (1995). Therefore, we address claimant's argument for an attorney fee under ORS 656.386(1).

claimant did not sustain a work-related injury or occupational disease. Under such circumstances, we conclude that Boise Cascade denied claimant's claim on the express ground that claimant's hearing loss condition was not compensable or otherwise did not give rise to entitlement to compensation.[3] ORS 656.386(1). Consequently, claimant is entitled an attorney fee award pursuant to ORS 656.386(1), payable by Boise Cascade.

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 pre-hearing services concerning the pre-hearing rescission of Boise Cascade's compensability denial is $1,500, payable by Boise Cascade. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated October 25, 1995 is affirmed in part and modified in part. In lieu of the ALJ's award of a $1,000 attorney fee to be paid by SAIF, claimant's attorney is awarded $1,000 for services at hearing and on Board review, to be paid by SAIF. Claimant's attorney is also awarded $1,500 for pre-hearing services regarding the rescission of Boise Cascade's compensability denial, to be paid by Boise Cascade. The remainder of the ALJ's order is affirmed.

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[3] In reaching this conclusion, we distinguish Michael J. Galbraith, 48 Van Natta 351 (1996). There, we concluded that a carrier's response to the claimant's hearing request, which stated that "The claimant is entitled to no relief," was not sufficient "on its own" to manifest a "denied claim" under ORS 656.386(1). In contrast to Galbraith, Boise Cascade in this case specifically denied that claimant had sustained a work-related injury or disease in its response to claimant's hearing request. Thus, we find that its response more definitively signaled an intention to deny compensability than did the carrier's response to the claimant's hearing request in Galbraith. See Emily M. Bowman, 48 Van Natta 1199 (1996). Moreover, unlike Galbraith, Boise Cascade's response to claimant's hearing request in this case is not the sole factor indicating that compensability was denied. Considering that Boise Cascade did not request a ".307" order, that its denial contained notice of hearing provisions and did not clearly concede compensability, we find that its denial (in conjunction with its response to claimant's hearing request) satisfied the requirements of a "denied claim" pursuant to ORS 656.386(1).

Board Chair Hall dissenting.

I agree with the majority that Boise Cascade's denial raised an issue of compensability, and that, therefore, claimant is entitled to an attorney fee pursuant to ORS 656.386(1). However, because I believe that claimant's compensation also remained at risk as a result of SAIF's "Disclaimer of Responsibility and Claim Denial," and because I disagree with the majority's application of ORS 656.308(2)(d), I must respectfully dissent.

To avoid an ORS 656.386(1) attorney fee, a carrier must clearly concede that a claim is compensable and state that only responsibility for the claim is at issue. See James D. Lollar, 47 Van Natta 740 (1995) (Board Member Hall dissenting). The carrier would then be bound by the express language contained in its denial. See Tattoo v. Barrett Business Service, 118 Or App 348, 351-52 (1993). With compensability admitted, responsibility would then be the only true issue.

In this case, SAIF's denial did not expressly admit compensability and did not make it clear to claimant that only responsibility was at issue. In fact, to the contrary, it expressly stated that it was a "denial of your claim for benefits" and recited that, in addition to being a responsibility disclaimer, it was also a "claim denial."

While SAIF's denial indicated that a "307" order had been requested, no such order appears in the record. Under these circumstances, I would find that a compensability issue remained viable with respect to SAIF. Accordingly, in order to protect the claimant's rights to compensation, an attorney fee payable by SAIF should be awarded pursuant to ORS 656.386(1).

Finally, I disagree with the majority's limitation of claimant's attorney fees on the responsibility issue to $1,000 under ORS 656.308(2)(d). Since, as the above discussion demonstrates, compensability remained at issue, I would find that ORS 656.308 does not apply in this case. Moreover, in Dan J. Anderson, 47 Van Natta 1929 (1995), we held that the attorney fee limitation of ORS 656.308(2)(d) does

not apply to cases that arise under ORS 656.307. In doing so, we recognized that ORS 656.308(2)(d) only applies to cases that arise under ORS 656.308. Id. at 1932 n. 7. Inasmuch as the majority finds that ORS 656.308 is not applicable in determining responsibility in this case, and instead determines responsibility under LIER, I submit that, consistent with our reasoning in Anderson, the attorney fee limitation in ORS 656.308(2)(d) ought not to apply in this case as well.

In the Matter of the Compensation of
ANDREW O. FUNKE, Claimant
WCB Case Nos. 95-02144 & 95-02143
ORDER ON REVIEW
David C. Force, Claimant Attorney
Judy C. Lucas (Saif), Defense Attorney

Reviewed by Board Members Hall and Christian.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Michael Johnson's order which upheld the SAIF Corporation's denial of claimant's occupational disease claim for a low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following supplementation. Claimant's low back pain did not begin while undergoing traction for his neck. (Ex. 17-8).

CONCLUSIONS OF LAW AND OPINION

Applying the major contributing cause standard, the ALJ found that claimant failed to prove the compensability of his claim. In so doing, the ALJ discounted the opinion of claimant's attending physician, Dr. Mossberg.

On review, claimant contends that Dr. Mossberg's opinion supports the compensability of his occupational disease claim for a low back condition. Specifically, claimant asserts that Dr. Mossberg's opinion is well explained and based on an accurate history. Additionally, claimant contends that the ALJ erred in admitting a video tape of claimant's work activities into the record because the video was allegedly edited and portrayed claimant's work activities after his work station was modified by his employer. Finally, claimant contends that any medical opinion based on the video tape should be discounted.

Because claimant's low back condition symptoms were gradual in onset, we analyze his condition as an occupational disease. (Tr. 16-18; 26); See Valtinson v. SAIF, 56 Or App 186 (1982). As such, claimant must prove that his work activities prior to November 1994 were the major contributing cause of his low back condition. See ORS 656.802(2).

Since 1987, claimant has performed the job of "edger" at a lumber company. The work of an edger required that claimant trim off the edge of "dimension size lumber." (Tr. 15). In 1992, claimant began to sit at a computer control console and initially sat on a large block of wood. The block of wood was replaced by a round metal disk attached to a metal pole which was not adjustable. This "seat" was then replaced with an old forklift chair bolted to the metal pole. Thereafter, a new forklift chair was installed. Because the chairs provided to claimant were not fully adjustable and because an old beam partially obstructed claimant's view while working, he was always bending, slouching and leaning forward in order to perform his job duties.

Subsequent to claimant filing his workers' compensation claim in November 1994, claimant's employer began to modify claimant's work station with the modifications continuing in 1995. Among the modifications was the installation of a fully adjustable seat and the cutting of the "old beam" which had previously obstructed claimant's view.

In January 1995 (after claimant's work station was modified) a video was made of claimant's work activities. (Tr. 81).

In July 1994, claimant was examined by Dr. Mossberg for right leg, posterior thigh and anterior foot pain radiating from his right lumbosacral area. Dr. Mossberg reported that claimant's work required sitting in a "somewhat awkward position manning a machine." (Ex. 18). A September 1994 MRI ordered by Dr. Mossberg revealed disc herniation at L4-5. (Ex. 21).

In December 1994, Dr. Mossberg stated that claimant's "lower back problems have originated because of [claimant's] positioning at work where he sits in a position manning a machine and is very uncomfortable to his back." (Ex. 27). Dr. Mossberg opined that claimant's lumbosacral disc herniation was related to chronic back strain related to positioning in an awkward position in a chair. Id.

In August 1995, Dr. Mossberg stated that she did not concur with Dr. Karasek's April 1995 report (which did not attribute claimant's low back condition to his work). (Ex. 38b). Dr. Mossberg opined that claimant's C6-7 and L5-S1 disc herniations were "highly probable results of [claimant's] work activities."

On January 13, 1995, Dr. Arbeene, who examined claimant on behalf of SAIF, opined that claimant's L5-S1 disc herniation resulted from claimant's work activities. (Ex. 29). Dr. Arbeene stated that claimant's low back complaints were not related to degenerative changes. Id. Dr. Arbeene recommended that claimant may benefit from ergonomic changes in his work place so that claimant would not have to do as much prolonged sitting.

After completion of his evaluation, Dr. Arbeene reviewed additional medical records (most of which concerned claimant's cervical condition) and a video of claimant's work activities. In an addendum to his original report, Dr. Arbeene stated that, based on claimant's medical records and the video, he no longer could attribute claimant's L5-S1 disc herniation to his working activities. (Ex. 29-10).

Dr. Karasek, who examined claimant on behalf of SAIF, opined that claimant's L5-S1 disc herniation was not related to his work activities. (Ex. 36).

Dr. White, who performed a records review on behalf of SAIF, opined that the major contributing cause of claimants lumbar disc herniation was a spontaneously herniating disc resulting from natural causes (i.e. spondylosis). (Ex. 39).

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 to discount the opinion of Dr. Mossberg, claimant's treating physician. Dr. Mossberg opined that claimant's lumbosacral disc herniation originated because of claimant's sitting in a chair at work in an awkward position. Further, Dr. Mossberg stated that claimant's lumbosacral herniation was a "highly probable result" of claimant's work. As such, we conclude that claimant's work activities were the major contributing cause of his disc injury. See McClendon v. Nabisco Brands, Inc., 77 Or App 412, 417 (1986) (no incantation of "magic words" or statutory language is required, provided that the opinion otherwise meets the appropriate legal standard).

In contrast, we decline to rely on the changed opinion (which did not attribute claimant's low back condition to his work) of Dr. Arbeene because it was based on an inaccurate history. Specifically, Dr. Arbeene's changed opinion was based on reviewing "additional medical records" and a video of claimant's work. However, the video viewed by Dr. Arbeene was filmed in January 1995 (after modifications to claimant's work site were undertaken) and represented claimant's work as modified. Consequently, the video viewed by Dr. Arbeene was inaccurate, as it was not representative of claimant's work activities during the period (prior to November 1994) when claimant alleges that his occupational injury occurred. See Miller v. Granite Construction Co., 280 Or App 473, 478 (1977). Further, Dr. Arbeene stated that the "additional medical records" primarily concerned claimant's cervical region. Finally, Dr. Arbeene failed to subsequently explain how these records altered his opinion concerning claimant's low back condition. See Kelso v. City of Salem, 87 Or App 630 (1987). As such, we conclude that Dr. Arbeene's changed opinion is of little persuasive weight.

Similarly, we discount the opinion of Dr. Karasek because of its conclusory analysis. See Somers v. SAIF, supra. Dr. Karasek opined that claimant's disc herniation was not related to his work activities; however, Dr. Karasek offered an inadequate explanation to support his opinion.

Finally, we do not rely upon the opinion of Dr. White because it largely relied upon an erroneous assumption not supported by the record. Dr. White stated that claimant's low back problem was the result of natural causes (i.e. spondylosis). However, none of the records reviewed by Dr. White diagnosed spondylosis. In fact, Dr. Arbeene reported that claimant's MRI studies did not reflect any degenerative changes and that in his opinion natural degenerative changes were not the cause of claimant's lumbosacral condition. Therefore, because Dr. White attributed claimant's low back problems to spondylosis, a condition which was not diagnosed and, in fact, was ruled out as a contributing cause, we do not find his opinion persuasive. Consequently, we find that Dr. Mossberg's opinion persuasively establishes the compensability of claimant's occupational disease claim for a low back condition.

Inasmuch as we have discounted the opinions of the physicians who relied on the video tape, it is unnecessary to discuss whether the ALJ abused his discretion in admitting the video into evidence.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $6,250, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, claimant's counsel's statement of services and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated October 23, 1995 is reversed in part. The SAIF Corporation's January 30, 1995, denial is set aside and the claim is remanded to SAIF for processing according to law. For services on review and at hearing, claimant's attorney is awarded an assessed fee of $6,250, payable by SAIF. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
RONALD A. McCOSKER, Claimant
WCB Case No. 95-00344
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys
Steven A. Wolf (Saif), Defense Attorney

Reviewed by Board Members Hall, Christian and Haynes.

The noncomplying employer, Frontier Construction Company (Frontier), requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's acceptance of claimant's injury claim. Frontier contends that it was not claimant's employer at the time of the injury. On review, the issue is subjectivity.

We adopt and affirm the ALJ's order.

Claimant's attorney is entitled to an assessed fee for services on review. See ORS 656.382(2); 656.054(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000 to be paid by SAIF on behalf of Frontier. 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 December 15, 1995 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the SAIF Corporation on behalf of Frontier Construction Company.

Board Member Haynes Dissenting.

This is a case of mistaken identity. The majority mistakes Mr. Metarese, who did hire claimant, for Mr. Barnes (sole proprietor of Frontier Construction), who did not hire claimant. Metarese (Barnes' son-in-law) was claimant's employer, not Barnes or Frontier Construction.

Barnes/Frontier would only be liable for claimant's injury if Metarese somehow had authority to hire claimant on its behalf. Metarese did not have express authority to hire claimant. In fact, Barnes specifically told claimant that persons outside the Barnes family would not work on Frontier jobs. Therefore, the issue is whether Metarese had implied or apparent authority to hire claimant for Barnes/Frontier.

Metarese's authority to act for Barnes/Frontier was limited to charging minimal quantities of materials to the Frontier business. Therefore, even if Metarese was an agent of Barnes/Frontier, he was not an agent for purposes of hiring.

The majority's reliance on Croisant v. Watrud, 248 Or 234 (1967), as support for its conclusion that Metarese had inherent (implied) or apparent authority to hire claimant, is misplaced. Croisant involved the vicarious liability of a partnership for the wrongful acts of a partner. In Croisant, the partnership was liable, because an agency relationship existed based on the fiduciary relationship among the partners. See Roach v. Mead, 301 Or 383, 388 (1986) (discussing Croisant v. Watrud, supra); Rough & Ready Lumber v. Blue Sky Forest Products, 105 Or App 227, 231-32 (1991) (discussing fiduciary nature of agency relation). Here, in contrast, there is no partnership and Barnes imbued Metarese with little or no authority to act on his behalf. Consequently, Croisant is inapplicable.

In Wiggins v. Barrett & Associates, Inc., 295 Or 679 (1983), the Supreme Court summarized the relevant law of agency as follows:

> "Apparent authority is to be distinguished from implied authority. Implied authority is such as the principal actually intends his agent to have * * *. If implied authority exists there is no need to consider whether the principal has held out the agent as having certain authority * * *.

On the other hand, a principal may be held bound to a third person for an act of the agent completely outside the agent's implied (or express) authority if the principal has clothed the agent with apparent authority to act for the principal in that particular. We have stated the elements necessary to establish apparent authority in Jones v. Nunley, 274 Or 591, 595, 547 P2d 616 (1976):

> " 'Apparent authority to do any particular act can be created only by some conduct of the principal which, when reasonably interpreted, causes a third party to believe that the principal consents to have the apparent agent act for him on that matter. The third party must also rely on that belief.' "

Wiggins v. Barrett & Associates, Inc., supra at 687-88 (emphasis added); see Badger v. Paulson Investment Co., Inc., 311 Or 14, 24 (1991) (quoting Wiggins, supra).

According to the Supreme Court in Nunley and Wiggins, supra, there must be "conduct of the principal" to create apparent authority.

Here, claimant argues that Metarese had apparent authority to hire him, because Metarese gave him a Frontier business card which listed Metarese's name and phone number as well as Barnes'. Based on the business card and a belief (otherwise unsupported) that Metarese "was Frontier," claimant contends that Metarese, as Barnes' apparent agent, hired claimant on Barnes' behalf and that Barnes/Frontier is liable for claimant's workers' compensation coverage because Frontier was claimant's employer when claimant was injured.

The business card in question lists Barnes as owner of Frontier and includes Metarese's name, with no title. There are (or were) two phone numbers printed on the only Frontier business card in evidence. Someone crossed out one of the numbers and wrote in another. Metarese explained that the hand-written number had "nothing to do with the card" and that his number was there as a "message number," in case Barnes could not be reached. The record does not reveal which number is Metarese's.

Who can say what the much-beleaguered business card means in this case? We should say what it does not mean.

There is no evidence that the existence or content of the card led claimant to believe that Metarese was authorized to hire him on Barnes behalf or that the card had anything to do with the employment relationship between Metarese and claimant. The only "conduct of the principal" was procuring the card and allowing Metarese to carry it. I am hard-pressed to understand how such conduct could be sufficient to clothe Metarese with apparent authority to hire claimant. Without conduct by Barnes (upon which claimant might reasonably rely), the principal in this case has simply not clothed anyone with apparent authority.

There is no evidence that Metarese had ever hired Frontier employees or that he told claimant that he had. Even if claimant had worked for Metarese before, he had never worked for Barnes or Frontier, and he had only met Barnes once, briefly. Barnes did not hire claimant. Barnes did not authorize Metarese to hire claimant. Barnes did not clothe Metarese with apparent authority to hire claimant and claimant did not rely on any such appearance of authority. Because I believe the majority's conclusions to the contrary constitute reversible legal error, I must dissent.

In the Matter of the Compensation of
THOMAS R. WILLIAMS, Claimant
WCB Case Nos. 94-03163, 94-03162 & 93-05344
ORDER ON REVIEW
Charles G. Duncan, Claimant Attorney
Moscato, Byerly, et al, Defense Attorneys
Scott Terrall & Associates, Defense Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Morgan Manufacturing/Nicolai Door (Nicolai) requests review of those portions of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denial of claimant's current torn left rotator cuff condition; and (2) upheld the responsibility denials of Barrett Business Services (Barrett) and the SAIF Corporation of claimant's new occupational disease claim for the same condition. Claimant cross-requests review, contending that Barrett should be held responsible. Barrett argues that it cannot be responsible for claimant's left shoulder condition because Nicolai's responsibility disclaimer was not timely under ORS 656.308(2). On review, the issues are disclaimer notice and responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

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

We do not adopt finding number 33. (Opinion and Order p.6). Instead, we find that claimant's work activities since his exposure at Nicolai were the major contributing cause of a pathological worsening of his left shoulder condition.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's current left shoulder condition was compensable. However, the ALJ upheld Nicolai's denial of claimant's aggravation claim for that condition because claimant's aggravation rights under the 1987 injury claim had expired prior to filing of the aggravation claim. We agree, noting that the parties do not dispute these conclusions.

The ALJ then found Nicolai initially responsible for claimant's current left shoulder condition (a torn rotator cuff) under ORS 656.308. The ALJ further found a "new" occupational disease established, based on claimant's work activities since his exposure with Nicolai. However, because the record failed to establish that any one of claimant's latter employments was the major contributing cause of his current condition, the ALJ concluded that responsibility did not shift from Nicolai. We reach a different result, based on the following reasoning.

Nicolai is presumptively responsible for claimant's compensable left shoulder condition in the first instance.[1] ORS 656.308(1). However, if claimant's subsequent work exposure was the major contributing cause of a pathological worsening of the compensable condition, responsibility shifts from Nicolai to a later employer. See ORS 656.802(2); Tivis E. Hay, 48 Van Natta 558 (1996).

Only Dr. Lantz addressed and evaluated claimant's "post-Nicolai" work exposure[2] specifically. Considering claimant's work history, clinical presentation, and the absence of contributing non-occupational factors, Dr. Lantz opined that "the few years"[3] preceding his January 1993 evaluation of claimant were the major contributing cause of the 1993 torn rotator cuff condition.[4] (Ex. 57A). Because we find Dr. Lantz's opinion in this regard consistent with claimant's work exposure[5] and effectively unrebutted, we rely on it.[6] Accordingly, because claimant did not work for Nicolai following his April 1988 surgery, we further find that Dr. Lantz's opinion supports a finding that claimant suffered a "new" occupational disease involving his compensable left shoulder condition during his subsequent employment. Accordingly, responsibility shifts from Nicolai to a later employer under ORS 656.308(1).

Claimant and Nicolai argue that the last injurious exposure rule should be applied to determine which of the subsequent employers is responsible for his current left shoulder condition. We agree. See Michael J. Joseph, 47 Van Natta 2043, 2047 (1995) (When a new occupational disease is established as to multiple employment exposures under ORS 656.308, the last injurious exposure rule is then applied to determine which of the subsequent carriers is responsible).

The last injurious exposure 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 receives treatment for a compensable condition before experiencing time loss due to the 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).

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[1] In reaching this conclusion, we note that the parties do not contest the ALJ's initial application of ORS 656.308 or his finding that claimant's current left shoulder condition involves the same condition previously accepted by Nicolai.

[2] Claimant last worked for Nicolai on April 25, 1988.

[3] Dr. Lantz had previously identified 1988-1993 as the relevant time period. (Ex. 37-7).

[4] The parties do not dispute the fact that the torn rotator cuff condition represents a pathological worsening of the compensable condition.

[5] Claimant performed heavy work which required repetitive left shoulder use in 1992 when his shoulder condition worsened. (See Exs. 63-2; see also Ex. 68-1).

[6] Barrett argues that Dr. Lantz's opinion is unpersuasive because it is inconsistent. However, we find nothing inconsistent about the doctor's statements that claimant's left shoulder problems began with "pre-work exposure" degeneration, that all work activity contributed (but no one specific "job" was the major cause), that the biceps tendon rupture (while working for Nicolai) was the underlying pathological process, and that the work between 1989 and 1993 was the major contributing cause of the current torn rotator cuff condition. In other words, we find Dr. Lantz's opinion internally consistent, as well as consistent with his summary concurrence with Dr. James' opinion. (See Exs. 57A, 66-4, 66, 73, 75, 76). Moreover, to the extent that Barrett would have us read the summary concurrence as a further concurrence with Dr. Woolpert's opinion, (Ex. 65), we decline to do so. See Beverly M. Brown, 46 Van Natta 2455 (1994) (We give little if any weight to conclusory opinions such as unexplained "check-the-box" reports, which lack persuasive foundation) (citing Marta I. Gomez, 46 Van Natta 1654 (1994)).

Here, we find no evidence that claimant experienced time loss due to his compensable left shoulder condition since his last aggravation claim with Nicolai was closed on April 5, 1989. He first treated for his shoulder condition (since the prior claim closed) in 1993. (See Ex. 37). Accordingly, because Barrett was the last employer before claimant sought treatment in 1993, we assign responsibility to Barrett. Timm v. Maley, supra, 125 Or App at 401.

Barrett may escape liability for claimant's "new" 1993 occupational disease claim, if it proves that: (1) subsequent employment was the major cause of another "new" injury or occupational disease; (2) prior employment was the sole cause of the condition; or (3) it was impossible for its exposure to have caused it. See Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992); FMC Corp. v. Liberty Mutual Ins. Co., 70 or App 370, 374, on recon 73 Or App 223, rev den 299 Or 203 (1985). Because we find no such evidence in this case, responsibility remains with Barrett.[7]

The ALJ awarded claimant a $4,750 attorney fee (payable by Nicolai) for his counsel's services at hearing (under ORS 656.386(1) and 656.308(2)(d)). We award the following fee instead.

Under 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 on review. Here, claimant has finally prevailed over Barrett's compensability denial. Thus, he is entitled to a carrier-paid attorney fee award under ORS 656.386(1) for his counsel's services provided at hearing and on review. After applying 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 $4,750 payable by Barrett. 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.

Claimant is also entitled to a carrier-paid attorney fee award under ORS 656.308(2)(d) for his attorney's active and meaningful participation in the responsibility dispute at hearing and on Board review. Claimant filed a hearing request contesting Barrett's responsibility denial and has successfully prevailed over that denial.[8] Accordingly, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services at hearing and on review in this regard is $1,000, to be paid by Barrett.[9] 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, and the value of the interest involved.

ORDER

The ALJ's order dated November 29, 1995 is reversed in part and affirmed in part. That portion of the order that set aside Morgan Manufacturing/Nicolai Door's denial is reversed. The denial is reinstated and upheld. Barrett Business Service's denial is set aside and the claim is remanded to Barrett for processing according to law. In lieu of the ALJ's attorney fee award to be paid by Nicolai, claimant is awarded a total of $5,750 in attorney fees, payable by Barrett. The remainder of the order is affirmed.

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[7] We acknowledge Barrett's contention that Nicolai is necessarily responsible for claimant's compensable left shoulder condition because its responsibility disclaimer was untimely under former ORS 656.308(2). However, even assuming that Barrett's disclaimer was untimely, that does not prevent claimant from successfully arguing that Barrett is responsible. See Darral T. Morrow, 47 Van Natta 2030, 2032 (1995); Penny L. Hamrick, 46 Van Natta 14, on recon 46 Van Natta 410 (1994).

[8] We find that claimant's attorney's participation in the responsibility dispute was meaningful, because he obtained a longer period of aggravation rights for claimant. See e.g., Shelley C. Nikolaus, 48 Van Natta 750, 751 (1996).

[9] See Tammy Locke, 48 Van Natta 150 (1996) (Absent extraordinary circumstances, $1,000 is the maximum attorney fee awardable under ORS 656.308(2)(d) for all levels of litigation).

In the Matter of the Compensation of
RANDY L. CARTER, Claimant
WCB Case Nos. 94-11195 & 94-04775
ORDER ON REVIEW
Welch, Bruun, et al, Claimant Attorneys
Alice M. Bartelt (Saif), Defense Attorney
Bailey & Associates, Defense Attorneys

Reviewed by Board Members Haynes and Hall.

Crawford & Company (Crawford), on behalf of Stone Forest Industries, requests review of that portion of Administrative Law Judge (ALJ) Garaventa's order which awarded a penalty because of its allegedly unreasonable claim processing. On review, the issue is penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, but with the following addition. Crawford did not receive Dr. Ellison's April 20, 1995 report until the day of the hearing (April 25, 1995).

CONCLUSIONS OF LAW AND OPINION

The ALJ assessed a penalty pursuant to ORS 656.262(11)(a) for Crawford's allegedly unreasonable denial of compensability. In reaching this conclusion, the ALJ determined that, when it issued its compensability denial, Crawford had a legitimate doubt regarding its liability for claimant's claim because there was no evidence relating claimant's right shoulder condition to his work activities. However, the ALJ found that the employer unreasonably maintained its denial after receipt of an April 20, 1995 medical report from Dr. Ellison, claimant's attending physician and the only physician to address the causation issue.[1]

On review, Crawford contends that it did not act unreasonably in the administration of the claim and should not have been assessed a penalty. We agree.

The reasonableness of a carrier's denial of compensability must be gauged based upon the information available to the carrier at the time of the denial. Brown v. Argonaut Insurance Co., 93 Or App 588 (1988). However, continuation of that denial in the light of new medical evidence becomes unreasonable if the new evidence destroys any legitimate doubt about liability. Id. at 592.

Here, there is no dispute that Crawford's denials of compensability were reasonable at the time they were issued on April 8, 1994 and June 8, 1994. On February 22, 1994, Dr. Ellison had diagnosed acromioclavicular arthrosis aggravated by claimant's work activities. (Ex. 4-3). However, Dr. Ellison had provided no explanation of how claimant's work activities had "aggravated" his right shoulder condition.

The ALJ apparently believed that Crawford received Dr. Ellison's April 20, 1995 report on April 21, 1995 (4 days prior to the April 25, 1995 hearing) and failed to further investigate the claim, thus making continuation of its denial unreasonable. However, Crawford avers that it did not receive Dr. Ellison's report until the date of the hearing. (Tr. 3). Claimant does not dispute Crawford's assertion as to the date it received the report. Therefore, we find that Crawford did not receive Dr. Ellison's report until the April 25, 1995 hearing.

Crawford objected to the admission of Dr. Ellison's April 20, 1995 report. (Tr. 3). The ALJ admitted the report, but allowed Crawford the right to depose Dr. Ellison. Id. The deposition did not occur until November 1995.[2] The record closed on January 4, 1996, and the ALJ's order issued on January 12, 1996.

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[1] Dr. Ellison opined without explanation that claimant's work activities "caused" claimant's shoulder condition. (Ex. 28).

[2] Claimant does not contend that Crawford unreasonably delayed arranging the deposition.

Crawford contends that continuation of the denial was not unreasonable, given that it did not receive Dr. Ellison's report until the date of the hearing and was then given the right to depose Dr. Ellison. We agree that, under these circumstances, Crawford's continuing denial of compensability was not unreasonable. Considering the lack of persuasive medical evidence before the hearing supporting the compensability of the claim, we do not find it unreasonable for Crawford to await the ALJ's review of the entire record (including the medical report submitted at hearing and the "post-hearing" deposition/cross-examination) and her ultimate decision regarding compensability.[3]

Claimant also contends that any legitimate doubt about Crawford's liability was destroyed after the deposition of Dr. Ellison in November 1995 and that it should have conceded compensability at that time. Even assuming that we can assess a penalty based on Crawford's "post-hearing" conduct, see Warren D. Battle, 45 Van Natta 1169, 1171(1993) (since fact finder generally does not have evidence regarding the reasonableness of a carrier's post-hearing conduct, no factual basis to award penalty based on amounts due after hearing), we decline to do so here. The fact that Dr. Ellison agreed during his deposition that claimant's work activities were the major contributing cause of his right shoulder condition does not alter our conclusion that Crawford's failure to rescind its compensability denial was reasonable. (Ex. 30-16, 17).

It is well-settled that even the uncontradicted medical opinion of a physician is not binding on the trier of fact. See William K. Young, 47 Van Natta 740, 744 (1995) (uncontradicted medical opinion found unpersuasive); Edwin Bollinger, 33 Van Natta 559 (1981) (uncontradicted medical opinion need not be followed). Moreover, since the hearing was continued for the admission of Dr. Ellison's deposition, we do not consider it unreasonable for Crawford to maintain its denial while awaiting the ALJ's determination of the reliability and persuasive weight of Dr. Ellison's observations and conclusions. Accordingly, we find that Dr. Ellison's "post-hearing" testimony did not destroy any legitimate doubt regarding Crawford's liability for the claim.

In conclusion, Crawford's continuation of its compensability denial was not unreasonable under the circumstances presented in this case. Therefore, we reverse the ALJ's decision to assess a penalty.

ORDER

The ALJ's order dated January 12, 1996 is reversed in part and affirmed in part. That portion which assessed a penalty for Crawford's allegedly unreasonable claim processing is reversed. The remainder of the ALJ's order is affirmed.

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[3] In reaching this conclusion, we do not wish to suggest that a carrier may ignore the Brown proscription against continuation of a denial when "post-denial" medical evidence destroys legitimate doubt regarding a carrier's liability. "Legitimate doubt" may be destroyed at any time, and, when that occurs, the carrier should act in accordance with the court's directive in Brown. However, under the circumstances of this case, we do not find it unreasonable for Crawford to have awaited the ALJ's ultimate decision regarding compensability when that determination necessarily involved an assessment of the persuasiveness and reliability of Dr. Ellison's "post-hearing" medical opinion.

In the Matter of the Compensation of
GREG H. BOOTH, Claimant
WCB Case No. 95-04876
ORDER ON RECONSIDERATION
Karl Goodwin (Saif), Defense Attorney

On May 23, 1996, we affirmed an Administrative Law Judge's (ALJ's) order that upheld the SAIF Corporation's denial of his occupational disease claim for his sinus and upper respiratory condition. In reaching our decision, we also declined to remand this case to the ALJ for the admission of a "post-hearing" and "post-surgery" medical report. Since issuance of our decision, we have received several additional submissions from claimant. Noting that the "post-surgery" report states that his significant industrial exposure "results in ethmoid maxillary disease," claimant contends that the report satisfies the "major contributing cause" standard for establishing a compensable occupational disease.

In reaching our prior conclusion, we took into consideration the entire post-surgery report submitted by claimant. Consequently, although our prior order did not specifically repeat Dr. Lee's statement that "[e]xposure results in ethmoid maxillary disease...," such a fact does not mean that we did not consider the entire report. Additionally, Dr. Lee's statement must be read in context. That is, Dr. Lee first stated that claimant has significant industrial-related nasal responses and has had clinical and x-ray evidence of ongoing sinusitis. Dr. Lee's clinical diagnosis was "chronic sinusitis." As explained in our prior order, because the record shows that claimant has had ongoing sinus problems since the eighth grade, we are unable to disregard the contribution of that condition and find that work is the major contributing cause. In other words, even if we consider the "post-surgical" report, we must also consider the remaining medical evidence in the record.

The result of our review of the entire record, including Dr. Lee's report, is that we are not persuaded that claimant's work is the major contributing cause of his sinus and upper respiratory condition. Consequently, we continue to conclude that remand is not warranted and that the ALJ's order should not be affirmed.

Accordingly, we withdraw our May 23, 1996 order. On reconsideration, as supplemented herein, we republish our May 23, 1996 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

June 27, 1996 Cite as 48 Van Natta 1273 (1996)

In the Matter of the Compensation of
WCB Case No. 93-13236
SHARMAN R. CROWELL, Claimant
SECOND ORDER ON REMAND
Schneider & Hooton, Claimant Attorneys
Schwabe, et al, Defense Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

On May 9, 1996, we abated the Board's April 9, 1996 Order on Remand that affirmed a Determination Order which had classified her injury claim as "nondisabling." We took this action to consider claimant's motion for reconsideration. Having received self-insured employer's response, we proceed with our reconsideration.

In its prior order, the Board determined that claimant's claim was properly classified as "nondisabling" because no temporary disability benefits were due and payable and because the record did not establish a reasonable expectation of permanent disability. See ORS 656.005(7)(c); Karren S. Maldonado, 47 Van Natta 1535 (1995). Relying on ORS 656.262(4)(b) (which provides that a self-insured employer's payment to a "disabled" worker at the same pay interval that the worker received at the time of injury shall be deemed timely payment of temporary disability in accordance with ORS 656.210 and 656.212), claimant asserts that she has met the definition of a "disabling compensable injury" under ORS 656.005(7)(c) because temporary partial disability payments are deemed to have been made and paid to her by the self-insured employer when she was paid her regular wages on her return to work at a modified job.

We are not persuaded by claimant's argument. For ORS 656.262(4)(b)[1] to apply, claimant must first be "disabled." Whether claimant is "disabled" is the very issue to be decided in this case. As explained in our order, because notemporary disability benefits were due and payable and because the

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[1] ORS 656.262(4)(b) provides:

"Notwithstanding any other provision of this chapter, if a self-insured employer pays to an injured worker who becomes disabled the same wage at the same pay interval that the worker received at the time of injury, such payment shall be deemed timely payment of temporary disability payments pursuant to ORS 656.210 and 656.212 during the time the wage payments are made." (Emphasis added).

record does not establish a reasonable expectation of permanent disability, this claim was properly classified pursuant to ORS 656.005(7)(c) as "nondisabling." Inasmuch as claimant was not "disabled," ORS 656.262(4)(b) is inapplicable. It, therefore, follows that the employer's payment of regular wages to claimant does not satisfy the requirements of ORS 656.005(7)(c).

On reconsideration, as supplemented herein, we adhere to and republish our April 9, 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
DANNY R. FULLER, Claimant
WCB Case No. 93-12935
THIRD ORDER ON RECONSIDERATION
Schneider & Hooton, Claimant Attorneys
Lundeen, et al, Defense Attorneys

On June 4, 1996, we issued our Second Order on Reconsideration in this matter. In our June 4, 1996 order, we: (1) affirmed that portion of an Administrative Law Judge's (ALJ's) order which set aside the insurer's denial of claimant's aggravation/current condition claim for an upper neck condition; (2) adhered to our prior decision which reversed that portion of the ALJ's order that had set aside the insurer's partial denial of claimant's right shoulder impingement syndrome; and (3) awarded an assessed attorney fee of $1,200 for claimant's counsel's services on review.

On reconsideration, claimant argues that our Second Order on Reconsideration neglected to reinstate the ALJ's attorney fee award. We agree with claimant that an assessed attorney fee is appropriate for claimant's counsel's services at hearing. However, in her Opinion and Order, the ALJ awarded claimant a total attorney fee of $4,000 for prevailing against both of the insurer's denials. As noted above, we have reversed the ALJ's decision with respect to the issue of compensability of claimant's right shoulder condition. Therefore, we modify the ALJ's attorney fee to reflect the fact that claimant has prevailed only on the issue of compensability of the upper neck condition.

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 at hearing (on the issue of claimant's upper neck condition) is $2,500. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the hearings record), the complexity of the issue, the value of the interest involved, and the risk that claimant's counsel might go uncompensated. This award is in lieu of the ALJ's attorney fee award and in addition to the $1,200 fee granted in our June 4, 1996 order.

Accordingly, we withdraw our prior orders. On Reconsideration, as modified and supplemented herein, we republish our prior orders. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MELVIN L. GORDON, Claimant
WCB Case Nos. 95-10988, 95-07123, 94-13102 & 94-13056
ORDER ON REVIEW
Darris K. Rowell, Claimant Attorney
Lundeen, et al, Defense Attorneys
Meyers, Radler, et al, Defense Attorneys
Lane, Powell, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) found that claimant's hearing loss claim with Liberty, on behalf of Fort Hill Lumber Company (Fort Hill), for the period October 1984 through December 1988, was not time- barred; (2) set aside Liberty's denial of claimant's hearing loss claim, on behalf of Fort Hill, for the period October 1984 through December 1988; (3) upheld Liberty's denials of the same condition on behalf of Fort Hill and Willamina Lumber Company (Willamina) for other periods; and (4) upheld the SAIF Corporation's denials of the same condition. Claimant cross-requests review of that portion of the ALJ's order that held that Liberty and SAIF, on behalf of Willamina, for the period after March 1, 1989, were prejudiced by claimant's late hearing loss claims. On review, the issues are timeliness of claims and responsibility. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Timeliness of Claims

Liberty asserts that the ALJ erred by holding that claimant's untimely claim regarding his employment at Fort Hill, for the period October 1984 through December 1988, was not prejudicial and, therefore, that the claim was not void. We disagree.

Occupational disease claims are void if they are filed with a carrier more than one year from the date that the worker first discovered, or in the exercise of reasonable care should have discovered, the disease. ORS 656.807(1). Because, however, occupational disease claims are to be processed in the same manner as provided for accidental injuries, ORS 656.807(3), to establish a late filing defense, the carrier must prove that it was prejudiced by the failure to receive timely notice of the claim. Joanne C. Rockwell, 44 Van Natta 2290, 2292 (1992); see former ORS 656.265(4)(a).[1] For the reasons stated in the ALJ's order, we agree that Liberty, on behalf of Fort Hill, for the period October 1984 through December 1988, has failed to establish that it was prejudiced by claimant's late filed hearing loss claim. Therefore, we agree that, as to that period, claimant's claim is not time-barred.

Liberty asserts that Senate Bill 369 has overruled our decision in Joanne C. Rockwell, supra. Particularly, Liberty asserts that, because the 1995 Legislature did not amend ORS 656.807, and because that statute makes no reference to prejudice, Rockwell is no longer good law. We disagree.

As Liberty correctly asserts, Senate Bill 369 did not amend ORS 656.807. It did, however, amend ORS 656.265. As amended, ORS 656.265(4)(a) now provides that "[f]ailure to give notice as required by this section bars a claim under this chapter unless the notice is given within one year after the date of the injury and: (a) The employer had knowledge of the injury or death[.]" As amended, the statute eliminates the prejudice requirement. The amended statute, however, applies only to injuries

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[1] Former ORS 656.265(4)(a) provided that "[f]ailure to give notice as required by this section bars a claim under this chapter unless: (a) The employer had knowledge of the injury or death, or the insurer or self-insured employer has not been prejudiced by the failure to receive the notice[.]" The parties do not argue this case under the knowledge prong of that statute. Accordingly, we limit our analysis to the prejudice prong of the statute.

occurring on or after June 7, 1995, the effective date of the Act. Or Laws 1995, ch 332, §§ 66(2), 69. As to injuries (or diseases) occurring before June 7, 1995, pre-Senate Bill 369 law remains viable in this context. Accordingly, because claimant's disease arose before that date, under ORS 656.807(3), former ORS 656.265(4)(a) and Joanne C. Rockwell, supra, Liberty can avoid claimant's claim only by establishing that it was prejudiced by the claim's late filing. As stated earlier, Liberty has not established any prejudice; therefore, we affirm the ALJ's finding that claimant's claim with Liberty, on behalf of Fort Hill, for the period October 1984 through December 1988, was not time-barred.

Claimant cross-requests review of that portion of the ALJ's order that held that Liberty and SAIF, on behalf of Willamina, for the period after March 1, 1989, were prejudiced by claimant's late hearing loss claims. In light of our conclusion, see infra, that Liberty, on behalf of Fort Hill, for the period October 1984 through December 1988, is responsible for the claim, we need not address that issue. Hence, we turn to the responsibility issue.

Responsibility

We adopt and affirm the ALJ's reasoning and conclusions regarding this issue, with the following supplementation.

Claimant has worked in the wood products industry since 1948, and in Oregon since 1970. He first noticed hearing loss in the 1960's, and first received a hearing aid in the 1970's. Claimant filed his hearing loss claims in 1994. At hearing, the parties disputed compensability and responsibility. The ALJ found the hearing loss compensable, and assigned responsibility to Liberty, on behalf of Fort Hill, for the period October 1984 through December 1988. On review, the parties contest responsibility, but not compensability.

The parties do not dispute that this case is governed by the last injurious exposure rule (LIER). 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, 243 (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).

Here, no party disputes the ALJ's assignment of initial responsibility under Maley to Liberty, on behalf of Fort Hill, for the risk period October 1984 through December 1988. Therefore, to shift responsibility to a later carrier, Liberty must show that a later employment actually contributed to a worsening of claimant's hearing loss. Oregon Boiler Works v. Lott, 115 Or App 70, 74 (1992). For the reasons stated in the ALJ's order, we agree that Liberty has not made that showing.

Liberty asserts that, under Beneficiaries of Strametz v. Spectrum Motorwerks, 135 Or App 67, recon 138 Or App 9 (1995), and Meyer v. SAIF, 71 Or App 371 (1984), rev den 299 Or 203 (1985), it can shift responsibility to a later carrier by establishing that claimant's exposure after December 1988 was of the type that could have contributed to claimant's hearing loss. We disagree.

Strametz was not a case that concerned shifting responsibility after an initial assignment of responsibility had been made under LIER. Therefore, it did not overturn the well-settled rules for shifting responsibility forward to a subsequent employer. See Karen J. White, 48 Van Natta 1109 (1996) (evidence of "actual contribution" from a subsequent employment still necessary in order to shift responsibility forward after initial responsibility assignment under LIER). Moreover, Meyer also did not concern shifting responsibility after an initial assignment of responsibility under LIER. Accordingly, we conclude that Strametz and Meyer are distinguishable. We, therefore, reject Liberty's arguments based on those cases.

Claimant's attorney is entitled to an assessed fee for services on review. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by Liberty, on behalf of Fort Hill, for the period October 1984 through December 1988. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated October 23, 1995, as reconsidered November 30, 1995, is affirmed. For services on Board review, claimant's attorney is awarded $1,000, payable by Liberty Northwest Insurance Corporation, on behalf of Fort Hill Lumber Company, for the period October 1984 through December 1988.

June 24, 1996 Cite as 48 Van Natta 1277 (1996)

In the Matter of the Compensation of
CECIL L. HUDSON, Claimant
WCB Case No. 95-11267
ORDER ON REVIEW
Dobbins, McCurdy & Yu, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the insurer's denial of claimant's low back injury claim. On review, the issue is compensability.

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

We find that claimant began working for the employer in June 1995, rather than June 1994. (See Tr. 10, Opinion and Order p.2, paragraph 2).

Claimant argues that he filed claims for two separable conditions: a low back strain and a herniated disc. In this regard, claimant relies on medical reports based on examinations 5 days, 9 days, and about 2 months after the alleged July 8, 1995 work incident. (Exs. 20, 23, 35). On July 13, 1995, Dr. Campbell examined claimant and assessed: "Lumbosacral strain. Rule out herniated lumbar disc at L6-S1." (Ex. 20). On July 17, 1995, Dr. Campbell refined his assessment: "Lumbosacral strain with disc herniation at L4-5, resulting in spinal stenosis, as well as impingement of the right L5 nerve root from enhanced scar tissue." (Ex. 23). Following a September 18, 1995 examination, Dr. Zivin stated: "Preexisting conditions define the baseline upon which the falling incident of 7-8-95 superimposed; the incident of 7-8-95 precipitated need for treatment and current time loss. The 7-8-95 injury is a lumbar strain/contusion with precipitation of recurrent radiculopathic pain the right leg." (Ex. 35-8). Dr. Zivin identified claimant's preexisting conditions to include "Preexisting constitutional narrowing of the lumbar spine canal; anomalous low lumbar vertebral body formation; status post L4-5 discectomy (remote)." (Id).

Based on this evidence (and the remainder of the record), we are not persuaded that any disability or treatment under this claim results from a low back strain without significant contribution from preexisting problems. Under these circumstances, we agree with the ALJ that claimant is subject to the major contributing cause standard of proof under ORS 656.005(7)(a)(B). See Charles L. Grantham, 48 Van Natta 1094 (May 30, 1996). Because we further agree with the ALJ that the opinions of Drs. Zivin and Young are more persuasive than those of Dr. Mason, we conclude that claimant has failed to carry his burden under the statute.

ORDER

The ALJ's order dated January 31, 1996 is affirmed.

In the Matter of the Compensation of
JEANA LARSON, Claimant
WCB Case No. 95-09641
ORDER ON REVIEW
Max Rae, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Moller and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that affirmed an Order on Reconsideration that awarded no permanent disability for claimant's lumbar strain. On review, the issue is extent of unscheduled permanent disability.

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

Claimant contends that Bulletin No. 242 (Rev.) (November 9, 1992), which was applied in this case, is not a properly promulgated administrative rule. Claimant asserts that, because the bulletin contains a statement of general applicability, it must be promulgated as a rule. Because the bulletin is not a properly promulgated administrative rule, claimant argues that it can play no role in disability determination. Claimant's argument is not well-taken.

First, we acknowledge that we have no statutory authority to invalidate a Director's rule regarding the evaluation of permanent disability and are bound by statute to apply the standards adopted by the Director. Gregory D. Schultz, 47 Van Natta 2265 (1995). However, even if we had authority to invalidate a Director's rule, we find that Bulletin 242 is not subject to the rulemaking provisions of the Administrative Procedures Act (APA), ORS chapter 183.

The criteria for establishing whether "informal embellishments of validly promulgated rules," as is the bulletin here, must be promulgated as a rule under the APA have been addressed in Wehrman v. Public Welfare Div., 24 Or App 141, rev den (1976), Clark v. Pub. Wel. Div., 27 Or App 473 (1976), and Burke v. Public Welfare Div., 31 Or App 161 (1977). In each of these cases, the court held that it is not the method of promulgation that establishes the validity of the informal directive, but whether the content of the directive is such that it should be considered as a rule and thus be subject to the rulemaking provisions of the APA.

In Wehrman, the court held that an informal bulletin which stated that tax rebates should be considered as income was not a rule within the meaning of ORS 183.310(7) because it was "merely a specific application of the broad definition of income set forth in a validly adopted rule."

In Clark, the court held that a provision in the Food Stamp Manual which defined "medical expenses" was not merely an application of a rule which provides that medical expenses can be deducted from income, but that it was a definition and amplification of a term used in that rule. Therefore, the manual provision itself should have been promulgated as a rule under the APA. 27 Or App at 475.

In Burke, the court held that the principle which emerges from Wehrman and Clark is that an agency's pronouncement of how a validly promulgated rule operates in a specific context need not itself be promulgated as a rule if the existing rule necessarily requires the result set forth in that pronouncement; that is, no formal rulemaking is required whenever an agency undertakes to explain the necessary requirements of an existing rule. In contrast, interpretive amplification or refinement of an existing rule is a new exercise of agency discretion and must be promulgated as a rule under the APA to be valid. 310 Or App at 164.

Accordingly, whether the bulletin in question should have been promulgated as a rule under the APA is determined by whether the bulletin explains the necessary requirements of an existing rule, or whether it interprets or amplifies an existing rule. We conclude that the bulletin merely undertakes to explain the necessary requirements of the existing rule and, therefore, is not subject to the rulemaking provisions of the APA.

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[1] note that the citation in the last paragraph on page 2 should be [former] OAR 436-35-007(4), not 436-45-007(4).

The Director's rules provide that only the methods described in the AMA Guides to the Evaluation of Permanent Impairment (3rd ed., 1990) may be used to establish impairment under the "standards." Former OAR 436-35-005(5) and 436-35-007(4). Former OAR 436-35-007(4) also provides that methods the Director may prescribe by bulletin shall be used to measure and report impairment.

The AMA Guides provide a validation measure for range of motion findings in the low back independent of reproducibility, which requires comparison of tightest straight leg raising (SLR) with hip flexion plus hip extension. The comparison must be within 10 degrees or the measurements are not valid. AMA Guides, supra, at 96, 98.

As provided by former OAR 436-35-007(4), the Director has also prescribed by bulletin the SLR method for testing the validity of lumbar flexion. See Bulletin No. 242, supra at 7. The bulletin also provides that "[m]easurements which do not meet the validity criterion shall be noted in the examiner's report." Id. at 2.

The Director's bulletin establishes the same method for determining validity of lumbar flexion as provided in the AMA Guides, with the additional requirement that the examiner note in his or her report any measurements that do not meet the validity criterion. Hence, we conclude that the bulletin prescribes a specific application of the validity criteria set forth in a validly adopted rule. Accordingly, the provisions in the Bulletin need not have been promulgated as a rule under the APA. Wehrman v. Public Welfare Div., supra; Clark v. Publ Wel. Div., supra; Burke v. Public Welfare Div., supra. Therefore, Bulletin 242 was appropriately applied in this case.

ORDER

The ALJ's order dated November 29, 1995 is affirmed.

June 24, 1996 Cite as 48 Van Natta 1279 (1996)

In the Matter of the Compensation of
DAVID C. TSHAPPAT, Claimant
WCB Case Nos. 95-11630 & 95-08958
ORDER ON REVIEW
Lundeen, et al, Defense Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant, pro se, requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) upheld the SAIF Corporation denial of compensability and disclaimer of responsibility for claimant's right knee condition; and (2) upheld Liberty Northwest Insurance Corporation's denial of compensability and disclaimer of responsibility for the same condition. On review, the issues are compensability and, potentially, responsibility.

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

Claimant injured his right knee during a 1978 nonwork-related motorcycle accident. Eventually, he underwent right knee surgery. In 1979, claimant again injured his right knee while working for SAIF's insured. In 1980, he underwent a second surgery. In 1993, following an injury while working for Liberty's insured, Liberty accepted a claim for a right knee sprain.

In early 1995, claimant began experiencing progressively worsening symptoms in his right knee. Applying ORS 656.005(7)(a)(B), the ALJ found that the more persuasive medical evidence showed that the major contributing cause of claimant's current right knee treatment was the 1978 motorcycle accident. Thus, the ALJ concluded that claimant failed to prove compensability and, therefore, it was not necessary to address responsibility between SAIF and Liberty.

In requesting review, claimant acknowledges that his prior 1978 accident is a causative factor in his need for treatment. Claimant further asserts, however, that his industrial accidents are causing his condition and, thus, "the insurance companies should accept some of the responsibility also."

The physicians, including claimant's treating orthopedic surgeon, Dr. Ruggeri, agree that claimant's current condition is due to degenerative arthritis. (Exs. 43-5, 45-1, 46, 48-4, 50A-8). According to Dr. Ruggeri, the major contributing cause of claimant's current condition is the 1993 injury. (Exs. 45, 46, 47). Because such evidence indicates that claimant has a combined condition (that is, the preexisting arthritis combined with the 1993 injury), we agree with the ALJ's application of ORS 656.005(7)(a)(B). Under that statute, it is not enough that a compensable injury is a cause of a combined condition. Instead, claimant must prove that the compensable injury is the major contributing cause of the combined condition. Furthermore, this standard is not met if the compensable injury is only the precipitating cause of making the preexisting condition symptomatic. Dietz v. Ramuda, 130 Or App 397 (1994).

Dr. Ruggeri bases his opinion on his understanding that claimant's condition became, and remained, symptomatic following the 1993 injury. (Exs. 45, 46, 47). That is not enough to prove that the 1993 injury is the major contributing cause of a combined condition. Instead, Dr. Ruggeri only indicates that the 1993 injury was the precipitating cause of making the arthritis symptomatic. Under the statutes that the Board must apply, such an opinion is not enough to prove compensability. Dietz v. Ramuda, supra.

ORDER

The ALJ's order dated January 29, 1996 is affirmed.

June 25, 1996 Cite as 48 Van Natta 1280 (1996)

In the Matter of the Compensation of
KATHY L. LANIER, Claimant
WCB Case No. 95-10871
ORDER ON REVIEW
Vick & Gutzler, Claimant Attorneys
Karl Goodwin (Saif), Defense Attorney

Reviewed by Board Members Haynes and Christian.

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

FINDINGS OF FACT

On April 10, 1995, claimant, a "Habilitative Training Technician" at Fairview Training Center, experienced neck, upper back, left shoulder and left leg symptoms as a result of being grabbed from behind by a "client." Claimant came under the care of Dr. Pribnow on April 11, 1995 with a diagnosis of cervical, left quadriceps and trapezius strain.

On April 18, 1995, Dr. Pribnow reported that claimant was experiencing "new low back pain," which claimant stated occurred as a result of physical therapy prescribed for her compensable injury. (Ex. 4-4). By April 25, 1995, Dr. Pribnow observed that claimant's main problem was low back and leg pain; whereas her initial presentation had concerned the upper back and neck. (Ex. 4-6). Dr. Pribnow subsequently diagnosed "myofascial pain mainly involving the left low back." (Ex. 4-15).

On June 28, 1995, SAIF formally accepted the April 10, 1995 claim for left trapezius strain, cervical strain and left quadriceps strain. (Ex. 12-1). SAIF then issued Notices of Closure on July 26, 1995 and August 22, 1995, which awarded temporary disability only.

On September 18, 1995, Dr. Pribnow reported that claimant still had left lumbar and left leg symptoms. (Ex. 4-17). However, Dr. Pribnow commented that there was "nothing to relate this to her work activity." Id.

On September 18, 1995, SAIF issued a denial of aggravation. On October 11, 1995, SAIF denied claimant's low back condition. Claimant appealed both denials.

In November, 1995, claimant began treating with Dr. Johnson, a chiropractor, who diagnosed sacroiliac sprain and opined that claimant's mechanism of injury supported his diagnosis. (Ex. 37).

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial of aggravation, finding that claimant had failed to prove a compensable worsening. However, the ALJ set aside the denial of claimant's low back condition, concluding that claimant had sustained her burden of proving that this condition was compensable.[1] In finding that claimant's low back condition was materially related to her April 10, 1995 injury, the ALJ determined that the medical opinion of Dr. Johnson was more persuasive than that of Dr. Pribnow and that claimant's low back injury claim was supported by objective findings.

On review, SAIF's contentions are two-fold. First, SAIF contends that the ALJ mistakenly relied on Dr. Johnson's opinion over Dr. Pribnow's. Second, SAIF contends that claimant's low back claim is not supported by objective findings. We agree with SAIF that Dr. Pribnow's opinion is the most persuasive and accordingly conclude that this claim is not compensable.[2]

The ALJ stated that Dr. Pribnow's early involvement in the claim did not give him an advantage in assessing causation because he did not take claimant's low back symptoms seriously. Therefore, the ALJ did not defer to Dr. Pribnow's opinion. We disagree with the ALJ's reasoning.

Dr. Pribnow noted that claimant's "new" low back pain arose several days after the compensable injury. Dr. Pribnow also observed that claimant's initial symptoms involved different body parts and opined that he could not relate claimant's low back problems to the compensable injury.

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. As the former attending doctor, Dr. Pribnow's opinion is entitled to considerable deference, especially since he examined the claimant close to the time of injury. See Kienow's Food Stores v. Lyster, 79 Or App 416 (1986); Stedman v. Garrett Freightlines, 67 Or App 129 (1984); William V. Bellamy, 42 Van Natta 651, 654 (1990).

In contrast, Dr. Johnson did not begin treating claimant until November 1995, more than six months after her compensable injury. We, therefore, decline to give his opinion the greater weight ordinarily given to attending physicians' opinions. See McIntyre v. Standard Utility Contractors, Inc., 135 Or App 298, 302 (1995) (treating physician's opinion less persuasive when the physician did not examine the claimant immediately after injury). Douglas B. Robbins, 47 Van Natta 806 (1995) (when treatment follows long after key event, treating physician's opinion not given the usual deference).

Moreover, there are additional reasons to discount Dr. Johnson's opinion, apart from the fact that Dr. Johnson did not treat claimant immediately after her April 10, 1995 injury. Dr. Johnson states that claimant had back pain prior to April 18, 1995, but that observation is not supported by the record. Dr. Johnson cites an April 14, 1995 physical therapy chart note that allegedly states that claimant had complaints of left hip and leg symptoms. (Ex. 37-2). However, that chart note is not in the record. In addition, the chart note to which Dr. Johnson refers does not provide documentation of low back symptoms. Our review of the record discloses no medical records that document low back pain prior to April 18, 1995, when Dr. Pribnow reported claimant's history that her low back symptoms occurred after physical therapy.[3]

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[1] The ALJ applied a material contributing cause standard inasmuch as claimant alleged that her low back condition is a direct result of her accidental injury. See ORS 656.005(7)(a)(A); Albany General Hospital v. Gasperino, 113 Or App 411 (1992). SAIF does not contest that standard.

[2] Given this conclusion, we need not, and do not, address SAIF's "objective findings" argument.

[3] No party contends that claimant's low back condition is related to her physical therapy.

Moreover, since Dr. Pribnow was the initial attending physician, we conclude that his statement that claimant's low back pain on April 18, 1995 was "new" is more reliable than Dr. Johnson's observations rendered in November and December 1995. Dr. Johnson also did not acknowledge or address other physicians' references to pain behavior and did not affirmatively relate claimant's low back symptoms to the April 10, 1995 injury. While use of "magic words" is not necessary to establish causation, see McClendon v. Nabisco Brands, Inc., 77 Or App 412 (1986), we, nonetheless, find that Dr. Johnson's December 1995 report fails to satisfy claimant's burden of proof.

In conclusion, we find that claimant has failed to sustain her burden of proving that her low back condition is compensable. Therefore, we reverse the ALJ's decision to set aside SAIF's denial.

ORDER

The ALJ's order dated January 18, 1996 is reversed in part and affirmed in part. That portion which set aside SAIF's denial of claimant's low back condition is reversed. SAIF's denial of claimant's low back condition is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
CANDACE R. LAUDAHL, Claimant
WCB Case No. 95-06425
ORDER ON REVIEW
Victor Calzaretta, 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) Poland's order that: (1) set aside its denial of claimant's claim for post-traumatic stress syndrome, major depression and panic attacks; and (2) awarded a 25 percent 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 established a compensable mental stress claim. Specifically, relying on the opinion of claimant's treating psychiatrist, Dr. Mackles, the ALJ concluded that the major contributing cause of claimant's post-traumatic stress syndrome, depression and panic attacks was the traumatic events she experienced in the course of her job as a deputy sheriff.

The employer argues on review that claimant has not proven by clear and convincing evidence that her diagnosed mental disorders arose out of and in the course of her employment, as required by ORS 656.802(3)(d).[1] We disagree.

It is undisputed that, in the course of her work as a patrol officer, claimant was involved in a series of stressful and traumatic incidents in the early 1990s. Dr. Mackels was aware when these events occurred and also that, in the meantime, claimant experienced some personal problems with her daughter and her boyfriend. He opined that the traumatic events claimant encountered at work were the major contributing cause of her emotional condition. We find that, in making this determination, Dr. Mackles evaluated the relative contribution of the work-related incidents and the non-work related stressors, as required by Dietz v. Ramuda, 130 Or App 397 (1994) (determining "major contributing cause" involves evaluating the relative contribution of different causes of an injury or disease and deciding which is the *primary* cause). Finally, we conclude that claimant has proven, by clear and convincing evidence, that her work was the major contributing cause of her mental disorder.

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[1] The employer apparently concedes, and we find, that claimant has established the other elements of a compensable mental disorder set forth in ORS 656.802(3)(a) - (c): That the employment conditions producing her mental disorders existed in a real and objective sense, that the employment conditions were conditions other than those generally inherent in every working situation and that there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community.

In reaching our conclusion, we specifically reject the employer's contention that the lapse of time between the traumatic work events (1990-1992) and claimant's inability to work and need for psychiatric treatment (January 1995) raises questions about claimant's credibility. The record elicits no reason to doubt claimant's credibility. In fact, claimant's supervisor testified that he never had reason to question claimant's integrity or truthfulness and that he did not know claimant to exaggerate the traumatic events that she witnessed. (Tr. 64, 81).

Considering the entire record, especially claimant's credible testimony and the expert medical opinion, we agree with the ALJ that there is clear and convincing evidence that claimant's mental condition arose out of and in the course of her employment.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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 January 27, 1996 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

June 25, 1996 Cite as 48 Van Natta 1283 (1996)

In the Matter of the Compensation of
OSCAR J. MYERS, Claimant
WCB Case No. 95-07700
ORDER ON REVIEW
Gloria D. Schmidt, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

Claimant requests review of Administrative Law Judge (ALJ) McWilliams' order that: (1) found that the SAIF Corporation had properly calculated the rate of claimant's temporary disability benefits; and (2) declined to assess penalties and attorney fees for an allegedly unreasonable calculation of temporary disability benefits. On review, the issues are rate of temporary disability benefits, penalties, and attorney fees.

We adopt and affirm the ALJ's order with the following corrections and supplementation. In the third paragraph of the "Findings of Fact" and the first paragraph of the "Conclusions of Law and Reasoning," the ALJ states that SAIF recalculated claimant's temporary disability rate "by averaging claimant's wages over a 26-week period." We find that SAIF recalculated claimant's temporary disability rate by averaging claimant's wages over the 52-week period prior to the date of injury. (Exs. 1A, 4). Thus, we correct the above mentioned references to a "26-week period" to read a "52-week period."

In addition, we replace the last full sentence in the ninth paragraph of the "Conclusions of Law and Reasoning" with the following: Because claimant was not employed less than 52 weeks, had no "extended gaps," and was paid hourly, claimant's weekly wage was properly calculated based on his average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. OAR 436-60-025(5)(a). WCD Admin. Order 94-055.

In Earin I. Hadley, 48 Van Natta 216 (1996), we adhered to our long-standing interpretation of OAR 436-60-025(5)(a) that an extended gap must include a break in the work, and the "break" must cause a change in the work relationship between the employer and the employee. See Steven Caldwell, 44 Van Natta 2566 (1992). We reasoned that each particular work relationship must be examined to determine whether the break in the performance of the work activities constituted a change in that work relationship. As such, we concluded that this determination must be made on a case-by-case basis. We agree with the ALJ's reasoning and conclusions that, here, the breaks in employment did not cause a change in the work relationship and did not constitute "extended gaps."

Finally, to the extent that claimant argues that SAIF incorrectly calculated his temporary disability rate based his average earnings over the 26-week period prior to the date of injury, rather than the 52-week period prior to the injury date, claimant presents no evidence to support that argument. In addition, the only evidence in the record on this issue indicates that SAIF calculated claimant's temporary disability rate based on his average earnings during the 52-week period prior to the date of injury. (Exs.1A, 4). It is claimant's burden to prove that the rate of temporary disability was incorrect and he has not met his burden in this case. Coombe v. SAIF, 111 Or App 71 (1992); Jose Rodriquez, 42 Van Natta 1186 (1990).

ORDER

The ALJ's order dated November 3, 1995, as amended January 11, 1996, is affirmed.

Board Chair Hall dissenting.

I direct the parties to my dissent in Earin J. Hadley, supra, in which I stated:

> In requiring a change in the employment relationship before excluding "extended gaps" from the calculation [of the temporary disability rate], 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 [the] term ["extended gaps"] 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." Id at 218.

I continue to find that, by requiring a worker to prove that there has been a "change in the work relationship" in order to establish an "extended gap" in employment, the majority has placed a greater burden on the worker than the administrative rule intended. For this reason, I respectfully dissent.

June 26, 1996 Cite as 48 Van Natta 1284 (1996)

In the Matter of the Compensation of
JOHN F. CASSIDY, Claimant
WCB Case Nos. 93-07111, 93-00760, 93-07110 & 93-00761
ORDER OF ABATEMENT
Schneider, et al, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
Priscilla M. Taylor, Defense Attorney

Claimant requests abatement and reconsideration of our June 4, 1996 Order on Remand. Specifically, claimant seeks an award of a $3,000 attorney fee under ORS 656.388(1) and 656.382(2) for services before the Court of Appeals.

In order to further consider this matter, we withdraw our June 4, 1996 order. Albertsons, Inc. and Fred Meyer, Inc. are granted an opportunity to respond. To be considered, those responses must be filed within 14 days from the date of this order. Thereafter, we shall take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
SILVERIO FRIAS-MOLINERO, Claimant
WCB Case No. 95-11920
ORDER ON REVIEW
Michael R. Dehner, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Hall.

Claimant requests review of Administrative Law Judge (ALJ) Daughtry's order that: (1) reduced claimant's scheduled permanent disability award for his left foot from 10 percent (13.5 degrees), as awarded by an Order on Reconsideration, to zero; and (2) reduced claimant's unscheduled permanent disability award for his low back from 24 percent (76.8 degrees), as awarded by the same Order on Reconsideration, to zero. On review, the issues are extent of scheduled and unscheduled permanent disability.

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

We briefly summarize the pertinent facts. Claimant sustained a compensable strain injury to his low back in February 1994 while working for an employer insured by the SAIF Corporation. On August 23, 1994, a Notice of Closure issued awarding claimant no permanent disability, based on the closing examination of claimant's treating physician for his back, Dr. Stringham. Claimant received no further treatment to his low back due to the February 1994 injury, but was treated for a new, compensable low back injury with a different employer/carrier. After treatment, claimant was released to modified work.

On November 1, 1994, claimant was diagnosed with a left inguinal hernia. SAIF accepted claimant's claim for the hernia and reopened the February 1994 claim for hernia surgery. Dr. Rios, claimant's treating physician for his hernia, declared claimant medically stationary on May 23, 1995. On July 21, 1995, a Notice of Closure issued that awarded no permanent disability. Claimant requested reconsideration and the appointment of an arbiter. On October 17, 1995, relying on the arbiters' examination, the Department issued an Order on Reconsideration awarding 24 percent unscheduled permanent disability for the low back and 10 percent scheduled permanent disability for the left foot.

The ALJ concluded that claimant had no permanent impairment due to the February 1994 injury. Claimant contends, first, that the ALJ erred by assuming that the arbiters were unaware of the intervening August 1994 low back injury, and, second, that extent must be established by the arbiters. We disagree.

Awards of both scheduled and unscheduled permanent disability must be the result of the compensable injury. ORS 656.214(2), (5). The worker has the burden to prove the nature and extent of any disability resulting from a compensable injury. ORS 656.266. Here, the medical arbiters documented low back and left foot impairment which they indicated was due to claimant's low back strain. (Ex. 36). However, the issue is whether those findings are the result of permanent impairment due to the February 1994 compensable low back injury. See OAR 436-35-007(1).

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 relies on the most thorough, complete and well-reasoned evaluation of the claimant's injury-related impairment).

Here, the preponderance of the medical evidence establishes a different level of impairment due to the February 1994 injury. The arbiters, Dr. Olson, neurosurgeon, and Dr. Robertson, general surgeon, found low back and left foot impairment due to a low back strain. However, there is no evidence that the arbiters were aware of claimant's intervening low back injury. Moreover, the medical history of the August 1994 injury was absent from their analysis. (See Exs. 32-1, -2, 33-1). We are not persuaded, without more explanation, that the low back and left foot impairment found by the arbiters constitute findings of permanent impairment which are due to the February 1994 compensable injury.

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[1] We note that claimant compensably injured his low back and groin on February 4 (not February 14), 1994.

We therefore give the portion of the arbiters' report finding low back impairment no weight. Miller v. Granite Construction Co, 28 Or App 473, 476 (1977) (medical opinions based on an inaccurate history are not afforded persuasive force); 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).

In contrast, we are more persuaded by the impairment findings of Dr. Stringham, who performed a closing examination on July 14, 1994, about a month prior to claimant's second low back injury with the other employer/carrier. Dr. Stringham found no objective impairment resulting from claimant's February 1994 low back injury and released claimant to regular work. (Exs. 1-2, 10). Moreover, we note that the first mention of pain in claimant's legs occurred during treatment for the new injury with the other employer/carrier. (Ex. 11B). We further note that, during the period that claimant's 1994 claim was reopened by SAIF, there was no treatment for claimant's low back. Based on this medical record, we conclude that the preponderance of medical evidence establishes a level of impairment different from that of the medical arbiters.[2]

The ALJ correctly reduced claimant's scheduled and unscheduled permanent disability awards to zero.[3]

ORDER

The ALJ's order dated December 15, 1995 is affirmed.

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[2] We distinguish this case from Kim E. Danboise, 47 Van Natta 2163, on recon 47 Van Natta 2281 (1995). In Danboise, the claimant experienced, inter alia, a compensable cervical injury. An Order on Reconsideration granted no permanent disability. The ALJ concluded that, based on the medical arbiters' findings, claimant had established that his cervical impairment was due to his compensable injury. The insurer contended that there was insufficient evidence that the claimant's cervical impairment was related to his compensable injury. We 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. Id. at 2164.

Here, unlike in Danboise, claimant suffered a second injury to the same body part prior to the arbiter examination. As noted above, claimant's attending physician found no permanent impairment due to the February 1994 low back injury. Given claimant's subsequent low back injury with leg involvement, we are not persuaded, without more explanation, that the impairments found by the medical arbiters are consistent with claimant's February 1994 compensable injury.

[3] The medical evidence does not show, nor does claimant argue, impairment due to the accepted inguinal hernia condition. See Exs. 26, 36.

In the Matter of the Compensation of
LEE R. JONES, Claimant
WCB Case No. 92-05254
ORDER DENYING RECONSIDERATION
Schneider, et al, Claimant Attorneys
Wallace & Klor, Defense Attorneys

On February 26, 1996, we issued an Order on Remand which dismissed claimant's hearing request regarding a vocational assistance dispute. Contending that "[o]ur records don't show that we ever received the 2/26/96 Order on Remand," claimant's counsel asks us to republish that order. We treat claimant's counsel's letter as a motion for reconsideration/republication of our February 26, 1996 order. We deny the 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).

We may republish an order if we find that we failed to mail a copy of our prior order to a party. Berliner v. Weyerhaeuser Company, 92 Or App 264, 266-67 (1988); Mary J. Gates, 42 Van Natta 1813 (1990). "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. An attorney is not a party. ORS 656.005(21); Berliner v. Weyerhaeuser Company, supra page 266, n. 1; Frank F. Pucher, Jr., 41 Van Natta 794, 795 (1989).

Here, claimant's counsel asserts that he did not receive a copy of our February 26, 1996 order. Yet, the Board's file indicates that a copy of the order was mailed to claimant's counsel's firm. Furthermore, the record does not contain a copy of the order which has been returned to the Board as undeliverable by the postal service. Such circumstances strongly support a conclusion that, regardless of whether claimant's counsel received a copy of our February 26, 1996 order, a copy of our order was mailed to claimant's attorney.

In any event, even assuming that claimant's counsel did not receive a copy of our order, that does not invalidate the order. See Berliner v. Weyerhaeuser Company, supra; Frank E. Pucher, Jr., supra. Rather, to prompt the reissuance of our order, claimant must establish that a copy of the order was not mailed to claimant or to another party to the proceeding. See Theresa F. Trahan, 44 Van Natta 62 (1992); Bryan Thompson, 42 Van Natta 2299 (1990). The record does not support such a finding.

To the contrary, our order and the Board's file indicate that copies of the order were mailed to all parties, as well as to their representatives. Moreover, there has been no contention from either claimant, the employer, or its insurer that this mailing to the parties was defective. Such circumstances persuade us, at a minimum, that copies of the Board's February 26, 1996 order were mailed to all parties to the proceeding. See Bryan Thompson, supra.

Based on the foregoing reasoning, we are persuaded that a copy of our February 26, 1996 order was mailed to claimant's attorney and to all parties to the proceeding. Inasmuch as our order has neither been stayed, withdrawn, modified, nor appealed within 30 days of its mailing to the parties, it has become final. See ORS 656.295(8); Berliner v. Weyerhaeuser Company, supra; International Paper Co. v. Wright, supra; Fischer v. SAIF, supra. Consequently, we are without authority to reconsider our order.

Accordingly, claimant's counsel's request for reconsideration or republication of our February 26, 1996 order is denied.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARK L. McCOY, Claimant
WCB Case No. 95-11553
ORDER ON REVIEW
Strooband & Ousey, Claimant Attorneys
Michael Fetrow (Saif), Defense Attorney

Reviewed by Board Members Haynes, Christian and Hall.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Mongrain's order that awarded claimant 9 percent (13.5 percent) scheduled permanent disability for loss of use or function of the left leg, whereas an Order on Reconsideration awarded no scheduled disability. On review, the issue is extent of scheduled permanent disability. We modify.

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 on January 20, 1994. He underwent surgery for a herniated disc at L5-S1, which was impinging on the S1 nerve root. Claimant's surgeon, Dr. Henderson, declared him medically stationary with no work restrictions on January 26, 1995. Examination at that time revealed normal reflexes, normal sensation, normal motor power, no evidence of nerve root irritation and no visible atrophy.

SAIF issued a Notice of Closure on May 30, 1995 (amended June 23, 1995), awarding 23 percent (73.6 degrees) unscheduled permanent disability. Claimant requested reconsideration, asserting premature closure of his claim, as well as challenging the medical impairment findings and the rating of scheduled and unscheduled permanent disability.

In connection with the reconsideration process, claimant was examined by Dr. MacD. Watson as a medical arbiter on August 25, 1995. Among other things, the arbiter's examination revealed some weakness and sensory findings in claimant's left foot. The arbiter also reported that claimant had seen Dr. Henderson two weeks prior complaining of continued back and leg discomfort, and that Dr. Henderson had prescribed an anti-inflammatory and suggested another MRI. The arbiter concluded that claimant should not be found to be medically stationary until or unless Dr. Henderson reviewed his findings and the repeat imaging studies and assessed the need for further treatment. (Ex. 14).

On September 25, 1995, the Appellate Review Unit issued an Order on Reconsideration affirming the Notice of Closure in all respects. The Appellate Review Unit affirmed the medically stationary date of January 23, 1995, as determined by the attending physician, and declined to rely on the medical arbiter's report pursuant to former OAR 436-35-007(9) because it did not reflect the worker's impairment at the time of closure.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was medically stationary on January 23, 1995 and at the time of the arbiter's August 25, 1995 examination. The ALJ further found that the medical arbiter's examination findings established a greater award of permanent disability than previously awarded.[1] With regard to scheduled permanent disability, the ALJ awarded claimant 5 percent impairment under former OAR 436-35-200(1) for partial loss of sensation of the left foot and 4 percent impairment under former OAR 436-35-007(14)(b) for partial loss of left foot strength, for a combined total award of 9 percent for loss of use or function of the left leg.

On review, SAIF argues that the medical evidence is insufficient to support the ALJ's 4 percent award for loss of strength in the left foot because no doctor has identified the specific nerve responsible for the strength loss, as required by former OAR 436-35-007(14). We agree.

Former OAR 436-35-007(14) provides, in pertinent part, that "[a] preponderance of medical opinion shall be used to identify the named spinal nerve root, peripheral nerve, or plexus which is responsible for the loss of strength." In evaluating claimant on January 23, 1995 for purposes of claim closure, Dr. Henderson found no evidence of nerve root irritation and concluded that claimant's motor power was within normal limits. Although the medical arbiter found "apparent weakness, 4/5, of great toe dorsiflexors," which he considered evidence of radiculopathy, he did not identify the specific nerve or nerves involved. Considering Dr. Henderson's "post-surgery" finding of no nerve root irritation, we cannot find, as did the ALJ, that the S1 nerve root is responsible for the great toe weakness identified by the medical arbiter.[2]

Because a preponderance of the evidence fails to identify a spinal nerve root responsible for the loss of strength finding, we conclude that claimant is not entitled an scheduled award for loss of strength under the applicable standards. See, e.g., Corrine M. Esperanza, 47 Van Natta 1914 (1995) (the absence of the requisite medical evidence constitutes a failure of proof under the applicable standards; the Board is without the expertise to "infer" an injury to a specific nerve).

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[1] SAIF does not challenge that part of the ALJ's order that increased claimant's award of unscheduled permanent disability to 26 percent (83.20 degrees), nor that part that awarded 5 percent scheduled permanent disability for loss of sensation of the left foot.

[2] The ALJ relied, in part, on a May 1994 chart note in which Dr. Henderson reported that claimant had a large extruded disc fragment at L5-S1 impinging on the S1 nerve root, left side. (Ex.1A). This chart note reflected claimant's condition prior to undergoing the L5-S1 diskectomy in July 1994, however. (Ex. 3).

ORDER

The ALJ's order dated January 22, 1996 is modified in part and affirmed in part. In lieu of the ALJ's award of 9 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the left leg, claimant is awarded 5 percent (6.75 degrees) scheduled permanent disability for loss of use or function of the left foot. Claimant's "out-of-compensation" attorney fee award is modified accordingly. The remainder of the order is affirmed.

Board Chair Hall dissenting.

The majority finds that there is insufficient evidence of an injury to a specific nerve and therefore claimant is not entitled to an award for loss of strength in his left foot under former ORS 436-35-007(14). Because I believe there is sufficient medical evidence from which to make the reasonable inference that the S1 nerve is responsible for claimant's great toe weakness, I respectfully dissent.

Claimant's medical records establish that claimant had a large, extruded disc fragment at L5-S1 impinging on the S1 nerve root, left side. Although Dr. Henderson found no evidence of nerve root irritation post-surgery, the medical arbiter did. The medical arbiter's exam reveled both sensory findings and weakness in claimant's left foot, which he attributed to "radiculopathy." Although the medical arbiter did not use the "magic words" to specifically note that the S1 nerve was responsible for that radiculopathy, I believe that fact may be inferred from the medical record as a whole. It was, afterall, the S1 nerve which was reasonably involved all along. Therefore, I would affirm the ALJ's decision to award claimant 4 percent permanent disability for loss of strength of the left foot.

In the Matter of the Compensation of
JOANN K. RUSSUM, Claimant
WCB Case No. 95-10001
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes, and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Baker's order that: (1) found that claimant was not entitled to temporary disability benefits after her March 22, 1995 surgery; and (2) declined to assess penalties and attorney fees for the self-insured employer's allegedly unreasonable claim processing. On review, the issues are the preclusive effect of the parties' stipulation, and, alternatively, temporary disability, penalties and attorney fees. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We briefly recap the facts. Claimant compensably injured her back on December 13, 1991 and the employer accepted a disabling low back strain in March 1992. (Ex. 2). On April 9, 1992, Dr. Hill performed a lumbar laminectomy and discectomy for a large herniated fragment at L1-2 on the right.

Claimant subsequently developed problems with her right shoulder. Claimant challenged the employer's denial of the right shoulder condition and a prior ALJ set aside the employer's denial on July 6, 1993, holding that the shoulder condition was a compensable consequence of the back injury and back surgery. (Ex. 14). The Board affirmed the ALJ's order on March 4, 1994. (Ex. 20a).

On August 2, 1993, the employer offered claimant a modified job approved by Dr. Schader. (Ex. 17). Claimant declined the job because she was moving and did not feel capable of performing work on a regular basis. (Tr. 23, 25).

Claimant continued to have back problems and received nerve root block treatments. (Exs. 20B-20E). On May 17, 1994, Dr. Hill requested permission to do a nerve root decompression at L5 and foraminotomy. (Exs. 20B, 21-3).

After the Board's order concerning claimant's shoulder condition, the parties entered into settlement negotiations. The stipulation did not resolve any issues or claims arising from processing the compensable claim prior to the ALJ's July 6, 1993 Opinion and Order. (Ex. 22). In other words, the stipulation resolved issues/claims "Arising from the time of the July 6, 1993 Opinion and Order through the date this settlement is approved by a referee." On July 13, 1994, a prior ALJ approved the parties' stipulation, which provided, in part:

> "The claim remains in an open status, but claimant agrees that employer has offered employment to her at a wage equal to or greater than what she was making at the time of the injury and the offer of employment is procedurally and substantively correct so that no temporary total disability or temporary partial disability is due." (Id.)

Claimant's second back surgery was authorized in March 1995. (Ex. 22B). On March 22, 1995, Dr. Hill performed a lumbar laminectomy at L5-S1 on the right with foraminal decompression of the L5 nerve root. (Ex. 22D).

By late February 1995, the parties agreed to a second settlement, which provided, in part, that the employer would accept the L5 surgery as a compensable consequence of the December 1991 work injury and the employer would "process the claim according to law." (Ex. 23). The parties agreed to settle "[a]ll issues and/or claims which were raised or which could have been raised" on or before the date of ALJ approval. The employer's attorney signed the stipulation on February 27, 1995. The employer stipulated to accept the L5 surgery as a compensable consequence of the December 1991 work injury and to process the claim according to law. Claimant signed the stipulation on May 5, 1995 and claimant's attorney signed it on May 6, 1995. A prior ALJ approved the stipulation on May 19, 1995. (Ex. 23).

On May 9, 1995, claimant's attorney wrote to the employer, asserting that claimant had surgery three weeks ago and had not received any disability benefits. (Ex. 22J). Claimant's attorney asked for the employer's immediate attention to the matter. The employer did not pay temporary disability benefits and claimant requested a hearing.

The ALJ found that claimant was temporarily disabled in July 1994 with substantially the same symptoms and limitations that ultimately led to the March 1995 surgery. The ALJ reasoned that nothing of legal or factual significance occurred after July 1994 that would entitle claimant to time loss compensation, considering the terms of the July 1994 stipulation. The ALJ concluded that claimant did not lose any wages when she went in for the 1995 surgery. In addition, the ALJ found that claimant was barred from asserting her entitlement to temporary disability benefits because that matter could have been raised on or before the date the parties' settlement was approved by the prior ALJ on May 19, 1995.

Claimant argues that the stipulation does not shield the employer from its responsibility because paragraph 3 of the stipulation provides that "[e]mployer and its claim servicing agent will process the claim according to law." (Ex. 23). Claimant also relies on the May 9, 1995 letter from her attorney to the employer's attorney, asserting that claimant had surgery three weeks ago and had not received any disability benefits. (Ex. 22J). According to claimant, paragraph 3 of the stipulation was intended to deal with her time loss benefits from the date of her surgery. Claimant argues that she did not intend to waive her right to time loss benefits when she signed the stipulation and she contends that should have been clear to the employer when claimant's attorney sent the May 9, 1995 letter.

Subsequent to the issuance of the ALJ's order, we decided Maria R. Fuentes, 48 Van Natta 110 (1996). In Fuentes, a prior ALJ approved a stipulation agreement in which the insurer agreed to rescind its denial of the claimant's left carpal tunnel syndrome (CTS) and right elbow lateral epicondylitis and "to provide benefits and process claims for those conditions in accordance with the law." 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." The claimant subsequently filed a hearing request, asserting an entitlement to temporary total disability related to the CTS and epicondylitis.

In Fuentes, we noted that the claimant's benefits for her left CTS and right elbow lateral epicondylitis were at issue at the time of the settlement agreement. We concluded that, 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 barred the insurer from litigating its obligation to provide benefits for those conditions. We found that a separate inquiry was

required to determine whether, "in accordance with the law," the claimant was entitled to any particular benefits. After conducting that inquiry, we concluded that the claimant was not entitled to any additional temporary total disability benefits.

Here, even if we assume, without deciding, that claimant is not barred by the May 19, 1995 stipulation from asserting her entitlement to temporary disability benefits after the March 22, 1995 surgery, the next inquiry would be whether, "according to law," claimant was entitled to any benefits. (See Ex. 23). For the following reasons, we conclude that claimant is not entitled to any additional temporary disability benefits.

Under ORS 656.262(4)(f), 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. Gerald A. Zeller, 48 Van Natta 501 (1996). 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."

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 656.262(4)(f) 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 656.262(4)(f) applies here. See Shannon M. Oliver, 48 Van Natta 386 (1996).

In 1993, Dr. Schader approved claimant for release to modified employment. (Ex. 20). On June 29, 1994, Dr. Wilson examined claimant on behalf of the employer and commented that claimant "could return to full gainful employment if she so desired but it is unlikely that she will make any attempt to return to gainful employment." (Ex. 21-8). In the July 13, 1994 stipulation, claimant agreed that the "employer has offered employment to her at a wage equal to or greater than what she was making at the time of the injury and the offer of employment is procedurally and substantively correct so that no temporary total disability or temporary partial disability is due." (Ex. 22). Claimant testified that she had not received any temporary disability benefits from the employer at any time since she was offered a modified job in 1993. (Tr. 33).

On March 22, 1995, Dr. Hill performed a lumbar laminectomy at L5-S1 on the right with foraminal decompression of the L5 nerve root. (Ex. 22D). In March 1995, the employer's attorney's office contacted Dr. Hill in March 1995 to ask about claimant's time loss. (Ex. 22B). Dr. Hill's chart note indicates that he "was unable to tell her [the legal assistant] the situation in terms of time loss." (Id.) Dr. Hill commented that claimant had not indicated whether she had been working or not. (Id.).

Although it is not entirely clear from the record whether Dr. Schader or Dr. Hill qualified as claimant's "attending physician,"[1] there is no evidence that either Dr. Schader or Dr. Hill or any other physician authorized temporary disability after the March 22, 1995 surgery. See ORS 656.262(4)(f). Therefore, we conclude that claimant is not entitled to temporary disability benefits.[2]

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[1] An "attending physician" is a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury. ORS 656.005(12)(b).

[2] In light of our conclusion, we agree with the ALJ that the employer's refusal to pay the compensation was not unreasonable. Moreover, since there is no evidence that claimant's attending physician authorized temporary disability benefits after the March 22, 1995 surgery, it is not necessary to determine whether claimant was in the work force at the time of the disability. See Dawkins v. Pacific Motor Trucking, 308 Or 254, 258 (1989); Weyerhaeuser v. Kepford, 100 Or App 410, 414, rev den 310 Or 71 (1990).

ORDER

The ALJ's order dated January 8, 1996 is affirmed.

June 26, 1996 Cite as 48 Van Natta 1292 (1996)

In the Matter of the Compensation of
KEITH THOMAS, Claimant
WCB Case Nos. 95-02928 & 94-15031
ORDER ON REMAND
Heiling, Dodge & Associates, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys
James B. Northrop (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. On April 30, 1996, the court granted the parties' motion to remand this matter for our consideration of their proposed settlement. In dismissing the SAIF Corporation's petition for judicial review, the court also granted "leave to seek reinstatement [of judicial review] if the Board should fail to approve the settlement."

After Board receipt of the parties' proposed settlement, the agreement was returned to the parties for supplementation and/or clarification. The Board then received claimant's handwritten note asking that the Board "stop all work concerning this case."

Shortly thereafter, claimant's counsel submitted materials in support of claimant's contention that SAIF had accepted claimant's injury claim while its appeal of the Administrative Law Judge's compensability decision concerning the claim was pending Board review. Under such circumstances, claimant sought dismissal of SAIF's appeal, as well as penalties and attorney fees.

On receipt of claimant's request, a supplemental briefing schedule was implemented. Thereafter, the parties presented their respective positions. Asserting that SAIF's acceptance letter moots further litigation of the compensability dispute, claimant seeks admission of this evidence either at the Board level or, after remand, at hearing. In reply, SAIF contends that the Board's authority is limited to either approving a settlement or republishing its prior order. In addition, SAIF has announced claimant's rejection of the latest proposed settlement. Having received the parties' respective positions, we proceed with our review of this matter.

Pursuant to the court's remand order, our authority is limited to consideration of the parties' proposed settlement. Furthermore, in the event that Board approval of the settlement is not granted, the court has expressly provided the parties with a remedy. Specifically, leave to seek reinstatement of the petition for judicial review has been offered to the parties.

Claimant raises several issues and seeks a number of Board rulings. Without commenting on the substance of such matters, we acknowledge that some of the arguments are colorable. See SAIF v. Mize, 129 Or App 636 (1994); Gerald J. Dahl, 47 Van Natta 1055 (1995). Nonetheless, as previously noted, our current authority only extends to consideration of the parties' settlement. See Aguilar v. J. R. Simplot Company, 94 Or App 658 (1989). (Board without authority to award attorney fee on remand under ORS 656.388(1) when the court's mandate to Board was to take ministerial action of reinstating ALJ's order). As a result of the parties' continuing disputes, no such settlement presently exists. Consequently, we have not approved the parties' settlement.

Under such circumstances, in accordance with the court's April 30, 1996 order, the parties are authorized to seek reinstatement of the judicial review which was previously pending before the court.[1] Presumably, at that time, the parties can present their respective positions regarding the contentions raised in claimant's request.

IT IS SO ORDERED.

[1] Since the court neither reversed nor vacated our prior order, it is unnecessary to republish our decision. In other words, our order stands as previously issued.

In the Matter of the Compensation of
FRANK L. BUSH, Claimant
Own Motion No. 93-0149M
OWN MOTION ORDER
Daniel M. Spencer, Claimant Attorney
Scott Terrall & Associates, Defense Attorneys

Claimant contends that the insurer has failed to comply with the Board's March 25, 1993 Own Motion Order, and requests that the Board enforce its order by requiring the self-insured employer to resume payment of temporary disability compensation commencing December 15, 1995. In addition, claimant seeks penalties and attorney fees for the employer's allegedly unreasonable claims processing and refusal to pay temporary disability compensation. Finally, the employer requests that the matter be referred to the Hearings Division for fact finding, and it seeks Board approval to close claimant's claim.

FINDINGS OF FACT

On March 25, 1993, the Board issued its own motion order, which authorized the reopening of claimant's 1982 neck injury claim for the payment of temporary disability compensation commencing the date claimant underwent surgery for the compensable injury.

Claimant underwent neck surgery on April 7, 1993. In an August 11, 1994 chart note, Dr. Newby, claimant's treating physician, released claimant to regular work and noted that claimant would return for follow-up in six weeks. In an August 11, 1994 Supplemental Medical Report, Dr. Newby responded "no" to a check-the-box question asking if claimant was medically stationary. In addition, Dr. Newby indicated that it was "unknown" when claimant would become medically stationary.

Claimant began treating with Dr. Altrocchi, neurologist, on March 2, 1995. Dr. Altrocchi evaluated and treated claimant for severe headaches. In an August 17, 1995 chart note, Dr. Altrocchi noted that claimant "is getting worsening neck pain, thoracic pain, and lumbar pain," because of "overuse at work." Dr. Altrocchi referred claimant to Dr. Cross for chiropractic treatment. In a September 7, 1995 prescription note, Dr. Altrocchi opined that claimant "has significant back & neck pain & I have taken [claimant] off [work] completely from this afternoon until Oct. 7, 1995." In chart notes dated October 5, 1995 and October 17, 1995, Dr. Altrocchi opined that claimant's neck "shows significant decrease in translation both inflexion and extension, with greater restriction in flexion and decrease in rotation both directions." Dr. Altrocchi referred claimant to Dr. Maloney for another opinion regarding treatment.

In a November 6, 1995 medical report, Dr. Maloney diagnosed lumbar and cervical pain, and noted that claimant could return only to sedentary work. In a November 8, 1995 report, Dr. Watson, examining claimant at the employer's request, opined that "all [of claimant's] conditions are medically stationary." Taking no x-rays, Dr. Watson observed that "[t]here is no report from Dr. Maloney regarding her intentions, if any." Dr. Watson reported that he, along with Dr. Altrocchi, suspected "ongoing clinical depression and employee/employer "disharmony," otherwise unevaluated.

Claimant continued with physical therapy through November 16, 1995. The physical therapist noted that claimant complained of increased cervical pain upon driving to the clinic. In addition, the physical therapist, through Dr. Maloney, continued working with claimant on a return-to-work plan for a proposed back rip light duty operator position. On November 16, 1995, Dr. Maloney notified the employer that:

> "[Claimant] currently demonstrates tolerance for sedentary employment two hours a day three days a week. I have actually held him off employment as of this week given his current participation in work simulation, work hardening and general therapeutic exercise activities."

Claimant filed a low back "new injury" claim with the same employer. That claim was denied on November 17, 1995.

Temporary disability compensation was being paid to claimant in the 1982 neck claim until November 17, 1995.

On December 15, 1995, Dr. Newby examined claimant and reported that claimant had "suboccipital tenderness and markedly restricted range of motion of his neck and low back." Dr. Newby diagnosed cervical spondylosis, ordered a cervical MRI scan to further evaluate that condition, and prescribed a home cervical traction device. Dr. Newby opined that "[a]t the present time [claimant] is not working and is not medically stationary."

In a December 21, 1995 chart note, Dr. Newby, after reviewing the cervical x-rays and scans, opined that:

> "[Claimant's] cervical MRI scan shows an interval cervical disc herniation at C3-4, more on the left than the right. His July, 1994 [x-ray/examination] reveals that this was not present [at that time]."

In a January 22, 1996 letter, Dr. Maloney advised that:

> "Work restrictions I would place this claimant on as a result of the neck condition alone include release within a sedentary/light work range. I have not release[d] the claimant to return to regular work in so far as the neck condition is concerned."

In a January 29, 1996 letter, Dr. Newby agreed that claimant's current work limitations with regard to his neck would be sedentary to light duty, and that these restrictions would be permanent.

In a February 26, 1996 letter, Dr. Newby opined that claimant became "non-medically stationary on December 15, 1995 with regard to further aggravation and worsening of his prior [neck] work injury." Dr. Newby further opined that:

> "There has been no new injury[,] but further progression of his prior cervical injury which has moved up a level from his prior cervical fusions to the current C3-4 level."

On February 26, 1996, Dr. Newby directed that claimant was not to return to work.

On March 5, 1996, Dr. Newby declared that claimant was totally disabled as of December 15, 1995, due to his neck condition. In a March 12, 1996 work release, Dr. Newby prescribed again that claimant was not to return to work.

Claimant requested a hearing contesting the "new injury" denial, and the termination of time loss in the 1982 neck claim. (WCB Case Nos. 95-13721 and 96-01137). On April 15, 1996, Administrative Law Judge (ALJ) Michael Johnson issued an Order of Dismissal in both cases, holding in the neck claim (WCB Case No. 96-01137), that "[t]he pending issues are before a more appropriate forum before the Worker's Compensation Board under its own motion jurisdiction." Claimant withdrew his request for hearing on the denial in the "new injury" claim. The ALJ's orders were not appealed. Currently, the employer requests that, "[b]ecause of the confusion created by all of this evidence, the employer recommends that this matter be referred to an Administrative Law Judge for the taking of evidence with the protection of due process and hearings procedures."

CONCLUSIONS OF LAW AND OPINION

Evidentiary Hearing

We acknowledge our authority to refer disputes to the Hearings Division for fact finding. See OAR 438-012-0040(3). Such actions are normally taken when the disputes are directly attributable to a witness' credibility or reliability (there is a need to develop testimonial and documentary evidence), or when the factual record is insufficiently developed to permit the Board adequate and proper review. See e.g. Charles Tedrow, 48 Van Natta 616 (1996).

Here, the matter in dispute is not contingent upon an appraisal of a witness' credibility or reliability, nor is the medical record incomplete. Rather, the issue pertains to the employer's termination of temporary disability compensation in an open claim, which is appropriately evaluated based on the medical reports available to the employer at the time of its claim processing decision. Under such circumstances, because we consider the record to be adequately developed, we need not refer this matter to another forum for taking of further evidence. See Gary A. Toedtemeier, 48 Van Natta 1014 (1996); Ernest R. Miller, 44 Van Natta 2139 (1992).

Claim Closure

In another matter, in a March 19, 1996 letter, the employer asks the Board "for approval to issue a closure for claimant's cervical C4-C7 condition as being medically stationary on August 11, 1994." Our March 25, 1993 order which reopened claimant's claim contained a statement advising the parties that:

> "When claimant is medically stationary, the employer shall close the claim pursuant to OAR 438-12-055."

The Board's authority extends to the authorization of the reopening of claims for the payment of temporary disability compensation, and to review of a carrier's closure, if appealed. We do not authorize claim closure, nor do we give advisory opinions. It is incumbent upon the carrier to close the claim. Because this has not been accomplished, we are without authority to affirm (or set aside) a claim closure. Therefore, we are unable to grant the employer's request to approve claim closure in this case. OAR 438-012-0055.

Entitlement to Temporary Disability Compensation

Claimant contends that he is entitled to further temporary disability compensation. The employer contends that claimant was unable to work in 1995 due to his low back condition or to conditions other than his neck condition. Alternatively, the employer contends that claimant's current neck condition involves an area of the neck other than that for which the Board reopened the claim in 1993.

The Board has exclusive own motion jurisdiction over this claim, which includes the authority to enforce the Board's own motion orders. See Thomas L. Abel, 45 Van Natta 1768 (1993); Darlene M. Welfl, 44 Van Natta 235 (1992); Ivan Davis, 40 Van Natta 1752 (1988); David L. Waasdorp, 38 Van Natta 81 (1986). Pursuant to former OAR 438-12-040 (the administrative rule in effect at the time of our March 25, 1993 order), the Board authorized the reopening of claimant's 1982 neck injury claim for the payment of temporary disability benefits. Further, pursuant to former OAR 438-12-035, our March 25, 1993 order provided that temporary disability compensation be paid until termination of such benefits was authorized by the terms of ORS 656.268.

Pursuant to ORS 656.268 and our rules, a carrier may not terminate temporary disability compensation in an open claim until a claimant has satisfied one or more of the criteria in ORS 656.268(3). That statute provides that temporary total disability benefits shall continue until whichever of the following events first occurs: (a) the worker returns to regular or modified employment; (b) the attending physician gives the worker a written release to return to regular employment; or (c) the attending physician gives the worker a written release to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment. See Jean M. Bates, 45 Van Natta 152 (1993).

In evaluating medical opinions, we generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. Weiland v. SAIF, 64 Or App 810 (1983). In addition, we give the most weight to opinions that are both well-reasoned and based on complete information. Somers v. SAIF, 77 Or App 259 (1986).

Dr. Watson's November 8, 1995 IME report that claimant was medically stationary with respect to all conditions, was made without benefit of current x-rays. Indeed, Dr. Watson believed claimant to be medically stationary at a time when claimant actually suffered from a C3-4 disc herniation, as verified by Dr. Newby's MRI x-rays of December 15, 1995. Further, Dr. Watson apparently did not have Dr. Maloney's November 6, 1995 report, as he stated that there was "no report from Dr. Maloney regarding her intentions, if any." Therefore, Dr. Watson's medical record was incomplete. He did not generate new x-rays, nor did he possess the latest report from claimant's treating physician. Because Dr. Watson examined claimant only one time, generated no new x-rays, and based his opinion on an incomplete record, we are not persuaded by Dr. Watson's report.

Rather than Dr. Watson, we rely on the observations registered by Dr. Maloney. Claimant filed a Change of Attending Physician Form on November 6, 1995. Although Dr. Maloney "temporarily" released claimant to sedentary work on November 6, 1995, her medical report of the same date indicates that "[claimant] will commence general work simulation activities to improve his overall physical capacity for employment." Further, in that medical report, Dr. Maloney asserts that "[claimant] will continue to determine his return to employment plans. I will plan to review his recent job analysis."

The record establishes that the "back rip saw operator" position was proposed to claimant in November 1995, however, claimant was undertaking "work simulation" activities (as prescribed by Dr. Maloney) in order to return at some point to the modified employment offered by the employer. In a November 16, 1995 letter, Dr. Maloney advised the employer that:

> "[Claimant] currently demonstrates tolerance for sedentary employment two hours a day three days a week. I have actually held him off employment as of this week given his current participation in work simulation, work hardening and general therapeutic exercise activities."

Dr. Maloney also noted that she would "readdress [claimant's] timing for return to work on [November 21, 1995]."

Because Dr. Maloney did not opine that claimant was medically stationary nor was claimant released to return to modified work prior to November 21, 1995, we conclude that the employer had no authority to terminate temporary disability compensation in claimant's 1982 neck claim on November 17, 1995. ORS 656.268(3).

In the alternative, the employer contends that claimant was not working in 1995 due to conditions other than his accepted neck condition. Although this argument is not relevant to our inquiry regarding termination of time loss in an open claim, because claimant requests a penalty for the employer's unreasonable termination of compensation, we will briefly address the issue. Dr. Maloney's November 21, 1995 prescription note identified claimant's current conditions as "neck and lbp" (lower back pain) and advised that claimant was not to return to work. The record indicates that Drs. Altrocchi, Maloney and Newby opined that claimant's current conditions involved both the neck and the back conditions.

Considering such reports, we conclude that the employer had no authority to terminate temporary disability compensation in claimant's neck claim. None of the medical reports in the record indicate that any physician opined that claimant suffered only from low back pain, or that the low back pain was the cause of claimant's inability to work. On the contrary, all of the physicians noted that claimant had significant back and neck pain. Although the employer denied the back claim, it did not indicate that it denied the C3-4 condition.[1] Therefore, it was obligated to continue the payment of temporary disability compensation until any subsection of ORS 656.268(3) was satisfied, or until claimant was medically stationary with respect to his accepted "left shoulder/cervical injury," and it closed the claim. See March 25, 1993 Own Motion Order; ORS 656.268(3); OAR 438-012-0035; 438-012-0055. Consequently, we conclude that claimant is entitled to further temporary disability compensation in this claim until such benefits can be lawfully terminated.

In reaching this conclusion, we wish to emphasize that our decision is confined to claimant's procedural entitlement to temporary disability. To the extent that the insurer contends that claimant was unable to work due to conditions other than the compensable neck condition (which affects his substantive entitlement to temporary disability), that is an argument which would be ripe for determination at the time of claim closure. See Galvin C. Yoakum, 44 Van Natta 2403 (1992) on recon 44 Van Natta 2492 (1992); Jean M. Bates, supra.

Penalties/Attorney Fees

Claimant requests penalties and attorney fees for the employer's allegedly unreasonable claims processing and failure to pay compensation. Under ORS 656.262(11)(a), if the carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount of 25 percent of the amounts "then due."

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[1] However, had the employer denied claimant's current C3-4 condition, that denial may have resulted in an invalid preclosure denial of an accepted condition. On February 26, 1996, Dr. Newby opined that "[claimant] subsequently became non medically stationary on December 15, 1995 with regard to further aggravation and worsening of his prior work injury. There has been no new injury but further progression of [claimant's] prior cervical injury which has moved up a level from his prior cervical fusions to the current C3-4 level." Since claimant's current cervical condition is the same condition as the accepted "cervical" condition, and the claim remains in open status, the extent of the accepted condition has not been determined pursuant to statutory procedures. See Elizabeth B. Berntsen, 48 Van Natta 1219 (1996) citing Roller v. Weyerhaeuser Co., 67 Or App 583, mod 68 Or App 743, rev den 297 Or 124 (1984).

The employer's refusal to pay is not unreasonable if it has a legitimate doubt about its liability. Castle & Cook, Inc. v. Porras, 103 Or App 65 (1990). On the one hand, the employer argues that claimant was medically stationary with respect to the neck condition in August 1994, and contends that claimant was unable to work after that time due to conditions other than the compensable neck condition. However, the employer did not deny any other "neck" condition, nor did it close the claim. Further, because the C3-4 condition was not identified until December 21, 1995 by Dr. Newby, the employer could not have known that the condition was allegedly "different" on November 17, 1995, when it terminated payment of claimant's temporary disability. Finally, in light of our finding that none of the subsections in ORS 656.268(3) were satisfied, the employer did not have authority to terminate temporary disability in the 1982 neck injury claim.

On this record, we find that claimant has established that the employer unreasonably refused to pay compensation in claimant's 1982 neck claim. The employer does not offer a reasonable explanation for terminating temporary disability compensation on November 17, 1995 when it denied the new low back injury claim. Therefore, under ORS 656.262(11)(a), we find that claimant is entitled to a 25 percent penalty of the amounts "then due" claimant as a result of our order, payable in equal shares to claimant and his attorney. See John R. Woods, 48 Van Natta 1016 (1996); Jeffrey D. Dennis, 43 Van Natta 857 (1991).

Accordingly, the insurer is directed to process the claim to closure pursuant to OAR 438-012-0055 and our March 25, 1993 Own Motion Order. The insurer shall recommence temporary disability compensation beginning November 17, 1995 when it terminated compensation, until it lawfully terminates temporary disability compensation. The penalty assigned herein shall be based on the unpaid temporary disability compensation between November 17, 1995 and the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
TERRY J. HOCKETT, Claimant
WCB Case No. 95-07640
ORDER ON REVIEW
Philip H. Garrow, Claimant Attorney
Roberts, et al, Defense Attorneys

Reviewed by Board Members Haynes, Christian and Hall.

The insurer requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) vacated an Order on Reconsideration which had awarded 35 percent (47.25 degrees) scheduled permanent disability for claimant's loss of use or function of the left foot; and (2) remanded the matter to the Director for the promulgation of a temporary rule. In its reply brief, the insurer contends that, pursuant to ORS 656.268(8), claimant may not raise the issue of a temporary rule, as he did not seek such a rule on reconsideration. On review, the issues are whether claimant may raise the issue of a temporary rule, whether the ALJ correctly remanded the claim to the Director, and extent of scheduled permanent disability. We reverse the remand ruling and affirm the Order on Reconsideration.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact, with the exception of the last paragraph in that section.

CONCLUSIONS OF LAW AND OPINION

ORS 656.268(8)

The insurer argues that claimant may not request remand to the Department for a temporary rule, as ORS 656.268(8) does not permit a hearing to be held on any issue that was not raised and preserved before the Department at reconsideration.[1] Consequently, the insurer contends that, because claimant did not request a temporary rule at the time of reconsideration, the statute does not permit him

[1] ORS 656.268(8), in relevant part, provides: "No hearing shall be held on any issue that was not raised and preserved before the department. However, issues arising out of the reconsideration order may be addressed and resolved at hearing."

to raise that issue for the first time at hearing. In light of our decision on the merits of claimant's remand request, however, we find it unnecessary to address the insurer's contentions.

Remand to the Department

The ALJ concluded that claimant's hypersensitivity condition of the left foot constituted impairment that was not rated under the standards. Accordingly, the ALJ relied on Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993), and remanded the claim to the director to stay further proceedings and adopt a temporary rule to accommodate claimant's impairment. For the following reasons, we conclude that remand is not warranted.

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...." The Board has the 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; Susan D. Wells, 46 Van Natta 1127 (1994).

Here, claimant contends that he is entitled to additional scheduled permanent disability for his "hypersensitivity to temperature extremes and limited material handling ability/capacity." Claimant also argues that the Director's adoption of temporary rules in other cases involving sensitivity resulting from crush injuries supports his entitlement to a similar award.

We first note that the Order on Reconsideration (OOR) makes an express finding that, "[t]he Director finds that the worker's disability is adequately addressed by the rating Standards." (Ex. 48-2) Furthermore, the OOR awarded impairment for loss of sensation, loss of flexion, ligament instability, and an inability to walk or stand for greater than two hours in an 8-hour period. The OOR also found that claimant had not established an entitlement to a chronic condition award. (Ex. 48-2).

We find that the present case is distinguishable from Gallino. In Gallino, on remand from the court, we concluded that remand to the Director was appropriate because the Director had not made an express finding that claimant's disability was not addressed by existing standards. Gary D. Gallino, 46 Van Natta 246 (1994). Here, the Director did make such a finding.

Additionally, as noted above, the OOR awarded claimant impairment for loss of sensation, flexion, instability, and an inability to walk or stand for more than two hours in an 8-hour period. Under these circumstances, we are unable to find support for claimant's assertion that the standards do not adequately address his impairment.

We contrast our conclusion in this case to our recent decision in Omar Mendoza, 48 Van Natta 952 (1996). In Mendoza, we found that remand to the Director was appropriate, even though the order expressly found no permanent impairment "as ratable under the standards." In Mendoza, there was no finding whether the claimant's loss of grip strength was covered by the standards, and there was no award of permanent disability made at the time of reconsideration. Here, however, the Director did identify several impairments, which were the basis of claimant's award on reconsideration.

Finally, we are not persuaded by claimant's argument that, because other workers have been awarded impairment for cold sensitivity, an award is appropriate in this case. First, as noted by the insurer, the temporary rules referred to by claimant involved workers with cold sensitivity of the hands, rather than the feet. Consequently, we are unable to find that the rules referenced by claimant would automatically apply in this case, which involves hypersensitivity of a different body part.

Furthermore, the temporary rules are promulgated to address individual workers' impairment. See Wanda E. Scanlon, 47 Van Natta 1464 (1995). Consequently, because the circumstances and disabilities of all workers vary, we are unable to say that the Director's failure to promulgate a temporary rule in this situation is inconsistent with his actions on other cases. Moreover, as the insurer argues, the fact that the Director did promulgate temporary rules in other cases involving sensitivity conditions is support for the proposition that, in this case, claimant's impairment was adequately addressed by the standards themselves. But see Dennis L. Martindale, 47 Van Natta 299 (1995).[2]

[2] In Martindale, we determined that remand was appropriate. We distinguish Martindale from the present case. Here, the Director made an express finding that claimant's disability was adequately addressed by the "standards." In Martindale, there was no express finding that the existing standards addressed the claimant's disability.

In February 1991, claimant reported severe right neck and shoulder symptoms to Dr. Athay. On February 28, 1991, Dr. Athay informed the insurer that claimant had exacerbated his chronic cervical spine condition, which Dr. Athay attributed to the 1983 injury. (Ex. 12). In June 1991, the insurer denied the compensability of claimant's treatment on the basis that claimant's symptoms were not related to the 1983 injury. (Ex. 14).

In December 1991, claimant and the insurer entered into a stipulation. The agreement in part provided that "claimant alleged an injury on March 10, 1983. This claim was accepted as a nondisabling cervical strain." (Ex. 17). The agreement further provided that the insurer would withdraw its denial and process the claim in accordance with law.

In a January 15, 1992 letter to the insurer, Dr. Athay described claimant's condition as a "chronic pain condition." (Ex. 18). In March 1992, the insurer issued a second denial which reiterated that the claim remained accepted for "neck, upper back, left arm, and left shoulder pain." (Ex. 20). The letter, however, also denied the compensability of all other conditions, as well as claimant's current neck, upper back, left arm and shoulder condition and emotional problems related to anxiety. Id.

On May 27, 1993, a prior ALJ, relying on Georgia-Pacific Corp. v. Piwowar, 305 Or 494 (1988), found that the insurer accepted the chronic pain syndrome condition by indicating in its denial letter that it had accepted neck, upper back, left arm and left shoulder "pain." (Ex. 25). In particular, the ALJ found that the insurer had accepted symptoms rather than a specific disease or condition and, therefore, had accepted any underlying disease or condition.

The prior ALJ also concluded that claimant had a preexisting cervical degenerative/arthritic condition that was not independently compensable. In addition, the ALJ determined that claimant's chronic pain syndrome was preexisting and had combined with his compensable injury to cause a need for medical treatment. The ALJ concluded that, since the chronic pain syndrome had been accepted and had not changed since its acceptance, claimant's compensable injury was the major contributing cause of the "resultant condition." See former ORS 656.005(7)(a)(B). Finally, the ALJ found that, although claimant's cervical degenerative/arthritic conditions were not separately compensable, insofar as those conditions individually or in combination played a causal role in claimant's chronic pain syndrome, the related need for medical services and disability was compensable. (Ex. 26B-1).

The Board affirmed the ALJ's order on March 23, 1994. Harry L. Lyda, 46 Van Natta 478 (1994). In a subsequent May 26, 1994 letter to claimant's attorney, Dr. Athay explained that claimant was medically stationary, but that "his underlying neck condition with degenerative cervical disc disease and degenerative arthritis has gradually gotten worse, and therefore his condition has actually gotten a little bit worse over the past several years." (Ex. 31-2). In a July 1994 letter, Dr. Athay reiterated his opinion that there had been a gradual deterioration of claimant's arthritis and degenerative disc disease. (Ex. 32). However, Dr. Athay has consistently maintained that claimant's chronic pain condition is related to the compensable 1983 injury. (Exs. 31, 32, 36A, 42).

On November 8, 1994, a Determination Order issued, which awarded 41 percent unscheduled permanent disability and 7 percent scheduled permanent disability for loss of use or function of claimant's left arm. (Ex. 34). Claimant requested reconsideration.

As part of the reconsideration process, medical arbiter examinations were performed on May 17, 1995 by a psychiatrist, Dr. Glass, a neurologist, Dr. Platt, and an orthopedist, Dr. Dinneen. (Ex. 38, 39). A July 7, 1995 Order on Reconsideration increased claimant's unscheduled award to 46 percent and otherwise affirmed the Determination Order. (Ex. 40).

On July 19, 1995, based on information received in the medical arbiter examinations, the insurer issued another denial, alleging that claimant's current chronic pain syndrome was not compensable. (Ex. 41). Claimant appealed the denial.

The ALJ in this proceeding found that claimant failed to prove that his compensable 1983 injury was the major contributing cause of his current "combined condition" under amended ORS 656.005(7)(a)(B). The ALJ determined that there was a persuasive reason not to defer to Dr. Athay's opinion because of its "brevity and conclusory" nature.

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, we find no persuasive reason not to defer to Dr. Athay's opinion because it is sufficiently explained and has the advantage of long-term observation of claimant's chronic pain syndrome. (Exs. 31, 32).

Moreover, the compensability of claimant's chronic pain syndrome was previously litigated before an ALJ, who determined that it was compensable. We affirmed the ALJ's order. Harry L. Lyda, supra. We recognize that ORS 656.262(6)(c) allows a carrier to deny a "combined condition" even if it had been previously accepted as a result of an order, provided that the otherwise compensable injury "ceases" to be the major contributing cause of the combined condition. However, 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 the claimant's combined condition. Elsa S. Wong, 48 Van Natta 444, 445 n.1 (1996).

Although the medical arbiters, Drs. Platt and Dinneen, opined that claimant's present condition was not related to the March 1993 injury in a "major way," (Ex. 39-9), they did not identify any change in claimant's condition or a change of circumstances such that claimant's compensable injury is no longer or "ceased" to be the major contributing cause of claimant's combined condition. In a single unexplained sentence, Dr. Glass opined that claimant's compensable injury was not the major contributing cause of claimant's psychiatric symptoms. (Ex. 38-6). However, he, too, did not identify any change of circumstances or change in claimant's condition.

We recognize that there is evidence from Dr. Athay that claimant's degenerative conditions have gradually deteriorated. (Ex. 32). However, Dr Athay also observed that there had been no "major changes" and that claimant's conditions have remained medically stationary. (Ex. 31-2). Thus, based on Dr. Athay's persuasive medical opinion, we are not inclined to find that there has been a change in claimant's condition or a change in circumstances to warrant the issuance of a denial under ORS 656.262(6)(c).[1]

In any event, even if the requisite change of circumstances was present to support the procedural validity of such a denial, the persuasive medical evidence does not establish that claimant's compensable injury has "ceased" to be the major contributing cause of his chronic pain disorder. As previously noted, we find no persuasive reason not to defer to the opinion of the attending physician, Dr. Athay. In addition, we find his opinion more persuasive than those of the medical arbiters who provided the basis for the insurer's denial. Although the ALJ found the opinions of Drs. Glass, Platt and Dinneen complete and persuasive, we disagree with the ALJ's assessment. None of the above doctors explained why claimant's 1983 injury is no longer the major factor in claimant's compensable chronic pain condition. Inasmuch as they are conclusory and inadequately reasoned, we give the opinions of the medical arbiters little weight and find them less persuasive than the opinion of the attending physician, Dr. Athay.[2] See Somers v. SAIF, 77 Or App 259 (1986).

In conclusion, we find claimant has sustained his burden of proving that his compensable 1983 injury remains the major contributing cause of his chronic pain syndrome. Accordingly, we reverse the ALJ's decision upholding the denial.

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[1] The insurer argues that claimant's degenerative disc disease and degenerative arthritis have become the major factor in claimant's current condition, citing Dr. Athay's medical reports indicating that these conditions have worsened. Inasmuch as the prior ALJ determined that these conditions were not independently compensable and preexisted claimant's 1993 injury, the insurer asserts that claimant's chronic pain disorder cannot be compensable if these conditions are the major factor in claimant's condition. We find the insurer's contentions unpersuasive, since Dr. Athay never stated that these preexisting conditions were the major contributing cause of claimant's condition, nor did the medical arbiters.

[2] The insurer argues that Dr. Athay has failed to exercise independent judgment and that his opinion should be discounted because of his bias toward claimant. See Diana M. Hafemann, 47 Van Natta 379, 381 (1995) (where physician failed to provide independent opinion regarding the reasonableness and/or necessity of the proposed procedure, medical opinion was discounted); Mike Sepull, 42 Van Natta 970 (1990) (physician's opinion discounted when he acted as advocate, rather than as medical expert). However, based on our review of the record, we are not persuaded that Dr. Athay has been biased by his long-term treatment of claimant.

Accordingly, on this record, we conclude that claimant has failed to prove that the standards do not adequately address his disability. ORS 656.266; Susan D. Wells, supra.; Valorie L. Leslie, 46 Van Natta 1919 (1994). Therefore, we have no authority to remand to the Director pursuant to ORS 656.726(3)(f)(C). The ALJ's remand ruling is reversed.

Extent of scheduled permanent disability

On review, claimant contends that, if we reverse the ALJ's remand ruling, we should award 5 percent for a chronic condition which resulted from the compensable injury. Claimant relies on the opinions of Drs. Karmy and Holmboe. (Exs. 45, 43).

Claimant is entitled to a chronic condition award if he can establish that he is unable to repetitively use his left foot. OAR 436-35-010(6)(a). After reviewing the reports of Drs. Karmy and Holmboe, and the medical arbiter's report, we are not persuaded that claimant has established that he is unable to repetitively use his left foot. Accordingly, we do not find that claimant has proven that he is entitled to an increased award of scheduled permanent disability. Therefore, the Order on Reconsideration award of 35 percent scheduled permanent disability is affirmed.

ORDER

The ALJ's order dated December 6, 1995 is reversed. The ALJ's ruling which remanded the claim to the Director for a temporary rule is reversed. The Order on Reconsideration which award 35 percent (47.25 degrees) scheduled permanent disability for loss of use or function of the left foot is reinstated and affirmed. The ALJ's attorney fee award is also reversed.

Board Chair Hall dissenting.

I believe that the ALJ correctly remanded this claim to the Director for the promulgation of a temporary rule. Consequently, for the following reasons, I dissent from the majority's opinion.

First, I disagree with the insurer's contention that claimant may not request remand because he failed to seek a temporary rule at the time of reconsideration. ORS 656.268(8). The statute provides, in part, 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." ORS 656.268(8). Here, the arbiter found that claimant had impairment in the form of hypersensitivity of the foot, due to the injury. The Director relied on the arbiter's report to establish impairment findings on reconsideration. Therefore, the failure of the Director to consider a temporary rule based on the arbiter's impairment findings is an issue that arose out of the reconsideration order and, thus, was properly raised at hearing. Also see Michael R. Wickstrom, 46 Van Natta 906 (1994) (A claimant's hearings level request for remand to the Director was timely).

With respect to the merits of claimant's remand request, I agree with the ALJ that this matter must be remanded to the Director. The majority has found that, in this case, the Director made an "express finding" that claimant's disability was addressed by existing standards. In reality, however, the Department has merely inserted boilerplate language into the reconsideration order which recites that, "the Director finds that the worker's disability is adequately addressed by the rating standards." Nowhere in the reconsideration order is there any acknowledgment of the existence of claimant's hypersensitivity condition, which was documented by the medical arbiter.

Consequently, I find that the present case is distinguishable from the Leslie case, supra, in which the Department specifically found that the claimant's anterior capsular reconstruction surgery was not considered an impairment under the standards. In Leslie, the Department further found that residuals of the surgery would be evidenced by recurrent dislocation, weakness, or loss of motion. Based on such reasoning, the Department concluded that the claimant's disability in Leslie was addressed by the standards and promulgation of a temporary rule was not appropriate.

In the present case, however, the Department has not even acknowledged the existence of claimant's hypersensitivity impairment, much less discussed it in the sort of detail found in the Leslie case. Under the circumstances, I disagree with the majority's conclusion that the Director expressly found that claimant's disability was adequately addressed by the standards. In light of such facts, the claim should be remanded to the Director for the promulgation of a rule.

Alternatively, I conclude that, even if the Director did consider claimant's hypersensitivity condition, he incorrectly determined that a temporary rule was not required. It is clear that the Department, in rating claimant's permanent impairment, relied on the arbiter's report. Accordingly, the arbiter's identification of a particular condition, such as hypersensitivity, which has been related to the compensable injury, similarly deserves to be rated. Additionally, because there is no specific rule in the standards which provides for such an award, the Director was required to promulgate a temporary rule. Gallino v. Courtesy Pontiac, supra.

Finally, the majority has declined to remand, even in light of the fact that the Director has promulgated temporary rules for similar sensitivity conditions. It is too fine of a distinction to argue that the Director would not promulgate such a rule in this case because the facts of the case involve a foot, rather than a hand condition. The majority's approach is inconsistent with our decisions in other cases, which rely on the Director's promulgation of rules in similar cases as a factor weighing in favor of remand. See e.g. Gary D. Gallino, 46 Van Natta 246 (1994) (The lack of an express finding regarding whether the claimant's disability was addressed by the standards, in conjunction with the Director's post-order promulgation of disability standards addressing chondromalacia caused the Board to find that, at the time of the reconsideration order, the claimant's disability was not addressed by the standards); Dennis L. Martindale, 47 Van Natta 299 (1995) (In remanding to the Director for consideration of promulgation of a temporary rule, the Board noted that the Director had promulgated numerous temporary rules addressing grip strength loss in other cases). In other words, that the Director has pomulgated temporary rules in other similar cases actually supports a decision to remand in the present case.

Under the circumstances, I disagree with the majority's conclusion that the Director made an express finding regarding claimant's disability, and alternatively, that claimant's disability is addressed by the existing standards. Therefore, I would affirm the ALJ's order which remanded this claim to the Director for the promulgation of a temporary rule addressing claimant's hypersensitivity condition.

June 27, 1996 Cite as 48 Van Natta 1300 (1996)

In the Matter of the Compensation of
HARRY L. LYDA, Claimant
WCB Case No. 93-06409
ORDER ON REVIEW
Burt, Swanson, et al, Claimant Attorneys
Garrett, Hemann, et al, Defense Attorneys

Reviewed by Board Members Hall and Christian.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order which upheld the insurer's denial of his current chronic pain disorder. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the insurer's denial of claimant's current chronic pain disorder, reasoning that claimant's compensable 1983 injury was no longer the major contributing cause of his disability and need for treatment. On review, claimant contends that the opinion of his attending physician, Dr. Athay, satisfies his burden of proving the compensability of his ongoing chronic pain disorder. We agree.

Before proceeding with our analysis, we begin by summarizing the factual and procedural background of the claim. Claimant compensably injured his arm, neck, shoulder, and upper back on March 10, 1983 while pulling on a file cabinet drawer. (Ex. 1). Dr. Athay, internal medicine specialist, and Dr. Ambrust, a neurosurgeon, treated claimant.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review is $3,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record and claimant's 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 February 5, 1996 is reversed. The insurer's denial is set aside and the claim is remanded to the insurer for processing. For services at hearing and on review, claimant's counsel is awarded an attorney fee of $3,500, to be paid by the insurer.

In the Matter of the Compensation of
MURIEL D. NELSON, Claimant
WCB Case No. 95-10716
ORDER ON REVIEW
Rasmussen, et al, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Christian and Hall.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of her occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Finding that the opinion of Drs. Wilson and Strum, examining physicians, was more persuasive than those of Drs. Thompson, treating family physician, La France, treating neurologist, and Dodds, treating orthopedic surgeon, the ALJ concluded that claimant failed to prove her CTS claim. We disagree.

Claimant bears the burden of establishing, by medical evidence supported by objective findings, that her work activities for the employer were the major contributing cause of her bilateral CTS condition. ORS 656.802(2)(a). If such a condition preexisted her work exposure, claimant must prove that her work activities were the major contributing cause of a worsening of the preexisting condition. ORS 656.802(2)(b).

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).

Drs. Strum and Wilson opine that any "person who develops carpal tunnel syndrome has to have a predisposition to that condition[.]" In claimant, they identify the predisposing factors as "being female and slightly overweight." They identified no other "underlying pathology." Based on Drs. Strum and Wilson's reasoning, SAIF argues that because claimant had a preexisting condition, she must establish that her work activities caused a worsening of her "underlying pathology." See amended ORS 656.005(24) ("Preexisting condition" is defined, in part, 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 * * *."). Claimant, on the other hand, argues that she had no preexisting or predisposing condition.

Even if we were to impute the predisposing factors of "being female and slightly overweight" to claimant, on this record, we are persuaded that claimant has satisfied the requisite major causation standard and established the compensability of her CTS. We do so based on the following reasoning.

Drs. Strum and Wilson's opinion is too generic, addressing the general predisposition of all woman to develop CTS, and then proceeding from that assumption to conclude that claimant's CTS is not work-related. Because their opinion is, for the most part, general rather than specific to claimant, we do not find it particularly persuasive. See Sherman v. Western Employers Insurance, 87 Or App 602 (1987). Instead, we find that Drs. Thompson, La France and Dodds' opinions concerning causation are based on claimant's detailed and accurate history concerning her hand-intensive work and her symptoms. Considering the treating doctors' accurate history, their advantageous positions as treating physicians, and their weighing of the relative contributions of claimant's gender, weight, and work exposures, we find their opinions the most persuasive. See Weiland v. SAIF, 64 Or App 810 (1983). Accordingly, based on Drs. Thompson, La France and Dodds' opinions, we find that claimant's work activities were the major contributing cause of her CTS. Consequently, claimant has carried her burden under ORS 656.802(2)(a).

Claimant is entitled to an assessed attorney fee for prevailing on the compensability issue. ORS 656.386(1). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable assessed attorney fee for claimant's counsel's services at hearing and on review concerning the claim is $3,000, to be paid by the SAIF Corporation. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the hearing record and claimant's appellate briefs), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated January 30, 1996 is reversed. The SAIF Corporation's denial is set aside, and the claim is remanded to SAIF for processing according to law. For services at hearing and on review, claimant's counsel is awarded an attorney fee of $3,000, payable by SAIF.

In the Matter of the Compensation of
WALTER J. ROA, Claimant
WCB Case Nos. 95-05027 & 95-03491
ORDER ON REVIEW
Pozzi, Wilson, et al, Claimant Attorneys
Roberts, et al, Defense Attorneys

Reviewed by Board Members Moller and Christian.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Galton's order that: (1) awarded a $2,000 fee to claimant's attorney for prevailing against its current condition denial; and (2) set aside its denial of claimant's new injury claim for a low back condition. On review, the issues are compensability and attorney fees. We modify in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact. We do not adopt the ultimate findings of fact.

We briefly summarize the pertinent facts. On September 19, 1994, claimant slipped at work, injuring his low back. The insurer accepted the claim as a disabling lumbar strain. Claimant, who was treated by Dr. Barnhouse, was also diagnosed with degenerative disc disease (DDD) at L3-4 and L5-S1 which combined with the injury. (Exs. 4, 13-3, 45AB, 52A-3). On January 27, 1995, claimant was released to return to modified work with limits on lifting. (Exs. 32, 36, 39-1).

On March 21, 1995, the insurer denied claimant's current condition and the preexisting DDD. An April 5, 1995 Determination Order closed the claim with no award of permanent disability. Claimant requested reconsideration and a July 14, 1995 Order on Reconsideration, which has become final, awarded claimant 6 percent scheduled and 14 percent unscheduled permanent disability.

Meanwhile, on March 15, 1995, claimant experienced increased low back pain with radiation into his buttocks and leg after bending and lifting at work. On April 21, 1995, the insurer denied the March 15 incident as a new injury claim on the basis that the major contributing cause of claimant's low back condition was his preexisting DDD. (Ex. 51). Claimant's treating physician for his low back since January 17, 1995 was Dr. Bentz.

The insurer rescinded its "current condition" denial at the beginning of the hearing. (Tr. 4, 5).

CONCLUSIONS OF LAW AND OPINION

Attorney Fee - Current Condition Denial

The ALJ found that the insurer's March 21, 1995 denial included both a denial of claimant's current condition and a denial of his preexisting degenerative disc disease (DDD) condition. Addressing the compensability of claimant's current condition, the ALJ concluded that the major contributing cause of claimant's current need for treatment remained his 1994 lumbar strain injury. The ALJ accordingly awarded an assessed fee of $2,000 to claimant's attorney for having prevailed against the "current condition" portion of the insurer's denial.

On review, the insurer contends, first, that its denial was limited to a partial denial of claimant's DDD[1] and not a current condition denial. Alternatively, if the denial included a current condition denial, the insurer contends that the ALJ's attorney fee award of $2,000 for claimant's counsel's services at hearing for having prevailed on that issue is excessive.

We agree with the ALJ's conclusion that the unambiguous terms of the denial encompassed both a current condition denial and a denial of claimant's preexisting DDD. However, we modify the ALJ's attorney fee award based on the following reasoning.

At hearing, the insurer attempted to amend its denial to deny only the DDD and not claimant's current condition, in effect rescinding the current condition portion of the denial. (Tr. 4, 5). Claimant made no objection to the insurer's amendment of the denial, neither asserting surprise nor requesting a continuance. Thus, the insurer effectively amended its denial at hearing. See Marsha K. Flanary, 44 Van Natta 393 (1992); Donna J. Wilson, 42 Van Natta 1026 (1990); see also Dolph M. Wiedenmann, 46 Van Natta 1584 (1994) (where the claimant objected to proceeding on a basis not raised by the denial, the insurer was not allowed to orally amend its denial). Accordingly, on review, we find that the insurer effectively rescinded its current condition denial at hearing and consider the denial, as amended, to deny only claimant's preexisting DDD.

Inasmuch as 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. ORS 656. 386(1).

Claimant's attorney requested a hearing contesting the insurer's compensability denial. He also wrote letters to Dr. Barnhouse and Dr. Bentz seeking their medical opinions regarding the cause of claimant's current condition. (Exs. 45AB, 52A, 57). At hearing, claimant's attorney identified the compensability of the current condition issue in his opening remarks, to which the insurer's attorney responded by effectively rescinding the compensability denial. (Tr. 1, 2, 3, 4, 5). Based on claimant's efforts prior to and at hearing, we conclude that claimant's attorney was instrumental in obtaining rescission of the denial.

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 rescission of the denial prior to a decision by the ALJ is $1,200, 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.

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[1] Claimant does not dispute the denial of the DDD.

Compensability - 1995 Injury

The ALJ concluded that claimant had established that he sustained a new compensable industrial injury in March 1995.[2] We disagree.

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."

Here, claimant has been diagnosed with DDD that preexisted his March 1995 injury. Consequently, if claimant's March 1995 industrial injury combined with his preexisting condition, he must prove that the 1995 injury is the major contributing cause of the disability or need for treatment of his combined condition. ORS 656.005(7)(a)(B).[3]

Considering the number of possible causes, the determination of the major cause of claimant's condition is complex and requires expert medical opinion. Uris v. Compensation Dept., 247 Or 420 (1967). 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). In this case, we find such reasons.

Drs. Duff and Calhoun examined claimant for the insurer on April 15, 1995. (Ex. 50). They noted that claimant had been constantly symptomatic since the September 1994 injury, which is confirmed by the record. (See Exs. 41, 41A, 43). They found that claimant's low back and right leg symptoms after the March 15, 1995 incident were virtually identical (although more intense) to those at the time of their previous examination on February 20, 1995, which was prior to the March 1995 incident. They opined that there had been no objective worsening of claimant's condition since that time and that, while claimant experienced a new incident that caused a symptomatic exacerbation, his current symptomatology was a continuation of his previously diagnosed problems. They further opined that the major cause of claimant's condition after the March 15, 1995 incident was his preexisting DDD.

In contrast, Dr. Bentz, claimant's attending physician since January 1995, opined that claimant experienced a new injury on March 15, 1995, to which he was predisposed because of his prior back problems. (See Ex. 57-2). We are not persuaded by Dr. Bentz' opinion, as he relied solely on claimant's report of a "new injury" without discussing the relative contributions of claimant's continuing symptoms from the 1994 injury and his DDD. Somers v. SAIF, 77 Or App 259 (1986). Consequently, claimant has failed to establish that the March 15, 1995 incident constituted a new compensable injury.

ORDER

The ALJ's order dated December 29, 1995 is reversed in part and modified in part. That portion of the ALJ's order setting aside the insurer's denial of claimant's new injury claim is reversed. In lieu of the ALJ's attorney fee award of $2,000, we award $1,200 for claimant's counsel's services in obtaining the insurer's rescission of its current condition denial.

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[2] As noted above, the insurer conceded compensability of claimant's current condition, which is the 1994 injury combined with the preexisting DDD. The insurer does not contend that claimant's condition subsequent to the 1995 incident is not compensably related to his 1994 accepted claim. Consequently, we direct our analysis solely to whether claimant's "new injury" claim is compensable in light of the DDD.

[3] We note that claimant acknowledged that he must satisfy the major contributing cause standard.

In the Matter of the Compensation of
JEAN B. ROGERS, Claimant
WCB Case Nos. 93-14437 & 93-14436
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Hall and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Daughtry's order that: (1) declined to reclassify her aggravation claim from nondisabling to disabling; and (2) declined to assess a penalty or related attorney fee for the self-insured employer's allegedly unreasonable claims processing. The employer cross-requests review of that portion of the ALJ's order which held that the Hearings Division was authorized to address the classification dispute. On review, the issues are jurisdiction, claim classification, 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

In September 1991, claimant, a software engineer, developed bilateral upper extremity complaints, for which she filed a workers' compensation claim. The claim was accepted as a nondisabling bilateral wrist overuse condition. Claimant's work site was modified, but claimant did not miss any work, nor was any permanent disability anticipated by claimant's attending physician, Dr. Stevens.

In May 1993, claimant was required to perform increased keyboarding. Claimant's bilateral wrist symptoms returned, worse on the left. Claimant filed a new injury claim. (Ex. 17). The claim was accepted as a "nondisabling" aggravation claim and denied as a "new injury" claim. (Exs. 24, 26)

Requesting a hearing before the Board's Hearings Division, claimant sought to change the employer's acceptance of her aggravation claim from nondisabling to disabling. See ORS 656.277(2). The ALJ determined that, since the Hearings Division had jurisdiction over aggravation claims, it, therefore, had jurisdiction over the classification issue concerning the aggravation claim. Turning to the merits of the classification issue, the ALJ held that the employer's classification of the claim as nondisabling was proper.

In reaching this conclusion, the ALJ reasoned that, in order for an aggravation claim to be classified as "disabling," there either had to be temporary disability benefits due or a reasonable expectation of permanent disability. See ORS 656.005(7)(c). Inasmuch as no temporary disability was authorized and since there was no reasonable expectation of permanent disability, the ALJ concluded that claimant's claim should remain classified as "nondisabling." Given this conclusion, the ALJ declined claimant's request for penalties and attorney fees for the employer's allegedly unreasonable failure to properly classify the aggravation claim.

On review, claimant contends that, by accepting claimant's aggravation claim, the employer was necessarily required to classify it as "disabling." Moreover, claimant asserts that the employer's failure to properly classify claimant's aggravation claim was unreasonable, justifying an award of penalties under ORS 656.262(11) or an attorney fee under ORS 656.382(1). In its cross-request for review, the employer contends that the Board does not have jurisdiction to address the classification dispute. Although we agree with the ALJ's reasoning that the Board has jurisdiction over this matter, we conclude, for the following reasons, that claimant's accepted aggravation claim should have been accepted as "disabling."

We first address the jurisdictional issue. Citing Charles B. Tyler, 45 Van Natta 972 (1993), and Charles L. Simon, 47 Van Natta 908 (1995), the employer contends that neither the Board nor the Hearings Division has jurisdiction to reclassify claimant's claim. Moreover, the employer asserts that, inasmuch as claimant's condition has not changed since her original injury, she is in effect seeking to reclassify her original claim. Since claimant did not do so within one year of her original injury, the employer argues that her request for reclassification is time-barred under ORS 656.277(1). We disagree with the employer's contentions.

Tyler and Simon are inapposite because both cases involved reclassification of original injuries. Here, claimant is alleging that her aggravation claim should be reclassified. We do not accept the employer's argument that claimant is attempting to have her original claim reclassified. Although the employer asserts that there has been no change in claimant's condition since the original injury, it neglects to mention that it voluntarily accepted claimant's May 1993 claim on August 11, 1993 as a compensable aggravation claim. (Ex. 24). Such acceptance necessarily involves a concession that claimant's current compensable nondisabling injury has become disabling and has "actually worsened." See ORS 656.277(2); ORS 656.273(1). Consequently, we conclude that claimant is attempting to have her aggravation claim reclassified, not her original injury. Inasmuch as the Board has jurisdiction over aggravation claims pursuant to ORS 656.273, we agree with the ALJ that the Hearings Division has jurisdiction over this matter.[1]

We now proceed to a determination of whether claimant's aggravation claim should be reclassified from "nondisabling" to "disabling." For the following reasons, we conclude that the claim is disabling.

Amended ORS 656.277(2) provides that "A claim that a nondisabling injury originally was or has become disabling, if made more than one year after the date of injury, shall be made pursuant to ORS 656.273 as a claim for aggravation." Although claimant's May 1993 claim was one for a "new injury," it was accepted as an "aggravation" of her previously accepted September 1991 claim. Moreover, claimant does not challenge the employer's "new injury" denial or dispute the employer's processing of the May 1993 claim. Under these circumstances, we conclude that the May 1993 claim was an "aggravation" claim made more than one year after the date of injury pursuant to ORS 656.277(2).

We now determine the effect of the employer's acceptance of claimant's aggravation claim. ORS 656.277(2) furnishes the exclusive means by which a claimant can obtain reclassification of a nondisabling injury more than a year after the date of injury. It provides that a claim that a nondisabling injury originally was or has become disabling must be made through an aggravation claim. It, therefore, follows that the only means by which a carrier can either agree or decline to reclassify a claim is by either accepting or denying the aggravation claim. In other words, in accepting an aggravation claim, the carrier necessarily concedes that claimant's request for reclassification is meritorious, i.e., that the injury has become "disabling." Granted, ORS 656.277(2) does not explicitly provide that, if an aggravation claim made more than one year after the date of injury is compensable, the classification should necessarily be changed to "disabling." However, we find that such a conclusion necessarily follows from the statutory scheme set forth in ORS 656.277(2).[2]

In this case, the employer accepted claimant's May 1993 claim as a compensable aggravation. Inasmuch as this aggravation claim was made pursuant to ORS 656.277(2) as a request for reclassification of claimant's injury claim, the employer's acceptance of the claim necessarily requires it to reclassify the claim as "disabling." The employer's acceptance of the May 1993 claim as a "nondisabling" aggravation implies that it believed that claimant's right upper extremity condition had not worsened. If this is correct, it should have issued a denial of the aggravation claim based on a lack of an "actual worsening," instead of accepting the claim and classifying it as "nondisabling." What the employer has done in this case is, in effect, to deny claimant's aggravation claim in the guise of classifying as nondisabling an already accepted aggravation claim asserted pursuant to ORS 656.277(2). This it cannot do.

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[1] Even if claimant was attempting to have her original claim reclassified, amended ORS 656.277(2) allows for a nondisabling claim that "originally was or has become" disabling to be made pursuant to ORS 656.273 as a claim for aggravation. Inasmuch as the claim that the nondisabling injury originally was or has become disabling occurred more than a year after the date of injury in 1991, claimant would be allowed to contest the classification of her original injury via the May 1993 claim the employer accepted as an aggravation. See also ORS 656.283(1); OAR 436-30-045(3)(a) (No claim shall be reviewed for reclassification by the Department unless the request or notice to an insurer that a nondisabling injury is disabling is made within one year of the date of injury).

[2] We acknowledge ORS 656.273(6), which provides that an aggravation shall be processed in accordance with ORS 656.262, and ORS 656.262(6)(b)(B), which in turn provides that a notice of acceptance shall advise a claimant of whether a claim is considered disabling or nondisabling. Taken together, these statutes suggest that an aggravation claim may be accepted as "nondisabling." We need not, and do not, decide the issue of whether an aggravation claim made outside the context of ORS 656.277(2) can be accepted as "nondisabling." Rather, our decision in this case is limited to those aggravation claims asserted pursuant to ORS 656.277(2) in the context of a request for claim reclassification. Under those circumstances, we find that acceptance of an "aggravation" claim for a nondisabling claim necessarily involves a concession that a claim is "disabling."

In summary, we conclude that, consistent with the statutory scheme of ORS 656.277(2) (which provides that a nondisabling injury which has become disabling more than a year after the injury must be processed as an aggravation claim), an acceptance of an aggravation claim made pursuant to that statute necessarily constitutes a determination that the aggravation claim is disabling. We, thus, disagree with the ALJ's decision upholding the employer's "nondisabling" classification of this claim.[3]

Next, claimant contends that the employer's conduct in classifying her claim was unreasonable, thereby entitling her to either an attorney fee pursuant to ORS 656.382(1) or a penalty based on any permanent disability due at claim closure. We disagree.

As previously noted, ORS 656.273(6), together with ORS 656.262(6)(b)(B), suggest that an aggravation claim may be accepted as "nondisabling." Moreover, the record does not establish that claimant was entitled to temporary disability and we agree with the ALJ's reasoning that it does not demonstrate a reasonable expectation of permanent disability. Under these circumstances, the employer's classification of claimant's aggravation claim as "nondisabling" was not unreasonable in light of the aforementioned statutes, as well as ORS 656.005(7)(c). We further note that, prior to issuance of this order, there was no decision stating that an "aggravation" claim in the context of ORS 656.277(2) could not be classified as "nondisabling." For these reasons, we conclude that the employer's claim processing was not unreasonable.

Moreover, even if the employer's claim processing was unreasonable, we would still decline to assess a penalty pursuant to ORS 656.262(11) because there is no indication in the record that there were amounts "then due." Given the fact that no compensation was due, we would also decline to award an attorney fee pursuant to ORS 656.382(1) in the absence of resistance to the payment of compensation. See SAIF v. Condon, 119 Or App 194 (1993).[4]

ORDER

The ALJ's order dated August 23, 1995 is reversed in part and affirmed in part. That portion of the ALJ's order which declined to reclassify claimant's claim is reversed. Claimant's aggravation claim is reclassified as "disabling" and the claim is remanded to the insurer for processing in accordance with law. Claimant's attorney is awarded an out-of-compensation attorney fee equal to 25 percent of the increased temporary disability compensation (if any) created by this order, not to exceed $3,800, payable directly to claimant's attorney. The remainder of the ALJ's order is affirmed.

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[3] We acknowledge ORS 656.005(7)(c), which provides that "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." While the record does not establish that claimant is entitled to temporary disability or that there is a reasonable expectation of permanent disability, the employer's acceptance of an aggravation claim asserted pursuant to ORS 656.277(2) (which necessarily constitutes a determination that the aggravation claim is "disabling") serves as a concession that the requirements of ORS 656.005(7)(c) for a "disabling" injury have been satisfied.

[4] Claimant's counsel is entitled to an "out-of-compensation" attorney fee based on the right to temporary disability, if any, created by an order reclassifying a claim. See Joseph M. Lewis, 47 Van Natta 381, on recon 47 Van Natta 616 (1995) (where compensation created by order reclassifying the claim was temporary disability benefits, "out-of-compensation" attorney fee limited to a percentage of the claimant's temporary disability benefits). Although, as result of our order, claimant is entitled to claim closure, we are unable to award an out-of-compensation fee based on future permanent disability awards. See Julie A. Johnson, 48 Van Natta 29 (1996).

In the Matter of the Compensation of
WILLIAM G. SHEFFIELD, Claimant
WCB Case No. 95-06941
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Haynes and Christian.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order which awarded an assessed attorney fee pursuant to ORS 656.386(1). On review, the issue is attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

This hearing was conducted based on the following stipulated facts. Claimant's accepted right knee claim was closed by a March 31, 1995 Determination Order. On May 17, 1995, the insurer issued an aggravation denial. Claimant requested a hearing on June 9, 1995, contesting the denial. In the meantime, claimant requested reconsideration of the Determination Order, alleging that the claim had been prematurely closed. A September 26, 1995 Order on Reconsideration found the claim was prematurely closed and rescinded the Determination Order.

At hearing, the only issue was claimant's entitlement to an attorney fee under amended ORS 656.386(1).[1] The ALJ held that claimant's attorney was entitled to an attorney fee. The ALJ reasoned that claimant's counsel had obtained a "rescission" of the insurer's aggravation denial prior to a decision by an ALJ by requesting reconsideration which resulted in a finding that the March 31, 1995 Determination Order was prematurely issued.

On review, the insurer contends that the ALJ improperly awarded an attorney fee because claimant's attorney never obtained a "rescission" of its aggravation denial. We agree.

In Candy M. Kayler, 44 Van Natta 2424 (1992), we held that the claimant did not "prevail" on her aggravation claim within the meaning of former ORS 656.386(1)[2] where the carrier's denial of aggravation was rendered moot by an Order on Reconsideration which set aside a Determination Order as premature. See also Mindi M. Miller, 44 Van Natta 1671, on recon 44 Van Natta 2144 (1992) (where an aggravation denial was rendered moot by a reclassification of the claimant's claim as disabling, the claimant was not entitled to an assessed attorney fee under former ORS 656.386(1)). Therefore, we concluded that the claimant's attorney was not entitled to an attorney fee under the former statute.

While it is clear that claimant's attorney would not be entitled to an attorney fee under the former statute, amended ORS 656.386(1) now requires that an attorney be instrumental in obtaining the "rescission" of a denial prior to a decision by the ALJ. Compare William C. Becker, 47 Van Natta 1933

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[1] Amended ORS 656.386(1) provides in part:

"In such cases involving denied claims where the claimant prevails finally in a hearing before an Administrative Law Judge or in a review by the Workers' Compensation Board, then the Administrative Law Judge or board shall allow a reasonable attorney fee. In such cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the Administrative Law Judge, a reasonable attorney fee shall be allowed. . . ."

[2] Former ORS 656.386(1) provided in part:

"In such rejected cases where the claimant prevails finally in a hearing before the referee or in a review by the board itself, then the referee or board shall allow a reasonable attorney fee. If an attorney is instrumental in obtaining compensation for a claimant and a hearing is not held, a reasonable attorney fee shall be allowed. . . ."

(1995) (where the claimant withdrew his claim and would not receive benefits as a result of the Board's decision that SAIF's denial of a "withdrawn" claim is a nullity, the claimant did not prevail over a denied claim and was not entitled to an attorney fee award under amended 656.386(1)). The ALJ reasoned that claimant's counsel had been instrumental in obtaining a "rescission" of the insurer's aggravation denial by securing a finding from the Department that the claim had been prematurely closed, which effectively "negated" the aggravation denial. See Daniel K. Keliiheleua, 47 Van Natta 2172, 2173 (1995) (no aggravation claim can occur while claim still open).

However, we are unwilling to equate the Department's finding that the claim had been prematurely closed with a "rescission" of the insurer's denial. While the Department's finding of premature closure may have "negated" or rendered moot the aggravation denial, there is no evidence that the insurer "rescinded" its denial in response to the reconsideration order. Claimant cites various definitions of "rescission" and "rescinded" in support of his argument that, inasmuch as the statute does not prohibit an act in another forum from constituting a "rescission" of a denial, his attorney was instrumental in obtaining a rescission of the aggravation denial by obtaining a finding of premature closure.[3]

We are not persuaded by claimant's argument. Even assuming that a "rescission" within the meaning of amended ORS 656.386(1) can occur in the absence of an affirmative act by the carrier issuing the denial, we would not find a "rescission" in this case. When the insurer issued its denial of aggravation, it proceeded on the assumption that the claim was properly closed. However, when the Department determined that the claim had been prematurely closed, the claim reverted to open status. Thus, the insurer's denial was not "rescinded" by operation of law. Rather, it was rendered "moot" by the Department's finding that the claim had not been properly closed and should remain open. Candy M. Kayler, supra.[4]

Furthermore, the statutory criterion which formed the basis of the insurer's denial (i.e., no worsening of claimant's condition since the last award or arrangement of compensation) was neither withdrawn nor conceded. Instead, by virtue of the Order on Reconsideration setting aside the claim closure as premature, the claim has returned to open status. There can be no aggravation when a claim remains open. See Carol J. Knapp, 41 Van Natta 855, 856 (1989). Consequently, the insurer's denial is a legal nullity, rendered "moot" by the Order on Reconsideration.

Accordingly, under these circumstances, we conclude that claimant's counsel did not obtain a "rescission" of a denial prior to a decision by the ALJ.[5] Amended ORS 656.386(1). It follows that claimant's counsel is not entitled to a carrier-paid attorney fee.[6] Therefore, we reverse the ALJ's order.

ORDER

The ALJ's order dated January 17, 1996 is reversed.

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[3] Black's Law Dictionary (Revised 5th Edition) defines "rescind" as meaning "to abrogate, annul, avoid, or cancel a contract; particularly, nullifying a contract by the act of a party." (emphasis supplied)

[4] "Moot" is defined by Black's Law Dictionary (Revised 5th Edition) as a question that "presents no actual controversy or where the issues have ceased to exist."

[5] Where, in response to a hearing request, a carrier withdraws a denial of aggravation before a decision by an ALJ on the ground that the denial is "null and void," an assessed fee pursuant to ORS 656.386(1) is appropriate. Vicki M. Emerson, 48 Van Natta 821 (1996). Unlike Emerson, however, there is no evidence that the insurer here withdrew its denial after the Department determined that the claim had been prematurely closed. Moreover, the "rescission" in Emerson occurred as a direct result of an affirmative act by the carrier, i.e., the carrier's decision to refer the claim to the Director to determine whether a nondisabling claim should be reclassified under ORS 656.277. Emerson does not stand for the proposition that, when a denial is rendered moot through the act of another party or forum, there has been a "rescission" within the meaning of ORS 656.386(1).

[6] Claimant's attorney is likely entitled to receive an out-of-compensation fee pursuant to ORS 656.386(2), payable from any increased compensation resulting from the Order on Reconsideration. Therefore, claimant's attorney likely will not go uncompensated for his efforts on claimant's behalf.

In the Matter of the Compensation of
MARILYNN A. WHEELER, Claimant
WCB Case No. 94-10789
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our May 29, 1996 Order on Review that reversed the Administrative Law Judge's (ALJ's) order and upheld the insurer's denial of her aggravation claim for a bilateral wrist and forearm condition. Asserting that the compensability of her current condition as a "compensable consequence" of the accepted injury was not raised as an issue by the insurer, claimant argues that the issue should not have been addressed.

In our review of the hearing transcript, we find that claimant's attorney specifically raised "compensability of current treatment and/or disability" as a contested issue. (Tr. 3). Having found that the compensability of the current condition was specifically raised as an issue in this case, it is our obligation as the fact finder to apply the appropriate legal standard in determining compensability. See Hewlett-Packard Co. v. Renalds, 132 Or App 288, 292 (1995) (quoting Dibrito v. SAIF, 319 Or 244, 248 (1994)); see also Michelle K. Dibrito, 47 Van Natta 970 (1995); Daniel S. Field, 47 Van Natta 1457 (1995). Based on our finding that claimant's current condition is a consequential condition, we properly applied the "major contributing cause" standard in ORS 656.005(7)(a)(A) as the appropriate legal standard of compensability.

Next, claimant challenges our finding that her current condition is a "consequential condition." She argues that her current condition, diagnosed as fibrositis and lateral epicondylitis in 1994, was directly caused by the accepted 1989 injury. She points to evidence indicating that she had elbow symptoms in 1989 and 1990. In fact, the record does show that claimant had pain in her wrists which radiated to the elbows, shoulders and interscapular area in 1989-90. (Exs. 1, 8, 10). However, claimant's condition primarily involved the wrists. (Ex. 12). At hearing, claimant testified she did not even recall having elbow symptoms in 1989-90. (Tr. 10). Based on our review of the record, therefore, we find that any elbow symptoms claimant had in 1989-90 were relatively minor compared to the wrist condition. Ultimately, only the wrist tendinitis was accepted, and the claim was closed in June 1990 with no permanent disability award for the injury. (Ex. 16). Later, the parties entered a stipulation awarding claimant 5 percent scheduled permanent disability for each wrist. (Ex. 21).

Subsequent to 1990, however, claimant was working at a new job in North Dakota and had developed progressively worsened symptoms which "crept up [her] arm." (Tr. 14). Her elbow symptoms, in particular, became the focus of medical attention, and in 1994 she was diagnosed with fibrositis and lateral epicondylitis. We find no medical evidence, however, to support claimant's assertion that her 1994 condition was directly caused by the 1989 employment exposure. Rather, as discussed in our prior order, the medical evidence related the 1994 condition to the prior accepted condition or subsequent work activities in North Dakota. Absent medical evidence showing that the current condition was caused directly by work exposure for the employer, rather than the accepted condition, we find the current condition is a "consequential condition" within the meaning of ORS 656.005(7)(a)(A). Hence, the "major contributing cause" standard was properly applied here.

Finally, citing Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996), claimant argues that the insurer should be deemed to have accepted more than bilateral wrist tendinitis conditions. Noting that she was awarded, by final Order on Stipulation, 5 percent scheduled permanent disability for each wrist, claimant argues that the insurer is barred from denying whatever condition was compensated by the award. We find, however, that the 5 percent award was made for bilateral wrist tendinitis. Our finding is supported by the insurer's Notice of Acceptance which expressly accepted left wrist tendinitis, (Ex. 5), and the diagnosis of bilateral wrist tendinitis (due to overuse) by claimant's treating chiropractor and treating physician. (Exs. 10, 11, 12, 14, 15). In any event, inasmuch as permanent disability was awarded for the wrist conditions only, we conclude the insurer is not barred, either by Messmer or any other applicable law, from denying a separable, consequential condition involving the entire arm.

Accordingly, our May 29, 1996 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 29, 1996 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

Chair Hall dissenting.

I need not conclusively resolve the arguments advanced in claimant's motion for reconsideration because, for the reasons expressed in my prior dissenting opinion, I am persuaded that claimant has proven that her compensable wrist condition was the major contributing cause of her elbow condition. Therefore, even if the "major contributing cause" standard of ORS 656.005(7)(a)(A) was applicable, I would conclude that claimant has satisfied that statutory prerequisite.

In the Matter of the Compensation of
MICHAEL L. WOFFORD, Claimant
WCB Case No. 94-04772
SECOND ORDER ON REMAND
Coons, Cole, et al, Claimant Attorneys
Cowling, Heysell, et al, Defense Attorneys

On May 29, 1996, we issued an Order on Remand which upheld the self-insured employer's denial of medical treatment for a non-work related preexisting condition as a prelude to treatment of a compensable condition. Michael L. Wofford, 48 Van Natta 1087 (1996). Alleging that we erred in interpreting ORS 656.225 and the evidence, claimant seeks reconsideration. After reviewing claimant's motion, the employer's response, and claimant's reply, we continue to find that the prescribed medication was solely directed to the preexisting fungal condition.

As a preliminary matter, claimant argues that, because the employer did not raise ORS 656.225(3) as an affirmative defense at hearing, we may not consider it on review. We disagree. The Board applies the law as the record/evidence leads it. See Daniel S. Field, 47 Van Natta 1457 (1995) (citing Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995); Dibrito v. SAIF, 319 Or 244, 248 (1994)) (it is our obligation as a fact finder to apply the appropriate legal standards to determine the compensability of a worker's claim). Here, the law applicable to these facts is ORS 656.225(3).[1]

In any event, even if the employer was required to raise the issue, we find that it did so. Specifically, at hearing, the employer challenged its responsibility for the disputed treatment. Addressing the holding of Williams v. Gates, McDonald & Co., 300 Or 278 (1985),[2] the employer argued that treatment due to a noncompensable condition is likewise not compensable.

Finally, claimant renews his contention that, as there is no evidence of a preexisting condition, ORS 656.225(3) is not applicable to this case. Our prior order has explained that the fungal condition preceded the "aggravation claim" (viz., the claim was reopened after the fungal condition arose). The underlying facts establish a fungal condition (a disease, congenital abnormality, or similar condition) that preceded the eventual reopening of claimant's claim for surgery pursuant to ORS 656.273. Such circumstances satisfy the "preexisting condition" requirement of ORS 656.005(24).

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[1] ORS 656.225 provides, in pertinent 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.

"* * * * *

"(3) In medical service claims, the medical service is prescribed to treat a change in the preexisting condition as specified in subsection (1) * * *, and not merely as an incident to the treatment of a compensable injury or occupational disease."

[2] Decided prior to the enactment of ORS 656.225, and finding that if prescribed medical services constitute an integral part of the total medical treatment for the condition due to the compensable injury, the medical services are likewise compensable.

Turning to the merits, claimant challenges our interpretation of subsection (3) of ORS 656.225. Specifically, citing Williams v. Gates, McDonald & Co., supra, claimant contends that where treatment of noncompensable conditions allows a compensable condition to be "completely treated," such treatments are not "incidental," but rather "necessary conditions precedent to the successful treatment of an injured worker." We are not persuaded by claimant's contention.

As explained in our prior order, pursuant to the clear and unambiguous language of ORS 656.225(3),[3] in order to find the treatment of the fungal condition compensable, the treatment must have been prescribed to treat a change in the preexisting fungal condition, and not merely as an incident to the treatment of claimant's compensable carpal tunnel syndrome (CTS). Inasmuch as the medical record does not attribute the need for the medication to any reason other than claimant's preexisting fungal condition, and because the evidence does not establish that the medication was prescribed to treat a change in that preexisting condition, we are unable to find that the prescribed treatment was more than an incident to the treatment of the compensable CTS. Consequently, we continue to conclude that claimant's fungal medication treatment is not compensable.

Claimant argues that our interpretation of ORS 656.225 does nothing to further the policies and intentions of the legislature to "restore the injured worker physically and economically to a self-sufficient status in an expeditious manner and to the greatest extent practicable[.]" ORS 656.012(2)(c). However, ORS 656.012(2)(e) provides for "benefits on account of injuries or diseases arising out of and in the course of employment[.]" By virtue of ORS 656.225(3), the legislature has mandated that treatments such as this do not arise out of or in the course of employment. Therefore, injured workers are not entitled to benefits for such treatment.

Finally, Colin J. McIntosh, 47 Van Natta 1965 (1995), cited by claimant, does not require a different result. There, finding that the claimant's disputed condition was not a preexisting condition, we concluded that ORS 656.225(2) was not applicable. In the instant case, however, the issue is whether medical treatment for claimant's non-work related preexisting condition as a prelude to the treatment of claimant's compensable condition is compensable under ORS 656.225(3). In view of the fact that McIntosh did not apply ORS 656.225(3), it is inapposite.

Accordingly, our May 29, 1996 order is withdrawn. On reconsideration, as supplemented herein, we adhere to and republish our May 29, 1996 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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[3] Claimant takes exception with footnote 1 in our prior order, for "relying upon" testimony offered before the legislature by interested parties. Contrary to claimant's assertion, while we found the legislative history provided further support for our reading of ORS 656.225, we did not rely on it. Rather, we began and ended the process of statutory interpretation with the text and context of the statute. See PGE v. Bureau of Labor and Industries, 317 Or 606, 610 (1993).

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Cite as 323 Or 154 (1996) May 9, 1996

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of Brian W. Andrews, Claimant.
Brian W. ANDREWS, *Petitioner on Review,*
v.
TEKTRONIX, INC., Sedgwick James & Co., Associated Plumbing & SAIF Corporation, *Respondents on Review.*
(WCB 93-08329, 93-05174; CA A85441; SC S42504)

On review from the Court of Appeals.*

Argued and submitted January 3, 1996.

James L. Edmunson, Eugene, argued the cause for petitioner on review. With him on the brief was James Francesconi, Portland.

Michael 0. Whitty, Special Assistant Attorney General, Salem, argued the cause for respondent on review SAIF Corporation as insurer of Associated Plumbing. James W. Moller, Special Assistant Attorney General, Salem, filed the brief. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Deborah Sather, Portland, waived oral argument for respondents on review Tektronix, Inc., and Sedgwick James & Co.

Before Carson, Chief Justice, and Gillette, Van Hoomisen, Fadeley, Unis, and Durham, Justices.* *

GILLETTE, J.

323 Or 155> The decision of the Court of Appeals is reversed. The case is remanded to the Workers' Compensation Board for further proceedings.

* Judicial review from the Workers' Compensation Board. 134 Or App 628, 894 P2d 1268 (1995).

* * Graber, J., did not participate in this decision.

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323 Or 157> In this workers' compensation case, employer instructed claimant to avoid heavy lifting on the job. Claimant was injured when he fell (or slipped) while carrying a heavy piece of equipment at a job site. The Workers' Compensation Board denied compensability, concluding that claimant's violation of his employer's instructions placed his injury outside the course and scope of claimant's employment. The Court of Appeals affirmed that decision, and claimant petitioned for review by this court. We allowed the petition to decide whether and when an employee's failure to follow an employer's instructions may bar compensation of an ensuing injury. We hold that such instructions did not create a *per se* bar to recovery here.

Claimant had a history of employment-related back injuries. He first injured his back in 1983, while employed by Tektronix, Inc. He received workers' compensation benefits for that injury. That claim was closed in 1986. Claimant reopened the claim on two separate occasions, claiming aggravation of the original injury.

In May 1992, claimant's present employer, Associated Plumbing, hired him to purchase and pick up equipment and other supplies, deliver parts to job sites, and to act as a plumber's assistant. In October 1992, he told his supervisor about his prior back injuries and his concerns that his back problems ultimately might pose a threat to his job. His supervisor told him at that time that lifting was not an essential part of his job and that he should not engage in heavy lifting in the future. The supervisor also instructed Associated Plumbing's main supplier that, when claimant came to pick up supplies, the supplier, rather than claimant, should load them onto Associated Plumbing's truck.

In March 1993, claimant was dispatched to a newly constructed restaurant to deliver some parts to a coworker who was installing plumbing there. When claimant arrived, his coworker was away at lunch. While claimant awaited his coworker's return, an employee of a coffee company approached him and asked if he would assist in carrying a 200-pound espresso machine into the restaurant. Claimant **<323 Or 157/158>** agreed and, as indicated, suffered an injury to his back while engaged in that task.

SAIF, Associated Plumbing's insurer, denied responsibility for, and the compensability of, the injury. Shortly thereafter, Tektronix, apparently responding to the possibility that the injury might be deemed another aggravation of claimant's 1983 injury at Tektronix, also issued a denial.

Claimant sought a hearing before a workers' compensation referee. After hearing the evidence, the referee concluded that, under the totality of the circumstances, claimant's back injury arose out of and in the course of his employment with Associated Plumbing and was, therefore, compensable. The referee stated in part:

> "While the claimant's employer in this case would not have condoned the specific activity claimant was engaged in on the day of injury, it is clear from the testimony of claimant, Mr. Scovil and claimant's employer that it is a practice and custom among the trades to voluntarily assist each other when loading and unloading. Claimant was expected to receive help when he delivered heavy hot water heaters to the job sites and Mr. Scovil testified that he expected others to help him when he was delivering heavy equipment.
>
> " * * * * *
>
> "Given the testimony at hearing regarding the custom and practice of assisting noncoworkers, I conclude that the activity was an ordinary risk of claimant's employment[.]"

The referee also concluded that claimant's 1992 injury was distinct and separate from the 1983 Tektronix injury and, therefore, that Associated Plumbing, rather than Tektronix, was responsible.

On SAIF's request for review, the Workers' Compensation Board reversed. The Board first stated that Associated Plumbing had prohibited claimant from lifting heavy equipment and that claimant had violated that restriction by helping to carry the espresso machine. The Board then identified the following test, which is drawn from Professor Larson's treatise on workers' compensation law, as the appropriate **<323 Or 158/159>** rule for determining when an injury that results from an employee's failure to follow the employer's instructions is compensable:

> "When misconduct involves a prohibited overstepping of the boundaries defining the *ultimate work* to be done by the claimant, the prohibited act is outside the course of employment. But when misconduct involves a violation of regulations or prohibitions relating to the *method* of accomplishing that ultimate work, the act remains within the course of employment."

Arthur Larson, 1A Workmen's *Compensation Law* § 31.00, 6-10 (1995) (emphasis in original).

Applying that rule to its finding that claimant had violated his employer's no heavy lifting instruction, the Board concluded that claimant's injury occurred outside the course and scope of his employment and was, consequently, noncompensable:

> "Here, * * *, the employer's prohibition against heavy lifting actually established the boundaries of claimant's ultimate work duties. That is, it contemplated that claimant would perform his usual duties *with the exception of those activities that involved heavy lifting.* On this record, we conclude that claimant's violation of the employer's heavy lifting rule involved a prohibited overstepping of the boundaries defining his ultimate work. Therefore, we conclude that claimant's injuries occurred outside the course and scope of his employment."

Claimant sought judicial review of that conclusion, as well as the analysis that supported it, in the Court of Appeals. That court affirmed without opinion. *Andrews v. Tektronix,* 134 Or App 628, 894 P2d 1268 (1995). Claimant now renews his challenges to the Board's reasoning and conclusions here.

It is unfortunate, we think, that the parties in this case, along with the Board and even the legal scholar whose summary of the law the Board relied on, have insisted on referring to the issue presented here in terms of employee "misconduct," a word that carries with it a connotation of blameworthiness or fault. Fault is an idea that has no place in our workers' compensation scheme: Indeed, if our workers' **<323 Or 159/160>** compensation laws stand for anything, it is that fault is irrelevant in determining a worker's entitlement to compensation. *See, e.g., Ore-Ida Foods v. Indian Head,* 290 Or 909, 918, 627 P2d 469 (1980) (under Oregon Workers' Compensation Law, employer is

liable for compensation "[w]hether the cause be the fault of the employer, the fault of the worker, the fault of a third person, or the fault of no one"); *McDonough v. National Hosp. Assn,* 134 Or 451, 460, 294 P 351 (1930) (right to compensation "is not dependent upon any negligence or wrongful act of the employer but is based wholly upon the fact of employment").

It would be foolish, of course, to dismiss an otherwise legitimate analytical rule purely on the basis of the terminology that it employs. If, despite that terminology, the rule actually carried out the intention of the legislature with respect to entitlement to workers' compensation, we could not say that the Board was wrong in embracing it. If, on the other hand, the rule served to import into the workers' compensation scheme a concept—fault—that the legislature has rejected as irrelevant to that scheme, or was otherwise incompatible with the legislature's intent with regard to compensability, we could not allow it, or any decision that relied on it, to stand.

The essential legislative statement regarding entitlement to workers' compensation is found at ORS 656,005(7)(a).[1] To be entitled to workers' compensation under **<323 Or 160/161>** that provision, an injured worker need only establish that his or her injury arose "out of and in the course of employment." *See also Clark v. U.S. Plywood,* 288 Or 255, 259, 605 P2d 265 (1980) ("All that a claimant must prove is that the injury arose 'out of and in the course of employment.' ").

We previously have described ORS 656.005(7)(a) as setting out "two elements of a single inquiry[.]" *Norpac Foods, Inc. v. Gilmore,* 318 Or 363, 366, 867 P2d 1373 (1994). One element, the requirement that the injury occur "in the course of employment," concerns the time, place, and circumstances of the injury. *Id.* The other requirement, that the injury "arise out of" the worker's employment, examines the causal connection

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[1] The legislature amended ORS 656.005 in 1995. Or Laws 1995, ch 332, § 1. Those amendments do not affect our legal analysis in this case. For ease of reference we refer throughout to the current version of the statute.

ORS 656.005(7)(a) provides:

"A 'compensable injury' is an accidental injury, or accidental injury to prosthetic appliances, arising out of and in the course of employment requiring medical services or resulting in disability or death; an injury is accidental if the result is an accident, whether or not due to accidental means, if it is established by medical evidence supported by objective findings, subject to 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.

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

Claimant advances one argument that treats ORS 656.005(7)(b), rather than ORS 656.005(7)(a), as the essential legislative statement regarding compensability. ORS 656.005(7)(b) provides:

"'Compensable injury' *does not* include:

"(A) 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;

"(B) Injury incurred while engaging in or performing, or as the result of engaging in or performing, any recreational or social activities primarily for the worker's personal pleasure; or

"(C) Injury the major contributing cause of which is demonstrated to be by a preponderance of the evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged or had actual knowledge of such consumption."

(Emphasis added.) Claimant argues, in particular, that ORS 656.005(7)(b) expresses a complete and exclusive legislative policy regarding the effect of an employee's conduct on the compensability of a workers' compensation claim: The three circumstances described therein, and only those circumstances, provide grounds for concluding that an at-work injury is noncompensable. Consequently (claimant argues), noncompliance with an employer's instructions, which is not one of the three types of conduct described at ORS 656.005(7)(b), cannot render an injury noncompensable.

Claimant's theory fails to account for the legislature's definition of "compensable injury" at ORS 656.005(7)(a). Paragraph (7)(a) is the primary definition of compensability. Paragraph (7)(b) states grounds for exclusion that are additional to those that are inherent in the primary definition found in paragraph (7)(a).

between the injury and the employment. *Id.* Although both elements must be evaluated, neither is dispositive: Ultimately, they merely serve as analytical tools for determining whether, "in light of the policy for which [that] determination is to be made[,]" the *connection* between the **<323 Or 161/162>** injury and the employment is sufficient to warrant compensation. *Rogers v. SAIF,* 289 Or 633, 642, 616 P2d 485 (1980) [2]

In particular factual circumstances, various tests may prove helpful in measuring and conceptualizing the strength of the connection between the claimant's injury and employment. Still, the ultimate test is the same: Considering all the pertinent circumstances, are the temporal, spatial, circumstantial, and causal connections between the claimant's injury and employment sufficient to justify compensation, when sufficiency is evaluated in the light of the Act's policy of providing financial protection to workers who are injured in the course of employment, regardless of fault? Thus, when confronted with a test that purports to determine whether an injury sustained under a particular set of factual circumstances is compensable, we must ask, "Is the test compatible with that formulation?"

SAIF contends that the "misconduct" rule at issue in this case is compatible with that formulation. In so arguing, SAIF acknowledges the basic principle inherent in the statutory test, *viz.,* that compensability is purely a function of the claimant's status as a worker. SAIF asserts, however, that that status is, in turn, a function of the employer's right to "direct and control" the claimant's activities: "When a worker's activities are such that the worker can no longer be said to act subject to the employer's right of direction and control, then the employee's status as a subject worker has been interrupted."

From that standpoint, SAIF argues, it should be evident that a claimant's violation of a work rule may render an ensuing injury noncompensable, not because the violation demonstrates that the injury was the claimant's fault or is otherwise blameworthy, but because it demonstrates a rejection by the claimant of the employer's right of direction and control and, consequently, of the claimant's status as a worker.

323 Or 163> Because we disagree with the basic contention underlying SAIF's argument, we do not accept the conclusion that SAIF draws from that argument. Although it is true that, for general purposes, the Workers' Compensation Act defines the term "worker" in terms of the employer's "direction and control,"[3] it is also clear that, for purposes of determining whether a claimant's injury is *compensable,* his or her status as a worker does not depend on demonstrable submission to the employer's right of direction and control at the precise moment in time that the injury was sustained. This court's opinions on the issue of at-work "horseplay" are a case in point: Employees who engage in on-the-job horseplay can hardly be said to be subject to the direction and control of their employers for the period of time that they are so engaged, yet injuries sustained in the course of horseplay may nevertheless be deemed to "arise out of and in the course of employment." *See, e.g., Stark v. State Industrial Acc. Com.,* 103 Or 80, 98, 204 P 151 (1922) (shipbuilder injured while participating in scuffle with fellow workman using air hoses arose out of and in the course of employment).

From the foregoing, we think that it is inescapable that a general rule denying compensation for injuries sustained as the result of a worker's failure to follow an employer's instructions is not compatible with the Workers' Compensation Act. However, we still must consider the validity of Professor Larson's rule, which is far more limited. That rule purports to deny compensability only when a certain type of prohibition—a "prohibited overstepping of the boundaries defining the [claimant's] *ultimate work*"—is involved. Larson, 1A *Workmen's Compensation Law* § 31.00 at 6-10 (emphasis in original).

We cannot say that the quoted rule is inconsistent with the work-connectedness test that has informed our previous decisions. An employee who is injured while engaged in a prohibited activity that is outside the boundaries defining his or her ultimate work cannot prevail on a claim that the **<323 Or 163/164>** injury is work connected.

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[2] *Rogers* describes that policy as "'the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer.'" 289 Or at 643 (quoting *Allen v. SAIF,* 29 Or App 631, 633, 564 P2d 1086 (1977)).

[3] ORS 656.005(30) defines "worker" as "any person * * * who engages to furnish services for a remuneration, subject to the direction and control of an employer * * *." The definition of "employer" at ORS 656.005(13) is complementary: it defines "employer" as "any person * * * who contracts to pay a remuneration for and secures the right to direct and control the services of any person."

But neither can we say that that rule adds anything of value to the analysis. It merely states what we already know: that, regardless whether it is forbidden or condoned, an activity that is outside the boundaries of a claimant's job is not part of the claimant's job. Ultimately, then, Professor Larson's rule, as adopted by the Board, does little, if anything, to alter the basic work-connectedness test of compensability that our workers' compensation statute requires.

Although we conclude that Professor Larson's rule is consistent with the statutory standard for compensability, we cannot say the same for the Board's particular gloss on that rule. In that regard, we note that the Board did not attempt to determine, in the first instance, whether the conduct that occasioned claimant's injury occurred while claimant was engaged in a job-related activity. Instead, the Board treated its determination that claimant had disobeyed his employer's instruction as a complete substitute for an analysis of work-connectedness. Thus, under the Board's version of the "misconduct" rule, work-connectedness and, consequently, compensability, may be decided entirely on the basis of a single fact—the worker's obedience to the employer's instructions—at least insofar as those instructions purport to define the boundaries of the claimant's ultimate work .[4]

We see at least two problems with the Board's approach. First, it assumes that an act loses its work-connectedness solely by virtue of an employer's instruction not to perform it. That assumption is unduly simplistic and unjustified: Even when a worker is injured while engaged in a task that the employer appears to have removed from the worker's job description, the injury still may bear a sufficient connection to the worker's assigned tasks to warrant a conclusion that the injury is compensable.

323 Or 165> In addition, because the Board's approach makes compensability turn entirely on a factor that is loaded with implications of blameworthiness, it suggests that compensability is, or at least can be, a function of fault. As previously indicated, that suggestion long has been rejected by the legislature.

In view of those problems, we are not prepared to say that the simple fact of disobedience to an employer's orders is of such overarching significance that it, alone, can render an ensuing injury noncompensable. Even when an order purports to set the boundaries of the claimant's ultimate work, a worker's disobedience is not necessarily determinative.

That is not to say that an employer's delineation of what does and does not constitute an employee's job is inconsequential. The Workers' Compensation Act does not purport to apportion liability for a worker's injuries on the basis of a mere nominal relationship between the worker and employer. But the facts that an employer has instructed a worker to avoid certain work, and that the worker's injury occurred when he or she disregarded that instruction, are only two of many factors that must be considered in the overall calculation of work-connectedness. Among the additional factors are the degree of connection between what the worker is authorized to do and is forbidden to do, the degree of judgment and latitude normally given the worker, workplace customs and practices, the relative risk to the worker when compared to the benefit to the employer, and the like. Moreover, when a worker's failure to follow a work-defining instruction is taken into consideration, the manner in which the instruction was conveyed, and the worker's consequent perception of the instruction's purpose and scope, also must be considered.

To conclude otherwise would be to approve a scheme whereby employers could insulate themselves from workers' compensation liability simply by providing the narrowest possible job descriptions to their employees, and instructing them to avoid any work that is not in either scope or manner precisely within the tasks thus assigned. Such an arrangement would be inconsistent with the previously recognized policy underlying the Workers' Compensation Act, *viz.*, the protection of workers from the financial consequences of the **<323 Or 165/166>** injuries that are a common byproduct of production, regardless of fault.

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[4] In the Board's view, the employer's instruction to avoid heavy lifting "established the boundaries of [his] ultimate work duties" because it effectively removed heavy lifting from claimant's job description: It "contemplated that claimant would perform his usual duties with the exception of those activities that involved heavy lifting." (Emphasis deleted.) By disobeying that instruction, claimant "overstepp[ed] the boundaries defining his ultimate work," thus rendering the ensuing injury noncompensable.

We conclude, then, that, regardless of the type of rule involved, an employee's violation of an employment rule does not render his or her claim *per se* noncompensable. The Board's contrary conclusion was error. The Board should have decided the question of compensability by deciding, in the first instance, whether claimant was engaged in an activity that was within the boundaries of his ultimate work. That determination is made, of course, by evaluating all the factors that are pertinent to the question of work-connectedness, and weighing those factors in the light of the policy underlying the Workers' Compensation Act. *Rogers*, 289 Or at 643.

The Board's order does not address the question of work-connectedness, as we have explained it. Although the workers' compensation referee concluded that claimant's act of assisting in carrying the espresso machine was the practice or custom on such job sites, made findings that support that conclusion, and then concluded that claimant's injury was work connected, the Board chose to ignore that issue and focused, instead, on claimant's failure to comply with his employer's instructions. Because we have no way of knowing whether the Board would have agreed with the referee's ultimate findings and conclusions with regard to the issue of work-connectedness, including the issue of custom and practice in the trade, we remand to the Board to address that question.

The decision of the Court of Appeals is reversed. The case is remanded to the Workers' Compensation Board for further proceedings.

Cite as 139 Or App 518 (1996) March 13, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Ramon M. Marin, Claimant.
SAIF CORPORATION and Oregon Garden Products, *Petitioners,*
v.
Ramon M. MARIN, *Respondent.*
(WCB 92-07796; CA A85619)

Judicial Review from Workers' Compensation Board.

Argued and submitted March 10, 1995.

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.

Bradley P. Avakian argued the cause for respondent. On the brief were Lynn-Marie Crider and James Francesconi.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

DEITS, P. J.

Reversed and remanded.

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139 Or App 520> This case is before us for the second time. In *SAIF v. Marin*, 128 Or App 161, 875 P2d 529 (1994), we reversed an order of the Workers' Compensation Board (Board) that held that claimant's injury was compensable. We remanded the case to the Board for reconsideration in the light of *Norpac Foods, Inc. v. Gilmore,* 318 Or 363, 867 P2d 1373 (1994), which was decided after the Board had initially decided the case. In particular, we remanded for the Board to consider whether claimant's injury "arose out of" his employment. ORS 656.005(7)(a). On remand, the Board held that claimant's injury did arise out of his employment and, thus, that claimant's injury was compensable.[1] SAIF seeks review of that order, and we reverse.

We quote the material facts, which are undisputed, from the Board's order:

> "On January 8, 1992, after completing his shift with his employer, claimant walked to his truck, which was parked in a lot leased by the employer for use by its employees and customers. Claimant could not start his truck, because the battery was dead. He waited approximately half an hour for other employees to get off work so that he could ask one of them for a jump start.
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> "A supervisor's car was parked near claimant's truck. At claimant's request, the supervisor agreed to give claimant a jump start. The jumper cables were not long enough to connect the two vehicles, so the supervisor's wife moved the supervisor's car closer to claimant's truck. In the process of that move, the supervisor's car struck a flower box, which in turn was pushed into claimant, squeezing him against his truck and resulting in injuries to his legs, knees and right ankle. The employer had built the flower box that struck claimant."

In concluding that claimant's injury arose out of his employment, the majority of the Board reasoned as follows:

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[1] The "in the course of employment" component of the unitary work connection test is not at issue here. That element was satisfied by the "parking lot rule," which provides that injuries that occur on the employer's premises while the claimant is proceeding to or from work are "in the course of employment." See *Norpac Foods, Inc. v. Gilmore,* 318 Or 363, 366-67, 867 P2d 1373 (1994).

139 Or App 521> "[T] o establish that an injury 'arose out of' employment, the claimant must prove that there is some causal connection between the injury and his or her employment. Norpac *Foods, Inc. v. Gilmore, supra,* 318 Or at 368-69. In a 'parking lot' case, that causal connection exists when the claimant's injury was 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 legal duty to maintain) * * *. In other words, claimant must prove that his employment conditions put him in a position to be injured. *See Henderson v. S.D. Deacon Corporation,* 127 Or App 333 (1994).

"At hearing, the parties stipulated that the employer had built the flower box that was pushed into claimant. Accordingly, we conclude that the flower box was a hazard associated with the parking lot over which the employer exercised control. * * * Because claimant was injured when the flower box was moved out of place, thus trapping claimant in between the box and his truck on the employer's parking lot, we conclude that claimant's employment conditions put him in a position to be injured. *See Henderson v. S.D. Deacon Corporation, supra.* Therefore, we conclude that the causal connection between claimant's injuries and his employment is sufficient to establish that his injuries 'arose out of' his employment."

Board Chair Neidig dissented, arguing that the flower box, by itself, was not a "hazard." She concluded that the flower box presented a risk of injury only when claimant needed to jump start his car, an activity "entirely attributable to claimant's personal needs." Because she believed that the causal connection between claimant's injury and his employment was "tenuous at best," she concluded that his injuries did not arise out of his employment and, thus, were not compensable.

SAIF asserts that the Board erred in concluding that claimant's injury arose out of his employment. SAIF first argues that the Board improperly focused on the employer's construction of the flower box that was pushed into claimant. As set forth above, the Board concluded that claimant's injury was causally connected to his employment because: (1) the employer built the flower box; (2) the flower box was a "hazard" associated with the employer-
<139 Or App 521/522> controlled parking lot; and (3) claimant was injured by the flower box.

SAIF argues that the flower box, in its static state, was not a hazard and that the Board should have focused on the "whole injury event" to determine whether it was connected to claimant's employment. We agree for a number of reasons. First, there is no evidence that the flower box, by itself, presented any risk of harm. As Board Chair Neidig pointed out in her dissent, the flower box presented a risk of harm only when it was struck by claimant's supervisor's wife, who.was trying to help claimant jump start his car:

"Had there been no outside force dislodging the flower box or had the box collapsed while claimant was leaning on the structure, I would be more inclined to find a sufficient causal connection between claimant's injuries and his employment. Such circumstances would lend credence to a conclusion that the flower box constituted a 'hazard' on the employer's parking lot. However, because the falling flower box was triggered by an 'outside force' and since the activity which prompted that 'force' had no connection to claimant's employment, I cannot share my fellow members' conclusion that claimant's injuries 'arose out of' his employment. "

Second, the Board improperly focused only on the fact that claimant was injured by an instrumentality over which the employer had control. Instead, the Board should have considered whether the totality of the events that gave rise to claimant's injury was causally related to his employment. *See Kaiel v. Cultural Homestay Institute,* 129 Or App 471, 480, 879 P2d 1319, *rev den* 320 Or 453 (1994); *Henderson v. S.D. Deacon Corp.,* 127 Or App 333, 874 P2d 76 (1994).

In *Henderson, Id.* at 338, we set forth the proper inquiry:

"In assessing whether there is a sufficient causal link between a claimant's injury and employment, the connection between the claimant's work and what happened must be evaluated. Part of that inquiry is whether what occurred was an anticipated risk of employment. As explained by Larson [Larson, 1 *Workmen's Compensation Law,* § 7.00, 3-12 (1995)]:

139 Or App 523> " 'All risks causing injury to a claimant can be brought within three categories: risks distinctly associated with the employment, risks personal to the claimant, and "neutral" risks - i.e., risks having no particular employment or personal character. Harms from the first are universally compensable. Those from the second are universally noncompensable. It is within the third category that most controversy in modern compensation law occurs. The view that the injury should be deemed to arise out of employment if the conditions of employment put claimant in a position to be injured by the neutral risk is gaining increased acceptance.' "

Accordingly, we must first categorize the nature of the risk of harm that befell claimant. SAIF argues that the risk of being injured by the planter box was personal to claimant, because he was injured while attempting to jump start his car. Claimant argues that the risk of injury was employment-related, because his injury occurred on the employer's premises during an activity in which his supervisor assisted. We conclude that neither SAIF nor claimant correctly categorize the risk of injury here.

Larson describes personal risks as

"origins of harm so clearly personal that, even if they take effect while the employee is on the job, they could not possibly be attributed to the employment. If the time has come for the employee to die a natural death, or to expire from the effects of some disease or internal weakness of which he would as promptly expired whether he had been working or not, the fact that his demise takes place in an employment setting rather than at home does not, of course, make the death compensable. Or if the employee has a mortal personal enemy who has sworn to seek him out wherever he may be, and if this enemy happens to find and murder the employee while the latter is at work, the employment cannot be said to have had any causal relation to the death. The same is true if the employee, for reasons of his own, carries a bomb in his bosom * * * and if the bomb goes off during business hours." Larson, 1 *Workmen's Compensation Law,* § 7.20, 3-13 (1995)(footnotes omitted).

According to Larson, "personal risks" are risks of injury that arise from idiopathic conditions that the claimant may **<139 Or App 523/524>** have, from personal confrontations, or from instrumentalities personal to the claimant. There is no evidence here that claimant was predisposed to injure his leg, that his supervisor's wife injured him for personal reasons, or that claimant owned the flower box or the car that ran into it. Thus, the risk of injury was not personal to claimant.

Conversely, Larson describes employment-related risks of injury as

"all the obvious kinds of injury that one thinks of at once as industrial injury. All the things that can go wrong around a modern factory, mill, mine, transportation system, or construction project—machinery breaking, objects falling, explosives exploding, tractors tipping, fingers getting caught in gears, excavations caving in, and so on * * *. Equally obviously associated with employment, however, are also the occupational diseases, which as the very name implies, are produced by the particular substances or conditions inherent in the environment of the employment." *Id.* at § 7.10, 3-12.

As contemplated by Larson, employment-related risks are those that are inherent to the claimant's job and that either produce injury while the claimant is engaged in his or her usual employment or that became manifest later in the form of occupational diseases. There is no evidence here that claimant'sjob,involved working around the flower box. Nor does claimant contend that he was working at the time of the injury. The fact that the persons helping claimant were his supervisor and his wife does not make what occurred an employment-related risk, because there is no indication that the supervisor was acting in a supervisory role. Thus, the risk of injury was not directly related to claimant's employment.

Instead, the risk of claimant being injured by the flower box while jump starting his car in the parking lot is more properly denominated a neutral risk, a "risk[] of neither distinctly employment nor distinctly personal character."[2] Accordingly, claimant's injury is compensable only **<139 Or App 524/525>** if his work conditions caused him to be in a position to be injured by the flower box. *Kaiel*, 129 Or App at 480; *Hender*son, 127 Or App at 338-39.

We conclude that claimant's work conditions did not cause him to be in a position to be injured by the flower box. It is undisputed that the employer leased the parking lot in which claimant was injured for use by customers and employees. Where an employee, like claimant, drives to work, it is generally necessary to walk to and from the parking lot while entering and leaving work. Thus, in a general sense, walking through the parking lot to his car on the way home after work could be viewed as a condition of claimant's employment. We might conclude that his conditions of employment caused him to be in a position to be injured by the flower box if the flower box had tipped over on him or if it had been pushed into him by another vehicle as he was walking to or from work through the parking lot. Claimant's injury here, however, was not precipitated simply by his walking through the parking lot on the way to his car after work. Claimant's efforts to jump start his car and the circumstances that followed more directly caused him to be in a position to be injured by the flower box. We conclude that those activities were sufficiently removed from his normal ingress and egress to and from work as to break the causal connection between his normal conditions of employment and his injury. Thus, the Board erred in holding that claimant's injury arose from his employment.

Reversed and remanded.

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[2] Examples of other neutral risks include:

"A man hard at work in the middle of a factory yard may be hit by a stray bullet out of nowhere, bit by a mad dog, stabbed by a lunatic running amuck, struck by lightening, thrown down by a hurricane, killed by an enemy bomb, injured by a piece of tin blown from someone's roof, shot by a child playing with an air rifle, murdered as a result of mistaken identity, felled by debris from a distant explosion, or blinded by a flying beetle. Another kind of neutral-risk case is that in which the cause itself, or the character of the cause, is simply unknown." Larson, 1 *Workmen's Compensation Law*, § 7.30, 3-13 (1995).

Cite as 140 Or App 14 (1996) March 27, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Daniel M, Valencia, Claimant.

SAIF CORPORATION, *Petitioner,* and MILLS MINT FARM, INC.,
v.
Daniel M. VALENCIA, *Respondent.*
(WCB No. 94-03439; CA A87028)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 29, 1995.
Michael 0. Whitty, Special Assistant Attorney Gener argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia Linder, Solicitor General.
Hollis Ransom argued the cause for respondent. On the brief was Michael A. Gilbertson.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DEITS, P. J.
Reversed and remanded for reconsideration.

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140 Or App 16> SAIF seeks review of an order of the Workers' Compensation Board that awarded claimant a penalty under ORS 656.268(4)(g), on the ground that claimant's permanent partial disability (PPD) was increased on reconsideration by the Department of Consumer and Business Services. We reverse and remand for reconsideration.

The pertinent statute here, ORS 656.268(4)(g), provides:

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

SAIF first argues that the Board erred in imposing a penalty under ORS 656.268(4)(g), because the increase in claimant's PPD award was based on new information about his condition, not on any misconduct on its behalf, which it contends is a prerequisite to the imposition of a penalty. However, as we concluded in *SAIF v. St. Clair,* 134 Or App 316, 320, 894 P2d 1264 (1995), under ORS 656.268(4)(g), a penalty shall be imposed regardless of whether employer engaged in misconduct if the two conditions specified in the statute are met.

SAIF also argues that the penalty was not proper, because one of the statutory conditions was not satisfied; namely, the total award of claimant's disability was not at least 20 percent. Under our decision in *SAIF v. Cline,* 135 Or App 155, 897 P2d 1172, *rev den* 321 Or 560 (1995), SAIF is right. In that case, we held that under the language of ORS 656.268(4)(g), and the Board's rule adopted to implement the statute, OAR 436-30-050(13), the requirement of "20 percent permanently disabled," as a prerequisite to the imposition of a penalty, means 20 percent of the whole worker or 64 **<140 Or App 16/17>** degrees. Claimant's disability here is less than 64 degrees. Accordingly, the statutory prerequisite to imposing a penalty was not met, and the Board erred in doing so.

Reversed and remanded for reconsideration.

Cite as 140 Or App 159 (1996) April 17, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

Victoria TRABOSH, Personal Representative of the Estate of Charlene Jensen,
for the benefit of her estate, *Appellant,*
v.
WASHINGTON COUNTY, a public body, *Respondent.*
(C930095CV; CA A84206)

Appeal from Circuit Court, Washington County.
Holger M. Pihl, Jr., Judge.
Argued and submitted September 13, 1995.
Lawrence Baron argued the cause for appellant. With him on the opening brief were Kimberley Chaput and Pozzi Wilson Atchison.
Michael A. Lehner argued the cause for respondent. With him on the brief was Lehner, Mitchell, Rodrigues & Sears.
Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.
WARREN, P. J.
Reversed and remanded.

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140 Or App 161> Plaintiff, the personal representative of the estate of Charlene Jensen (Jensen), appeals from the trial court's grant of judgment for defendant in this wrongful death action. The issue is whether, at the time of her death, Jensen was a subject worker[1] under the Workers' Compensation Act. If she was a subject worker, defendant, a public body, is immune from liability. ORS 30.265(3)(a). The trial court held that Jensen was a subject worker. We reverse.

Jensen and Robert Jensen (Robert), her husband, operated Baseline Belgians, a business that showed horses at fairs and provided hayrides to individuals, groups, and businesses. During the Washington County Fair in 1992, the fair[2] provided a hayride shuttle service from the parking lot to the main gate of the fairgrounds, using the services of those fair exhibitors who wished to participate (the teamsters). On July 31, 1992, while the Jensens were working in the shuttle service, their horses bolted, a pin that secured the connection between the wagon and the horses popped out, and they were both thrown to the ground. Jensen was killed and Robert was injured. When Robert submitted Jensen's medical and burial expenses to defendant for payment, it treated the submission as a workers' compensation claim, which it denied on the ground that Jensen was an independent contractor and thus not a subject worker. Robert did not request a hearing on that decision.

Plaintiff filed this action in March 1993, seeking damages for Jensen's death. Defendant alleged a number of affirmative defenses, including that it was immune because Jensen was entitled to workers' compensation benefits. Both parties moved for summary judgment on that issue; the court denied both motions on the ground that there were issues of fact that precluded summary judgment. It thereafter granted defendant's motion for a separate trial to the court on the workers' compensation issue. At that trial the parties relied **<140 Or App 161/162>** on the factual record developed for the summary judgment motions; the trial itself consisted solely of the arguments of counsel and. the court's decision. The court concluded that Jensen was a subject worker and dismissed the case.

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[1] The parties, following the example of a number of appellate decisions, state the question as whether Jensen was an "employee" or an independent contractor. We will use the statutory term "subject worker" instead of "employee."

[2] The fair is an agency of defendant Washington County.

Under the Workers' Compensation Law, a subject worker is a person whom the law defines as a worker and who does not satisfy one of the exceptions described in 0RS 656.027. A worker is a person "who engages to furnish services for a remuneration, *subject to the direction and control an employer*[.]" ORS 656.005(30) (emphasis supplied).[3] In trial court, plaintiff relied on the exception for the partners of a partnership to the general rule that all workers are subject workers. ORS 656.027(8). Under that exception, if the partnership performs labor or services under a contract, it must qualify as an independent contractor under ORS 670.600 in order for its partners to be exempt. Because of an intervening Supreme Court decision that we discuss below, on appeal plaintiff correctly relies primarily on the argument that Jensen did not fit the definition of a worker.[4]

The legislature adopted ORS 670.600 in 1989 to establish a uniform test for independent contractor status under the personal income tax, workers' compensation unemployment insurance, and construction contractor laws. At the time of the trial our decisions assumed that the statutory criteria provided the only appropriate test for independent contractor status and that the statute had superseded "right to control" and "nature of the work" tests that Supreme Court described in *Woody v. Waibel*, 276 Or 18 554 P2d 492 (1976). *S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 121 Or App 402, 405-07, 854 P2d 944 (1993) [5] **<140 Or App 162/163>** *rev'd* 318 Or 614, 872 P2d1 (1994). For that reason, the parties focussed their arguments at the trial court on the criteria of ORS 670.600. Those criteria generally include the criteria that are relevant to the right to control test but make them conclusive rather than factors to be weighed.

After the trial court entered judgment for defendant and after the time for plaintiffs to seek a new trial had passed, the Supreme Court reversed our decision in *S-W Floor Cover Shop* in an opinion that made the criteria of ORS 670.600 essentially irrelevant to determining whether a person is a worker under the Workers' Compensation Law. S-W *Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 872 P2d1 (1994). It pointed out that the issue of whether a person is a subject worker under ORS 656.027 can arise, and thus the criteria of ORS 670.600 can become relevant, only if the person is a worker under ORS 656.005(30). 318 Or at 622. Because the definition of worker incorporates the right to control test without using the term "independent contractor" or otherwise referring to ORS 670.600, the traditional test of an independent contract remains the operative one; the exemptions of ORS 656.027, with their incorporation of ORS 670.600, never come into play. 318 Or at 630-31.

Since the Supreme Court's decision, we have applied the right to control and nature of the work tests to determine a person's status under the Workers' Compensation Law without reference to ORS 670.600 and without apparent regard to how the parties argued the case below. *See, e.g., Kaiel v. Cultural Homestay Institute,* 129 Or App 471, 475, 879 P2d 1319, *rev den* 320 Or 543 (1994); Cy *Investment, Inc. v. Natl. Council on Comp. Ins.*, 128 Or App 579, 582-83, 876 P2d 805 (1994). When, as in this case, the essential facts are undisputed, the question of plaintiff's status is one of law for the court. [6] *Woody,* 276 Or at 192 n 3; *Kaiel,* 129 Or App at 471.[7] The court first applies the right to control test; if that test proves inconclusive, it moves to the nature of the work test. *Id.*

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[3] Because of the legislature's amendments to the Workers' Compensation Law in 1995, the subsection numbers of some of the statutes involved in this case are different from the numbers at the time of trial. The legislature made no other changes to those subsections, and for convenience we will refer to them by the current numbers.

[4] The issues that plaintiff discusses on appeal were among the issues that she discussed at the trial court. The change of focus, thus, does not affect the evidence that is relevant to the parties' arguments or to our decision.

[5] At the time of our decision in *S-W Floor Cover Shop,* current ORS 670.600 was *former* ORS 701.025.

[6] We do not, as plaintiff states, review questions of law "de novo." That term derives from appellate review of equity cases and refers solely to the court's ability to make its own determination of the facts when it has the authority to "try the cause anew upon the record." *See* ORS 19.125(3). Although some federal courts misuse the phrase to describe review of issues of law as well as of fact, in Oregon it is clear that it applies only to issues of fact. *See* ORAP 5.45 n 1. We assume that plaintiff means to say, as our rules suggest, that we review the trial court's legal determination for errors of law rather than for abuse of discretion, not that we find facts, something that is beyond our authority in an action at law. *See* Or Const, Art 7 (Amended), § 3; ORS 19.125.

[7] Because the facts are undisputed, plaintiffs arguments that the trial court erred by not submitting the issue to a jury and by segregating the issue for a separate trial are without merit. There were no facts for a jury to find, and trying this issue first was within the court's discretion. ORCP 53 B.

The primary elements of the 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, 769 P2d 215 (1989). Determining Jensen's status under that test requires a more extended statement of the relevant facts.

A number of horse owners normally attend the fair in order to show their horses and compete in various contests. At the suggestion of a fair employee, around 1990 some of them began providing the hayride shuttle service. At the employee's request, two of the exhibitors coordinated the shuttle, receiving no pay for doing so. They generally arranged each day's schedule by allowing the teamsters to volunteer for particular times on a first-come-first-served basis, making sure that there was sufficient coverage for all periods.[8] Those who participated received $20 for each hour that they actually provided rides; they were expected to have their own liability insurance. They did not receive any benefits or other compensation, and the fair did not withhold any amounts from their checks. The teamsters used their own horses; they could either use their own wagons or choose one of the wagons that the fair made available. The fair did not own those wagons; rather, various horse owners lent them to the fair for its duration.

The first year that the Jensens participated in the shuttle service, they used their own wagon. After that they used one of the wagons that the fair provided, primarily because they did not need to bring their own hayride wagon to the fair. The wagon that they used on the day of the accident was one that they had used previously and with which **<140 Or App 164/165>** they were satisfied. All parties—the fair, the volunteer coordinators, and the teamsters—believed that those providing the rides were independent contractors. The fair did not tell the teamsters how to conduct the rides, but it expected them to use good sense in doing so.

These facts give us a basis for evaluating the factors of the right to control test. First, the fair exercised some control over the Jensens' work by establishing the hours for them to perform and the physical limits of the performance. Although they could express their wishes for a particular time, the fair had to coordinate all those involved to make sure that there was adequate coverage at all times. That, however, is not control over the method of the performance; rather, it establishes the result to be achieved, which is consistent with independent contractor status. Cy *Investment,* Inc., 128 Or App at 583. The very nature of the work required that it be done at times when the fairgoers needed rides.[9] Defendant's control over timing, thus, reflects more the task to be done than the status of those who did it. In this respect the case is similar to *Bell v. Hartman*, 44 Or App 21, 604 P2d 1273, *rev'd on other grounds* 289 Or 447, 615 P2d 314 (1980), in which we held that a jockey who rode for several owners was an independent contractor and, thus, was not a worker. Jockeys are engaged for a particular race. Although the horse's owner may give the jockey instructions on how to ride it, those instructions "no more make the jockey the owner's employee than a patient's informed consent to a surgical procedure makes the physician an employee of the patient." 44 Or App at 25. In this case there is no evidence that the fair gave the teamsters any instructions on how to conduct the hayrides.

Second, the fair paid the Jensens by the hour, a method that would normally indicate a right to control. However, their work was to provide rides for specific peiiods of time that varied each day, making that method of payment the only logical one. It was also the way in which they normally charged other customers for hayrides; those other **<140 Or App 165/166>** customers clearly did not have any right to control their performance. This factor does not, therefore, lean strongly one way or the other.

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[8] On the day of the accident Robert was the first person to seek a time and therefore had his choice of when to work.

[9] The trial court suggested that a true independent contractor could choose when to perform—perhaps between midnight and 7 a.m.—and that Jensen's inability to do so suggested that she was an employee. Although that might be true in other circumstances, in this case the nature of the task required performance at a time when the fairgoers needed the rides.

Third, the Jensens partly used their own equipment—the horses—and partly the equipment that the fair provided—the wagon. Using the fair's wagon was their choice; in at least one previous year they had used their own. It was not even truly the fair's wagon; rather, it was a wagon that belonged to another teamster who had loaned it to the fair without charge for the duration. If anything, this factor suggests that the fair did not have a right to control.

Finally, there is no indication whether the fair could terminate the contract at will. There was, in essence, a new contract each day when the teamsters signed up for that day's rides. It would be surprising if either the fair or the teamsters tried to terminate that contract during the two hours or so that particular teamsters were providing rides. In sum, the right to control test leans toward Jensen not being a worker but is not conclusive. [10] We therefore turn to the nature of the work test.

The purpose of the nature of the work test is to consider factors that are relevant to the workers' compensation system rather than to the common law issues that the right to control test describes. Under the nature of the work test, a worker whose services are a regular and continuing part of the cost of a product, and whose method of operation is not so independent that it forms a separate route through which the costs of industrial accident can be channeled, is presumptively a subject worker. *Woody*, 276 Or at 195. The elements of the test are (1) the character of the person's work or business—its skill, status as a separate enterprise, and the extent to which it may be expected to carry the burden of its accidents itself; and (2) the relation of that work to the employer's business—how much it is a regular part of the **<140 Or App 166/167>** employer's regular work, whether it is continuous or intermittent, and whether it is of sufficient duration to be the hiring of continuing services rather than contracting for a particular job. *Id.*

These factors suggest that Jensen was not a worker. Providing hayrides was a separate business for the Jensens that could be expected to carry its own burden and that did, in fact, carry its own liability insurance. They had their own business cards and advertised in the Yellow Pages. Although the hayrides were a special feature for those who attended the fair, they were tangential to the fair's primary business. The Jensens and the others who provided rides did so as a sideline to their primary purpose of being at the fair, which was to show their horses. The work had limited duration and could best be described as hiring for the completion of a particular job. We therefore hold that Jensen was not a subject worker and that the trial court erred in dismissing this case on the ground that defendant is immune under ORS 30.265(l)(a).

Reversed and remanded.

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[10] The parties all considered Jensen to be an independent contractor, both before and after the accident, at least until after defendant denied Robert's workers' compensation claim. Although the parties' characterization of their relationship is not dispositive, in a close case it may swing the balance. *Cy Investment, Inc.*, 128 Or App at 583.

Cite as 140 Or App 177 (1996) April 17, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Archiel F. Sanford, Claimant.

Archiel F. SANFORD, *Petitioner,*
v.
BALTEAU STANDARD/SAIF CORPORATION,
Balteau Standard/Scott Wetzel Services and Balteau Standard/ Fireman's Fund Insurance Company,
Respondents.
(WCB Nos. 93-10958, 93-06783, 93-10147; CA A85855)

Judicial Review from Workers' Compensation Board.

Argued and submitted June 23, 1995.

Robert F. Webber argued the cause for petitioner. With him on the brief was Black, Chapman, Webber & Stevens.

Michael 0. Whitty, Special Assistant Attorney General, argued the cause for respondents Balteau Standard/SAIF Corporation. With him on the brief were Theodore Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Joshua L. Palmer argued the cause for respondents Balteau Standard/Scott Wetzel Services. With him on the brief were Karen O'Kasey and Schwabe, Williamson & Wyatt.

Adam T. Stamper argued the cause for respondents Balteau Standard/Fireman's Fund Insurance Company. With him on the brief was Cowling, Heysell, Plouse, Ingalls & Moore.

Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.

DEITS, P. J.

Reversed and remanded.

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140 Or App 179> Claimant petitions for review of an order of the Workers' Compensation Board allocating responsibility for his most recent back strain to SAIF. We reverse and remand.

At all material times, claimant was employed by Balteau Standard (employer). In February 1984, when employer was insured by SAIF, claimant filed an injury claim for "back strain, lower back." SAIF accepted the claim. Claimant was eventually diagnosed with bilateral Sl root irritation and received a micro lumbar diskectomy. He was awarded 35 percent unscheduled disability for that condition. Claimant sought treatment again in 1988, when his symptoms increased. He was diagnosed with "post-surgical failed back syndrome" causing degenerative damage to his L4-L5 disc and resulting in joint synovitis and joint pain. SAIF accepted the claim for that treatment as an aggravation of the 1984 injury.

In December 1990, when employer was self-insured and represented by Scott Wetzel, Inc., claimant again sought treatment after he experienced a sharp pain in his lower back while bending at work. He was diagnosed with a lumbar strain, and Scott Wetzel accepted his claim for medical treatment on behalf of employer. By early February 1991, claimant had returned to his pre-exacerbation state. In June 1991, he suffered another back strain, and Scott Wetzel accepted his claim on behalf of employer as a temporary exacerbation of the 1990 lumbar strain. Claimant had again returned to his pre-exacerbation state by early July 1991.

Claimant sought further treatment in 1993 when his back "went out" while he was bending over at work. At that time, Balteau Standard was insured by Fireman's Fund Insurance Company. Claimant experienced burning pain down his legs and tenderness in his right lumbar back. Dr. Lichtenstein, his treating physician, diagnosed "a new lumbar strain, albeit superimposed on his preexisting condition." Claimant filed an aggravation claim with Scott Wetzel. On behalf of employer, Scott Wetzel denied responsibility **<140 Or App 179/180>** alleging that either SAIF or Fireman's Fund were responsible. Both SAIF and Fireman's Fund also denied responsibility.

The referee[1] concluded that SAIF was the responsible insurer, explaining:

"No physician indicates that there was any residua from the Scott Wetzel injury. The compensable condition was not the post-injury status. The compensable condition that has combined with the most recent injury arose out of the 1984 injury, insured by SAIF. As the last insurer of the accepted compensable condition, SAIF bears the burden of proving by a preponderance of the evidence that a new injury [has occurred]. It has failed to sustain its burden."

The Board adopted the order of the ALJ with the following supplementation:

"After reviewing the record, we conclude that the medical evidence fails to establish that claimant's temporary lumbar strain in 1991, which resolved without permanent impairment, is related to his prior 1984 injury which resulted in L5 disc surgery, degenerative changes of the spine and joint pain and synovitis. Furthermore, we agree with the Referee that there is no persuasive medical evidence which relates claimant's current condition to the 1991 strain. Finally, we conclude that, under ORS 646.308(l), the persuasive medical evidence does not establish that the May 1993 injury while the employer was selfinsured * * * is the major contributing cause of claimant's current low back condition."

Claimant and SAIF argue that the Board erred in assigning responsibility to SAIF under ORS 656.308(l). That statute provides:

"When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition **<140 Or App 180/181>** 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.[2]

Our decision in *Smurfit Newsprint v. DeRosset*, 118 Or App 368, 848 P2d 116 (1993), involved the application of ORS 656.308(1)[3] in circumstances similar to these. We explained there that

"ORS 656.308(l) is presumably intended to simplify the processing of claims involving multiple employers or insurers and successive compensable injuries involving the same condition or body part. We conclude that, when benefits are sought for further compensable medical services and disability subsequent to a new injury,' ORS 656.308 is applicable if it is determined that the 'further' disability or treatment for which benefits are sought is compensable, i.e., that it is materially related to a compensable injury, and that it involves a condition that has previously been processed as a part of a compensable claim. Responsibility is then assigned to the employer or insurer with the most recent claim for that condition." *Id.* at 371-72.

In *Smurfit*, we remanded the case to the Board because it had not addressed whether the claimant's cuitrent need for treatment involved the same condition that was involved in either of his earlier accepted claims. We stated:

"The remaining question for the Board to decide is whether the surgery involves the same condition as was determined to be compensable in either 1977 or 1984. If it does, then either EBI or Smurfit, the one with the most recent accepted claim for the condition, must process the claim pursuant to ORS 656.308(l). If it does not involve the same **<140 Or App 181/182>** condition, then the statute is inapplicable, and the claim should be processed without regard to it." *Id.* at 372.

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[1] Referees are now called administrative law judges (ALJ). Or Laws 1995, ch 332. Hereafter, we will refer to the referee as the ALJ.

[2] ORS 656.308(l) was amended in 1995, and the amended version applies here. *See Volk v. America West Airlines*, 135 Or App 565, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996). However, the amended portion of the statute is not pertinent and cannot alter our analysis of the case. Thus, remand to the Board for it to reconsider in the light of the amendment is not required. *Baar v. Fairuiew Training Center*, 139 Or App 196, ___ P2d ___ (1996).

[3] In *Smurfit*, we relied, in part, on our decision in *SAIF v. Drews*, 117 Or App 596, 845 P2d 217 (1993), which was later reversed in *SAIF v. Drews*, 318 Or 1, 860 P2d 254 (1993). The portion of *Smurfit* upon which we rely here was not founded on our earlier decision in *Drews*.

Accordingly, in this case, under ORS 656.308(l), responsibility for claimant's 1993 treatment is assigned to the insurer with the most recent accepted claim involving that same condition. Notably, neither claimant nor SAIF challenges the Board's conclusion that claimant's 1993 need for treatment relates to the 1984 treatment accepted by SAIF. [4] Instead, they argue that claimant's 1990 and 1991 treatments, which were accepted by Scott Wetzel on behalf of employer, involved the same condition as the 1984 and 1985 treatments, which were accepted by SAIF, and that consequently, under ORS 656.308(l), self-insured employer is responsible for all future treatments involving the same condition as that present in the 1984 and 1985 treatments as well as the 1990 and 1991 treatments.

Thus, the critical issue here is whether Scott Wetzel's acceptance, on behalf of employer, of claimant's claims for "lumbar strain" did, in fact, involve the same condition as that accepted by SAIF in 1984 and 1985. If the condition accepted by Scott Wetzel on behalf of employer did involve the same condition as that accepted by SAIF, then self-insured employer is responsible for claimant's 1993 need for treatment. If the condition accepted by Scott Wetzel did not involve the same condition as the one accepted by SAIF, then SAIF is responsible for claimant's 1993 need for treatment.

Claimant and SAIF argue that the Board's conclusion that claimant's treatment in 1990 and 1991 is not related to his treatment in 1984 and 1985 is not supported by the Board's findings and the medical evidence. The Board adopted the following finding of the ALJ:

> "[Claimant's] back condition due to the 1990 injury is lumbosacral strain, superimposed on degenerative and mechanical changes due to the 1985 surgery."

140 Or App 183> SAIF notes that that finding is consistent with the opinion of claimant's treating physician, who opined that claimant's 1990 and 1991 lumbar strains were "superimposed on his pre-existing condition." However, after making the above finding, the Board went on to conclude:

> "After reviewing the record, we conclude that the medical evidence fails to establish that claimant's temporary lumbar strain in 1991 which resolved without permanent impairment, is related to his prior 1984 injury which resulted in L5 disc surgery, degenerative changes of the spine and joint pain and synovitis."

SAIF argues that it is inconsistent for the Board to conclude that the 1991 strain is not related to the 1984 injury while, at the same time, finding that claimant's 1990 injury was "superimposed" on the residua of the 1985 surgery. It contends that the term "superimposed" necessarily connotes that the 1990 injury involved the same condition as the 1984 and 1985 injuries.

Whether SAIF is correct depends on how the term "superimposed" was used by the Board and by Dr. Lichtenstein. However, there is nothing in the record or in the Board's order that indicates how the term was used. Further, none of the parties advance a formal definition for "superimpose." *Webster's Third New International Dictionary* (unabridged 1971), at 2294, defines "superimpose" as follows:

> "**l:** to place in a covering position: overlay * * * **2a:** to cause to become attached, united, coexistent, or *interrelated in* the manner of a layer, stratum, or accretion * * * **b:** to add or impose *without integrating:* attach as an unassimilated entity." (Emphasis supplied.)

Under the above definition, "superimpose" may mean to become interrelated with something else or to overlap something without integration. Depending on which meaning Dr. Lichtenstein and the Board intended, SAIF may be correct that the Board's conclusion contradicts its finding and the medical evidence. The Board is obligated to " 'clearly and precisely state what it found to be the facts and fully explain why those facts lead it to the decision it makes.' " *Furnish v. Montavilla Lumber Co.,* 124 Or App 622, 624-25, 863 P2d 524 (1993) (quoting *Home Plate, Inc. v. OLCC,* 20 Or **<140 Or App 183/184>** App 188, 190, 530 P2d 862 (1975)). It did not do so here. Because we cannot determine whether the Board's findings and its conclusion are consistent, we reverse and remand for the Board to clarify its decision.

Reversed and remanded.

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[4] Neither claimant nor SAIF challenges the Board's conclusion that claimant did not suffer a new injury in 1993 or Fireman's Fund's denial on that basis. Accordingly, it is hot necessary to consider whether, under ORS 656.308(l), responsibility shifted to Fireman's Fund as a new injury.

Cite as 140 Or App 194 (1996) April 17, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Arlene J. Koitzsch, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION and Agripac, Inc., *Petitioners,*
v.
Arlene J. KOITZSCH, *Respondent.*
(WCB No. 94-04361; CA A89457)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 17, 1996.
Barbara Woodford argued the cause and filed the brief for petitioners.
Linda Love argued the cause for respondent. With her on the brief were Annette E. Talbott and Craine & Love.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DEITS, P. J.
Affirmed.

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140 Or App 196> Employer seeks review of an order of the Workers' Compensation Board establishing the date from which claimant's aggravation rights run as October 29, 1993, the date that claimant's claim was first closed. We affirm.

Claimant worked in employer's cannery for a number of years. On April 17, 1989, she sought medical care for numbness and tingling in her hands and for arm pain principally on her right side. Employer accepted claimant's occupational disease claim for carpal tunnel syndrome (CTS) for her right side in 1989. In March, 1991, she filed a separate claim for left CTS, using the date of injury as March 15, 1991. Employer denied the claim. However, the Board set aside the denial and, on February 12, 1993, in response to the Board's order, employer accepted the left CTS, classifying the claim as disabling. On October 29, 1993, a determination order was issued closing claimant's left CTS claim and awarding claimant temporary total disability. The determination order stated that the date of injury for the left wrist was October 27, 1989, and that claimant had five years from that date within which to file an aggravation claim.

Claimant requested a hearing regarding the aggravation date included in the determination order. The Board concluded that the aggravation date should be modified to October 29, 1993, the date that the claim was first closed. The Board reasoned that because the claim was originally accepted as disabling, ORS 656.273(4)(b) does not apply and, therefore, the date of injury is not the proper date from which claimant's aggravation rights begin to run. Rather, the Board held that under ORS 656.273(4)(a), the appropriate time from which claimant's aggravation rights run is the date of first closure.

Employer assigns error to the Board's conclusion that claimant's aggravation date runs from the date of claim closure. The critical issue here is whether claimant's aggravation rights are governed by subsection (a) or (b) of ORS 656.273(4), which provide:

> **140 Or App 197>** "(4)(a) The claim for aggravation must be filed within five years after the first determination or the first notice of closure made under ORS 656.268.
>
> "(b) If the injury has been in a nondisabling status for one year or more after the date of injury, the claim for aggravation must be filed within five years after the date of injury."

The key question in determining which subsection applies here is whether an injury must be *accepted* as nondisabling before it is considered to be "in a nondisabling status" under ORS 656.273(4). The Board held

that the claim must be accepted as nondisabling before it is in "nondisabling status" under ORS 656.273(4)(b). We agree. As claimant correctly points out, under ORS 656.262(6), it is at the time of acceptance that an employer is required to designate an injury as disabling or nondisabling. It is this action of the employer that a claimant must challenge if the claimant disagrees with the classification. ORS 656.262(6). Although we have not directly addressed this question, the Board has consistently held that "a claim is not deemed to be in nondisabling status unless and until it is accepted and classified as nondisabling." *Gary G. Koker,* 47 Van Natta 1513, 1514 (1995); *see also Donald R. Dodgin,* 45 Van Natta 1642 (1993). We agree with that conclusion.

Employer argues that the Board's conclusion is contrary to the Board's and our decision in *Stacy v. Corrections Div.,* 131 Or App 610, 886 P2d 1085 (1994), *rev den* 320 Or 567 (1995), and with our decision in *Papen v. Willamina Lumber Co.,* 123 Or App 249, 859 P2d 1166 (1993), *rev den* 319 Or 81 (1994). However, as the Board correctly explains in its order, the decision in *Stacy* does not govern here because, in contrast to this case, the claim involved in *Stacy* had been *accepted* as nondisabling. The same distinction applies to our decision in *Papen*. We conclude that because the daim here was not in nondisabling status at the time of acceptance, ORS 656.273(4)(a) applies. Accordingly, the Board did not err in setting the date from which claimant's aggravation rights run.

Affirmed.

Cite as 140 Or App 210 (1996) April 17,1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Joan C. Gillander, Claimant.

Joan C. GILLANDER, *Petitioner,*
v.
SAIF CORPORATION and Thrifty Car Rental, *Respondents.*
(WCB No. 92-03284; CA A87801)

Judicial Review from Workers' Compensation Board.
Submitted on record and briefs January 29, 1996.
James L. Edmunson and Nancy F.A. Chapman filed the brief for petitioner.
Theodore R. Kulongoski, Attorney General, Virginia L. Linder, Solicitor General, and James W. Moller, Special Assistant Attorney General, filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
RIGGS, P. J.
Affirmed.

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140 Or App 212> Claimant seeks review of an order of the Workers' Compensation Board dismissing her claim for failing timely to request a hearing, contending that the case should be remanded to the Board for reconsideration in the light of a recently enacted statute. We affirm.

Claimant was injured in Washington during the course of her employment transporting a vehicle from Portland to Seattle. She filed a claim in Washington against the individuals who had hired her to do the driving, and in Oregon against Thrifty Car Rental, the company to whom the vehicle belonged. On October 28, 1991, SAIF denied her Oregon claim, on the ground that claimant was not an Oregon subject worker. On November 1, 1991, the Washington Department of Labor and Industries issued a temporary order requiring payment of time loss to claimant from September 25 through November 4, 1991. Claimant received that payment and further time loss payments and was under the impression that her Washington claim had been accepted. For that reason, she took no steps to request a hearing on SAIF's denial of the Oregon claim, until she received a notice from the Washington Department of Labor and Industries that her Washington claim had been denied. She retained legal counsel and filed a request for hearing in Oregon on February 6, 1992.

On May 14, 1992, SAIF issued an amended denial, reiterating that claimant was not an employee of Thrifty at the time of the injury.

The Board held that claimant had not shown good cause for her failure to request a hearing on SAIF's initial denial within 60 days of the date of the denial. Claimant does not challenge that determination. The Board further held that claimant was barred by claim preclusion from contesting the second denial, because it is based on the same factual transaction as the first and claimant failed to pursue her right to a hearing on the first.

140 Or App 213> After the Board issued its opinion, the legislature enacted Oregon Laws 1995, chapter 332, section 39. That section amends ORS 656.319 by adding subsection (6). The statute now provides, in relevant part:

> "(1) With respect to objection by a claimant to denial of a claim for compensation under ORS 656.262, a hearing thereon shall not be granted and the claim shall not be enforceable unless:
>
> "(a) A request for hearing is filed not later than the 60th day after the mailing of the denial to the claimant; or
>
> "(b) The request is filed not later than the 180th day after mailing of the denial and the claimant establishes at a hearing that there was good cause for failure to file the request by the 60th day after mailing the denial.
>
> "(4) With respect to objections to a reconsideration order under ORS 656.268, a hearing on such objections shall not be granted unless a request for hearing is filed within 30 days after the copies of the reconsideration order were mailed to the parties.
>
> "(5) With respect to objection by a claimant to a notice of refusal to close a claim under ORS 656.268, a hearing on the objection shall not be granted unless the request for hearing is filed within 60 days after copies of the notice of refusal to close were mailed to the parties.
>
> "(6) A hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred."

Claimant contends that the Board should consider in the first instance whether her request for hearing was timely under ORS 656.319(6). She contends that, because she was confused about the process for obtaining compensation for her injury that occurred in Washington, and because the way her claim was processed in Oregon confused her further, this case implicates the longer time limitation of ORS 656.319(6).

We need not decide whether ORS 656.319 applies retroactively to this claim. *See* Or Laws 1995, ch 332, § 66. The text and context of ORS 656.319(6) show that it is **<140 Or App 213/214>** intended to apply to challenges of the insurer's processing of a claim. The fact that claimant was confused about how her claim would be processed does not raise an issue concerning the correctness of SAIF's processing of her Oregon claim. The dispute in this case is not about a processing error but about a substantive denial of the claim.

In her second assignment of error, claimant contends that the Board erred in holding that her hearing request on the second denial is barred by claim preclusion. She contends that by issuing a new denial, SAIF created a new right of action for claimant under ORS 656.319(l). Claimant first raised her contention concerning SAIF's second denial in her motion for reconsideration to the Board, filed approximately two weeks after claimant had filed her petition for review in this court. We agree with SAIF that the issue was not timely raised before the Board and we will not consider it on review.

Affirmed.

Cite as 140 Or App 227 (1996) April 17, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of John P. Plummer, III, Claimant.

PRECISION CASTPARTS CORP., *Petitioner,*
v.
John P. PLUMMER, III, *Respondent.*
(WCB No. 93-14478; CA A88689)

Judicial Review from Workers' Compensation Board.

Argued and submitted January 29, 1996.

Krishna Balasubramani argued the cause for petitioner. With her on the brief were Deborah L. Sather and Stoel Rives.

Robert D. Wollheim argued the cause for respondent. With him on'the brief were Patrick K. Cougill and Welch, Bruun, Green & Wollheim.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

RIGGS, P. J.

Affirmed.

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140 Or App 229> Employer seeks review of an order of the Workers' Compensation Board, contending that the Board erred in determining the extent of claimant's impairment. We conclude that the Board's order is supported by substantial evidence and affirm it.

Claimant injured his right knee in 1985 while working as manager for Skipper's Seafood Restaurant. In January 1986, the claim was closed by a determination order and claimant received an award of 15 percent scheduled disability for loss of use of the right knee.

In November 1992, while working for employer, claimant sustained a second right knee injury. An order on reconsideration awarded claimant 15 percent permanent partial disability. Employer requested a hearing, contending that it was entitled to an offset of compensation paid on 1985 claim, pursuant to ORS 656.222 and *former* OAR 436-35-007(3)(a). The statute provides:

> "Should a further accident occur to a worker who is receiving compensation for a temporary disability, or who has been paid or awarded compensation for a permanent disability, the award of compensation for such further accident shall be made with regard to the combined effect of the injuries of the worker and past receipt of money for such disabilities."

The administrative rule provided, in part:

> "Unless the preponderance of evidence demonstrates that a condition or finding of impairment rated for disability in the prior claim has returned to a normal state, an offset will be applied in a manner provided in this section. A condition or finding is considered returned to a normal state if the condition or finding would not be recognized as an impairment under these rules. (a) A worker is not entitled to be doubly compensated for a permanent loss of use or function for a scheduled body part which would have resulted from the current injury but which has already been produced by an earlier injury and has been compensated by a prior award."

140 Or App 230> The administrative law judge (ALJ) found that claimant's 1985 injury had resolved before he suffered the 1992 injury. The ALJ affirmed the order on reconsideration and also awarded an additional amount for claimant's chronic inability to repetitively use the right knee, for a total impairment award of 19 percent. The Board adopted the ALJ's order.

In its petition for review, employer contends that the Board erred in failing to consider whether employer was entitled to an offset, in failing to grant an offset without expressly finding that claimant's knee had returned to its normal state after his prior injury, and in awarding 19 percent permanent partial disability. We agree with claimant that the first assignment of error is without merit. The ALJ's order expressly considered the offset question and found that no offset was necessary; the Board affirmed that order.

But for the arguments of the parties, we would have disposed of the second assignment as we disposed of the first. The ALJ's order contains an express finding that claimant's condition had returned to its normal state. The Board's order affirmed and adopted that finding. In their arguments, however, the parties appear to agree that employer's concern is not with an absence of findings but with whether the Board's findings are supported by substantial evidence. That, in turn, depends in part on whether certain 1995 statutory changes, which became effective after the Board's order and after the filing of the petition for review, are applicable to this case.

As amended by Oregon Laws 1995, chapter 332, section 34, ORS 656.283(7) 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 * * *."

Chapter 332 is intended to be retroactive, § 66(l), and we have held that it generally applies to pending cases. *Volk v. America West Airlines,* 135 Or App 565, 899 P2d 746 (1995). There are no express exceptions applicable to the amendment of ORS 656.283(7).

In his response to the second assignment of error, claimant described evidence that had been admitted at the **<140 Or App 230/231>** hearing and that supported the Board's determination that his 1985 injury had resolved. Part of that evidence was claimant's own testimony, which had not been offered at the proceeding on reconsideration. Employer filed a memorandum of additional authorities and a motion to strike the brief's reference to the testimony, contending that, pursuant to the 1995 amendments to ORS 656.268(7), the testimony is retroactively inadmissible before the ALJ and cannot be considered in determining whether the ALJ's order is supported by substantial evidence. We denied the motion to strike.

The unmistakable import of the text of OR 656.283(7) is that any evidence, including a claimant's testimony concerning the notice of closure or reconsideration order, is inadmissible at a subsequent hearing concerning the extent of the injured worker's permanent disability if not submitted at reconsideration and not made a part of the reconsideration record. However, we need not consider claimant's challenges to the provision in this case, because we conclude that it does not apply. The new language is included in a subsection governing the rules of evidence at hearing; it purports to bar from *admission* at hearing evidence not previously offered on reconsideration. It makes no provision concerning the review of evidence previously and properly admitted. Here, claimant's testimony was admissible when it was offered and considered by the ALJ and the Board; its admission was not error and correctly is not assigned as error. That being the case, there is no basis for correcting the Board's action and we review claimant's testimony as we review the other evidence in the record. We reject employer contention that claimant's testimony concerning the nature of his impairment before the second injury, admissible at the hearing, must be disregarded on review.

Finally, on the merits, we conclude that substantial evidence supports the Board's determination that claimant's 1985 injury had completely resolved at the time of his second injury. Accordingly, we affirm the Board's order denying employer's request for an offset for compensation previously awarded. The Board's award of 19 percent scheduled permanent partial disability is also supported by substantial evidence.

Affirmed.

Cite as 140 Or App 373 (1996) April 17, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Leota J. Doolittle, Claimant.

SAIF CORPORATION, *Petitioner,* and FEATHER MERCHANT PET SHOP, *Employer,*
v.
Leota J. DOOLITTLE, *Respondent.*
(94-03703; CA A88667)

Judicial Review from Workers' Compensation Board.
Argued and submitted December 13, 1995.
Michael 0. Whitty, Special Assistant Attorney General, argued the cause for petitioner. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Robert L. Ackerman argued the cause for respondent. With him on the brief was Ackerman, DeWenter & Huntsberger, P.C.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LEESON, J.
Remanded for reconsideration.

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140 Or App 375> SAIF seeks review of an order of the Workers' Compensation Board, contending that the Board erred in calculating claimant's unscheduled permanent partial disability, because it did not use the Dictionary of Occupational Titles (DOT) code that most accurately describes claimant's job at the time of injury. We remand for reconsideration.

Claimant worked in a pet store. She compensably injured her upper back while moving boxes of aquarium rock. Her claim was closed with an award of 26 percent unscheduled permanent partial disability (PPD). Claimant requested reconsideration. After examination by a medical arbiter, an Order on Reconsideration reduced her PPD to 17 percent. Claimant requested a hearing, seeking to increase her PPD award.

At the hearing, the parties stipulated to the rating factors for age, education and impairment. With respect to the final factor—adaptability—they stipulated that her residual functional capacity is "light." The only issue in contention was the strength requirement of her job at the time of injury. The administrative law judge (ALJ) determined that claimant's duties involved most aspects of operating a retail pet shop that sells fish and birds, related equipment such as tanks and cages, food for dogs, cats and birds, and portable dog kennels. She found that

> "[claimant] would clean the fish tanks and bird cages to include disinfecting the bird cups. Claimant would wait on customers and ring up sales. Between customers claimant would help stock the shelves and aisles with merchandise. Finally, claimant would help clean the store by vacuuming and dusting. To accomplish the cleaning and stocking aspects of her job, claimant would have to lift/carry fish tanks, bird cages, dog kennels, and pet food sacks on an *occasional basis."* (Emphasis supplied.)

The ALJ concluded that "the DOT code that most closely describes claimant's prior work is pet and pet supplies salesperson (DOT # 277.357-042)[, which] requires the physical **<140 Or App 375/376>** capacity to perform light work," and left undisturbed the award of 17 percent PPD.[1]

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[1] DOT # 277.357-042, SALESPERSON, PETS AND PET SUPPLIES (retail trade):

"Sells pets and pet accessories, equipment, food and remedies: Advises customer on care, training, feeding, living habits, and characteristics of pets, such as dogs, cats, birds, fish, and hamsters. Explains use of equipment, such as aquarium pumps and filters. Feeds and provides water for pets. Performs other duties as described under SALESPERSON (retail trade; wholesale tr.) Master Title. May clean cages and tanks. May suggest remedies for certain animal diseases or recommend services of VETERINARIAN (medical ser.)."

The Salesperson "Master Title" provides that any salesperson performs the following generic tasks:

"Sells merchandise to individuals in store or showroom, utilizing knowledge of products sold: Greets customer on sales floor and ascertains make, type, and quality of merchandise desired. Displays merchandise, suggests selections that meet customer's needs, and emphasizes selling points of article, such as quality and utility. Prepares sales slip or sales contract. Receives payment or obtains credit authorization. Places new merchandise on display. May wrap merchandise for customer. May take inventory of stock. May requisition merchandise from stockroom. May visit customer's home by appointment to sell merchandise on shop-at-home basis. Classifications are made according to products sold[.]"

The Board adopted the ALJ's findings but made the following additional findings in the section of its order denominated "Conclusions of Law and Opinion":

> "Particularly, we note that a *significant portion of claimant's work involved lifting heavy equipment and stock.* We find that *this activity was more* than an *incidental part of claimant's work.* [Citation omitted.] Further, we find that, although several of the work duties of Pet and Pet Supplies Salesperson DOT code apply to claimant, we find that code inapplicable to this case, because it assumes that the salesperson's duties require only light strength. On this record, *we find that claimant's at-injury job required more than light strength* on a *relatively routine basis.* In making this finding, we have relied on claimant's essentially unrebutted testimony concerning her lifting and cleaning responsibilities." (Emphasis supplied.)

The Board concluded that, although claimant's job at the time of the injury involved some work in the "light" category, "the medium strength DOT code for Pet Shop Attendant (retail trade) more accurately describes that job."[2] It calculated claimant's PPD at 29 percent.

140 Or App 377> On review, SAIF contends that the Board erred as a matter of law, because it calculated claimant's PPD award "in a manner that did not comply with the requirements of [former OAR 436-35-310 (1993)]," entitled "Adaptability to Perform a Given Job." Claimant responds that there is substantial evidence in the record to support the Board's conclusion regarding claimant's job-strength requirement at the time of injury and that the Board correctly applied the rule to calculate the adaptability factor.

The adaptability factor is based on "a comparison of the highest prior strength (physical demand)" and a claimant's residual functional capacity at the time of determination. Piior strength is based either on the jobs the worker has performed "during the last ten years preceding the time of determination," or "on the worker's job at time of injury." In claimant's case, the comparison was to be based on her job at the time of injury. *Former* OAR 436-35-310(l)(a), (b) (1993). The term "strength" is defined by OAR 436-35270(3)(g):

> "'Strength' means the physical demands of each job as described by the SCODDOT. Prior strength (physical demand) shall be derived from the strength category assigned in the DOT for the worker's job at injury. For the purposes of these rules, 'occasionally' means'the activity or condition exists up to 1/3 of the time, 'frequently ' means the activity or condition exists from 1/3 up to 2/3 of the time, and'constantly'means the activity or condition exists 2/3 or more of the time."

Light work is defined as "Lifting 20 pounds maidmum with frequent lifting and/or carrying of objects weighing up to 10_**<140 Or App 377/378>** pounds," while medium work is defined as "Lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 25 pounds." OAR 436-35-270(3)(g)(B), (C).

In this case, the Board adopted the ALJ's finding that claimant lifted up to 50 pounds only on "an occasional basis." However, the Board also noted that "a significant portion of claimant's work involved lifting heavy equipment" and found that that activity "was more than an incidental part of claimant's work" and that her "at-injury job required more than light strength on a relatively routine basis." Regardless of the standard of review, we cannot discern whether the inconsistencies in the Board's findings are intentional or an oversight, or whether the Board might be able to reconcile them. Until the Board has resolved them, and has explained how its findings lead to its conclusion, we are unable to review its order. *Furnish v. Montavilla Lumber Co.,* 124 Or App 622, 625, 863 P2d 524 (1993). Consequently, we remand.

Remanded for reconsideration.

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[2] Pet Shop Attendant (retail trade), a specified alternate title included within DOT # 410.674-010, Animal Caretaker, is described as follows

"Performs any combination of the following duties to attend animals, such as mice, canaries, guinea pigs, mink, dogs, and monkeys, on farms and in facilities, such as kennels, pounds, hospitals, and laboratories: Feeds and waters animals according to schedules. Cleans and disinfects cages, pens, and yards and sterilizes laboratory equipment and surgical instruments. Examines animals for signs of illness and treats them according to instructions. Transfers animals between quarters. Adjusts controls to regulate temperature and humidity of animals' quarters. Records information according to instructions, such as genealogy, diet, weight, medications, food intake, and license number. Anesthetizes, inoculates, shaves, bathes, clips, and grooms animals. Repairs cages, pens, or fenced yards. May kill and skin animals, such as fox and rabbit, and pack pelts in crates. May be designated according to place worked such as * * * Pet Shop Attendant (retail trade)[.]"

Cite as 140 Or App 548 (1996) May 1, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Richard J. Messmer, Claimant.

DELUXE CABINET WORKS and Aetna Casualty & Surety, *Petitioners - Cross-Respondents,*
v.
Richard J. MESSMER, *Respondent - Cross-Petitioner.*
(91-12265; CA A87910 (Control), CA A88122) (Cases Consolidated)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 29, 1996.
Jerald P. Keene argued the cause and filed the brief for petitioners.
Kevin Keaney argued the cause and filed the brief for respondent.
Before Riggs, Presiding Judge, and Landau and Leeson, Judges.
LANDAU, J.
Affirmed on petition for review; cross-petition for review dismissed.

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140 Or App 550> The principal issue in this case is whether the legislature has enacted a statute that has the effect of overruling our prior decision, *Messmer v. Deluxe Cabinet Works,* 130 Or App 254, 881 P2d 180 (1994), *rev den* 320 Or 507 (1995), holding that employer is precluded from contesting compensability. Armed with what it characterizes as dispositive legislative history, employer argues that the legislature did so intend. Armed with the language of the statute itself, claimant argues that, whatever its intentions may have been, the legislature's enactment does not require a change in the result in this case. We agree with claimant.

In 1987, claimant injured his neck and shoulder at work. The injury was diagnosed as thoraco-cervical strain and myofascitis. Employer accepted the claim. The following month, claimant's physician diagnosed degenerative disc disease in claimant's neck. Although it neither accepted nor denied compensability of that condition, employer did authorize surgery for it. In 1989, the claim was closed by a determination order awarding claimant permanent partial disability based in part on the effects of the surgery for the degenerative disc disease. Employer did not request a hearing on the determination order.

Claimant's pain worsened, and in 1991, his physician requested authorization for treatment of degenerative changes to the cervical spine. Employer denied compensability, contending that there was no connection between claimant's condition and the accepted thoraco-cervical strain. On review of the Board's order denying the claim, we held:

> *"Employer could have appealed* the determination order and challenged the award if it believed that it was being made in part for a noncompensable condition. *It did not do that. Therefore, claim preclusion bars it from later arguing that the condition for which the award was made is not part of the compensable* claim."

Messmer, 130 Or at 258 (emphasis supplied). We remanded the case to the Board, and the Board ordered employer to accept and process the claim.

140 Or App 551> On review, employer argues that recent changes in the workers' compensation statutes effectively overrule our decision in *Messmer.*[1] Those changes, codified at ORS 656.262(10), are reflected in the following boldfaced text:

> "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."**

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[1] Claimant has withdrawn his cross-petition for review.

Or Laws 1995, ch 332, § 28 (boldface in original). Employer argues that the foregoing amendatory language, which applies retroactively[2] was intended to permit employers to challenge the compensability conditions for which compensation has been awarded even though the employers have failed to request a hearing on the determination order. Employer concedes that the language of the statute itself says nothing about the determination order being unchallenged but refers only to benefits having been paid. Nevertheless, employer insists that the legislature intended that language to effect the change in the law that it suggests. In support of that assertion, employer relies on two portions of legislative history.

The first is a statement of Representative Mannix, one of the sponsors of Senate Bill 369, before the Senate **<140 Or App 551/552>** Labor Committee. Mannix explained that the amendment to ORS 656.262

> "is meant to overrule a recent decision which stated that once an award of permanent disability has been made, this will constitute a tacit irrevocable acceptance of the condition. What's the problem here? If that court case stays in place, insurers and employers will be tempted to fight many awards of permanent disability that they might otherwise have eaten. Why will they fight it? Because they suddenly feel that they are now permanently obligated to provide benefits for life for a condition that was never really litigated. This says no, go ahead and pay out the disability benefits, you don't have to litigate it. Later on, if you develop evidence that this was a preexisting condition that's resolved, or subsequently developed condition that is not attributable to the injury, you can rescind the denial, you can litigate it, but go ahead and pay out the permanent disability award, you don't have to litigate it at that time."

Tape recording, Senate Committee on Labor and Government Operations, January 30, 1995, Tape 15, Side B at 14055. Second, employer relies on a statement of a workers' compensation attorney who also testified before the Senate committee that the proposed amendment "overrules *Mess*mer *v. Deluxe Cabinet Works* in the manner described by Representative Mannix." Tape recording, Senate Committee on Labor and Govemment Operations, February 1, 1995, Tape 19, Side A at 132-36. [3]

140 Or App 553> Claimant argues that, although the legislative history may demonstrate that some legislators thought the proposed amendment would effectively overrule *Messmer,* the fact remains that the language that the legislature actually enacted did not do that. Claimant relies on the fact that the statute says nothing about claim preclusion or failure to appeal a determination order and says only that the payment of benefits does not preclude a later challenge.

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[2] Subject to exceptions not pertinent to this case, the legislature has provided that the 1995 amendments to the workers' compensation statutes apply retroactively to all pending cases. *Volk v. America West Airlines,* 135 Or App 565, 572-73, 899 P2d 746 (1995), *rev* den 322 Or 645 (1996). Generally, once we determine that such retroactive amendments apply in a given case, we remand to the Board for its initial construction and application of the new law. *Baar* v. *Fairview Training* Center, 139 Or App 196, 204, 911 P2d 1232 (1996). The Board, however, already has decided, in another case, that the 1995 amendments codified at ORS 656.262(10) effectively overrule our decision in *Messmer. Craig L. Hiatt,* 47 Van Natta 2287 (1995). Accordingly, we find no good reason to delay our decision as to the proper construction of the statute.

[3] We note that additional legislative history reflects the same understanding. A summary submitted by Senator Gene Derfler, for example, stated that the proposed amendment, ultimately enacted and codified at ORS 656.262(10),

> "overrules a recent court decision which stated that once an award of permanent disability has been made for a condition, this will constitute a tacit irrevocable acceptance of the condition."

Summary, Senate Committee on Labor and Government Operations, January 30, 1995, Ex A at 14. That summary was repeated in another Senate staff summary. Summary, Senate Committee on Labor and Government Operations, February 17, 1995, Ex F at 12. That summary, in turn, was submitted to the House. Summary, House Committee on Labor, March 6, 1996, Ex A at 8. Mannix also testified before the House Committee on Labor, describing the effect of the amendment he proposed:

> "[T]here's been some case law that recently said that, by, when you paid out an award of permanent disability, that you were suddenly accepting everything that was included in that award, even though there may have been a rating of the condition that you didn't think should have been covered. Well this says, no, you can pay on it, but if you later want to raise that issue by a denial you may do so."'

Tape recording, House Committee on Labor, March 6,1995, Tape 46, Side A at 13546.

When we construe the language of a statute, we are to effectuate the intentions of the legislature, "if possible." ORS 174.020. To ascertain the intentions of the legislature, we examine the text, its context and, if necessary, the legislative history. *PGE v. Bureau of Labor and Industries,* 317 Or 606, 610-12, 859 P2d 1143 (1993). In all events, however, we are constrained by the reasonable construction of the language that the legislature actually enacted. We are forbidden, both by statutory connnand and by constitutional principles, to insert language that the legislature, whether by design or by default, has omitted. ORS 174.010; *Fernandez v. Board of Parole,* 137 Or App 247, 252, 904 P2d 1071 (1995).

The language of ORS 656.262(10), as amended, says nothing about the preclusive consequences of an employer's failure to appeal a determination order. The only subject of the sentence is the "payment of permanent disability benefits." The act of payment, the statute now says, does not preclude an employer from subsequently contesting compensability. Employer urges us to read "[p]ayment of permanent disability benefits" to mean " [p]ayment of permanent disability benefits *or failure to appeal* a determination *order."* The emphasized language, however, is not part of the enacted statute, and we are not at liberty to add it. Nor can the words "payment of * * * benefits" reasonably be construed by themselves to contain the missing words employer seeks to have inserted. Payment of benefits is one thing; failing to appeal a determination order is another.

That very distinction was at the heart of our prior decision in this case:

> **140 Or App 554>** "Although employer's payment of the compensation, by itself, does not constitute acceptance of a claim for the degenerative condition, ORS 656.262(9), employer's failure to challenge the award on the basis that it included an award for a noncompensable condition precludes employer from contending later that that condition is not part of the compensable claim."

Messmer, 130 Or App at 258. Our decision was expressly based on employer's failure to challenge the determination order, not on its payment of permanent disability benefits. The statute addresses only the latter. Thus, our holding in *Messmer* is unaffected by the amended version of ORS 656.262(10).

Employer argues that such a reading of the statute would make a redundancy of the 1995 amendments, because the workers' compensation statutes already said that payment of benefits does not preclude later challenge to compensability. It may well be that the amended language is a redundancy. Nevertheless, the potentially redundant effect of statutory language does not give us license to redraft the statute so that it means something "new." *See Fifth Ave. Corp. v. Washington Co.,* 282 Or 591, 597-98, 581 P2d 50 (1978).

Employer insists that our reading of the statute ignores the manifest intentions of the legislature, as revealed in the cited portions of the legislative history.

We reject that argument for two reasons. First, whatever the legislative history shows, the fact remains that the language of the statute cannot reasonably be read to accomplish what employer suggests, and we may not rewrite that language so that it more closely tracks with the legislature's unenacted intentions. ORS 174.010. Second, assuming for the sake of argument that the language of the statute is sufficiently ambiguous to warrant examination of the legislative history, we do not read the legislative history to demonstrate so conclusively the intentions employer asserts. Mannix did say that he intended Senate Bill 369 "to overrule a recent decision" of this court which he described as holding that

> **140 Or App 555>** "when you paid out an award of permanent disability, you were suddenly accepting everything that was included in the award [of permanent disability] "

and that his proposed amendment would effectively say "no you can pay for it, but if you later want to raise that issue [of compensability] you may do so." The problem is that what Mannix described clearly is not what we said in *Messmer. As* we have noted, *Messmer* addressed employer's failure to challenge the determination order,

not the decision to pay benefits.[4] Therefore, if the legislative history reveals anything at all, it is that the legislature mistakenly read one of our opinions and then enacted language to overrule a holding that we did not make.

We acknowledge, and respect, the legislature's constitutional prerogative to amend statutes in order to alter the effect of our prior decisions. Nevertheless, if that is what the legislature intends, it must enact language that, reasonably construed, actually changes that law. In this case, it is apparent that the legislature proceeded from an inaccurate understanding of our decision and enacted language that changes nothing of substance in that decision. Under the circumstances, we cannot rewrite the statute to give effect to what we may speculate the legislature would have intended had it correctly read our prior decision. As the Supreme Court stated when confronted with similar circumstances:

> "Whatever the legislative history of an act may indicate, it is for the legislature to translate its intent into operational language. This court cannot correct clear and unambiguous language for the legislature so as to better serve what the court feels was, or should have been, the legislature's intent."

140 Or App 556> *Monaco v. U. S. Fidelity &* Guar., 275 Or 183, 188, 550 P2d 422 (1976); *see also Digler v. School District 24CJ,* 222 Or 108, 112, 352 P2d 564 (1960) ("[i]t is axiomatic that the courts cannot in the guise of construction supply an integral part of a statutory scheme omitted by the legislature"); *Eslamizar v. American States Ins. Co.,* 134 Or App 138, 145 n 3, 894 P2d 1195, *rev* den 322 Or 228 (1995) (if "the legislature has made a mistake, * * * only the legislature may remedy it").

We conclude that ORS 656.262(10) did not effectively overrule our prior decision in this case and does not require reversal of the Board's decision on remand.

Affirmed on petition for review; cross-petition for review dismissed.

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[4] The same misunderstanding is reflected in the other relevant portions of legislative history. Senator Derfler's summary, for example, summarizes Messmer as holding that

> "once an award of permanent disability is made for a condition, this will constitute a tacit irrevocable acceptance of the condition."

Summary, Senate Committee on Labor and Government Operations, January 30, 1995, Ex A at 14. That is simply wrong. In *Messmer,* we held that an

> "employer's payment of the compensation of a claim * * * does *not* constitute acceptance of a claim."

130 Or App at 258 (emphasis supplied).

Cite as 141 Or App 138 (1996) May 22, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Cindy Lankford, Claimant.
Cindy LANKFORD, *Petitioner - Cross-Respondent,*
v.
Claude COPELAND, *Respondent - Cross-Petitioner,*
and
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, *Respondent - Cross-Respondent.*
(WCB 92-06391; CA A82936)

Judicial Review from Workers' Compensation Board.

Argued and submitted September 23, 1994.

David R. Nepom argued the cause and filed the briefs for petitioner - cross-respondent.

Willard E. Fox argued the cause for respondent - crosspetitioner. With him on the brief was Allen Stortz Fox Susee & Olson.

Stephanie L. Striffler, Assistant Attorney General, argued the cause for respondent - cross-respondent. With her on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Richardson, Chief Judge, and De Muniz and Leeson, Judges.

RICHARDSON, C. J.

On petition and on cross-petition, reversed and remanded with instructions to dismiss request for review and to remand order to Director for issuance of a new corrected order.

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141 Or App 140> Claimant seeks review of an order of the Workers' Compensation Board that held that she was not a worker subject to the Act because her employment with Copeland was casual. ORS 656.027(3). Copeland cross-petitions, contending that the Board erred in holding that claimant was a "casual worker" because, he contends, claimant was not a worker, ORS 656.005(30), and, therefore, was not covered by the workers' compensation law. The Department of Consumer and Business Services (DCBS), in its respondent's brief, asserts two cross-assignments of error. The first is the same as Copeland's, that claimant is not a worker subject to the Workers' Compensation Act. The second cross-assignment is that the Board did not have jurisdiction to review the Administrative Law Judge's (ALJ's) decision that claimant was not a subject worker. It contends that the ALJ's decision should have been reviewed directly by the Court of Appeals. ORS 656.704(2). We conclude that the Board did not have jurisdiction in this case.

The facts as found by the ALJ and adopted by the Board are not disputed by any party. Copeland breeds horses and races them. He does all of the work on his farm and has no payroll nor any employees. He uses the services of a trainer on occasion and contracts with a farrier to shoe his horses. Claimant was a race horse jockey licensed to ride in Oregon and five other states. She was injured while exercising a horse owned by respondent Copeland.

On the morning that she was injured, claimant approached Copeland to see if she could ride a horse that he had entered in a race. Copeland agreed to let her exercise his horse. Claimant had never ridden for Copeland before and, although there was no discussion about fees, she anticipated being paid $5 for the ride. Copeland had planned to pay her that amount. Claimant was injured during that exercise ride. She filed a workers' compensation claim.

Claimant's claim for her injuries was investigated by the Director of DCBS to determine if Copeland was an employer for purposes of the Workers' Compensation Act and, if so, whether he was a noncomplying employer. The **<141 Or App 140/141>** investigation necessarily focused on claimant's status; whether she was a "worker," ORS 656.005(30), and, if so, whether she was subject to the workers' compensation laws. ORS 656.027. The Director concluded that claimant was not a subject worker for Copeland when she was injured and, therefore, that her claim would not be assigned for processing. Claimant requested a hearing. The ALJ concluded that claimant was not a worker because she was an independent contractor or, alternatively, if she was an employee of Copeland, she was not a subject worker because her employment was casual under ORS 656.027(3).

Claimant requested review by the Workers' Compensation Board, which adopted the AL.J's findings but determined that claimant was a worker, not an independent contractor. It held, however, that the ALJ was correct that claimant was not a subject worker because her employment with Copeland was casual.

DCBS argues, in its second cross-assignment, that the Board lacked jurisdiction to review the AL.J's decision upholding the Director's determination that claimant was not a subject worker. It contends that, whether a claimant is subject to the workers' compensation law is not a "matter concerning a claim" that gives rise to Board review, but, instead, is a matter other than one concerning a claim and therefore is reviewed directly by this court pursuant to ORS 656.704(2) and ORS 183.310 to ORS 183.550.

The demarcation line between the Director's and the Board's authority to conduct hearings and to review orders is set out in ORS 656.704, which provides:

> "(1) Actions and orders of the Director of the Department of Consumer and Business Services, and administrative and judicial review thereof, regarding matters concerning a claim under this chapter are subject to the procedural provisions of this chapter and such procedural rules as the Workers' Compensation Board may prescribe.
>
> "(2) Notwithstanding ORS 183.315(l), actions and orders of the director and the conduct of hearings and other proceedings pursuant to this chapter, and judicial review thereof, regarding all matters other than those concerning a claim under this chapter, are subject to ORS 183.310 to **<141 Or App 141/142>** 183.550 and such procedural rules as the director may prescribe. The director may make arrangements with the board pursuant to ORS 656.726 to obtain the services of Administrative Law Judges to conduct such proceedings or may make other arrangements to obtain personnel to conduct such proceedings. The director by rule shall prescribe the classes of orders issued by Administrative Law Judges and other personnel that are final, appealable orders and those orders that are preliminary orders subject to revision by the director.
>
> "(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. However, such matters do not include any disputes arising under ORS 656.245, 656.248, 656.260, 656.327, any other provisions directly relating to the provision of medical services to workers or any disputes arising under ORS 656.340 except as those provisions may otherwise provide."

The essential factor in determining whether review of a Director's order is by the Board or this court is whether the matter concerns a claim, which in turn means that a "worker's right to receive compensation, or the amount thereof, are directly in issue." ORS 656.704(3).

Claimant argues that the determination of whether she is a subject worker is a *sine qua non* of compensation. It is correct that, if she is determined to be subject to the Workers' Compensation Act by the Director, her claim will be assigned to a carrier for processing, ORS 656.054, and then her right to receive compensation and the amount will be directly in issue. Conversely, if claimant is not subject to the Act, then her claim will not be processed and she will receive no compensation. Although there is seemingly a direct line from the Director's decision to claimant's "right to receive compensation, or the amount thereof," the Director only decides *whether* claimant may seek compensation under the Workers' Compensation Act. The next step is assignment of the claim by the Director to a carrier for processing. Only then **<141 Or App 142/143>** are the claimant's right to receive compensation and the amount thereof directly in issue.

The assigned processing agent then will determine if the injury is compensable and, if so, what benefits are available. ORS 656.054(l). Because only a subject worker is entitled to seek compensation, the right to receive compensation is directly in issue only when a claimant is determined to be a worker. The process by which the Director determines if a putative employer and a claimant are both subject to the Act is within the

admiinistrative purview of the Director. See *ORS* 656.726(3). Because the Director's determination, affirmed by the ALJ, was not a matter concerning a claim, the Board did not have jurisdiction to review that decision, ORS 656.704, and review of the ALJ's order is pursuant to ORS 183.482. ORS 656.704(2).

ORS 183.413(2)(i) requires that the ALJ, in a contested case, give the parties "[a] description of the appeal process from the determination or order of the agency." *See also* ORS 656.289(3). The ALJ's opinion concluded with a "Notice to all parties" that any request for review of the order should be filed with the Workers' Compensation Board. This clearly was an incorrect statement of the appeal rights. Because the ALJ's order incorrectly advised the parties of the appeal rights and that error affected a substantial right of claimant, we remand the case to the Board for it to dismiss the request for review and remand the order to the Director for the issuance of a corrected order. *See Callahan v. Employment Division,* 97 Or App 234, 776 P2d 21 (1989).

On petition and on cross-petition, reversed and remanded with instructions to dismiss request for review and to remand order to Director for issuance of a new corrected order.

Cite as 141 Or App 200 (1996) May 22, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Jacquelyn E. Bailey, Claimant.

Jacquelyn E. BAILEY, *Petitioner,*
v.
BOEING COMPANY and Aetna Casualty Co., *Respondents.*
(93-04303; CA A85645)

Judicial Review from Workers' Compensation Board.

Argued and submitted October 30, 1995.

Robert Wollheim argued the cause for petitioner. With him on the briefs was Welch Bruun Green & Wollheim.

Vera Langer argued the cause for respondents. With her on the brief was Scheminske Lyons & Bussman.

Before Riggs, Presiding Judge, and Landau and Leeson, Judges.

LANDAU, J.

Affirmed.

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141 Or App 202> Claimant seeks review of an order of the Workers' Compensation Board denying her request for attorney fees. We affirm.

The relevant facts are uncontested. Claimant sustained a compensable low back injury in 1989. In 1990, insurer declined to pay benefits for services provided by Dr. Long, because he had not been approved as a treating physician and claimant had exhausted her three choices as to attending physicians without approval by the insurer or the Director of the Department of Consumer and Business Services. *See* OAR 436-10-060. Claimant requested the Director to approve Long as her attending physician. The Director ultimately determined that claimant had not, in fact, exhausted her right to select three different attending physicians and concluded that she could select Long without the approval of the insurer or the Director. Insurer then paid for Long's medical services.

Claimant then requested a hearing seeking attorney fees under ORS 656.386(l) (since amended by Or Laws 1995, ch 332 § 43), which provides in relevant part:

> "If an attorney is instrumental in obtaining compensation for a claimant and a hearing by the referee is not held, a reasonable attorney fee shall be allowed."

The administrative law judge dismissed the request for attorney fees on the ground that the Hearings Division lacked jurisdiction to award fees under ORS 656.386(l) (1993). The administrative law judge reasoned that the statute applies only when an attorney is instrumental in obtaining "compensation" where "compensation" is a matter in dispute before the Hearings Division, and, because entitlement to attorney fees is not a dispute as to "compensation," there was no basis for allowing the requested award.

On review, the Board determined that it did have jurisdiction to determine whether claimant was entitled to attorney fees, but, on the merits, it concluded that claimant was not entitled to them. The Board held that, to trigger the portion of ORS 656.386(l) (1993) on which claimant relied, **<141 Or App 202/203>** there must be an order or decision before it denying a claim for compensation. Because there was no order before it denying a claim for compensation, the Board concluded that attorney fees were not authorized.

Following the Board's decision, the Supreme Court decided *SAIF v. Allen*, 320 Or 192, 203, 881 P2d 773 (1994), in which it held that attorney fees may be awarded under the aforementioned provision of ORS 656.386(l) (1993) when an attorney is instrumental in obtaining medical services benefits. The court assumed, but did not decide, that a denial of a claim for compensation was a predicate for recovery of attorney fees under the statute. *Id.* at 200 n 8.

Meanwhile, in 1995, the legislature amended ORS 656.386(l) so that attorney fees are allowed only if 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."

The amendments apply retroactively. *Volk v. America West Airlines,* 135 Or App 565, 573, 899 P2d 746 (1995), *rev den* 322 Or 645 (1996).

On review of the Board's decision, claimant concedes that, under the current version of ORS 656.386(l), she is not entitled to a Board award of attorney fees. Claimant nevertheless argues that she is entitled to fees, on the ground that the retroactive amendments to ORS 656.386(l) (1993) cannot constitutionally apply to her. According to claimant, before the 1995 amendments to the statute, the Supreme Court's decision in *Allen* confirmed her entitlement to attorney fees under the law that existed at the time of her claim. Therefore, claimant concludes, the legislature cannot eliminate that entitlement by retroactive application of statutory changes without violating the constitutional prohibition on impairment of contract or unilaterally destroying a "vested right." Insurer contends that claimant's constitutional arguments are predicated on the unwarranted assumption that, under *Allen*, claimant had a right to a Board award of attorney fees. **<141 Or App 203/204>** Even assuming that claimant had such a right, insurer contends that the retroactive application of the 1995 amendments effects no unconstitutional elimination of vested rights or impairment of contract obligations.

We agree with insurer that claimant's arguments fail at the outset, because they are based on the incorrect assumption that she was entitled to an award of attorney fees from the Board before the enactment of the 1995 amendments to ORS 656.386(l) (1993). In *O'Neal v. Tewell,* 119 Or App 329, 332, 850 P2d 1144 (1993), we held that a claimant is entitled to attorney fees under ORS 656.386(l) (1993) for obtaining compensation without a hearing only in an appeal " 'from an order or decision denying the claim for compensation' " (quoting *Shoulders v. SAIF,* 300 Or 606, 611, 716 P2d 751 (1986)). We applied the same rule in our decision in *SAIF v. Allen*, 124 Or App 183, 185, 861 P2d 1018 (1993), *rev'd on other grounds* 320 Or 192 (1994), and the Supreme Court expressly declined to disturb that portion of our opinion on appeal. *Allen*, 320 Or at 200 n 8.

There is no dispute in this case that there was no order or decision denying a claim for compensation. Rather, the Director having ruled in favor of claimant, the only matter before the Hearings Division was a petition for attorney fees. Claimant, therefore, was not entitled to an award of attorney fees under the pre-1995 version of ORS 656.386(l), and she cannot complain that her right to such fees was unconstitutionally eliminated by the retroactive application of amendments to that statute.

Affirmed.

Cite as 141 Or App 281 (1996) May 29, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

James L. LOLLEY, *Petitioner,*

v.

SAIF CORPORATION and Department of Consumer and Business Services, *Respondents.*

(H94-034; CA A87859)

Judicial Review from Workers' Compensation Division.

Argued and submitted January 26, 1996.

Brad L. Larson argued the cause and filed the brief for petitioner.

Michael 0. Whitty, Special Assistant Attorney General, argued the cause for respondents. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Warren, Presiding Judge, and Edmonds and Annstrong, Judges.

EDMONDS, J.

Affirmed.

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141 Or App 283> Claimant seeks review of an order of the Department of Consumer and Business Services (DCBS), contending that DCBS erred in granting SAIF's motion to dismiss claimant's request for vocational assistance because he did not have good cause for his failure to appear at a scheduled hearing. We review for substantial evidence and errors of law under ORS 183.482(8) and affirm.

In May 1994, claimant's counsel requested that the Dispute Resolution Section of the Workers' Compensation Division conduct an administrative review of SAIF's denial of claimant's request for vocational assistance. The Division dismissed the request, ruling that claimant had not sought review within 60 days of the denial as required by ORS 656.283. Following that order, claimant's counsel requested a hearing before the director of DCBS on the order of dismissal. A hearing was scheduled for September 19, 1994. The notice of the hearing was sent to claimant's counsel, who received it on August 15, 1994. The notice provided, in part:

> "Pursuant to a request for hearing dated May 19, 1994, this contested case is set for hearing as follows:
>
> "Date: September 19, 1994
>
> "Time: 10:00 a.m.
>
> "Place: Basement - Hearing Room A - Labor and Industries Building Department of Consumer and Business Services 350 Winter Street SE Salem, Oregon[.]"

Claimant's counsel informed claimant of the date and time for the hearing. However, claimant and his counsel did not appear at the hearing because counsel mistakenly believed that the hearing would occur through a telephone conference call. At the scheduled time, they were in claimant's attorney's office.

When claimant failed to appear personally at the hearing, SAIF moved to dismiss his request for a hearing. The Administrative Law Judge (ALJ) deferred ruling on the motion and allowed claimant to submit additional written argument. In October 1994, the ALJ, acting on behalf of the director, ruled:

> **141 Or App 284>** "Claimant received notice that the hearing on September 19, 1994 was to be an in-person hearing in Salem at 10:00 a.m.
>
> "Claimant's failure to appear for the September 19, 1994 in-person hearing did not constitute 'good cause.' "

Claimant requested reconsideration of the ALJ's order and an opportunity to present evidence about his failure to appear. A hearing was held in December 1994. After the hearing, the ALJ entered a "Reconsidered Preliminary Order" in which she made the following findings:

"On August 11, [1994], a hearing notice was sent to claimant's attorney addressed to 525 N.E. Oregon Street #303, Portland, Oregon 97232. He received the notice on August 15, 1994.

"The Notice of Hearing was also sent to SAIF's counsel. He received the notice on August 18, 1994.

"The hearing notice stated that the hearing would be held on September 19, 1994 at 10:00 a.m. in Hearing Room A at the Labor and Industries Building in Salem, Oregon.

"The hearing notice was not sent to claimant * * * but his attorney notified him about the hearing by telephone the Friday before the September 19, 1994 hearing."

The ALJ concluded:

"Claimant's lack of notice of the in-person hearing did not constitute good cause for his failure to attend because his attorney, acting as his agent with regard to this matter, did receive notice."

On review, the gravamen of claimant's argument is that there must be personal service on each party at every procedural step of the process. In his first assignment of error, he argues that the ALJ erred in "holding that a Notice of Hearing to [claimant's counsel] was notice to [claimant] in compliance with ORS 183.415 and OAR 436-01-020," and relies on those sources as authority for his argument. ORS 183.415 provides, in part:

"(1) In a contested case, all parties shall be afforded an opportunity for hearing after reasonable notice, served personally or by registered mail.

"(2) The notice shall include:

"(a) A statement of the party's right to hearing, or a statement of the time and place of the hearing;

"(b) A statement of the authority and jurisdiction under which the hearing is to be held;

"(c) A reference to the particular sections of the statutes and rules involved; and

"(d) A short and plain statement of the matters asserted or charged."

Former OAR 436-01-020, [1] which governed contested case notices, implemented and essentially mirrored the provisions in ORS 183.415. It provided:

"Reasonable notice of a contested case hearing shall be served on all parties. The notice shall include:

"(i) The time and place of the hearing;

"(2) A statement of the authority and jurisdiction under which the hearing is held;

"(3) Reference to the particular statutes and rules involved; and

"(4) A statement of the matters asserted or charged."

Both the statute and administrative rule cited by claimant apply to the notice requirement to a party in a contested case proceeding. As part of its initial order of dismissal, dated May 17, 1994, the Division included the following notice in its order dismissing claimant's request for administrative review:

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[1] This rule was repealed effective February 12, 1996. The Model Rules of Procedure in Contested Cases have replaced *former* OAR 436-01-020.

> "NOTICE TO ALL PARTIES: If you disagree with this order, you may request a hearing before the Director as provided by ORS 656.704(2) and the Administrative Procedures Act (ORS Chapter 183). Your request must be submitted in writing, directed to the Administrator of the Workers' Compensation Division * * *. The request for hearing must be received by the Administrator within 30 calendar days from the date of mailing of copies of this order to the parties. **<141 Or App 285/286>** The hearing will be by telephone conference, unless otherwise requested, and the scope of the hearing will be limited to the jurisdictional basis for this dismissal. If you do not file a request for hearing within the time allowed, this dismissal order will become final and will not be subject to review by any agency or court."

Claimant's reliance on ORS 183.415 and OAR 436-01-020 as authority for the proposition that he was entitled to personal notice of the September hearing is misplaced. The Division complied with those provisions when it issued the order of dismissal. There is nothing in the provisions that requires that the notification be repeated throughout every intermediate stage of the proceedings, once proper notice was given. Accordingly, we conclude that the statute and the rule did not govern the notice requirements for the September hearing, and we reject claimant's first assignment of error.

In his second assignment of error, claimant contends that the ALJ erred in concluding that he did not demonstrate good cause for his failure to appear at the hearing. Claimant first argues that the appropriate test for good cause is articulated in OAR 438-06-07.[2] However, claimant did not make that specific argument to the ALJ, and we decline to address it. Rather, the ALJ concluded that claimant's failure to appear did not constitute good cause based on former OAR 436-01-200,[3] which provides:

> "(1) Except as provided in section (2), failure of a party to appear at the hearing shall be considered a default and a waiver of all rights except the right to be served with a copy of the department's decision and the right to request judicial review * * *.
>
> **141 Or App 287>** "(2) Upon a showing of good cause, the hearings officer may excuse a party's failure to appear, and postpone or reconvene the hearing."

For purposes of the rule, good cause is defined in OAR 436-01-004(7), [4] which provides:

> " 'Good Cause' means a cause beyond a person's reasonable control."

In her order, the ALJ concluded:

> "[I]nasmuch as the Notice of Hearing clearly stated the time, date and place of the hearing, I further find the claimant has failed to establish good cause for his failure to appear at the hearing."

The ALJ's findings are supported by substantial evidence. We may reverse her decision only if she has erroneously interpreted a provision of law. *SAIF v. Curtis,* 107 Or App 625, 630, 813 P2d 1112 (1991). Claimant asserts that he had good cause for failing to appear at the hearing because he did not receive notice of the hearing. However, claimant, through his attorney, received notice of the time and place of hearing. That notice is imputable to claimant. Under the circumstances, the ALJ did not err when she held that claimant did not establish good cause for his failure to appear at the hearing.

Affirmed.

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[2] OAR 438-06-071 provides:

"(1) A request for hearing may be dismissed if a referee finds that the party that requested the hearing has abandoned the request for hearing or had engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days.

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

[3] Effective February 13, 1996, OAR 436-01-200 has been repealed.

[4] Effective February 12, 1996, OAR 436-01-004(7) was renumbered as OAR 436-001-0004(7). There were no substantive changes to the rule.

Cite as 141 Or App 295 (1996) May 29, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Estela Velazquez, Claimant.

BRONCO CLEANERS and Liberty Northwest Insurance Company, *Petitioners,*
v.
Estela VELAZQUEZ, *Respondent.*
(94-05931; CA A89443)

Judicial Review from Workers' Compensation Board.
Argued and submitted April 8, 1996.
Jerald P. Keene argued the cause and filed the brief for petitioners.
Brad Larson argued the cause and filed the brief for respondent.
Before Warren, Presiding Judge, and Edmonds and Haselton, Judges.
EDMONDS, J.
Affirmed.

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141 Or App 297> Employer[1] seeks review of an order of the Workers' Compensation Board holding that claimant's claim is compensable. We review the Board's findings for substantial evidence and its legal conclusions for errors of law, ORS 183.482(8)(a), (c), and affirm.

Claimant began working for employer, a dry cleaning business, in June 1992. While at work, she was exposed to chemicals and steam. In September 1993, she began noticing a rash on her face that gradually worsened. She sought treatment with Dr. Meckland, who diagnosed the condition as contact dermatitis and prescribed treatment with hydrocortisone cream. Although the cream helped, claimant's condition persisted, and in November 1993, Meckland advised claimant to seek other employment.

In February 1994, claimant filed a claim for the condition, which employer denied. A month later she stopped working for employer. After a hearing, the Administrative Law Judge (ALJ) upheld the denial of the claim. The ALJ concluded that claimant had failed to prove that her employment environment was the major contributing cause of her derrnatitis. On appeal, the Board reversed the ALJ.

On judicial review, employer argues that the Board's decision is contrary to ORS 656.266 because it relied solely on a "natural inference" drawn from the temporal relationship between claimant's condition and her employment to support its conclusion that the work exposure was the major contributing cause of claimant's condition. ORS 656.266 provides:

> "The burden of proving that an injury or occupational disease is compensable and of proving the nature and extent of any disability resulting therefrom is upon the worker. *The worker cannot carry the burden ofproving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred."* (Emphasis supplied.)

141 Or App 298> When interpreting what a statute means, we first consider 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 656.266 precludes a worker from proving compensability solely by disproving other possible explanations of how the injury or disease occurred. Our inquiry regarding the intent of the legislature when it enacted the statute need go no further. The statute plainly requires that there be some affirmative evidence that the condition is caused by the claimant's work exposure.

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[1] Petitioners on appeal are Bronco Cleaners and its insurer, Liberty Northwest Insurance Corp. We refer to petitioners as employer.

The Board found:

"Dr. Meckland was aware of claimant's medical and work history and he had numerous opportunities to examine her. * * * Following these examinations, *Dr. Meckland repeatedly evaluated the relationship between claimant's exposures, symptoms, and treatment, ruled out other diagnoses* (including atopic dermatitis, primary irritant dermatitis, and acne rosacea) and non-work related contributors, and *concluded that claimant's contact dermatitis condition was work-related.* * * * His reasoning and conclusions are essentially uncontradicted. Under these circumstances, we find that Dr. Meckland's opinion relating claimant's dermatitis condition to her dry cleaning work is consistent, well-reasoned, and persuasive.

" * * * * *

"Thus, we are persuaded that Dr. Meckland's opinion that claimant's contact dermatitis is work related is not based solely on the temporal relationship between work and symptoms. Dr. Meckland's reasoning reveals that his conclusion also arises from knowledge of the mechanism of the disease and the ruling out of other potential causes. * * * We further note that a claimant need not identify a particular (i.e., exact) cause, if the persuasive evidence indicates that the condition is work related. *See Volk v. Birdseye Division,* 116 Or App 349, 518 P2d 672 (1974)]." (Emphasis supplied.)

According to the Board, Meckland's conclusion that there is a nexus between claimant's condition and her work environment occurred after he had observed the course of her condition over a period of time. His observations were that **<141 Or App 298/299>** the rash appeared after claimant had been working and subsided when she was away from work. Nothing in the text of ORS 656.266 precludes the Board from relying on those observations as proof that a claimant's condition is work related.[2] Rather, the statute addresses the sufficiency of a record in which other explanations for the condition are excluded as the sole predicate for the conclusion that the condition is work related. The rationale forbidden by the statute depends on the absence of specific evidence of causation. Among other things, the statute provides that a claimant may not solely rely on the deductive reasoning that, because the condition did not occur until after the exposure to the work environment and cannot be proven to have been caused by another causative agent, it must have been caused by the work environment.

In the context of this case, if claimant had merely demonstrated that before she worked for employer, she did not have dermatitis, and now she does, her proof would be legally insufficient under the statute. However, claimant's evidence goes beyond that chronological connection. The evidence demonstrates a pattern of diminishment and enhancement of the condition that correlates to the eidstence of or lack of exposure to the work place. In that light, claimant's proof exceeds what the statute deems insufficient even though Meckland applied a methodology of exclusionary diagnosis .[3]

Additionally, employer argues that claimant failed to identify the specific agent or any agent at work that could be the cause of her condition. Claimant's treating physician **<141 Or App 299/300>** testified regarding the difficulty of identifying a particular agent:

"You know, it's very--contact dermatitis is very difficult to do that with. Some people up at the University, for example, [have] long lists that [they] will have patients go through, you know, of things that, you know, they are possibly exposed to at work; but even then, it's really finding a needle in a hay stack because a patient frequently won't recognize the name of the thing that they are working with * * *.

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[2] Employer cites *Allie v. SAIF,* 79 Or App 284, 288, 719 P2d 47 (1986), and *Edwards v. SAIF,* 30 Or App 21, 566 P2d 189, *rev den* 279 Or 301 (1977), for the proposition that a worker may not prove causation with evidence that merely reasons from or relies on a natural inference drawn from a temporal relationship between the worker's employment and the symptoms of the condition being claimed. Neither of these decisions, which were decided before ORS 656.266 was enacted in 1987 and involved our *de novo* review of the record, involved facts similar to this case.

[3] According to *Stedman's Medical Dictionary* 437 (unabridged 2nd lawyer ed 1966), one method of diagnosis by physicians is by exclusion, i.e., "made by excluding those affectations to which some of the symptoms belong, leaving only one to which all the symptoms point."

" * * * * *.

"It's difficult to find the particular agent."

When that testimony is considered with Meckland's observations of claimant's condition over a period of time, the Board's finding that claimant's condition is work related is supported by substantial evidence, and its legal conclusion about compensability does not implicate the prohibition of ORS 656.266. We conclude that the Board did not err.

Affirmed.

IN THE COURT OF APPEALS OF THE STATE OF OREGON
In the Matter of the Compensation of Warren Kemery, Claimant.
Warren KEMERY, *Petitioner.*
v.
SAIF CORPORATION, OREGON STATE PENITENTIARY and INMATE INJURY FUND, *Respondents.*
(92-13322; CA A88234)

Judicial Review from Workers' Compensation Board.
Argued and submitted November 29, 1995.
Ralph Yenne argued the cause and filed the brief for petitioner.
Julene M. Quinn, Special Assistant Attorney General, argued the cause for respondents. With her on the bnef were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.
Before Deits, Presiding Judge, and De Muniz and Haselton, Judges.
DE MUNIZ, J.
Affirmed.

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141 Or App 316> Claimant seeks review of an order of the Workers' Compensation Board (Board) holding that claimant's right to benefits under the Inmate Injury Act, ORS 655.505 *et seq,* [1] was time-barred, even though he reported his injury to a supervisor within the applicable 90-day time limit. ORS 655.520(3). We affirm.

Claimant, an inmate at Oregon State Penitentiary, accidentally cut off his finger while working in the prison kitchen on November 4, 1991. On January 10, 1992, claimant filled out and signed a "Report of Injury" form and gave it to his supervisor. His supervisor filled out and signed the pertinent portions of that form on January 21, 1992, and gave it to a prison safety officer. Department of General Services (department), which at that time administered inmate injury claims, did not receive the form until July 8, 1992, apparently because the safety officer neglected to forward it. SAIF Corporation, acting for the department,. denied the claim because it was not "filed with the department" within 90 days of claimant's injury, as required by ORS 655.520(3). Claimant appealed, and a referee agreed with SAIF. The Board affirmed the referee.

ORS 655.520(3) provides, in part:

> "The rights to benefits under ORS 655.505 to 655.550 [the Inmate Injury Act] shall be barred unless written claim is filed with the department within 90 days after the injury, or if death results therefrom, within 90 days after death."

Claimant assigns error to the Board's holding that ORS 655.520(3) bars his claim, arguing that he provided a written injury report to his supervisor within 90 days of his injury and should not be held responsible for the safety officer's failure to forward that form for more than six months. SAIF contends that the plain language of ORS 655.520(3) bars the claim because it was not "filed" with the department for more than eight months after the injury.

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[1] The 1995 legislature amended ORS chapter 655. Those amendments became effective June 30, 1995 and do not affect this petition. Or Laws 1995, ch 384, § 29.

141 Or App 317> Whether claimant met the statutory deadline depends on the meaning of the term "filed," as used in ORS 655.520(3). Construction and application of a statute is a question of law. ORS 183.482(8)(a); *Salem-Keizer School Dist. #24J v. Employment. Dept.*, 137 Or App 320, 323, 904 P2d 1082 (1995). In construing a statute, we must discern the legislature's intent. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610, 859 P2d 1143 (1993). At the first level of analysis, we consider the statute's text and context. *Id.* at 610-11. If intent is clear at this level, our inquiry ends. *Id.* at 611.

Claimant essentially argues that he "filed" a claim once he handed his supervisor the injury report form. However, the text of ORS 655.520(3) requires that the claim be "filed with the *department*." (Emphasis supplied.) At the time of claimant's injury, ORS 655.505(2) defined "Department" as "the Department of General Services."[2] *See also* ORS 655.520(l) (1991) (inmate compensation claims "shall be filed by application with the Department of General Services"). Claimant's prison supervisor was an employee of the Department of Corrections, not the Department of General Services.

The context of ORS 655.520(3) also does not support claimant's position. That context includes related provisions of the same statute. *PGE*, 317 Or at 611. ORS 655.520(l) at that timb provided, in part:

> "Claims for entitlement to benefits under ORS 655.505 to 655.550 [the Inmate Injury Act] shall be filed by application with the Department of General Services in *the manner provided for worker's claims in ORS chapter 656, to the extent not inconsistent with ORS 655.505 to 655.550[.]"* (Emphasis supplied.)

Through that statute, the legislature intended to incorporate into the Inmate Injury Act all the relevant filing provisions of the Workers' Compensation Act (ORS chapter 656), to the extent that those provisions are not inconsistent with the **<141 Or App 317/318>** inmate compensation statute. *Dept. of Justice v. Spear, 308* Or 594, 596, 783 P2d 998 (1989); *Johnson v. SAIF,* 267 Or 299, 303, 516 P2d 1289 (1973).

At the time of claimant's injury, workers instituted a claim under the Workers' Compensation Act by providing their employers with written notice of their injury within 30 days, either by mailing it to their employer or personally delivering it to their employer, foreman or other supervisor. ORS 656.265(l) to (3).[3] Workers under that system fulfill their "filing" obligations by doing essentially what claimant did here—notifying the employer of their injury in waiting within the applicable time period. However, filing procedures under the Workers' Compensation Act do not apply to inmate compensation claims because they are "inconsistent" with the Inmate Injury Act. QRS 655.520(l); *see also Dept. of Justice v. Bryant,* 101 Or App 226, 229, 790 P2d 42, *rev den* 310 Or 205 (1990) (exceptions to late filing in ORS 656.265(4) are inconsistent with, and thus do not apply to, inmate injury claims under ORS chapter 655).

The Workers' Compensation Act at that time required that workers notify their "employer" within 30 days of injury, ORS 656.265(l), but the inmate compensation statute then required filing with the "department" within 90 days. ORS 655.520(3). "The department" meant the Department of General Services, ORS 656.505(2), which is not the equivalent of an inmate claimant's "employer." The legislature at that time apparently gave inmates more time to institute claims because it wanted them to notify the Department of General Services, and not merely their "employer," i.e., the Department of Corrections.

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2 A 1993 statute replaced all references in the Oregon Revised Statutes to "the Department of General Services" with "the Oregon Department of Administrative Services," which was created to take over the duties and functions of the Department of General Services. Or Laws 1993, ch 500, §§ 1, 58. That statute does not affect our analysis.

3 A 1995 amendment to ORS 656.365(l) now allows workers 90 days to notify their employers. Or Laws 1995, ch 332, § 29. That amendment does not affect our analysis.

We conclude from the text and context of ORS 655.520(3), as it then existed, that a claim was not "filed" until it was received by the Department of General Services. Although claimant delivered the injury report form to his supervisor within the 90-day period, his claim was not "filed with the department" until the safety officer forwarded it six months later. Therefore, the claim was not timely, and the **<141 Or App 318/319>** Board was correct in upholding the denial of claimant's benefits under ORS 655.520(3).

We acknowledge the apparent inequity of holding claimant responsible for the safety officer's negligence. However, it is apparent that the legislature. intended to make inmates responsible for ushering the appropriate forms through the Department of Corrections and ensuring that they reached the proper agenc on time. Given the constraints of prison life, that may be an unfair burden, but that is the legislature's decision to make. The remedy lies with the legislature, not with this court.

Claimant next contends that the Board erred in holding that the department did not abuse its discretion in refusing to waive the 90-day deadline. ORS 655.520(3) provides, in part:

> "The requirements of this subsection may be waived by the department on the ground that, for good and sufficient reason, the claim could not be filed on time."

ORS 655.520(3) delegates to the department the authority to exercise its discretion in determining whether there was "good and sufficient reason" that the claim could not be filed on time, and if there was, to decide whether the time limit should be waived. *Bryant,* 101 Or App at 229.

The department adopted a policy that it would recognize only physical or mental incapacity as "good and sufficient" reason for failing to file a timely claim.[4] Claimant argues that the department abused its discretion in refusing to waive the 90-day requirement, because he was "physically incapacitated"—i.e., incarcerated. We review the department's decision for abuse of discretion. ORS 183.482(8)(b)(A); *Bryant,* 101 Or App at 230.

In *Bryant,* an injured inmate failed to file his claim on time because his supervisor did not tell him to submit an accident report or a claim for benefits. 101 Or App at 228. The Department of Justice, which at that time administered the **<141 Or App 319/320>** fund, determined, under the same "physical or. mental incapacity" policy, that there was no "good and sufficient reason" for missing the deadline. *Id.* at 229-30. We found no abuse of discretion. *Id.* at 230.

Here, claimant missed the deadline because he believed that giving his supervisor an injury report form would suffice—i.e., he did not know, as in *Bryant,* that he needed to file a claim with the applicable department. Because the department here used the same policy in rejecting essentially the same reason for late filing as in *Bryant,* we also find no abuse of discretion.

Affirmed.

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[4] The Department of General Services actually adopted this policy from the Department of Justice, which had previously administered the Inmate Injury Fund. *Bryant, 101* Or App at 229.

Cite as 141 Or App 417 (1996) June 12, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Monetary Adjustment between the SAIF Corporation, Insurer, and Liberty Northwest Insurance Corporation, Insurer, Lynette Barnes, Claimant.

LIBERTY NORTHWEST INSURANCE CORPORATION, *Petitioner,*

v.

SAIF CORPORATION, *Respondent.*

(H94-042; CA A88614)

Judicial Review from Department of Consumer and Business Services.

Argued and submitted April 8, 1996.

Barbara Woodford argued the cause and filed the brief for petitioner.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondent. With him on the brief were Theodore R. Kulongoski, Attorney General, and Virginia L. Linder, Solicitor General.

Before Warren, Presiding Judge, and Edmonds and Haselton, Judges.

EDMONDS, J.

Reversed and remanded.

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141 Or App 417> Petitioner Liberty Northwest Insurance Corporation (Liberty) seeks review of an order by the Director of the Department of Consumer and Business Services (DCBS), ordering it to reimburse respondent SAIF Corporation (SAIF) for medical expenses that SAIF paid to an injured worker (Barnes) pursuant to ORS 656.307 (since amended by Or Laws 1995, ch 332, § 36). We reverse.

In 1984, Barnes suffered a compensable knee injury while working for a restaurant insured by SAIF. SAIF paid that claim. In April 1990, Barnes injured her knee again while working for a restaurant insured by Liberty. As a result, Barnes filed claims with both insurers. Pursuant to ORS 656.307 and OAR 436-60-180, Liberty requested that DCBS[1] designate a paying agent until the issue of responsibility was resolved.[2] Apparently, DCBS believed that Barnes would be undergoing surgery or some other type of treatment that needed hospitalization, because it requested the Workers' Compensation Board's consent to the designation of a paying agent, pursuant to OAR 438-12-032 (since amended January 1, 1995).[3]

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[1] At the time of Liberty's request, DCBS was known as the Department of Insurance and Finance. It has since been renamed.

[2] ORS 656.307(l) provides, in part:

"(1) Where there is an issue regarding:

"* * * * *

"(c) Responsibility between two or more employers or their insurers involving payment of compensation for two or more accidental injuries;

"the director shall, by order, designate who shall pay the claim, if the employers and insurers admit that the claim is otherwise compensable[.]"

OAR 436-60-180 provides, in part:

"(7) Upon deciding that the responsibility for an otherwise compensable injury cannot be determined, the insurer shall request designation of a paying agent by applying in writing to the Division. Such a request, or agreement to designation of a paying agent, is not an admission that the injury is compensably related to that insurer's claim; it is solely an assertion that the injury is compensable against a subject Oregon employer."

[3] OAR 438-12-032 requires the Board's consent to an order designating a paying agent where one or more of the insurers involved, in this case SAIF, is subject to ORS 656.278 (since amended by Or Laws 1995, ch 332, § 33). ORS 656.278 provides, in part:

"(1) Except as provided in subsection (5) of this section, the power and jurisdiction of the board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

141 Or App 418> On September 13, 1990, the Workers' Compensation Board issued its consent, reciting that "[e]ach of the insurers has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim," and concluding that the record "establishes that there has been a worsening of claimant's compensable injury requiring either inpatient or outpatient surgery or other treatment requiring hospitalization." It therefore consented to an order designating a paying agent for temporary disability benefits "commencing the date [Barnes] is hospitalized." The following day, DCBS issued an order designating SAIF as the paying agent, requiring SAIF to pay "any temporary disability due for periods subsequent to any periods of disability already paid by any party and all *unpaid medical expenses incurred as a result of the disputed condition.*" (Emphasis supplied.)

On September 25, 1990, Barnes underwent knee surgery, and SAIF paid the medical expenses associated with the surgery. Sometime later, both insurers became aware that a congenital condition caused the need for the knee surgery. On July 5, 1991, an arbitrator determined pursuant to ORS 656.307 that Liberty rather than SAIF was responsible for the April 1990 injury. Liberty appealed, and the Board reversed and remanded the arbitrator's decision on grounds unrelated to the issues involved in this review. On remand, the arbitrator characterized the issue as "[t]he responsible insurer for claimant's current left knee condition, medical services and disability." On July 28, 1992, the arbitrator issued his decision, ruling that Liberty was responsible for the condition arising from the 1990 injury because Barnes had suffered a new injury. He also upheld SAIF's denial of **<141 Or App 418/419>** responsibility for claimant's medical services claim.[4] Liberty appealed the arbitrator's order to the Board.

During the pendency of that appeal, Liberty and Barnes entered into a disputed claim settlement (DCS) that eventually was approved by the Board as part of a claim disposition agreement (CDA). SAIF was not a party to the DCS or the CDA. The settlement included an agreement between Liberty and Barnes that Liberty denied compensability of the surgery and that in settlement of that and other denials, Liberty would pay Barnes $25,000. Liberty then sent a copy of the approved settlement to the Board, which still had Liberty's appeal of the arbitrator's decision under consideration. Liberty argued to the Board that the settlement resolved the issue of responsibility for the expenses of the September 25 surgery. The Board characterized the dispute as whether Barnes suffered a new injury on April 11, 1990, while working for Liberty's insured, or whether her need for medical services was related to her 1984 injury. The Board stated that the DCS pertained only to Barnes' new condition and held that it did not resolve the disputes before it. It then affirmed the decision of the arbitrator:

> "Turning to the merits of Liberty's appeal, our review is limited to questions of law. ORS 656.307(2). Finding no errors of law, we affirm the decision of the Arbitrator."

However, it also ruled:

> "In reaching this conclusion, we note that, on April 19, 1993, we approved Liberty and claimant's Claim Disposition Agreement (CDA), in which claimant released her rights to all workers' compensation benefits, except medical services, for her compensable injury. WCB Case No. C300695. Considering our approval of the CDA and the Referee's approval of the parties' DCS, this order regarding the Arbitrator's decision is limited to medical services resulting from the April 11, 1990 new injury to claimant's left knee condition *prior to September 25, 1990.*" (Emphasis supplied.)

On May 27, 1994, the Benefit Consultation Unit of DCBS ordered the final monetary adjustment between the insurers, pursuant to ORS 656.307. It determined that because the DCS only resolved the compensability of treatment received before September 25, 1990, Liberty could not be held responsible for the knee surgery, and therefore, was not required to reimburse SAIF for the medical expenses it paid in conjunction with the surgery. SAIF requested review by the Director of that decision. At the hearing on review, Liberty argued that the Director could not require Liberty to pay expenses for which the Board had determined it was not responsible. The Director disagreed and

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[4] In discussing who was responsible for the April 1990 injury, the arbitrator also referred to the September 1990 knee surgery, noting that, although the independent medical examiner "related [Barnes's] current condition to congenital factors, he did not dispute that the April 1990 injury was the major reason that claimant obtained further medical treatment."

concluded that the DCS did not bind SAIF in light of the fact that SAIF was not a party to it. It therefore ordered Liberty to reimburse SAIF for the medical expenses that SAIF had paid in conjunction with the September 1990 knee surgery. Liberty seeks review from that order.

Liberty contends in part that the Director lacked the authority to disregard the Board's earlier determination regarding responsibility for the September 25 surgical expenses. To answer that contention, we must consider what authority the Director had under ORS 656.307. ORS 656.307(2) and 656.307(3) provide:

> "(2) The director * * * shall request the board to appoint a referee to act as an arbitrator to determine the responsible paying party. * * * The determination of the arbitrator may be reviewed by the board, and then by the Court of Appeals within the same period of time as provided for review of an order after hearing. *Review of the determination of the arbitrator by the board and by the Court of Appeals is limited to questions of law and is not thereafter subject to review by any other court or administrative body.*
>
> "(3) When a determination of the responsible paying party has been made, the director shall direct any necessary monetary adjustment between the parties involved." (Emphasis supplied.)

Under the statute, the arbitrator and the Board determine the issue of responsibility, and the Director allocates payment according to that determination. Had the Board affirmed the arbitrator's upholding of SAIF's denial of **<141 Or App 420/421>** responsibility for the medical services claim without qualification, that would have been tantamount to a determination that as between SAIF and Liberty, Liberty was responsible for the costs of surgery. When the Board qualified the arbitrator's decision to exclude responsibility for the surgical expenses, it left the parties without a determination of the responsible insurer as to those expenses even though it had previously treated them as compensate. The Director's authority under ORS 656.307(3) to direct monetary aojustments is predicated on a determination of responsibility by the Board. Without that determination, the Director was without authority to proceed.

Liberty's other arguments do not require discussion.

Reversed and remanded.

Cite as 141 Or App 429 (1996) June 12, 1996

IN THE COURT OF APPEALS OF THE STATE OF OREGON

NORTH PACIFIC UTILITY CONTRACTORS, INC.; and North Sky Antenna Systems, Inc., dba North Sky Communications, *Petitioners,*

v.

The Filings of the NATIONAL COUNCIL ON COMPENSATION INSURANCE and SAIF Corporation, *Respondents.*

(INS 91-07-001; CA A85674)

Judicial Review from Department of Consumer and Business Services.

Argued and submitted September 20, 1995.

W.Brad Coleman argued the cause for petitioners. With him on the brief was W. Brad Coleman & Associates, P.C.

Michael O. Whitty, Special Assistant Attorney General, argued the cause for respondent SAIF Corporation. With him on the brief were Theodore R. Kulongoski, Attomey General, and Virginia L. Linder, Solicitor General.

Stephanie S. Andrus argued the cause for respondent Filings of the National Council on Compensation Insurance. With her on the brief was Meyers, Radler, Replogle & Bohy.

Before Warren, Presiding Judge, and Edmonds and Armstrong, Judges.

ARMSTRONG, J.

Affirmed.

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141 Or App 431> Employer seeks review of an order of the Department of Business and Consumer Services that held employer liable for an additional premium for workers' compensation insurance provided to employer by its insurer, SAIF. We review to determine whether the department's decision is supported by substantial evidence, ORS 183.482(8)(c), and affirm.

Employer is a specialty contractor that installs electrical and telephone lines and television cable above and below ground. In April 1990, employer applied for workers' compensation insurance with the Oregon Workers' Compensation Insurance Plan, which is administered by the National Council on Compensation Insurance (NCCI). NCCI assigned SAIF to be employer's insurer.

In its application for insurance, employer described its business as "TV & Telephone cable installations." Employer also listed its workers in certain risk classifications based on their job activities so that SAIF could determine.the premium to charge for the insurance coverage. It listed workers in six risk classifications: 6325, 7600, 7601, 8227, 8742 and 8810. Employer also estimated the annual amount it expected to pay to employees for work in each classification. It estimated its annual payroll for employees in classification 7600 as $125,000 and in classification 7601 as $80,000.

SAIF subsequently mailed to employer information about the workers' compensation insurance policy that it issued to employer. That information assigned all six risk classifications to employer's policy, and listed the premium rates per $100 of payroll. SAIF listed the premium rate as $21.38 per $100 of payroll for work in classification 7601, and $5.35 per $100 of payroll for work in classification 7600..

SAIF also explained to employer that it could reduce its overall workers' compensation premium by reporting employee payroll under the risk classifications for the work performed by its employees, provided that employer maintained verifiable payroll records that identified the work. SAIF explained that, if employer chose not to report work done by its employees by classification, it would be required **<141 Or App 431/432>** to report all employee wages under the highest rated classification that applied to any of the work performed by its employees.

During the period of April 1, 1990, to September 30, 1990, employer reported that all of its payroll went to workers performing work in classification 7600. That risk classification resulted in the lowest premium rate for employer.

On December 18, 1990, SAIF audited employer's payroll for the period of April 1, 1990, to September 30, 1990, and charged employer an additional insurance premium for the period. SAIF reallocated the payroll reported in classification 7600 to classifications 7601 and 6325. Petitioner timely filed a hearing request pursuant to ORS 737.318(3)(d) to contest the additional premium charged by SAIF. At issue in the hearing was whether employer erroneously reported all of its work for the period in classification 7600 and whether some of that work should have been classified under 6325 or 7601. Ultimately, the department determined that SAIF could properly reclassify employer's payroll from classification 7600 to classification 7601. The department also concluded that SAIF was not prohibited by ORS 737.310(12) from collecting the increased premium due for coverage under that classification.

ORS 737.310(12) (since *amended by* Or Laws 1991, ch 768, § 1) provided in relevant part:

> "At the time a workers'compensation guaranty contract is issued, the insurer shall give written notice to the insured of the rating classifications to which the insured's employees are assigned and shall provide an adequate description of work activities in each classification. The insurer shall not bill an insured for reclassifying employees during the policy year unless:
>
> "(a) The insured knew or should have known that the employees were misclassified * * *."

Under ORS 737.310(12), the burden is first on employer to establish that SAIF reclassified its employees and then shifts to SAIF to prove that one of the exceptions in ORS 737.310(12) applies to permit SAIF to bill employer for the **<141 Or App 432/433>** premium due for the reclassified employees. It is uncontested in this case that SAIF reclassified employer's employees.

The department found that employer "knew or should have known that all of the work performed by [employer] was not reportable under class code 7600." In determining that 737.310(12) permitted SAIF to collect the increased premiums, the department concluded:

> "[Employer] knew what specific work should be included in other class codes but chose to report payroll in the lowest, and therefore most advantageous, premium rate of all the rates assigned to [employer's] business, after the standard exception class codes.
>
> "We determine that [employer] knew the correct method to report its payroll and chose to report it only in the class code most favorable to its business. Therefore, SAIF proved subsection (a) [of ORS 737.310(12)]. SAIF was entitled to collect its final premium audit billing."

The department concluded that SAIF could issue a billing that assessed additional premiums at the rate for classification 7601. Employer argues that the department ignored relevant facts in making its determination. We review to determine whether the department's decision is supported by substantial evidence, ORS 183.482(8)(c). "Substantial evidence exists to support a finding of fact when the record, viewed as a whole, would permit a reasonable person to make that finding." ORS 183.482(8)(c).

The NCCI is the authorized compensation rating bureau for Oregon. NCCI promulgates workers' compensation classifications and rates and publishes numerical listings of the classification codes with descriptive terminology in the *Scopes of Basic Manual Classifications (Scopes). Scopes* defines each classification and describes the type of work included in each of them.

Scopes defines classification 7600, in part, as follows:

> "Code 7600 is applied to all employees of all telephone or telegraph companies other than those employees working within the offices or exchanges. * * *
>
> "This classification includes drivers and all employees involved in the operation and maintenance of lines away **<141 Or App 433/434>** from the exchanges, extension of lines away from the exchanges, extension of lines and the making of service connections. Specific operations contemplated by Code 7600 include clearing of right-of-ways; the erection of poles, cross-arms and insulators; the stringing of overhead low voltage lines or lead sheath cables used for multiple circuits; and the laying of underground cables. *If the operations are undertaken by specialist contractors, the classification applicable to their type of specialty work is applied.*
>
> "The following table indicates the proper classification for different types of business performing low voltage cable installation for communication purposes."

(Emphasis supplied.) The table shows that, for a specialist contractor,[1] the only types of work in the table that are placed in classification 7600 are "extension," "line maintenance" and "service connection."

Scopes defines classification 7601, in part, as follows:

> "Code 7601 is applied to tontractors engaged in telephone, telegraph or fire alarm line construction. *It is* an all*inclusive classification in that it applies to all work* normal *and incidental to the construction of such lines when undertaken by an individual contractor.* Operations contemplated by this code include drivers; the clearing of right-ofways; the erection of poles, cross-arms and insulators; the stringing of overhead low voltage lines or lead sheath cables used for multiple circuits; and the laying of underground cables. Code 7601 is assigned to the described operations whether the work is performed by separate crews of employees or employees who interchange between operations.
>
> "Specialist contractors engaged in overhead telephone, telegraph or fire alarm cable coating or wrapping to form a protective covering for such cables have been assigned by analogy to Code 7601 * * *."

(Emphasis supplied.)

[1] Employer does not dispute that it is a specialist contractor.

Thus, a comparison of classification 7600 and 7601 demonstrates that certain activities, such as "the clearing of **<141 Or App 434/435>** right-of-ways; the erection of poles, cross-arms and insulators; the stringing of overhead low voltage lines or lead sheath cables used for multiple circuits; and the laying of underground cables," are considered 7600 activities when performed by "employees of all telephone or telegraph companies," but are considered 7601 activities when performed by *"contractors* engaged in telephone, telegraph or fire alarm line construction." (Emphasis supplied.)

Employer argues that all of its activities properly are classified as "extension," "line maintenance" and "service connection," all of which fall within classification 7600. Employer argues that the record does not demonstrate that it performed any tasks that could be considered to fall within 7601.

Work orders in evidence show that employer performed the following tasks, among others, during the disputed period: "new aerial install," "underground install,"street cut," "plow/trench," "place pole," "remove pole." Many of the invoices include a charge for "new install." Employer does not contest that it erected and removed poles, strung lines and laid underground cables during the disputed period. Employer argues, nevertheless, that those activities properly were classified as "extension," "line maintenance" and "service connection." On this record, however, the department could conclude that that contention cannot be squared with the descriptions from the *Scopes* manual. The manual states that the activities listed on the work orders, when performed by a specialist contractor, are considered 7601 activities. Those activities are reported as 7600 activities only when they are performed by employees of a telephone or telegraph company. Employer is not such a company. Hence, the department could conclude, as it did, that employer wrongly reported those activities as 7600 activities.

Employer also contends that, even if some of the activities it performed should have been classified as 7601 activities, there was so much confusion surrounding the definitions of "extension," "line maintenance" and "service connection" that it could not correctly identify which classification applied.

141 Or App 436> There is evidence in the record of confusion about the definition of certain terms. However, there also is evidence that employer originally divided its work into six classifications, including classifications 7600 and 7601. In its application for insurance, employer allocated estimated payroll to each of those classifications. The agreement signed by employer states that "employer hereby certifies that [it] has read and understands the statement[s] in this application." There was no evidence that employer was unable to complete the application or was confused about how properly to classify its activities. Taken together, those facts could reasonably support a finding that employer knew how to distinguish among the various classifications. We conclude that the department's conclusion that employer "knew or should have known that all of the work performed by [employer] was not reportable under class code 7600" is supported by substantial evidence in the record. Hence, the department did not err.

Affirmed.

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