VAN NATTA'S
WORKERS' COMPENSATION REPORTER
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WCB Hearings Division
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Salem, OR 97302

VAN NATTA'S
WORKERS' COMPENSATION REPORTER

VOLUME 52

(Pages 1819-END)

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

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

OCTOBER-DECEMBER 2000

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CONTENTS

	Page
Workers' Compensation Board Orders	1819
Court Decisions	2262
Subject Index	2318
Citations to Court Cases	2342
Citations to Van Natta's Cases	2356
ORS Citations	2375
Administrative Rule Citations	2383
Larson Citations	2389
Oregon Rules of Civil Procedure Citations	2389
Oregon Evidence Code Citations	2389
Claimant Index	2390

CITE AS

52 Van Natta ____ (2000)

In the Matter of the Compensation of
DONALD V. BALL, Claimant
WCB Case No. 00-00392
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's claim for his right carpal tunnel syndrome. On review, the issue is compensability.

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

On review, SAIF argues that the ALJ should not have relied on the opinion of Dr. Grant. SAIF contends that Dr. Grant's opinion regarding causation of claimant's carpal tunnel condition is not persuasive because Dr. Grant relied on general statistical studies. SAIF also argues that Dr. Grant's opinion is based on a "precipitating cause" analysis, and therefore, is not sufficient to meet claimant's burden of proof. We disagree.

We have previously rejected a physician's report that was based solely on statistics and failed to analyze the claimant's individual circumstances. *See, e.g., Jackie T. Ganer,* 50 Van Natta 2189 (1998). Here, however, while Dr. Grant did discuss studies regarding workers with carpal tunnel syndrome, he also considered the particular facts of the incident which caused claimant's injury at work. Moreover, Dr. Grant's opinion is not based solely on statistical studies. (Ex. 13-1). Consequently, we do not find that his opinion should be discounted for the reasons set forth in *Ganer.*

SAIF also argues that a "precipitating cause" analysis is not sufficient to establish that the work injury is the major contributing cause of claimant's condition or need for treatment. *SAIF v. Nehl,* 149 Or App 309 (1997); *Robinson v. SAIF,* 147 Or App 157 (1997). We agree that portions of Dr. Grant's opinion suggest a precipitating cause analysis. Nevertheless, we must evaluate the opinion in the context in which it was rendered in order to determine its sufficiency. *SAIF v. Strubel,* 161 Or App 516 (1999); *Worldmark the Club v. Travis,* 161 Or App 644 (1999).

Here, Dr. Grant correctly described the work injury sustained by claimant and the position of the wrist during the incident. Dr. Grant described how the gripping involved exerted force on the tendons and stated that, in this case, a pathological change would have occurred. Finally, Dr. Grant reported that, after considering all possible causes, claimant's work activity was the major cause of his carpal tunnel syndrome. (Ex. 13-3). Under the circumstances, we agree with the ALJ that claimant has met his burden of proving that his work activity was the major cause of his right carpal tunnel syndrome. *See Lawrence L. Nicholson,* 51 Van Natta 1977 (1999) (the claimant met his burden of proof where the doctor's report was not based solely on a temporal relationship; the work injury was not only the precipitating cause but was also the primary cause of the claimant's need for treatment for his combined condition).

Claimant's attorney is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,600, 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 May 11, 2000 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $1,600, for services on review to be paid by the SAIF Corporation.

In the Matter of the Compensation of
ELLEN B. EICHAMER, Claimant
WCB Case No. 99-06330
ORDER ON REVIEW
Bruce D. Smith, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorneys

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

The self-insured employer requests review of Administrative Law Judge (ALJ) Mongrain's order that set aside its denial of claimant's injury claim for an upper back and neck condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We delete the third paragraph on page 3. We do not adopt the ALJ's ultimate findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on the opinions of Drs. Saviers and Lowengart to conclude that claimant's June 3, 1999 injury was the major contributing cause of the disability and need for treatment of her upper back and neck condition. The ALJ rejected Dr. Kirkpatrick's opinion as speculative.

The employer argues that the ALJ erred by discounting Dr. Kirkpatrick's opinion and the significance of claimant's serious, but undiagnosed, T1 pathology. The employer contends that the remaining medical opinions are not sufficient to compensability under ORS 656.005(7)(a)(B).

We briefly summarize claimant's treatment for neck and upper back symptoms. Claimant, a physical therapist, has experienced upper back pain since a 1986 injury. (Tr. 18). In the fall of 1998, she experienced increased soreness across her upper back and neck. (Tr. 20). During the first five months of 1999, claimant was doing more lifting at work and her shoulders and upper back were more sore. (Tr. 15, 20).

In November 1998, Dr. Tribelhorn treated claimant for various complaints, including cervical pain, especially around C7. (Ex. 10-3). Dr. Tribelhorn diagnosed multiple myofascial complaints and ordered a cervical x-ray. (*Id.*) A November 24, 1998 x-ray showed degenerative disc disease at C5-6 and C6-7 and small posterior osteophytes at both levels. (Ex. 11). On May 25, 1999, Dr. Tribelhorn reported that claimant was complaining of numbness intermittently in her arm and decreased sensation of her fingers. (Ex. 13). She recommended an MRI of C5 through T1. (*Id.*)

On June 3, 1999, claimant was injured while attempting to transfer a heavy, elderly woman from a low chair to a bed. (Tr. 6-14). She applied an ice pack to her back and finished her shift, but did not do any further lifting. (Tr. 5, 14).

On June 7, 1999, claimant sought treatment from Dr. Ampel. (Ex. 16). He reported that claimant had experienced chronic aches and pains in her neck and occasionally into her shoulder and arms. (*Id.*) He explained that claimant had noticed a gradual increase in her neck and upper thoracic symptoms since January 1999. (*Id.*) Dr. Ampel said that claimant had a "moderate" increase in symptoms on June 3, 1999, when lifting a patient. (*Id.*) Claimant's MRI results were not available at that time. Dr. Ampel diagnosed a "chronic recurrent cervical thoracic muscle strain with exacerbation especially on 06/03/99." (*Id.*)

Claimant's cervical MRI showed an abnormal T1 vertebral body, as well as spondylosis at C5-6 and C6-7, and moderate anterior extradural defects at C5-6 and C6-7. (Ex. 17).

Claimant was referred to Dr. Kirkpatrick, who examined her on June 22, 1999. He reviewed claimants cervical MRI and diagnosed C5-6-7 disc herniation and spondylosis and a questionable T1 lesion. (Ex. 23-3). He noted that the lesions at C5-6-7 appeared to be due to injuries and were consistent with her history of work injuries ten years ago and recently. (*Id.*) He needed additional information about the T1 abnormality. (*Id.*)

In July 1999, Dr. Kirkpatrick performed a biopsy of claimant's T1 vertebral lesion. (Ex. 28). He reported that the biopsy was benign, except for chronic inflammation and light fibrosis. (Ex. 30).

On August 5, 1999, claimant returned to Dr. Kirkpatrick. He said that her surgical pain was better, but she still had her original pain in the base of the neck and upper back. (Ex. 32-1). His diagnosis was T1 vertebral abnormality: Rule out infection vs. inflammation vs. neoplasm but no definite evidence for any of these. (*Id.*) Dr. Kirkpatrick referred claimant to Dr. Burchiel for further evaluation. (Exs. 32, 34). In a letter to Dr. Burchiel, Dr. Kirkpatrick said that after the biopsy, claimant had done well neurologically, but still had pain referable to the T1 vertebral area. (Ex. 34).

Dr. Israel examined claimant on September 23, 1999. (Ex. 35). He said that bulging or herniated disks at C5-6 or C6-7 can cause referred pain to the interscapular area. (Ex. 35-1). He recommended discography to determine whether the cervical discs were the pain generators. (*Id.*)

Dr. Kirkpatrick did not recommend discography (Ex. 40-9), and referred claimant to Dr. Saviers, who examined claimant on November 12, 1999. (Ex. 36A). He diagnosed a cervicothoracic strain/sprain related to the June 3, 1999 injury, as well as left-sided rib dysfunction and mild scapulothoracic bursitis. (Ex. 36A-3). He also diagnosed underlying C5-6 and C6-7 spondylosis with facet impingement pain, myofascial pain in the neck and shoulder girdle, and he noted that T1 vertebral body pathology of unclear etiology appears chronic and inflammatory in nature. (*Id.*) He recommended physical therapy and medication. On December 9, 1999 and January 18, 2000, Dr. Saviers reported that claimant's conditions were improving with treatment. (Exs. 38, 41).

On April 3, 2000, claimant began treating with Dr. Lowengart. (Ex. 45). She diagnosed C5-6 and C6-7 herniated discs, most likely due to work injury with pre-existing degenerative disc disease likely. (Ex. 45-2). Dr. Lowengart said that a T1 abnormality was noted on the MRI, but it had been subsequently evaluated and found to be insignificant. (*Id.*) She felt that surgery was not imperative, given the lack of neurologic symptoms. (*Id.*) She examined claimant on one other occasion. (Ex. 46).

Claimant does not dispute the employer's assertion that, based on her preexisting neck and upper back conditions, this is a "combined condition" injury claim, subject to ORS 656.005(7)(a)(B). We agree that ORS 656.005(7)(a)(B) applies and claimant must prove that the June 3, 1999 injury was the major contributing cause of the disability and/or need for treatment of the combined condition. Because of the multiple possible causes of claimant's upper back and neck condition, this issue presents a complex medical question that must be resolved on the basis of expert medical evidence. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993).

Claimant relies on the opinions of Drs. Saviers and Lowengart, whereas the employer relies on the opinion of Dr. Kirkpatrick. All three physicians have treated claimant for her upper back and neck symptoms.

Although Dr. Kirkpatrick had initially commented that claimant's lesions at C5-6-7 appeared to be due to injuries (Ex. 23-3), he subsequently explained that after reviewing additional records, he believed that claimant's C5-6-7 problems were due to old injuries and were not materially affected by the June 3, 1999 incident. (Ex. 40-13 to -16, -19, -20). In a concurrence letter from the employer's attorney, Dr. Kirkpatrick agreed that three factors had combined and contributed to claimant's need for treatment: the June 3, 1999 strain episode, degenerative changes at C5-6 and C6-7 and pathology at T1. (Ex. 39). He agreed that the June 3, 1999 injury was a 10 percent contributor, the C5-6-7 disc disease was a 35 percent contributor and the T1 pathology was a 55 percent contributor to claimant's symptoms and need for treatment. (*Id.*)

In a deposition, Dr. Kirkpatrick explained that claimant's primary problem was at the T1 level. (Ex. 40-8). He said that, from the very beginning, claimants pain seemed to be centered in the T1 area. (*Id.*) Although he could not diagnose the T1 lesion, he said it was was the main cause of her pain. (*Id.*) Dr. Kirkpatrick acknowledged that injured discs, especially at C6-7, can cause referred pain to the interscapular area, but he said that would not cause tenderness of the spine down at T1 or T2. (Ex. 40-9). Dr. Kirkpatrick explained that generally, after six to eight weeks, a sprain or strain would be a minimal factor. (Ex. 40-17). He said that claimant had recovered from the strain/sprain of her upper spine. (Ex. 40-16). As of June 22, 1999, when he first treated claimant, Dr. Kirkpatrick felt that the strain contributed 50 percent, the T1 lesion was 35 percent and the preexisting C5-6-7 disease was 15 percent. (Ex. 40-21).

Although Dr. Kirkpatrick said that claimant's strain contributed "50 percent" to her disability of need for treatment as of June 22, 1999, that is not sufficient to establish that the work injury was the major contributing cause of the combined condition. Moreover, Dr. Kirkpatrick felt that the sprain/strain had resolved and claimant's June 3, 1999 injury was contributing only 10 percent to her current need for treatment. (Exs. 39, 40-16). Dr. Kirkpatrick's opinion is not sufficient to establish compensability of claimant's upper back and neck condition.

Claimant relies, in part, on the opinion of Dr. Saviers to establish compensability. The only opinion on causation from Dr. Saviers was in his November 12, 1999 report. He explained that the "major cause for treatment is the work injury of June 3rd and is not related to the T1 vertebral body pathology." (Ex. 36A-3). He said that the T1 vertebral body pathology of unclear etiology appears chronic and inflammatory in nature. (*Id.*) We are not persuaded by Dr. Saviers' conclusory opinion because he did not properly evaluate the relative contribution of the preexisting conditions and the work injury and explain why the work injury was the major contributing cause. *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Furthermore, Dr. Saviers did not explain why claimant's need for treatment was unrelated to the T1 disc and did not respond to Dr. Kirkpatrick's comments that claimant's pain had been centered in the T1 area since the beginning.

Claimant also relies on the opinion of Dr. Lowengart, who initially examined her on April 3, 2000, ten months after the work injury. (Ex. 45). Dr. Lowengart diagnosed C5-6 and C6-7 herniated discs, most likely due to work injury with pre-existing degenerative disc disease likely[,] and obesity with type II diabetes. (Ex. 45-2). She said that a T1 abnormality was noted, but it had been evaluated and found to be insignificant. (*Id.*) Dr. Lowengart concluded that claimant's work injury aggravated an underlying condition and caused the need for her present care. (*Id.*) In a later concurrence letter from claimant's attorney, Dr. Lowengart agreed that the major cause of claimant's disability and need for treatment since June 3, 1999 was her C5-6 and C6-7 disc herniations, which were caused by the work injury. (Ex. 47-1).

We are not persuaded that Dr. Lowengart had an accurate understanding of claimant's upper back and neck symptoms before the June 3, 1999 incident. In her initial report, Dr. Lowengart said that claimant had a previous neck injury in 1986, which required a prolonged absence from work, but [t]hings got better[.] (Ex. 45-1). Dr. Lowengart said that claimant was lifting a patient on June 3, 1999 when she felt a pulling in her neck and snapped her right wrist. (*Id.*) In a later concurrence letter from claimant's attorney, Dr. Lowengart agreed that, although claimant had preexisting cervical degenerative disc disease, that condition did not require medical treatment prior to June 3, 1999. (Ex. 47-1).

As discussed earlier, claimant had increased upper back and neck symptoms beginning in fall of 1998. In November 1998, she sought treatment from Dr. Tribelhorn for cervical pain and an x-ray showed degenerative disc disease at C5-6 and C6-7 and small posterior osteophytes at both levels. (Exs. 10, 11). On May 25, 1999, shortly before the June 3, 1999 incident, Dr. Tribelhorn had recommended an MRI of C5 through T1 because of claimant's symptoms. (Ex. 13). There is no evidence that Dr. Lowengart was aware of these reports. Because Dr. Lowengart apparently did not have an accurate understanding of claimant's preexisting conditions and symptoms, her causation opinion is entitled to little weight. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

Furthermore, Dr. Lowengart agreed that claimant's work injury was the primary cause of the need for medical treatment (not including the T1 surgery), "primarily because the work incident was apparently the immediate cause of the cervical disc herniations and resulting symptoms." (Ex. 47-1). Dr. Lowengart's opinion establishes only that the work activity was the precipitating cause of claimant's upper back and neck symptoms. Such an opinion is insufficient to establish compensability. *See Dietz v. Ramuda*, 130 Or App at 401 (fact that work activities precipitates a claimant's injury does not necessarily mean that work was the major contributing cause of the condition). Finally, we note that Dr. Lowengart had reported that claimant's diabetes most certainly has an influence on her chronic pain and inflammation. (Ex. 45-3). She did not discuss the relative contribution of claimant's diabetes in evaluating causation of the upper back and neck condition.

In sum, we conclude that the medical evidence is insufficient to establish that claimant's June 3, 1999 injury was the major contributing cause of her upper back and neck condition. We therefore reverse the ALJ's order.

ORDER

The ALJ's order dated May 30, 2000 is reversed. The self-insured employer's denial of claimant's upper back and neck condition is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority's conclusion that claimant did not establish compensability. Instead, I would affirm the ALJ's order that set aside the self-insured employer's denial of claimant's upper back and neck condition.

In particular, the majority errs by finding that an "undiagnosed preexisting condition" is the major contributing cause of claimant's upper back and neck symptoms. The ALJ correctly found that Dr. Kirkpatrick's opinion was entitled to little weight because it was all speculative. I also agree with the ALJ that the opinion of Dr. Lowengart is the most persuasive. The majority unfairly characterizes Dr. Lowengart's opinion as based only on a "precipitating cause" analysis. To the contrary, Dr. Lowengart had an accurate history of claimant's symptoms and she carefully evaluated the mechanics of the lifting incident at work and reviewed the necessary medical records in concluding that claimant's work injury was the major contributing cause of her disability and need for treatment. Based on Dr. Lowengart's opinion, I would affirm the ALJ's order. Because the majority concludes otherwise, I dissent.

In the Matter of the Compensation of
JAMES R. CORUM, Claimant
WCB Case No. 97-10164
ORDER ON RECONSIDERATION
Roger Wallingford, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Claimant requests reconsideration of our September 13, 2000 Order on Review that reversed the Administrative Law Judge's (ALJ's) order setting aside the insurer's denial of claimant's left wrist and ankle injury claim. Specifically, claimant submitted a handwritten letter discussing his physical and financial difficulties and asking the Board to "please help me with this problem" as well as "help my lawyer with his work on this."

In order to be entitled to workers' compensation benefits, by statute, the worker must show by a preponderance of evidence that his claim is compensable. ORS 656.266. In proving compensability, the worker must establish medical causation; that is, the worker must show with persuasive medical evidence that employment conditions, such as a work event, caused an injury. *See* ORS 656.005(7)(a).

The Order on Review discussed why the medical evidence here was not sufficient to prove medical causation. We continue to agree with that reasoning and the conclusion that claimant did not prove compensability.

Accordingly, we withdraw our September 13, 2000 order. On reconsideration, as supplemented herein, we adhere to and republish our September 13, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
HAROLD G. MANGUM, Claimant
WCB Case No. 98-0486M
ORDER ON REVIEW REVIEWING CARRIER CLOSURE
Cole, Cary, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's April 27, 2000 "Notice of Closure Board's Own Motion Claim" that closed his claim with an award of temporary total disability compensation from August 4, 1997 through August 24, 1997, and declared claimant medically stationary as of December 9, 1998. Claimant contends that SAIF has refused to rate permanent disability for the new medical conditions it was ordered to accept. He states that he has filed a hearing request with the Hearings Division to seek an order requiring a rating of permanent disability. (WCB Case No. 00-03579). Claimant also states that "[o]ut of [an] abundance of caution, we submit this letter as a request for review of the notice of closure, alleging permanent partial disability benefits are due but were not awarded." Based on the following reasoning, we affirm SAIF's April 27, 2000 "Notice of Closure Board's Own Motion Claim."

FINDINGS OF FACT[1]

On August 17, 1973, claimant sustained a compensable right knee injury. On August 27, 1973, SAIF accepted claimant's workers' compensation injury claim without specifying any particular conditions it accepted. On June 24, 1974, claimant's claim was closed. Claimant's aggravation rights expired five years later, on June 24, 1979.

After recovering from the August 1973 injury, claimant continued working for the employer until it shut down its business. He then worked for other loggers. In about 1980, claimant began working in mills. Claimant went about 20 years without any right knee symptoms.

In April 1997, claimant developed symptoms in his right knee. On August 1, 1997, claimant underwent arthroscopic surgery. In October 1997, Dr. Buehler, M.D., took over claimant's post-surgical care. By May 1998, claimant had returned to his regular mill job.

On October 2, 1998, claimant requested that SAIF amend its acceptance of his 1973 claim to include his right "anterior cruciate ligament tear, chondromalacia, and medial meniscus tear" conditions. On November 25, 1998, SAIF issued a partial denial of claimant's "osteoarthritis" condition and his related disability and treatment. That same date, SAIF submitted a "Carrier's Own Motion Recommendation" to the Board recommending against reopening claimant's claim under the Board's Own Motion jurisdiction based on its partial denial.

Claimant requested a hearing regarding SAIF's November 25, 1998 partial denial. (WCB Case No. 98-09425). On January 29, 1999, we issued an order postponing action on claimant's Own Motion request pending resolution of the compensability issue.

On December 9, 1998, Dr. Buehler examined claimant and declared him medically stationary. He noted that claimant was back his regular job at the mill.

By Opinion and Order dated June 5, 1999, ALJ Crummé set aside SAIF's November 25, 1998 partial denial and ordered SAIF to accept claimant's right partial anterior cruciate ligament tear, partial medical meniscus tear, chondromalacia, osteoarthritis, and 1997/1998 treatment relating to his right knee injury. That order was not appealed and became final by operation of law. (WCB Case No. 98-09425).

On July 16, 1999, we issued an Own Motion Order authorizing the reopening of claimant's 1973 right knee injury claim to provide temporary disability compensation beginning August 1, 1997, the date claimant was hospitalized for surgery. We also ordered SAIF to close the claim pursuant to OAR 438-012-0055 when claimant was medically stationary.

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[1] Most of the findings of fact are derived from Administrative Law Judge (ALJ) Crummé's June 5, 1999 order that found claimant's current right knee condition compensable. (WCB Case No. 98-09425).

On April 27, 2000, SAIF issued a "Notice of Closure Board's Own Motion Claim" that that closed claimant's claim with an award of temporary total disability compensation from August 4, 1997 through August 24, 1997, and declared claimant medically stationary as of December 9, 1998.

On May 9, 2000, claimant requested a hearing with the Hearings Division seeking an order requiring rating of permanent disability. (WCB Case No. 00-03579). Subsequently, the parties agreed that ALJ Myzak, who was assigned to hear this matter, would decide the matter on the record. An order on that matter has not yet been issued.

On June 9, 2000, claimant requested review of SAIF's April 27, 2000 "Notice of Closure Board's Own Motion Claim," "alleging permanent partial disability benefits are due but were not awarded."

On June 14, 2000, Board staff requested that SAIF provide the Own Motion Board with copies of all materials it considered in closing the claim. Claimant was allowed the opportunity to respond. No response was received from claimant.

CONCLUSIONS OF LAW AND OPINION

Claimant requests that the Board, in its Own Motion authority, review SAIF's April 27, 2000 closure and alleges that "permanent partial disability benefits are due but were not awarded." We interpret claimant's request as a request to order SAIF to process the claim pursuant to ORS 656.262(7)(c)[2] and 656.268. In addition, claimant has requested a hearing before the Hearings Division, requesting the same relief before that forum. (WCB Case No. 00-03579). Claimant makes no argument regarding the merits of the closure.

Based on the following reasoning, we find that we have subject matter jurisdiction in our Own Motion capacity to review the April 27, 2000 closure. In addition, although we have no authority in our Own Motion capacity to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268, we note that claimant has made a request for that relief before another forum that has such authority, *i.e.*, the Hearings Division.

We find that our decision in *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000), resolves the issues presented here. In *Ledin*, the claimant had a new condition claim (a right knee meniscus tear condition) that had been validly reopened and subsequently closed pursuant to our Own Motion authority under ORS 656.278. There, as here, the claimant disputed the closure, contending that his condition should be rated and processed under ORS 656.268 and not treated as an Own Motion claim. The claimant requested review of the Own Motion Notice of Closure both before the Hearings Division and before the Board in our Own Motion jurisdiction. We postponed action on the Own Motion matter pending resolution of the litigation before the Hearings Division.

The ALJ held that, because our prior order authorizing the claim to be reopened in our Own Motion jurisdiction was not appealed, our determination of our Own Motion jurisdiction became final and was not subject to collateral attack before the Hearings Division. Therefore, the ALJ dismissed claimant's hearing request for lack of jurisdiction. Claimant requested Board review.

On review in our "regular" capacity, we agreed with the ALJ that the Hearings Division lacked jurisdiction to review the Own Motion closure of the claimant's claim because that was a matter within our Own Motion jurisdiction under ORS 656.278(1). Nevertheless, we held that, insofar as claimant's request pertained to the carrier's duty to process claimant's claim under ORS 656.262(7)(c), the ALJ was authorized to consider that matter. Therefore, we reinstated the claimant's hearing request.

In doing so, we explained that a condition found compensable after claim closure is entitled to reopening under ORS 656.262(7)(c) and processing under ORS 656.268, even if the aggravation rights have expired on the original claim. We noted that such a claim processing issue is a "matter concerning a claim" for which the claimant can request a hearing under ORS 656.283. Determining that the claimant's "new" condition was found compensable after claim closure, we held that the carrier was

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[2] ORS 656.262(7)(c), as amended in 1997, provides, in relevant part: "If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." This amendment applies retroactively to all claims existing or arising on or after the July 25, 1997 effective date, regardless of the date of injury or the date a claim is presented. *See Mario R. Castaneda*, 49 Van Natta 2135 (1997).

obligated to reopen the claim for processing of the condition in accordance with ORS 656.262(7)(c). In anticipation of the eventual "ORS 656.268" closure of the claim, we noted that the claimant would not be entitled to duplicate compensation for any time period coinciding with temporary disability benefits awarded pursuant to the carrier's Own Motion Notice of Closure.

Specifically addressing the carrier's Own Motion Notice of Closure, we also found that we had subject matter jurisdiction in our Own Motion capacity to review the closure. Because the claimant's aggravation rights had expired on his initial injury claim and his condition required surgery, we reasoned that we were authorized to reopen the claimant's claim pursuant to ORS 656.278(1)(a)[3] and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. Thus, we found that we had subject matter jurisdiction to review the carrier's subsequent closure of that claim. *See Larry L. Ledin*, 52 Van Natta at 685; *Paul E. Smith*, 52 Van Natta 730 (2000).

This same reasoning applies to the current claim. There is no dispute that claimant's aggravation rights have expired on his initial injury claim. Furthermore, claimant's condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the July 16, 1999 Own Motion Order[4] that authorized reopening claimant's claim pursuant to ORS 656.278(1)(a) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review the insurer's subsequent closure of that claim.[5] Therefore, we proceed with that review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 27, 2000 closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Here, the only medical evidence regarding the medically stationary issue is provided by claimant's treating physician, who opined that claimant was medically stationary as of December 9, 1998. That is the date SAIF declared claimant medically stationary when it closed the claim.

Claimant makes no argument that he was not medically stationary at the time of closure, nor does he argue that his medically stationary date was incorrect or his temporary disability compensation was incorrectly calculated. Instead, claimant's argument is solely procedurally based, *i.e.*, claimant

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[3] ORS 656.278(1)(a) provides:

"(1) Except as provided in subsection (6) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

[4] We note that the July 16, 1999 Own Motion Order was not appealed and has become final by operation of law. *See* ORS 656.278(4). Had that order been appealed or not become final, our decision today may well have been different. However, resolution of cases based on those specific circumstances must await a future case.

[5] Although we have subject matter jurisdiction to determine entitlement to temporary disability benefits where an injured worker's aggravation rights have expired, we generally defer making such a determination if there is litigation before the Hearings Division that may result in the payment of benefits under another claim or under another statute such as ORS 656.262(7)(c). *See* OAR 438-012-0050(1)(a)-(c); *Craig Prince*, 52 Van Natta 108, 111 (2000).

essentially argues that review of SAIF's Own Motion Notice of Closure should be under ORS 656.268 rather than the Board's Own Motion jurisdiction. Because we have rejected that argument and claimant raises no substantive arguments, we affirm SAIF's April 27, 2000 Own Motion Notice of Closure in its entirety.[6]

Finally, we turn to claimant's request that we order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268. As we have previously explained, where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *See Prince*, 52 Van Natta at 111.

In other words, in our Own Motion jurisdiction, we do not have authority to grant claimant's request to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268. Claimant's relief, if any, regarding his request for additional benefits for his right knee condition lies with the Hearings Division, not the Board in our Own Motion jurisdiction. As previously noted, claimant is currently pursuing that relief through his pending hearing request in WCB Case No. 00-03579.[7]

Accordingly, SAIF's April 27, 2000 Own Motion Notice of Closure is affirmed.

IT IS SO ORDERED.

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[6] To the extent that claimant's request may be interpreted as a request that we grant additional permanent disability in our Own Motion jurisdiction, we do not have authority to grant such a request. *See* ORS 656.278(1); *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990) (effective January 1, 1988, the legislature removed the Board's authority to grant additional permanent disability compensation in its Own Motion capacity).

[7] As we discussed in *Ledin*, a claimant is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985). Thus, consistent with the *Ledin* rationale, inasmuch as we have herein affirmed SAIF's Own Motion Notice of Closure, temporary disability benefits paid pursuant to that closure order will need to be taken into consideration should the proceeding pending before the Hearings Division eventually result in a reopening of his claim under ORS 656.262 and closure pursuant to ORS 656.268.

In the Matter of the Compensation of
MYRON O. RASMUSSEN, Claimant
WCB Case No. 00-01698
ORDER ON REVIEW
Lavis & Dibartolomeo, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

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

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

As SAIF points out, after the ALJ issued his order, we issued our decision in *Mary A. Egbert*, 52 Van Natta 1457 (2000), which further supports the ALJ's reasoning and conclusions in the present case. In *Egbert*, the claimant requested that the carrier accept shoulder conditions that were omitted from its acceptance notice. Within 30 days of the claimant's request, the carrier responded in writing, stating that it would be gathering information to determine compensability and that it would make a decision by a certain date. The claimant contended that the carrier's letter did not qualify as a timely response because it was neither an amendment of its acceptance nor a written clarification. We rejected that contention and found that the carrier's response qualified as a "written clarification" under ORS 656.386(1)(b)(B). We further concluded that because the carrier's claim processing was timely, the claimant's attorney was not entitled to an assessed attorney fee for prevailing over an alleged "de facto" denial. The same reasoning applies here.

ORDER

The ALJ's order dated June 12, 2000 is affirmed.

In the Matter of the Compensation of
DEBORAH SCHICHTEL, Claimant
WCB Case No. 99-05465
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of her occupational disease claim for her left carpal tunnel syndrome. In her appellant's brief, claimant argues that the ALJ abused his discretion by denying her request for a continuance. On review, the issues are continuance and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Continuance

At hearing, claimant requested a continuance in order to obtain a report from Dr. Murdock, a hand specialist.[1] Claimant argued that, because, during a deposition, her treating doctor deferred questions of causation to Dr. Murdock, the record should be left open to obtain Dr. Murdock's report. The ALJ denied claimant's request, however, and closed the record following testimony at hearing. On review, claimant argues that it was an abuse of discretion for the ALJ to deny her request for a continuance. We disagree.

OAR 438-006-0091 provides that, although continuances are disfavored, an ALJ may continue a hearing "upon a showing of due diligence" if necessary to afford reasonable cross-examination on documentary evidence, or for the party bearing the burden of proof to obtain and present final rebuttal evidence. *See* OAR 438-006-0091(2) and (3). We review the ALJ's ruling on a motion for continuance of abuse of discretion. *See e.g. Tonya L. Kristensen*, 50 Van Natta 1372 (1998).

Here, we find no abuse of discretion in the ALJ's decision to deny claimant's request for a continuance. Claimant was first seen by Dr. Mersch, D.O., for her left hand problems in September 1998. Dr. Mersch eventually referred claimant to a hand specialist, Dr. Murdock, in the fall of 1998. (Ex. 9-23). Following claimant's request for hearing, a hearing was set for October 1999. Prior to the date set for hearing, Dr. Mersch signed a letter agreeing that work was the major cause of claimant's carpal tunnel syndrome. (Ex. 8). The hearing was postponed in order for the employer to obtain a deposition from Dr. Mersch.

In the December 7, 1999 deposition, Dr. Mersch testified that he continued to agree with the position that he had previously taken regarding the major cause of claimant's carpal tunnel syndrome. (Ex. 9-33). However, Dr. Mersch also testified that he was unsure whether certain factors would have contributed to claimant's condition, and he believed that the answers to those questions would best be answered by Dr. Murdock. (Ex. 9-23, 9-26, 9-28).

Following the deposition, claimant's counsel attempted to depose Dr. Murdock, but the doctor indicated that he wished to speak to claimant before providing an opinion. At hearing, claimant's counsel asserted that Dr. Murdock was unable to see claimant until approximately one month after the hearing. (Tr. 3). For that reason, claimant's counsel requested a continuance.

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[1] There is no report authored by Dr. Murdock contained in the exhibits admitted at hearing.

In *Clifton L. Sweem*, 51 Van Natta 884 (1999), we relied on several Board cases in which we have held that there is no abuse of discretion in denying a continuance for rebuttal evidence when the claimant could have obtained such evidence prior to hearing. *See, e.g., Sharron D. Lemley*, 49 Van Natta 1365 (1997); *Larry E. Fournier*, 47 Van Natta 786 (1995); *Robert L. Armstrong*, 47 Van Natta 1399 (1995). In *Armstrong*, for example, we held that there was no abuse of discretion in denying a continuance to obtain rebuttal testimony in response to deposition evidence that was presented in earlier medical reports. 47 Van Natta at 1400.

Here, Dr. Mersch referred claimant to Dr. Ogisu for an electrodiagnostic evaluation in October 1998. Dr. Ogisu reported to Dr. Mersch that claimant had an "unusually mobile extensor carpal ulnaris tendon," and for that reason, a consultation with a hand surgeon was recommended. (Ex. 9-38). However, in his letter discussing causation of claimant's carpal tunnel syndrome, Dr. Mersch did not discuss the hypermobile condition. (Ex. 8). Nevertheless, in deposition, Dr. Mersch agreed that to determine the degree of contribution (to the development of the carpal tunnel syndrome) by the hypermobile condition, it would be necessary to ask Dr. Murdock for an opinion. (Ex. 9-25). Similarly, Dr. Mersch was apparently aware of claimant's weight and the fact that the carpal tunnel syndrome was in claimant's nondominant hand (Exs. 2, 9-19), but the contribution by those factors were not considered in his opinion. Dr. Mersch agreed in deposition that those factors could contribute to carpal tunnel condition, but he was uncertain of the degree of contribution in claimant's case. (Ex. 9-19, 9-20).

Under the circumstances, we conclude that the issues that arose in Dr. Mersch's deposition were present in the earlier medical reports, including the doctor's own reports and those of Dr. Ogisu and Dr. Melson, who examined claimant on behalf of the insurer. (Ex. 6). Moreover, Dr. Mersch did not change his opinion at the time of deposition, as he continued to adhere to his belief that work was the major cause of claimant's carpal tunnel. Consequently, we are unable to find that claimant was reasonably surprised by an expert's change of opinion, which could support a need for a continuance.[2] *See e.g. SAIF v. Kurcin*, 160 Or App 489 (1999).

Moreover, in light of the prior medical reports which were in existence well before the deposition of Dr. Mersch, we are unable to find that claimant acted with due diligence[3] to obtain a report from Dr. Murdock. Consequently, we conclude that the ALJ did not abuse his discretion in declining to grant claimant's request for a continuance.

Compensability

We adopt the ALJ's "Opinion" on the issue of compensability.

ORDER

The ALJ's order dated March 17, 2000 is affirmed.

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[2] Claimant also contends that, as the party with the burden of proof, she has the right to obtain and present final rebuttal evidence. However, as we noted in *Sweem*, 51 Van Natta 887, fn 4, the court in *Kurcin* has rejected the argument that, as the party with the burden of proof, the claimant has an absolute right to the last presentation of evidence.

[3] Claimant contends that it is inconsistent for the ALJ to have found (and counsel for the insurer to have conceded) that he acted with due diligence, yet to deny her request for a continuance. Although the ALJ initially found that claimant had acted with due diligence, and the insurer's counsel agreed (Tr. 9), the ALJ later reversed his decision to grant a continuance. The ALJ agreed with the insurer's attorney that "Dr. Murdock was in the game." (Tr. 16). Accordingly, we construe the ALJ's subsequent comments as a finding that claimant had not acted with due diligence to secure a report from Dr. Murdock.

Board Member Biehl dissenting.

I agree with claimant that this matter should be remanded to the ALJ in order for claimant to obtain the report of Dr. Murdock. Here, both the ALJ and counsel for the insurer agreed that claimant's counsel acted with due diligence in attempting to arrange for claimant to be examined by Dr. Murdock.

I disagree with the majority's contention that claimant should have known that a report from Dr. Murdock was going to be necessary in this case. Claimant's treating doctor was unable to discuss factors such as claimant's hypermobile tendon condition, her weight, and the fact that the carpal tunnel syndrome condition was in her nondominant hand. With regard to those issues, Dr. Mersch testified that he would defer to the opinion of a specialist, such as Dr. Murdock. (Ex. 9). However, until the time of deposition, claimant could not have known that Dr. Mersch would be unable to answer such questions.

Under the circumstances, I would find that claimant was reasonably surprised by Dr. Mersch's opinion at deposition. Furthermore, I would find that, because claimant's counsel acted with due diligence once he was aware of the deficiencies in Dr. Mersch's opinion, a continuance should have been granted by the ALJ. For these reasons, I respectfully dissent from the majority's opinion.

In the Matter of the Compensation of
BARRY M. SHELDON, Claimant
WCB Case No. 00-00231
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Stephen Brown's order that upheld the SAIF Corporation's denial of his injury claim. On review, the issue is course and scope of employment. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant was not within the course and scope of his employment when he was injured. We agree that the claim is not compensable. However, we rely on the following analysis.

Claimant was injured when he fell at a construction work site. Claimant argues that, if he did pass out, rather than trip, it was due to low blood sugar because he had not eaten. Claimant further contends that the reason he did not eat lunch that day was because the person giving him a ride had stopped at a second construction site. Consequently, claimant argues that this case is similar to *William H. Olson*, Jr., 45 Van Natta 85 (1993), and his injury was within the course and scope of employment. We disagree.

In *Olson*, the claimant was a long-haul truck driver who experienced a convulsion after making a delivery. The medical evidence showed that sleep deprivation was the major cause of the claimant's seizure. Consequently, the Board concluded that, because sleep deprivation was a risk inherent in the claimant's occupation, the seizure arose out of the employment activity.

In the present case, however, there is no evidence that skipping lunch is a risk inherent in claimant's occupation. Here, claimant agreed that he was provided time during the day to eat lunch, but did not do so because he had not brought a lunch. With respect to his not bringing a lunch, claimant testified: "more often than not, that's the case." (Tr. 19). Claimant further testified that he did not usually eat lunch and his lunch break usually consisted of taking a break, smoking a cigarette and drinking water. (Tr. 19, 20). When asked why he did not eat lunch, claimant responded that he did not usually eat that meal and he just ate two meals a day. (Tr. 8).

Under the circumstances, we do not find that claimant's work or his schedule was the reason he skipped lunch on the day he was injured. On the day he was injured, claimant was given time to eat lunch, but chose not to do so, as was customary for him. (Tr. 8, 9). Claimant was not aware of an exact date for the completion of the construction project and was not aware of any expectations on the employer's behalf with respect to that project. (Tr. 8, 9). Therefore, we do not find that claimant

missed lunch that day due to his work activity. Moreover, there is no evidence in the record that food deprivation was an inherent risk of his work for the employer. Consequently, *Olson* is not on point.

Finally, claimant's alternative theory is that he was injured because he tripped and fell while assisting on the construction site. At hearing, claimant testified that he tripped and fell and landed on his shoulder. (Tr. 13). Claimant further testified that he did not lose consciousness and still had all of his "faculties and senses" about him before he tripped. (Tr. 13). Claimant's testimony, however, is at odds with the contemporaneous emergency records which describe a "syncopal episode," of which claimant had "no memory." (Ex. 4). Claimant's initial symptoms included "confusion." (Ex. 50).

Dr. Gallagher, who treated claimant in the emergency room reported that claimant "passed out today while at work." Claimant reported to Dr. Gallagher that he had experienced "a similar episode to this 2-3 years ago and was felt to be secondary to low blood sugar[.]" Dr. Gallagher diagnosed a "syncopal episode must likely secondary to hypoglycemia[.]" (Ex. 6).

Accordingly, because there is no mention in the medical reports regarding a trip and fall at work, we are unwilling to accept claimant's testimony at hearing. *See, e.g., Kevin J. Silva,* 52 Van Natta 66 (2000) (history contained in the contemporaneous medical reports found to be more persuasive than the claimant's testimony and belated reports of a work-related injury). We reach this conclusion in light of the contemporaneous medical reports that attribute claimant's fall to a syncopal episode. In this regard, the medical reports are consistent with claimant's testimony that he had not eaten lunch that day, and that he had previously experienced a similar fainting episode in the past due to low blood sugar. (Tr. 20). Accordingly, we conclude that claimant has failed to eliminate idiopathic causes as the reason for his fall at work. He therefore has not established a sufficient work connection to satisfy his burden of proof. ORS 656.266; *Phil A. Livesley Co. v. Russ,* 296 Or 25, 30 (1983).

ORDER

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

October 3, 2000 Cite as 52 Van Natta 1831 (2000)

In the Matter of the Compensation of
EARL W. ROOKHUIZEN, Claimant
WCB Case No. 00-01175
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Howell's order that upheld the SAIF Corporation's denial of his current low back condition. On review, the issue is the procedural validity of the denial.

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

At hearing, claimant challenged SAIF's denial as both an improper "back-up" denial and on the merits. The ALJ upheld the denial on both bases. Conceding that the ALJ's analysis regarding the alleged "back-up" denial was correct, claimant's sole argument on review is that SAIF's denial did not comport with *Croman Corporation v. Serrano,* 163 Or App 136 (1999). SAIF contends that this issue was not raised below. We agree with SAIF and decline to consider claimant's argument on review. *See Leroy W. Steece,* 52 Van Natta 482 (2000) (Board declined to address claimant's argument based on *Serrano* raised for the first time on review).

ORDER

The ALJ's order dated May 31, 2000 is affirmed.

In the Matter of the Compensation of
AMADO T. SOTELO, Claimant
Own Motion No. 98-0449M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Cole, Cary, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's July 5, 2000 Notice of Closure which closed his claim with an award of temporary disability compensation from November 20, 1998 through June 16, 2000. The insurer declared claimant medically stationary as of June 16, 2000. Claimant contends that he is entitled to additional benefits as he was not medically stationary when his claim was closed.

A claim may not be closed unless the compensable 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 July 5, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

In an August 31, 2000 letter, we requested the insurer submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. The insurer submitted its response on September 8, 2000, however, no further response has been received from claimant. Therefore, we proceed with our review.

On June 16, 2000, claimant underwent an insurer-arranged medical examination (IME). Although the IME physician noted that claimant's overall left knee condition would probably slowly worsen requiring further surgery, he opined that claimant was medically stationary as to his compensable left knee medial meniscus condition. Dr. Morris, one of claimant's treating physicians, concurred with the IME physician as to claimant's medically status on July 3, 2000. Dr. Mohler, another of claimant's treating physicians, also concurred with the IME physician regarding claimant's medically stationary status on August 22, 2000. These opinions are unrebutted.

In his request for review of the insurer's closure, claimant states that he is not medically stationary because Dr. Morris was never his attending physician and Dr. Mohler, who claimant contends is his attending physician, "advised" him to seek treatment from a pain specialist.[1] He offers no medical documentation to support his contention regarding further treatment at a pain clinic. However, even if we were to consider claimant's assertion that he requires treatment with a pain specialist, this does not support the conclusion that he was not medically stationary when his claim was closed. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation, at claim closure, that further medical treatment would "materially improve" claimant's compensable condition. ORS 656.005(17); *Lois Brimblecom*, 48 Van Natta 2312 (1996).

Based on the uncontroverted medical evidence, we find that claimant has not met his burden of proving that he was not medically stationary on the date his claim was closed. Therefore, we conclude that the insurer's closure was proper.

Accordingly, we affirm the insurer's July 5, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] It appears from claimant's contention that he did not appoint Dr. Morris as his attending physician and assertion that Dr. Mohler continues in that capacity, that the closure is premature because Dr. Mohler has recommended treatment with a pain specialist. However, the issue of which doctor is claimant's attending physician is not determinative inasmuch as both physicians concurred with the IME physician that claimant was medically stationary when his claim was closed.

In the Matter of the Compensation of
LOUIS L. HARON, Claimant
Own Motion No. 66-0195M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Floyd H. Shebley, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requested review of the SAIF Corporation's April 12, 2000 Notice of Closure, as amended April 14, 2000, which closed his claim with an award of temporary disability compensation from January 8, 1990 through April 4, 2000. SAIF declared claimant medically stationary as of April 4, 2000. Claimant contended that he was entitled to additional benefits as he was not medically stationary when his claim was closed.

FINDING OF FACTS

Claimant suffered a compensable low back injury in 1960. His claim was reopened in 1989 for lumbar surgery and temporary disability compensation. Claimant has undergone several surgeries to his back, the last one in 1993.

In 1994, Dr. Nash, one of claimant's treating physicians, recommended further surgery for claimant's low back condition. SAIF declined to authorize the requested surgery. Dr. Noyes, claimant's attending physician, declared that claimant's compensable low back was medically stationary as of June 30, 1997. Relying on Dr. Noyes' opinion, SAIF issued a November 30, 1998 Notice of Closure, which it amended on December 11, 1998. Claimant requested review of that closure.

On July 22, 1999, we issued our Own Motion Order Reviewing Carrier Closure, which set aside SAIF's November 30, 1998 closure, as amended December 11, 1998. In our July 22, 1999 order, we found that, pursuant to the opinions of Drs. Nash, Misko and Noyes (who concurred with Dr. Misko's opinion), claimant's compensable low back condition had worsened since first declared medically stationary in June 1997 and that with further surgery, there was a reasonable expectation of material improvement. Accordingly, we did not find that claimant's compensable low back condition was medically stationary when SAIF closed his claim.

Because Drs. Nash and Misko were not CareMark Comp. member physicians, claimant sought further treatment with Dr. Meier. On August 24, 1999, Dr. Meier examined claimant and reviewed his medical records. Because of claimant's continued pain complaints, Dr. Meier recommended that claimant undergo a neurosurgery evaluation by Dr. Calhoun. Dr. Meier stated that he would "defer the question of being medically stationary to Dr. Calhoun." He also opined that if surgery was not indicated, that claimant would be considered medically stationary.

After evaluating claimant on October 18, 1999, Dr. Calhoun reported that further diagnostic studies were required. If the diagnostic testing demonstrated that claimant had pseudoarthrosis, Dr. Calhoun opined that he might benefit from further surgery.

On November 15, 1999, Dr. Calhoun reported that the CT scan and x-ray studies did not demonstrate any "excessive movement." As a result, Dr. Calhoun concluded that claimant did not have pseudoarthrosis and that there was "not much else to be done from a surgical standpoint."

Dr. Hermens, an orthopedic doctor, examined claimant, on November 30, 1999. Dr. Hermens opined that based on claimant's description of having more symptoms after the last surgery, it would be reasonable to proceed with further surgery as long as claimant understood the risks. Dr. Hermens had not reviewed claimant's medical record or recent diagnostic tests.

On December 16, 1999, in light of the fact that three physicians (Drs. Nash, Misko and Hermens) had recommended surgery versus Dr. Calhoun's unwillingness to do surgery, Dr. Meier opined it was reasonable for claimant to find an MCO surgeon willing to do the recommended surgery. He also reported that claimant still required pain medication.

After receipt of claimant's medical records and diagnostic testing, on December 21, 1999, Dr. Hermens continued to opine that claimant required further surgery.

Dr. Anderson, claimant's attending psychiatrist, reported that claimant's psychological condition could be considered stable on January 31, 2000.

On March 20, 2000, claimant underwent a Disability Prevention Consultation (DPC). Claimant underwent both psychological and physical evaluations. Psychologically, Dr. Friedman, one of the DPC examiners, stated that there were multiple contraindications to a "successful invasive procedure." He further opined that it was unlikely that claimant would obtain "substantial and substantive" pain relief from an additional surgical procedure.

Dr. Smith, another DPC examiner, noted that, although claimant had pain complaints, he did not have an instability at L3-4 and that it was "highly unlikely" that another fusion would result in any significant long-term pain relief. In the summary portion of the DPC report, Drs. Smith and Friedman reported that they had reviewed their evaluations with Dr. Meier and that Dr. Meier had agreed with their assessments. Dr. Meier agreed to schedule claimant for a closing examination.

In an April 4, 2000 chart note, Dr. Meier opined that claimant's lumbar foraminal stenosis was medically stationary. Dr. Meier stated that it was not clear to him whether surgery would benefit claimant, but deferred to Dr. Calhoun for a decision on further surgery.

Based on the DPC examination and Dr. Meier's concurrence, SAIF issued its April 12, 2000 Notice of Closure, which it amended on April 14, 2000.

On April 12, 2000, SAIF requested that we authorize reopening of claimant's claim to provide for "continued coverage of .245 treatment including medications and office visits." We issued an April 27, 2000 Own Motion Order which reopened claimant's claim for the provision of the requested medical services only.

In a May 23, 2000 chart note, Dr. Meier requested another opinion from an approved neurosurgeon regarding further surgery to treat claimant's condition. He stated that if surgery was not a treatment option, then claimant would be considered medically stationary.

At Dr. Meier's request, SAIF scheduled an evaluation with Dr. Brett. On September 12, 2000, Dr. Brett reviewed claimant's medical record and conducted a physical examination. Dr. Brett noted that claimant did not have pseudoarthrosis. He agreed with Dr. Calhoun's November 15, 1999 report that no further surgery should be undertaken. Dr. Brett also concurred with Dr. Smith's March 20, 2000 findings and opined that claimant was medically stationary as of the April 4, 2000 closing examination with Dr. Meier. Finally, Dr. Brett opined that "I feel that consideration of further surgery would not be in [claimant's] best interest."

CONCLUSIONS OF LAW

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the April 12, 2000 Notice of Closure, as amended April 14, 2000, considering claimant condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 or App 7, 12 (1980).

Claimant relies on the opinions of Drs. Nash, Misko and Hermens to support his contention that he requires further surgery. Because Drs. Nash and Misko are not members of the managed care organization (MCO), they have not treated or seen claimant since 1998 and their opinions do not relate to claimant's compensable low back condition as it existed in April 2000, when his claim was closed. Dr. Hermens has only examined claimant once on a consultation basis. Dr. Hermens opined that the surgery recommended by Dr. Nash was reasonable and appropriate because of claimant's description of symptoms and because Dr. Nash had determined that he had pseudoarthrosis.

SAIF relies on the opinions of Drs. Calhoun, Smith, Friedman, Meier and Brett. In October 1999, Dr. Calhoun examined claimant on a referral from Dr. Meier. After additional diagnostic tests were performed, Dr. Calhoun reexamined claimant and discussed the test results. Neither the CT scan nor x-rays revealed that claimant had pseudoarthrosis that Dr. Calhoun felt needed to be present in order to establish a need for further surgery. He therefore opined that surgery was not appropriate treatment for claimant's low back condition.

In March 2000, Drs. Smith and Friedman, the DPC examiners, after reviewing claimant's medical record, the diagnostic test results and performing an in-depth examination of claimant concluded that surgery would not afford claimant any material improvement. As did Dr. Calhoun before him, Dr. Smith noted that claimant did not have an instability at L3-4 and that it was highly unlikely that a fusion at that level would provide him any significant, long-term pain relief. Additionally, Dr. Friedman indicated that from a psychological standpoint, there were "multiple contraindications to a successful invasive procedure." They opined that claimant was medically stationary as to his low back condition.

Dr. Meier, who assumed claimant's care in 1999, although agreeing with the DPC examiners and performing a closing examination on April 4, 2000, recommended that claimant be examined by an MCO surgeon to determine whether he required further surgery. At Dr. Meier's request, SAIF scheduled an evaluation with Dr. Brett.

Dr. Brett's September 12, 2000 report is "post-closure" medical evidence. However, we may consider "post-closure" medical evidence regarding the question of whether a claimant was medically stationary at the time of claim closure, as long as that evidence relates to the claimant's condition at the time of closure, no subsequent changes in the claimants condition. *Scheuning v. J.R. Simplot & Co.*, 84 Or App 622 (1987). In his report, Dr. Brett addresses the surgery issue, which is relevant regarding claimant's medically stationary status at closure. Dr. Brett explained that claimant does not have pseudoarthrosis and agreed with Dr. Calhoun's November 1999 opinion that no further surgery should be undertaken. He further concurred with Dr. Smith's March 2000 evaluation regarding the inappropriateness of the recommended surgery. Dr. Brett concluded that claimant was medically stationary on April 4, 2000 per Dr. Meier's closing examination.

When there is a dispute between medical opinions, we rely on those opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 or App 259 (1986). After our review of all opinions, we find that of Drs. Calhoun, Smith, Friedman and Brett most persuasive. All these physicians conducted in-depth medical examinations and reviewed all of claimant's medical records. They all agreed that unless claimant demonstrated that he had pseudoarthrosis, surgery would be inappropriate treatment for his compensable low back condition. All agreed that claimant was medically stationary at the time of closure.

We give less weight to the opinion of Drs. Nash, Misko and Hermens for the reasons stated above. Both Drs. Nash and Misko have not seen nor treated claimant since 1998 and have not reviewed the current diagnostic test results which dispute their assertion that claimant had pseudoarthrosis. Dr. Hermens relied on Dr. Nash's opinion rendered in 1998 (that claimant had pseudoarthrosis) to support his recommendation that claimant surgery was reasonable and appropriate treatment for his current low back condition. Also, none of these opinions address claimant's medically stationary status nor relate to claimants low back condition at the time of closure.

Accordingly, based on the opinions of Drs. Calhoun, Smith, Friedman and Brett, we find that claimant's condition was medically stationary on the date his claim was closed. Therefore, we conclude that the SAIF's closure was proper.

Accordingly, we affirm SAIF's April 12, 2000 Notice of Closure, as amended April 14, 2000, in its entirety.

Claimant's entitlement to medical services as authorized by our April 27, 2000 Own Motion Order is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALBERT R. STOAKS, Claimant
WCB Case No. 99-07281
ORDER ON REVIEW
Coughlin, Leuenberger & Moon PC, Claimant Attorney
VavRosky, et al, Defense Attorneys

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

Claimant requests review of Administrative Law Judge (ALJ) Menashe's order that: (1) upheld the self-insured employer's denial of his occupational disease claim for a skin condition; and (2) declined to assess a penalty for the employer's allegedly unreasonable delay in accepting or denying the claim. On review, the issues are compensability and penalties.

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

The ALJ upheld the employer's denial of claimant's occupational disease claim for a skin condition, relying on the medical opinion of an examining physician, Dr. Larsen, who attributed claimant's condition in major part to lifelong exposure to the sun, especially during claimant's youth. (Ex. 23). In doing so, the ALJ noted that another examining physician, Dr. Overly, also stated that "many people" feel that much sun damage occurs in youth and teenage years. (Ex. 19-3). According to the ALJ, this observation added validity to Dr. Larsen's theory of causation.

On review, claimant emphasizes that portion of Dr. Overly's opinion that attributed claimant's skin condition in major part to working outside since 1973 using a narrow brimmed plastic hard hat. (Ex. 19-4). We interpret this opinion to mean claimant's employment that required him to use a hard hat for safety purposes (which did not provide protection from the sun) was primarily reponsible for the damage to claimant's skin. Claimant argues that Dr. Overly's opinion is the most well-reasoned and satisfies claimant's burden of proving a compensable occupational disease. *See* ORS 656.802(2)(a); *Paul N. Lacey*, 52 Van Natta 13 (2000) (to establish a compensable occupational disease, the claimant must prove that employment conditions are the major contributing cause of the disease).

We disagree with claimant's contention. Not only did Dr. Overly observe that "many people" believe that much sun damage occurs during youth and teen age years, but Dr. Overly later made a more definitive comment after reviewing one of Dr. Larsen's reports. While Dr. Overly took issue with some of Dr. Larsen's statements, Dr. Overly, specifically indicated his agreement with Dr. Larsen's conclusion that "I [Dr. Larsen] believe that the major cause of [claimant's] sun damage including actinic keratoses is attributable to sun exposure that [claimant] has had all of his life *especially during his childhood.*" (Ex. 27-3, emphasis added).[1]

Given this, we are persuaded that Dr. Overly agrees with Dr. Larsen's basic conclusion that the majority of claimant's sun damage is due to lifelong sun exposure, especially that which occurred during claimant's childhood. Accordingly, we conclude that claimant failed to prove a compensable occupational disease claim. Thus, we affirm.

ORDER

The ALJ's order dated April 13, 2000 is affirmed.

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[1] We also note Dr. Overly's comment that claimant spent 1973 to 1999 in the sun "5 days a week, 8 hours a day." (Ex. 27-3). This was an apparent reference to claimant's employment exposure. We agree, however, with the employer that this assumption by Dr. Overly is questionable in light of claimant's testimony indicating that a substantial portion of his work day did not involve exposure to the sun. (Trs. 19-32). Therefore, to the extent that Dr. Overly's opinion can be interpreted to support compensability, we find that it is based on an inaccurate or incomplete history and, thus, is not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 478 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

Board Member Phillips Polich dissenting.

The majority affirms the ALJ's conclusion that claimant failed to prove a compensable occupational disease for a skin condition (actinic keratoses). Because I would find that claimant satisfied his burden of proof, I dissent.

At the outset, I agree with claimant that his occupational disease claim is not for his entire sun exposure, but rather for skin damage on his ears and the v-part of his neck. (Ex. 1). Dr. Larsen, on whose opinion the ALJ relied in finding that claimant failed to sustain his burden of proof, did not distinguish sun damage on the areas of claimant's body that were claimed from damage to the rest of claimant's body. Moreover, in opining that blistering sunburns accelerate the incidence of actinic damage, Dr. Larsen also erroneously assumed that, when claimant was sunburned as a child, he developed blisters all over, mostly on his face and neck. (Ex. 24A-16). However, claimant testified that he never had blisters or sunburn damage to his ears or v-necked part of his chest, the areas for which claimant filed his claim. (Tr. 8). Therefore, Dr. Larsen also had an inaccurate history and thus, his opinion should be discounted. *See Donald J. Murray*, 51 Van Natta 2052 (1999). Finally, Dr. Larsen indicated that most of the "chronic" sun damage was below claimant's forehead, involving the face, neck and ears. (Ex. 22-3). Those are precisely the areas that claimant testified were exposed to sun as a result of his work wearing a narrow-brimmed hat. Thus, Dr. Larsen's own examination supports compensability of the claim and does not support his conclusion that claimant's most damaging sun exposure occurred during his youth.

In light of these defects in Dr. Larsen's opinion, I would conclude that Dr. Overly's opinion is the most persuasive. Dr. Overly understood that claimant had been working outside for the employer since 1971 and that since 1973 claimant had to wear a plastic hard hat for safety reasons. Dr. Overly was also aware of claimant's off-the job exposure to sun and that claimant wore a wide brimmed hat while engaged in these activities. Further, Dr. Overly was aware that claimant had a severe sunburn at age 9. (Ex. 19).

Based on a complete and accurate history, Dr. Overly attributed claimant's skin condition to his work exposure since 1973 while wearing a narrow-brimmed hat. Inasmuch as it is well-reasoned and based on a complete and accurate history, Dr. Overly's opinion is the most persuasive on this record.[1] *See Somers v. SAIF*, 77 Or App 259, 263 (1986). It should also be noted that Dr. Severns, the attending physician, concurred with Dr. Overly's opinion. *See Weiland v. SAIF*, 64 Or App 810 (1983) (greater weight normally accorded the attending physician's opinion).

In conclusion, I believe the most persuasive medical evidence establishes that claimant's skin damage in the areas for which the claim was filed is fairly attributable to claimant's long-term employment using a narrow-brimmed hat. Thus, I would conclude that the occupational disease claim is compensable. Because the majority concludes otherwise, I respectfully dissent.

[1] It is also significant that Dr. Overly examined claimant on behalf of the employer. Thus, Dr. Overly cannot be accused of being biased in claimant's favor. In addition, it was only after Dr. Overly rendered an unfavorable opinion, that the employer arranged another examination performed by Dr. Larsen.

In the Matter of the Compensation of
BENJAMIN J. COOPER, Claimant
WCB Case No. 00-03146
ORDER ON REVIEW
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Tenenbaum's order that dismissed his 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.

ORDER

The ALJ's order dated June 27, 2000 is affirmed.

Board Member Phillips Polich specially concurring.

While I agree with the legal analysis applied by the ALJ, and I find that the Board is compelled by the law and our prior decisions to reach this result, I conclude that the outcome is not particularly just. Here, both SAIF and the employer were aware that claimant was residing at an address that was different than the one that had been previously provided by claimant on the 827 form. Nevertheless, the denial was mailed to claimant's former address. At a minimum, SAIF and the employer should have investigated to determine which of the two addresses was appropriate; however, that was not done in this case.

I believe that claimant did what was reasonable in this situation and the carrier did less than it could have done to obtain a correct address before it mailed the denial. Claimant has been penalized because he moved frequently during the period of time. Nevertheless, as stated above, I am bound by precedent to reach this result.

October 4, 2000 Cite as 52 Van Natta 1838 (2000)

In the Matter of the Compensation of
EDUARDO DIAZ, Claimant
Own Motion No. 00-0298M
OWN MOTION ORDER
Kryger, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for claimant's low back condition. Claimant's aggravation rights expired on May 20, 1982. SAIF recommends that we authorize the payment of temporary disability compensation.

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

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

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
CARL J. WYLLIE, Claimant
WCB Case No. C002201
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Welch Bruun & Green, Claimant Attorneys
Thomas A. Andersen, Defense Attorney

Reviewed by Board Member Biehl and Meyers.

On September 13, 2000, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, for payment of a stated sum, claimant released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we approve the proposed disposition.

Accompanying the CDA is a letter from the Compliance Section of the Department of Consumer and Business Services (DCBS). This letter states that the claim is not eligible to receive reimbursement from the Reemployment Assistance Program. On page 5, however, the agreement provides a signature block for the Director of DCBS.

In light of this apparent inconsistency, we have reached the following conclusion regarding the parties intentions. Although the agreement provides a signature line for the Director, because the claim does not qualify for re-imbursement, the signature block was left in the agreement in error. Under such circumstances, we find the agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board, and is not unreasonable as a matter of law. *See* ORS 656.236(1). Accordingly, the parties' CDA is approved. An attorney fee of $2,937.50, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD J. KEEL, Claimant
WCB Case No. 99-08409
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Peterson's order that: (1) set aside its denial of claimant's aggravation claim for a left arm condition; and (2) awarded claimant's counsel a $4,000 assessed attorney fee for prevailing over SAIF's denial. On review, the issues are aggravation and attorney fees.

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

Claimant's counsel is entitled to an assessed attorney fee for services on review. ORS 656.382(2). On review, claimant has requested an assessed attorney fee of $2,600. The insurer, argues, however, that a more appropriate fee in this case is between $1,000 and $1,200.

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

The issue on review in this case was whether claimant had established an aggravation of his left arm condition. Claimant's attorney submitted a 8 page brief. With his brief, claimants counsel submitted a request for a fee of $2,600, based on 13 hours of time devoted to the brief. The record contains 57 exhibits. The case involved a aggravation issue of above-average complexity. The value of the claim and benefits secured are significant in that we have affirmed the ALJ's determination that claimant's left arm condition claim will be reopened which may entitle claimant to further disability benefits and medical services. The parties' respective counsels presented their positions in a thorough manner. No frivolous issues or defenses were presented. Finally, considering the insurer's vigorous defense of the claim and the conflicting medical evidence, there was a risk on Board review that claimant's counsel's efforts might have gone uncompensated.

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

ORDER

The ALJ's order dated January 31, 2000 is affirmed. For services on review, claimant's counsel is awarded $2,275 as a reasonable assessed attorney fee, payable by the SAIF Corporation.

In the Matter of the Compensation of
KEVIN R. NELSON, Claimant
WCB Case No. 99-09731
ORDER ON REVIEW
Cramer & Mallon, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the SAIF Corporation's denial of his claim for multiple injuries. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated April 21, 2000 is affirmed.

Board Member Phillips Polich specially concurring.

Although I concur with the result in this case, I reach the decision for different reasons than the ALJ and the majority.

ORS 656.005(7)(b)(C) provides that a compensable injury does not include:

> "Injury the major contributing cause of which is demonstrated to be by a preponderance of the evidence the injured worker's consumption of alcoholic beverages or the unlawful consumption of any controlled substance, unless the employer permitted, encouraged or had actual knowledge of such consumption."

The statute requires the weighing of the evidence to determine whether the preponderance of the evidence establishes that the alcohol use is the major contributing cause of the injury. The statute does not equate an elevated blood alcohol level with a conclusion that the alcohol use is the major contributing cause of the injury.

Based on this record, I agree that SAIF has met its burden of proof. In this regard, the medical evidence is unrebutted that claimant's blood alcohol level (BAL) of .17 two hours after the injury caused impairment. In addition, there is no allegation that the testing procedure was faulty or inaccurate, or any alternative explanation for claimant's elevated BAL.

I find this case troubling because the lay witness testimony conflicts with the medical evidence. The lay testimony established that claimant displayed no signs of intoxication prior to the injury. In addition, there is no evidence that claimant drank on a regular and heavy basis or had a significant tolerance to alcohol.

I also have concerns about Dr. Jacobsen's report and testimony. Dr. Jacobsen is an addiction specialist who was relied upon by the ALJ. Dr. Jacobsen stated:

> "Although [claimant's] high BAL [blood alcohol level] is the major source of impairment in this case, it is probable that there are several additive and contributing types of physical and mental impairments including:
>
> "1. Hangover/toxic effects associated with very heavy alcohol consumption. Hangover effects include reduced awareness, attention and concentration. Reaction times will be delayed.
>
> "2. Fatigue/sleep deprivation. [Claimant] slept a maximum of about 6 hours. Given the amount of fluid he consumed, he would have needed to awaken at least several times during the night to urinate." (Ex. 12-7).

Dr. Jacobsen bases his opinion in part on the assumption that the effects of alcohol on claimant were amplified by lack of sleep caused by frequent urination during the previous night. However, there is no evidence that establishes that claimant experienced sleep deprivation for this reason.

Dr. Jacobsen also opined that there was no evidence that claimant had developed a tolerance to alcohol and that, at 7 a.m. on the morning of the accident, he would have had a BAL of about 0.20 gm% and would have exhibited many visible signs of impairment including swaying (poor balance) and difficulty walking. In addition, Dr. Jacobsen indicated that claimant's speech would have been slowed and thick with probable slurring. This opinion is contradicted by the testimony of Mr. Berry, the foreman, who did not observe any problems with claimant's speech and noted that claimant did not sway, fall or stagger.

Although Dr. Jacobsen uses magic words in his opinion, my reading of his opinion in its entirety is that he would testify that an elevated blood alcohol level of .08 or higher would equate to a conclusion that alcohol was the major contributing cause of the injury. Because ORS 656.005(7)(b)(C) does not equate elevated blood alcohol levels to the major contributing cause, but rather requires a weighing of the evidence, I would not find Dr. Jacobsen's opinion alone enough to meet SAIF's burden of proof. However, when this record is reviewed in its entirety, I find SAIF met its burden of proof.

October 4, 2000 Cite as 52 Van Natta 1842 (2000)

In the Matter of the Compensation of
RAMONA ZARAGOZA, Claimant
WCB Case No. 00-01512
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its *de facto* denials of claimant's cervical strain and left shoulder impingement conditions; and (2) assessed a penalty for its alleged failure to process those claims. On review, the issues are compensability and penalties.

We adopt and affirm the ALJ's order. *See Fred Meyer, Inc. v. Crompton*, 150 Or App 531 (1997) (a consequential condition under ORS 656.005(7)(a)(A) is "a separate condition that arises from the compensable injury" and "not different occurrences of the same condition."); *Clarence A. Myers*, 45 Van Natta 1471, 1472 (1995) ("The passage of time alone does not necessarily mean that a late-developing condition is an indirect consequence of a compensable injury").

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,472.50, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 1, 2000 is affirmed. For services on review, claimant is awarded a $1,472.50 attorney fee, to be paid by the insurer.

In the Matter of the Compensation of
GERALD L. ANTILLA, Claimant
WCB Case No. 99-10149
ORDER ON REVIEW
Nicholas M. Sencer, Claimant Attorney
Hoffman, Hart & Wagner, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Poland's order that upheld the self-insured employer's denial of claimant's neck injury claim. On review, the issue is compensability.

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

Claimant disagrees with the ALJ's finding that claimant's treating surgeon, Dr. Franks, did not provide a sufficiently persuasive opinion to carry his burden of proof. Along with the ALJ's analysis of the medical evidence, we find the following reasoning supports the ALJ's conclusion.

First, the record shows that Dr. Franks examined claimant one time.[1] Thus, Dr. Franks did not have extensive contact with claimant.

Turning to his reports, when first requesting surgery authorization, Dr. Franks stated that he was "treating for stenosis." (Ex. 11). Dr. Franks' next report explained that "the accident of March 9, 1999, is the major reason why this man has symptoms, and made his spinal cord stenosis become clinically manifest." (Ex. 12A-3). Dr. Franks added that "the injury directly did result in the disc bulging per se." (*Id.*)

The last report is a summary from claimant's attorney. Dr. Franks agreed that claimant has preexisting age-related degeneration and that claimant's symptoms following the accident were consistent with "trauma to the C4-5 and C5-6 levels superimposed on the preexisting natural degeneration." (Ex. 20-1). The report then explained that the preexisting degeneration is the major contributing cause of the combined condition. (*Id.* at 2). Because the accident "pathologically worsened the preexisting condition" at the C4-5 and C5-6 discs by increasing the size of the bulging discs, Dr. Franks considered the accident as being the "major contributing cause of the need for treatment of the C4-5 and C5-6 discs." (*Id.*)

Looking at these reports together, it is not clear what Dr. Franks considered as the need for treatment because he initially implicated stenosis and then discussed the bulging discs. Furthermore, Dr. Franks inconsistently explained the effects of the injury by first stating that the accident caused the disc bulges and then finding that the event only increased the size of the disc bulge.

Because of these inconsistencies, we are not persuaded by Dr. Franks' subsequent distinction between the major contributing cause of the "combined condition" and the major contributing cause of the "need for treatment"; in other words, because Dr. Franks at different times implicated stenosis as the "combined condition" and the "need for treatment," we find that his opinion is not well-reasoned.

ORDER

The ALJ's order dated May 30, 2000 is affirmed.

[1] Dr. Franks also performed carpal tunnel syndrome surgery, a condition that is not at issue here.

In the Matter of the Compensation of
RAYMOND D. BARNES, Claimant
WCB Case No. 99-0592
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers, Bock and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of claimant's injury claim for a consequential depression condition. On review, the issue is compensability.

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

There is persuasive evidence that claimant's accepted "back pain" contributes to his depression. However, claimant's treating psychologist does not adequately explain her conclusion that claimant's pain contributed more to his depression than did other factors, including personality traits and workplace conflicts. (*See* Exs. 12, 43). Under these circumstances, we find the evidence supporting the claim unpersuasive and we agree with the ALJ that claimant has not proven that his 1988 back injury is the major contributing cause of his depression.

ORDER

The ALJ's order dated June 5, 2000 is affirmein

Board Member Phillips Polich dissenting.

SAIF accepted claimant's 1988 injury claim for back pain. (Ex. 2). Claimant returned to work after his injury, but his pain continued. In 1997, he consulted Dr. Tucker-McFarland, psychologist, because of problems dealing with pain, work, and family issues. Dr. Tucker-McFarland diagnosed depression, provided treatment, and opined that claimant's injury-related pain was the major contributing cause of his depression.

The majority finds Dr. Tucker-McFarland's causation opinion inadequ explained. I disagree.

Dr. Tucker-McFarland examined and treated claimant about 40 times. She had an accurate and complete history regarding claimant's symptoms, personality traits, and his stressors, on and off work. Considering claimant's presentation, his reporting, and his clinical progression with treatment, Dr. Tucker-McFarland opined that claimant's back pain was the major contributing cause of his depression. (Exs. 36, 43, 45).

Dr. Tucker-McFarland explained that claimant's depression and anxiety also contributed to his pain and his difficulty dealing with work and off work stress. (*See* Ex. 45-5). She was clearly aware of the factors contributing to claimant's depression and she considered and weighed all of them. Her reasoning regarding the interaction between contributing causes is thorough and persuasive.

Considering Dr. Tucker-McFarland's advantageous position as claimant's treating psychologist, her accurate and complete history, and her well-reasoned causation opinion, I would find her conclusions persuasive and rely on them. I would also stress that the fact that claimant's pain-related depression is a cause, as well as an effect, of his on-going problems (including chronic back pain) certainly should not weigh against his claim for consequential depression. For these reasons, I must respectfully dissent.

In the Matter of the Compensation of
STEPHEN A. BEAN, Claimant
WCB Case No. 99-07287
ORDER ON REVIEW
Popick & Merkel, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the SAIF Corporation's partial denials of claimant's cervical condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplement to address claimant's contention that the ALJ incorrectly concluded that claimant's cervical condition was not compensable.

The ALJ determined that the medical record did not contain an opinion supporting claimant's contention that the work incident of December 1998 was the major contributing cause of his disability or need for treatment for the "combined" cervical conditions. Consequently, the ALJ concluded that claimant had not established the compensability of the cervical conditions.

The parties agree with the ALJ's conclusion that claimant's cervical condition is a "combined condition" under the terms of ORS 656.005(7)(a)(B). (Appellant's Brief, 2; Respondent's Brief, 2). Therefore, the major contributing cause standard applies to this claim.[1]

To satisfy the "major contributing cause" standard, claimant must establish that his work incident of December 1998 contributed more to the disability or need for treatment of the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disability or need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). The fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or its need for treatment. *Dietz*, 130 Or App at 401; *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997); *Elaine M Baxter*, 51 Van Natta 1898 (1999).

Because of the possible alternative causes for his cervical condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

Claimant has been seen by five doctors who have rendered opinions on causation: (1) Dr. Kane, the attending physician; (2) Dr. Silver, the neurosurgeon who performed claimant's cervical laminectomy; (3) Drs. Coletti and Platt, SAIF-arranged medical examiners; and (4) Dr. Frank, a consulting neurologist.

Drs. Silver, Coletti, and Platt opined that the work injury is not the major contributing cause of claimant's cervical condition. (Exs. 13-12; 25; 30-7).

Dr. Frank opined: "I think he had pre-existing degenerative changes in his cervical spine and somehow with the injury that provoked the lumbar problem, he has had a spinal injury in the cervical region." (Ex. 20-3). Later Dr. Frank opined: "This gentleman has had an injury that I believe provoked pre-existing degenerative changes in the cervical spine. It is my opinion to a reasonable medical probability that the need for surgery resulted from the injury." (Ex. 26-1).

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[1] Claimant suffered a compensable injury to his low back in December 1998. The low back injury has been accepted. At issue is the compensability of a "combined" cervical condition (*i.e.*, a cervical injury that combines with a preexisting degenerative condition) alleged to have occurred as a part of the same incident that resulted in claimant's compensable low back condition.

Dr. Frank does not otherwise explain his opinion, nor does he offer any evaluation of the relative contributions of the preexisting degenerative changes and the work injury to produce claimant's need for surgery. Consequently, we find that, while Dr. Frank's opinion supports a conclusion that claimant's work injury was the precipitating cause of claimant's symptoms or need for treatment of the cervical condition, his opinion does not support the conclusion that the work incident was the major contributing cause of the disability from the cervical condition or its need for treatment.

Dr. Kane initially indicated, in a "check-the-box" concurrence, that he agreed with the opinions of Drs. Coletti and Platt. (Ex. 19). Later he opined: "In my judgement the pre-existing conditions are more than 51 percent responsible for the cervical cord contusion. Such an injury would not be expected in an individual with a more normal cervical spine undergoing an on-the-job injury such as claimant described." (Ex. 26A-2). Dr. Kane restated his opinion in a letter to claimant's counsel and in his deposition. (Ex. 28; 29-15).

On March 3, 2000, Dr. Kane wrote: "[T]he major impairment here, the cervical myelopathy, does in fact seem related in the majority to claimant's industrial injury. . . . He and the spinal stenosis were getting along just fine until the event in question." (Ex. 37). Dr. Kane's change of opinion is not further explained. Accordingly, we do not find it persuasive and do not rely upon it. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

Moreover, Dr. Kane, like Dr. Frank, does not offer any evaluation of the relative contributions of the preexisting degenerative changes and the work injury to produce claimant's cervical myelopathy. Consequently, at best, Dr. Kane's changed opinion supports a conclusion that claimant's work injury was the precipitating cause of claimant's symptoms or need for treatment of the cervical condition. His opinion (assuming we found it persuasive) does not support the conclusion that the work incident was the major contributing cause of the disability or need for treatment for claimant's combined cervical condition.

In conclusion, we agree with the ALJ that, based on this record, claimant has not established the compensability of his cervical condition.[2] *See* ORS 656.266; ORS 656.005(7)(a)(B).

ORDER

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

[2] We acknowledge claimant's contention that this case is similar to *Carol A. Bryant*, 51 Van Natta 1827 (1999), in which we found that the claimant's work injury was the major contributing cause of a combined cervical condition. The record in *Bryant* contained persuasive medical opinions supporting the claimant's contentions. Here, there is no such opinion. Therefore, *Bryant* is distinguishable.

In the Matter of the Compensation of
DANIEL B. COVERT, Claimant
WCB Case No. 00-01535
ORDER OF ABATEMENT
Welch, Bruun & Green, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requests abatement and reconsideration of our September 14, 2000 order that affirmed the Administrative Law Judge's order modifying an Order on Reconsideration to award temporary total disability benefits from March 2, 1998 through March 10, 1999. SAIF argues that pursuant to ORS 656.262(4)(d), temporary disability is not due for the period in question.

In order to consider SAIF's motion, we withdraw our September 14, 2000 order. Claimant is granted an opportunity to respond to SAIF's motion. 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
GERALD H. FAWCETT, Claimant
WCB Case No. 00-01322
ORDER ON REVIEW
Parker, Lane & Bush, Claimant Attorneys
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock and Phillips Polich.

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

FINDINGS OF FACT

Claimant was 23 years old at the time of hearing. In May 1998, claimant injured his low back and sought medical treatment. (Ex.8). He was released to regular work in June 1998. (*Id.*)

In July 1999, claimant lived in California and visited his aunt and uncle in Oregon. (Tr. 4). Claimant's uncle, Mr. Bryngelson, was the president of a hardwood floor business. In August 1999, claimant moved to Oregon and began working for his uncle as a hardwood floor installer helper. (Tr. 5, Ex. 2). Claimant's job duties involved installing hardwood floors and moving and carrying heavy materials. (Tr. 5). He moved boxes of wood weighing 50 to 60 pounds each. (Tr. 6). Claimant testified that he did not have any physical problems before working for the employer and he worked out with weights on a regular basis. (Tr. 4-6). Claimant left his job in November 1999 and moved to California on December 2, 1999. (Ex. 2, Tr. 16).

On January 5, 2000, claimant signed an "801" form, indicating he had injured his lower back while working for the employer on October 19, 1999. (Ex. 3). In response to whether he had previously injured that body part, claimant answered "no." (*Id.*) Claimant indicated that he had been moving a box of wood flooring when he felt a pain in his lower back and leg. (*Id.*)

On January 20, 2000, SAIF denied claimant's low back injury claim on the grounds that there was insufficient evidence that his injury arose out of or within the course of his employment, and that his injury had not resulted in any treatment or disability. (Ex. 5).

Claimant sought treatment from Dr. Kramer on February 2, 2000. (Ex. 5A). Dr. Kramer felt that claimant had right sciatica and may have herniated a disc. (Ex. 6).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant's work activities on October 21, 1999 were a material contributing cause of his right sciatica and low back condition. The ALJ found that, because claimant did not file his claim form until December 1999, his confusion about the exact date of the injury was understandable. Although the ALJ found that claimant's testimony revealed some minor inconsistencies, he found they were explained by claimant's youthful naivete, his failure to recognize the significance of events, his insistence that a serious injury had not occurred or that medical treatment was needed, and incomplete reporting.

SAIF argues that claimant did not sustain his burden of proving that he was injured at work. SAIF contends that claimant's testimony is not reliable and it is inconsistent with his own prior statement, as well as the employer's testimony.

The issue is whether claimant injured his back at work on or about October 19, 1999. Although the ALJ apparently relied on claimant's testimony, he did not make any express credibility findings regarding any of the witnesses. 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). Even minor inconsistencies can be a sufficient basis to disagree with the ALJ's credibility determination, particularly where factual inconsistencies in the record raise such doubt that we are unable to conclude that testimony of a witness is credible. *See, e.g., Debra L. Taylor*, 51 Van Natta 676 (1999).

In his "801 " form, claimant alleged that he had injured his lower back on October 19, 1999. (Ex. 3). He indicated he had been moving a box of wood flooring when he felt a pain in his lower back and leg. (*Id.*)

In a January 11, 2000 letter to SAIF, claimant explained how he injured his back at work on October 19, 1999:

> "This particular day I was given a list to move approxitmately [sic] 100 boxes of wood, each wheighing [sic] at least 50 lbs or more to a specific unit including heavy equipment up to the third floor which we were working on. It was the wrong unit and I ended up lifting all the wood back to the correct unit. No other employee would help me carry these heavy boxes of wood. After, lifting several cases of wood, I felt a serve [sic] sharp pain in my lower back shooting down into my leg. I thought I had pulled a muscel [sic] in my back which has happened before, and continued to work. I had to stop and lay on the floor because of the pain in my back. A co-worker named Matt came over to me to see why I was on the floor. I told him what had happened, I was lifting these boxes of wood and suddenly had this server [sic] sharp pain in my low back and it went down into my leg. I rested for awhile then continue to work. I didn't report it that day to my employer because I didn't see him or talk with him for several days until the job I was working on was completed. As several days went by the pain continued." (Ex. 4).

We find that claimant's testimony at hearing was materially inconsistent with his January 11, 2000 letter. At hearing, claimant explained that he was lifting and moving wood when he experienced pain in his back and down into his right leg. (Tr. 7-8). No witnesses saw claimant when he was injured. (Tr. 9). Claimant said that he stretched a couple of times and it seemed to go away, so he kept working. (*Id.*) The next morning, however, he could not get up. (*Id.*)

In his January 11, 2000 letter, claimant explained that he was injured at work lifting the boxes of wood and felt a severe sharp pain in his lower back shooting down into his leg. (Ex. 4). He thought he had pulled a muscle, but he continued to work. (*Id.*) However, he had to stop and lay on the floor because of the back pain. (*Id.*) Claimant said that a co-worker named Matt came over to him to see why he was on the floor and claimant told him what had happened. (*Id.*)

Claimant's testimony at hearing that he kept working after the injury is inconsistent with his January 11, 2000 statement that he had to lay on the floor because of the back pain. Furthermore, although claimant's written statement said that Matt came over to see why he was on the floor on the day of injury (Ex. 4), claimant testified that he told Matt about the injury "a couple days after" it had occurred. (Tr. 9). In addition, claimant acknowledged at hearing that the employer's records showed that on October 19, 1999, he was working with Mark, not Matt. (Tr. 7, Ex. 8A). Claimant's "801" form referred to the date of injury as October 19, 1999, as did his January 11, 2000 letter. (Exs. 3, 4). Claimant also told Dr. Kramer that his injury occurred on October 19, 1999. (Ex. 6). Even if we assume that claimant was mistaken about the date of injury, however, claimant's inconsistent statements about his symptoms immediately after the injury and when he told "Matt" about the injury, cast considerable doubt on his credibility.

Claimant argues that he was not "sworn" in the January 11, 2000 letter. There is no evidence that claimant objected to the admission of the January 11, 2000 letter. In any event, the fundamental problem for claimant is that he did not provide an explanation of why his testimony and the January 11, 2000 letter are inconsistent. Claimant has the burden of proving that his injury is compensable. ORS 656.266.

Furthermore, claimant's testimony about his report of injury to the employer is inconsistent with the employer's testimony. At hearing, claimant initially said that his first conversation with Mr. Bryngelson regarding his back injury at work occurred about a week after the injury. (Tr. 14). Claimant subsequently testified that he had "hinted it was related to work." (Tr. 15).

Mr. Bryngelson's testimony contradicts claimant's testimony. Mr. Bryngelson testified that claimant called him on November 8, 1999 and told him he needed a couple days off because he was sore. (Tr. 35, 42). Mr. Bryngelson said he asked claimant if had been hurt at work and he said "no." (Tr. 35). Similarly, on November 10, 1999, Mr. Bryngelson said he asked claimant if he had been hurt at work and claimant again said "no." (Tr. 36). Mr. Bryngelson said that claimant never told him how he hurt his back. (*Id.*) Mr. Bryngelson testified that claimant said on one other occasion that he had not been injured at work. (Tr. 36, 37).

Claimant's testimony and Mr. Bryngelson's testimony are also inconsistent in another respect. Claimant said he had about ten conversations with Mr. Bryngelson about his back and was never told by Mr. Bryngelson that he should see a doctor. (Tr. 15). After Mr. Bryngelson testified that he had recommended that claimant see a doctor (Tr. 40, 43), however, claimant then testified that Mr. Bryngelson *had* told him to see a doctor. (Tr. 57).

In summary, we find that claimant's testimony is materially inconsistent with his own written statement. His testimony is also materially inconsistent with Mr. Bryngelson's testimony. In addition, there are other discrepancies. In his "801" form, claimant indicated he had injured his lower back on October 19, 1999. (Ex. 3). In response to whether he had previously injured that body part, claimant answered "no." (*Id.*) Claimant's "801" statement is inconsistent with the medical record, which indicated that he had sustained a low back injury in May 1998, for which he sought medical treatment. (Ex. 8). Claimant did not explain this discrepancy.

Based on the material inconsistencies in the record, we are not persuaded that claimant was a credible witness. Moreover, because there is no other evidence to corroborate claimant's contention that he injured himself at work on or about October 19, 1999, he did not meet his burden of proof pursuant to ORS 656.266. *See L. C. Durette*, 52 Van Natta 410 (2000).

Finally, because the expert medical evidence in this case is based on claimant's history and we have found that claimant is not credible, it follows that the medical evidence is not based on a complete or accurate history. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977). Therefore, claimant has also failed to meet his burden of proving medical causation.

ORDER

The ALJ's order dated May 30, 2000 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

Board Member Phillips Polich dissenting.

The majority finds that claimant failed to sustain his burden of proving that his low back condition is compensable. Because I agree with the ALJ's analysis and would affirm his determination that the back injury is compensable, I dissent.

To begin, *all* of the witnesses who testified in this case stated that claimant described low back problems within one to two weeks after the October 1999 injury date. It is important to focus on the family relationships in this case. Even Mr. and Mrs. Bryngelson, claimant's aunt and uncle, testified that claimant told them his back was sore within about a week of the injury date. Claimant testified that he was hesitant to file a claim because his uncle and employer, Mr. Bryngelson, had complained about the cost of labor and claimant did not want to cause any problems. (Tr. 10-11). Furthermore, I agree with the ALJ's finding that claimant failed to tell his coworkers about the injury (except Matt) because he did not want to appear weak at work. The ALJ provided well-reasoned explanations for the minor inconsistencies in the record.

Although the majority focuses on the ALJ's failure to make express credibility findings, it is quite clear that the ALJ found that claimant was a credible witness and the ALJ did *not* rely on Mr. Bryngelson's testimony. We generally defer to the ALJ's determination of credibility when it is based on the ALJ's opportunity to observe the witnesses. *Coastal Farm Supply v. Hultberg*, 84 Or App 282, 285 (1987). I believe the ALJ is in a much better position to assess the credibility of claimant and other witnesses and the ALJ's determination is entitled to considerable weight. I would defer to the ALJ's findings.

The majority clearly errs by ignoring the testimony of some critical witnesses. The ALJ found that the testimony of claimant's mother and his good friend, Mr. Hardenburg, tipped the scale in claimant's favor. They both testified that claimant informed them that he had been injured at work within a week or two of its occurrence. Those witnesses consistently maintained that explanation for claimant's low back and right leg pain throughout the end of 1999. The ALJ correctly found that the testimony of claimant's mother and Mr. Hardenburg, along with claimant's testimony, was sufficient to overcome Mr. Bryngelson's testimony that claimant had denied any work injury. Unlike the majority, the ALJ carefully weighed *all* of the evidence and concluded that claimant had established that his October 21, 1999 work injury was a material contributing cause of his low back and right leg condition.

In conclusion, the ALJ's order was well-reasoned, legally sound and supported by the entire record. I strongly disagree with the majority's decision to reverse the ALJ's order. For the foregoing reasons, I dissent.

In the Matter of the Compensation of
SUSAN E. HARPER, Claimant
Own Motion No. 00-0043M
OWN MOTION ORDER
Allison Tyler, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer submitted claimant's request for temporary disability compensation for her compensable bilateral wrist condition. Claimant's aggravation rights expired on September 28, 1997. The insurer opposed reopening on the grounds that: (1) the current condition was not causally related to the accepted condition; and (2) claimant was not in the work force at the time of disability. In addition, the insurer issued a denial of the responsibility for claimant's current wrist condition. Claimant requested a hearing with the Hearings Division. (WCB Case No. 00-01047).

On April 7, 2000, we consolidated this own motion matter with the pending hearing. If the Administrative Law Judge (ALJ) found claimant's current condition causally related to the accepted injury, we requested that the ALJ make findings of fact and conclusions of law regarding whether claimant was in the work force at the time her condition worsened.

On July 17, 2000, ALJ Lipton issued an Opinion and Order, which set aside the insurer's denial. In doing so, ALJ Lipton found that claimant's current wrist condition was causally related to the September 1992 compensable injury. The ALJ's order has not been appealed.

Furthermore, ALJ Lipton found that claimant had returned to work on March 20, 2000 and work for approximately two and one-half months. The record demonstrates that claimant left her employment in June 2000 for reasons unrelated to her compensable injury. In light of the causal relationship between claimant's compensable injury and her need for surgery, ALJ Lipton recommended that claimant's claim be "reopened" for workers' compensation benefits at such time claimant undergoes surgery or hospitalization. Based on the record, ALJ Lipton noted that he was unable determine what benefits claimant would be entitled to under ORS 656.278.

Following the ALJ's July 17, 2000 order, we requested the parties' written positions regarding the ALJ's recommendation. Claimant reasserted that she is entitled to temporary disability benefits beginning when she has her surgery. The insurer contended that claimant had not demonstrated that she was in the work force at the time of the current worsening. Based on the following reasoning, we agree with claimant's contention.

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

On April 20, 2000, claimant underwent an insurer arranged medical examination (IME). The IME physicians noted that there was objective evidence demonstrating a worsening of claimant's bilateral wrist condition to justify surgical intervention. Thus, we conclude that claimant's compensable injury has worsened requiring surgery.

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

The insurer contended that claimant was not in the work force at the time of the current disability. In response to the insurer's contention, claimant has submitted various paystubs dating from July 2000 through September 2000 and copies of her 1999 W-2 tax form, which she contended demonstrates her presence in the work force at the time of the current worsening.

However, we have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's Own Motion jurisdiction,[1] is the date she enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish she was in the work force is the time prior to April 20, 2000, when her condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Paul M Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

The ALJ found that claimant was employed in March 2000 and remained employed for approximately two and one half months.[2] That finding is unrebutted. Inasmuch as claimant was working prior to April 20, 2000, when surgery was first recommended, we find that she was in the work force at the time of her current disability.

Accordingly, we authorize the reopening of claimant's 1992 injury claim to provide temporary disability compensation beginning the date claimant is hospitalized for surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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[1] The Board in its Own Motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

[2] Claimant's submission demonstrates that she reentered the work force in July 2000 and has remained employed. However, as noted above, the relevant period of time for which claimant must establish she was in the work force is the time prior to April 20, 2000, when surgery was first recommended.

In the Matter of the Compensation of
MYRNA GARDNER, Claimant
WCB Case Nos. 99-07634 & 99-04687
SECOND ORDER ON RECONSIDERATION
Ranson & Gilbertson, Claimant Attorneys
Stoel Rives LLP, Defense Attorney

Claimant requests reconsideration of our March 14, 2000 Order on Reconsideration, which republished our July 28, 2000 order that adopted and affirmed the Administrative Law Judge's order which: (1) upheld the self-insured employer's partial denial of her left ankle pain over dorsum; and (2) reduced her scheduled permanent disability award for the loss of use or function of her left foot (ankle) from 19 percent (25.65 degrees), as awarded by an Order on Reconsideration, to zero.

Claimant contends that our order should be reversed to set aside the employer's partial denial of her left ankle pain over dorsum. With her brief, claimant has attached a document dated September 22, 2000 from Dr. Thrall entitled "Aftercare Instructions for Workers Injured on the Job."

Again, our review must be based on the record certified to us. *See* ORS 656.295(5). Because claimant's brief refers to evidence not offered and admitted at hearing (and therefore not certified to us), we construe her submissions as a motion to remand to the ALJ for the taking of additional evidence. We deny such motion.

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing and is likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641 (1986).

Although this evidence was not available at the time of hearing, in light of the existing documentary and testimonial evidence already present in the record, we find that consideration of this additional evidence would not likely affect the outcome of the case. Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Accordingly, it does not merit remand. *See* ORS 656.295(5).

As we discussed in our September 19, 2000 order, the ALJ concluded in her January 14, 2000 Opinion and Order that the persuasive medical evidence provided by Dr. Thrall, claimant's attending physician, establishes that claimant's current pain over dorsum condition is not related to the accepted ankle sprain condition. We adopted and affirmed the ALJ's order with respect to both impairments. By adopting the ALJ's order, we addressed claimant's arguments concerning the compensability of the pain over dorsum condition and we continue to adhere to the conclusions reached in our prior decision. *See, e.g., Jorge Pedraza*, 49 Van Natta 1019 (1997).

Accordingly, we withdraw our prior orders. On reconsideration, after reconsidering the record in light of claimant's second motion, we continue to adhere to the conclusions reached in our prior decisions.

Consequently, on reconsideration, as supplemented herein, we republish our July 28, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.[1]

IT IS SO ORDERED.

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

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

In the Matter of the Compensation of
WILLIAM J. KANEHL, Claimant
WCB Case No. 99-07697
ORDER ON REVIEW
Pamela A. Schultz, Claimant Attorney
Scheminske, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Mills' order that set aside an Order on Reconsideration as premature. On review, the issue is premature closure. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following correction. We replace the ninth paragraph of the ALJ's findings of fact with the following:

As part of the reconsideration process, claimant's attorney submitted a report from Dr. Winans, claimant's attending physician. (Ex. 69). Dr. Winans indicated that his "current treating diagnosis" for claimant's low back condition was: "Lumbar Disc Syndrome, Sciatica, Multiple Trigger Points, Somatic Dysfunction Cervical, Dorsal, Lumbar." (Ex. 69-1). He checked a box indicating that claimant was not medically stationary and explained: "[Claimant] has current ongoing active symptomotology [sic] that may improve with serial epidural injections." (Ex. 69-2).

CONCLUSIONS OF LAW AND OPINION

On September 17, 1998, claimant sustained a compensable low back injury while digging a hole. On July 23, 1999, the insurer closed claimant's claim by a Notice of Closure that declared claimant medically stationary as of June 4, 1999, and awarded temporary and unscheduled permanent disability benefits for claimant's low back condition. (Ex. 65).

Claimant requested reconsideration, asserting, among other things, that his claim had been prematurely closed. (Ex. 68). On September 28, 1999, an Order on Reconsideration issued that, among other things, affirmed the medically stationary date. (Ex. 73).

Claimant requested a hearing, raising premature closure as the sole issue regarding the Order on Reconsideration. The ALJ set aside the insurer's closure as premature. The insurer requested review of that portion of the ALJ's order.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The propriety of the closure turns on whether claimant was medically stationary at the time of the July 1999 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1965). Claimant bears the burden of proving that he was not medically stationary at claim closure, based on competent medical evidence. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981); *Harmon v. SAIF*, 54 Or App 121, 125 (1981).

Several physicians have rendered opinions regarding claimant's medically stationary status. On February 2, 1999, Dr. Radecki, M.D., and Dr. Scheinberg, orthopedist, examined claimant on behalf of the insurer and opined that claimant was medically stationary at that time. (Ex. 53-7). They also noted that claimant had degenerative disc disease at a number of lumbar levels, unrelated to his work. (Ex. 53-5).

Dr. Winans, claimant's attending physician, referred claimant to Dr. Slack, M.D., who performed four epidural injections, the last two occurred on April 14, 1999, and June 26, 1999. (Exs. 46, 48, 57, 61). Claimant also participated in a work hardening program from May 5, 1999 through June 3, 1999. (Exs. 59, 60). Upon completion of this program, in a June 4, 1999 "discharge summary" report, Dr.

Morton, M.D., declared claimant medically stationary as related to his work injury, noting that no further diagnostic studies or curative treatments were recommended. (Ex. 60-1, -4). She also noted that, based on claimant's preexisting degenerative disc disease, it was not recommended that claimant return to his at-injury work. (Ex. 60-5).

Dr. Winans was sent a copy of Dr. Morton's June 4, 1999 report and asked whether he agreed with the findings. (Ex. 62). Dr. Winans indicated that he agreed, but he added the following comment: "On trial basis. [Claimant] continues to have aggravation of symptoms with only minimal activity." (*Id.*).

As part of the reconsideration process, claimant's attorney asked Dr. Winans' opinion regarding claimant's medically stationary status. (Ex. 69). On August 13, 1999, Dr. Winans responded by checking a box indicating that claimant was not medically stationary and explaining: "[Claimant] has current ongoing active symptomotology [sic] that may improve with serial epidural injections." (Ex. 69-2).

As noted by the ALJ, a medical arbiter examined claimant as part of the reconsideration process but offered no opinion regarding claimant's medically stationary status. (Ex. 71, 72).

On this record, we do not find that claimant has met his burden of proof. Only Dr. Winans' opinions might support claimant's position that he was not medically stationary at closure. However, Dr. Winans' strongest statement is that claimant's current symptoms "may" improve with epidural injections. But the statutory standard that claimant must meet to prove his condition was not medically stationary is that "further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). The "possibility" of improvement is not sufficient to establish a reasonable expectation of material improvement. *Gormley v. SAIF*, 52 Or App 1055, 1059-60 (1981) (probability, not possibility, is the requisite standard of proof); *Richard M. Mazza*, 52 Van Natta 28 (2000).

Moreover, while we realize that use of "magic words" or statutory language is not required where the record as a whole satisfies claimant's burden of proof, here, the record as a whole does not satisfy claimant's burden of proof. *See McClendon v. Nabisco Brands, Inc.*, 77 Or App 412 (1986). Furthermore, we note that a need for continuing medical treatment does not necessarily prove that a claimant was not medically stationary at claim closure. *See Maarefi v. SAIF*, 69 Or App 527, 531 (1984); *Kenneth W. Meyers*, 41 Van Natta 1375 (1989).

Accordingly, we disagree with the ALJ's determination that the claim was prematurely closed. Thus, we reverse.

ORDER

The ALJ's order dated May 16, 2000 is affirmed in part and reversed in part. That portion of the order that set aside the Order on Reconsideration as premature is reversed. The September 28, 1999 Order on Reconsideration is reinstated and affirmed. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
WILLIAM MASTERS, Claimant
WCB Case No. 00-02201
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Reinisch, Mackenzie, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that upheld the self-insured employer's denial of his injury claim for a low back condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following supplement to address claimant's contention that the ALJ incorrectly relied upon the opinions of Drs. Strum and Farris (insurer-arranged medical examiners) rather than the opinion of Dr. Moore (attending physician).

In April 1999, claimant compensably injured his low back lifting a tire and rim that he was attempting to mount on a vehicle. (Ex. 1). The claim was accepted on April 29, 1999 as a lumbosacral strain and processed to closure. (Ex. 21-1; 41-1).

During claimant's course of treatment for the accepted condition, Dr. Moore, the attending physician, ordered an MRI. (Ex. 33). Dr. Moore interpreted the MRI as showing a disc bulge at L5-S1, and based upon claimant's clinical presentation diagnosed a disc herniation at L5-S1. (Ex. 34). Relying on Dr. Moore's diagnosis, claimant requested that the insurer amend its Notice of Acceptance to include the additional condition of L5-S1 disc herniation. (Ex. 41B).

Drs. Strum and Farris, who examined claimant at the request of the insurer, have opined that claimant does not have a disc herniation at L5-S1. (Ex. 38-7; 46-1; 47-2). Based on their opinions, the insurer denied the compensability of the disc herniation. (Ex. 44).

It is the presence or absence of an L5-S1 disc herniation, that is the issue to be resolved. Resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the opinion of claimant's treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to the opinion of Dr. Moore.

In her chart note of August 4, 1999 Dr. Moore described the MRI scan as showing a L5-S1 "disc bulge, not a full blown herniation, ... that is not causing nerve root compression." (Ex. 34). In that same chart note, under the clinical impression section, Dr. Moore diagnosed a "small disk herniation". (Ex. 34). However, Dr. Moore does not explain her reasoning for concluding that the L5-S1 disc is herniated.

In December 1999, Dr. Moore concurred with a report by Drs. Farris and Strum, in which they opine that claimant has disc bulge at L5-S1, but not a disc herniation. (Ex. 39). In January 2000, Dr. Moore opined, in a "check-the-box" type concurrence letter authored by claimant's counsel, that claimant's L5-S1 disc was herniated. (Ex. 41A-2). Again, she did not explain her reasoning for concluding that the L5-S1 disc is herniated.

In light of Dr. Moore's own description of the MRI scan (a disc bulge, not a herniation), and her December 1999 concurrence with the opinion of Drs. Strum and Farris (disc bulge, not herniation), we consider her opinion that claimant has an L5-S1 disc herniation, without further explanation, to be inconsistent and conclusory. Consequently, we find her opinion unpersuasive, and accordingly, we do not rely upon it. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980). Finally, we conclude that Dr. Strum and Farris have provided the most well-reasoned opinion regarding causation.

Based on this record, we agree with the ALJ that claimant has not established that he has an L5-S1 disc herniation.

ORDER

The ALJ's order dated June 20, 2000 is affirmed.

October 9, 2000 Cite as 52 Van Natta 1856 (2000)

In the Matter of the Compensation of
DARALYNN NEVETT, Claimant
WCB Case No. 99-09461
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Jim Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Poland's order that affirmed an Order on Reconsideration awarding 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of claimant's right forearm (wrist). Claimant cross-requests review of that portion of the ALJ's order that awarded a $2,000 assessed fee under ORS 656.382(2). On review, the issues are extent of scheduled permanent disability and attorney fees. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that SAIF, as the party challenging the award of scheduled permanent disability in the reconsideration order, failed to carry its burden of establishing that claimant's accepted right tenosynovitis condition had not resulted in a significant loss of repetitive use of her right wrist.[1] In making this determination, the ALJ rejected SAIF's argument that the opinion of the attending physician, Dr. Farris, that claimant had "some limitation" in repetitive use meant that claimant's loss of repetitive use did not rise to the "significant" level required under OAR 436-035-0010(5)(c).[2] The ALJ reasoned that Dr. Farris was not responding to a question that specifically asked whether claimant had sustained a "significant" loss of repetitive use and that there was no evidence that Dr. Farris' use of the words "some limitation" was meant to signify an insignificant limitation on repetitive use.

On review, SAIF cites *Lorraine F. Fortado*, 52 Van Natta 446 (2000), and *Ronny G. Holland*, 50 Van Natta 2240 (1998), in arguing that an opinion that a claimant has "some limitation" in repetitive use does not prove that there is a "significant limitation." We find those cases helpful in resolving this case.

In both *Fortado* and *Holland*, we held that a medical opinion that a claimant has "some limitation" in repetitive use did not establish that the claimant had a "significant" limitation. In both cases, the relevant physician was responding to an express inquiry about whether the claimant had a "significant"

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[1] The ALJ determined that SAIF had the burden of proving that the Order on Reconsideration's award of permanent disability was incorrect under *Roberto Rodriguez*, 46 Van Natta 1722 (1994). SAIF argues that *Rodriguez* was incorrectly decided and that claimant should have the burden of proof. We need not decide this issue because we would reach the same result regardless of which party has the burden of proof.

[2] OAR 436-035-0010(5) provides, in relevant part:

"A worker is entitled to a 5% scheduled chronic condition impairment value for each applicable body part, stated in this section, when a preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, the worker is significantly limited in the repetitive use of one or more of the following body parts:

"* * * * *

"(c) Forearm (below elbow/hand/wrist) * * "

limitation in repetitive use. When each physician responded that the claimant had only "some limitation," we reasoned that the physician was drawing a distinction between "significant" and "some" limitation. *Fortado*, 52 Van Natta at 447; *Holland*, 50 Van Natta at 2241. Thus, in both *Holland* and *Fortado*, we held the medical evidence did not prove that the claimant was entitled to "chronic" condition impairment.

Here, Dr. Farris was asked if claimant's accepted bilateral tenosynovitis condition was "a part of that chronic condition which limits her ability to use her hands for a repetitive task?" (Ex. 18-2). In response, Dr. Farris replied that claimant's "bilateral tenosynovitis condition does cause *some limitation* in her ability to use her hands for repetitive work." *Id.* (emphasis added).

In accordance with *Holland* and *Fortado*, we conclude that Dr. Farris' opinion that claimant has "some limitation" in her ability to use her hands for repetitive work does not establish that she has a "significant limitation." We acknowledge that, in contrast to the physicians in *Holland* and *Fortado*, Dr. Farris was not specifically asked whether claimant had "significant" limitation. However, Dr. Farris'response must be considered with his conclusions that claimant's tenosynovitis had "essentially resolved" and that claimant had "no measurable impairment." (Ex. 13). When placed in this context, Dr. Farris' opinion, viewed as a whole, does not establish that claimant is "significantly" limited in repetitive use of the the right wrist.[3]

Accordingly, we disagree with the ALJ's decision to affirm the reconsideration order's award of 5 percent scheduled permanent disability for an alleged "chronic" condition. Thus, we reverse.[4]

ORDER

The ALJ's order dated February 25, 2000, as reconsidered on May 1, 2000, is reversed. The Order on Reconsideration's award of 5 percent (7.5 degrees) scheduled permanent disability for the right forearm (wrist) is reversed. The ALJ's attorney fee award is also reversed.

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[3] We also note that Dr. Farris advised claimant not to return to work that required vigorous repetitive use of her hands. (Ex. 13). It would, therefore, appear that Dr. Farris' restriction on repetitive use was intended to prevent a recurrence of symptoms. Such a restriction is inadequate to support a "chronic" condition award. *See Teena M. Headding*, 51 Van Natta 789, 790 (1999).

[4] In light of our resolution of this case, the ALJ's attorney fee award must also be reversed. Therefore, we need not address the attorney fee issue claimant raises.

October 9, 2000 Cite as 52 Van Natta 1857 (2000)

In the Matter of the Compensation of
GILBERTO M. PENA, Claimant
WCB Case No. 99-02871
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
James Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that reduced the scheduled permanent disability award to zero, as awarded by a Notice of Closure, whereas an Order on Reconsideration awarded 9 percent (13.5 degrees) scheduled permanent disability for loss of use or function of the left hand. On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the ALJ's order with the following correction and supplementation. The last sentence of the ninth paragraph of the ALJ's findings of fact is corrected to read as follows: "Claimant also asserted that current rules for the rating of impairment were *not* sufficient to compensate him fully." The first sentence of the 11th paragraph of the findings of fact is corrected to read as follows: "Claimant was referred to Dr. *Mayhall*, medical arbiter."

Where the ranges of motion findings do not conform to those found in the standards, we do not find those findings persuasive in rating the extent of a claimant's permanent impairment. *Lawrence E. Wilson*, 43 Van Natta 1131 (1991). Here, as the ALJ found, Dr. Mayhall's range of motion findings do not conform to those found in the standards. Therefore, they are not persuasive. In addition, the ranges of motion findings measured by (or concurred with by)[1] claimant's attending physician conform to those found in the standards and indicate no loss of range of motion. Therefore, we agree with the ALJ that the preponderance of the persuasive medical opinion establishes that claimant has no impairment due to the compensable left thumb injury.

ORDER

The ALJ's order dated June 9, 2000 is affirmed.

[1] As the ALJ explained, there is some confusion as to whether Dr. Buehler, M.D., or Dr. Matthews, M.D., was the attending physician at claim closure. However, that controversy is moot because there is no dispute that one of those physicians was claimant's attending physician, and Dr. Matthews concurred with Dr. Buehler's closing examination. (Exs. 17, 24-2).

In the Matter of the Compensation of
CLAUDIA M. PERRIN, Claimant
WCB Case No. 98-07391
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its 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.

The ALJ concluded that claimant had carried her burden of proving that an April 30, 1998 work injury was a material contributing cause of her low back injury. *See* ORS 656.005(7)(a). In making this conclusion, the ALJ found that claimant's treating physician, Dr. Cross, provided the most persuasive medical opinion. On review, the insurer asserts that Dr. Cross' opinion is not persusasive because he did not rely on a history that a specific work event caused claimant's low back injury.

We agree with the insurer's contention. Dr. Cross indicated that claimant's low back strain was "due to strain and overuse of her back with resulting muscle fatigue." (Ex. 18-1). We find that such evidence implicates claimant's work activities. Because Dr. Cross also established that "the major cause of her low back strain/facet overload syndrome is her work activities," (*id.*), and we otherwise agree with the ALJ's evaluation of the medical evidence, we conclude that claimant proved compensability. *See* ORS 656.802(2)(a).[1]

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

ORDER

The ALJ's May 8, 2000 order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

[1] Because the record did not show that claimant's low back condition was preexisting, we find no "combined condition" requiring the application of ORS 656.005(7)(a)(B) or 656.802(2)(b).

In the Matter of the Compensation of
TERESA L. STEVENS, Claimant
WCB Case No. 99-05820
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Lundeen, et al, Defense Attorneys

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

Claimant requests review of that portion of Administrative Law Judge (ALJ) Crumme's order that upheld the insurer's denial of claimant's claim for migraine headaches with blackouts. On review, the issue is compensability.

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

On this record, we are not persuaded that claimant's work exposure contributed more to her recent need for treatment than did her preexisting personal susceptibility to migraines. (*See* Exs. 56-7-8; 62-4-5). And we would reach the same result analyzing the claim as a disease under ORS 656.802, because the medical evidence does not establish that claimant's work exposure caused a worsening of her underlying susceptibility or that it was the major contributing cause of her recent migraine condition.

ORDER

The ALJ's order dated May 15, 2000 is affirmed.

Board Member Phillips Polich dissenting.

Claimant has had migraine headaches since she was 12 years old. She has a susceptibility to migraines that the experts agree is probably genetic.

However, claimant's migraines have changed since she started working for the employer in November 1998. The medical evidence clearly establishes that claimant's work exposure to at least two products the employer sells (potpourri and carpet freshener) contributed to a change in the triggers that combined with her preexisting susceptibility to cause the migraines she suffered after her work exposure. Claimant's work exposure also contributed to a change in her migraine symptoms and the treatment provided for those symptoms. These facts are essentially undisputed.

The majority finds that the claim is properly analyzed as an injurious event under ORS 656.005(7)(a), because claimant's 1999 migraine problems arose with a sudden onset of new symptoms. The majority also finds that claimant is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B), because her preexisting genetic susceptibility to migraines combined with her work exposure to cause her recent migraines. I agree, to this point, but no further.

The majority goes on to find "no persuasive basis to distinguish between the major cause of the combined condition versus the major cause of the disability or need for treatment for the combined condition." Accordingly, based on the medical evidence indicating that claimant's genetic makeup is the major cause of her *condition*, the majority upholds the insurer's claim denial.

I would find that the cause of claimant's recent need for treatment *is* medically distinguishable from the cause of her migraine condition generally. And I would find the claim compensable, because claimant's work exposure to odors was the major contributing cause of her *need for treatment* for the migraines she suffered following her work exposure.

In *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997), the court construed ORS 656.005(7)(a)(B) and held that when the claimant has a combined condition, not caused in major part by an on-the-job injury, the condition is nevertheless compensable if an on-the-job incident is primarily

responsible claimant's need for treatment. The *Nehl* decision turned on the fact that there was a difference between the primary cause of the claimant's combined condition and the primary cause of his need for treatment.[1] *See Nehl*, 149 Or App at 313; *compare Robinson v. SAIF*, 147 Or App 157 (1997) (no difference between the major contributing cause of the claimant's combined condition and the major contributing cause of his need for treatment of that condition).

In this case, the medical experts essentially agree that claimant's current migraine *condition* is due to her susceptibility to migraines and "triggers,"[2] especially odors. (*See Exs. 56-7, 60, 61, 62*). They also agree that claimant's work exposure was not the major contributing cause of her migraine *condition*. (*See* Ex. 60-2).

With regard to claimant's need for treatment for migraines, Drs. Williams and James, examining physicians, opined that all of claimant's treatment "would be related to her to her pre-existing condition of migraine headaches since age 12." (Ex. 56-8). This conclusion is unpersuasive, standing alone, because it is unexplained.[3]

Dr. Englander, treating physician, stated that he agreed with the examiners, (Ex. 62-18),[4] but he described claimant's recent need for treatment differently, with specific reference to her work exposure and related symptoms. He explained that migraine "is clearly a chemical thing" that is "mostly symptom driven." (*Id.* at 21, 22). In fact, because there is no cure for migraines, treatment is directed at relieving symptoms. (*Id.* at 23-24; -29, -31). Moreover, the migraines claimant has had since her work exposure differ from her prior migraines in that they are now triggered by odors.[5] (Exs. 60, 61).

Based on Dr. Englander's persuasive reasoning, the cause of the claimed need for treatment (for the combined condition) is medically separable from the cause of combined condition, as it was in *Nehl*. *Compare Leslie A. Crews*, 50 Van Natta 193, *on recon* 50 Van Natta 317 (1998). Claimant's need for treatment for migraines since her work exposure differs from her prior need for treatment, because her work exposure to odors changed her symptoms and treatment. Moreover, because her treatment is for symptoms solely (it does not affect her underlying susceptibility to migraines), I would conclude that claimant's need for treatment since her work exposure is due to that exposure, not her unaffected susceptibility. Thus, although claimant's preexisting condition contributes to her current condition, claimant's recent need for treatment for migraine symptoms is clearly due in major part to her work exposure. *See Robert P. Davis*, 49 Van Natta 2139 (1997). Under these circumstances, I must respectfully dissent.

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[1] In *Nehl*, prior to a February 1995 work incident, the claimant had a history of low back symptoms related to recurring disc herniations. He had undergone a lumbar surgical fusion with the installation of Steffe plates, which were secured to the spine with screws. Then, on February 8, 1995, the claimant experienced a change in his back pain when he stood up from a squatting position at work. The medical evidence established that this work incident caused a loosening of the claimant's fusion instrumentation, which was the primary cause of his need for further surgical treatment. Consequently, on those facts, the court was able to make a distinction between the primary cause of the claimant's overall combined low back condition and the primary cause of his need for treatment, *i.e.*, the February 8, 1995 work injury.

[2] A "trigger" is an identifiable exposure that starts a migraine. (Ex. 62-26).

[3] However, Drs. Williams and James acknowledged that allergy desensitization to odors may prove beneficial for claimant. (*Id.*). That portion of their opinion supports my conclusion that claimant's work exposure caused the claimed need for treatment.

[4] Specifically, Dr. Englander stated, "I don't think I have anything specifically in the way of disagreement with [the examiners' report]. I might phrase things a little differently, but they're not substantively different." (*Id.*). I would not rely on this statement (out of context), however, because Dr. Englander's explained deposition opinion does differ substantively from that provided by the examiners, as explained herein.

[5] Although many people have migraines without having (or identifying) a trigger, claimant's recent migraines *were* triggered by her work exposure to product odors. (Exs. 60-2, 61-1, 62-27-28).

In the Matter of the Compensation of
MELVIN J. WEAVER, Claimant
WCB Case No. 98-07807
ORDER ON REVIEW
Floyd H. Shebley, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of his occupational disease claim for a respiratory condition. With its respondent's brief, the employer contests the ALJ's admission of certain documents. On review, the issues are the ALJ's evidentiary rulings and compensability.[1]

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

Claimant seeks to establish the compensability of a respiratory condition, diagnosed as either asbestosis, silicosos, chronic hypersensitivity pneumonitis, or interstitial pulmonary fibrosis, as an occupational disease. Therefore, he must prove that his work activities are the major contributing cause of the disease itself, not just the major contributing cause of the disability or treatment associated with it. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).

To satisfy the "major contributing cause" standard, claimant must establish that his work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994); *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

The record establishes that claimant has some degree of emphysema related to smoking. (Ex. 67-5; 76-28). Dr. Tara, the attending physician, who is board certified in both internal and pulmonary medicine, has opined, based upon her interpretation of radiographic data and claimant's improvement in pulmonary function (ventilatory deficit reversibility), that emphysema plays a minor role in claimant's overall respiratory condition. (Ex. 76-28). In contrast, Dr. Montanaro, an employer-arranged medical examiner, who is an allergist and rheumatologist, opined that emphysema is the major cause of claimant's respiratory condition. (Ex. 67-6).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here we find persuasive reasons not to defer to Dr. Tara's opinion.

Dr. Tara's opinion is largely based upon her finding, through spirometry testing, that claimant's ventilatory deficit is reversible.[2] (Ex. 76-21). However, Dr. Tara also acknowledges that some people with emphysema show ventilatory deficit reversibility. (Ex. 76-22). We note that in expressing her opinion, she does not explain how she eliminates claimant from the class of people with emphysema who show ventilatory deficit reversibility. Without such an explanation, her opinion that emphysema plays a minor role in claimant's respiratory condition is merely an unsupported conclusion. Consequently, we do not find it persuasive and accordingly do not rely upon it. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980).

Consequently, we conclude that, on this record, claimant has failed to establish the compensability of his respiratory condition.

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[1] Because we conclude that claimant's respiratory condition is not compensable, we need not address the ALJ's evidentiary rulings on review.

[2] Dr. Tara considers such reversibility inconsistent with emphysema. (Ex. 76-23).

ORDER

The ALJ's order dated May 9, 2000 is affirmed.

Board Member Biehl dissenting.

I disagree with the majority's conclusion that claimant has failed to establish the compensability of his respiratory condition. Specifically, I find no persuasive reason not to defer to the opinion of Dr. Tara, the attending physician. *See Weiland v. SAIF*, 64 Or App 810 (1983). Therefore, I respectfully dissent.

Claimant has a clear history of exposure to silica dust at work. (Tr. 36; 39; 45; 75; 149; 152; 156; Ex. 66A). Based upon her examinations of claimant and the various diagnostic tests, Dr. Tara has determined that claimant has the following lung abnormalities: (1) multiple areas of local pleural thickening; (2) several areas of intralobular spetal thickening; (3) mild mediastinal lymph adenopathy; (4) at least 3 subcentimeter sized parenchymal nodular densities in the right lung; and, (5) some degree of diffuse emphysema. (Ex. 72-1). According to Dr. Tara, only the diffuse emphysema is attributable to tobacco smoking. (Ex. 72-1). Based upon claimant's clear history of exposure to silica dust at work, and the type of abnormalities found to exist in claimant's lungs, which are inconsistent with emphysema, I conclude that Dr. Tara has necessarily explained her opinion eliminating claimant from the class of people with emphysema who demonstrate ventilatory deficit reversibility.

Dr. Tara is board certified in both internal and pulmonary medicine. Her specialty is pulmonary critical care. (Ex. 76-4). She is the only pulmonary specialist in this record to render an opinion on causation.[1] Because Dr. Tara has been the attending physician since 1997, and because she has more expertise in the cause and treatment of pulmonary problems than the other medical examiners who have rendered causation opinions in this case, I find her opinion more persuasive than any other opinion in this record. *See Abbott v. SAIF*, 45 Or App 657, 661 (1980). Consequently, I find that claimant has established the compensability of his respiratory condition.

Accordingly, I would reverse the order of the ALJ, set aside the self-insured employer's denial, and remand the claim to the self-insured employer for processing.

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[1] The self-insured employer relies on Dr. Montanaro, an allergist, and Dr. Primack, a radiologist.

In the Matter of the Compensation of
RAYMOND P. WHITELEY, Claimant
WCB Case No. 99-07190
ORDER ON REVIEW
Swanson, Lathen, et al, Claimant Attorneys
Sheridan, Bronstein, et al, Defense Attorneys

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

The insurer requests review of Administrative Law Judge (ALJ) Nichols' order that set aside its denial of claimant's right foot injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant works as a swather operator cutting hay for the employer. On July 14, 1999, claimant was working with another operator at night on a 180 acre field in a rural area and sustained a gun shot injury to his right foot.

Claimant eventually was transported to the hospital. A police officer and her canine partner found the scene of the shooting and attempted to track a suspect, without success. (Tr. 72). At the scene, police found a .12 gauge shotgun and claimant's crutches.[1]

Police officers interviewed claimant on July 15 at the hospital and again on July 27 and August 10.

CONCLUSIONS OF LAW AND OPINION

At hearing, claimant testified that, around 10 p.m., he exited the swather to urinate and smoke a cigarette. (Tr. 48). Claimant then heard a man, described by claimant as Hispanic, behind him say "Hey"; claimant looked over his shoulder and saw a man with a gun. (*Id.*) According to claimant, the man ordered claimant to the ground and demanded his wallet. Claimant laid face down, took his wallet from his back pocket, and handed it up to the man. (*Id.* at 49). The man then shot him in the right foot.

The ALJ found "claimant to be credible and his versions of the story the correct version." The ALJ also concluded that, because claimant showed that he was shot by an unknown assailant while working, the injury occurred in the course of, and arose out of, his employment. Thus, the ALJ concluded that claimant proved compensability.

The insurer challenges the ALJ's order, asserting that claimant is not credible. According to the insurer, claimant provided inconsistent stories to the police and other matters, such as the location of the wound, are not consistent with claimant's testimony. Because claimant's testimony was the only evidence supporting compensability, the insurer argues that he did not carry his burden of proof.

Claimant has the burden of proving compensability. ORS 656.266. Because he is relying on his sole testimony to prove that an unknown assailant shot him, he must show that his testimony is credible and reliable. If claimant is not credible, his claim fails whether or not the insurer proved its defense that claimant's injury was self-inflicted.

In finding claimant credible, the ALJ discussed the consistency of his testimony with information he provided before the hearing without referring to claimant's demeanor. Thus, we understand the ALJ as assessing credibility based on the substance of claimant's testimony rather than demeanor. When the issue of credibility concerns the substance of a witness' testimony, the Board is equally qualified to make its own determination of credibility. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987). Thus, on *de novo* review, we review the record to assess claimant's credibility.

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[1] Claimant's left leg is amputated at the knee from a previous motor vehicle accident. Claimant was using his crutches when he was shot.

We first find that police reports show that claimant provided inconsistent statements concerning the shooting incident. From an interview with Brett Clark, the coworker who was swathing the same field on July 14, police learned that claimant first told Clark that more than one person shot him, but he later stated that it was only one man.

Police also noted that a .12 gauge shotgun was found in claimant's house, contradicting his first report that he did not own such a gun. During a July 27 interview, police officers told claimant that his fingerprints were found on the shell casing inside of the shotgun and asked for an explanation.[2] Claimant replied that he "must have touched it," taken out the shell casing and then put it back into the gun.

On August 10, police again asked claimant to explain how his fingerprints were on the shell casing found inside the shotgun. On this occasion, claimant first stated that "he must have touched it"; when police challenged this statement, claimant replied that "he really does not remember anything that happened." Claimant then stated that, after he was shot, he picked up the shotgun, activating the pump so the shell came out. Claimant followed this by stating that he "really didn't remember what happened," but when asked about who shot him, stated that "he remembered everything that happened." The police cited and arrested claimant for initiating a false report.

Thus, claimant's interviews with the police shows that he provided such contradicting statements that he was cited and arrested for initiating a false report. Furthermore, when faced with (inaccurate) information that police found fingerprints, claimant provided statements to explain the existence of fingerprints. At hearing, however, claimant had no recall of how fingerprints could be on the shotgun shell.

Additional evidence does not support claimant's testimony. Brett Clark saw a shotgun in claimant's vehicle that he believed to be a .12 gauge before he and claimant left in the swathers. After the shooting incident, claimant's truck was checked and no shotgun could be seen inside the vehicle. Although a police officer and her canine partner attempted to track a suspect at the shooting scene, no track was found.

At hearing, claimant testified that, before July 14, 1999, he had taken guns with him in the swather "to pop off coyotes and rodents" he saw in the fields. (Tr. 37). Thus, although denying he had a shotgun with him in the swather on July 14, 1999, claimant had a history of taking and using firearms while working in the swather.

Finally, during the hearing, claimant attempted to demonstrate how a bullet entered the top part of his foot, exiting from the bottom of the foot, while he was laying face down. According to the ALJ herself, while laying face-down, claimant's foot and ankle were at a 90 degree angle to the floor. (Tr. 46).[3] Nevertheless, claimant continued to maintain that he was shot by a person standing above him while he lay face down.

Consequently, as described above, claimant provided contradictory and inconsistent statements to the police.[4] Based on such evidence, we find that claimant is not credible. Furthermore, as noted above, because the claim is not supported by any other evidence than claimant's unpersuasive testimony, we conclude that he did not carry his burden of proving compensability.

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[2] In fact, no fingerprints were found on the gun or shell casing.

[3] The ALJ's order neither discussed nor referred to the angle of claimant's scar. Likewise, the ALJ's order did not refer to claimant's demonstration at the Hearing. In light of such circumstances, we disagree with the argument expressed by the dissent that our finding is inconsistent with the ALJ's observation of claimant's Hearing presentation.

[4] The dissent asserts that our decision is based on an assumption that claimant could not have been assaulted and robbed because violent crimes in rural areas are improbable. The dissent further asserts that we have engaged in some type of statistical analysis regarding the likelihood of violent crime in certain geographical areas. Both of these assertions are mistaken. We have neither made any assumptions nor engaged in any statistical studies. Rather, for the reasons expressed in this order, we have determined that the preponderance of the persuasive evidence does not support claimant's claim that he was injured in the manner that he has described.

ORDER

The ALJ's January 10, 2000 order is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant did not prove compensability. Instead, I would defer to the ALJ's demeanor-based finding that claimant was credible and thus affirm the ALJ's order concluding that claimant's gunshot wound to the right foot was compensable.

Claimant contends that on July 14, 1999, he was working at his regular job as a swather operator, cutting hay at night. At some point on the evening in question, claimant stopped his machine to smoke a cigarette and use the bathroom. During this time, claimant contends he was robbed and shot by an unknown assailant.

In finding claimant credible, the ALJ stated:

> "Claimant's testimony at the hearing was consistent with the information he provided to his employer and the police when the accident occurred. He did appear to have selective memory but there is nothing in his testimony that would cause one to be concerned about his credibility." (O&O, p. 2).

When an ALJ's credibility finding is based upon claimant's demeanor, we generally defer to that credibility finding. *See Bush v. SAIF*, 68 Or App 230, 233 (1984). Unlike the majority, I conclude that the ALJ's credibility finding is based upon both the substance of claimant's testimony and his demeanor. Because the ALJ had the opportunity to observe the claimant's testimony, she is in the better position to assess his credibility. Accordingly, her determination is entitled to considerable weight. *See Sherri L. Williams*, 51 Van Natta 75, 77 (1999).

The compensability of this claim depends upon whether claimant was shot by an unknown assailant or whether he accidentally shot himself with his own gun. In finding claimant's testimony not credible, the majority apparently finds that claimant accidentally shot himself with his own gun (the .12 gauge shotgun found at the scene). The uncontested evidence establishes that claimant owns a .12 gauge break-barrel model 38 shotgun, described as an antique. The record contains no description (beyond .12 gauge shotgun) of the gun found at the scene. Consequently, it can not be determined from this record whether the gun found at the accident scene is a break-barrel model 38 or some other type of shotgun. Claimant's fingerprints were not on the gun found at the scene; nor were his fingerprints on the shell casings the police removed from that gun. Although the police searched claimant's home, the record does not establish that claimant's shotgun was missing.[1] In short, there is no evidence linking claimant to the gun found at the scene. Nevertheless, the majority apparently concludes that the gun found at the scene is claimant's gun. That conclusion is not supported by substantial evidence.

In noting the location of claimant's wound, the majority evidences its belief that the wound in claimant's foot is not consistent with a gun fired by an assailant standing within an arm's length of claimant, while claimant was lying down. The majority makes this finding without the benefit of any medical or ballistic evidence.[2] Because we normally require expert medical opinion to establish a causal

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[1] The majority notes that the police found a .12 gauge shotgun in claimant's home. Assuming this true, then claimant's .12 gauge shotgun cannot be the one found in the field.

[2] I also note that the majority makes this finding without the benefit of the visual demonstration presented by claimant at the hearing. Among other things, the demonstration included the scar on his foot. The ALJ had the benefit of that demonstration; we do not. We have only the transcribed portion of the verbal description, which at best, is a poor substitute for the entire presentation.

link between something as simple as a muscle strain and as ordinary as heavy lifting, the majority's finding on this issue, without any evidence whatsoever, is incongruous and completely contrary to our normal reasoning process.[3]

The majority has chosen to reverse the ALJ largely because it considers violent crime in rural areas improbable. Consequently, it erroneously assumes that claimant could not have been robbed and assaulted as he described. While violent crime may not be as common in rural areas as it is in metropolitan areas, it still occurs; reading the daily newspaper establishes that fact. Moreover, in concluding that the event is improbable, the majority seems to have engaged in some type of statistical analysis for the likelihood of violent crime in certain geographic areas. We regularly reject this type of analysis when used in medical opinions. *See Sueyen A. Yang*, 48 Van Natta 1627 (1996); *See Steven H. Newman*, 47 Van Natta 244, 246 (1995); *Catherine M. Grimes*, 46 Van Natta 1861, 1862 (1994); *Mark Ostermiller*, 46 Van Natta 1556, 1558, *on recon* 46 Van Natta 1785 (1994). To the extent that it relies on this type of analysis, the majority ignores our ordinary practices in evaluating evidence.

Claimant has the burden to prove the nature and extent of his compensable injury. ORS 656.266. Claimant did that through his testimony that the ALJ found credible.

In response to claimant's testimony that he had been robbed and shot by an unknown assailant, the insurer offered its theory that claimant had shot himself with his own gun. In support of its theory, the insurer offered very weak circumstantial evidence, when it could have produced expert testimony and complete police reports in an effort to fill in the gaps in this record. A general legal principle is that if weaker and less satisfactory evidence is offered by a party when it appears that stronger and more satisfactory evidence was within the power of that party to produce, the evidence offered should be viewed with distrust. ORS 10.095; *see Roberts v. SAIF*, 18 Or App 590 (1974) (applying that principle to workers' compensation cases). Because the insurer had the means and opportunity to produce stronger and more satisfactory evidence in support of its theory and did not do so, I view what it did offer with distrust.

In conclusion, I would defer to the ALJ's credibility finding (especially because she had the benefit of a visual demonstration that we do not) and thus affirm the ALJ's order concluding that claimant's gunshot wound to the right foot was compensable. Because the majority comes to a different conclusion, which I find legally and factually unsupportable, I dissent.

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[3] Based upon the reasoning of the majority, I must conclude that it considers the analysis of the following factors: (1) the size, shape, and placement of gunshot entry and exit wounds; (2) the angle of entry of the wound; (3) the presence or absence of powder burns on claimant's shoe; and, (4) the placement of the shotgun shell wadding; as less complex than the causal relationship of a muscle strain to a lifting incident.

In the Matter of the Compensation of
GARY L. BLACKBURN, Claimant
WCB Case No. 00-00495
ORDER ON REVIEW
Schneider, et al, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that reduced claimant's award of 4 percent (6 degrees) scheduled permanent disability for loss of use or function of the right leg (knee), as granted by an Order on Reconsideration, to zero. The self-insured employer moves to dismiss claimant's request for Board review. On review, the issues are motion to dismiss and extent of scheduled permanent disability. We affirm the ALJ's decision that claimant is not entitled to permanent disability, but we do so based on different reasoning.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," but briefly summarize the pertinent facts as follows. Claimant sustained a compensable right knee injury on May 21, 1997. The employer closed the claim by a July 2, 1997 Notice of Closure that awarded temporary disability only. Claimant requested reconsideration.

Claimant filed an aggravation claim in September 1997 that the employer denied on September 24, 1997. Claimant requested a hearing from the denial.

An Order on Reconsideration issued on September 25, 1997 that affirmed the July 1997 Notice of Closure. Claimant requested a hearing from the reconsideration order.

On December 1, 1999, a prior ALJ upheld the denial of aggravation, but set aside the reconsideration order and remanded the claim to the Department for further reconsideration. (WCB Case No. 97-08691). The Department issued an Order on Reconsideration on Remand on January 12, 2000 that awarded 4 percent scheduled permanent disability. Both claimant and the employer requested a hearing. (WCB Case No. 00-00495).

CONCLUSIONS OF LAW AND OPINION

The ALJ denied claimant's request for additional scheduled permanent disability, but agreed with the employer that the Department erred in awarding scheduled permanent disability. Therefore, the ALJ eliminated the award of scheduled permanent disability in the reconsideration order. Claimant requested review of the ALJ's order.

The employer argues that we should dismiss claimant's request for review in light of our decision in WCB Case No. 97-08691, in which we affirmed the September 25, 1997 reconsideration order and determined that the prior ALJ had incorrectly remanded to the Department for further reconsideration. *Gary L. Blackburn*, 52 Van Natta 1373 (2000). The employer contends that our decision moots the appeal in this case because claimant's request for review was based on a "voided" reconsideration order.

In response, claimant agrees that our decision in WCB Case No. 97-08691 would moot this appeal but for the fact that claimant has requested court review in that case, as well as in the case on which we relied in *Blackburn*. *Donna J. Balogh*, 52 Van Natta 1057 (2000). However, we have held that, for purposes of administrative efficiency, we shall give precedential effect to our prior non-final litigation orders. *Elmer F. Knauss*, 47 Van Natta 826, 827, *recon* 47 Van Natta 949, *recon* 47 Van Natta 1064 (1995); *Michael S. Barlow*, 46 Van Natta 1627 (1994). Our reasoning is that an alternative approach (*i.e.*, giving no effect to the prior non-final litigation order or deferring a decision pending appeal of the prior order) would encourage further and potentially unnecessary litigation or result in inconsistent rulings and additional delays in the resolution of disputes.

In light of this case authority, we conclude that the fact that *Blackburn* is not a final order does not prevent us from giving it precedential effect in this case. Therefore, in view of our order in WCB Case No. 97-08691, we hold that the permanent disability issue arising from the January 2000 Order on Reconsideration has been rendered moot.[1] Thus, we affirm the ALJ's decision that claimant is not entitled to permanent disability resulting from the January 2000 Order on Reconsideration, but we do so based on the aforementioned reasoning.

ORDER

The ALJ's order dated May 16, 2000 is affirmed.

[1] We note that it is permissible to take administrative notice of our decision in WCB Case No. 97-08691. *See Janet R. Christensen*, 50 Van Natta 1152 (1998) (Board took official notice of the fact that certain conditions were found compensable subsequent to an Order on Reconsideration).

In the Matter of the Compensation of
JAMES M. EVANS, Claimant
Own Motion No. 99-0152M
OWN MOTION ORDER ON RECONSIDERATION POSTPONING ACTION
Ransom & Gilbertson, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

On August 25, 2000, we issued an Own Motion Order of Abatement which abated our July 27, 2000 Own Motion Order Reviewing Carrier Closure, which affirmed the insurer's April 24, 2000 Notice of Closure in its entirety. In our Order of Abatement we requested the parties' position regarding the status of the claim. Claimant responded that his claim is not within the Board's Own Motion jurisdiction because his aggravation rights had not expired when his condition worsened. Claimant advised that he requested a hearing with the Hearings Division regarding this issue. (WCB Case No. 00-00781).

Here, we issued our October 1, 1999 Own Motion Order on Reconsideration which authorized the reopening of claimant's 1992 claim for the payment of temporary disability compensation beginning the date he was hospitalized for surgery.

As directed by our October 1, 1999 order, when claimant was declared medically stationary, the insurer closed his claim on April 24, 2000. OAR 438-012-0055. On July 27, 2000, we affirmed the insurer's April 24, 2000 closure in its entirety. Thereafter, claimant requested reconsideration of our order and raised the jurisdictional issue.

Because litigation is pending involving this issue, we conclude that it would be in the best interest of the parties to postpone action until pending litigation has been resolved. Therefore, we defer action on this request for own motion relief and request that the assigned Administrative Law Judge (ALJ) in WCB Case No. 00-00781 submit a copy of the eventual order to the Board. In addition, if the matter is resolved by stipulation or Disputed Claim Settlement, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or approved agreement, the parties should advise us of their respective positions regarding claimant's request for own motion relief.

IT IS SO ORDERED.

In the Matter of the Compensation of
KEITH R. BURTON, Claimant
WCB Case No. 99-01047
ORDER OF DISMISSAL (REMANDING)
J. Michael Casey, Claimant Attorney
Employers Defense Counsel, Defense Attorney

The insurer requested review of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's "new medical condition" claim for his T10-11 intervertebral disc injury. The parties have both suggested that this case be remanded for the admission of additional evidence.

Claimant has submitted a June 9, 2000 arbiter's report, in which the arbiter attributed his findings to right thoracic T-9 radiculopathy, and a July 11, 2000 Order on Reconsideration. Claimant has requested a hearing on the reconsideration order, which is scheduled before ALJ Stephen Brown. (WCB Case No. 00-05386).

Based on the parties uncontested representations, we find that this case has been incompletely and insufficiently developed. *See Ronald D. Reynolds*, 51 Van Natta 1552 (1999). Consequently, we conclude that remand is warranted to allow ALJ Howell an opportunity to consider the compensability of the disputed thoracic conditions, which would assist the parties in resolving some of their disagreements. *See* ORS 656.295(5).

However, we decline to consolidate this case with the case pending before ALJ Brown. (WCB Case No. 00-05386). The case before ALJ Howell addressed compensability of claimant's thoracic disc conditions. The case pending before ALJ Brown is the closure of claimant's aggravation claim for a strain condition (which occurred prior to the hearing in this compensability case) and the rating of extent of disability for that condition. The compensability of claimant's thoracic disc condition would have no effect on the rating of the accepted strain condition. *E.g., Janet R. Christensen*, 50 Van Natta 1152 (1998) (evaluation of conditions ordered accepted after claim closure must await the reopening and processing of the claim for that new condition); *see also Bernard G. Hunt*, 49 Van Natta 223 (1997); *Bonnie J. Woolner*, 52 Van Natta 1579 (2000). Thus, contrary to the parties' assertions, we do not find this to be a case where inconsistent results are a possibility. *See Gaspar Lopez*, 48 Van Natta 1774, 1775 (1996) (remanding case for consolidation to avoid the possibility of inconsistent results).[1]

Accordingly, the ALJ's order dated July 6, 2000 is vacated. This matter is remanded to ALJ Howell for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the ALJ determines achieves substantial justice. Following those proceedings, ALJ Howell shall issue a final, appealable order.

IT IS SO ORDERED.

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[1] The parties may wish to seek postponement of the hearing pending before ALJ Brown to await the issuance of ALJ Howell's order. However, as explained herein, we would question the impact of ALJ Howell's decision on the issues pending before ALJ Brown. Nonetheless, any such postponement request would be a matter for ALJ Brown to consider and resolve.

In the Matter of the Compensation of
MIR ILIAIFAR, Claimant
WCB Case No. 96-05052
ORDER ON REMAND
Rex Q. Smith, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Iliaifar v. SAIF*, 160 Or App 116 (1999). The court has determined that, by directing claimant to deliver an "off-work" authorization to his place of employment at a time when he was injured and unable to work, the employer assumed the risk that claimant would be injured in an activity that was other than travel involved in going to work on an ordinary work day. Because of such circumstances, the court concluded that claimant's injury also arose out of the course of his employment. Consequently, the court held that we erred in concluding that claimant's injury was not compensable.

Based on the court's opinion that claimant's injury occurred in, and arose out of, the course of his employment, we conclude that claimant's injury claim is compensable.[1] We now turn to the matter of attorney fees.

Where, such as in this case, a claimant finally prevails after remand from the Court of Appeals, the Board shall approve or allow a reasonable attorney fee for services before every prior forum.[2] ORS 656.388(1); *Mark L. Hadley*, 47 Van Natta 725 (1995). Although statutory authority to award an attorney fee for services rendered at the hearings, Board, and court levels rests with this forum (because claimant did not finally prevail until the issuance of this Order on Remand), the court already granted claimant a $6,000 fee for services rendered on judicial review, conditioned on claimant prevailing on remand.

Neither party challenges the statutory basis for the court's attorney fee award for services on judicial appeal. In any event, after considering the factors set forth in OAR 438-015-0010(4), we would find that the court's $6,000 award represents a reasonable fee for claimant's counsel's services performed before that forum.

At hearing, the ALJ awarded claimant's counsel an assessed fee of $3,000 for prevailing over SAIF's denial. ORS 656.386(1). Neither party has objected to the ALJ's $3,000 attorney fee award. Accordingly, that award is republished.

The dispute in this case concerns the fee for services before the Board on review and on remand. Claimant requests a fee of $16,200 for services on review and $5,400 for services on remand. SAIF responds that claimant's request is excessive and that a fee of $1,500 for services on review and $1,000 for services on remand is more appropriate.

Our review of the record reveals the following. The hearing generated a 66 page transcript. The record contains 10 exhibits. The issue was whether claimant's injury arose out of and in the course of employment, an issue of above average legal and factual complexity, as compared to those normally presented to this forum for resolution. The ALJ set aside SAIF's denial and it requested Board review.

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[1] Noting that the court remanded for "reconsideration," rather than for acceptance, such as in *McKeown v. SAIF*, 116 Or App 295, 298 (1992), SAIF contends that the court did not decide the issue of compensability, despite its statement that claimant was injured in the course of employment and that the Board erred when it concluded that claimant's injury was not compensable. SAIF asserts that we are free to make a determination of the compensability issue, applying the court's "legal holding." We disagree. Although the court did remand for "reconsideration," rather than for acceptance of the claim, we are unwilling to ignore the court's express statements that claimant's injury occurred in the course of his employment. Inasmuch as the "course of employment" issue was the determinative question regarding the compensability of the claim, we decline SAIF's invitation to reevaluate the court's conclusion. In reaching this decision, we note that a motion for reconsideration of the court's decision or a petition for Supreme Court review would be a more appropriate avenue for SAIF's contentions regarding alleged flaws in the Court of Appeals' opinion.

[2] We determine the amount of attorney fees by applying the factors in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the 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.

Claimant's counsel submitted about 20 pages of briefing in his respondent's brief on Board review. After we reversed the ALJ's order and reinstated SAIF's denial, claimant made two reconsideration requests, involving approximately 20 pages of additional argument. After remand from the court, claimant has submitted approximately 70 pages of briefing. However, approximately 5 pages were devoted to argument on the attorney fee issue and to an itemization of work performed in preparing the respondent's brief on Board review. In addition, most of the brief on remand consists of copies of various portions of the record with interlineations and areas highlighted in yellow. In other words, there is relatively little written argument included among the records submitted as claimant's "brief" on remand.

As a result of the court's determination that claimant's disputed injury is compensable, claimant will likely receive compensation for a low back disc herniation, demonstrating a value of the interest involved that is generally comparable to other compensability disputes litigated before this forum. As demonstrated by the extent of litigation and the nature of the proceedings, there was a significant risk that claimant's counsel's efforts would go uncompensated. Finally, we note that the attorneys advocated their respective cases in a professional manner.

Consequently, after considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on Board review and on remand from the court is $7,000, payable by SAIF.[3] In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record, claimant's appellate arguments to the Board, claimant's counsel's statement of services and SAIF's response), the complexity of the issue, the value of the interest involved, and the risk that counsel might go uncompensated.[4] This award is in addition to the $6,000 awarded for services performed before the court and the ALJ's $3,000 attorney fee award, resulting in a total award for services rendered before all prior forums of $16,000, to be paid by SAIF.

Accordingly, on reconsideration of our previous orders, we affirm the ALJ's order dated October 16, 1996.

IT IS SO ORDERED.

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[3] Claimant is not entitled to an attorney fee for services devoted to the attorney fee issue. *See Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 461 (1986); *Amador Mendez*, 44 Van Natta 736 (1992).

[4] Claimant's counsel states that his hourly rate is $150 per hour and that, with a "contingency multiplier," he should be compensated at the rate of $225 per hour for his services on review and on remand, which, according to claimant's itemization, total 24 hours for remand services and 72 hours for Board review. Nevertheless, we do not apply a contingency factor or "multiplier" in a strict mathematical sense. Rather, in accordance with OAR 438-015-0010(4)(g), the amount of time expended in litigating a claim is but one of many factors considered in determining a reasonable attorney fee award. *See Karen M. Stone*, 51 Van Natta 1560 (1999); *June E. Bronson*, 51 Van Natta 928, 931 n. 5 (1999).

In the Matter of the Compensation of
JOSEPH J. NUCKOLLS, Claimant
WCB Case No. 00-02700
ORDER OF DISMISSAL
Michael G. Fetrow (Saif), Defense Attorney

Claimant, *pro se*, has requested review of Administrative Law Judge (ALJ) Mongrain's August 28, 2000 order. We have reviewed the request to determine whether we have jurisdiction to consider the matter. Because the record does not establish that either the Board or the other parties received a timely request for review within 30 days of the ALJ's order, we dismiss.

FINDINGS OF FACT

On August 28, 2000, the ALJ issued an order upholding the SAIF Corporation's denial of claimant's claim for a January 19, 2000 injury. A copy of the order was sent to claimant, claimant's attorney, the employer, SAIF, and SAIF's attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for Board review must be mailed to the other parties within the 30-day appeal period.

On October 3, 2000, the Board received claimant's letter dated September 26, 2000 asking for Board review.[1] Claimant's request was not mailed by registered or certified mail; nor did the request indicate that copies had been mailed to the Board. On October 4, 2000, the Board mailed its computer-generated letter to all parties acknowledging its receipt of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review, under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2). Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983).

Here, the 30th day after the ALJ's August 28, 2000 order was September 27, 2000. Therefore, September 27, 2000 was the final day to perfect a timely appeal of the ALJ's order. Because claimant's request was received by the Board on October 3, 2000, (more than 30 days after the ALJ's August 28, 2000 order) it was untimely filed. *See* ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

Moreover, the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period. Rather, the record suggests that SAIF's first notice of claimant's appeal occurred on October 2, 2000, when it received claimant's request for Board review. Consequently, the other parties did not receive notice of claimant's request within 30 days of the ALJ's August 28, 2000 order.

Based on claimant's untimely request for Board review and the untimely notice of her appeal to the other parties, 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, claimant's request for review is dismissed.

IT IS SO ORDERED.

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[1] Although the letter was addressed to SAIF and received by SAIF on October 2, 2000, we consider it as having been "received" by the Board because SAIF faxed it to the Board and it was accepted at a permanently staffed office of the Board.

In the Matter of the Compensation of
JOSE L. RIOS, Claimant
WCB Case No. 99-08252
ORDER ON REVIEW
Cathcart & Borden, Claimant Attorneys
Reinisch, Mackenzie, et al, Defense Attorneys

Reviewed by Board Members Phillips Polich and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that increased claimant's unscheduled permanent disability award for a low back condition from 5 percent (16 degrees), as awarded by an Order on Reconsideration, to 21 percent (67.2 degrees). In his respondent's brief, claimant contests that portion of the ALJ's order that declined to award 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function in his right foot. On review, the issues are extent of scheduled and unscheduled permanent disability. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact except for the specific finding that the reconsideration order did not adequately compensate claimant for the unscheduled impairment or disability attributable to the 1998 work injury.

CONCLUSIONS OF LAW

Prior to his 1998 compensable low back injury, claimant had disc conditions at L4-5 and L5-S1 that had been surgically repaired; the L5-S1 disc was repaired in July 1990, and the L4-5 disc was repaired in February 1991.[1] (Ex. 4, 20). On May 13, 1998, claimant compensably injured his back. The claim was originally accepted as a low back strain condition. (Ex. 81-2, 82). In February 1999, the insurer amended its Notice of Acceptance to include disc herniations at L4-5 and L5-S1. (Ex. 86).

The insurer closed the claim by Notice of Closure in May 1999, with no award for permanent disability. (Ex. 92). Claimant requested reconsideration. As a part of the reconsideration process, Dr. Dineen performed a medical arbiter exam, finding medically valid reduced ranges of motion in claimant's lumbar spine. Dr. Dineen concluded that "[f]indings are due to the incident as well as the past history, the prior laminectomy and the great majority of it is due to the preexisting condition, *i.e.* at least 90%." (Ex. 95-2).

Based upon Dr. Dineen's findings, an Order on Reconsideration apportioned the impairment findings and awarded claimant 5 percent unscheduled permanent disability.[2] (Ex. 96, 97).

Claimant filed a request for hearing, contending that the insurer had accepted a combined condition and, because no pre-closure "major contributing cause" denial had issued, apportionment of impairment was precluded. Consequently, claimant argued that all of his impairment was attributable to the 1998 work injury.

The ALJ determined that: (1) the insurer had not affirmatively accepted a combined condition; (2) the 1998 work injury did not combine with claimant's preexisting disc conditions; (3) the 1998 work injury was not superimposed upon a preexisting condition; and (4) all the impairment findings, as

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[1] During the 1991 surgery, the L5-S1 disc space was re-explored and a laminectomy was performed at that level. (Ex. 20).

[2] The Order on Reconsideration, as amended, found claimant's physical impairment, based upon Dr. Dineen's range of motion measurements, to be 15.4 percent. This was then reduced to 1.54 percent based upon Dr. Dineen's opinion that 90 percent of claimant's impairment was due to preexisting lumbar conditions and subsequently rounded up to 2 percent pursuant to OAR 436-035-0007(15). (Ex. 97-1).

measured by Dr. Dineen, were attributable to the 1998 work injury. Consequently, the ALJ concluded that claimant's permanent impairment from the 1998 work injury was 15 percent (15.4 percent rounded to 15 percent pursuant to OAR 436-035-0007(15)).[3]

On review, the insurer agrees that it accepted claimant's L4-5 and L5-S1 herniated discs, but it contends that because it did not accept those conditions as "combined conditions," it has not accepted claimant's previous problems at L4-5 and L5-S1. Accordingly, the insurer argues that claimant's "ratable" permanent impairment should be limited to that attributable to the 1998 work injury and his accepted conditions. We agree.

The scope of acceptance is a factual determination. *SAIF v. Tull*, 133 Or App 449 (1992). When a carrier does not identify the specific condition accepted, or if the specific acceptance is ambiguous, we look to contemporaneous medical records to determine what condition was accepted. *Jack L. Kruger*, 52 Van Natta 627, 628 (2000); *Fred L. Dobbs*, 50 Van Natta 2293, 2295 (1998).

Here, the insurer specifically and unambiguously accepted "L4-5 disc herniation and L5-S1 disc herniation." (Ex. 86). The insurer did not accept the disc herniations as "combined conditions." Nor did it accept claimant's prior surgeries or preexisting condition as "combined conditions." Under such circumstances, we find that the insurer did not accept a "combined condition."

Having identified that the accepted disc conditions are not "combined conditions," we proceed to an evaluation of claimant's permanent disability attributable to the accepted conditions. OAR 436-035-0007(14) (WCD Admin Order No. 99-056) provides that: "Where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment."

Dr. Laycoe, who examined claimant at the request of the insurer, and with whom Dr. Peacock, the attending physician concurs, performed a closing examination on March 20, 1999. (Ex. 89, 91). Dr. Laycoe concluded that there was no additional impairment due to the compensable 1998 injury. (Ex. 89-6). The medical arbiter exam of Dr. Dineen was performed on September 13, 1999, within a week of the Order on Reconsideration. (Ex. 95, 96). Because Dr. Dineen's medical arbiter exam was performed much closer in time to the Order on Reconsideration than Dr. Laycoe's closing exam, we conclude that Dr. Dineen's medical arbiter report is more persuasive. *See Kelly J. Zanni*, 50 Van Natta 1188 (1998). Accordingly, we use the medical arbiters measurements for rating purposes.

Using the medical arbiter's findings, we conclude that claimant has reduced ranges of lumbar motion, establishing a 15.4 percent impairment. (Ex. 96-2). The medical arbiter opined that 90 percent of claimant's lumbar impairment was related to his prior surgeries and preexisting condition. (Ex. 95-2).

OAR 436-035-0007(1) provides:

> "Except for sections (4) and (5) of this rule, a worker is entitled to a value under these rules only for those findings of impairment that are permanent and were caused by the accepted compensable condition, an accepted consequential condition and direct medical sequelea. Unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules. Permanent total disability shall be determined pursuant to OAR 436-030-0055."

Under OAR 436-035-0007(1), we conclude that claimant is entitled to an impairment value of 1.54 percent (10 percent of 15.4). *See Zebedee Mathews*, 52 Van Natta 1594 (2000) (in absence of accepted combined condition, ratable permanent impairment is limited to impairment due to the accepted condition).

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[3] The ALJ also determined that claimant was entitled to 6 percent for age and adaptability factors, which were added to claimant's impairment for a total award of 21 percent. The parties do not object to the ALJ's determinations associated with claimant's age and adaptability.

Pursuant to OAR 436-035-0007(15), claimant's impairment is rounded to 2 percent. This is added to the previously noted education and adaptability factors (which total 6) as determined by the ALJ, for a total unscheduled permanent disability award of 9 percent. Accordingly, we modify the ALJ's 21 percent award regarding claimant's unscheduled permanent disability.[4]

ORDER

The ALJ's order dated March 8, 2000 is modified. In lieu of the ALJ's unscheduled permanent disability award, and in addition to the 5 percent (16 degrees) granted by the Order on Reconsideration, claimant is awarded 4 percent (12.8 degrees) for a total of 9 percent (28.8 degrees) unscheduled permanent disability. The ALJ's "out-of-compensation" attorney fee award is modified accordingly. The remainder of the ALJ's order is affirmed.

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[4] Claimant seeks a scheduled permanent disability award for partial loss of plantar sensation in his right foot. Because claimant's position is based on his contention that the insurer has accepted a combined condition, we reject his argument.

Board Member Phillips Polich specially concurring.

I agree with the conclusion that claimant is entitled to a total unscheduled permanent disability award of 9 percent from his compensable injury of May 1998. I write separately to express my concerns that both claimant and the insurer have failed to utilize the statutory schemes for "combined conditions" and "omitted conditions," which have been designed to achieve "substantial justice" when those situations arise.

I believe the medical evidence supports a conclusion that claimant's May 1998 compensable injury combined with his preexisting conditions at L4-5 and L5-S1. Consequently, I believe the insurer should have processed this claim as a "combined condition" as defined in ORS 656.005(7)(a)(B). Thereafter, upon determining that the accepted injury was no longer the major contributing cause of the "combined condition" (based on my reading of the medical record), the insurer should have issued a "pre-closure" denial under the terms of ORS 656.262(7)(b).[1] Had the claim been processed in this manner, claimant would likely have received his 9 percent permanent disability award via Notice of Closure or Determination Order, thereby eliminating the tortured path of litigation that ultimately brought this matter to us for resolution.

Claimant also shares some of the responsibility for the lack of precise claims processing in this matter. Claimant could have, but did not, request acceptance of his L4-5 and L5-S1 discs as a "combined condition" utilizing ORS 656.262(6)(d).[2] Had claimant done so (based upon my reading of the medical record), it is likely that the insurer would have modified its previous acceptance to accept the disc herniations as "combined conditions." Had this occurred, the normal claims closure process outlined above (assuming a "pre-closure" denial under ORS 656.262(7)(b)) most likely would have given claimant a 9 percent unscheduled permanent disability award.

In conclusion, I urge both claimants and insurers to utilize the statutory scheme provided when dealing with "combined conditions" or "omitted" conditions. Doing so is the best method to ensure "substantial justice" is accomplished in processing these medically complicated cases.

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[1] OAR 436-035-0007(5) provides the method for the rating disability of a combined condition when the compensable condition is no longer the major contributing cause of the combined condition.

[2] ORS 656.262(6)(d) provides:

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

In the Matter of the Compensation of
DOUGLAS W. STILES, Claimant
WCB Case No. 99-09929
ORDER ON REVIEW
Carney, et al, Claimant Attorneys
Bostwick, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's C5-6 cervical radiculopathy claim. On review, the issue is compensability.

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

On review, the employer contests the ALJ's reliance on the opinions of Dr. Rosenbaum, claimant's treating surgeon, and Dr. Cline, who also treated claimant's cervical radiculopathy condition. In asserting that the opinions are not persuasive, the employer in part contends that both physicians relied on an inaccurate history. Specifically, the employer argues that claimant provided varying histories concerning the onset of symptoms and, because Drs. Rosenbaum and Cline relied on a history of onset during April 7, 1999, and such history is not accurate, their opinions are not sufficient to carry claimants burden of proof.

We disagree with the employer's contention. Although claimant did not provide a detailed history of his activities on April 7, 1999 until October 5, 1999 (when claimant's attorney met with claimant and obtained the history), he did not provide varying accounts concerning the onset of symptoms. On the contrary, he told Dr. Nye that, between April 5, 1999 (when claimant returned to work following hand surgery) and May 12, 1999 (when Dr. Nye examined claimant), he "developed some neck discomfort and numbness in the radial distribution[.]" (Ex. 19-1).

Claimant then reported to Dr. Rosenbaum on June 11, 1999 that "[s]ometime in April while he was driving to Canada he noted the onset of left arm pain to the hand with numbness about the left thumb and radial index digit" and called his company to report that he was not able to drive. (Ex. 22-1). Similarly, claimant told the examining panel of Dr. Gambee and Dr. Rich on June 29, 1999 that "he returned to work in April of 1999 but only lasted two days and began to develop hypesthesia involving the index and thumb" and had "radiation up the left upper extremity[.]" (Ex. 27-2). Finally, claimant informed the examining panel of Dr. Williams and Dr. Sacamano on August 16, 1999 that he "returned to work in April or May of 1999 and worked two days with increased symptoms of decreased sensation along the left thumb and index finger with radiation * * * up the left radial forearm[.]" (Ex. 37-2).

The only physician who initially did not note a history of symptom onset in April was Dr. Cline, who saw claimant on April 29, 1999. Instead, she indicated that claimant's neck symptoms began some time after a 1991 injury. (Ex. 14-1). We do not find that this sole chartnote is enough, however, to show that claimant provided inconsistent accounts of his condition. When weighed against the remaining medical reports showing that claimant consistently reported an onset of symptoms when he returned to work in April 1999, and the ALJ's demeanor-based finding of credibility, we conclude that claimant proved the accuracy of this history. Thus, reliance on this history by Drs. Rosenbaum and Cline is not a reason to reject their opinions.

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 April 13, 2000 order is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,500, to be paid by the self-insured employer.

In the Matter of the Compensation of
MELINDA J. BOGLE, Claimant
WCB Case No. 99-09313
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that decreased claimant's scheduled permanent disability award for loss of use or function of the right leg (knee) from 20 percent (30 degrees), as awarded by an Order on Reconsideration, to 12 percent (18 degrees). On review, the issue is extent of scheduled permanent disability.

We adopt and affirm the order of the ALJ with the following supplement to address claimant's contentions that: (1) she is entitled to an award for lateral collateral ligament laxity; and (2) she is entitled to an award for a chronic condition limiting repetitive use of her leg.

OAR 436-035-0010(2) provides in pertinent part: "Scheduled disability is rated on the permanent loss of use or function of a body part due to an accepted compensable, consequential, combined condition (pursuant to these rules) and any direct medical sequelae." Claimant's accepted condition is anterior cruciate ligament disruption of the right knee. (Ex. 39).

We acknowledge that Dr. Cronin, the medical arbiter, determined that claimant had 1+ laxity of the lateral collateral ligament in both knees.[1] (Ex. 44-1). Even assuming that Dr. Cronin's finding of 1+ laxity in the lateral collateral ligament is correct, there is nothing in the medical record relating this finding in any way to the accepted anterior cruciate ligament disruption. Without such a showing, claimant is not entitled to an award for Dr. Cronin's finding of 1+ laxity in the lateral collateral ligament. ORS 656.214(2); OAR 436-035-0007(1).

Claimant would be entitled to a 5 percent scheduled chronic condition impairment value for her right leg (knee) if the preponderance of medical opinion establishes that, due to a chronic and permanent medical condition, she is significantly limited in the repetitive use of her right leg (knee). OAR 436-035-0010(5)(b).

Here, Dr. Cronin, the medical arbiter, has expressly stated that claimant does not appear to be significantly limited in her ability to repetitively use the right knee. (Ex. 44-2). Dr. Mandiberg, the attending physician, essentially agreed with that assessment.[2] (Ex. 41-1). Consequently, on this record, we conclude that claimant is not entitled to a 5 percent scheduled chronic condition impairment value for her right leg (knee).

ORDER

The ALJ's order dated May 15, 2000 is affirmed.

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[1] Attending physician, Dr. Mandiberg, reported no ligament instability in his closing exam. (Ex. 38).

[2] In a check-the-box concurrence, Dr. Mandiberg characterizes claimant's limitations as mild and appears to agree that claimant is not significantly limited in the repetitive use of her right knee. (Ex. 41-1).

In the Matter of the Compensation of
SIDNEY F. CARTER, Deceased, Claimant
WCB Case No. 00-00798
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant's widow requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the SAIF Corporation's denial of her claim for permanent total disability survivor benefits. On review, the issue is survivor's benefits. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld SAIF's denial[1] of permanent total disability survivor benefits to claimant's widow based on our decision in *Darrell Hankel, Dc'd*, 45 Van Natta 2056 (1993). We agree with the ALJ and with SAIF that *Darrell Hankel, Dc'd* controls our decision in this case.

Claimant was injured on December 16, 1971. At that time, *former* ORS 656.208(1) provided:

> "If the injured workman dies during the period of permanent total disability, whatever the cause of death, leaving: a) a widow *who was his wife either at the time of the injury causing disability or within two years thereafter*; * * * the surviving widow * * * shall receive [survivor benefits]." (Emphasis added) 1971 Or Laws Ch. 415.

At the time of his injury, claimant was married to Dixie Lee Carter. This marriage ended by a divorce decree dated September 16, 1976. (Ex. 2). Claimant was awarded permanent total disability benefits on January 24, 1977. (Ex. 1A-5). Claimant married Donna Carter (claimant's widow) on June 14, 1980, more than two years after his 1971 date of injury. (Ex. 3A). Accordingly, if the version of ORS 656.208(1) in effect on the date of claimant's *injury* applies, claimant's widow is not entitled to survivor benefits.

Claimant's widow contends that *current* ORS 656.208(1), the version of the statute applicable on December 2, 1999, the date of claimant's *death*, applies because she did not become a "beneficiary" until the time of death. *Larry D. Allen*, 52 Van Natta 430 (2000); *Robert K. Wilson*, 45 Van Natta 1747 (1993). We disagree.

Current ORS 656.208(1) provides:

> "If the injured worker dies during a period of permanent total disability, whatever the cause of death, leaving a spouse, * * * payment shall be made in the same manner and in the same amounts as provided in ORS 656.204."

It is clear that, if *current* ORS 656.208(1) applies, claimant's widow is entitled to survivor benefits, because the "two-year" limitation has been eliminated from the statute. However, in *Darrell Hankel, Dc'd*, we concluded that the version of ORS 656.208(1) in effect on the date of claimant's *injury* applied to determine claimant's widow's entitlement to survivor's benefits. 45 Van Natta at 2058. We reasoned that in general we apply the law in effect at the time of claimant's claim. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990). Moreover, we found no legislative intent to make an exception to the general rule that statutes will not be applied retroactively. *See Johnson v. SAIF*, 78 Or App 143, *rev den* 301 Or 240; *Whipple v. Howser*, 291 Or 475 (1981). Therefore, we held that the claimant's widow, whom the claimant had married more than two years after his injury, was not entitled to survivor's benefits. *Id.*

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[1] The ALJ interpreted SAIF's December 8, 1999 letter to claimant's widow advising her that total disability benefits would cease as of the date of claimant's death (Ex. 5) as a denial of survivor benefits. We agree with this interpretation of SAIF's letter.

This case is indistinguishable from *Darrell Hankel, Dc'd.*[2] Accordingly, we affirm the ALJ's determination that claimant's widow is not entitled to survivor's benefits.

ORDER

The ALJ's order dated May 26, 2000 is affirmed.

[2] Claimant's citations to *Larry D. Allen*, 52 Van Natta 430 (2000), and *Robert K. Wilson*, 45 Van Natta 1747 (1995), are inapposite. Those cases involved the ability of a claimant's spouse to release benefits under ORS 656.204 and ORS 656.208 pursuant to a claim disposition agreement (CDA) before the time of the claimant's death. They did not address the issue of whether the date of injury or date of death controls for purposes of determining eligibility for survivor's benefits under ORS 656.208(1).

In the Matter of the Compensation of
LARRY B. COX, Claimant
WCB Case No. 00-01016
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Jacqueline A. Weber, Defense Attorney

Reviewed by Board Members Biehl, Bock, and Meyers.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its denial of claimant's claim for a consequential psychological condition (adjustment disorder with depressive features); (2) set aside its denial of claimant's "new medical condition" claim for a lumbosacral disc condition; and (3) awarded an attorney fee for its allegedly unreasonable denial of the disc condition. On review, the issues are compensability and attorney fees.

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

The last sentence of the order portion of the ALJ's order is corrected to direct the employer (not claimant) to pay claimant's counsel an assessed fee of $750.

The third sentence of the second paragraph in the section entitled "Unreasonable Denial" is corrected to indicate that the employer issued only one denial (not two) of the claim for a disc condition. (*See* Exs. 107, 113, 120).

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 issues is $2,200, 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 counsel's statement of services and 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-related" attorney fee issue.

ORDER

The ALJ's order dated May 3, 2000 is affirmed. For services on review, claimant is awarded a $2,200 attorney fee, to be paid by the self-insured employer.

Board Member Meyers dissenting.

I agree with the majority that claimant's lumbosacral disc condition is compensable. However, I would not find the claim for a consequential psychological condition compensable, for the following reasons.

Dr. Glass, psychiatrist, and Mr. Deshler, clinical psychologist, provide the expert evidence addressing the diagnosis and cause of claimant's psychological problems. The majority concludes that claimant's 1997 work injury was the major contributing cause of his consequential adjustment disorder with depressive features, based on Mr. Deshler's opinion. In reaching this conclusion, the majority discounts Dr. Glass' opinion to the contrary, finding it inconsistent with the medical evidence regarding claimant's back problems and claimant's work history.

I would rely on Dr. Glass, rather than Mr. Deshler, for two interrelated reasons. First, Dr. Glass has superior *medical* training. He is simply better qualified to determine whether claimant has a diagnosable psychiatric condition. Dr. Glass' opinion that claimant's psychological problems do not amount to a diagnosable condition is also better-informed that Mr. Deshler's diagnosis, because Dr. Glass' evaluation of claimant's psychological complaints is based on MMPI tests which he administered and interpreted. Mr. Deshler's evaluation, on the other hand, is based solely on claimant's subjective complaints.

Considering Dr. Glass' thorough, objective evaluation and his training and expertise, I would rely on his conclusion that claimant's psychological complaints are a "problem in living," not a diagnosable medical condition. Therefore, I must respectfully dissent from the majority's conclusion regarding the consequential psychological condition claim.

In the Matter of the Compensation of
MARY L. FLYNN, Claimant
WCB Case No. 99-09099
ORDER ON REVIEW
Gilroy Law Firm, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Howell's order that upheld the self-insured employer's denial of claimant's injury claim for a left foot condition. With her briefs, claimant submits several documents, copies of documents, and photographs. We treat claimant's submissions as a motion to remand. On review, the issues are remand and timeliness and, if the claim was timely, compensability.

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

Claimant submits several documents, copies of documents, and photographs with her briefs. We treat this submission as a motion for remand to the ALJ for further development of the hearings record, because our review is limited to the record developed at hearing. *Judy A. Britton*, 37 Van Natta 1262 (1985); *see* ORS 656.295(5).

We may remand to the ALJ should we find that the hearings record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988); *Bernard L. Osborn*, 37 Van Natta 1054, 1055 (1985), *aff'd mem*, 80 Or App 152 (1986).

Claimant's proposed evidence consists of: August 17, 2000 letters from Dr. DeKorte and Dr. Bieraugel; an August 21, 2000 letter from Judy Coleman, 6 photographs labeled "Mary L. Flynn Left Foot Injury Taken 8/1/00"; 2 copies of photographs labeled "Pictures taken in Jan. 2000. Compare to pictures taken this month. Left foot is worse."; a copy of page 41 of the hearings transcript (entitled "Certificate"); a copy of a page describing hearing procedures relating to evidence; 6 pages from Campbell's *Operative Orthopaedics*; 6 pages from "*Imaging Orthopedic Trauma*," by Thomas H. Berquist; a copy of the ALJ's Opinion and Order; and a document entitled "Regarding the Foot Injury of Mary L. Flynn," signed by Susan C. Close.

There has been no showing that the proposed evidence submitted for the first time on review[1] was unavailable with due diligence at the time of hearing (except for the photographs annotated to indicate that they were taken after the hearing). Moreover, in light of the existing documentary and testimonial evidence already present in the record, we find that consideration of the additional proposed evidence would not likely affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or at 646. As the ALJ explained, the threshold issue is whether claimant gave timely notice of her accident to the employer, as required by ORS 656.265. Because none of claimant's post-hearing submissions address the timeliness issue, the proposed evidence is not reasonably likely to effect the outcome of the case. Under these circumstances, we deny claimant's motion for remand.

ORDER

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

[1] We note that the hearings transcript and the Opinion and Order are already in the record.

In the Matter of the Compensation of
THEA M. MICKOLA, Claimant
WCB Case Nos. 00-00585 & 00-00097
ORDER ON REVIEW
Bottini, Bottini & Oswald, Claimant Attorneys
Schwabe, Williamson & Wyatt, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Davis' order that upheld the self-insured employer's denial of her occupational disease claim for right ulnar neuropathy. In its brief, the employer contends that claimant's claim for right ulnar neuropathy was precluded by prior litigation. On review, the issues are claim preclusion and compensability.

We adopt and affirm the ALJ's order, with the following supplementation to address the employer's argument regarding claim preclusion.

The employer contends that it issued its "updated notice of acceptance" for claimant's bilateral carpal tunnel condition after it was ordered to do so by a prior ALJ and that, therefore, claimant's right ulnar condition was not an "omitted medical condition." The employer accurately states that it accepted claimant's bilateral carpal tunnel condition as a result of the prior order. Upon issuance of the prior order, the employer was required to process the claim according to law. The issuance of an "updated notice of acceptance" is a claim processing matter required under ORS 656.262(7)(c) before the claim may be closed.

Here the employer correctly issued the "updated notice of acceptance" pursuant to ORS 656.262(7)(c) and ORS 656.262(6)(d). Likewise, claimant properly communicated in writing that a condition had been incorrectly omitted from the notice of acceptance or that the notice was otherwise deficient pursuant to ORS 656.262(6)(d).

Because this claim arose under ORS 656.262(6)(d), the principles of claim preclusion are not applicable. *Wallace M. Prince*, 52 Van Natta 45, 47 (2000); *compare Eugene J. Senger*, 52 Van Natta 1324 (2000) (condition previously litigated under injury theory is barred by claim preclusion from being relitigated under occupational disease theory where the condition is not related to or based on the initial injury claim; *i.e.*, is not a "new medical condition" claim under ORS 656.262(7)(a) or an "omitted" condition under ORS 656.262(6)(d)).

ORDER

The ALJ's order dated June 29, 2000 is affirmed.

In the Matter of the Compensation of
FRIEDA M. NEVIN, Claimant
WCB Case No. 00-00699
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Fulsher's order that upheld the insurer's partial denial of claimant's new medical condition claim for a left knee condition. On review, the issues are the procedural validity of the denial and compensability.

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

Claimant suffered a compensable injury to her back and left knee on August 30, 1999 when she slipped on a wet floor and fell on her knees. An MRI performed on October 28, 1999 revealed an oblique tear of the posterior horn of the medial meniscus with probable degeneration in the mid portion of the meniscus. (Ex. 38). On November 30, 1999, the insurer accepted claimant's claim for left knee strain and lumbar strain. (Ex. 49). On December 21, 1999, claimant's attorney wrote the insurer and requested acceptance of a left knee medial meniscus tear. (Ex. 57A). The insurer issued a partial denial of this condition on January 13, 2000. On March 13, 2000, the insurer issued an Updated Notice of Acceptance and closed claimant's claim for the accepted left knee strain and lumbar strain conditions. (Exs. 68, 69).

The ALJ upheld the insurer's denial on both procedural and substantive grounds. As to the procedural validity of the denial, the ALJ determined that the insurer did not accept a "combined condition" and did not issue its denial pursuant to ORS 656.262(6)(c) or ORS 656.262(7)(b). In those circumstances, the ALJ reasoned, *Croman Corporation v. Serrano*, 163 Or App 136 (1999), did not apply to preclude a "pre-closure" denial. Moreover, the ALJ reasoned that the insurer's "pre-closure" denial of the left knee medial meniscus tear condition was procedurally proper because the medical evidence unequivocally indicated that the medial meniscus tear condition was a separate condition from the accepted left knee strain and lumbar strain conditions. We agree with the ALJ's analysis and in addition, offer the following reasoning.

A "pre-closure denial is procedurally valid if it pertains to a condition or conditions separate or severable from the accepted condition. *Guerrero v. Stayton Canning Co.*, 92 Or App 209, 212 (1988); *Pamela J. Gentry*, 52 Van Natta 918, 919 (2000)[1]; *Corrine L. Birrer*, 51 Van Natta 163, 165, *on recon* 51 Van Natta 467 (1999); *Zora A. Ransom*, 46 Van Natta 1287 (1994). Here, we agree with the ALJ's reasoning that the medical evidence unequivocally indicates that the denied medial meniscal tear condition is unrelated to the previously accepted lumbar strain and left knee strain conditions. Accordingly, the insurer's denial was procedurally proper.[2]

ORDER

The ALJ's order dated May 24, 2000 is affirmed.

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[1] In *Pamela J. Gentry*, we concluded that the employer's denial was not a valid "pre-closure" denial, stating that "the medical evidence does not unequivocally indicate that claimant's current condition is unrelated to the accepted *injury*." 52 Van Natta at 919. That statement could be interpreted as inconsistent with our statements in *Corrine L. Birrer*, 51 Van Natta at 165 and *Zora A. Ransom*, 46 Van Natta 1287 (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 *condition*). The statements in *Birrer* and *Ransom* represent a correct statement of the law. *See Guerrero v. Stayton Canning Co.*, 92 Or App at 212 ("An employer may not issue a denial of a previously accepted inseparable condition while the claim is still open.").

[2] We adopt and affirm the ALJ's reasoning on the merits of the compensability issue, *i.e.* that claimant did not meet her burden of proving that her compensable injury was the major contributing cause of the medial meniscal tear condition.

In the Matter of the Compensation of
DOYCE G. PRINCE, Claimant
WCB Case Nos. 00-02142 & 00-01799
ORDER ON REVIEW
Flaxel & Nylander, Claimant Attorneys
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) denied his request to direct the self-insured employer to process his accepted radial/ulnar irritation condition as part of the December 1996 injury claim; and (2) declined to award additional temporary disability compensation from May 21, 1997 through December 1, 1997. On review, the issues are claim processing and temporary disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. In the third paragraph on page 2, we change the date in the first sentence to "October 7, 1997." In the sixth paragraph on page 2, we change the date to "December 2, 1997."

CONCLUSIONS OF LAW AND OPINION

Claim Processing

At hearing, claimant argued that his accepted radial/ulnar irritation condition should be processed as part of his 1996 claim, whereas the employer had processed it as part of his original 1994 claim. The ALJ concluded that, based on the procedural history of the case, the prior December 4, 1998 order and the evidence leading thereto, the employer properly processed claimant's radial/ulnar condition as part of the 1994 claim. The ALJ reasoned that claimant's radial/ulnar condition was a consequence of the original surgery resulting from the 1994 injury and his need for treatment of the radial/ulnar portion of the forearm was primarily due to reasons unrelated to the 1996 event.

We recap the procedural history of this case. Claimant was compensably injured in January 1994 and the employer accepted a nondisabling left wrist strain. (Exs. 2-2, 26A-1).[1] On January 5, 1995, Dr. Bert performed left wrist arthodesis surgery. (Ex. 26A-2). A May 2, 1995 Opinion and Order set aside the employer's partial denial of claimant's left wrist degenerative arthritis and radial-scaphoid joint and scapholunate dissociation conditions. (Ex. 2). The employer accepted "symptomatic worsening of degenerative arthritis to the radial scaphoid joint and scapholunate dissociation. (Ex. 3).

Claimant had a second injury on December 2, 1996, when a box of frozen meat fell and caused his left wrist to hyperextend. (Ex. 26A-2). On May 21, 1997, Dr. Bert diagnosed extensor tendinitis of the ring and small fingers, and lateral epicondylitis. (Ex. 7). Dr. Bert recommended a "Darrach" surgical procedure to resolve claimant's radial ulnar irritation and tendinitis. (Ex. 8, 9). Dr. Bert performed surgery on December 2, 1997. (Ex. 17).

The employer issued several denials of claimant's condition. On October 7, 1997, the employer denied an aggravation claim for a left wrist condition, as well as claimant's current need for treatment involving the Darrach procedure. (Ex. 11). Claimant subsequently made a formal aggravation claim and filed an injury claim related to the December 2, 1996 incident. (Exs. 13, 14). The employer issued another aggravation denial on November 13, 1997 and denied claimant's current need for treatment. (Ex. 15).

On February 9, 1998, the employer denied compensability and responsibility of claimant's left forearm radial/ulnar irritation condition on the ground that the December 2, 1996 injury did not occur in the course and scope of his employment. (Ex. 22). On May 13, 1998, the employer reiterated its February 9, 1998 position in an amended denial. (Ex. 25). The employer issued another denial on May 13, 1998, asserting that claimant had not sustained a pathological worsening of the accepted conditions. (Ex. 26).

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[1] The citations are to the exhibit file for WCB Case No. 00-02142.

A hearing was held concerning the denials and the prior ALJ issued an order on December 4, 1998. (Ex. 26A). The prior ALJ upheld the employer's October 7, 1997 and November 13, 1997 denials insofar as they denied claimant's aggravation claim, although the denials were set aside insofar as they denied liability for claimant's Darroch procdure surgery. (Ex. 26A-7). The prior ALJ set aside the employer's February 9, 1998 and May 13, 1998 denials. (*Id.*) The prior ALJ found that claimant had suffered a compensable consequential condition in late 1996 and early 1997, which was caused in major part by the compensable treatment he received for the 1994 injury. (Ex. 26A-6). The prior ALJ relied on Dr. Bert's opinion that the 1995 surgery caused a degenerative condition of the ulna and radial areas of the left wrist because of the ulna's inability to properly articulate. (Ex. 26A-7). The prior ALJ also found that claimant had sustained a new injury in December 1996, *i.e.*, lateral and extensor epicondylitis. (*Id.*) On May 11, 1999, the Board adopted and affirmed the December 4, 1998 order with supplementation on the issue of whether claimant was compensably injured on December 2, 1996. (Ex. 27).

On July 1, 1999, the employer accepted a consequential condition of radial/ulnar irritation in the left wrist, as well as left arm lateral epicondylitis and left arm extensor epicondylitis. (Exs. 28, 29). On August 25, 1999, the employer issued an updated notice of acceptance at closure, which said that the accepted condition for the January 28, 1994 claim was radial/ulnar nerve irritation. (Ex. 34). Another updated notice of acceptance at closure said that the accepted conditions for the December 2, 1996 claim were left arm lateral epicondylitis and left arm extensor epicondylitis. (Ex. 36).

A September 10, 1999 Determination Order regarding the January 28, 1994 claim awarded temporary disability from December 1, 1997 through April 27, 1998. (Ex. 39). A September 10, 1999 Determination Order regarding the December 2, 1996 claim awarded temporary disability from May 21, 1997 through July 14, 1997. (Ex. 40).

On September 16, 1999, claimant's attorney wrote to the employer, asserting that the radial/ulnar nerve irritation of the left wrist was not properly part of Claim No. 19100810." (Ex. 41). The reference to "Claim No. 19100810" was to the January 28, 1994 claim. (Exs. 34, 39).

On November 7, 1999, the employer responded to the letter, stating that the radial/ulnar nerve irritation of the left wrist had been properly processed as part of the January 28, 1994 injury, as a consequential condition. (Ex. 42). On December 8, 1999, the employer issued an amended updated notice of acceptance at closure regarding the January 28, 1994 claim, stating that the accepted conditions were radial/ulnar irritation in the left wrist, symptomatic worsening of degenerative arthritis to the radial scaphoid joint and scapholunate dissociation. (Ex. 43). The employer noted that, for purposes of the current closure, the only condition to be rated was the radial/ulnar irritation in the left wrist. (Ex. 43).

A February 3, 2000 Order on Reconsideration regarding claimant's December 2, 1996 claim awarded 2 percent scheduled permanent disability for loss of use or function of the left arm and affirmed the remainder of the September 10, 1999 Determination Order. (Exs. 45, 47). A February 4, 2000 Order on Reconsideration concerning the January 28, 1994 claim awarded 68 percent scheduled permanent disability for loss of use or function of the left forearm (wrist) and affirmed the remainder of the September 10, 1999 Determination Order.[2] (Ex. 46).

Claimant requested a hearing regarding the employer's *de facto* denial of additional conditions per claimant's attorney's September 16, 1999 letter to the employer. The ALJ concluded that the employer properly processed claimant's radial/ulnar condition as part of the 1994 claim. The ALJ reasoned that claimant's radial/ulnar condition was a consequence of the original surgery resulting from the 1994 injury and claimant's need for treatment of the radial/ulnar portion of claimant's forearm was primarily due to reasons unrelated to the 1996 event.

On review, claimant argues that the Board's May 11, 1999 Order on Review "judicially determined" that his current left wrist condition for which he had the "Darrach" procedure was a new injury and, therefore, his radial nerve irritation of the left wrist should be covered under the 1996 injury claim.

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[2] A March 6, 1996 Order on Reconsideration regarding claimant's January 28, 1994 claim had previously awarded 64 percent scheduled permanent disaiblity for loss of use or function of the left forearm (wrist). (Ex. 5; WCB Case No. 00-01799). The Order on Reconsideration was later affirmed by an August 16, 1996 Opinion and Order. (Ex. 6; WCB Case No. 00-1799).

Claimant focuses on the Board's May 11, 1999 Order on Review, rather than the ALJ's December 4, 1998 order. The Board's order, however, expressly adopted and affirmed the ALJ's order. In light of this unappealed and unambiguous conclusion, the prior ALJ's conclusions are an integral component in determining the propriety of the employer's claim processing obligations.

The opening paragraph in the Board's May 11, 1999 order said that ALJ's order had "(1) set aside [the employer's] denial of claimant's 'new injury' claim for a left wrist condition; and (2) set aside its denial of a consequential condition claim for a left wrist condition." (Ex. 27-1). The Board's order explained that the ALJ found that claimant had sustained a "new injury" to his left wrist in December 1996. (*Id.*)

Notwithstanding this introductory paragraph and the Board's comment, it is apparent that the Board adopted and affirmed the prior ALJ's order that set aside the employer's denial of claimant's "new injury" claim for a left *elbow* condition. The prior ALJ's December 4, 1998 order further found that claimant had sustained a new injury in December 1996, *i.e.*, lateral and extensor epicondylitis. (Ex. 26A-7). Finally, and of most importance to the present case, the prior ALJs December 4, 1998 order expressly and unambiguously found that claimant had suffered a compensable consequential condition in late 1996 and early 1997, which was caused in major part by the compensable treatment he received for the 1994 injury. (Ex. 26A-6). Under these circumstances, we agree with the current ALJ that the employer properly processed claimant's radial/ulnar condition as part of the 1994 claim.

Temporary Disability

Claimant also requested a hearing on the February 4, 2000 Order on Reconsideration regarding his entitlement to temporary disability from May 21, 1997 through December 1, 1997. At hearing, claimant argued that he was off work during that period as a result of his compensable injury, as acknowledged by Dr. Bert on May 21, 1997. The employer contended that claimant was not entitled to time loss for the period requested because he had been previously terminated from his employment for reasons unrelated to his compensable injury.

The ALJ reasoned that when an injured worker is terminated from his employment, he must establish that the termination resulted from an inability to work due to the compensable injury in order to qualify for temporary disability. The ALJ found that the record did not establish that claimant was terminated on December 16, 1996 for reasons related to the left wrist injury. The ALJ noted that the employer asserted that the reasons for termination were disciplinary. The ALJ also found that claimant had failed to establish that he was in the work force after December 16, 1996.

On review, claimant argues that the evidence "clearly establishes" that his inability to work from May 21, 1997 through December 1, 1997 was due to the compensable injury. Claimant contends that the fact that he had been terminated on December 16, 1996 should be irrelevant. He argues that there is no evidence he withdrew from the work force between May 21, 1997 and the date of surgery.

We briefly review the facts pertaining to temporary disability issue. Claimant was compensably injured on January 28, 1994 and the employer accepted a nondisabling left wrist strain. (Ex. 2-2).[3] After litigation, the employer accepted "symptomatic worsening of degenerative arthritis to the radial scaphoid joint and scapholunate dissociation. (Ex. 3). A November 8, 1995 Determination Order awarded temporary disability and 51 percent scheduled permanent disability for loss of use or function of claimant's left forearm (wrist). (Ex. 4). A March 6, 1996 Order on Reconsideration increased claimant's scheduled permanent disability award to 64 percent. (Ex. 5). The March 6, 1996 Order on Reconsideration was affirmed by an August 16, 1996 Opinion and Order. (Ex. 6).

On May 21, 1997, claimant sought treatment from Dr. Bert for wrist and elbow pain. (Ex. 7). Dr. Bert explained that "[s]ome two weeks ago he was lifting about 30 pounds overhead, hyperextended his fingers and has had pain over the ulnar aspect of his wrist and over the lateral aspect of his elbow ever since." (*Id.*) He diagnosed extensor tendinitis of the ring and small fingers, and lateral epicondylitis. (*Id.*) Dr. Bert explained: "I am going to put the hand to rest, take him off work, although he tells me he has been fired and has not worked for a week." (*Id.*) On July 14, 1997, Dr. Bert reported that claimant continued to have pain over his distal ulna on the left. (Ex. 8). He recommended a "Darrach" procedure for claimant's radial ulnar irritation and subsequent tendinitis. (Exs. 8, 9).

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[3] The citations are to the exhibit file for WCB Case No. 00-01799.

On October 23, 1997, Dr. Bert signed an aggravation form. (Ex. 13). In response to whether time loss was authorized, Dr. Bert wrote: "[m]ay do light work." (*Id.*)

On December 1, 1997, Dr. Bert admitted claimant for a Darrach procedure. (Ex. 15). He noted that claimant was "unemployed because of pain in his left arm." (*Id.*) Dr. Bert performed surgery on December 2, 1997. (Ex. 16).

The employer issued several denials regarding claimant's condition and need for treatment. (Exs. 11, 14, 21). A hearing was held concerning the denials and the prior ALJ issued an order on December 4, 1998. (Ex. 22). As we discussed earlier, the prior ALJ found that claimant had suffered a compensable consequential condition in late 1996 and early 1997, which was caused in major part by the compensable treatment claimant received for the 1994 injury. (Ex. 22-6). The prior ALJ also found that claimant had sustained a new injury in December 1996, *i.e.*, lateral and extensor epicondylitis. (Ex. 22-7). In addition, the prior ALJ found that the employer had received information in December 1996 from claimant's coworkers that claimant, a meat cutter, was allegedly grinding outdated meat into hamburger and making it available for sale. (Ex. 22-2). The employer had investigated the allegation and concluded that claimant had violated company policy. (*Id.*) Claimant was terminated on December 16, 1996.[4] (*Id.*) The Board adopted and affirmed the December 4, 1998 order. (Ex. 23). The employer accepted claimant's consequential condition of radial/ulnar irritation in the left wrist. (Ex. 24).

Claimant's attorney wrote to Dr. Bert on July 22, 1999, asking, among other things, whether claimant was disabled from work between May 21, 1997 and December 1997. (Ex. 25A). On August 2, 1999, Dr. Bert responded that claimant was disabled from the December 1997 surgery until April 27, 1998, when he was medically stationary. (Ex. 27). He explained:

> "In regards to disability between May of 1997 and the date of surgery, he would have been disabled as far as his elbow was concerned. He had epicondylitis for a month, and further was disabled because of the wrists, a radial ulnar irritation until his surgery." (*Id.*)

On August 24, 1999, the employer reclassified the January 1994 claim as disabling. (Ex. 28). A September 10, 1999 Determination Order regarding the January 28, 1994 claim awarded temporary disability from December 1, 1997 through April 27, 1998. (Ex. 32). Claimant requested reconsideration. (Ex. 33).

On January 14, 2000, Dr. Studt performed a medical arbiter examination. (Ex. 38). He reported that claimant worked until December 1996, when he was fired by the employer due to violations of company policy. (Ex. 38-2). Dr. Studt noted that "[f]ollowing the firing, the subject looked around for a new job but there were none available and he was continuing to have pain in the left wrist." (*Id.*) A February 4, 2000 Order on Reconsideration concerning the January 28, 1994 claim awarded additional scheduled permanent disability and affirmed the temporary disability compensation awarded by the September 10, 1999 Determination Order. (Ex. 39).

For the following reasons, we find that claimant has failed to prove that he is entitled to temporary disability compensation from May 21, 1997 through December 1, 1997. Temporary disability benefits are intended to provide replacement for wages lost due to a compensable injury. *Cutright v. Weyerhaeuser Co.*, 299 Or 290, 296 (1985). Where a worker leaves work for reasons other than an inability to work as a result of the compensable injury, the worker is not entitled to temporary disability benefits. *Noffsinger v. Yoncalla Timber Products*, 88 Or App 118, 121 (1987); *Lino Villa-Acosta*, 51 Van Natta 211 (1999); *George B. Orazio*, 49 Van Natta 1982 (1997).

Here, claimant was injured on December 2, 1996. He continued to work until December 16, 1996, when he was terminated for violating company policy. We agree with the ALJ that there is no evidence that claimant left work due to an inability to work as a result of a compensable injury.

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[4] Although the prior ALJ found that claimant was terminated on December 16, 1997 (Ex. 22-2), he also found that claimant had filed a claim in May 1997, "some six months after his termination." (Ex. 22-6). Both parties assert that claimant was terminated from the employer on December 16, 1996 and the record supports that conclusion.

Furthermore, a claimant must remain in the work force to be entitled to temporary disability. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989). Work force status is determined at the time of disability. *Id.*; *Weyerhaeuser Co. v. Kepford*, 100 Or App 410, 414, *rev den* 310 Or 71 (1990). Claimant has the burden of proving the nature and extent of his disability. ORS 656.266.

Claimant relies on Dr. Bert's May 21, 1997 chart note. Dr. Bert took claimant off work on May 21, 1997. (Ex. 7). Dr. Bert said that claimant had been injured two weeks earlier and had not worked for a week because he had been fired. (*Id.*) In a later August 2, 1999 report, Dr. Bert reported that claimant was disabled between May 1997 and the date of surgery as far as his elbow was concerned. (Ex. 27). He noted that claimant had epicondylitis for a month and further was disabled because of the wrists, a radial ulnar irritation until his surgery. (*Id.*)

Even if we assume that Dr. Bert's reports are sufficient to establish entitlement to temporary disability for the accepted radial/ulnar irritation in the left wrist for the time period at issue, we agree with the ALJ that claimant has failed to establish that he was in the work force after his termination on December 16, 1996. A claimant is deemed to be in the work force if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work and is making reasonable efforts to obtain employment; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins*, 308 Or at 258.

Claimant relies on the report from Dr. Studt, the medical arbiter, and argues that he was in the job market seeking employment, but could find none. Dr. Studt reported that "[f]ollowing the firing, the subject looked around for a new job but there were none available and he was continuing to have pain in the left wrist." (Ex. 38-2). We find that Dr. Studt's statement that claimant looked around for a new job but there were none available is not sufficient to establish that he was willing to work and was making reasonable efforts to obtain employment. *See Linda M. Storns*, 51 Van Natta 876 (1999) (the claimant was unable to offer details regarding her job-seeking activities; her testimony was unpersuasive and insufficient to establish that she was in the work force at the relevant time). In addition, although Dr. Studt noted that claimant was continuing to have pain in the left wrist" (Ex. 38-2), that statement is not sufficient to establish that claimant's efforts to obtain employment would be futile. In sum, we agree with the ALJ that claimant has failed to establish that he was in the work force after December 16, 1996 and, therefore, he is not entitled to temporary disability compensation from May 21, 1997 through December 1, 1997.[5]

ORDER

The ALJ's order dated July 14, 2000 is affirmed.

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[5] Claimant asks why, if he must establish that he was in the work force to be entitled to temporary disability, the employer paid temporary disability from the date of surgery to the medically stationary date. Because neither party has contested review of that portion of the February 4, 2000 Order on Reconsideration that affirmed the award of temporary disability from December 1, 1997 through April 27, 1998 (Exs. 32, 39), we do not address that issue.

In the Matter of the Compensation of
ERROL L. SCHROCK, Claimant
WCB Case No. 99-09897
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Poland's order that: (1) directed it to process claimant's "new medical condition" claim for right adhesive capsulitis and rotator cuff conditions under ORS 656.262 and ORS 656.268; and (2) assessed a penalty for the insurer's allegedly unreasonable claim processing. On review, the issues are claim processing and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured his right upper extremity in June 1992. (Ex. 1). The insurer initially accepted right ulnar compression neuropathy at the elbow. (Ex. 5). A January 21, 1993 Determination Order awarded 6 percent scheduled permanent disability for loss of use or function of the right forearm (wrist). (Ex. 11).

The insurer accepted an aggravation claim on June 23, 1997. (Ex. 28). A March 25, 1998 updated notice of acceptance at closure referred to the accepted conditions as a right shoulder strain and right cubital tunnel syndrome/ulnar compression neuropathy of the right elbow. (Ex. 31). An April 10, 1998 Determination Order awarded only temporary disability. (Ex. 32). Claimant requested reconsideration. (Ex. 33). An August 19, 1998 Order on Reconsideration affirmed the Determination Order. (Ex. 42). Claimant requested a hearing of the August 19, 1998 Order on Reconsideration, but he subsequently withdrew that request. (Exs. 43, 56).

On June 24, 1998, Dr. Puziss diagnosed claimant with right shoulder adhesive capsulitis and right rotator cuff tendinitis and impingement. (Ex. 36-3). He felt that claimants shoulder conditions were related to treatment for the accepted conditions. (Ex. 36-3, 40). Dr. Puziss recommended the following treatment:

> "With respect to the shoulder, he requires cortisone injections in the bursal area for impingement testing, and then he will very likely need a manipulation under anesthesia with an intra-articular cortisone injection. If this is not adequate he might require arthroscopic evaluation and treatment, depending upon surgical findings, *i.e.*, decompression or possible capsulotomy." (Ex. 36-3).

Claimant's attorney asked the insurer to accept right shoulder adhesive capsulitis and frozen right shoulder. (Ex. 44). Dr. Puziss signed an aggravation form on September 4, 1998. (Ex. 45).

The insurer amended its acceptance to include adhesive capsulitis syndrome of the right shoulder as a compensable consequence of the accepted conditions. (Ex. 49). In December 1998, the insurer submitted the claim to the Board under its Own Motion authority with a recommendation against reopening. (Exs. 51, 52). The insurer asserted that Dr. Puziss had recommended a cortisone injection and manipulation, which did not involve inpatient or outpatient surgery. (Ex. 51-4).

On January 25, 1999, the Board issued an Own Motion order denying the reopening because the record failed to demonstrate that claimant required surgery or hospitalization for treatment. (Ex. 53). The order was not appealed.

The insurer amended the acceptance to include right rotator cuff tendonitis and impingement of the right shoulder as a compensable consequence of the previously accepted conditions. (Ex. 57).

On April 13, 1999, Dr. Puziss requested authorization to perform surgery on claimant's right shoulder. (Exs. 58, 59). His diagnoses included right shoulder adhesive capsulitis, internal derangement and right rotator cuff tendinitis and impingement. (Ex. 58). He said that claimant's shoulder condition had worsened. (Ex. 58-2).

On June 12, 1999, claimant's attorney asked the Board to reopen claimant's injury claim under its Own Motion jurisdiction for exploratory surgery for the right shoulder condition. (Ex. 62). Dr. Puziss performed surgery on June 28, 1999. (Ex. 67).

The insurer recommended voluntary reopening of claimant's claim under the Board's Own Motion authority. (Ex. 69). Claimant's attorney requested temporary disability benefits on September 14, 1999. (Ex. 72). A November 22, 1999 Own Motion Notice of Closure awarded temporary disability benefits from June 28, 1999 to November 12, 1999. (Ex. 74).

On December 5, 1999, claimant's attorney asked the insurer to reopen the claim for processing and for closure of a new medical condition, namely, adhesive capsulitis of the right shoulder. (Ex. 75). Claimant requested a hearing regarding the insurer's failure to reopen the claim.

CONCLUSIONS OF LAW AND OPINION

The ALJ directed the insurer to process claimant's "new medical condition" claim for right adhesive capsulitis and rotator cuff conditions under ORS 656.262 and ORS 656.268. The ALJ also assessed a penalty for the insurer's allegedly unreasonable claim processing.

The insurer argues that the ALJ misinterpreted the medical evidence. The insurer contends that claimant asked it to process a claim for adhesive capsulitis under ORS 656.268, but Dr. Puziss said in his operative report that claimant did not have that particular condition. The insurer argues that the "new medical condition" that claimant wanted to have processed was the non-existent adhesive capsulitis. We disagree.

The insurer amended its acceptance on November 25, 1998 to include adhesive capsulitis syndrome of the right shoulder as a compensable consequence of the accepted conditions. (Ex. 49). On April 1, 1999, the insurer amended the acceptance to include right rotator cuff tendonitis and impingement of the right shoulder as a compensable consequence of the previously accepted conditions. (Ex. 57).

On December 5, 1999, claimant's attorney asked the insurer to reopen the claim "for processing and for closure of a new medical condition, namely, adhesive capsulitis of the right shoulder." (Ex. 75). Although claimant's request for reopening referred to the adhesive capsulitis condition, claimant's attorney framed the issue more broadly at hearing by arguing that the insurer had an obligation to process the new shoulder conditions of adhesive capsulitis syndrome of the right shoulder and rotator cuff tendinitis and impingement syndrome of the right shoulder. (Tr. 4). The insurer did not object to claimants characterization of the new shoulder conditions at issue. Because the insurer did not object at hearing, we find that it has waived any potential procedural challenge based on claimant's December 5, 1999 request for reopening. *See Thomas v. SAIF*, 64 Or App 193 (1983); *see also Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for the ALJ and Board not to decide that issue). Thus, the issues litigated at hearing were whether claimants adhesive capsulitis syndrome, right rotator cuff tendonitis and impingement of the right shoulder should be reopened under ORS 656.262 and ORS 656.268.

Next, the insurer argues that claimant forfeited his right to pursue this claim by failing to request review of the Board's January 25, 1999 Own Motion Order or the November 22, 1999 Own Motion Notice of Closure. The insurer contends that claimant is precluded from pursuing benefits in this matter by the doctrine of claim preclusion and he forfeited his right to assert a new medical condition under the doctrine of issue preclusion.

The ALJ found that the holding in *John R. Graham*, 51 Van Natta 1740 (1999), controlled this case. The ALJ relied on *Olive M. Bonham*, 51 Van Natta 1710 (1999), and concluded that the present claim was not barred by claim preclusion. The ALJ also found that claimant's new medical condition claim was not barred by issue preclusion. The ALJ reasoned that the Board's January 25, 1999 Own Motion Order had not addressed whether the claim for the new right shoulder condition should have been processed under ORS 656.262 and 656.268. The ALJ found that the November 22, 1999 Own Motion Notice of Closure was a nullity because the claim for the new right shoulder condition was properly processed under ORS 656.262 and 656.268 and the initial injury claim had not been reopened under the Board's Own Motion authority.

In *Larry L. Ledin*, 52 Van Natta 682 (2000), we held that the claimant was not barred by an earlier Own Motion Order from seeking reopening and processing of his right knee torn meniscus condition. We found that the Board's Own Motion Order authorizing time loss for his right knee surgery did not eliminate his right to have his right torn meniscus condition processed under ORS 656.262(7)(c). *See also Robert A. Olson*, 52 Van Natta 1540 (2000); *Craig J. Prince*, 52 Van Natta 108 (2000). Based on those cases, we agree with the ALJ that claimant was not barred from seeking reopening of his newly accepted conditions because of the January 25, 1999 Own Motion Order.

In addition, for the following reasons, we find that the Board's January 25, 1999 Own Motion Order has no preclusive effect on this case. The January 25, 1999 order denied reopening because the record failed to demonstrate that claimant required surgery or hospitalization for treatment. (Ex. 53). The order specifically said that, if claimant's condition worsens in the future to require that surgery, he may again request Own Motion relief. (Ex. 53-1).

On April 13, 1999, Dr. Puziss requested authorization to perform surgery on claimant's right shoulder. (Exs. 58, 59). His diagnoses included right shoulder adhesive capsulitis, internal derangement and right rotator cuff tendinitis and impingement. (Ex. 58). He said that claimant's shoulder condition had worsened. (Ex. 58-2). He explained that claimant required a right shoulder examination under anesthesia, manipulation and arthroscopy. (*Id.*) Depending on the findings, Dr. Puziss said that claimant may require a capsulotomy and/or decompression, as well as a right distal clavicle resection. (*Id.*) The Board's January 25, 1999 Own Motion Order denied reopening because the record *at that time* failed to demonstrate that claimant required surgery or hospitalization for treatment. (Ex. 53). The Board expressly left open the possibility that claimant's medical condition could change, and the medical evidence indicates that his condition did change. Under these circumstances, neither issue nor claim preclusion is applicable to the Board's January 25, 1999 Own Motion Order.

We also address the insurer's argument that claimant forfeited his right to pursue rights in this claim by failing to request review of the November 22, 1999 Own Motion Notice of Closure.

In *John R. Graham*, 51 Van Natta 1746 (1999) (Own Motion Order), we reasoned that, because we had directed the carrier to close the claimant's "new medical condition" claim under ORS 656.268, it followed that the claim should not be closed under ORS 656.278. We found that, because the initial claim did not qualify for reopening under ORS 656.278, the carrier's Own Motion Notice of Closure did not "close" any "reopened" Own Motion claim. We concluded that the carrier's "closure" was a nullity.

In *Robert A. Olson*, 52 Van Natta at 1540, we affirmed the ALJ's order that directed the carrier to reopen the claimant's right knee strain claim for processing of his "post-closure" conditions of right medial meniscus tear and right patellar displacement. The claimant had knee surgery on April 4, 1999 and the carrier issued a modified Notice of Acceptance for posttraumatic arthritis of the right knee. On September 15, 1999, the carrier issued an Own Motion Notice of Closure awarding temporary disability benefits. We concluded that the ALJ did not have authority to set aside the carrier's Own Motion Notice of Closure. We reasoned that the Board, not the Hearings Division, had continuing authority to alter Own Motion awards.

In *Robert A. Olson*, 52 Van Natta 1544 (2000) (Own Motion Order), we affirmed the carrier's September 15, 1999 Own Motion Notice of Closure. We noted that the temporary disability benefits paid pursuant to the closure order would need to be considered in determining the claimant's temporary disability benefits, if any, that would be eventually payable as a result of our Order on Review that directed the carrier to reopen the claimant's claim pursuant to ORS 656.262(7)(c).

Here, the insurer's November 22, 1999 Own Motion Notice of Closure awarded temporary disability benefits from June 28, 1999 to November 12, 1999. (Ex. 74). Claimant did not appeal that Notice of Closure. The ALJ declared the Own Motion Notice of Closure a nullity. However, the ALJ did not have authority to set aside the Own Motion closure. *See Robert A. Olson*, 52 Van Natta at 1541-42; *Larry L. Ledin*, 52 Van Natta at 683.

Nevertheless, in the present case, we agree with the ALJ that, based on *Graham*, the insurer is directed to process claimant's "new medical condition" claim for adhesive capsulitis syndrome of the

right shoulder and right rotator cuff tendonitis and impingement of the right shoulder under ORS 656.262 and ORS 656.268. In processing claimant's "new medical condition" claim, the employer may consider the temporary disability benefits paid pursuant to the November 22, 1999 Own Motion Notice of Closure in determining claimant's temporary disability benefits, if any, that would be eventually payable as a result of this order directing the employer to reopen claimant's claim.

Finally, the insurer argues that the ALJ erred by assessing a penalty for its allegedly unreasonable claim processing. The insurer contends that there is no showing that it unreasonably delayed or refused to pay compensation, and there is no evidence of any compensation due claimant.

A carrier is liable for a penalty of up to 25 percent of the amounts then due when it "unreasonably delays or unreasonably refuses to pay compensation, or unreasonably delays acceptance or denial of a claim." ORS 656.262(11)(a). In determining whether a denial is unreasonable, the question is whether the carrier had a legitimate doubt as to its liability at the time of the denial. *Brown v. Argonaut Insurance Company*, 93 Or App 588, 591 (1988). "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available at the time of the denial. *Id.*

In the present case, we need not determine whether there are any "amounts then due" because we find that the insurer had a legitimate doubt about its claim processing obligations. In *Camilla S. Kosmoski*, 52 Van Natta 1573 (2000), we found that it was not until issuance of *Larry L. Ledin*, 52 Van Natta at 682, that it became clear that, notwithstanding the submission of an Own Motion recommendation (as well as the issuance of an unappealed Own Motion order), a carrier was still obligated to reopen, process and close a claim for a new medical condition pursuant to ORS 656.262 and ORS 656.268. In *Kosmoski*, we reasoned that, because *Ledin* issued after the carrier's claim processing actions, it had a legitimate doubt regarding its liability for processing the new condition claim. *See also Robert A. Olson*, 52 Van Natta at 1540. We reach the same conclusion in this case. We conclude that the insurer had a legitimate doubt regarding its liability for processing the new medical condition claim under ORS 656.262 and ORS 656.268 and, therefore, it was not unreasonable for the insurer to refuse to close the claim. Accordingly, we reverse that portion of the ALJ's order that assessed a penalty.

Claimant's attorney is entitled to an assessed fee for services on review regarding the claim processing issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the claim processing issue is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services on review regarding the penalty issue.

ORDER

The ALJ's order dated June 3, 2000 is affirmed in part and reversed in part. That portion of the ALJ's order that assessed a penalty is reversed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

In the Matter of the Compensation of
BEVERLY B. STIGALL, Claimant
WCB Case No. 99-08379
ORDER ON REVIEW
Phillip H. Garrow & Janet H. Breyer, Claimant Attorneys
Reinisch, et al, Defense Attorneys

Reviewed by Board Members Meyers and Bock.

The self-insured employer requests, and claimant cross-requests, review of that portion of Administrative Law Judge (ALJ) Myzak's order that awarded claimant 8 percent (25.6 degrees) unscheduled permanent disability for claimants low back condition, whereas an Order on Reconsideration had awarded no unscheduled permanent disability. 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

The ALJ concluded that the medical arbiter's general statement that claimant had "no impairment" was inconsistent with: (1) the medical arbiter's specific objective finding that claimant had a valid reduced range of motion for lumbar extension; and (2) the medical arbiter's opinion that no unrelated causes contributed to claimant's condition. Consequently, the ALJ determined that claimant was entitled to an impairment value for loss of lumbar flexion.

OAR 436-035-0007(14) (WCD Admin Order No. 99-056) provides: "Where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment." Here, the medical arbiter, Dr. Neumann, found claimant's lumbar extension angle to be limited to 14 degrees. (Ex. 45-3). Specifically referencing Bulletin 239 and the AMA Guides, he opined that his findings were valid as measured, except for straight leg raising validity test that did not meet the appropriate criteria for the lumbar flexion measurement.[1] (Ex. 45-7). Therefore, unless the preponderance of medical opinion establishes otherwise, we use Dr. Neumann's findings for claimant's lumbar extension angle to establish claimant's entitlement to a physical impairment award for her low back condition.[2]

OAR 436-035-0007(28) provides in pertinent part:

> "[F]indings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based upon sound medical principles, explaining why the findings are invalid."

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[1] Claimant argues that she is entitled to an award for lumbar flexion because Dr. Neumann did not explain his reasoning for invalidating the flexion measurement based upon the SLR validity test. We disagree. We have previously held that lumbar ranges of motion are properly excluded from the calculation of impairment if found invalid based upon the SLR validity test. *See Dana M. Peterson*, 50 Van Natta 1554, 1555 (1998); *Benjamin G. Santos*, 46 Van Natta 1912, 1914 (1994).

We also disagree with claimant's contention that her highest strength category for employment in the five years preceding determination is heavy for her "regular housekeeping working." OAR 436-035-0310(4)(a) requires the use of the highest strength category assigned in the DOT for the most physically demanding job performed by the worker in the five years prior to the date of issuance. Because the record does not reflect when claimant performed "regular housekeeping work," we are unable to find that claimant performed such duties within five years prior to the determination. Consequently, the strength category for "regular housekeeping work" cannot be applied.

[2] The ALJ determined that the medical arbiter's range of motion findings were the only such findings in the record that could be considered in rating claimant's impairment. (O&O 2). Neither party objects to the ALJ's determination.

Because Dr. Neumann has specifically found claimant's lumbar extension angle to be valid according to the AMA's Guides, that finding shall be rated unless he provided a written opinion, based upon sound medical principles, explaining why his findings are otherwise invalid. OAR 436-035-0007(28); *Labor Force of Oregon v. Frierson*, 169 Or App 573 (2000) (a physician is permitted to explain why findings that do not comply with AMA guidelines should nonetheless be used and to explain why findings that do comply with the guidelines should nonetheless not be used).

Here, in explaining his range of motion findings for claimant's "true lumbar flexion, extension, and right/left lateral flexion" (emphasis in original), Dr. Neumann indicated: "I find no impairment and feel the range of motion measurements as measured are normal for this person." (Ex. 45-6). Based on that statement, we conclude that Dr. Neumann did not relate claimant's restricted range of lumbar extension to the compensable injury. *See Rebecca S. Mundell*, 52 Van Natta 106 (2000) (medical arbiter's characterization of cervical range of motion as "normal for this individual" failed to relate decreased range of motion to the compensable injury).[3] In expressing his opinion, Dr. Neumann considered the treatment records of Dr. Huber, the attending physician, as well the treatment records of LaPine physical therapy, and claimant's physical capacity evaluation of April 1999. Consequently, we conclude that Dr. Neumann has supplied a written opinion, based upon sound medical principles, explaining why his findings should not be used.

Accordingly, claimant is not entitled to an impairment value of 3 percent for reduced lumbar extension. Consequently, claimant's unscheduled permanent disability award, as granted by the ALJ's order, is reversed.

ORDER

The ALJ's order dated March 31, 2000, as amended and republished on April 12, 2000 is reversed in part and affirmed in part. The ALJ's awards of 8 percent (25.6 degrees) unscheduled permanent disability and an "out-of-compensation" attorney fee are reversed. The remainder of the ALJ's order is affirmed.

[3] In *Timothy W. Stone*, 50 Van Natta 909, 912 (1998) we found a medical arbiter's opinion that "ranges of motion of the lumbar spine are normal for this individual" was unexplained, and therefore not persuasive in the presence of a more thorough and complete assessment of the claimant's impairment from another medical examiner. Here, similar to the circumstances in *Stone*, the Medical Arbiter states that claimant's measurements were normal for her. Nonetheless, in addition, the Arbiter also expressly found no impairment. Finally, unlike *Stone*, there is no contrary medical findings for rating purposes. Consequently, we conclude that *Stone* is distinguishable.

October 13, 2000 Cite as 52 Van Natta 1893 (2000)

In the Matter of the Compensation of
JIMMY L. MASSEY, Claimant
Own Motion No. 99-0442M
OWN MOTION ORDER ON RECONSIDERATION
Richard A. Sly, Claimant Attorney
Saif Legal Department, Defense Attorney

On August 29, 2000, we withdrew our August 10, 2000 Own Motion Order which declined to reopen claimant's 1980 industrial injury claim for the payment of temporary disability compensation because he failed to establish that he remained in the work force when his compensable condition worsened requiring surgery or hospitalization. Claimant requested reconsideration of our August 10, 2000 order and submitted additional medical documentation, which he contends support his contentions.

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

It is undisputed that claimant's compensable condition has worsened requiring surgery. However, in order to be entitled to temporary disability compensation, a claimant must be in the work

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

In order to satisfy the third *Dawkins* criterion, claimant must first establish that he was willing to work. Failing to demonstrate his willingness to work, a claimant would not be considered a member of the work force, and thus, not entitled to temporary disability compensation. *See Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996); *Arthur R. Morris*, 42 Van Natta 2820 (1990).

In our prior order we were persuaded that claimant had demonstrated his willingness to work. We based our conclusion on claimant's submission of paystubs evincing his working status from September 1998 through February 1999. On reconsideration, and based on the record before us, we continue to find that claimant was and is willing to work.[1]

However, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion, in order to be found in the work force. We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[2] is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to August 13, 1999, when his condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

On reconsideration, claimant an August 21, 2000 report from Dr. Mason, his treating physician and a September 11, 2000 report from Dr. Tse, his treating chiropractor. Dr. Mason opined that claimant would not have been able to work prior to August 1999 due to his compensable low back condition. He explained that when he examined claimant in August 1999 he believed that claimant was unable to work at that time. Given claimant's longstanding spinal stenosis due to his compensable low back condition, Dr. Mason opined that claimant's condition in February 1999, when he first left work, was comparable to his condition when he examined him in August 1999. For that reason, Dr. Mason opined that claimant was unable to work due to his compensable condition. Dr. Tse concurred with Dr. Mason's opinion that claimant was unable to work after February 1999. These opinions are unrebutted.[3]

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[1] Claimant submitted various paystubs dating from September 1998 through February 1999, which he contended, that although he was not then currently employed, demonstrated his willingness to work. Based on his paystub submission, we were persuaded that claimant was willing to work and working prior to February 1999.

[2] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

[3] In response to claimant's request for reconsideration, SAIF relies on ORS 656.262(4)(g) to refute Dr. Mason's August 21, 2000 doctor's report. ORS 656.262(4)(g) states:

> "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."

SAIF's reliance on this statute is misplaced. Unlike benefits payable under ORS 656.268, temporary disability benefits payable under ORS 656.278 arise by means of voluntary reopening by the carrier or Board authorization. *See* OAR 438-012-0035(1). Board authority to award temporary disability benefits under ORS 656.278 is not contingent on an attending physician's time loss authorization. *Terri A. Briggs*, 52 Van Natta 1009 (2000); *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996). Consequently, in this instant case, it is not determinative whether or not Dr. Mason, or any attending physician has authorized temporary disability benefits. Rather, claimant's entitlement to temporary disability compensation is dependent of whether he qualifies for said benefits under ORS 656.278.

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.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

October 13, 2000 Cite as 52 Van Natta 1895 (2000)

In the Matter of the Compensation of
JUANA M. LOPEZ, Claimant
WCB Case No. 99-09380
ORDER ON RECONSIDERATION
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our September 19, 2000 Order on Review that affirmed the Administrative Law Judge (ALJ's) order affirming an Order on Reconsideration that awarded no additional permanent disability beyond that which claimant had been awarded in prior awards.

On reconsideration, claimant contends that she has not "recovered fully with [her] ankle" and requests an additional medical evaluation. Initially, we note that claimant's rights to medical services related to her accepted claim are not directly affected by our order. ORS 656.245(1). Moreover, we generally do not have jurisdiction over requests for medical services. *See* ORS 656.327(1). For those reasons, we decline to reconsider our initial order.[1]

Accordingly, we withdraw our September 19, 2000 order. On reconsideration, we adhere to and republish our September 19, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] The Workers' Compensation Board is an agency of the State of Oregon and, as such, is an adjudicative body. In other words, it addresses issues presented to it from disputing parties. Because of that role, the Board cannot extend advice to the parties. Nonetheless, the Board notes that claimant is unrepresented. Under such circumstances, if she has further questions, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. The Ombudsman can be contacted, free of charge, at 1-800-927-1271, or written to at:

Workers' Compensation Ombudsman
Department of Consumer and Business Services
350 Winter St. NE
Salem, OR 97301

In the Matter of the Compensation of
ALEXANDER NEWTON, Claimant
Own Motion No. 00-0264M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 18, 2000 Own Motion Order which declined to authorize reopening of his 1985 injury claim for the payment of temporary disability compensation because he had not demonstrated that he was in the work force at the time of his 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.*

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

For the purpose of determining whether claimant is in the work force under the Board's own motion jurisdiction,[1] the "date of disability" is the date he is hospitalized due to a worsening of his compensable condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Thus, the relevant time period for which claimant must establish he was in the work force is the time prior to his June 12, 2000 hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

SAIF contended that claimant had withdrawn from the work force at the time of his disability because he had failed to provide medical documentation in support of his assertion that he was unable to work due to his compensable condition.

With its initial recommendation, SAIF submitted a copy of an August 9, 2000 letter from claimant wherein he stated that "the revision which [he] received in [19]94 had by then knocked [him] out of the workforce, because the pain was both ongoing, and unbearable." Claimant also stated that he began receiving Social Security Disability around four years ago. On reconsideration, claimant submitted a copy of a March 21, 1994 letter from Dr. Auld, his attending physician, in support of his contention that he was unable to work because his compensable condition made a work search futile. In his March 21, 1994 letter, Dr. Auld noted that claimant had undergone several surgeries on both knees, and opined that claimant's "disability will more or less be permanent."

Pursuant to *Dawkins*, "[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 that the entitlement to disability benefits is due to the compensable condition. *See Kenneth C. Felton*, 48 Van Natta 725 (1996).

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[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

Here, claimant 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 condition or some noncompensable condition. Although Dr. Auld opined (in 1994) that claimant's "disability" would be more or less permanent, he does not opine that claimant is disabled because of his compensable left knee condition.

In addition, as explained above, the relevant time period for the purpose of determining whether claimant was in the work force is the time prior to his June 2000 hospitalization. Dr. Auld's 1994 opinion regarding claimant's "disability" does not address his ability to work and/or seek work at the relevant time, *i.e.*, the time prior to the June 2000 hospitalization.

Finally, claimant contended that he was "knocked" out of the work force following his 1994 surgery because his pain was "ongoing and unbearable." He further contended that because of the multiple surgeries to both his knees, he is "obviously unable to work." However, whether it would be futile for claimant to seek work is not a subjective test viewed through the eyes of claimant; it is an objective test determined from the record as a whole, especially considering persuasive medical evidence regarding claimant's ability to work and/or seek work. *Jackson R. Scrum*, 51 Van Natta 1062 (1999). In short, the question is whether the work injury made it futile for claimant to make reasonable efforts to seek work, not whether claimant reasonably believes it to be futile.

Claimant does not offer a *medical* opinion that would support his "futility" contentions, nor does the record demonstrate that it would have been futile for him to work or seek work at the time of the current worsening. There is no medical evidence that demonstrates that it would have been futile for him to seek work prior to his June 2000 surgery. Consequently, we find that claimant has failed to meet his burden of proof regarding his work force status. Therefore, we conclude that claimant was not in the work force at the time of the June 2000 worsening for his compensable condition.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our September 18, 2000 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RICHARD YOREK, Claimant
Own Motion No. 99-0161M
OWN MOTION ORDER

On January 25, 2000, we authorized the reopening of claimant's claim for the payment of temporary disability compensation beginning the date he was hospitalized for the proposed surgery. Claimant requests enforcement of our January 25, 2000 order, contending that the self-insurer employer unilaterally terminated his temporary disability benefits from March 15, 2000 through May 15, 2000. Specifically, claimant requests payment of those benefits as well as continuing benefits until he is medically stationary.

In response, the employer contends that it had not paid claimant's temporary disability benefits because it had not received any medical documentation authorizing said benefits for the relevant period of time. The employer further notes that it reinstated claimant's temporary disability benefits when it received claimant's attending physician's May 23, 2000 letter authorizing time loss.

Temporary disability compensation shall be paid on an "open" own motion claim until one of the following events occurs: (1) the claim is closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement (CDA) is submitted to the Board pursuant to ORS 656.236(1); or (3) termination of such benefits is authorized by the terms of ORS 656.268(4)(a) through (c). *See* OAR 438-012-0035(4).

Unlike benefits payment under ORS 656.268, temporary disability benefits payable under ORS 656.278 arise by means of voluntary reopening by the carrier or Board authorization. *See* OAR 438-012-0035(1). Board authority to award temporary disability benefits under ORS 656.278 is not contingent on an attending physician's time loss authorization. *Jeffrey T. Knudson*, 48 Van Natta 1708 (1996); *Terri A. Briggs*, 52 Van Natta 1009 (2000). In *Knudson*, we reasoned that, because an attending physician's time loss authorization is not required for commencement of temporary disability benefits pursuant to ORS 656.278, the lack of such authorization is not a basis for the withholding or "termination" of such benefits. *Id.*

Here, our January 25, 2000 Own Motion Order authorized the reopening of claimant's claim for the provision of temporary disability compensation beginning the date claimant was hospitalized surgery. Thus, as noted, the employer is obligated to pay temporary disability compensation until claimant is medically stationary, or when a CDA extinguishes a claimant's right to further temporary disability compensation, or when termination of such benefits is authorized under ORS 656.268(a) through (c). Although claimant's attending physician may not have provided the employer with written time loss authorizations, based on the *Knudson* rationale, such a failure does not constitute grounds to delay or terminate the payment of claimant's temporary disability benefits under OAR 438-012-0035(1). Consequently, we find that claimant is entitled to temporary disability benefits for the relevant time period.

Accordingly, the employer is directed to provide claimant with temporary disability compensation for the period between March 15 and May 15, 2000 and to continue providing said benefits until it can lawfully terminate them. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DUANE A. FERREN, Claimant
Own Motion No. 99-0258M
OWN MOTION ORDER DENYING RECONSIDERATION
Cole, Cary, et al, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our July 18, 1999 Own Motion Order of Dismissal which dismissed his request for reopening of his 1978 injury claim for the payment of temporary disability compensation because he had withdrawn his request for own motion relief.

Pursuant to OAR 438-012-0065(2), a reconsideration request must be filed within 30 days after the mailing date of the order, or within 60 days after the mailing date if the party requesting reconsideration establishes good cause for the failure to file the request within 30 days. The standard for determining if good cause exists has been equated to the standard of "mistake, inadvertence, surprise or excusable neglect" recognized by ORCP 71B(1) and *former* ORS 18.160. *Anderson v. Publishers Paper Co.*, 78 Or App 513, 517, *rev den* 301 Or 666 (1986); *see also Brown v. EBI Companies*, 289 Or 455 (1980). Lack of due diligence does not constitute good cause. *Cogswell v. SAIF*, 74 Or App 234, 237 (1985). However, OAR 438-012-0065(3) also provides that "[n]otwithstanding section (2) of this rule, in extraordinary circumstances the Board may, on its own motion, reconsider any prior Board order." *See Larry P. Karr*, 48 Van Natta 2182 (1996); *Jay A. Yowell*, 42 Van Natta 1120 (1990).

In our July 8, 1999 order, we dismissed claimant's request for Own Motion relief because we had received a letter from claimant's former attorney acknowledging that since claimant was receiving Social Security benefits, it did not appear that he qualified for temporary disability compensation. We interpreted claimant's former attorney's submission to indicate that claimant had withdrawn his request for Own Motion relief. Our July 8, 1999 order included a notice explaining that any appeal or request for reconsideration must be filed within 30 days of the orders mailing (or, if good cause was established, a request for reconsideration filed within 60 days could be considered).

Claimant's request for reconsideration was received by the Board on August 28, 2000, more than 60 days after the issuance of our July 8, 1999 order. In his request for reconsideration, claimant explains why his request for reconsideration was filed beyond the 30-day appeal period. He indicates that while he was represented by his former counsel, he was "unaware that he did in fact qualify for time loss compensation even though he was receiving Social Security disability benefits."[1] In January 2000, claimant retained his current attorney who apparently advised him that he qualified for reopening of his 1978 claim for the payment of temporary disability compensation. Claimant contends that this unawareness constitutes extraordinary circumstances to warrant our reconsideration under OAR 438-012-0065(2). We disagree.

Even accepting claimant's characterization of his former attorneys actions, we do not find that reliance on such advice establishes good cause for failing to request reconsideration of the July 8, 1999 order.

It is well-settled law that an attorney's alleged conduct does not constitute good cause unless such conduct would be good cause if attributed to claimant. *See Sekermestrovich v. SAIF*, 280 Or 723, 727 (1977); *EBI Companies v. Lorence*, 72 Or App 75, 78, *rev den* 299 Or 118 (1985); *Jeanne C. Rusch*, 45 Van Natta 163 (1993) (the claimant's reliance on her attorneys representations that he had timely filed her hearing request when he had not done so did not provide good cause for her failure to timely file hearing request). Here, if his former attorney's actions were attributed to claimant, they would not constitute good cause.

Therefore, claimant has not established good cause for his failure to timely request reconsideration, nor has he provided persuasive evidence that would constitute extraordinary circumstances which would lead us to conclude that an exception outside of the deadlines imposed by OAR 438-012-0065(2) is appropriate.

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[1] We note that receipt of Social Security benefits does not necessarily establish that a claimant was in the work force, unless it is established that those benefits compensate the claimant for an inability to work because of a compensable injury. *Kenneth C. Felton*, 48 Van Natta 725 (1996); *Robert E. Carper*, 48 Van Natta 1160 (1996).

Accordingly, claimant's request 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); *Fischer v. SAIF*, 76 Or App 656 (1985).

IT IS ORDERED.

October 16, 2000 Cite as 52 Van Natta 1900 (2000)

In the Matter of the Compensation of
KATHLEEN C. FIESTER, Claimant
WCB Case No. 00-00034
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorneys
Terrall & Terrall, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its *de facto* denial of claimant's injury claim for a left forearm contusion; and (2) set aside its *de facto* denial of claimant's occupational disease or consequential condition claim for a right wrist overuse condition. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except for the last paragraph.

CONCLUSIONS OF LAW AND OPINION

We begin with a summary of the pertinent facts.

Claimant operated a chop saw for the employer. On June 28, 1999, claimant fractured her left middle finger when the saw blade caught in the wood that she was cutting and three of her fingers were crushed between the wood and the back of the saw. At the same time, the saw blade threw the boards out and the wood struck claimant's left forearm.

Claimant experienced pain in her fingers, reported her injury, and sought treatment. Dr. Feldman provided conservative treatment, including a splint for claimant's broken finger, limited her work activities, and told her to return in a week. That evening, claimant discovered a bruise on her left forearm and her left arm was sore, but her broken finger hurt more than her arm.

Claimant returned to modified work on June 29, 1999. For about 2 1/2 weeks after the injury, her work involved lifting and handling boards with her right hand and placing them on her upturned left forearm for carrying. During this time claimant's wrists started hurting and her left forearm was tender when she stacked wood on it in the course of her modified work.

Claimant returned to Dr. Feldman on July 5, 1999. He checked her finger, advised continued use of the splint, and restricted use of her left hand.

Claimant sought treatment again on July 17, 1999. Drs. Kaib and Lapoma diagnosed right arm overuse syndrome, left forearm contusion, and healing left middle finger fracture. They also restricted her work. Claimant performed two modified jobs for a few days each, then a third "fire watch" position for about two months. She was fired on or before September 30, 1999.

The employer accepted claimant's claim for a fractured left middle finger on July 23, 1999. On August 26, 1999 claimant requested that the employer amend its acceptance to include her right wrist overuse syndrome and left forearm contusion. (Ex. 27A). The employer did not respond to claimant's request and claimant requested a hearing.

Left Forearm Contusion

The ALJ determined that the compensability of claimant's left forearm contusion was not a complex issue requiring expert evidence to prove causation. He reasoned that the situation was not complicated, noting that claimant reported her accident and sought treatment the day of the injury, she had no similar problem previously, and no physician stated that the work incident could not have caused her bruise. In addition, based on claimant's credible testimony that she first noticed the bruise on the evening after the injury, the ALJ found that claimant's symptoms appeared immediately. Based on these findings, the ALJ concluded that the work injury was at least a material cause of her contusion, citing *Barnett v. SAIF*, 122 Or App 279 (1993).

The employer argues that this is not a "simple claim" and medical evidence is required to prove causation, because there is no indication in the medical record that claimant had a bruised forearm until July 17, 1999, almost three weeks after the work incident.

We agree with the ALJ's reasoning and conclusion that medical evidence is not required to establish causation in this case. Accordingly, we adopt the ALJ's reasoning in this regard, with the following supplementation responding to the employer's arguments on review.

Like the ALJ, we accept claimant's credible testimony that a board struck her left forearm at work on June 28, 1999, and she first noticed her left forearm bruise when she removed her long-sleeved shirt at home to take a shower the evening after the injury. We also accept claimant's explanation that she was not aware of pain in her left forearm until then, because she was concentrating on the burning and swelling of her fractured finger. (Tr. 8, 11). Considering the nature of the accident and the concurrent injuries, and the fact that claimant experienced left forearm arm pain on the day of the injury, we agree with the ALJ that claimant bruised her left forearm when she fractured her left middle finger on June 28, 1999.

The employer also argues that it did not "*de facto* deny" a claim for a left forearm contusion because--absent disability or treatment--there was no such claim and there could be no such denial. We disagree.

ORS 656.262(6)(d) sets out the communication requirements for requesting acceptance of a condition omitted from a notice of acceptance.[1] Here, because claimant complied with the requirements of ORS 656.262(6)(d) and the employer did not respond to her written request, claimant did perfect a claim for her left forearm contusion. *See Wallace M. Prince*, 52 Van Natta 45, 46 (2000) (where the claimant complied with ORS 656.262(6)(d), he perfected claims for the condition that he alleged was incorrectly omitted from the notice of acceptance). And, when claimant requested a hearing regarding the compensability of the omitted contusion condition, the issue was properly before the ALJ. *Compare Ralph L. Morris*, 50 Van Natta 69, 71 (1998) (Where the claimant had not complied with the requirements of ORS 656.262(6)(d), he was precluded from proceeding to the hearing on the issue of "de facto" denial).[2]

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[1] ORS 656.262(6)(d) provides:

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

[2] *See also* ORS 656.386(1)(b)(B), which provides that a "denied claim" includes a claim for a condition omitted from the notice of acceptance made pursuant to ORS 656.262(6)(d).

In summary, we find that claimant suffered a compensable contusion to her left forearm on June 28, 1998, when the chop saw she operated at work "kicked back" a piece of wood and the wood struck her left forearm.[3] Accordingly, we agree with the ALJ that the employer's *de facto* denial of claimant's claim for that condition should be set aside.

Right Forearm Overuse

Drs. Schilperoort, Williams, Wilson, and Feldman provide the medical evidence addressing the cause of claimant's right forearm overuse condition (tendinitis). Drs. Schilperoort and Williams opined that claimant's right hand use (while performing modified work after her injury) and her deconditioning caused her overuse condition, but her preexisting deconditioning was its major contributing cause. (Ex. 32-6-8). Drs. Wilson and Feldman concurred with Schilperoort and Williams "in every particular." (Exs. 42, 43).

The ALJ found that claimant's modified work activities after her injury were the major contributing cause of her right forearm overuse condition, whether the claim was analyzed as an occupational disease or as a "consequential condition." The ALJ reasoned that claimant's deconditioning does not legally qualify as a cause for purposes of determining the major contributing cause of her condition, because it is "not related to a disease" and "simply normal for her." Therefore, based on the medical evidence, the ALJ set aside the employer's *de facto* denial of the right arm overuse condition.

The employer argues that claimant's deconditioning is a "preexisting condition" that contributed to claimant's right forearm overuse condition and the claim must fail because claimant's deconditioning, rather than her work activities is the major contributing cause of the condition. We agree that the claim fails, for the following reasons.

First, claimant's deconditioning is a "cause" of her overuse condition, because the medical evidence describes it as such. *See, e.g., Brown v. A-Dec, Inc.*, 154 Or App 244, 248 (1998) (the claimant's degenerative process was a "disease," because the medical evidence said it was).

We need not decide whether claimant's deconditioning is a "preexisting condition" as that term is used in ORS Chapter 656, because this claim arises under ORS 656.802 or 656.005(7)(a)(A), not ORS 656.005(7)(a)(B).[4] Under either of the former statutes, the pivotal issue is whether work-related causes (the work injury and/or "post injury" work activities) contributed more to claimant's right forearm overuse condition than all other causes combined.

The medical evidence here indicates that claimant's right forearm overuse results from deconditioning and "post injury" modified work activities. It also uniformly indicates that the deconditioning, not the work activities, is the major contributing cause of the overuse. (Exs. 32-7-8, 42, 43). There is no evidence that claimant's contributory deconditioning is work-related. Accordingly, because nonwork-related causes contribute more to claimant's overuse condition than work-related causes,[5] we conclude that the claim must fail. *See David L. Easley*, 50 Van Natta 2112 (1998) (where no medical evidence established that the claimant's work injuries or activities were the major contributing cause of his condition (or need for treatment therefore), the claim was not proven under ORS 656.005(7)(a)(A) or 656.802).

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[3] We also agree with the ALJ that claimant sought and received treatment for her left forearm contusion when she reported right *and* left forearm symptoms to Drs. Lapoma and Kaib and the doctors reported the bruise, restricted claimant's work, and prescribed medication. (Exs. 9, 10). We note that Dr. Lapoma understood that claimant's "bruising about the left forearm with some swelling" came about when claimant stacked wood on her left forearm during her "post injury" modified work. (*Id.*) And we find this history consistent with claimant's credible testimony that her left forearm hurt *more* when she used it for modified work.

[4] However, we note that ORS 656.005(24), defining "preexisting condition," "speaks of 'any' disease or 'similar condition' that contributes or predisposes a worker to disability or a need for treatment." *Brown v. A-Dec, Inc.*, 154 Or App at 248 (the claimant had a "preexisting condition" where there was no question that her degenerative cervical condition contributed or predisposed her to her need for treatment).

[5] We acknowledge claimant's argument that the examining physicians' opinion regarding the extent and contribution of claimant's deconditioning is unpersuasive because the doctors variously referred to it as "moderate," "substantial," and "extreme" and they described claimant's strength as "normal for her." (*See* Ex. 36). We are not persuaded by claimant's argument because we do not find the doctors' descriptive terms inconsistent in context. Accordingly, we rely on the experts' agreement that claimant's deconditioning is the primary cause of her right forearm overuse condition.

Claimant's attorney is entitled to an assessed fee for services at hearing and on review only with regard to the compensable left forearm contusion. ORS 656.386(1); 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services at hearing and on review regarding the left forearm contusion is $2,000, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by the record and claimant's appellate briefs), the complexity of the issue, the value of the interest involved, and the risk that counsel may go uncompensated.

ORDER

The ALJ's order dated reversed in part, modified in part, and affirmed in part. That portion of the order that set aside the self-insured employer's "de facto" denial of claimant's right forearm overuse condition is reversed. The denial is reinstated and upheld. That portion of the order that awarded a $3,400 attorney fee is modified. In lieu of the ALJ's attorney fee award, claimant is awarded a $2,000 attorney fee for services at hearing and on review regarding the claim for a left forearm contusion. The remainder of the ALJ's order is affirmed.

October 16, 2000 Cite as 52 Van Natta 1903 (2000)

In the Matter of the Compensation of
MARYSOL HARRITT-DIAZ, Claimant
WCB Case No. 99-05778
ORDER ON REVIEW
Adams, Day & Hill, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the insurer's denial of her occupational disease claim for a bilateral wrist condition. On review, the issue is compensability.

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

The ALJ upheld the insurer's denial, finding that the medical evidence supportive of causation did not meet claimant's burden of proof. We agree with the ALJ's reasoning and in addition, offer the following.

In this occupational disease claim, claimant must prove that her work activities are the major contributing cause of her bilateral carpal tunnel syndrome condition. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).

Medical opinions that are based solely on a "temporal relationship" will not satisfy the claimant's burden of proof. *Allie v. SAIF*, 79 Or App 284, 288 (1986); *Rodney A. Black*, 52 Van Natta 1632 (2000). Here, we find that Dr. Bliven's reasoning rests on a "temporal relationship" between claimant's work activity and the onset of her symptoms. Dr. Bliven stated that "[Claimant] denied any prior history of similar symptoms, as well as any outside activities which I felt precipitated her problem. Therefore, it is my opinion that the major contributing cause of her carpal tunnel syndrome was her workplace activity." (Ex. 27-1). Accordingly, we find Dr. Bliven's opinion insufficient to meet claimant's burden of proof. *Rodney A. Black*, 52 Van Natta 1632.

The only other medical opinion which is arguably supportive of claimant's burden of proof comes from Dr. Teal, who signed a "check-the-box" letter concurring with Dr. Bliven's opinion. (Ex. 29). However, we have found Dr. Bliven's opinion unpersuasive for the reason stated above, as well as those expressed by the ALJ. Moreover, earlier, Dr. Teal had concurred with Dr. Nolan, who performed an examination of claimant at the request of the insurer and concluded that claimant's work activities were not the major contributing cause of her "long-standing" carpal tunnel condition. (Exs. 18, 20). Inasmuch as Dr. Teal's change in opinion is completely unexplained, we find it unpersuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987).

Because we have found Dr. Bliven and Dr. Teal's opinions unpersuasive, we need not address claimant's arguments that the opinions of Dr. Nolan and Dr. Smith (who performed a records review for the insurer) rely on an inaccurate history of claimant's work activity and are therefore unpersuasive. *See Lorraine W. Dahl*, 52 Van Natta 1576 (2000) (if medical opinions supporting compensability are insufficient to meet the claimant's burden of proof, the claimant's claim fails, regardless of persuasiveness of countervailing opinions).

ORDER

The ALJ's order dated June 9, 2000 is affirmed.

In the Matter of the Compensation of
SUSAN M. HEMINGS, Claimant
WCB Case No. 00-02034
ORDER ON REVIEW
Starr & Vinson, Claimant Attorneys

Reviewed by Board Members Haynes and Biehl.

The Workers' Compensation Division (WCD), on behalf of Johnson & Culberson, Inc., requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) set aside its denials of claimant's aggravation claim; and (2) assessed a penalty for allegedly untimely denial. On review, the issues are aggravation and penalties.

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

On review, WCD argues that the ALJ erred in deferring to the treating doctor, Dr. White. Specifically, WCD contends that, because Dr. White did not treat claimant until after her worsening, he is not in an advantageous position to provide an opinion comparing her current condition to her condition at the time of closure. We agree with WCD's contention. Nevertheless, Dr. White did treat claimant over a significant period of time and was more familiar with her condition than Dr. Hill, who examined her on one occasion. For that reason, and the remaining reasons expressed by the ALJ, we conclude that the ALJ correctly relied on the opinion of Dr. White. We further agree that Dr. White's opinion establishes an actual worsening of claimant's compensable condition, which is supported by objective medical findings. ORS 656.273(1); *SAIF v. Walker*, 330 Or 102 (2000).

Claimant's counsel is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,400, to be paid by Johnson & Culberson. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and request for attorney fees), the complexity of the issue and the value of the interest involved.

ORDER

The ALJ's order dated July 24, 2000 is affirmed. Claimant's counsel is awarded an assessed attorney fee of $2,400, to be paid by Johnson & Culberson.

In the Matter of the Compensation of
LOWELL R. TEASLEY, Claimant
WCB Case No. 99-04500
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the self-insured employer's denial of his claim for a left inguinal hernia. On review, the issue is compensability.

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

On review, claimant argues that the ALJ erred in concluding that his claim requires expert medical evidence to prove. In addition, claimant argues that the ALJ erred in analyzing his claim as one for an occupational disease. Claimant asserts that his claim should be analyzed as an industrial injury. We disagree with claimant's contentions for the following reasons.

We first address claimant's argument that his case does not require expert medical evidence to prove. In *Barnett v. SAIF*, 122 Or App 279 (1993), the court reversed a Board order that upheld a back injury denial because no physician had offered a medical opinion relating the claimant's back condition to her work activities. Citing *Uris v. Compensation Dept.*, 247 Or 420 (1967), the court listed five relevant factors for determining whether expert evidence of causation is required: (1) whether the situation is complicated; (2) whether the symptoms appear immediately; (3) whether the worker promptly reports the occurrence to a supervisor; (4) whether the worker was previously free from disability of the kind involved; and (5) whether there was any contrary expert evidence.

In *Barnett*, the claimant had never experienced low back pain previously, had suffered immediate low back pain after the injury, had reported the incident to her employer the next day and had sought medical treatment within 24 hours. In addition, there was no medical evidence that indicated that the injury did not cause the back condition. Under those circumstances, the court held that the claimant was not required to introduce expert medical testimony to prove causation.

Here, claimant did not promptly report the occurrence of the injury or the discovery of the bulge to his employer. Consequently, we conclude that the present case is distinguishable from *Barnett* and *Uris* and that medical evidence is necessary to establish compensability.

Claimant also argues that his claim should be analyzed as an industrial injury. We have concluded above that expert medical evidence is required to meet claimant's burden of proof regarding compensability. The only medical opinion in the record is from Dr. Chang. Dr. Chang was asked whether claimant's work activities were the major contributing cause of his need for treatment of his hernia. Thus, Dr. Chang only addressed causation in terms of an occupational disease claim and did not attribute claimant's hernia to an industrial injury. Moreover, for the reasons given by the ALJ, Dr. Chang's opinion is unpersuasive.

ORDER

The ALJ's order dated April 24, 2000 is affirmed.

In the Matter of the Compensation of
ROBERT WEST, Claimant
Own Motion No. 00-0293M
OWN MOTION ORDER
Phillip H. Garrow & Janet H. Breyer, Claimant Attorneys

The self-insured emplyer has submitted claimant's request for temporary disability compensation for claimant's right knee condition. Claimant's aggravation rights expired on August 24, 1989. The employer recommends that we authorize the payment of temporary disability compensation.

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

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

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ALAN P. WROBEL, Claimant
WCB Case No. 99-04348
ORDER ON REVIEW
David R. Fowler (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

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

FINDINGS OF FACT

Claimant first requested a hearing in May 1999. The scheduled hearing was postponed three times before the hearing in this case convened.

At the hearing, the ALJ stated that claimant's wife called him that morning to tell him that claimant (who lives in Vermont) would not be able to attend the hearing. The ALJ treated the information as a motion to postpone. Finding that claimant's absence was due to occupational or professional business appointments, a reason that does not constitute "extraordinary circumstances" to justify a postponement, the ALJ denied the motion.

The ALJ then issued an Order of Dismissal after finding that claimant's failure to appear was not justified.

CONCLUSIONS OF LAW AND OPINION

An ALJ shall dismiss a request for hearing if claimant or his or her attorney fails to attend a scheduled hearing unless extraordinary circumstances justify a postponement or continuance of the hearing. OAR 438-006-0071(2). The ALJ, however, must consider a motion for postponement even if submitted after the ALJ issues an order of dismissal. *E.g., Olga G. Semeniuk*, 46 Van Natta 152 (1994). In those cases where the ALJ does not have the opportunity to rule on the motion to postpone, the Board remands the case to the ALJ for consideration of the motion. *Id.* The exception is when the motion to postpone contains no explanation concerning the claimant's failure to appear; in the absence of such discussion, we have found no compelling reason to remand. *E.g., James C. Crook, Sr.*, 49 Van Natta 65 (1997).

Here, following Order of Dismissal, claimant wrote to the Board saying that he "had an emergency situation that prevented my attendance at the hearing." Because the letter provides an explanation for his failure to appear at the hearing, we find that it constitutes a motion for postponement. *James C. Crook*, 49 Van Natta at 65. Furthermore, we conclude that, because the ALJ did not have the opportunity to rule on the motion to postpone, the case should be remanded for the ALJ to decide if there are extraordinary circumstances preventing dismissal. *Id.* We emphasize that our order does not address the substance of claimant's allegations and it is up to the ALJ to evaluate the grounds of the motion.

Accordingly, the ALJ's June 21, 2000 order is vacated. This matter is remanded to ALJ Thye to determine whether to postpone claimant's hearing request. The ALJ shall proceed in any manner that will achieve substantial justice. If the ALJ grants the motion to postpone, the case will proceed to a hearing on the merits at an appropriate time as determined by the ALJ. If the ALJ does not grant the motion to postpone, the ALJ shall dismiss the request for hearing.

IT IS SO ORDERED.

In the Matter of the Compensation of
ANDREW C. MABRAY, Claimant
WCB Case No. 00-03468
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorneys
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the SAIF Corporation's denial of his low back injury claim. On review, the issues are compensability and penalties. We affirm.

FINDINGS OF FACT

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

At some time after claimant assisted in pulling a large stove from a wall, but before he sought medical treatment, claimant walked on a treadmill to get into shape. On April 12, 2000, he reported to emergency room personnel that his condition was aggravated by walking on a treadmill. (Ex. 3).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's act of moving a stove was not within the boundaries of his ultimate work as a painter and that, therefore, claimant was not in the course and scope of his work at the time of his alleged injury. On review, claimant argues that the ALJ failed to apply the proper legal standard in deciding this case. We conclude that, even if claimant injured himself within the course and scope of his work, claimant has not proved that his alleged injury is compensable.

On or about April 4, 2000, claimant assisted several other workmen in pulling a heavy stove. At some time after this incident, but before he sought medical treatment, claimant walked on a treadmill to get in shape. (Ex. 3; Tr. 19, 68). On April 12, 2000, claimant sought treatment from an emergency room, complaining of increasing right hip pain that referred to his knee. Claimant reported no low back discomfort. Claimant reported that he had felt mild discomfort in his thigh when arising after pulling the stove. He also reported that his condition was aggraved by walking on the treadmill. (Ex. 3).

Although claimant was examined and treated by several medical personnel, only Dr. O'Neill diagnosed a herniated disc at L3-4 and gave an opinion as to the cause of claimant's condition. Dr. O'Neill first treated claimant on April 27, 2000. (Ex. 8).

Claimant reported that, on April 5, 2000, "he was helping several other gentleman [sic] pull a stove out of a small area. He pulled with the other gentleman [sic] and developed right-sided paraspinal pain, acutely. * * * He states that he dealt with this right-sided back pain for a day or two and then he began to get tingling dysesthetic sensation rather profound in the right leg from mid thigh to mid anterior calf." Dr. O'Neill opined that the major contributing cause of claimant's herniated disc was his activity of pulling the stove. *Id.* Dr. O'Neill based this opinion entirely on the history claimant reported to him. *Id.*

The record, however, demonstrates off-work activity that claimant reported affected his condition. Dr. Neill was apparently unaware of this prior reported history. Therefore, because we find Dr. Neill's opinion to be based on an inaccurate or incomplete history, we do not find it persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *Weiland v. SAIF*, 64 Or App 810 (1983). Accordingly, we agree with the ALJ that claimant has failed to establish a compensable injury claim.

ORDER

The ALJ's order dated July 6, 2000 is affirmed.

In the Matter of the Compensation of
MONIREH TALACHIAN, Claimant
WCB Case No. 99-10026
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorneys
Cavanagh & Zipse, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Stephen Brown'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."

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the insurer's denial, finding that claimant had sustained her burden of proving that her current low back condition was compensable. In so doing, the ALJ relied on the opinion of Dr. Weller, an attending physician, whose opinion, the ALJ acknowledged, was not "overwhelmingly persuasive." The ALJ reasoned, however, that, in combination with the opinion of another attending physician, Dr. Wilson, it satisfied claimant's burden of proof.

On review, the insurer contends that the medical evidence is insufficient to satisfy claimant's burden of proof. Therefore, the insurer asserts that the ALJ incorrectly set aside its denial. For the following reasons, we agree.

At the outset, we determine the legal applicable legal standard. *See Daniel S. Field*, 47 Van Natta 1457 (1995) (citing *Dibrito v. SAIF*, 319 Or 244, 248 (1994)). Both Dr. Weller and Wilson opined that claimant's compensable injury "combined" with underlying, preexisting degenerative conditions to cause a need for treatment. (Exs. 32A, 37-35). Based on this evidence, we apply the major contributing cause standard of ORS 656.005(7)(a)(B). Accordingly, claimant must prove that her compensable injury is the major contributing cause of the disability or need for treatment of the "combined condition."

Given the contrary causation opinions of medical experts, and given the number of potential causes of claimant's current condition, we conclude that the causation issue involves complex medical issues that must be resolved by expert medical opinion. *Uris v. Compensation Department*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). Greater weight is generally given to the opinion of a treating physician, absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Wilson, a family practitioner now involved in occupational injury practice, was claimant's initial attending physician for a compensable low back injury that occurred on May 17, 1999, when, employed a cook, claimant lifted a heavy object. The insurer eventually accepted a lumbar strain, but denied claimants current low back condition December 1999. When claimant did not respond as well as expected to treatment, Dr. Wilson referred her to Dr. Weller, a physiatrist.

As previously noted, Dr. Weller opined that claimant's condition consisted of a "combined condition" composed of a stain injury superimposed upon preexisting degenerative disc disease at L1-2 and moderate stenosis. According to Dr. Weller's December 6, 1999 concurrence opinion, the compensable injury was the major contributing cause of claimant's current back condition and need for medical treatment. (Ex. 32A). Dr. Weller reasoned that, prior to the compensable injury, claimant was pain free, with no history of prior back injuries or medical treatment for back problems. Therefore, Dr. Weller concluded that the compensable injury was playing a significant role in claimants need for treatment. *Id.*

We do not find Dr. Weller's opinion persuasive for the following reasons. First, it is questionable whether Dr. Weller's history of no prior back problems is entirely accurate since the record

indicates that claimant had prior back symptoms, albeit rather minor and remote in time. (Ex. 2-2). More importantly, Dr. Weller's opinion is based primarily on a temporal relationship between the onset of claimant's symptoms and the occurrence of the May 1999 injury. Such an opinion is not persuasive. *See Allie v. SAIF*, 79 Or App 284 (1986) (causation cannot be inferred from temporal relationship alone). Finally, in the comments section of the concurrence letter, Dr. Weller wrote, "I believe that [claimant] is reaching a point of being medically stationary. I believe the strain injury may no longer be playing a significant role in the persistence of her pain." (Ex. 32A). Thus, in light of this comment, it appears that even Dr. Weller questions whether the compensable injury remains the major contributing cause of claimant's need for treatment.

We now turn to Dr. Wilson's opinion. Dr. Wilson concurred with a series of reports written by an examining physician, Dr. Coletti, one of which stated that claimant exhibited a great deal of pain behavior and nonanatomic findings and that Dr. Coletti was unable to observe or elicit any objective findings that supported claimants complaints. (Ex. 35, 36). Dr. Wilson was later deposed. There, Dr. Wilson conceded that Dr. Coletti's examination report did, in fact, contain objective findings. (Ex. 37-8, 10). Dr. Wilson, however, opined that it was medically probable that claimant's lumbar strain had resolved and that the major reason for her pain was other conditions, such as degenerative disc disease. (Ex. 37-28).

Having reviewed the opinions of Drs. Weller and Wilson, we conclude that they do not satisfy claimant's burden of proof under ORS 656.005(7)(a)(B). The remaining medical opinion is from Dr. Coletti, the examining physician.

As previously noted, Dr. Coletti opined that claimant did not have objective findings supporting her complaints and that claimant demonstrated excessive pain behavior. Dr. Coletti also disagreed with Dr. Weller's December 6, 1999 concurrence opinion that the major contributing cause of claimant's need for treatment was the compensable injury. (Ex. 35). We do not find Dr. Coletti's opinion persuasive given the inconsistency between his statement that claimant did not demonstrate objective findings of injury and his examination, which did reveal objective findings, as pointed out by Dr. Wilson. In any event, regardless of its persuasiveness, Dr. Coletti's causation opinion does not support compensability since he specifically disagreed with Dr. Weller's December 6, 1999 concurrence report that stated that the May 1999 injury was the major contributing cause of claimant's need for treatment.

Therefore, we conclude that, on this record, claimant has failed to satisfy her burden of proving that her current combined low back condition is compensable under ORS 656.005(7)(a)(B). Thus, we reverse.

ORDER

The ALJ's order dated May 7, 2000 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
SUSAN M. BACKMAN, Claimant
WCB Case Nos. 99-02538 & 99-02312
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorneys
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

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

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

The ALJ set aside the insurer's denial based on the opinion of claimant's treating surgeon, Dr. Silver. On review, the insurer contends that Dr. Silver based his opinion on an incorrect history and utilized an analysis that is inconsistent with the law on causation. We disagree.

Both parties agree that claimant suffers from preexisting degenerative disc disease that has combined with her compensable injury to cause her disability and need for treatment. If an otherwise compensable injury combines at any time with a preexisting condition to cause or prolong disability or need for treatment, the combined condition is compensable only if, so long as and to the extent that the otherwise compensable injury is the major contributing cause of the disability of the combined condition, or the major contributing cause of the need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309, 311-312 (1997), *rev den* 326 Or 389 (1998).

Where the medical evidence is divided, we give more weight to those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986). In addition, absent persuasive reasons to the contrary, we generally defer to the opinion of claimant's attending physician. *Weiland v. SAIF*, 64 Or App 810 (1983). We also accord special deference to the treating surgeon due to the unique opportunity to observe the claimant's condition firsthand. *Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 702 (1988); *Paul R. Grasham*, 52 Van Natta 385 (2000). Here, we find no persuasive reasons not to defer to the opinion of claimant's treating surgeon, Dr. Silver.

The insurer first contends that claimant "enhanced" the history of her November 1998 injury with more details as time progressed. Specifically, claimant recalled no specific injury in her initial history given to Drs. Stahl and Tangredi. (Exs. A, 1). Moreover, Dr. Tangredi recorded a history of claimant's experiencing "some" neck and left shoulder area pain after her injury, as opposed to claimant's report of a "pull" in the back of her neck with "stabbing" pain in later medical reports and at hearing. (Exs. 1, 19-2; Tr. 14).

However, the ALJ found claimant's description of her injury and onset of symptoms at hearing (supported by the testimony of her former supervisor and a coworker) to be credible based on her demeanor. (*O&O* at 4). We generally defer to the ALJ's demeanor-based credibility finding. *See International Paper Co. v. McElroy*, 101 Or App 61 (1991). Here, we do not find the inconsistencies in claimant's medical history to be significant enough to depart from the ALJ's demeanor-based credibility finding. *See Amelia Villanueva*, 50 Van Natta 1577 (1998). In light of such circumstances, we find that Dr. Silver relied on a complete and accurate history of claimant's injury (consistent with her testimony at hearing) to reach his opinion on causation. (Exs. 12, 30, 34).

Next, the insurer contends that Dr. Silver engaged in an impermissible "precipitating cause" analysis to arrive at an opinion that implicates the work injury as the cause only of claimant's *symptoms*, which the insurer contends are related to the preexisting degenerative condition. We disagree.

Dr. Silver's opinion synthesized the effects of claimant's acknowledged preexisting degenerative disc disease[1] and her on-the-job injury, stating that the injury was the major contributing cause of claimant's disability and need for treatment for the combined condition. (Exs. 27, 30-2). Dr. Silver explained that the lifting injury as described by claimant was a mechanism sufficient to cause claimant's annulus to tear, leading to her extruded disc at C5-6. (Ex. 34-2). Dr. Silver supported his opinion with reference to his surgical findings, his general experience treating herniated discs, and by referencing specific medical literature regarding the biomechanics of the cervical spine and degenerative changes thereto. (Exs. 27, 34-2, -3). Dr. Silver's opinion therefore was not based solely on the onset of claimant's symptoms, as the insurer contends.

In contrast, Dr. Fuller, who examined claimant at the request of the insurer, based his opinion in part on the assumption that claimant had suffered a "fairly remote" traumatic injury to the neck which had caused her degenerative disc disease at C5-6. (Ex. 24). However, there is no evidence in the

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[1] Although the insurer criticizes Dr. Silver for stating that the degree of degeneration was not important in his analysis (*see* Ex. 28), we are satisfied that Dr. Silver considered the effect of claimant's degenerative condition. (Exs. 27, 34). Such consideration satisfies the analysis set forth in *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995) (in determining major contributing cause, persuasive medical opinion must evaluate the relative contribution of all potential causes and explain why the work injury or exposure contributes more to the claimed condition than all other causes or exposures combined).

record of any remote neck injury. Claimant credibly testified that she had never injured her neck prior to November 1998. (Tr. 16). Furthermore, Dr. Silver persuasively rebutted Dr. Fuller's theory of a remote injury, stating instead that claimant's degenerative disc disease at C5-6 was more consistent with microtrauma associated with the activities of daily living. (Ex. 30-2). We therefore find Dr. Fuller's opinion less persuasive.

For all of these reasons, we agree with the ALJ's determination to set aside the insurer's denial of claimant's combined cervical 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 $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated June 29, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

In the Matter of the Compensation of
JULIA A. BJUR, Claimant
Own Motion No. 00-0202M
OWN MOTION ORDER
Grocers Insurance, Insurance Carrier

The insurer submitted claimant's request for temporary disability compensation for claimant's upper back condition. Claimant's aggravation rights expired on August 17, 1992. The insurer opposed authorization of temporary disability compensation, contending that: (1) claimant's current condition does not require surgery or inpatient hospitalization; (2) claimant's current condition is not causally related to the accepted condition; (3) it is not responsible for claimant's current condition; and (4) it is unknown whether surgery and/or hospitalization is reasonable or necessary for claimant's current condition.

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

Claimant's 1985 claim was first closed on August 17, 1987, and her aggravation rights expired on August 17, 1992. ORS 656.273(4)(a). Thus, when claimant's condition worsened in November 1999, claimant's claim was under our own motion jurisdiction. Inasmuch as we have exclusive own motion jurisdiction over claimant's 1985 claim, we turn to whether claimant is entitled to temporary disability benefits as set forth in ORS 656.278.

The Board's Own Motion authority is provided under ORS 656.278. Except for claims for injuries which occurred prior to January 1, 1966, ORS 656.278 limits the Board's authority to those cases where there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the workers condition becomes medically stationary, as determined by the Board.

Our Own Motion jurisdiction extends only to the authorization of temporary disability compensation under the specific circumstances set forth in ORS 656.278. The Board, in its Own Motion authority, does not have jurisdiction to decide matters of compensability, responsibility or reasonableness and necessity of surgery or hospitalization (pre-1966 injuries excepted). Rather,

jurisdiction over these disputes rests either with the Hearings Division pursuant to ORS 656.283 to 656.295 and 656.704(3)(b) or with the Director under ORS 656.245, 656.260 or 656.327 and 656.704(3)(b). *See Gary L. Martin*, 48 Van Natta 1802 (1996).

On August 24, 2000, the insurer submitted its recommendation to deny claimant's request for own motion relief. The insurer disputed the compensability of and responsibility for claimant's current condition. The insurer further contended that claimant's current condition did not require surgery and/or it was unknown whether surgery or hospitalization was reasonable and necessary for claimant current condition. The Board wrote, on several occasions, to both the insurer and claimant requesting further clarification of the insurer's recommendation. The Board requested copies of medical evidence regarding the surgery issue and a copy of the denial if one had issued. To date, no response has been received from either party.

Thus, the issue of whether claimant's current condition is part of her accepted 1985 claim remains a compensability and responsibility question which is undetermined at this time. As noted above, jurisdiction over matters of compensability, responsibility or reasonableness and necessity of surgery or hospitalization disputes rest with the Hearings Division or with the Director.

Inasmuch as the dispute between the parties remains unresolved, we are not authorized to reopen claimant's 1985 injury claim for the payment of temporary disability benefits. *See* ORS 656.278(1)(a). Accordingly, claimant's request for temporary disability compensation is denied.[1]

IT IS SO ORDERED.

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[1] It appears from claimant's request that she is unclear as to her rights and benefits under the Workers' Compensation laws. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot extend legal advice to either party. However, since claimant is unrepresented, she may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters. She may call free of charge at 1-800-927-1271,or write to:

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

October 19, 2000 Cite as 52 Van Natta 1913 (2000)

In the Matter of the Compensation of
ROBERT E. LANCE, Claimant
WCB Case No. 99-00944
ORDER ON RECONSIDERATION
Bottini, Bottini & Oswald, Claimant Attorneys
Cavanagh & Zipse, Defense Attorneys

On August 31, 2000, we abated our August 3, 2000 order that affirmed an Administrative Law Judge's (ALJ's) order that set aside the insurer's denial of claimant's current low back condition. We took this action to consider the parties' settlement.

The parties have submitted a Disputed Claim Settlement that is designed to resolve the dispute pending in this case, as well as the dispute pending before the Board in WCB Case No. 00-01401. Those portions of the settlement pertaining to the dispute pending in WCB Case No. 00-01401 have received our approval. Pursuant to the settlement, claimant agrees that the January 16, 1999 denial shall forever remain in full force and effect and that the execution of this document shall constitute a full and final waiver of the claimant's right to challenge or appeal the denial. The parties further agree that all Requests for Hearing and all issues which have been or could have been raised at this time, whether known or unknown, are hereby deemed settled by this settlement agreement.

We have approved those portions of the parties' settlement that pertain to this case, thereby resolving the parties' dispute, in lieu of all prior orders. Accordingly, on reconsideration, this matter is dismissed with prejudice.

IT IS SO ORDERED.

In the Matter of the Compensation of
FRED A. COX, Claimant
WCB Case No. 00-01542
ORDER ON RECONSIDERATION
Popick & Merkel, Claimant Attorneys
Lundeen, et al, Defense Attorneys

Claimant requests reconsideration of our September 21, 2000 Order on Review, in which we reversed that portion of an Administrative Law Judge's (ALJ's) order that affirmed a Director's order reclassifying claimants claim to disabling. Claimant contends that our conclusion that "no temporary disability was authorized" is inconsistent with our finding that Dr. Rodriguez "took claimant off work from November 15 through November 22, 1999." Claimant also contends that, because Dr. McMillan authorized modified work from November 1, 1999 through November 12, 1999, and Dr. Ramsthel authorized modified work in January 1999, time loss was authorized within one year from the date of injury and date of claim acceptance. Consequently, claimant argues that his claim should be classified as disabling.

ORS 656.005(7)(c) provides:

> "A 'disabling compensable injury' is an injury which entitles the worker to compensation for disability or death. An injury is not disabling if no temporary benefits are due and payable, unless there is a reasonable expectation that permanent disability will result from the injury."

Although Dr. Rodriguez took claimant "off work," being "off work" is not synonymous with authorization of temporary disability benefits. Only an attending physician may authorize payment of temporary disability benefits. ORS 656.245(2)(b)(B); ORS 656.262(4)(a) and (h); *see First Interstate v. Morris*, 132 Or App 98 (1994); *Food Services of America v. Ewen*, 130 Or App 297 (1994).

Here, the record shows that Dr. McMillan referred claimant to Dr. Rodriguez for evaluation of claimant's low back pain. (Exs. 115, 116). However, it does not appear that Dr. Rodriguez became claimant's attending physician. *See* Exs. 115-3; 116; 121-2.

Moreover, in *Karron S. Maldonado*, 47 Van Natta 1535 (1995), we concluded that it is not enough that a claimant be limited to modified work; there also must be entitlement to temporary benefits or a reasonable expectation of permanent disability. Generally, a claimant is entitled to temporary disability compensation if he or she has sustained wage loss as a result of the compensable injury. *See RSG Forest Products v. Jensen*, 127 Or App 247, 250-51 (1994). Temporary total disability benefits are based on the wage paid at the time of injury. ORS 656.210; *Coombe v. SAIF*, 111 Or App 71, 75 (1992). ORS 656.212(2) provides that temporary partial disability is to be calculated based on the loss reflected in a comparison of claimant's wages at modified employment with his at-injury wages.

Thus, where a claimant's wages at modified employment are the same as his at-injury wages, the calculation of claimant's temporary partial disability rate may result in zero, *i.e.*, there are no temporary disability benefits due and payable. Here, at the time of injury, claimant was earning a wage of $1,050 per week. (Ex. 91). Although Dr. Ramsthel and Dr. McMillan each released claimant to light duty work, the unrebutted record evidence indicates that full wages were paid. *Id.* Consequently, the record does not support a conclusion that temporary disability benefits were due and payable.

In sum, we conclude that claimant has not established that temporary disability benefits were due and payable within one year from the date of the acceptance of his claim. Therefore, the claim must be classified as nondisabling.

Accordingly, we withdraw our prior order. On reconsideration, after reconsidering the record in light of claimant's motion, we continue to adhere to the conclusions reached in our prior decision.

Consequently, on reconsideration, as supplemented herein, we republish our September 21, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LINDA M. DUGGER, Claimant
WCB Case Nos. 99-02996 & 98-04395
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorneys
Jerald Keene, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denials of claimant's L4-5 disc condition. The insurer also contends that the ALJ improperly admitted into evidence a rebuttal medical report obtained by claimant after hearing. On review, the issues are the propriety of the evidentiary ruling and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Ruling

The insurer contends the ALJ abused his discretion by admitting Exhibit 63A, a "post-hearing" rebuttal report by Dr. Long, into evidence. For the following reasons, we disagree.

On June 2, 1999, the day of the hearing, the insurer offered into evidence Exhibits, 61, 62, 54A, and 63.[1] (Tr. 1). The ALJ admitted those exhibits into evidence subject to claimant's right to obtain and submit rebuttal evidence from Drs. Long and Jenkins. (Tr. 2). The insurer did not initially object to the ALJ's ruling. (Tr. 3). Somewhat later, based upon the insurer's concerns over the scope of claimant's rebuttal evidence, the ALJ decided not to limit claimant's approach to her rebuttal evidence, but would afford the insurer the opportunity for cross-examination. (Tr. 23).

By letter dated September 30, 1999, claimant submitted Dr. Long's rebuttal report. Rather than cross-examine Dr. Long, the insurer objected to the admission of the report, arguing that it was based, in part, on new information regarding claimant's history from an alleged "post-hearing" conversation between Dr. Long and claimant. The ALJ determined that the report did not establish that Dr. Long had received any new information regarding claimant's history of injury, and admitted the report, Exhibit 63, into evidence. (Opinion & Order, p. 6).

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem, LeMasters v. Tri-Met, Inc.*, 133 Or App 258 (1995).

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[1] Exhibits 61, 62, and 63 are medical reports from Drs. Fuller, Farris, and Thompson, respectively. Exhibit 54A consists of videotapes and accompanying reports.

The insurer cites *Wayne J. Land*, 51 Van Natta 442, 443 (1999), in support of its position that the ALJ abused his discretion in admitting Exhibit 63A into evidence. In *Land*, we held that an ALJ did not abuse his discretion in excluding a rebuttal report that fell outside the purpose for which the record had been left open. Here, however, unlike *Land*, claimant preserved her right to present such rebuttal evidence. Accordingly, we find *Land* distinguishable. Furthermore, even if we assume that Dr. Long had a "post-hearing" conversation with claimant as the insurer alleges, we conclude, as did the ALJ, that any information he derived therefrom did not affect his understanding of the history of injury, which forms part of the basis of his medical opinions.[2]

Accordingly, we find no abuse of discretion in the ALJ's admitting Exhibit 63A into evidence.

Compensability

We adopt and affirm the "compensability" portion of the ALJ's order with the following supplementation. The insurer contends that the ALJ erred in relying on attending physician Long's opinion to conclude that the major contributing cause of claimant's current disability or need for treatment is her compensable injury of May 1997. We disagree.

On May 7, 1997, while working as a gymnastics instructor, claimant compensably injured her low back attempting to catch and break the fall of a student who fell off the uneven parallel bars. (Tr. 37; Ex. 2). The claim was originally accepted as a lumbar strain and later amended as a lumbar strain combined with a noncompensable preexisting grade I spondylolisthesis. (Ex. 49-1). On June 1, 1998, the insurer denied claimant's current condition on the ground that her compensable lumbar strain was no longer the major contributing cause of her disability or need for treatment. (Ex. 50).

The parties do not dispute the ALJ's finding that claimant's grade I spondylolisthesis preexisted her compensable injury of May 1997. Nor do they dispute the ALJ's conclusion that the compensability of claimant's current low back condition is subject to ORS 656.005(7)(a)(B). Therefore, in order to establish that her low back condition remains compensable, claimant must show that her work injury remains the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, 106 (1997), *aff'd as modified on recon*, 149 Or App 309, 315 (1997), *rev denied*, 326 Or 389 (1998).

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

The parties agree that claimant's current problems are due to her L4-5 disc condition. Therefore, in applying the above-listed principles, to establish the compensability of her current condition, claimant must establish that the May 1997 work incident contributes more to her current disability or need for treatment of her L4-5 disc condition than all other factors combined.

Because of claimant's preexisting condition and the possible alternative causes contributing to her current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions that are well reasoned and based on complete information.. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). In evaluating medical opinions we generally defer to the treating physician, absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here we find no persuasive reasons not to defer to Dr. Long's opinion.

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[2] The specific history in question indicates that claimant had no significant back problems prior to her work injury, and additionally establishes that claimant was the one employee who always worked with the gymnastic students in circumstances that required spotting. That history is set forth in both Exhibit 63-1 and Exhibit 47-2. Exhibit 47 is Dr. Long's letter to the insurer of May 29, 1998.

Dr. Long, the attending physician since August 1997, opined that when claimant caught the falling student, she did so while standing in a position of trunk flexion, thus subjecting the L4-5 disc to relatively high forces. He further opined that, as a result of that loading, the posterior annulus of the L4-5 disc was damaged. (Exs. 47-2, 3; 54-2; 63A-3). Dr. Long ultimately concluded that the work incident of May 1997 was the major contributing cause claimant's disability and need for treatment for the combined L4-5 disc condition. (Exs. 54-2; 63A-3). His opinion is based upon claimant's history, his analysis of the mechanics of the injury, the results of his physical examinations, the diagnostic testing performed by Dr. Slack, and imaging studies. (Ex. 63A-3). Dr. Long's opinion is supported by Dr. Jenkins, a consulting orthopedist. (Exs. 57, 59, 64). Accordingly, we find Dr. Long's opinion persuasive.

Dr. Farris, one of the doctors on whom the insurer relies, opined that claimant "sustained nothing more than a simple soft tissue strain" as a result of her May 5, 1997 work injury. (Ex. 61-2). His opinion appears to rest, in part, on a chart note dated May 7, 1997, from Dr. Kelsall that Dr. Farris believed noted no abnormal orthopedic or neurologic findings.[3] (Ex. 55-2). However, Dr. Kelsall reported that claimant exhibited low back pain radiating to the left lateral buttock and mid thigh. (Ex. 55A-2). To the extent that Dr. Farris' opinion rests on an incorrect reading of Dr. Kelsall's May 7, 1997 chart note, his opinion rests on incomplete information, and is therefore, not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998). Accordingly, the ALJ correctly did not rely on it.

The insurer also relies on Dr. Fuller, who, like Dr. Farris, examined claimant at the insurer's request. Dr. Fuller believed that claimant's L4-5 disc was not damaged in the May 1997 work incident. (Ex. 62). His opinion rests on the proposition that the work incident was not severe enough to cause a forward slippage of the L4 vertebra onto the L5 vertebra. (Ex. 62-1). He does not discuss the scenario posed by Dr. Long, whereby the work incident is severe enough to damage the L4-5 disc, but not so severe as to cause slippage of the vertebra. Moreover, his opinion does not appear to consider the diagnostic testing performed by Dr. Slack, which establishes that claimant's pain is from the L4-5 disc itself, not the L4-5 facets. (Ex. 38-2, 54-2). Under these circumstances, because he does not explain his reasoning for excluding the May 1997 work incident from the type of trauma that can damage a disc without causing slippage of the vertebra, we find his opinion is merely an unsupported conclusion and as such, is not persuasive. Accordingly, the ALJ correctly did not rely on it.

In conclusion, we find Dr. Long's opinion, as supported by Dr. Jenkins, to be the best reasoned and most persuasive opinion in this record. Consequently, we conclude that claimant's work injury of May 5, 1997 was the major contributing cause of her disability and need for treatment for her L4-5 disc condition.

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

ORDER

The ALJ's order dated February 4, 2000 is affirmed. For services on review, claimant is awarded a $2,000 attorney fee, payable by the insurer.

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[3] Exhibit 55 is a letter from Dr. Farris to the insurer's counsel. Dr. Farris information regarding the contents of Dr. Kelsall's chart note, as expressed in Exhibit 55, appears to come not from Dr. Farris' own reading of that chart note, but from a letter by the insurer's counsel describing the chart note. That letter is not in evidence. It also does not appear that Dr. Farris was made aware of Exhibit 55A, in which Dr. Kelsall corrected the insurer's counsel's perception that claimant had no abnormal orthopedic or neurologic findings on May 7, 1997.

In the Matter of the Compensation of
TAMERA J. FLESHMAN, Claimant
WCB Case Nos. 99-08074 & 99-08073
ORDER ON REVIEW
Steven T. Maher, Defense Attorney
Lundeen, et al, Defense Attorneys

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*,[1] requests review of Administrative Law Judge (ALJ) Davis' order that: (1) upheld the insurer's denial, on behalf of Shilo Management (Shilo), of claimant's aggravation claim for a current low back condition; and (2) upheld the insurer's denial, on behalf of Shari's Management Corporation (Shari's), of claimant's new injury or occupational disease claim for the same condition. Claimant also asks for an opportunity to present additional testimony.[2] We treat claimant's request as a motion for remand. On review, the issues are remand, compensability, and potentially, responsibility.

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

Our review must be based on the record certified to us. *See* ORS 656. 295(5). Consequently, we treat claimant's request to present additional testimony on review[3] as a motion to remand to the ALJ for the taking of additional evidence. *Judy A. Britton*, 37 Van Natta 1262 (1985).

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence it must be clearly shown that material evidence was not obtainable with due diligence at the time of hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, there is no evidence that the testimony claimant would submit for the first time on review was unavailable with due diligence at the time of hearing. Moreover, in light of the existing documentary and testimonial evidence already present in the record, we find that consideration of this additional evidence would not likely affect the outcome. *See Compton*, 301 Or at 646. Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Accordingly, it does not merit remand. *See* ORS 656.295(5).

In addition, we offer the following comments about the merits of the claims. This case presents a complex medical question, because evidence addressing causation is conflicting. Therefore, claimant cannot carry her burden of proof without persuasive expert evidence supporting her claims. *See William T. Johnson*, 51 Van Natta 1750 (1999). And we agree with the ALJ that the medical evidence supporting

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[1] Although claimant was represented at hearing, she is proceeding *pro se* on review.

[2] On review, claimant expresses dissatisfaction with her former counsel's efforts. Claimant's remedy, if any exists for her dissatisfaction with her counsel's representation, lies outside the workers' compensation system.

[3] In her brief, claimant refers to excerpts from *Mayo Clinic Family Health, Johns Hopkins Family Health Book*, and the *Time Life Medical Advisor*. Shilo and Shari's object to claimant's references to these texts and ask that we consider only evidence admitted at hearing. As we explain herein, our review is limited to the record certified to us. And we decline to take administrative notice of the materials claimant cites, because these submissions constitute evidence from a source not subject to confrontation and cross-examination. *See, e.g., Richard H. Olsen*, 41 Van Natta 1300 (1989) (Board did not have authority to consider the most recent version of a medical treatise where the evidence was not admitted at the hearing and not a part of the record). Consequently, we have not considered those portions of claimant's appellant's brief that refer to extraneous material.

compensability is not persuasive, because it is not based on an accurate and complete history. Consequently, we also agree with the ALJ that the claims must fail.[4]

ORDER

The ALJ's order dated June 14, 2000 is affirmed.

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[4] Finally, it appears from claimant's citations to Workers' Compensation court cases and her arguments about "permanent disability," that she may not understand her rights and benefits under the Workers' Compensation Law. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot give legal advice to either party. Because claimant does not have an attorney, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters. She may contact the Workers' Compensation Ombudsman, at (503)-378- 3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street, NE
Salem, OR 97301

In the Matter of the Compensation of
GERALD S. GAAGE, Claimant
Own Motion No. 66-0136M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On April 26, 1999 and October 1, 1992, we authorized the reopening of claimant's claim for the provision of medical treatment for his compensable October 7, 1959 industrial injury which resulted in the amputation of his right leg. On September 15, 2000, the SAIF Corporation submitted claimant's request for a College Park Tru Step prosthetic foot. SAIF recommended denying reopening of claimant's 1959 claim to provide for the requested prosthetic foot.

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 contended that the requested College Park Tru Step prosthetic foot was not medically necessary at this time. On September 19, 2000, the Board requested claimant's position regarding the medical necessity of the requested prosthetic foot. Claimant has not responded to the Board's inquiry or to SAIF's contention.

Thus, based on the record before us, we find that the medical evidence in the record does not establish that the requested medical service, specifically the provision of a College Park Tru Step prosthetic foot, is reasonable and necessary at this time.

Accordingly, we decline to authorize payment of the requested prosthetic foot. However, claimant's claim shall remain open to provide medical services that are found to be reasonable and necessary and causally related to the compensable injury pursuant to our April 26, 1999 and October 1, 1992 orders. 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. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD P. OLSON, Claimant
Own Motion No. 98-0119M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Popick & Merkel, Claimant Attorneys
Williams & Fredrickson, Defense Attorneys

Claimant requested review of the self-insured employer's March 29, 1999 Notice of Closure which closed his claim with an award of temporary disability compensation from May 5, 1998 through July 5, 1998. The employer declared claimant medically stationary as of October 7, 1997. Claimant contends that he is entitled to temporary disability compensation beyond July 5, 1998.

By Own Motion Order dated June 5, 1998, we authorized the reopening of claimant's claim to provide temporary disability compensation beginning February 2, 1998, the he was hospitalized for the proposed surgery. ORS 656.278(1)(a).[1]

A claim may not be closed unless the claimant's condition is medically stationary. *See* OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). 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 does not contend that his medically stationary date is incorrect or that he was not medically stationary when the employer closed his claim. In any event, the record would not support such a contention.[2] Rather, claimant contends that he is entitled to "ongoing compensation until benefits are properly terminated."

We have previously noted that temporary disability compensation shall be paid on an "open" own motion claim until one of the following event occurs: (1) the claim is closed pursuant to OAR 438-012-0055; (2) a claim disposition agreement (CDA) is submitted to the Board pursuant to ORS 656.236(1); or (3) termination of such benefits is authorized by the terms of ORS 656.268(4)(a) through (c). *See* OAR 438-012-0035(4).

However, here, the claimant's claim is in "closed" status. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure. Inasmuch as temporary disability benefits were paid through July 5, 1998, the date he was declared medically stationary, we conclude that claimant is not entitled to additional temporary disability and that it was appropriately terminated. Therefore, we conclude that the employer's closure was proper.

Accordingly, we affirm the employer's March 29, 1999 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] On September 14, 1998, claimant requested enforcement of our June 5, 1998 order, contending that the employer had unilaterally terminated his temporary disability benefits on May 5, 1998. On March 3, 1999, we found that the employer had unreasonably terminated claimant's temporary disability benefits and directed the employer to recommence temporary disability compensation beginning May 5, 1998 when it terminated compensation until it could lawfully terminate such benefits.

[2] In this regard, Dr. Hayes, claimant's attending physician, provided the only medical evidence regarding claimant's medical stationary status. On May 5, 1998, Dr. Hayes noted that claimant was released to modified work and recommended that claimant return in two months for a "follow-up and probably a closing exam." On October 7, 1998, in response to an inquiry from the employer, Dr. Hayes reiterated that, although claimant did not return for a follow-up or closing examination, he expected him to be medically stable and "ready for a closing examination, two months after my last examination on 5-5-98." Dr. Hayes explained that there was no additional treatment to perform and therefore, opined that claimant would have probably been medically stationary at the July 5, 1998 examination, if he had returned. Dr. Hayes' opinion is unrebutted. Furthermore, there is no evidence that claimant was not medically stationary at the time his claim was closed on March 29, 1999.

In the Matter of the Compensation of
ANA ROSA L. SANCHEZ, Claimant
WCB Case No. 98-07619
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorneys
Sather, Byerly & Holloway, Defense Attorneys

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its denial of claimant's claim for a neck and right shoulder injury; and (2) awarded a $10,000 assessed attorney fee. On review, the issues are compensability and attorney fees. We modify 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 lifted a rack of 25 panels at work and that this incident was a material contributing cause of her right shoulder/neck injury.

On review, the insurer argues that claimant is not credible and has failed to meet her burden of proof. Claimant relies on Dr. Rodriguez' opinion and argues that she is credible and attributes embellishment of pain, inconsistencies and confusion in the record to difficulty communicating in English, lack of education and cultural differences.

Claimant speaks little English and had problems communicating with her physicians. She received only five years of schooling in her native country. Claimant first sought medical treatment for right shoulder/neck pain on April 27, 1998 with Dr. Mears. Dr. Mears' chart note indicates, in part, that "She denies injury but has to lift heavy sheets of copper where she works." (Ex. 1). In a May 8, 1998 chart note, Dr. Mears attributes claimant's pain to a "work overuse injury." (Ex. 2). Dr. Mears took claimant off work on May 26, 1998.

Claimant filed a claim on May 27, 1998. Her daughter, who is fluent in Spanish, helped her complete the claim form. The incident was described as occurring while moving panels in a rack from a high place to a low place. (Ex. 5).

Claimant sought treatment with Dr. Lohman, an orthopedist, on July 7, 1998. Claimant's daughter acted as translator. Dr. Lohman took a history that claimant was trying to transfer a rack of plastic/metal tools from high chest level to a lower position and the parts shifted. Dr. Lohman reported that claimant's right shoulder was injured while attempting to keep the rack from falling. An arthrogram showed no evidence of a rotator cuff tear. Dr. Lohman noted that pain behavior made the examination difficult. (Ex. 15). An MRI showed a C5-6 posterior disk protrusion that indented the thecal sac. (Ex. 17).

Dr. Lohman referred claimant to Dr. Platt. Dr. Platt recorded a history that claimant lifted a 25-pound rack of panels from a high to low position and felt pain after the rack slipped as she tried to hold it. Dr. Platt diagnosed "probable cervical and/or right shoulder strains with symptoms suggestive of radiculopathy, C6 or C7, widespread, right sided pain and secondarily decreased shoulder movement with possible early adhesive capsulitis." (Ex. 19).

Claimant was seen by neurologist, Dr. Hills, who performed nerve conduction and electromyography studies that were mildly abnormal and suggested possible mild active C5 radiculopathy. (Ex. 24). Dr. Hills ordered a repeat MRI that showed a "posterior bulging disk, C5-6, encroaching upon ventral margin of dural sac and displacing spinal cord posteriorly. This appearance is unchanged since the last examination of 7/15/98. Otherwise negative exam." (Ex. 27).

In an October 8, 1999 opinion, Dr. Lohman indicated that he had not examined claimant until approximately three months after the injury so was unable to comment on whether claimant sustained a cervical or right shoulder strain secondary to the injury. Dr. Lohman indicated that potential diagnoses of rotator cuff tear and frozen shoulder (adhesive capsulitis) had been ruled out. Dr. Lohman opined that the disk protrusion at C5-6 most likely represented an incidental finding. (Ex. 29-2). Dr. Lohman stated that in order for claimant's MRI findings of a C5-6 disk herniation to be clinically relevant, they must correlate with the patient's clinical findings and clinical symptoms. Dr. Lohman indicated that claimant's pain behavior interfered with her clinical examination and her response appeared exaggerated. Dr. Lohman explained that the functional component to claimant's presentation implied that her response to the clinical exam was inappropriately exaggerated, but did not mean that it did not cause a degree of pain. (Ex. 29-3).

Claimant was seen on November 9, 1999, by Dr. Rodriguez, an internist who is fluent in Spanish, which is claimant's native language. Dr. Rodriguez diagnosed C5 disk radiculopathy consistent with the mechanism of injury. Dr. Rodriguez stated:

> "Because I spoke the native language, and I was able to specifically ask her to show me how the original injury occurred, she very clearly demonstrated that she caught the stack of 25 panels with her chin and demonstrated a maneuver where she was actually forward bending and side bending to the right, pushing down on her chin as she tried to stabilize the panels at the same time she was trying to hold with the right side. So she was creating a compression force between her right chin and her right arm to try to stabilize the load. This is consistent with causing a compressive force in a flexed forward bent position that could have easily produced a disc herniation with a posterior bulge." (Ex. 30).

Dr. Rodriguez also attributed claimant's exaggeration of pain, noted by other physicians in the record, to her limited education and limited coping mechanism.

The medical record contains multiple references to pain behavior or exaggeration that made diagnosis of claimant's problems difficult. In addition, claimant has had difficulty communicating with her doctors. Although claimant's pain behavior and language difficulties have made diagnosis and treatment of claimant's condition very difficult, we conclude, based on this record, that a preponderance of the evidence supports a conclusion that claimant sustained an injury to her neck/right shoulder while lifting a rack of panels at work. *See Boeing Aircraft Co. v. Roy*, 112 Or App 10, 15 (1992) (a claimant need not prove a specific diagnosis if he proves that his symptoms are attributable to his work).

In reaching this conclusion, we do not interpret Dr. Lohman's opinion as establishing that claimant's right shoulder/neck injury is not compensable. In this regard, although Dr. Lohman stated that the herniation at C5-6 most likely represented an "incidental finding," he also stated that in order for claimant's findings at C5-6 to be clinically relevant, they must correlate with her clinical findings and clinical symptoms. Based on Dr. Rodriguez' report, we are persuaded that claimant's examination findings and symptoms did correlate with the disc herniation.

In summary, after reviewing all of the medical evidence from Drs. Mears, Lohman, Platt, Rodriguez and Hills, we conclude that claimant has established that the April 9, 1998 incident is a material contributing cause of her right shoulder/cervical condition.

In reaching our conclusion, we note that Dr. Mears, who initially treated claimant, had the impression that claimant's condition was caused by overuse at work. Because of the language barrier, and because the qualifications and skill of the translator used by Dr. Mears are unknown, we are not persuaded that the inconsistency in the history obtained by Dr. Mears is fatal to claimant's case. The histories given to the subsequent physicians after claimant's daughter began acting as translator are substantially consistent.

The insurer also argues that claimant told her employer, through a co-worker, Ms. Arellano, that her right shoulder/neck problems were not work-related. Ms. Arellano recorded the conversation in Exhibit 1A. Ms. Arellano was subpoenaed by the insurer, but failed to attend the hearing. The parties stipulated that this witness would have testified to the facts contained in Exhibit 1A, that she is a co-worker of claimant's who is fluent in Spanish and that she prepared Exhibit 1A on May 5, 1998.

Notwithstanding the parties' stipulations, the conversation between claimant and Ms. Arellano was not overheard by anyone else who could speak Spanish. Ms. Arellano's level of skill at translating between Spanish and English is unknown. Moreover, Ms. Arellano did not present herself at the hearing to testify. Under such circumstances, we find that Exhibit 1A is entitled to little weight.

The insurer also argues that the facts that claimant did not file the claim until 6 weeks after the injury and that claimant did not receive medical treatment until 3 weeks after the injury support a conclusion that claimant is not believable. Given the language barrier, claimants lack of education, lack of sophistication and the fact that claimant had never filed a claim before, we do not find that the delay in seeking treatment or filing the claim to be fatal to claimant's claim.

Attorney Fees

The ALJ awarded a $10,000 assessed attorney fee to claimant's counsel for prevailing over the denial. On Board review, the insurer contests the amount of the attorney fee, arguing that it is excessive.

The factors to be considered under OAR 438-015-0010(4) in awarding a reasonable attorney fee are: the time devoted to the case, the complexity of the issue, the value of the interest involved, skill of the attorneys, the nature of the proceedings, the benefits secured for the represented party, the risk that an attorney's efforts may go uncompensated, and the assertion of frivolous issues or defenses. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

The hearing involved 3 sessions. The first session was 3 hours long and the transcript is 46 pages long. The second session was also 3 hours long and the transcript is 84 pages. The third session lasted one and a half hours and the transcript is 18 pages. Seven witnesses testified. There was one deposition that lasted an hour. Claimant's attorney submitted 19 exhibits. The record contains approximately 37 exhibits.

The factual and medical issues were of moderate complexity. The value of the interest involved is substantial in that claimant will receive medical treatment and possibly other benefits for her right shoulder/neck condition. The attorneys were skilled and presented their positions in a thorough manner. No frivolous issues or defenses were raised. There was a risk that claimant's attorney might go uncompensated.

Based on our application of the factors set forth above and considering the parties' arguments, we find that an attorney fee of $7,000 is reasonable for services regarding compensability at the hearing level. In reaching this conclusion, we have particularly considered the time devoted to the issue, the value of the interest involved and the risk that claimant's counsel might go uncompensated.

Although we recognize that the hearing involved three sessions and warrants a larger attorney fee than would a routine case, we are not persuaded, based on the remaining factors, that a fee of $10,000 is reasonable. In this regard, the issue was of moderate complexity, the benefits, although substantial because the claim has been found compensable, are comparable to those involved in typical compensability cases. The remaining factors do not bring this case outside the range of typical compensability cases seen in this forum. In short, other than the time factor which is atypical, the remaining factors were not outside the range of typical compensability cases seen in this forum. Thus, after our review of the case and consideration of the factors, we conclude that the ALJ's attorney fee award should be modified.

Claimant's counsel is also entitled to an assessed fee for services on Board 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 services on review regarding the compensability issue is $1,500, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimants respondents brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 27, 2000 is affirmed in part and modified in part. In lieu of the ALJ's award of a $10,000 attorney fee, claimant's attorney is awarded $7,000, payable by the insurer. For services on Board review, claimant's attorney is awarded $1,500, payable by the insurer. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
DELBERT SHAY, Claimant
WCB Case Nos. 99-06917 & 99-06916
ORDER OF DISMISSAL
Allison Tyler, Claimant Attorney
Mustafa T. Kasubhai, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The Department of Consumer and Business Services (Department) requests, and claimant cross-requests, review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside it Proposed and Final Order declaring the employer, Michael G. and Carol L. O'Brion, to be noncomplying. We dismiss for lack of appellate jurisdiction.

FINDINGS OF FACT

On August 19, 1999, the Department issued a Proposed and Final Order declaring the employer to be noncomplying and assessing a civil penalty (NCE order). (Ex. 8). The employer requested a hearing. The Department requested, and claimant cross-requested, Board review of the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

An alleged noncomplying employer may contest the Department's order of noncompliance by filing a request for hearing with the Department pursuant to ORS 656.740. The ALJ's order is deemed to be a final order of the Director. ORS 656.740(1), (3). Jurisdiction for review of the ALJ's order is as provided in ORS 656.740(4).

Under this statute, we lack appellate jurisdiction to review an ALJ's order addressing the issue of noncompliance in cases where the proceeding was not consolidated with a matter concerning a claim or where the employer contested only the Director's noncompliance order. ORS 656.740(4)(c); *Ferland v. McMurty Video Productions*, 116 Or App 405 (1992), *Spencer House Moving, NCE*, 44 Van Natta 2522 (1992), *aff'd Miller v. Spencer*, 123 Or App 635 (1993).

Also, in the absence an ALJ's order arising from a hearing request raising a matter concerning a claim, the Board lacks appellate jurisdiction to review a Department's NCE order deciding whether the claimant was a subject worker and whether the employer was a subject employer; instead, appellate jurisdiction lies with the Court of Appeals under ORS 656.740(4). *Spencer House Moving, NCE*, 44 Van Natta at 2523.

Here, the employer requested a hearing regarding the Department's NCE order. No party challenged the compensability of claimant's claim. Thus, no request for hearing raised a matter concerning a claim. Thus, the ALJ's order did not result from a hearing in which the issue of noncompliance was consolidated with a matter concerning a claim. *See* ORS 656.740(3)(c). Because the ALJ's order solely pertained to the employers appeal from the Director's NCE order, we lack appellate review authority. Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES P. SUTER, Claimant
Own Motion No. 99-0106M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Welch, Bruun & Green, Claimant Attorneys
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's June 20, 2000 Notice of Closure, which closed his claim with an award of temporary disability compensation from April 13, 1999 through June 8, 2000. SAIF declared claimant medically stationary as of April 13, 2000.

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 claim closure turns on whether claimant was medically stationary at the time of the June 20, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

In letters dated August 18, September 5 and September 27, 2000, we requested that SAIF submit copies of materials considered in closing the claim. Upon submission of these materials, claimant was allowed 15 days to submit additional materials. SAIF submitted its response on September 29, 2000, however, no further response has been received from claimant. Therefore, we proceed with our review.

Typically, there are only two issues to be raised when a claimant requests review of an insurer's claim closure. The most common issue raised is that the claimant was not medically stationary at claim closure. A second issue raised less often, is that, although medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability compensation during the time the claim was open.

Here, claimant states that he is "very much in disagreement with the Notice of Closure," and requests review of SAIF's June 20, 2000 Notice of Closure. We interpret claimant's request for review as a challenge to both the medically stationary determination and the temporary disability compensation award. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

On June 6, 2000, Dr. Yates, claimant's attending physician, submitted a progress report wherein he opined that claimant was medically stationary as of April 13, 2000. This opinion is unrebutted.

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on June 20, 2000. Inasmuch as temporary disability compensation was paid through June 8, 2000, and the claim was closed on June 20, 2000, we conclude that claimant is not entitled to additional temporary disability and that SAIF's claim closure was proper.

Accordingly, we affirm SAIF's June 20, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLARA J. SCURLOCK, Claimant
WCB Case No. 98-08394
ORDER ON REVIEW
Martin J. McKeown, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that affirmed a June 1, 1999 Order on Reconsideration that awarded no additional scheduled permanent disability for the loss of use or function of claimant's left foot (ankle). On review, the issue is extent of scheduled permanent disability. We modify.

FINDINGS OF FACT

Claimant compensably injured her neck and left ankle on December 20, 1995. (Ex. 1). The insurer accepted a disabling cervical disc herniation at C5-6, central and left, and a left ankle sprain. (Exs. 2, 4).

On July 17, 1996, Dr. Kendrick performed an anterior cervical discectomy at C5-6. (Ex. 3).

On March 19, 1997, Dr. Holmboe performed a chondroplasty of the talus and Brostrom procedure for a diagnosis of instability left ankle anterior talofibular ligament, mild calcaneofibular ligament laxity, synovitis to the anterolateral ankle, and a small osteochondral lesion, lateral dome talus. (Ex. 5).

On April 18, 1998, Dr. Schilperoort examined claimant for the insurer. (Ex. 7). Dr. Kendrick and Dr. Holmboe each concurred with Dr. Schilperoort's report. (Exs. 8, 9).

A May 27, 1998 Notice of Closure awarded 15 percent unscheduled permanent disability for the neck and 7 percent scheduled permanent disability for the left ankle. (Ex. 11). On June 24, 1998, claimant requested reconsideration. (Ex. 12).

On August 5, 1998, Dr. Tiley, orthopedist, performed an arbiter's examination for claimant's accepted conditions of cervical disc C5-6 and left ankle sprain. (Ex. 13).

On August 19, 1998, claimant requested that the Notice of Acceptance be amended to include left ankle synovitis and left ankle instability. (Ex. 14).

An October 19, 1998 Order on Reconsideration reduced the unscheduled permanent disability award for claimant's neck condition to 3 percent and increased the scheduled permanent disability award for claimant's ankle sprain condition to 16 percent. (Ex. 16). On October 22, 1998, claimant requested a hearing challenging the unscheduled permanent disability award. The hearing was set for January 20, 1999.

On December 22, 1998, the insurer accepted the new synovitis and instability conditions and requested determination of the newly accepted conditions. (Exs. 17, 18). A January 8, 1999 Determination Order closed the claim with no additional scheduled permanent disability awarded for the newly accepted conditions. (Ex. 19).

The January 20, 1999 hearing was cancelled and, on January 26, 1999, a deferral order issued. The order deferred the hearing on the October 19, 1998 Order on Reconsideration on the basis that the claim was reopened for acceptance of new medical conditions and must be re-closed with a new rating of claimant's permanent disability.

On May 8, 1999, Dr. Neumann performed a medical arbiter examination. (Ex. 22).

A June 1, 1999 Order on Reconsideration found that claimant's scheduled permanent disability due to the additional conditions was 9 percent, but, applying OAR 436-035-0007(12), awarded no additional scheduled permanent disability because the disability was less than the 16 percent award

granted by the October 19, 1998 Order on Reconsideration. (Ex. 23). On June 29, 1999, claimant requested a hearing, which was consolidated with the request for hearing on the October 19, 1998 Order on Reconsideration.

CONCLUSIONS OF LAW AND OPINION

Relying on arbiter Dr. Neumann's impairment findings, the ALJ concluded that claimant was entitled to 9 percent scheduled permanent disability. But because claimant had already been awarded 16 percent scheduled permanent disability for her left ankle sprain by the October 19, 1998 Order on Reconsideration, the ALJ denied claimant's request for additional permanent disability.[1] The ALJ reasoned that, because only the most recent closure included all of claimant's compensable left ankle conditions, claimant's scheduled permanent disability must be evaluated as of the time of the June 1, 1999 Order on Reconsideration that reconsidered the January 8, 1999 closure.

On review, claimant argues that the ALJ erred in denying her an additional scheduled permanent disability award for loss of repetitive use as a result of the newly accepted conditions. Specifically, claimant argues that, because the range of motion measurements were less in the second order on reconsideration than in the first, the values for lost range of motion and loss of strength from the first reconsideration order should be combined with the chronic condition value from the second reconsideration order, for a total value of 20 percent.

Claimant provides no authority, and we have found none, that requires the combining of values from two different reconsideration orders. Rather, we have previously determined that, in rating permanent disability under the current statutory scheme, the focus is on accepted conditions at the time of claim closure and reconsideration. *Bonnie J. Woolner*, 52 Van Natta 1579 (2000); *see also Janet R. Christensen*, 50 Van Natta 1152 (1998) (evaluation of conditions ordered accepted after claim closure must await the reopening and processing of the claim for that new condition); *James L. Mack*, 50 Van Natta 338, 339 (1998) (same). Consequently, in light of the above precedent, permanent disability is rated based on the accepted left ankle synovitis and instability conditions.

The insurer argues that the ALJ's order awarding no additional permanent disability should be affirmed because, where a claimant has compensable conditions that were newly accepted since the last arrangement of compensation, an offset under OAR 436-035-0007(6) should be applied. In response, claimant contends that, because her additional conditions resulted from the same injury, she has no "subsequent" claim and that the applicable rule is OAR 436-035-0007(9). Claimant argues that the rule applies because the medical arbiter's examination demonstrated that her condition worsened, as established by the arbiter's finding of a chronic condition that resulted in a loss of repetitive use of her ankle.

OAR 436-035-0007(6) (WCD Admin. Order 99-056) provides, in part:

> "If a worker has a prior award of permanent disability under Oregon Workers' Compensation Law, the award shall be considered in subsequent claims pursuant to ORS 656.222 and ORS 656.214.[2] * * *
>
> * * * * * *
>
> "(b) 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 or disease but which has already been produced by *an earlier injury or disease* and had been compensated by a prior award. * * * Only that portion of such loss which was not present prior to the current injury or disease shall be awarded." (Emphasis supplied).

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[1] Although claimant had requested a hearing on the October 19, 1998 Order on Reconsideration's unscheduled permanent disability award, she did not pursue that issue at hearing. Moreover, neither party challenged the October 19, 1998 Order on Reconsideration's award of 16 percent scheduled permanent disability for claimant's left ankle strain condition. Consequently, we do not disturb those awards.

[2] ORS 656.214 defines permanent partial disability and establishes the criteria to be used for the rating of disability for scheduled and unscheduled permanent disability.

ORS 656.222 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." (Emphasis supplied).

There is no dispute that claimant experienced only one injury. Pursuant to the above-mentioned statute and rule, an offset is applicable where a claimant has a *further* accident or injury. Therefore, because ORS 436-035-0007(6), which implements ORS 656.222, applies when a claimant sustains subsequent injuries, and claimant here experienced a single injury, ORS 656.222 is not applicable.[3]

We next address claimant's argument that OAR 436-035-0007(9)[4] applies to this case.

In *Johansen v. SAIF*, 158 Or App 672, 680, *on recon* 160 Or App 519, *rev den* 329 Or 527 (1999), the court found that the carrier's acceptance of a herniated disc following its acceptance of an acute low back strain obligated it to provide benefits under ORS 656.262(4)(a) rather than 656.273 because the herniated disc condition constituted a new medical condition rather than a worsening of the accepted condition.

Here, claimant's left ankle synovitis and left ankle instability were newly accepted since the last arrangement of compensation on October 19, 1998. Consequently, because claimant's newly accepted conditions constitute new medical conditions, not a worsening of the previously accepted ankle sprain

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[3] Although the courts have not directly addressed whether an offset under ORS 656.222 should be applied where a claimant has suffered only one injury with multiple compensable conditions that are newly accepted since the last arrangement of compensation, our interpretation is consistent with the Court's application of ORS 656.222 to cases in which the claimant has experienced two or more successive injuries. *See, e.g., Norby v. SAIF*, 303 Or 536 (1987) (ORS 656.222 prescribes that compensation for permanent disability shall be counted in an award for a subsequent accident); *Nesselrodt v. State Compensation Dept.*, 248 Or 452 (1967) (ORS 656.222 requires an offset where a worker has been paid permanent disability compensation and sustained a further accident and further award of compensation); *see also Offill v. Greenherry Tank and Iron Company*, 142 Or App 351 (1986) (where disability caused by the claimant's prior injury had not resolved before his current injury, rule requiring offset of prior unscheduled permanent disability awards was not inconsistent with ORS 656.222). In each of these cases, the court held that the offset prescribed by ORS 656.222 applied where there were two or more successive injuries. We find nothing in these cases to indicate that an offset under ORS 656.222 would be applicable to the circumstances of this case.

[4] OAR 436-035-0007(9) provides in part:

> "When a claim has been reopened pursuant to ORS 656.273, the worker's compensable condition at the time of of the last award or arrangement of compensation for the compensable condition as it existed at the time of the last closure or reconsideration, whichever occurred most claim closure or reconsideration is compared with the worker's compensable condition as it existed at the time recently, to determined if there is an actual worsening of the worker's compensable condition.
>
> "(a) For purposes of this section, actual worsening shall be established by physician opinion substantiated by objective clinical findings, demonstrating a worsened medical condition at the time of the current claim closure compared with the worker's medical condition at the last award or arrangement of compensation for the compensable condition as it existed at the last claim closure or reconsideration, whichever occurred most recently.
>
> "(b) When an actual worsening of the worker's compensable condition occurs, the extent of permanent disability shall be redetermined. When an actual worsening of the worker's compensable condition does not occur, the extent of permanent disability shall not be redetermined, but shall remain unchanged.
>
> "(c) If a claim has multiple compensable conditions which are either newly accepted since the last arrangement of compensation and/or which have actually worsened, the extent of permanent disability shall be redetermined. There shall be no redetermination for those conditions which are either unchanged or improved. In any case, the impairment value for those conditions not actually worsened shall continue to be the same impairment values that were established at the last arrangement of compensation."

condition, ORS 656.273 does not apply. Hence, because claimant's claim was not reopened under ORS 656.273, the provisions of OAR 436-035-0007(9)(a) and (b) do not apply.[5] However, OAR 436-035-0007(9)(c) applies when a claim has multiple compensable conditions newly accepted since the last arrangement of compensation.

Here, claimant's left ankle synovitis and left ankle instability were newly accepted since the last arrangement of compensation. Therefore, the extent of permanent disability shall be redetermined, except for those conditions that are either unchanged or improved. OAR 436-035-0007(9)(c).

We next turn to the medical evidence to establish whether redetermination is appropriate. The ALJ relied on Dr. Neumann's arbiter report, reasoning that it was the only report that included all of claimant's compensable left ankle conditions. We, too, rely on Dr. Neumann's arbiter report, but for different reasons.

Dr. Neumann described the accepted conditions as "left ankle synovitis and instability." Moreover, he recorded his "impression" as "Ankle sprain injury, left ankle, with *resultant* chondral fracture lesion and chronic synovitis;" and "poststatus chondroplasty and ankle stabilization procedure for ankle instability." We find that Dr. Neumann's report described claimant's newly accepted conditions accurately and that his examination was properly limited to those conditions.

However, Dr. Neumann evaluated the same body part as had been evaluated by Dr. Tiley in relation to claimant's left ankle sprain. Because claimant's left ankle range of motion and strength findings have increased and improved, as demonstrated by Dr. Neumann's findings, there is, in effect, no range of motion or strength impairment as a result of the "new medical conditions." Therefore, claimant is not entitled to an additional permanent disability award for those "new medical conditions" based on range of motion or strength impairment.

However, in contrast to Dr. Tiley's findings, Dr. Neumann found that, due to claimant's chronic and permanent synovitis condition, claimant is significantly limited in the repetitive use of her ankle. Therefore, claimant is entitled to an impairment value of 5 percent for her chronic condition due to her newly accepted left ankle synovitis and left ankle instability conditions. OAR 436-035-0010(5)(a).

The last arrangement of compensation for claimant's left ankle sprain condition established an impairment value of 16 percent, so the impairment value for that condition shall continue to be 16 percent scheduled permanent disability. The medical evidence establishes a value of 5 percent scheduled permanent disability for claimant's chronic condition due to her left ankle synovitis and instability conditions. Because neither an offset nor redetermination is appropriate here, the impairment value for claimant's left ankle and synovitis and left ankle instability conditions remains 5 percent.

However, claimant seeks an award of 4 percent scheduled permanent disability for her newly accepted conditions.[6] In light of such circumstances, we award 4 percent scheduled permanent disability for the loss of use and function of claimant's left foot (ankle) due to her left ankle synovitis and left ankle instability conditions. *See, e.g., Herbert C. Kaler*, 47 Van Natta 1607 (1995) (Board will not increase or reduce an award of permanent disability in the absence of a request to do so by one of the parties); *Carlos S. Cobian*, 45 Van Natta 1582, 1583 (1993) (same).

Because our order results in increased compensation, claimant's counsel is entitled to an out-of-compensation attorney fee equal to 25 percent of the increased compensation, not to exceed $5,000. ORS 656.386(2); OAR 438-015-0055.

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[5] For the same reason, we find that OAR 436-035-0007(12), which applies where there is a redetermination of permanent disability pursuant to ORS 656.273 (and applied in the June 1, 1999 Order on Reconsideration), is inapplicable.

[6] As discussed above, claimant suggests that the October 19, 1999 Order on Reconsideration's award of 16 percent scheduled permanent disability should be combined with the 5 percent value for loss of repetitive use, as found by Dr. Neumann, for a total impairment value of 20 percent. In other words, claimant is requesting a value of 4 percent scheduled permanent disability for the synovitis and instability conditions.

ORDER

The ALJ's order dated May 9, 2000 is modified. In lieu of the ALJ's order and in addition to the Order on Reconsideration, claimant is awarded an additional 4 percent (5.4 degrees) scheduled permanent disability for her left foot (ankle) due to her synovitis and left ankle instability conditions. Claimant's attorney is awarded 25 percent of the increased compensation created by this order, not to exceed $5,000, payable directly to claimant's counsel.

In the Matter of the Compensation of
SHERRY A. GOMES, Claimant
WCB Case No. 99-07107
ORDER OF ABATEMENT
James B. Northrop (Saif), Defense Attorney

On September 22, 2000, we issued an Order on Review (Remanding), that remanded this case to Administrative Law Judge (ALJ) Black to consider claimant's explanation for her failure to appear at the scheduled hearing. We have now received the SAIF Corporation's motion for reconsideration. Contending that claimant did not provide notice of her request for Board review to all parties to this proceeding within 30 days of the ALJ's May 25, 2000 Order of Dismissal, SAIF argues that we should have dismissed claimant's appeal.

In order to consider SAIF's contentions, we withdraw our September 22, 2000 order. Claimant is granted an opportunity to respond to SAIF's argument that she did not mail a copy of her request for Board review to SAIF within 30 days of the ALJ's May 25, 2000 order. To be considered, claimant's written response must be filed with the Board within 14 days from the date of this order. (Claimant is reminded to mail a copy of her response to SAIF's attorney.) Thereafter, the Board will proceed with its reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL T. BERGMANN, Claimant
WCB Case Nos. 00-01126 & 99-0177M
ORDER ON REVIEW
Mitchell & Associates, Claimant Attorney
Bruce A. Bornholdt, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that directed it to process claimant's "new medical condition" claim for a left anterior cruciate ligament tear under ORS 656.262 and ORS 656.268. On review, the issues are jurisdiction and claim processing. We affirm.

FINDINGS OF FACT

Claimant compensably injured his left knee on October 17, 1991. SAIF accepted a disabling horizontal tear of the posterior horn and mid sector of the medial meniscus. (Ex. 2). On November 13, 1991, Dr. Kaesche performed a partial medial meniscectomy. (Ex. 3). A May 1, 1992 Notice of Closure awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of claimant's left knee. (Ex. 6). A December 9, 1992 Order on Reconsideration affirmed the Notice of Closure. (Ex. 7).

On December 1, 1998, claimant returned to Dr. Kaesche, complaining of pain and swelling in his left knee. (Ex. 8). Dr. Kaesche signed an aggravation claim form on that date. (Ex. 9). A January 7, 1999 MRI showed a tear of the anterior cruciate ligament (ACL). (Ex. 11). When Dr. Kaesche performed surgery on claimant's left knee on February 26, 1999, he found that claimant had a 50 percent tear of the ACL. (Ex. 14).

On April 22, 1999, claimant's attorney requested that SAIF amend the notice of acceptance to include a left ACL tear. (Ex. 18). Claimant's attorney also requested acceptance of a partial ACL tear of the left knee. (Ex. 22). On November 17, 1999, a stipulation and order was approved whereby SAIF agreed to accept a 50 percent tear of the left ACL. (Ex. 26). The parties disagreed whether the acceptance required a reopening of the claim and they expressly preserved that issue. (*Id.*) On November 23, 1999, SAIF modified its acceptance to include a 50 percent tear of the left knee ACL. (Ex. 27).

Claimant's attorney requested closure of the claim on January 26, 2000. (Ex. 28). SAIF responded that the claim would be processed as an Own Motion claim upon receipt of an Own Motion order authorizing time loss. (Ex. 29). Claimant requested a hearing regarding SAIF's failure to close the claim.

On March 30, 2000, the Board issued an Own Motion order under ORS 656.278 consolidating a request for Own Motion relief with claimant's request for hearing regarding SAIF's failure to close his claim. (Ex. 30). The Board assigned the case to an ALJ to resolve the claim processing issue. (*Id.*)

CONCLUSIONS OF LAW AND OPINION

The ALJ found that SAIF was required to process the claim as a "new medical condition" and close the claim pursuant to ORS 656.268.

On review, SAIF raises several arguments. To begin, SAIF argues that the ALJ did not have jurisdiction because claimant's aggravation rights have expired. SAIF contends that the Board has jurisdiction only under ORS 656.278. We disagree.

Because claimant's request pertains to SAIF's duty to process his claim under ORS 656.262(7)(c), the ALJ had jurisdiction over the matter. ORS 656.283(7); *Robert A. Olson*, 52 Van Natta 1540 (2000); *Larry L. Ledin*, 52 Van Natta 682 (2000); *Craig J. Prince*, 52 Van Natta 108 (2000).

SAIF contends that claim preclusion bars a further award of benefits under ORS 656.262 and ORS 656.268 after the claim has been closed. SAIF argues that, because claimant's aggravation rights have expired, the entire claim is in Own Motion status.

In *John R. Graham*, 51 Van Natta 1740 (1999), we held that, where a "new medical condition" claim is accepted after claim closure, the claim must be reopened under ORS 656.262(7)(c) for the payment of benefits (including the payment of temporary disability benefits under ORS 656.262 and claim closure under ORS 656.268), even where the claimant's aggravation rights had expired on the original claim. *See also Robert A. Olson*, 52 Van Natta at 1541; *Larry L. Ledin*, 52 Van Natta at 684. We reach the same conclusion in this case.

SAIF contends that *John R. Graham* and *Johansen v. SAIF*, 158 Or App 672, *on recon* 160 Or App 579, *rev den* 329 Or 527 (1999), were wrongly decided. Because the court has not yet reached a decision addressing the rationale expressed in *Graham*, we adhere to our decision in that case and continue to rely on it. *See Camilla S. Kosmoski*, 52 Van Natta 1573, 1574 n.4 (2000). We have no authority to decide whether *Johansen v. SAIF* was wrongly decided and we continue to rely on that case as precedent.

SAIF also argues that ORS 656.262(7)(c) applies only to conditions in existence and omitted at closure. SAIF relies primarily on the sentence in ORS 656.262(7)(c), which provides that the "procedures specified in subsection (6)(d) of this section apply to this notice." SAIF contends that we improperly determined in *Graham* that acceptance of any new condition triggers reopening.

Under ORS 656.262(7)(a), a new medical condition: (1) arises after acceptance of an initial claim; (2) is related to an initial claim; and (3) involves a condition other than the condition initially accepted. *Johansen v. SAIF*, 158 Or App 672, 679, *adhered to on recon*, 160 Or App 579, *rev den* 329 Or 527 (1999). The preponderance of medical evidence establishes that claimant's ACL tear arose after acceptance of the initial claim. Consequently, we agree with the parties that the ACL tear constitutes a "new medical condition" under ORS 656.262(7)(a).

In *John R. Graham*, 51 Van Natta at 1740, the claimant's claim also involved a "new medical condition." The claimant's aggravation rights had expired under the original claim. We held that, where a "new medical condition" claim is accepted after claim closure, the claim must be reopened under ORS 656.262(7)(c) for the payment of benefits. In *Graham*, we focused primarily on the last sentence in ORS 656.262(7)(c), which provides that if a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition. We proceed to review ORS 656.262(7)(c) in its entirety.

ORS 656.262(7)(c) provides:

> "When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable. The procedures specified in subsection (6)(d) of this section apply to this notice. Any objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268. If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

In construing ORS 656.262(7)(c), our task is to discern legislative intent. *See* ORS 174.020. We begin by examining the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). The context includes other provisions of the same statute and other related statutes. *Id.* at 611. If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. *Id.*

ORS 656.262(7)(c) was enacted in 1997. Or Laws 1997, ch. 605, section 1. The first sentence of ORS 656.262(7)(c) provides:

> "When an insurer or self-insured employer determines that the claim qualifies for claim closure, the insurer or self-insured employer shall issue at claim closure an updated notice of acceptance that specifies which conditions are compensable."

ORS 656.262(7)(c) adds a new requirement that carriers are to issue an updated notice of acceptance at claim closure that specifies which conditions are compensable. The first sentence of ORS 656.262(7)(c) applies to claims in general. Under ORS 656.005(6), a "claim" is defined, in part, as a "written request for compensation from a subject worker or someone on the worker's behalf[.]" The first sentence of ORS 656.262(7)(c) also applies to accepted conditions generally. It is not limited to particular types of accepted conditions, *i.e.*, it does not apply only to conditions accepted in response to a request for acceptance under ORS 656.262(6)(d).

An inquiry into the context of a statute includes review of other sections of the same Act. *State ex rel Hall v. Riggs*, 319 Or 282, 287-89 (1994). As part of 1997 chapter 605 (HB 2971), the legislature also amended ORS 656.262(6)(b) to include subsection (F). ORS 656.262(6)(b)(F) provides that the notice of acceptance shall "[b]e modified by the insurer or self-insured employer from time to time as medical or other information changes a previously issued notice of acceptance." Thus, the first sentence of ORS 656.262(7)(c) and ORS 656.262(6)(b)(F) indicate that the legislature intended to allow a carrier to modify its notice of acceptance and then clarify the accepted conditions at claim closure by issuing an updated notice of acceptance.

The second sentence of ORS 656.262(7)(c) provides that "[t]he procedures specified in subsection (6)(d) of this section apply to this notice." ORS 656.262(6)(d) provides:

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

In *Johansen v. SAIF*, 158 Or App at 678, the court summarized the procedures in ORS 656.262(6)(d) as follows:

> "Under subsection (6)(d) [of ORS 656.262], a claimant who believes that a condition has been incorrectly omitted from the notice of acceptance may object to the notice in writing. The insurer then has 30 days to revise the notice or make another response. A claimant who fails to object to the notice may not later assert that a notice of acceptance is a *de facto* denial of a condition not included in the acceptance."

The second sentence of ORS 656.262(7)(c) provides that the "procedures specified in subsection (6)(d)" apply to this notice[,] *i.e.*, the updated notice of acceptance. Therefore, in issuing an updated notice of acceptance at closure, the carrier must consider whether the claimant has objected in writing to the original notice of acceptance and asserted that a condition was incorrectly omitted from the acceptance or that the acceptance was otherwise deficient.

The third sentence of ORS 656.262(7)(c) provides that "[a]ny objection to the updated notice or appeal of denied conditions shall not delay claim closure pursuant to ORS 656.268." In other words, the fact that a claimant has objected to the updated notice of closure or the fact that a claimant has appealed a denied condition shall not delay claim closure. The third sentence of ORS 656.262(7)(c) refers to "*[a]ny* objection to the updated notice or appeal of denied conditions[.] (Emphasis supplied). The wording of the statute is broad. The third sentence could pertain to a claimants objection to the notice of acceptance pursuant to ORS 656.262(6)(d) or to a claimants request for acceptance of a new medical condition under ORS 656.262(7)(a), which was denied by the carrier. The statutory language indicates that the legislature intended that the claim closure process should continue regardless of a dispute about the updated notice of acceptance.

Finally, the fourth sentence of ORS 656.262(7)(c) provides:

> "If a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition."

Like the first sentence of ORS 656.262(7)(c), the fourth sentence refers to "conditions" generally and is not limited to either an "omitted" condition or a "new medical condition." The legislature's use of the term "condition" is inconsistent with SAIF's argument that ORS 656.262(7)(c) applies only to omitted conditions, not new medical conditions. Although the term "condition" is not defined, ORS 656.262(6) and (7) both refer to that term in several instances. ORS 656.262(6)(b)(A) requires that the notice of

acceptance shall [s]pecify what conditions are compensable. ORS 656.262(6)(c) refers to acceptance of combined or consequential conditions. ORS 656.262(6)(d) pertains to conditions omitted from a notice of acceptance. ORS 656.262(7)(a) discusses new medical conditions. ORS 656.262(7)(b) refers to combined conditions. We find that the legislatures use of the term condition in ORS 656.262(7)(c) was intended to refer to all types of conditions, including combined, consequential, omitted and new medical conditions. *See Joseph A. Gerber*, 51 Van Natta 278 (1999) (the only limitation to the type of condition in ORS 656.262(7)(c) is that it must have been found compensable after claim closure).

In sum, after examining ORS 656.262(7)(c) in its entirety, we conclude that the statute was intended to apply to all conditions found compensable after claim closure.[1] We adhere to our conclusion in *John R. Graham*, 51 Van Natta at 1740, that when a "new medical condition" claim is accepted after claim closure, the claim must be reopened under ORS 656.262(7)(c) for the payment of benefits. We agree with the ALJ that SAIF is directed to reopen claimant's left ACL tear condition under ORS 656.262(7)(c) for processing to closure under ORS 656.268.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $200, 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.[2]

ORDER

The ALJ's order dated May 23, 2000 is affirmed. For services on review, claimant's attorney is awarded $200, payable by the SAIF Corporation.

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[1] To the extent that ORS 656.262(7)(c) is ambiguous, we found no evidence in the legislative history to support SAIF's argument that the legislature intended to limit reopening to conditions in existence and omitted at closure.

[2] We note that, on review, claimant's attorney relied on his written arguments submitted to the ALJ.

October 24, 2000 Cite as 52 Van Natta 1934 (2000)

In the Matter of the Compensation of
SALVADOR MACEDONIO, Claimant
WCB Case No. 00-00347
ORDER ON REVIEW
McGinty & Belcher, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that denied claimant's request for a penalty for the self-insured employer's allegedly unreasonable claim processing on the basis that the Hearings Division lacked jurisdiction over the dispute. On review, the issues are jurisdiction, and potentially, penalties.

We adopt and affirm the ALJ's order. *See Donald L. Holcomb, on recon*, 50 Van Natta 874 (1998) (request for hearing properly dismissed for lack of jurisdiction where amounts due at the time of the request for hearing were paid before the record closed and only remaining issue was penalties); *Ronald L. French*, 48 Van Natta 773 (1996) (where the only misconduct alleged by the claimant was that the insurer unreasonably delayed claim closure, penalty was the sole issue and the Director had exclusive jurisdiction).

ORDER

The ALJ's order dated August 1, 2000 is affirmed.

In the Matter of the Compensation of
TIM EDELBACH, Claimant
WCB Case No. 00-01415
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the SAIF Corporation's denial of claimant's low back injury claim. On review, the issue is course and scope of employment.

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

Claimant was injured when, after teasing a coworker, the coworker chased him and claimant slipped and fell on a floor he had just mopped. On review, claimant challenges the ALJs order concluding that the claim was not compensable. In particular, claimant argues that *Lorenzo Soriano-Garcia*, 51 Van Natta 1493 (1999), supports his position. We disagree.

In *Soriano-Garcia*, the claimant was injured by a coworker who discharged a compressed air hose near the claimant as he was bent over working on an auto. About an hour earlier, the claimant had discharged a compressed air hose near the coworker's backside. We found the injury compensable based on our decision that horseplay activities, including horseplay involving compressed air hoses, were common at the claimant's workplace and the employer acquiesced in such activities. We made our finding based on the following information. The employer had no written rules prohibiting horseplay. The direct supervisor was aware of the horseplay activities and did nothing to discourage them. In addition, there was no evidence to establish that, prior to the claimant's injury, management took any active, meaningful measures to end horseplay activities.

In contrast to *Soriano-Garcia*, here, the employer had written rules prohibiting horseplay and enforced those rules. (Ex. C-4, Tr. 60-62). Furthermore, claimant acknowledged that he had received the employer's guidebook containing those rules and agreed to comply with the employer's policies. (Ex. C-1).

We also disagree with claimant's argument that the employer acquiesced in the horseplay that lead to his injury. Claimant argues that, because the employer acquiesced in jokes between workers, his "joke" directed at a coworker constituted "horseplay" that was acquiesced in by the employer. Although both the coworker and the office manager testified that the workers joked among themselves, the office manager testified that the policy against horseplay included offensive jokes. In any event, claimant understated his participation in the horseplay activity that lead to his injury. In this regard, the horseplay did not end with claimant's "joke." Instead, the coworker's reaction to claimant's "joke" included chasing claimant, who responded by running away. Claimant ultimately slipped on a wet floor and fell. There is no evidence that the employer knew of or acquiesced in employees chasing each other about the workplace.

Finally, we find unpersuasive claimant's argument that his injury at most resulted from his possible negligence in maneuvering back to his work area. In support of this argument, claimant cites *Wilson v. State Farm Ins.*, 326 Or 413 (1999). In *Wilson*, the claimant injured her leg when taking a "skip step" while returning to her work station. The Court held that the claimant sustained an injury that arose out of employment, even in the absence of some particular hazard arising from the employer's premises. The Court found that the claimant's possible negligence in maneuvering around her employer's workplace was irrelevant.

However, *Wilson* is inapposite because it does not involve an injury caused by horseplay. Here, claimant was not simply running back to his work area, he was running from a coworker he had just teased. On this record, we agree with the ALJ that claimant was injured while actively participating in horseplay.

ORDER

The ALJ's order dated June 16, 2000 is affirmed.

Board Member Biehl dissenting.

I disagree with the majority's conclusion that claimant was not in the course and scope of employment when he injured his low back. Therefore, I respectfully dissent.

ORS 656.005(7)(a) provides that a "'compensable injury' is an accidental injury * * * arising out of and in the course of employment[.]" Under Oregon case law, an active participant or instigator in horseplay who is injured may not receive compensation unless the employer knew or should have known of and acquiesced in the behavior. *Liberty Northwest Ins. Corp. v. Johnson*, 142 Or App 21, 25-26 (1996); *Kammerer v. United Parcel Service*, 136 Or App 200, 204 (1995). The theory behind excluding active participants in horseplay from coverage is that, in engaging in the horseplay, a claimant may have engaged in a "voluntary stepping-aside from the employment." *Kammerer*, 136 Or App at 204.

Here, the horseplay that claimant engaged in was teasing or joking with a coworker. As a result of that teasing/joking, the coworker chased claimant, who ultimately slipped and fell on the floor he had just mopped.

Both claimant and the coworker testified that joking among coworkers was accepted at their workplace. (Tr. 19, 50). In addition, Ms. Dyer, the office manager, apparently was aware that workers joked with each other, although she testified that she included "offensive jokes" as prohibited horseplay. On this record, I would find that the employer knew or should have known that workers joked/teased each other. It stands to reason that such joking/teasing could easily go beyond verbal jibes, as it did here.

Furthermore, although the employer had a written policy against horseplay and Ms. Dyer testified that the employer had enforced that policy in the past, I find that the employer's actions regarding this incident establishes that the employer also acquiesced in certain types of horseplay. In this regard, Ms. Dyer testified that it was her policy to immediately investigate any incident of horseplay when it was reported. (Tr. 62). However, when claimant reported the incident he was involved in two weeks after it occurred, Ms. Dyer did not investigate it. (Tr. 63). She testified that there were not enough facts to warrant discipline for either party. (*Id.*). She did not discuss the incident with claimant or the coworker and first heard the details during testimony at the hearing. (Tr. 64). Two weeks delay is not so long that an investigation of the horseplay incident could not have been conducted. In any event, Ms. Dyer did not even try to investigate the incident. Such lax attitude toward horseplay demonstrates that the employer acquiesced in it. Due to this acquiescence, I would find that claimant has established that he was in the course and scope of his employment when his injury occurred. Because the majority finds otherwise, I respectfully dissent.

In the Matter of the Compensation of
EARL W. ROOKHUIZEN, Claimant
WCB Case No. 00-01175
ORDER OF ABATEMENT
Michael B. Dye, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Claimant requests reconsideration of our October 3, 2000 Order on Review that affirmed that portion of the ALJ's order that upheld the SAIF Corporation's denial of claimant's current low back condition. In order to consider this matter, we withdraw our October 3, 2000 order. SAIF is granted an opportunity to respond. To be considered, SAIF's response must be filed within 14 days from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT G. GREEN, JR., Claimant
WCB Case No. 00-00622
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Johnson's order that: (1) upheld the insurer's denial as it related to his "new medical condition" claim for an L4-5 disc condition; and (2) did not address the denial as it related to an "omitted" condition for the same problem. The insurer cross-requests review of that portion of the ALJ's order that found Dr. Olsen's opinion on causation was persuasive. On review, the issues are scope of the ALJ's review and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes. We delete footnote 1 on page 2. In the last line on page 3, we change the seventh word to "Unquestionably." On page 6, we change the dates in the second, third, fourth and fifth full paragraphs to "July," rather than "June." In the fifth full paragraph on page 6, we change the last sentence to read: "Dr. Poulson said that the 'findings were not invalid' and he noted reduced sensation at L4-5 and LS. (Ex. 52-2)."

CONCLUSIONS OF LAW AND OPINION

Scope of Review

The ALJ found that claimant's attorney's November 18, 1999 letter to the insurer requesting acceptance of "L4-5 nerve root disruption" was a request for acceptance of a "new medical condition." (Ex. 54). The ALJ concluded that the L4-5 condition was not a "new" medical condition, but was a condition that had been in existence and omitted from the original acceptance. The ALJ reasoned that the insurer's denial must be upheld as it related to claimant's "new medical condition" claim. The ALJ noted that claimant may bring a future claim under ORS 656.262(6)(d) for the L4-5 disc condition.

On review, claimant argues that the November 18, 1999 letter could be interpreted as either a claim for a "new medical condition" under ORS 656.262(7)(a) or an "omitted" condition under ORS 656.262(6)(d). In any event, claimant contends that the insurer's January 18, 2000 partial denial referred generally to a claim for L4-5 nerve root disruption and that was the issue to be decided by the ALJ. The insurer agrees that the parties litigated compensability of his L4-5 disc condition and the issue at hearing was not limited to a "new medical condition" claim.

The insurer's January 18, 2000 partial denial referred to claimant's claim for "L4-5 nerve root disruption." (Ex. 56). At hearing, the parties agreed with the ALJ that the issues to be litigated were the January 18, 2000 partial denial and penalties. (Tr. 4). We agree with the parties that the issue at hearing was not limited to a "new medical condition" claim for "L4-5 nerve root disruption." *See Weyerhaeuser Co. v. Bryant*, 102 Or App 432, 435 (1990) (when it is apparent from the record that the parties tried a case by agreement with a particular issue in mind, it was improper for the ALJ and Board not to decide that issue). We proceed to address the merits of compensability.

Merits

The ALJ found that claimant's treating physician, Dr. Olson, had provided the most persuasive opinion. On review, the insurer argues that Dr. Olson's opinion is not sufficient to establish compensability under ORS 656.005(7)(a)(B). The insurer contends that Dr. Strum's opinion is the most persuasive.

We briefly review the procedural history of claimant's claim for an L4-5 disc condition. On April 10, 1996, claimant was compensably injured when he helped lift a bottle of compressed gas into a pickup. (Ex. 1). The insurer initially accepted disabling bilateral inguinal hernias. (Ex. 3). Claimant sought treatment for mild low back pain with right leg numbness related to the April 10, 1996 injury. (Ex. 4). On June 10, 1997, claimant's attorney wrote to the insurer, requesting that the acceptance be expanded to include "L1-2 and L5-S1 disc herniations." (Ex. 18). As a result of litigation, the insurer modified its acceptance to include herniated discs at L1-2 and L5-S1. (Ex. 23).

Claimant continued to have low back problems. On November 18, 1999, claimant's attorney wrote to the insurer, stating that claimant had been diagnosed with "L4-5 nerve root disruption" and requesting that the insurer accept that condition. (Ex. 54). On January 18, 2000, the insurer issued a partial denial of claimant's L4-5 nerve root disruption. (Ex. 56). Despite the reference to an "L4-5 nerve root disruption," the parties indicate that the issue litigated at hearing was compensability of the L4-5 disc condition.

Claimant contends that the April 10, 1996 injury was the major contributing cause of his L4-5 disc condition. He relies on Dr. Olson's opinion to establish compensability. Claimant does not dispute the insurer's assertion and the ALJ's finding that ORS 656.005(7)(a)(B) applies to this case. At the time of the April 1996 injury, claimant had ongoing degenerative problems at several lumbar levels, including L4-5, and the acute injury impacted the preexisting condition. (*See* exs. 5, 8, 10, 58-7). Consequently, claimant must prove that the April 1996 injury was the major contributing cause of the disability or need for treatment of the L4-5 disc condition. *See* ORS 656.005 (7)(a)(B).

There are three medical opinions on causation of the L4-5 disc condition. Dr. Poulson performed a medical arbiter examination and reported that there was no preexisting condition, according to the history. (Ex. 52-4). Therefore, he felt that claimant's condition was related 100 percent to the April 10, 1996 injury. (*Id.*) Because Dr. Poulson's history is inconsistent with the medical evidence, his conclusory opinion is entitled to little weight.

The insurer relies on Dr. Strum's opinion to argue that claimant's L4-5 disc condition is the result of a natural progression of degenerative disc disease. After reviewing claimant's imaging studies, Dr. Strum found there was clear evidence of "progression of degenerative disk disease at L4-5, primarily a degenerative disk bulge and most notably degenerative changes in the facet joints, which have combined to produce a neural foraminal stenosis of a moderately severe degree on the right and a moderate degree on the left." (Ex. 58-8). He concluded that the major contributing cause of claimant's combined condition was the natural progression of the preexisting degenerative disc disease at L4-5. (*Id.*) He said that the imaging studies showed that claimant's L5-S1 disc had been the most "severely involved" throughout his treatment and it remained the most likely source of his clinical symptoms. (*Id.*) Dr. Strum rejected the diagnosis of L4-5 "nerve root disruption," reasoning that a true disruption of any spinal nerve root was extremely rare. (Ex. 58-6). He did not explain whether he had reviewed the medical record concerning claimant's L4-5 disc problems since April 1996.

In contrast, claimant relies on the opinion of his attending physician, Dr. Olson, who has been treating him for low back pain since September 1996. (Ex. 8). In a "check-the-box" letter from the insurer on December 29, 1999, Dr. Olson agreed that claimant's current accepted conditions of bilateral inguinal hernias and herniated discs at L1-2 and L5-S1 reasonably apprised claimant and medical providers of the nature of all of the compensable conditions on this claim. (Ex. 55).

In a later report, however, Dr. Olson said that he had reviewed the medical record and found that from the initial onset in 1996, he had diagnosed claimant as having L4-5 involvement with radiculitis, which is still persisting. (Ex. 59-1). He explained:

> "At various times the patient has had other diagnoses, in addition to radiculitis which have include Si joint disturbance, etc., but overall since 1996 the diagnosis has been the same with radiculitis that has involved multiple nerve roots including L1-2 and L5-S1 but on each occasion, from the beginning it has included L4-5." (*Id.*)

Dr. Olson felt that claimant's L4-5 disc should be included as an accepted condition. (*Id.*) He said that claimant's radiculopathy had included the nerve root at L5, which exits the dural sac at L4-5 and exits the spinal column at L5-S1. (Ex. 59-2). Dr. Olson summarized that claimant's L5 nerve root is involved and always has been and has been documented in the record. (*Id.*)

The record supports Dr. Olson's assertion that claimant's symptoms after the April 1996 injury have included the L4-5 disc. On September 13, 1996, Dr. Olson said that claimant had some congenital variations of the lumbar vertebra with a sacralization of L5, "with what appears to be the possibility of movement at the 4-5 level." (Ex. 8-2). An October 14, 1996 lumbar MRI showed, among other things, a bulge at L4-5. (Ex. 10). After reviewing the lumbar MRI, Dr. Olson felt that claimant had an "L5" problem on the right side. (Exs. 12, 15). He recommended a facet block at L4-5 and L5-S1 on the right. (Exs. 12, 14).

Claimant's March 1, 1998 lumbar MRI showed, among other things, a mild to moderate diffuse disc bulge at L4-5. (Ex. 26). In August 1998, Dr. Heibert performed radiofrequency facet nerve lesioning of the bilateral L5-S1 facet joints at the bilateral L4, alar and S1 levels. (Ex. 33). The radiofrequency needle was passed to the junction of the left transverse process of L4 and the lamina of L4, the left alar notch and the superolateral aspect of the left S1 foramen. (Ex. 33-1). Dr. Olson reported that claimant was much better after the blocks done by Dr. Heibert. (Ex. 34).

A March 16, 1999 lumbar MRI included an L4-5 bulge with moderate facet hypertrophy that produced right lateral recess stenosis. (Ex. 39). After reviewing the March 1999 MRI, Dr. Olson said that claimant's spine had considerable involvement at multiple levels, including lateral recessed stenosis at L4-5. (Ex. 40-1). He recommended a lumbar facet block and medial branch block on the left. (Ex. 41). On June 21, 1999, Dr. Olson performed a facet block at L4-5. (Ex. 44-2). His diagnosis was radiculitis with nerve root impingement, irritation right side and left side with spinal stenosis. (*Id.*)

In evaluating medical opinions, we generally rely on the opinion of a worker's treating physician, because of his or her opportunity to observe the claimant over an extended period of time. *See Weiland v. SAIF*, 64 Or App 810 (1983). In this case, Dr. Olson has been treating claimant since 1996 and has first-hand knowledge of his symptoms and treatment. We are persuaded by his opinion because it is well-reasoned and based on accurate and complete information. *See Somers v. SAIF*, 77 Or App 259 (1986). To the extent that Dr. Olson's "check-the-box" letter from the insurer is inconsistent with his later report on causation, Dr. Olson explained that he had subsequently reviewed the medical records and determined that he had been treating claimant's L4-5 disc condition since the original injury. *See Kelso v. City of Salem*, 87 Or App 630, 633 (1987) (when there was a reasonable explanation for a change of opinion, medical opinion was persuasive).

We find that Dr. Olson's opinion is entitled to more weight than that of Dr. Strum, who examined claimant on only one occasion. Although Dr. Strum dismissed the diagnosis of L4-5 "nerve root disruption," he did not explain whether he had reviewed the medical record for claimant's L4-5 disc problems since the original injury. We are not persuaded by Dr. Strum's conclusory opinion regarding causation of claimant's L4-5 disc condition.

In sum, based on Dr. Olson's opinion, we conclude that claimant's April 1996 injury was the major contributing cause of his disability or need for treatment for his L4-5 disc condition.[1]

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

ORDER

The ALJ's order dated May 18, 2000 is reversed. The insurer's denial of claimant's L4-5 disc condition is set aside and the claim is remanded to the insurer for processing according to law. For services at hearing and on review, claimant is awarded an assessed fee of $4,500, payable by the insurer.

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[1] At hearing, claimant argued that the insurer's denial was unreasonable and he was entitled to a penalty. Because he does not raise that issue on appeal, we do not address it.

In the Matter of the Compensation of
JEFF LINERUD, Claimant
WCB Case No. 99-09856
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

We adopt and affirm the ALJ's order with the following supplement to address SAIF's contention that the ALJ incorrectly relied upon the opinions of Dr. Loganbill, the attending physician, and Dr. Gabr, a consulting neurologist instead of the opinion of Dr. Zivin, who performed a records review at SAIF's request.

Claimant injured his back and neck during a lifting incident at work in May 1999. (Exs. 1; 3). As a result of that event, SAIF accepted the following conditions: (1) cervical strain; (2) thoracic strain; and (3) lumbosacral strain. (Ex 12). In August 1999 claimant was diagnosed with cervical torticollis. (Ex. 18-2). It is the compensability of the cervical torticollis condition that is at issue, not the accepted strain conditions. (Ex. 33).

The ALJ determined that claimant's cervical torticollis condition was a consequential condition of the compensable injury under the terms of ORS 656.005(7)(a)(A). Consequently, the ALJ concluded that the "major contributing cause" standard applies to this case. Neither party objects to the ALJ's conclusion. Accordingly, we use the "major contributing cause" standard on review.

Dr. Loganbill, a neurologist and the attending physician, has opined that claimant is suffering from a post-traumatic cervical torticollis, the major cause of which is claimant's May 1999 work injury. (Ex. 32). Dr. Loganbill is supported by Dr. Gabr, a consulting neurologist. (Ex. 37). In contrast, Dr. Zivin, also a neurologist, but who performed a medical records review at SAIF's request, has opined that claimant suffers from psychogenic torticollis, which is unrelated to the May 1999 work injury.[1] (Ex. 35-7).

Because of the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). To satisfy the "major contributing cause" standard, claimant must establish that his work incident of May 1999 contributed more to the disability or need for treatment of the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disability or need for treatment of the consequential condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information.[2] *See Somers v. SAIF*, 77 Or App 259, 263 (1986). 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). Here, we find no persuasive reasons not to defer to Dr. Loganbill's opinion.

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[1] All three neurologists agree that claimant has cervical torticollis. The difference in their opinions is whether the torticollis condition developed from trauma (the compensable neck strain) or is an idiopathic psychiatric condition completely unrelated to claimants work incident.

[2] The medical record contains opinions regarding the nature of claimant's cervical condition from practitioners who are not neurologists. However, the record also establishes that the diagnosis of torticollis and the determination of the cause of that condition are subjects that are solely within the expertise of neurologists. Neither party suggests otherwise.

Dr. Loganbill has explained that "torticollis can affect any number of the muscles of the neck and can produce postures including strong head flexion, strong head extension, strong head tilting to one side or the other, and strong head turning or a combination of these postures." (Ex. 32-1). She also explained that it is typical for torticollis to result in the alternate contraction and relaxation of the neck muscles to produce the "lolling" appearance (moving of the head from side to side in an irregular fashion) that claimant has exhibited. (Ex. 32-1). Finally, she has explained that cervical torticollis can be precipitated by any form of injury including head injury or slight neck injury and that development of cervical torticollis "can be at sometime after an injury." (Ex. 32-1).

Based upon claimant's history, her own examinations of claimant, including EMG testing which she performed[3], and her experience as a specialist dealing with cervical torticollis, Dr. Loganbill opined that the work incident of May 1999 was the major contributing cause of claimant's cervical torticollis condition. (Ex. 32; 36). Dr. Gabr supports Dr. Loganbill's opinion.[4] (Ex. 37).

Dr. Zivin, in contrast to Drs. Loganbill and Gabr, opined that claimant suffers from psychogenic torticollis, which is not related to the work incident of May 1999. (Ex. 35-7). Dr. Zivin's opinion is based upon his review of the medical records and on a belief that trauma caused torticollis is so "decidedly rare" as to be nonexistent. (Ex. 35-2). To find support for his opinion Dr. Zivin spoke with two colleagues, who like Dr. Zivin, are not personally aware of a posttraumatic case of torticollis, and researched medical journals.[5] (Ex. 35-3).

The medical literature upon which Dr. Zivin relies suggests that psychogenic movement disorders, which includes psychogenic torticollis, are identified by the presence of three items, one of which is a psychiatric abnormality. (Ex. 35-15). Here, there is no evidence in the record that claimant has a psychiatric abnormality.[6] Consequently, Dr. Zivin's opinion is inconsistent with the medical literature upon which he relies. Without a further discussion explaining how psychiatric torticollis can exist absent a psychiatric abnormality, we find his opinion to be an unsupported conclusion, and as such, not persuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980). Accordingly, we do not rely on it.

We also note that Dr. Zivin rendered his opinion without examining claimant. While Dr. Zivin has expressed confidence that he could in render an opinion from the records alone, he did that indicate examining claimant and viewing his movements would have been helpful. (Ex. 39-11; 39-22). He also indicated that the description of claimant's movements contained in the records was "sparse." (Ex. 39-28). Under these circumstances we also find his opinion is based upon incomplete information, and as such, is not persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1997).

Unlike Dr. Zivin, both Dr. Loganbill and Dr. Gabr have personal experience treating patients with posttraumatic cervical torticollis. (Ex. 32-2; 36-1; 37-1). Additionally, Dr. Loganbill is a specialist regarding cervical torticollis. (Ex. 32-2; 37-1). Because Dr. Loganbill is the attending physician, and because she has more expertise in the cause and treatment of cervical torticollis than the other medical examiners who have rendered causation opinions in this case, and because the EMG testing supports her conclusion that claimant's condition is organic, rather than psychiatric, in origin, we find her opinion, as supported by Dr. Gabr, persuasive.[7] *See Abbott v. SAIF*, 45 Or App 657, 661 (1980). Consequently, we agree with the ALJ that claimant has established the compensability of his cervical torticollis condition.

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[3] The EMG test as performed and interpreted by Dr Loganbill demonstrates "electrophysiologic evidence for a disorder of motor control consistent with the clinical diagnosis of cervical torticollis." (Ex. 23).

[4] Additionally, Dr. Gabr indicated that Dr. Loganbill is a specialist regarding cervical torticollis. (Ex. 37).

[5] The articles on which Dr. Zivin relied are attached to his report and contained in the record as pages 8 to 56 of Exhibit 35.

[6] Dr. Goranson, a psychiatrist, examined claimant at SAIF's request and opined: "I can find no evidence of a psychiatric problem that is affecting this man." (Ex. 27-8).

[7] We note that Dr. Zivin criticized Dr. Loganbill for not considering the possibility that claimant might have psychogenic torticollis. (Ex. 36-5). SAIF argues that because Dr. Loganbill did not respond to that criticism, her opinion is not persuasive. Because the record establishes that claimant has a no evidence of a psychiatric problem, and because Dr. Zivin's opinion is not consistent with the medical literature he relies upon to support his opinion, we are not persuaded that Dr. Loganbill's opinion should be discounted on that basis. *See Raul R. Velasquez*, 52 Van Natta 1072 (2000).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,000, 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 June 14, 2000 is affirmed. For services on review, claimant's counsel is awarded a $2,000 attorney fee, payable by the SAIF Corporation.

October 26, 2000 Cite as 52 Van Natta 1942 (2000)

In the Matter of the Compensation of
NANCY INGALLINERO, Claimant
WCB Case No. C002354
ORDER DENYING RECONSIDERATION OF CLAIM DISPOSITION AGREEMENT
Malagon, et al, Claimant Attorney

Reviewed by Board Members Biehl and Haynes.

On September 27, 2000, the parties submitted a Claim Disposition Agreement (CDA). Pursuant to that agreement, in consideration for the payment of $33,518, claimant released her rights to future workers' compensation benefits, except medical services, for her compensable injury. In addition, claimant waived the 30-day "cooling off" period. On October 5, 2000, we approved the parties' CDA.

Claimant's attorney moves to set aside the CDA on the ground that claimant no longer wishes to go through with the agreement after learning that she would need additional surgery and a year of convalescence. The insurer opposes claimant's motion, contending that our approval of the CDA is final under ORS 656.236(2). We treat claimant's motion as a request for reconsideration of our order approving the CDA.

ORS 656.236(1) provides that a disposition shall be approved in a final order unless: (a) the Board finds the proposed disposition is unreasonable as a matter of law; (b) the Board finds the proposed disposition is the result of an intentional misrepresentation of material fact; or (c) within 30 days of submitting the disposition for approval, the worker requests the Board to disapprove the disposition. ORS 656.236(2) further provides that an order approving the disposition of a claim is not subject to review.

Here, the request for reconsideration is based on circumstances that have arisen since our approval of the CDA. No contention is made, nor do we find, that the CDA on its face was either unreasonable as a matter of law or the result of an intentional misrepresentation of material fact. *See* ORS 656.236(1)(a), (b). Finally, because claimant waived the 30 day "cooling off" period under ORS 656.236(1)(c), disapproval of the disposition would not be justified.[1]

Inasmuch as no reason for disapproval was brought to our attention before we approved a disposition that was in complete compliance with all statutory and administrative prerequisites, we decline to retroactively disapprove the disposition.

IT IS SO ORDERED.

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[1] Had claimant not waived the 30-day period, we would not have been authorized to approve the CDA until expiration of that "cooling off" period. Thus, in the absence of the "30-day waiver," claimant's request to disapprove the CDA would have been timely because it was made within 30 days of submission of the CDA. *See Michael A. White*, 43 Van Natta 582 (1991). However, because the 30-day period had been waived and we have already approved the CDA, claimant's attempt to withdraw her approval of the CDA and obtain our disapproval of the CDA is untimely.

In the Matter of the Compensation of
CAROL J. LOOMIS, Claimant
WCB Case Nos. 99-06430 & 99-06429
ORDER ON REVIEW
Jensen, Elmore & Stupansky, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that: (1) upheld the insurer's denial of her occupational disease claim for a right carpal tunnel syndrome condition; and (2) upheld the insurer's denial of her occupational disease claim for a left carpal tunnel syndrome condition. On review, the issue is compensability.[1]

We adopt and affirm the order of the ALJ with the following supplementation to address claimants contention that the ALJ incorrectly determined that claimant had failed to establish the compensability of her bilateral carpal tunnel syndrome condition. Claimant seeks to establish the compensability of her carpal tunnel syndrome conditions as an occupational disease. Therefore, she must prove that her work activities are the major contributing cause of the disease itself, not just the major contributing cause of the disability or treatment associated with it. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000). With regard to the right carpal tunnel syndrome condition, the claim is based on a worsening of a preexisting condition. Therefore, insofar as her right wrist condition is concerned, claimant must also prove that the employment conditions were the major contributing cause of the pathological worsening of the disease. ORS 656.802(2)(b).

To satisfy the "major contributing cause" standard, claimant must establish that her work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimants disease and deciding which is the primary cause. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994); *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995).

The record establishes that claimant has a preexisting right carpal tunnel syndrome condition. (Ex. 1-2). The record also establishes that claimant's obesity preexists and contributes somewhat to her carpal tunnel condition on both the right and left sides. (Ex. 12-1). Those preexisting conditions are deemed causes in the determination of the major contributing cause of the carpal tunnel syndrome condition. ORS 656.005(24); ORS 656.802(2)(e). Because of the possible alternative causes for her current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

Dr. Wilson, claimant's attending physician, has opined that claimant's work activities "aggravated or flared up" the previous right carpal tunnel syndrome. (Ex. 31-1). He further opined that because it is difficult to correlate worsening symptoms with true pathological worsening, it would be difficult to state that claimant's condition (right carpal tunnel syndrome) had pathologically changed. (Ex. 31-1, 2). Dr. Wilson does not discuss claimant's left carpal tunnel syndrome.

Dr. Lynch, a consulting orthopedist, and Dr. Ewing, also an attending physician, have opined, via "check-the-box" concurrence letters, that claimant's work activities were the major contributing cause of her disability and need for treatment. (Ex. 33-2; 34-2). Those "check-the-box" letters do not discuss whether or not claimant's work activities are the major contributing cause of the disease (condition) itself. Consequently, these opinions do not meet claimant's burden of proof. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).

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[1] Claimant also contends that the denial of the right carpal tunnel syndrome is not sufficiently specific to satisfy the terms of OAR 436-060-0140(7). Because that contention was not raised at hearing, we do not consider it on review. *Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991).

Additionally, Dr. Lynch has opined, via the same concurrence letter previously mentioned, that claimant has sustained a pathological worsening of her underlying condition and that this worsening was caused in major part by claimant's work activities. (Ex. 34-2). However, Dr. Lynch does not further explain her opinion nor does she offer any evaluation of the relative contributions of the alternative causes of the pathological worsening of the right carpal tunnel syndrome. Without such an evaluation, her opinion is merely an unsupported conclusion and, as such, not persuasive. *Moe v. Ceiling Systems, Inc.* 44 Or App 429 (1980).

Consequently, we conclude that, on this record, claimant has failed to establish the compensability of her bilateral carpal tunnel syndrome conditions.

ORDER

The ALJ's order dated May 22, 2000 is affirmed.

October 24, 2000 Cite as 52 Van Natta 1944 (2000)

In the Matter of the Compensation of
MARLYS M. VICK, Claimant
WCB Case No. 98-07096
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Thye's order that upheld the insurer's *de facto* partial denial of claimant's injury claims for a cervical strain condition and a combined condition for C5-6 and C6-7 disc protrusions. On review, the issue is compensability.

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

The insurer accepted a disabling dorsal spine strain injury as a result of claimant's activity mopping and cleaning a school bus over a half hour period on October 23, 1997. Claimant relies on some early reports from Dr. Underhill, treating chiropractor, and Dr. Puziss, treating orthopedist, to argue that she also sustained a compensable cervical strain during that activity. However, the consensus of the medical expert opinions, including those of Drs. Underhill and Puziss, is that the cervical injury combined with claimant's preexisting degenerative cervical disc disease to cause or prolong disability or a need for treatment. (Exs. 93-5, 94-1, 95-2, 97-1, 102-7). Accordingly, we conclude that claimant's cervical condition is a combined condition under the terms of ORS 656.005(7)(a)(B).

In order to establish that her cervical condition is compensable, claimant must show that her work injury was the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, 106 (1997), *aff'd as modified on recon*, 149 Or App 309, 315 (1997), *rev den*, 326 Or 389 (1998). Because of the possible alternative causes for her current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

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

On review, claimant argues that we should rely on the opinion of her treating physician, Dr. Puziss. Although we generally defer to the conclusions of a treating physician, we do not do so when, as here, there are persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). For the reasons explained by the ALJ, we do not find Dr. Puziss' opinion persuasive. Like the ALJ, we find

that Dr. Puziss' causation opinion does not provide the required evaluation of the relative contribution of claimant's preexisting degenerative cervical condition and the mopping activities. Instead, it is based on "but for" reasoning. (Exs. 94, 107); *see Joanne C. Broyles*, 51 Van Natta 1250 (1999); *Alec E. Snyder*, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned).

In addition, we find that the preponderance of the medical evidence establishes that there was no increase in the C5-6 and C6-7 disc bulges after the October 1997 mopping incident (outside of normal degenerative changes since a pre-injury MRI performed in March 1995). (Exs. 99B, 102-5-7). Like the ALJ, we do not find Dr. Puziss' opinions to the contrary persuasive. Although stating that the April 1999 MRI showed a worsened protrusion at C5-6, Dr. Puziss did not explain why the February 1998 MRI did not show a worsening, nor did he address the contrary opinion that any minor changes represented normal degenerative changes. (Exs. 107-4, -5). Dr. Puziss also stated that the injury caused a torn or significantly stretched annulus that lead to increased symptoms. (Ex. 107-8). However, he did not explain why this significant change was not evident on the post-injury MRIs. In addition, Dr. Puziss was equivocal about what the MRIs showed, stating that separate MRIs can look the same, which undermined his opinion that the MRIs show a worsening. (Ex. 107).

Accordingly, we agree with the ALJ that claimant failed to meet her burden of proof.

ORDER

The ALJ's order dated May 3, 2000 is affirmed.

October 26, 2000 Cite as 52 Van Natta 1945 (2000)

In the Matter of the Compensation of
JUVENTINO VAQUERA, Claimant
WCB Case No. 00-01049
ORDER ON REVIEW
Stanley Fields, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Nichols' order that 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.

Claimant argues, for the first time on Board review, that the insurer's denial is procedurally improper. We generally do not consider issues that are not raised at hearing. *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). Moreover, we have previously declined to consider challenges to the procedural validity of denials raised for the first time on review. *See Leroy W. Steece*, 52 Van Natta 482 (2000); *Trever McFadden*, 48 Van Natta 1804 (1996). We likewise decline to address the procedural validity of the denial in this case.

ORDER

The ALJ's order dated May 31, 2000 is affirmed.

In the Matter of the Compensation of
PATRICK K. CHARLEBOIX, Claimant
WCB Case No. 00-01033
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's new medical condition claim for a low back condition. With his respondent's brief, claimant moves to waive the Board's briefing rules. SAIF opposes claimant's motion and moves to strike claimant's respondent's brief. On review, the issues are motion to strike and compensability. We grant SAIF's motion to strike and reverse.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

SAIF moves to strike claimant's respondent's brief on the ground that it was untimely filed. SAIF filed its opening brief on August 17, 2000. The filing deadline for claimant's respondent's brief was September 7, 2000. OAR 438-011-0020(2). Claimant mailed his brief on September 11, 2000 and the brief was received by the Board on September 12, 2000. Therefore, claimant's brief was untimely filed. Claimant apparently concedes that the brief was untimely, but moves to waive the Board's briefing rules. *See* OAR 438-011-0030.

A motion to waive the Board's briefing rules may be allowed if the Board finds that extraordinary circumstances beyond the control of the moving party justify such action. OAR 438-011-0030. Claimant asserts that the reason for untimely filing was the departure of a law clerk who retained possession of the file and "did [not] notify counsel of impending deadlines." Recently, in *Charles E. Jesse*, 52 Van Natta 1504 (2000), we granted the claimant's motion to strike a brief that had been untimely filed due to a clerical error attributed to a recent transition in personnel. Citing *Antonina Gnatiuk*, 50 Van Natta 976 (1998) and *Lester E. Saunders*, 46 Van Natta 1153 (1994), we found no extraordinary circumstances beyond the control of the moving party for such an error. 52 Van Natta 1504.

We find this case analogous to *Charles E. Jesse*. Although claimant's attorney's former law clerk evidently retained physical possession of the file after leaving employment, it was claimant's attorney's responsibility to monitor deadlines in relation to SAIF's request for Board review. Accordingly, we find no extraordinary circumstances beyond the control of claimant's attorney. We therefore grant SAIF's motion to strike claimant's untimely filed respondent's brief.

Compensability

The ALJ set aside SAIF's denial based on the opinion of claimant's treating physician, Dr. Kirkpatrick. On review, SAIF contends that Dr. Kirkpatrick's opinion is not persuasive. We agree.

The medical evidence indicates that claimant had preexisting degeneration at multiple levels in his lumbar spine that combined with his work injury to produce his disability and need for treatment for his L4-5 disc herniation condition. (Exs. 5, 11, 36-6). Therefore, claimant must establish that the February 6, 1999 compensable injury was the major contributing cause of his disability and need for treatment for his L4-5 disc herniation. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997); *Alexander Huizar*, 52 Van Natta 390 (2000). Determination of major contributing cause involves evaluation of all potentially contributing causes and determining which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401, *rev dismissed* 320 Or 416 (1995).

This case contains conflicting medical opinions as to the compensability of claimant's low back condition. Where the medical evidence is divided, we rely on those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Absent persuasive reasons to the contrary, we generally rely on the opinion of claimant's treating physician. *Weiland v. SAIF*, 64 Or App 810 (1983).

Here, we find persuasive reasons not to defer to claimant's treating physician Dr. Kirkpatrick. Initially, we note that Dr. Kirkpatrick reversed his opinion on causation without explanation. An unexplained change in opinion is not persuasive. *Kelso v. City of Salem*, 87 Or App 630 (1987). Dr. Williams, who performed an examination of claimant at the request of SAIF, concluded that claimant's preexisting degenerative changes were the major contributing cause of his low back condition and need for treatment. (Ex. 36-7). On October 11, 1999, Dr. Kirkpatrick concurred with the findings and conclusions in Dr. Williams' report. (Ex. 40). Although Dr. Kirkpatrick later altered his opinion to state that claimant's February 6, 1999 compensable injury was the major contributing cause of his disability and need for treatment for his L4-5 disc herniation, this change in opinion was never explained. (Exs. 45, 49). Accordingly, Dr. Kirkpatrick's opinion is entitled to little weight. *See George H. Gale*, 52 Van Natta 339, 342 (2000).

Moreover, we find Dr. Kirkpatrick's opinion less well-reasoned than that of Dr. Williams. In particular, Dr. Kirkpatrick's opinion is based in part on the reasoning that: 1) claimant's February 1999 injury was a "classic lifting injury" sufficient to cause a disk herniation and which caused him to "go down," and 2) claimant's imaging studies prior to February 1999 did not reveal a herniated disk, whereas the April 22, 1999 MRI scan revealed an extruded L4-5 disk with free fragment. (Ex. 28, 49).

However, Dr. Kirkpatrick did not distinguish between the February 6, 1999 work injury and claimant's April 16, 1999 injury at home, when, after lifting a shovel out of his truck, claimant also "went down" with severe back pain and sought emergent medical treatment. (Ex. 25; Tr. 8, 9). Both the February 6, 1999 and April 16, 1999 injuries preceded the April 22, 1999 MRI scan. Due to the history provided in a letter from claimant's attorney, Dr. Kirkpatrick was presumably aware of the April 16, 1999 injury at home. (Ex. 48A). However, Dr. Kirkpatrick never discussed the April 1999 injury, nor did he explain why the February 1999 injury caused the disc herniation, as opposed to the April 16, 1999 non work-related injury.

Finally, Dr. Kirkpatrick's opinion rests on the premise that he "would not expect significant degeneration of the disks at that age [39]." (Ex. 49). However, an x-ray taken on October 8, 1997 revealed degenerative changes at L3-4 which were "decidedly unusual" for claimant's age. (Ex. 5). Although these degenerative changes were noted at L3-4 and claimant's disk herniation occurred at L4-5, Dr. Kirkpatrick's opinion states that he would not expect "significant degeneration of the *disks*," at claimant's age, without distinguishing between the various levels of the lumbar spine. (Ex. 49). Moreover, a later MRI scan (but still before the February 1999 injury) revealed desiccation of all of the disc spaces above L5-S1, with mild annular bulges at four levels, including L4-5. (Ex. 11-1). Although Dr. Kirkpatrick reviewed these imaging studies in his initial evaluation of claimant (Ex. 35-3), he did not specifically discuss the above-mentioned findings in his ultimate opinion on causation. (Ex. 49). For these reasons, we conclude that Dr. Kirkpatrick's opinion is less well-reasoned. His opinion is therefore unpersuasive.

Because there is no other expert medical opinion supporting compensability of the claim, we find that claimant has failed to meet his burden of proving the compensability of his L4-5 herniated disk condition. Accordingly, we reverse the ALJ's order and accompanying attorney fee award.

ORDER

The ALJ's order dated June 22, 2000 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
GLORIA L. GARDNER, Claimant
Own Motion No. 00-0251M
OWN MOTION ORDER OF POSTPONEMENT AND CONSOLIDATION
Stebbins & Coffey, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer submitted a request for temporary disability compensation for claimant's low back condition. The insurer opposed authorization of temporary disability compensation, contending that claimant had withdrawn from the work force. Claimant responded to the insurer's recommendation contending that she timely perfected an aggravation claim and, therefore her claim is not within the Board's Own Motion jurisdiction. The insurer disputes claimant's contention and contends that she failed to timely perfect an aggravation claim.

The Board's own motion jurisdiction extends only to claims for which the claimant's aggravation rights have expired. ORS 656.278(1)(a); *Miltenberger v. Howards Plumbing*, 93 Or App 475 (1988). While we have the authority to determine whether a claim comes within our Own Motion jurisdiction, we find the record before us inadequately developed to make such a determination. *SAIF v. Reddekopp*, 137 Or App 102, *rev den* 322 Or 360 (1995). Furthermore, any decision we might make in our own motion authority regarding the jurisdiction issue, once final, would preclude the parties from relitigating that issue in another forum. *Id.* at 137 Or App 107.

Finally, insofar as claimant contends that she timely perfected an aggravation claim, her submission has been interpreted as a request for hearing under ORS 656.283(1). Consequently, claimant's submission has been referred to the Hearings Division for the creation of a new WCB Case Number and the scheduling of a hearing.

Under these circumstances, we consider it appropriate to postpone Board action regarding this Own Motion petition and refer this matter to the Hearings Division for consolidation with claimant's hearing request. *See* OAR 438-012-0040(3); *Charles Tedrow*, 48 Van Natta 616 (1996). At the hearing, the Administrative Law Judge (ALJ) assigned to the matter shall make findings of fact and conclusions of law and opinion on the issue of whether claimant's aggravation rights have expired on her claim so as to bring that claim within the Board's Own Motion jurisdiction.

Further, at the hearing, if jurisdiction is found to be under our Own Motion authority pursuant to ORS 656.278(1)(a), the assigned ALJ shall make findings of fact and conclusions of law and issue a separate, unappealable Own Motion Recommendation with respect to whether claimant was in the work force at the time her condition worsened. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); *SAIF v. Blakely*, 160 Or App 242 (1999).

At the conclusion of the hearing, the ALJ shall forward to the Board the unappealable Own Motion Recommendation, if any, and a copy of the appealable order issued in response to claimant's hearing request. After issuance of that order, the parties should advise the Board of their respective positions regarding own motion relief.

Finally, since further Board action will be required before resolution of this case, we emphasize that our action today constitutes an interim order.

IT IS SO ORDERED.

In the Matter of the Compensation of
RAYMOND L. PRESNELL, Claimant
Own Motion No. 00-0035M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Malagon, Moore & Jensen, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests review of the SAIF Corporation's August 16, 2000 "Notice of Closure Board's Own Motion Claim" that closed his claim with an award of temporary disability compensation from December 14, 1999 through July 25, 2000. Claimant contends that this claim never should have been opened under Own Motion and should have been opened under ORS 656.273 from the beginning. In addition, claimant has requested a hearing before the Hearings Division, requesting the same relief before that forum.[1] We affirm SAIF's August 16, 2000 "Notice of Closure Board's Own Motion Claim."

FINDINGS OF FACTS

On January 29, 1971, claimant compensably injured his low back. SAIF accepted the claim for a disabling lumbar sprain/strain and processed it to closure on November 3, 1971. Claimant's aggravation rights expired on November 3, 1976.

On December 14, 1999, claimant underwent a left total hip replacement. On January 21, 2000, SAIF submitted a "Carrier's Own Motion Recommendation" form recommending that the claim be reopened under the Board's Own Motion jurisdiction.

On January 25, 2000, the Board issued an Own Motion Order that authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant was hospitalized for surgery. When claimant's condition became medically stationary, SAIF was ordered to close the claim under the Board's own motion rules.

On July 25, 2000, Dr. Streitz, his attending physician, examined claimant. Dr. Streitz found claimant to be "medically stable and stationary." He opined that claimant's "claim may be closed."

On August 16, 2000, SAIF closed claimant's claim by Notice of Closure that awarded temporary benefits from December 14, 1999 through July 25, 2000, and declared claimant medically stationary as of July 25, 2000. Claimant requested Board review of that Notice of Closure. He also requested a hearing with the Hearings Division regarding that Notice of Closure and other processing issues.

CONCLUSIONS OF LAW AND OPINION

Claimant requests that the Board, in its own motion authority, review SAIF's August 16, 2000 closure challenging SAIF's processing of the claim as an "Own Motion" claim. We interpret claimant's request as a request to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268. In addition, claimant has requested a hearing before the Hearings Division, requesting the same relief before that forum. WCB Case No. 00-06493. Claimant's only argument regarding the merits of the closure is that his attending physician has indicated that he is "medically stable." Based on the following reasoning, we find that we have subject matter jurisdiction in our own motion capacity to review the August 16, 2000 closure.[2]

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[1] Specifically, claimant raises the following issues in his request for hearing: (1) de facto denial; (2) unreasonable conduct; (3) failure to process claim pursuant to WCB decision in *John* [R.] *Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999)] and Court of Appeal's decision in [*Paul D.*] *Johansen*, [158 Or App 672 (1999)]; (4) penalty; and (5) attorney fees. Claimant's hearing request has been assigned WCB Case No. 00-06493. That hearing is schedule before Administrative Law Judge (ALJ) Howell on November 29, 2000.

[2] In addition, although we have no authority in our own motion capacity to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268, we note that claimant has made a request for that relief before another forum that has such authority, *i.e.*, the Hearings Division.

In *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000), we issued orders in our own motion capacity and our "regular" capacity involving issues similar to those presented in the current case. In *Ledin*, the claimant had a new condition claim (a right knee meniscus tear condition) that had been validly reopened and subsequently closed pursuant to our own motion authority under ORS 656.278. There, the claimant disputed the closure, contending that his condition should be rated and processed under ORS 656.268 and not treated as an Own Motion claim. The claimant requested review of the Own Motion Notice of Closure both before the Hearings Division and before the Board in our Own Motion jurisdiction. We postponed action on the own motion matter pending resolution of the litigation before the Hearings Division.

The ALJ held that, because our prior order authorizing the claim to be reopened in our Own Motion jurisdiction was not appealed, our determination of our Own Motion jurisdiction became final and was not subject to collateral attack before the Hearings Division. Therefore, the ALJ dismissed claimant's hearing request for lack of jurisdiction. Claimant request Board review.

On review in our "regular" capacity, we agreed with the ALJ that the Hearings Division lacked jurisdiction to review the own motion closure of the claimant's claim because that was a matter within our Own Motion jurisdiction under ORS 656.278(1). Nevertheless, we held that, insofar as claimant's request pertained to the carrier's duty to process claimants claim under ORS 656.262(7)(c), the ALJ was authorized to consider that matter. Therefore, we reinstated the claimant's hearing request.

In doing so, we explained that a condition found compensable after claim closure is entitled to reopening under ORS 656.262(7)(c) and processing under ORS 656.268, even if the aggravation rights have expired on the original claim. We noted that such a claim processing issue is a "matter concerning a claim" for which the claimant can request a hearing under ORS 656.283. Determining that the claimant's "new" condition was found compensable after claim closure, we held that the carrier was obligated to reopen the claim for processing of the condition in accordance with ORS 656.262(7)(c). In anticipation of the eventual "ORS 656.268" closure of the claim, we noted that the claimant would not be entitled to duplicate compensation for any time period coinciding with temporary disability benefits awarded pursuant to the carrier's Own Motion Notice of Closure.

Specifically addressing the carrier's Own Motion Notice of Closure, we also found that we had subject matter jurisdiction in our own motion capacity to review the closure. Because the claimant's aggravation rights had expired on his initial injury claim and his condition required surgery, we reasoned that we were authorized to reopen the claimant's claim pursuant to ORS 656.278(1)(a) and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. Thus, we found that we had subject matter jurisdiction to review the carrier's subsequent closure of that claim. *See Larry L. Ledin*, 52 Van Natta at 685; *Paul E. Smith*, 52 Van Natta 730 (2000).

This same reasoning applies to the current claim. There is no dispute that claimant's aggravation rights have expired on his initial injury claim. Furthermore, claimant's condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the January 25, 2000 Own Motion Order[3] that authorized reopening claimant's claim pursuant to ORS 656.278(1)(a) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review SAIF's subsequent closure of that claim.[4] Therefore, we proceed with that review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17).

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[3] We note that the January 25, 2000 Own Motion Order was not appealed and has become final by operation of law. *See* ORS 656.278(4). Had that order been appealed or not become final, our decision today may well have been different. However, resolution of cases based on those specific circumstances must await a future case.

[4] Although we have subject matter jurisdiction to determine entitlement to temporary disability benefits where an injured worker's aggravation rights have expired, we generally defer making such a determination if there is litigation before the Hearings Division that may result in the payment of benefits under another claim or under another statute such as ORS 656.262(7)(c). *See* OAR 438-012-0050(1)(a)-(c); *Craig Prince*, 52 Van Natta 108, 111 (2000).

Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the August 16, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Here, claimant makes no argument that he was not medically stationary at the time of closure, nor does he argue that his medically stationary date was incorrect or his temporary disability compensation was incorrectly calculated. Instead, claimant's argument is solely procedurally based, *i.e.*, claimant essentially argues that his claim should have been processed under ORS 656.262(7)(c) and 656.268 rather than under the Boards own motion jurisdiction pursuant to ORS 656.278. However, as noted above, we have already concluded that we had subject matter jurisdiction to issue our January 25, 2000 Own Motion Order which authorized the reopening of claimant's claim pursuant to ORS 656.278 and its closure pursuant to our Own Motion rules. As such, we have subject matter jurisdiction to review SAIFs closure. Because claimant raises no substantive arguments, we affirm SAIF's August 16, 2000 Own Motion Notice of Closure in its entirety.

Accordingly, SAIF's August 16, 2000 Own Motion Notice of Closure is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
DIANNA R. BALL, Claimant
WCB Case No. 00-02235
ORDER ON REVIEW
Dean Heiling & Associates, Claimant Attorney
Bostwick, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Podnar's order that: (1) found that the employer's denial of her current condition was a premature denial; and (2) declined to assess an attorney fee. On review, the issues are the propriety of the denial and attorney fees.

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

On review, claimant argues that the ALJ erred in not awarding an assessed attorney fee. Claimant relies on the Board's decision in *Elizabeth Markuson*, 52 Van Natta 781 (2000), for the proposition that an attorney fee may be awarded in a case where the current condition denial is improper. However, the fee awarded in *Markuson* was an attorney fee for Board services on review in a case in which the carrier had requested review but had not prevailed. *See* ORS 656.382(2). There is no indication that an attorney fee was awarded in *Markuson* by the ALJ pursuant to ORS 656.386(1). Moreover, at the Board level in that case, there is no discussion regarding claimant's entitlement to an attorney fee pursuant to ORS 656.386(1).

Here, the ALJ correctly relied on *Robert E. Johnson*, 50 Van Natta 7 (1998), which held that there is no statutory basis for an attorney fee where a premature denial has been set aside as a nullity, due to the fact that a claim has not been filed. *See* ORS 656.386(1); *Stephenson v. Meyer*, 150 Or App 300 (1997). Because we find that *Johnson* and *Stephenson* are directly on point and reject claimant's contention that she is entitled to an attorney fee pursuant to ORS 656.386(1), we affirm the ALJ's order.

ORDER

The ALJ's order dated July 6, 2000 is affirmed.

In the Matter of the Compensation of
LETICIA R. TATE, Claimant
WCB Case No. 99-09723
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
James B. Northrop (Saif), Defense Attorney
Donald M. Hooton, Attorney

Reviewed by Board Members Meyers, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that declined to award temporary disability for the period from November 15, 1999 to November 29, 1999. On review, the issue is temporary disability (interim compensation).

We adopt and affirm the ALJ's order. *See Teri L. Caouette*, 52 Van Natta 767 (2000); *Ted B. Minton*, 50 Van Natta 2423 (1998) (carrier not obligated to process aggravation claim until it is perfected under ORS 656.273(3)); *David L. Dylan*, 50 Van Natta 276, 279 n. 3 (completed aggravation claim form by itself not construed as notice to the carrier that the claimant's compensable condition had medically worsened).

ORDER

The ALJ's order dated May 12, 2000 is affirmed.

Board Member Biehl dissenting.

The majority finds that claimant's aggravation claim was procedurally defective because the aggravation claim form was not physically accompanied by the attending physician's report supporting the claim. Because the SAIF Corporation did not receive both documents at the same time, the majority concludes that claimant failed to perfect an aggravation claim. Therefore, the majority holds that claimant is not entitled to interim compensation for the period from November 15, 1999 to November 29, 1999 (the date she was released to return to work).

I acknowledge that the 1995 amendments to ORS 656.273(3) require a form for filing an aggravation claim in order to prevent assertion of a "de facto" denial of an aggravation claim of which the carrier had not been adequately informed. *See Teri L. Caouette*, 52 Van Natta 767, 768 (2000) (Board Member Biehl dissenting).

Here, SAIF was clearly informed of the aggravation claim on November 5, 1999 when it received claimant's aggravation claim form. (Ex. 9). Claimant's doctor accidentally sent the wrong chart note with the form, but SAIF did receive the claim form on November 5, 1999 and the correct supporting chart note (the one the doctor intended to send earlier, with the form) on November 19, 1999. (*See* Ex. 10). Thus, SAIF received the aggravation claim form *and* the supporting November 2, 1999 chart note by November 19, 1999. Under these circumstances, I would hold that claimant's aggravation claim was perfected on November 19, 1999.

ORS 656.273(3) does not necessarily require that the aggravation form and "accompanying" report be physically attached or arrive at precisely the same time. Here, because SAIF had notice of the claim, *via* the claim form, the delay in submission of the correct supporting medical report should not defeat the claim. I would hold that the claim *was* perfected on November 19, 1999, when SAIF had received both documents, and SAIF should have processed it and paid claimant interim compensation. Because the majority concludes otherwise, I respectfully dissent.

In the Matter of the Compensation of
ROSENDO M. VALENCIA, Claimant
WCB Case No. 00-01501
ORDER ON REVIEW
Max Rae, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) declined to allow claimant to testify at hearing; and (2) affirmed an Order on Reconsideration's award of 21 percent (67.2 degrees) unscheduled permanent disability for his left and right shoulder conditions. On review, the issues are remand and extent of unscheduled permanent disability. We deny remand and modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Remand

On October 4, 1999, claimant's claim was closed by a Notice of Closure that awarded 22 percent unscheduled permanent disability. Claimant requested reconsideration of that order. A February 17, 2000 Order on Reconsideration reduced the award for unscheduled permanent disability to 21 percent. Claimant requested a hearing. The ALJ denied claimant's request to testify at hearing. On review, claimant argues that he was denied his constitutional rights under the United States Constitution and the Oregon Constitution by being denied the opportunity to testify and requests remand so that his testimony may be taken. We deny claimant's request.

First, we find no merit to claimant's constitutional arguments. *Koskela v. Willamette Industries, Inc.*, 159 Or App 229 (1999) (the administrative review and hearing structure of ORS 656.283(7), which prohibits the admission of evidence at hearing that was not submitted during the reconsideration proceeding, did not violate the claimant's right to due process of law under the 14th Amendment to the U.S. Constitution), *review allowed*, 329 Or 318 (1999); *Rogue Valley Medical Center v. McClearen*, 152 Or App 239 (1998) (under ORS 656.283(7), any evidence not submitted during the reconsideration process is inadmissible at a subsequent hearing, including the claimant's testimony).

We may remand to the ALJ only if we find that the record has been "improperly, incompletely or otherwise insufficiently developed." ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *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 the hearing; and (3) is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Because claimant's testimony would not be admissible at hearing, we find no compelling reason to remand. That is, because claimants testimony could not be considered at another hearing, we find no reason to remand. Consequently, we decline to remand this matter to the ALJ.

Unscheduled Permanent Disability

The parties disagreement is limited to two values that are a part of the calculation of the extent of claimant's unscheduled permanent disability: Specific Vocational Preparation (SVP) and Residual Functional Capacity (RFC). We address each in turn.

SVP

In confirming the Order on Reconsideration's award of 21 percent unscheduled permanent disability, the ALJ rated claimant's SVP as 4, based on the vocational counselor's Dictionary of Occupational Titles (DOT) classification of claimant's jobs at injury. Claimant contends that the DOT classification for Log Chipper Operator (DOT 564.662-010) was in error and instead should be Chipper (DOT 564.685-014). SAIF, in effect, argues that claimant's job as Planer Operator should be DOT 665.482-018, for an SVP of 4, rather than DOT 669.686-030, for an SVP of 2.

Claimant's SVP value is the highest SVP of any job he has held in the five years prior to determination. OAR 436-035-0300(3)(b). Here, the parties do not challenge the SVP value of 2 for claimant's job as Green Chain Offbearer (DOT 663.686-018). Based on the vocational counselor's description of the work claimant performed,[1] we agree with claimant that Chipper (DOT 564.685-014)[2] more closely corresponds with claimant's work than Log Chipper Operator (DOT 564.662-010)[3]. However, we also agree with SAIF that the description of Planer Operator (DOT 665.482-018)[4] more closely corresponds with claimant's work than Woodworking-Machine Feeder (Woodworking) (DOT 669.686-030)[5]. Planer Operator has an SVP of 4.

Consequently, whether classified as Log Chipper Operator or Planer Operator, claimant's SVP is 4. Because claimant's highest level of SVP is 4, claimant is entitled to a skills value of 3. OAR 436-035-0300(4).

RFC

Under OAR 436-035-0310(5), RFC is the worker's greatest physical capacity, evidenced by:

"(a) The attending physician's release; or

"(b) A preponderance of medical opinion which includes but is not limited to a second-level PCE or WCE as defined in OAR 436-010-0005 and 436-009-0020(30) or any other medical evaluation which includes but is not limited to the worker's capability for lifting, carrying, pushing/pulling, standing, walking, sitting, climbing, balancing, stooping,

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[1] Ms. Wallace, the vocational counselor, stated that claimant's duties at the employer, a saw mill, consisted of "[pulling] various sizes of lumber including 5x14, 6x6, and 5x12 pieces off of the green chain and [stacking] it. Also tended the chipper machine, operated a planer ** *." (Ex. 88-2).

[2] DOT 564.685-014 Chipper (chemical; paper & pulp; saw. & plan.) provides in part:

"Tends machine that reduces log slabs, stump wood, trimmings, and other scrap wood to chips of uniform size for making paper pulp and charcoal, and for use in wood distilling: Starts conveyor system that feeds wood into hopper of chipping machine. Positions pieces of wood on conveyor, using *picaroon* to prevent congestion and to regulate flow. May replace worn and bent knives and adjust knives to vary size of chips, using handtools." (Emphasis in original.)

[3] DOT 564.662-010 Log-Chipper Operator (logging) alternate titles: chipper, provides:

"Operates trailer-mounted grapple-loader and chipping machine to reduce logs and logging waste to wood chips: Controls loading boom and power-grapple attachment to pick up logs and place them on feed conveyor. Adjusts speed and opening of feed rolls according to log diameter, and activates feed rolls that pushes log through chipper unit. Monitors gauges and adjusts speed and opening of feed rolls to prevent equipment strain. Replaces defective chipping knives, suing wrenches and feeler gauges. May control opening of debarking spuds (tined rotating drums) that remove bark from log before chipping."

[4] DOT 665.482-018 Timber Sizer Operator (saw. & plan.) alternate titles: planer operator, provides in part:

"Operates planing machine to surface planks and timbers and reduce stock to specified dimensions: Installs cutting heads on machine drive spindles and adjusts blade exposure according to specified depth of cut, using wrenches and gauges. Adjusts feed roll tension and positions fences that guide stock between cutterheads. Starts machine, exhaust blower, and conveyors, and slides timber against guide to align timber on feed rolls. Verifies dimensions of sized stock, using gauge or rule."

[5] DOT 669.686-030 Woodworking-Machine Feeder provides in part:

"Feeds woodstock on conveyors, into hoppers, or between rollers of woodworking machines that cut, saw, sand, bore, or shape woodstock: Conveys woodstock from cart and feeds stock onto conveyor, into hopper, or between rollers of machine. Stops machine to remove jammed pieces or make minor adjustments, using handtools. May assist machine operator in setting up machine and wood from machine areas to *hog mill* and feed scrap into machine." (Emphasis in original.)

kneeling, crouching, crawling and reaching. If multiple levels of lifting and carrying are measured, an overall analysis of the worker's lifting and carrying abilities should be provided in order to allow an accurate determination of these abilities. Where a worker fails to cooperate or use maximal effort in the evaluation, the medical opinion of the evaluator may establish the worker's likely RFC had the worker cooperated and used maximal effort."

Dr. Rand was claimant's attending physician. In a September 14, 1999 letter to SAIF, Dr. Rand agreed with the PCE that was performed on August 2, 1999 and restricted claimant to light sedentary work.[6] Dr. Rand also stated that claimant is permanently restricted from forceful pushing, pulling, reaching, and climbing, and from crawling using both shoulders. (Ex. 89).

On January 15, 2000, Drs. Schilperoort, Bald and Staver performed an arbiter examination. The panel felt that claimant's lifting and carrying capacity in pounds could be considered in the medium category on the basis of occasional frequency. They also believed that there was permanent preclusion from pushing, pulling and reaching.

Even though the arbiter panel's report was issued more than five months after Dr. Rand's closing examination, we find Dr. Rand's opinion more persuasive than that of the arbiter panel. Dr. Rand is claimant's long-time treating physician, who released claimant to light-sedentary work, based on a detailed PCE. The arbiter's evaluation of claimant's residual functional capacity is conclusory and unexplained. *Somers v. SAIF*, 77 Or App 259, 263 (1986) (where the medical evidence is divided, we rely on those opinions that are well-reasoned and based on complete and accurate information). Consequently, based on Dr. Rand's release and the PCE, we find that claimant's RFC was "light" with restrictions, which puts claimant in the sedentary/light category. *See* OAR 436-035-0310(3)(e). Thus, comparing claimant's BFC of "heavy" with his RFC of "sedentary/light" results in an adaptability factor of 6. OAR 436-035-0310(6).

The total value of claimant's age (0), education (1) and skills (3) is (4). That value is multiplied by the adaptability value of (6) for a total of 24. OAR 436-035-0280(6). When this value is added to the value for impairment (5), the result is 29. OAR 436-035-0280(7). Therefore, claimant's unscheduled permanent disability is 29 percent (92.8 degrees). Consequently, we modify the ALJ's order to increase claimant's unscheduled permanent disability award from 21 percent to 29 percent. In other words, we increase claimant's unscheduled permanent disability award for a left shoulder condition from 21 percent (67.2 degrees), as awarded by an Order on Reconsideration, to 29 percent (92.8 degrees).

ORDER

The ALJ's order dated July 7, 2000 is modified in part and affirmed in part. In lieu of the ALJ's permanent disability award, claimant's unscheduled permanent disability award for a left shoulder condition is increased from 21 percent (67.2 degrees), as awarded by an Order on Reconsideration, to 29 percent (92.8 degrees). Claimant's counsel is awarded an out-of-compensation attorney fee of 25 percent of the increased compensation, not to exceed $5,000. The remainder of the ALJ's order is affirmed.

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[6] We note that SAIF requested an opinion from the evaluator to establish the worker's likely RFC had the worker cooperated and used maximal effort. (Ex. 87). In this opinion, the evaluator indicated that claimant's residual functional capacity was light, with restrictions. *Id.* This opinion places claimant in the light-sedentary range.

In the Matter of the Compensation of
AMADOR R. GALLARDO, Claimant
WCB Case No. 00-02293
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Menashe's order that: (1) found that claimant was not precluded from filing an aggravation claim where an earlier aggravation claim was judged invalid; (2) found that claimant's aggravation claim was valid; and (3) set aside the insurer's alleged *de facto* denial of claimant's aggravation claim for a low back and thoracic condition. Claimant cross-requests review of that portion of the ALJ's order that declined to assess a penalty for allegedly unreasonable claim processing. On review, the issues are claim preclusion, aggravation and penalties.

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

The ALJ concluded that claimant was not precluded from proceeding on his aggravation claim because the first aggravation claim was invalid and the insurer's denial declared a nullity. On review, the insurer contends that claimant's current aggravation claim is barred by claim preclusion because he had the opportunity to litigate the aggravation issue in the first case. We disagree with the insurer's argument.

In *Charles L. Chittim, Jr.*, 51 Van Natta 764 (1999), the claimant and his attending physician submitted a completed Director's aggravation form to the carrier, but the claim form was not accompanied by the required written medical report documenting objective findings of a worsened condition attributable to the accepted condition. Based on the statutory requirement that an aggravation claim form be accompanied by an attending physician's report documenting a worsened condition (and because the carrier had challenged the validity of the claim on this basis), we held that the claimant's aggravation claim was procedurally defective and that the carrier's aggravation denial was a nullity and without legal effect. *See also Ted B. Minton*, 50 Van Natta 2423, 2424 (1998).

Here, because claimant's prior aggravation claim was invalid and the denial issued in response to an invalid claim is a nullity and without legal effect, there was no claim outstanding at the time of the prior aggravation denial. Therefore, the denial has no preclusive effect.

The insurer cites to *Drews v. EBI Companies*, 310 Or 134 (1990), to argue that claimant's aggravation claim is barred by the doctrine of claim preclusion. In *Drews*, the Supreme Court described "claim preclusion" as follows:

> " '[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [i.e., precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been joined in the first action.' " 310 Or at 140 (*quoting Rennie v. Freeway Transport*, 294 Or 319, 323 (1982)) (brackets in original).

Claim preclusion does not require actual litigation of an issue of fact or law, nor that the determination of the issue be essential to the final result. *Id.* Claim preclusion requires the opportunity to litigate, as well as finality. *Id.* Thus, the determination of whether claim preclusion applies to preclude litigation of claimant's aggravation claim depends on whether claimant had an opportunity to litigate that issue in the prior hearing.

As discussed above, claimant's prior aggravation claim was invalid. The insurer's denial of that claim was null and void. A null and void denial is invalid *ab initio*. *E.g., William C. Becker*, 47 Van Natta 1933 (1995). Consequently, there was no claim, no denial, and no opportunity for claimant to litigate that issue in the prior hearing. Therefore, claim preclusion does not apply to the present proceeding.

The insurer also argues that claimant's claim is procedurally defective because Dr. Thomas' October 25, 1999 report does not exclude the possibility that claimant's worsened condition arose as a result of causes other than the compensable injury. Because this argument is raised for the first time on Board review, (*see* Tr. 8, 9), we do not address it. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to the aggravation issue, we find that a reasonable fee for claimant's attorney's services on review regarding the aggravation issue is $1,500, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the aggravation issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services on review regarding the penalty issue.

ORDER

The ALJ's order dated July 7, 2000 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,500, to be paid by the insurer.

October 30, 2000 Cite as 52 Van Natta 1957 (2000)

In the Matter of the Compensation of
DEBORAH L. GOTTHARDT, Claimant
WCB Case Nos. 00-00620 & 00-00307
ORDER ON REVIEW
Swanson, Thomas & Coon, Claimant Attorney
Thaddeus J. Hettle (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Peterson's order that upheld the self-insured employer's partial denial of her injury claim for a right elbow condition. On review, the issue is compensability.

We adopt and affirm the order of the ALJ with the following supplementation to address claimant's contention that the ALJ incorrectly failed to find the opinion of Dr. Gritzka, a consulting orthopedist, persuasive.

On May 1, 1999, claimant compensably injured her right shoulder as the result of her work activities as a bus driver. That claim was accepted on August 12, 1999 as a "disabling impingement of right shoulder." (Ex. 33). Subsequent to the acceptance of her shoulder claim, claimant developed pain in the right elbow, which has been diagnosed as epicondylitis. It is the compensability of the epicondylitis condition, as a work-related injury, that is at issue. Under such circumstances, to establish that her epicondylitis condition is compensable, claimant must prove that her work injury is a material contributing cause of the disability or need for treatment of that elbow condition. ORS 656.005(7)(a); *Albany General Hospital v. Gasperino*, 113 Or App 411 (1992).

The medical record contains the opinions of five doctors regarding the nature and cause of claimant's elbow condition. All the doctors agree that claimant has epicondylitis in her right elbow. However, they disagree regarding the cause of that condition. Because of the possible alternative causes contributing to claimant's elbow condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986).

Dr. Davin is claimant's attending physician for both the accepted right shoulder condition and the disputed epicondylitis condition. He has had the opportunity to examine claimant before and after the onset of the epicondylitis condition. As a general rule, such an opportunity can place a physician in an advantageous position to offer an opinion. *See Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). Dr. Davin, who is an orthopedist, opined that epicondylitis irritations are the result of activities in which

extension of the wrist is resisted. (Ex. 80A-1). He concluded that claimant's work activities of driving a bus or operating a ticket punch, may cause mild discomfort, but were not sufficient to cause claimant's epicondylitis condition. (Ex. 80A-1). Dr. Davin's opinion is supported by Drs. Sacamano and Tesar, orthopedists, who saw claimant at the employer's request. (Ex. 78; 80).

Claimant relies on the opinion of Dr. Gritzka, a consulting orthopedist. Dr. Gritzka, who personally tested claimant's ticket punch, opined that using a ticket punch was an activity consistent with the development of lateral humeral epicondylitis. (Ex. 77A-11). He further concluded that claimant's activity of tearing tickets involved a thumb-index pinch and supination of the forearm which were maneuvers associated with the development of epicondylitis. (Ex. 77A-11). Consequently, Dr. Gritzka believed that claimant's elbow condition was caused by her work activities. (Ex. 77A-12). Dr. Gritzka is supported by Dr. Weintraub, an orthopedist. (Ex. 79A).

However, Dr. Gritzka is unable to quantify the extent of claimant's use of the ticket punch, because claimant herself has "no idea" how often she used her hand punch. (Tr. 46). Consequently, we find that Dr. Gritzka's opinion is based upon an incomplete information, and accordingly, we do not find it persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here, because Dr. Davin had the opportunity to observe claimant over time and because he had the opportunity to examine claimant both before and after the onset of the epicondylitis, we find no persuasive reasons not to defer to his opinion. Consequently, we conclude that, on this record, claimant has failed to establish the compensability of her right elbow condition.

ORDER

The ALJ's order dated June 19, 2000 is affirmed.

October 30, 2000 Cite as 52 Van Natta 1958 (2000)

In the Matter of the Compensation of
ELYATA J. GURITZ, Claimant
WCB Case No. 99-09213
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the insurer's denial of claimant's occupational disease claim for cervical and right shoulder conditions. On review, the issue is compensability.

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

Claimant's work as an order selector for the employer involved primarily pulling orders; 60-70% of her work time required looking and/or reaching upward. (Tr. 9-10).

Dr. Stiger provides the medical evidence supporting the claim. He opined that claimant's work activities as an order puller for the employer "were the major contributing causes of her need for treatment" for her cervical herniated discs, right shoulder tendinitis, and right upper extremity cervical radiculitis. (Ex. 66). Dr. Stiger explained that looking up and reaching put claimant "in her situation to begin with." (Ex. 47). He stated that claimant's right arm pain and right hand parasthesia were clearly aggravated with looking upward and reaching overhead and, "[b]cause of her short stature this had been an ongoing problem [that] is the cause of her difficulties." (Ex. 49). And Dr. Stiger specifically opined that degenerative disc disease predisposed claimant to injury: Her work activities placed stress on the previously degenerated cervical spine, causing further breakdown of the discs. (Ex. 52-1-2).

Thus, Dr. Stiger explained the mechanism of claimant's "injury." Although the doctors reasoning is more persuasive than the conclusory opinions to the contrary, (*see* Ex. 50-6-7, 64-2), that does not help claimant's cause. We find Dr. Stiger's opinion insufficient to carry claimant's burden of proof because the doctor did not explain why claimants work activities contributed more to her cervical condition than did her undisputed preexisting degeneration. ORS 656.266; *see Elizabeth M. Buitron*, 51 Van Natta 1768 (1999) (although doctor weighed off work causes, he did not explain why work related causes contributed more to the claimant's condition) (*citing Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 or 416 (1995)). And we find Dr. Stiger's opinion regarding claimant's shoulder condition unpersuasive because it is entirely conclusory. Under these circumstances, we agree with the ALJ that the claim must fail.

ORDER

The ALJ's order dated July 3, 2000 is affirmed.

October 30, 2000 Cite as 52 Van Natta 1959 (2000)

In the Matter of the Compensation of
LARRY L. HAILEY, Claimant
WCB Case No. 00-00340
ORDER ON REVIEW
Bennett, Hartman & Reynolds, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the insurer's denial of his claim for a thoracic strain/sprain. On review, the issue is compensability.

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

On review, claimant argues that, because his claim involves a thoracic strain, the ALJ erred in rejecting the opinions of claimant's family physician and chiropractor in favor of the orthopedic surgeons and neurosurgeons. Claimant contends that there is no reason to discount the opinions of his doctors based on a lack of expertise.

After reviewing the record, we agree with the ALJ that the claim requires expert medical evidence. Although claimant's condition was initially diagnosed as a strain, the doctors later opined that claimant had a preexisting degenerative condition. Moreover, one of claimant's doctors, Dr. Croy, expressly agreed that the issue was an orthopedic problem and the causation question should be addressed by someone with more expertise in those areas. (Ex. 49-9). Under the circumstances, we conclude that the ALJ properly gave more weight to the opinions of the specialists.

Finally, claimant argues that, based on his testimony and the opinion of Dr. Croy, he has established compensability. Specifically, claimant contends that his testimony establishes that, once his working conditions were changed, his condition improved. Claimant contends that Dr. Croy's opinion also supports causation as he indicated that if the symptoms resolved and the spinal findings continued to be present, claimant's condition must be due to work-related causes.

We agree with the ALJ that Dr. Croy's opinion is not persuasive as his opinion regarding a causal connection with claimant's work factors was premised on his belief that claimant's symptoms would resolve within, at most, six to eight weeks. If claimant's symptoms did not resolve in that time, then Dr. Croy believed that the condition would be due to the preexisting degenerative disease and stress factors. (Ex. 46). As the ALJ noted, claimant's symptoms did not resolve in the time period. Moreover, we agree with the insurer that claimant's theory regarding the timing of the resolution of his symptoms is essentially a temporal analysis which cannot meet claimant's burden of proof. *Allie v. SAIF*, 79 Or App 284 (1986). We therefore affirm the ALJ's order.

ORDER

The ALJ's order dated June 30, 2000 is affirmed.

In the Matter of the Compensation of
TERRIE L. HEATLEY, Claimant
WCB Case No. 99-05372
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denial of claimant's injury claim for bilateral carpal tunnel syndrome. On review, the issue is compensability.

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

Claimant argues that Dr. Casey's reports are sufficient to establish the compensability of her bilateral carpal tunnel syndrome claim. We disagree.

Dr. Casey examined claimant on May 12, 1999. Claimant told Dr. Casey that she had experienced tingling and numbness in her hands when she performed work as a grader, and significant problems since then, but not a major problem until her work on April 26, 1999, when she spent about four hours as a grader. (Ex. 4). Dr. Casey reported that claimant thought her present problem is related to that work, "and she could easily be right." *Id.*

Dr. Casey also stated, "If a patient tells me that the one activity that made their symptoms bad enough for them to consider treatment for the first time was a work-related activity, I simply choose to believe that is the major contributing cause of the need for medical treatment." (Ex. 11).

Subsequently, however, in response to questions from claimant's attorney, Dr. Casey stated that, if claimant had done the grading job for one day that it was not likely to cause a repetitive work injury, but if she did it for several weeks it would. (Ex. 12). Dr. Casey also indicated that, although claimant's work activities (shoveling fiber and occasional grinding, and grading) are the kinds of activities that would cause carpal tunnel syndrome, if claimant was asymptomatic prior to her grading skins, that the grading would have to have occurred for a period longer than one day and more like several days before he would expect that such an activity in and of itself could cause the development of CTS. (Ex. 12A-1). We agree with the ALJ that Dr. Casey's opinions are inconsistent and not well reasoned, and, therefore, are insufficient to carry claimant's burden of proof. *Constance D. Wilbourn*, 51 Van Natta 1541 (1999) (inconsistent medical opinions are entitled to little, if any, weight); *Somers v. SAIF*, 77 or App 259 (1986) (we rely on those opinions that are both well-reasoned and based on complete information).

ORDER

The ALJ's order dated June 9, 2000, as republished on June 13, 2000 is affirmed.

In the Matter of the Compensation of
GEORGE D. SMIRNOFF, Claimant
WCB Case No. 99-06222
ORDER ON REVIEW
J. Michael Casey, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hoguet's order that: (1) concluded that claimant was an Oregon subject worker; and (2) set aside its denial of claimant's right knee condition. On review, the issues are subjectivity and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Subjectivity

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

Compensability

The ALJ found claimant's right knee condition compensable as an occupational disease claim. SAIF argues that claimant's claim is not properly analyzed as an occupational disease because it was sudden in onset. We agree.

An occupational disease stems from conditions that develop gradually over time. ORS 656.802; *Mathel v. Josephine County*, 319 Or 235, 240 (1994). In contrast, an injury is sudden, arises from an identifiable event, or has an onset traceable to a discrete period of time. *Active Transportation Co. v. Wylie*, 159 Or App 12, 15 (1999); *Valtinson v. SAIF*, 56 Or App 184, 188 (1982).

Here, it is undisputed that claimants right knee symptoms began on June 11, 1999. Claimant had right knee arthroscopic surgery twenty years ago following a motor vehicle accident, but has not had any significant right knee symptoms until June 11, 1999. Because the onset of claimant's right knee condition was sudden and occurred on a specific date, the claim is analyzed as an industrial injury. No medical evidence in the record supports compensability of claimant's claim as an industrial injury.[1] Accordingly, we conclude that SAIF's denial must be upheld.

ORDER

The ALJ's order dated July 10, 2000 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside SAIF's denial of compensability is reversed. SAIF's denial of compensability is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

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[1] Dr. Hormel, claimant's treating physician, supported compensability under an occupational disease theory. However, as explained above, because the onset of claimant's right knee problems was sudden, the claim is analyzed as a claim for an industrial injury. Dr. Hormel opined that claimant's right knee condition was not caused by an injury on June 11, 1999. Thus, Dr. Hormels opinions do not establish compensability of claimant's claim as an industrial injury.

Dr. Gripekoven examined claimant on behalf of SAIF. Dr. Gripekoven opined that claimant's work exposure combined with preexisting post traumatic arthritis of the right knee. Dr. Gripekoven opined that the major contributing cause of claimant's combined right knee condition was the preexisting degenerative process. Dr. Roberts also attributed claimant's condition to preexisting degenerative arthritis. Thus, the medical evidence does not establish compensability of claimant's injury claim.

In the Matter of the Compensation of
VERA TANNENBAUM, Claimant
WCB Case No. 00-0229M
OWN MOTION ORDER
Jolles, Bernstein & Garone, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer submitted claimant's request for temporary disability compensation for her low back injury claim. Claimant's aggravation rights on that claim expired on October 10, 1984. The insurer recommends against reopening the claim, contending that claimant does not meet the requirements of ORS 656.278(1)(a) because the treatment she underwent (surgical implantation of a morphine pump) was not for curative purposes. Based on the following reasoning, we find that claimant meets the requirements of ORS 656.278(1)(a).

As a preliminary matter, we note that there was some question as to whether the insurer's last closure of claimant's Own Motion claim had been set aside as premature and, if so, whether the claim had been subsequently reclosed. Board staff requested the parties positions regarding this matter.

In response to this inquiry, the insurer submitted a copy of the Board's February 26, 1993 Own Motion Order that authorized reopening the claim as of July 30, 1992, the date of claimant's L3-4 fusion surgery. It also sent a copy of its October 27, 1993 "Notice of Closure Board's Own Motion Claim." That closure awarded temporary disability benefits from July 30, 1992 through February 14, 1993, and declared claimant medically stationary as of October 19, 1993. The insurer noted that it had no indication that the claim was closed prior to the October 27, 1993 closure or that the October 1993 closure had been set aside as premature.

Claimant's only response to the Board's inquiry was to state that "to the extent that the claim for the prior own motion reopening in 1993 was never closed by the carrier, it should be closed at some point and the time loss resulting from the current surgery [implantation of the morphine pump] should be granted on that prior claim." Thus, claimant does not argue or submit any evidence from which we can find that the October 27, 1993 closure was set aside as premature. On this record, we find that the October 27, 1993 claim closure was not appealed and became final by operation of law.

Therefore, the issue before us is whether claimant is entitled to have her claim reopened for temporary disability benefits related to the June 2, 2000 surgical implantation of a morphine pump.[1] Pursuant to ORS 656.278(1)(a), temporary disability benefits may be awarded only when there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization.

Here, claimant had chronic intractable pain secondary to a failed lumbar back syndrome. The insurer approved Dr. Grewe's request for authorization to surgically implant a morphine pump. As noted above, this surgery took place on June 2, 2000.

On May 12, 2000, Dr. Grewe initially agreed with the insurers assessment that placement of the morphine pump was a pain control device. He also agreed that, although the procedure required hospitalization, claimant's underlying condition remained medically stationary.

Dr. Grewe subsequently clarified his opinion. He explained that claimant was getting progressively worse before the morphine pump surgical procedure. Concluding that this procedure required hospitalization, as well as a period of convalescence, Dr. Grewe determined that claimant would not be stationary until after this convalescence period.

Reading Dr. Grewe's opinions as a whole, we conclude that the record establishes that the need for the surgical procedure was caused by a worsening of claimant's compensable condition. Although Dr. Grewe initially stated that claimant's underlying low back condition remained medically stationary, he later opined that she was not stationary. In addition, he explained that, prior to the surgical implant, claimants condition was progressively worsening. Under these circumstances, we find that claimant's compensable condition worsened requiring surgery as of June 2, 2000. *See Durwood McDowell*, 47 Van

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[1] Claimant notes that she had a second surgery to repair the malfunctioning morphine pump on July 12, 2000. She submits a copy of that operative report.

Natta 2370 (1995) (worsening requiring hospitalization under ORS 656.278(1)(a) found where the claimant's condition worsened to the extent that it could only be managed by treating the compensable condition during inpatient hospitalization); *Earl Prettyman*, 46 Van Natta 891 (1994) (although worsening requiring surgery under ORS656.278(1)(a) found where the claimant's condition worsened to the extent that it required diagnostic arthroscopy to determine whether total knee replacement necessary, reopening denied because the claimant had voluntarily removed himself from the work force).

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning July 12, 2000, the date of surgery. When claimant is medically stationary, the insurer shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
LELAND J. WILSON, Claimant
WCB Case No. 99-09755
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Biehl, Bock, and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Herman's order that increased claimant's unscheduled permanent disability award for a low back condition from 15 percent (48 degrees), as awarded by Order on Reconsideration, to 22 percent (70.4 degrees). On review, the issue is extent of unscheduled permanent disability.

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

On review, the insurer relies on the court's recent decisions in *Roseburg Forest Products v. Clemons*, 169 Or App 231 (2000), and *Labor Force of Oregon v. Frierson*, 169 Or App 573 (2000). In *Frierson*, the court held that, in applying *amended* OAR 436-035-0007(28), the Board must resolve two issues; first, whether the physician's findings of impairment satisfied the AMA criteria, and if they did not, whether the physician's explanation regarding why the impairment findings were valid or invalid was sufficient under the rule. In *Frierson*, because it was not clear whether the Board had undertaken such an analysis, the court remanded for further proceedings.

Here, the ALJ explained that, while the arbiter noted that claimant failed the straight leg raising test, he found that claimant had reduced range of lumbar flexion and also expressly stated that the flexion finding was valid. (Ex. 43-2). Specifically, the arbiter reported that claimant had failed the validity check by only two degrees. The arbiter further reported that claimant had given good effort with all muscle testing and had been very cooperative during the examination. (Ex. 43).

On *de novo* review, we agree with the ALJ that the reasons set forth by the arbiter constitute a written rationale, based on sound medical principles, explaining why the findings are valid. OAR 436-035-0007(28). Accordingly, we conclude that the ALJ's order is consistent with the court's analysis in *Frierson*.

Claimant's counsel is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,400, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and counsel's statement of services), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated April 10, 2000 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,400, to be paid by the insurer.

Board Member Meyers dissenting.

For the following reasons, I disagree with the majority's opinion that claimant is entitled to an award of unscheduled permanent disability. First, I do not believe that the arbiter's report contains a sufficient explanation providing why claimant's invalid findings should be considered "valid." The brief comments made by the arbiter are neither sufficient nor are they based on sound medical principles.

Specifically, while the arbiter noted that claimant "only" missed the straight leg raising validity test by two degrees, the fact is that claimant did not pass the test as required by the criteria set forth in the AMA Guidelines. Moreover, while the arbiter commented that claimant seemed to give good effort with all "muscle testing," the claim in this case involved only claimant's lumbar spine. Accordingly, I conclude that the arbiter's opinion attempting to validate claimant's findings is not persuasive and is not based on sound medical principles.

Finally, I would reject the arbiter's report for the additional reason that a preponderance of medical evidence establishes that claimant is not entitled to an award. Dr. Fuller examined claimant and reported that claimant's only loss of range of motion was due to the preexisting degenerative disease. Dr. Malos, claimant's treating doctor, concurred with Dr. Fuller's opinion. Furthermore, Dr. Malos, who performed claimant's surgery, reported claimant to be medically stationary with no permanent impairment. Consequently, relying on the opinion of claimant's treating doctor, I would find that claimant is not entitled to an award of permanent impairment. I therefore respectfully dissent from the majority opinion.

November 2, 2000 Cite as 52 Van Natta 1964 (2000)

In the Matter of the Compensation of
RODNEY SULLIVAN, Claimant
WCB Case No. 96-0269M
OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

The SAIF Corporation requested reconsideration of our August 1, 2000 Own Motion Order that set aside its January 26, 2000 Notice of Closure as premature. In order to fully consider SAIF's motion, we abated our August 1, 2000 Own Motion Order and granted claimant the opportunity to respond. Having received claimant's response, we proceed with our reconsideration.

SAIF contends that we erred in determining that the medical evidence supported a finding that claimant's compensable left knee condition was not medically stationary. We disagree and write only to address SAIF's contention regarding Dr. Colville's status as a non-member of the MCO.

It is well-settled that for purposes of determining whether a claimant is medically stationary at the time of claim closure, all competent medical evidence is considered. *See John R. Graham*, 51 Van Natta 1858, 1859 n. 2 (1999); *Charlotte A. O'Neal*, 47 Van Natta 1994 (1995). Consequently, the fact that Dr. Colville is not a member of the MCO does not render his opinion less persuasive. For the reasons set forth in our prior order, we continue to find that Dr. Colville's opinion supports the conclusion that claimant's claim was prematurely closed.

Accordingly, as supplemented herein, we adhere to and republish our August 1, 2000 Own Motion Order Reviewing Carrier Closure. The parties' rights of appeal shall begin running from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
DENNIS SOSNOSKI, Claimant
WCB Case No. 00-00867
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Myzak's order that: (1) set aside its denial of claimant's injury claim resulting from a motor vehicle accident; and (2) awarded a $10,500 attorney fee. On review, the issues are compensability and attorney fees.[1] We reverse.

FINDINGS OF FACT

Claimant began working for the employer in 1997. (Ex. 5A-2). In 1999, he was a technical advisor, which involved solving problems with the employer's products and helping customers find service and repair facilities across the country. (Tr. 8). Claimant's job required out-of-state travel. (*Id.*)

On Monday, November 15, 1999, claimant flew to Texas as part of his employment. (*Id.*) He was to work at Integrity Motor Coach (Integrity) in Lewisville, Texas. (*Id.*) The employer paid for his air transportation, rental car and hotel. (Tr. 25; Ex. 5A-4).

Claimant worked at Integrity on Monday, November 15, 1999, and then checked into a hotel in Lewisville. (Tr. 8, 9). He also worked at Integrity on Tuesday, November 16, from 7:50 a.m. to 5:30 p.m. (Tr. 9). He went back to his hotel and then to the pool to relax for about an hour. (Tr. 9-10). Claimant then went to his room and watched television and fell asleep. (Tr. 10). He woke up about 9:30 p.m. and drove the rental car to get something to eat. (*Id.*)

Claimant arrived at a restaurant in Carrollton about 10:30 p.m. (Tr. 10, 29). He testified that he had two beers with his dinner. (Tr. 11). Claimant struck up a conversation with two people at the restaurant as they were watching television. (*Id.*) After 1:00 a.m., claimant gave one of them a ride back to his apartment, when the other individual's plans changed. (Tr. 11). The apartment in Carrollton was about three to four miles from the restaurant (Tr. 32). Claimant testified that he had a beer there and watched television. (Tr. 11-12, 32). He left the apartment after 1:30 a.m. to return to his hotel room in Lewisville. (Tr. 12, 33).

On his way back to the hotel, claimant was pulled over by a Carrollton police officer. (Tr. 12, Ex. 7-3). Claimant was on a service road parallel to the freeway. (Tr. 35, 51, Ex. 11). The police officer recorded that claimant was traveling 84 mph in a 35 mph zone. (Tr. 51, Ex. 7-4). Claimant was placed under arrest at about 2:30 a.m. on November 17, 1999 and charged with driving while intoxicated. (Ex. 7-3, Tr. 55, 78).

Claimant was held in jail until he could arrange bail. (Ex. 5A-6). He was released from jail at 6:00 or 7:00 p.m. on November 17, 1999. (Tr. 15). He then had to obtain the rental car out of the impound lot. (Tr. 12, Ex. 5A-7). Claimant testified that an employee from Integrity paid the bond and took him to the impound lot. (*Id.*) After claimant picked up the rental car, he was following the Integrity employee through an intersection when claimant was involved in a motor vehicle accident. (Tr. 13, Ex. 5A-7). The accident occurred about 8:40 p.m. (Ex. 2). Claimant was taken to the hospital by ambulance and released. (Tr. 13, Ex. 5A-8). He testified that he had neck and lower back pain. (Ex. 5A-8, -9). He returned to his hotel room at about midnight. (Tr. 13, 14). Claimant returned to Oregon on November 20, 1999. (Tr. 17).

SAIF denied the claim on the grounds that claimant's injury did not arise out of or occur within the course of his employment. (Ex. 6). Claimant requested a hearing.

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[1] We modify the ALJ's order to note that Exhibit 11 was also admitted in evidence. (Tr. 70).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, even if claimant had departed from his employment on a personal errand with his alcohol consumption, driving, arrest and detention, any personal errand of driving under the influence and its attendant consequences was completed when he resumed possession of the rental car and began driving back (sober) to his hotel room. The ALJ reasoned that there was no departure or detour at the time of his injury and she found that claimant's return activity to the hotel room was reasonably related to his status as a traveling employee.

SAIF acknowledges that claimant was a "traveling employee," but it argues that claimant was engaged in a personal deviation that took him out of the course of his employment at the time of his injury. SAIF contends that the entire intoxication/arrest episode, including the retrieval of the rental car from the impound lot and the return journey, was outside the course and scope of claimant's employment and was unrelated to his status as a traveling employee. SAIF asserts that claimant's personal deviation was behavioral, temporal and geographic. In addition, SAIF argues that claimant had not completed the personal deviation at the time of the motor vehicle accident.

For an injury to be compensable, it must "arise out of" and be "in the course of" employment. ORS 656.005(7)(a). The court applies a unitary work-connection test. The requirement that the injury occur "in the course of employment," concerns the time, place, and circumstances of the injury. *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 366 (1994). The other requirement, that the injury "arise out of" the worker's employment, examines the causal connection between the injury and the employment. *Id.* Although both elements must be evaluated, neither is dispositive. *Id.*

Both parties assert, and we agree, that claimant was a "traveling employee." The court has held that a person who has the status of a traveling employee is continuously within the course and scope of employment while traveling, except when it is shown that the person has "engaged in a distinct departure on a personal errand." *Savin Corp. v. McBride*, 134 Or App 321, 324 (1995); *Proctor v. SAIF*, 123 Or App 326, 330 (1993). The court has relied on the general rule governing the compensability of injuries to traveling employees, which is stated in 2 Larson, *Workers' Compensation Law*, section 25.01 (2000):

> "Employees whose work entails travel away from the employer's premises are held in the majority of jurisdictions to be within the course of their employment continuously during the trip, except when a distinct departure on a personal errand is shown. Thus, injuries arising out of the necessity of sleeping in hotels or eating in restaurants away from home are usually compensable." (Footnote omitted).

In determining whether a traveling employee's injury is compensable, we consider whether the activity that resulted in the injury was reasonably related to the employee's travel status. *McBride*, 134 Or App at 325; *Proctor v. SAIF*, 123 Or App at 330; *Slaughter v. SAIF*, 60 Or App 610, 616 (1982).

In *Proctor*, the claimant attended an overnight conference and was deemed to be a "traveling employee." After one of the sessions, the claimant drove 15 miles to an athletic club and was injured playing basketball. In deciding whether the claimant had engaged in a distinct departure on a personal errand, the court reviewed previous cases involving after-work activities and noted that many traveling employees relax through activities that have little relationship to work, including time spent in bars. The court explained:

> "Those cases looked beyond the claimant's presence in a bar to find whether the claimant's presence or activity in the bar had a work connection, and whether the activity violated employer directives or was 'so inconsistent with the purpose of his trip * * * as to constitute an abandonment of his employment or such a deviation therefrom as should have caused us to conclude that he was no longer in the course of his employment.'" *Proctor*, 123 Or App at 332 (quoting *Slaughter v. SAIF*, 60 Or App at 615 n. 4; other citations omitted).

In the present case, claimant argues that he never left the course and scope of his employment and there was no distinct deviation for a personal purpose. He contends that, even if there had been a hiatus, he was returning to normal activities in an expeditious manner, advancing the employer's interest when the accident occurred. Claimant urges the Board to affirm the ALJ's conclusion that his injury, which occurred while he was driving in a sober state 6 or 7 miles from his hotel, was reasonably related to his travel status.

We must decide whether the activity that resulted in claimant's injury was reasonably related to his travel status. *McBride*, 134 Or App at 325. We examine whether claimant's activities had a work connection and whether those activities violated employer directives or were so inconsistent with the purpose of his trip as to constitute an abandonment of his employment or "such a deviation therefrom as should have caused us to conclude that he was no longer in the course of his employment." *Proctor*, 123 Or App at 332.

For the following reasons, we need not decide whether claimant violated the employer's work rule by operating a company vehicle under the influence of alcohol.[2] *See Andrews v. Tektronix, Inc.*, 323 Or 154, 166 (1996) (an employee's violation of an employment rule does not render his or her claim per se noncompensable). Even if we assume, without deciding, that claimant did not violate the employer's work rule by driving under the influence of alcohol, we conclude that claimant's activities at the time he was injured were not reasonably related to his status as a "traveling employee."

On November 16, 1999, claimant worked until 5:30 p.m and returned to his hotel. (Tr. 9). At about 9:30 p.m., he drove the rental car to get something to eat. (Tr. 10). Although there were other restaurants closer to his hotel than the one claimant chose (Tr. 28, 29), claimant's decision to drive about six or seven miles to a restaurant in Carrollton was not unreasonable. (Tr. 60).

Claimant testified that after eating and consuming two beers, he gave one of the people he met a ride to his apartment, which was about three to four miles from the restaurant (Tr. 11, 32). He testified that he had a beer there and watched television. (Tr. 11-12, 32). Claimant left the apartment after 1:30 a.m. to return to his hotel in Lewisville. (Tr. 12, 33).

On his way back to the hotel, claimant was pulled over by a Carrollton police officer. (Tr. 12, Ex. 7-3). The police officer recorded that claimant was traveling 84 mph in a 35 mph zone. (Tr. 51, Ex. 7-4). Claimant was placed under arrest at about 2:30 a.m. on November 17, 1999 and charged with driving while intoxicated. (Ex. 7-3, Tr. 55, 78). Claimant was held in jail until he could arrange bail. (Ex. 5A-6). He was released from jail at 6:00 or 7:00 p.m. on November 17, 1999 and had to obtain the rental car out of the impound lot. (Tr. 12, 15, Ex. 5A-7). Claimant testified that an employee from Integrity took him to the impound lot. (*Id.*) After claimant picked up the rental car, he was following the Integrity employee when claimant was involved in a motor vehicle accident. (Tr. 13, Ex. 5A-7). The accident occurred at about 8:40 p.m. (Ex. 2). Claimant was taken to the hospital by ambulance and released. (Tr. 13, Ex. 5A-8).

We find that claimant's activity at the time he was injured was not reasonably related to his status as a traveling employee. We conclude that claimant's arrest, his detention in jail, the retrieval of the rental car from the impound lot and the return journey were outside the course and scope of his employment and those activities were unrelated to his status as a traveling employee. *Compare McBride*, 134 Or App at 321 (the claimant's personal bank business required a diversion of three to five blocks from her route home and it took about five minutes; the claimant's personal errand was not so unrelated to her travels as to be excluded from coverage). We find that claimant's entire episode as summarized above had no work connection. Furthermore, those activities constituted a distinct departure from his employment such that claimant was no longer in the course of his employment. Claimant's accident occurred after a nonbusiness delay of about 18 hours, from the time of his arrest at 2:30 a.m. on November 17, 1999 to the time of the accident at 8:40 p.m. on the same day.

In reaching this conclusion, we reject claimant's argument that, even if there had been a hiatus, he was returning to normal activities in an expeditious manner, advancing the employer's interest when the accident occurred. We are not persuaded that claimant's deviation had ended just because he was returning to the hotel. Claimant was injured at a place he would not have been, but for his arrest, temporary incarceration and impoundment of his car. In sum, we conclude that claimant was injured while he was engaged in a distinct departure that took him out of the course of his employment. We therefore reverse the ALJ's order.[3]

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[2] One of the employer's rules provided that "[a]ll employees are prohibited from being under the influence of alcohol, drugs or controlled substances during work hours, or while operating a company vehicle." (Ex. 9-5).

[3] In light of our conclusion that the claim is not compensable, we need not address SAIF's argument that the ALJ's attorney fee award was excessive.

ORDER

The ALJ's order dated June 16, 2000 is reversed. The SAIF Corporation's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

In the Matter of the Compensation of
TRUMAN MILLER, Claimant
WCB Case No. 99-08237
ORDER ON REVIEW
Craine & Love, Claimant Attorney
VavRosky, MacColl, Olson, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Herman's order that awarded temporary disability compensation from November 13, 1998 until terminated in accordance with the law. On review, the issue is temporary disability compensation. We modify.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded temporary disability compensation from November 13, 1998 until terminated in accordance with the law. We adopt the ALJ's reasoning and conclusions on this issue except to the extent that the ALJ found claimant entitled to temporary total disability (TTD) from November 13, 1998 through December 4, 1998. In this regard, the ALJ found that Dr. Cox, claimant's attending physician, released claimant from work from November 13, 1998 through December 4, 1998, at which time Dr. Cox released claimant to modified work. Based on the following reasoning, we find that Dr. Cox ultimately released claimant to modified work for the entire period from November 13, 1998 onward. Thus, claimant is entitled to temporary partial disability (TPD) from November 13, 1998 until terminated in accordance with the law.[1]

During an open claim, a claimant is entitled to temporary disability for those periods of time for which an attending physician has authorized temporary disability. ORS 656.262(4)(g);[2] *Gerald A. Zeller*, 48 Van Natta 501, *on recon* 48 Van Natta 735 (1996).

Furthermore, OAR 436-060-0020(11)[3] and OAR 436-060-0150(5)(h)[4] provide the requirements for payment of temporary disability benefits on a claim that has been determined compensable following

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[1] Of course, this holding does not prohibit payment of TTD prior to claim closure if claimant's attending physician releases him from work. We address only that period of time at issue before the ALJ at hearing.

[2] ORS 656.262(4)(g) provides:

"Temporary disability compensation is not due and payable pursuant to ORS 656.268 after the worker's attending physician ceases to authorize temporary disability or for any period of time not authorized by the attending physician. No authorization of temporary disability compensation by the attending physician under ORS 656.268 shall be effective to retroactively authorize the payment of temporary disability more than 14 days prior to its issuance."

[3] OAR 436-060-0020(11) provides:

"If a denied claim has been determined to be compensable, the insurer shall begin temporary disability payments pursuant to ORS 656.262, including retroactive periods, if the time loss authorization was open ended at the time of denial, and there are no other lawful bases to terminate temporary disability."

[4] OAR 436-060-0150(5)(h) provides:

"(5) Timely payment of temporary disability benefits means payment has been made no later than the 14th day after:

"(h) The date any litigation authorizing retroactive temporary disability becomes final. Temporary disability accruing from the date of the order shall begin no later than the 14th day after the date the order is filed[.]"

litigation. Here, the insurer issued a denial of claimant's bilateral carpal tunnel syndrome (CTS) claim on February 9, 1999. Following an August 30, 1999 Opinion and Order that set aside that denial, the insurer accepted the bilateral CTS claim on September 10, 1999. (Ex. 13).

For the reasons stated by the ALJ, we agree that claimant left work due to the bilateral CTS condition that was subsequently determined to be compensable against the insurer. Furthermore, at the time of the insurer's February 9, 1999 denial, Dr. Cox, claimant's attending physician, had issued an open-ended authorization for temporary disability benefits.

In this regard, in his November 13, 1998 chart note, Dr. Cox related bilateral hand and wrist symptoms to repetitive work activities. Dr. Cox filled out an 827 form that same date that indicated claimant was not released to regular work. (Exs. 6, 6A). Dr. Cox did not indicate on the 827 form that claimant was released to modified work. Instead, Dr. Cox responded "not applicable" to a request for a statement regarding "any specific medical limitations." (Ex. 6A).

On December 3, 1998, Dr. Cox examined claimant and stated that claimant needed surgery for his CTS condition, and could not "currently" return to his "line of work" due to his symptoms. (Ex. 8). Dr. Cox also noted that he was trying to obtain authorization from "Workers' Compensation" for carpal tunnel release and that claimant "cannot work until this insurance snafu is straightened out." (Ex. 8). In addition, that same date, Dr. Cox authored a work release authorization, stating that claimant was unable to work from August 8, 1998 until December 4, 1998, and was released to light duty work effective December 4, 1998. (Ex. 7). This is the last information in the record from Dr. Cox prior to the insurer's February 1999 denial.

Therefore, at the time of the insurer's denial, claimant's attending physician had issued an open-ended authorization for temporary disability benefits. However, given the variation in Dr. Cox's language, it is not entirely clear whether that authorization included a release from work (or just claimant's "line of work") before December 4, 1998, although it is clear that Dr. Cox released claimant to light duty work effective December 4, 1998. In any event, at the time of the prior ALJs August 30, 1999 order finding the bilateral CTS condition compensable and assigning responsibility to the insurer, Dr. Cox had not changed his modified work release. (Exs. 11, 12). Thus, pursuant to OAR 436-060-0150(5)(h), payment of accruing temporary disability benefits was due 14 days from the date of the August 30, 1999 order, and payment of retroactive temporary disability benefits was due 14 days from the date that order became final.

As of the date of hearing, the insurer had paid no temporary disability benefits on this claim. On January 18, 2000, Dr. Cox agreed with a conversation summary from the insurer regarding his prior temporary disability authorizations. (Ex. 14). Despite his contemporaneous statement that claimant was unable to work from August 28, 1998 until December 4, 1998, Dr. Cox explained that claimant "could not perform the type of job he had been doing at the time he quit his job. However, he has been continuously released to seek any form of work that does not involve repetitive hand activity." (Exs. 7, 14-2 (emphasis in original)).

On this record, we find that Dr. Cox ultimately released claimant to modified work during the period in question, *i.e.*, the period from November 13, 1998. In this regard, in his January 18, 2000 concurrence letter, Dr. Cox stated that claimant was released to seek work that did not involve repetitive hand activity. (Ex. 14-2). Thus, claimant is entitled to TPD under ORS 656.262(4) beginning November 13, 1998 and continuing until termination is allowed by law.[5]

Because we have reduced the compensation awarded by the ALJ, claimant's attorney is not entitled to an assessed fee for services on review. ORS 656.382(2).

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[5] We note that claimant performed several odd jobs for his landlord during the period from October 14, 1998 through November 10, 1999, for which he was paid a total of $1,371.38 in wages and rent credit. (Ex. 16-1). Thus, claimant's TPD rate would be calculated pursuant to OAR 436-060-0030(2).

ORDER

The ALJ's order dated April 3, 2000 is modified in part and affirmed in part. In lieu of the ALJ's award of temporary total disability (TTD) benefits for the period from November 13, 1998 through December 3, 1998, and temporary partial disability (TPD) benefits from December 4, 1998 until termination is allowed by law, claimant is awarded TPD benefits from November 13, 1998 until termination is allowed by law. The ALJs out-of-compensation attorney fee award shall be modified accordingly. The remainder of the order is affirmed.

In the Matter of the Compensation of
MILAN P. SHUBERT, Claimant
WCB Case No. 94-08858
ORDER ON REMAND (REMANDING TO WORKERS' COMPENSATION DIVISION APPELLATE UNIT)
Preston, Bunnell, et al, Claimant Attorney
Julene M. Quinn (Saif), Defense Attorney

This matter is pending before the Board on remand from the Supreme Court. *Shubert v. Blue Chips*, 330 Or 554 (2000). The Supreme Court has reversed the Court of Appeals decision, 151 Or App 710 (1997), that had affirmed our prior order, *Milan F. Shubert*, 47 Van Natta 1297 (1995), that, in affirming an Order on Reconsideration (which did not award claimant additional permanent disability for a left shoulder condition), held that the Director was authorized to adopt a temporary rule under ORS 656.726(4)(f)(C) that assigned an impairment rating of zero for claimant's surgical procedure that was not addressed in the existing disability standards. Although agreeing that the Director could adopt a temporary rule that assigns an impairment value of zero, the Court concluded that, rather than making some categorical pronouncement about the ordinary and expected effects of the event that caused the impairment, the Director must promulgate a temporary rule that addresses the worker's particular impairment.

Reasoning that the Director failed to address claimant's personal circumstances in adopting a temporary rule (as opposed to the generality of circumstances attendant upon the two kinds of surgeries claimant had undergone), the Supreme Court determined that the Director's temporary rule was unresponsive as a matter of law. Holding that the Director had not performed the function contemplated by ORS 656.726(4)(f)(C) with respect to claimant's condition, the Court has remanded with instructions to remand to the Director for further proceedings.

Consistent with the Supreme Courts mandate, this matter is remanded to the Director for further proceedings consistent with the Supreme Court's decision and this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ELEANOR NAGAI, Claimant
WCB Case No. 98-07355
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The self-insured employer requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) set aside its denial of claimant's occupational disease claim for a mental disorder; and (2) awarded an assessed attorney fee of $35,000. Claimant cross-requests review of that portion of the ALJ's order that awarded the attorney fee. On review, the issues are compensability and attorney fees. We reverse.

FINDINGS OF FACT

Claimant, age 52, was employed as a medical technologist ("med tech") in the microbiology department of a regional laboratory since February 14, 1990. (Ex. 1). She was hired primarily to read gram stains (a preliminary level of identifying whether bacteria are present in a specimen), a "miscellaneous bench" duty. From August to December 1997, claimant worked at the miscellaneous bench most of the time. (Ex. 7AB; Tr. 77, 78, 79). Claimant generally worked three varying days a week on swing shift, although she was expected to be reasonably available to work up to 40 hours a week as needed. (Ex. 5-6).

In 1992-1993, the employer considered the possibility of closing the laboratory because of increasing financial pressures. This was not done; instead, the employer decided to keep the lab open and expand its scope. In 1994, the employer began to prepare for changes expected as a result of new federal statutory and regulatory measures regarding laboratory protocols. The employer was also concerned about the impact of the planned closure of one of its hospitals and the need to streamline its laboratories. In 1995, the employer began confidential negotiations with Oregon Health Sciences University (OHSU) and other medical providers to perform laboratory services for those entities on a contract basis. Agreement was reached with OHSU and, in March 1996, the employer's microbiology department began doing OHSU's lab work.

Implementation of the OHSU contract occurred at about the same time that one of the employer's hospitals closed. Both changes, as well as overall cutbacks in funding for medical services generally, resulted in an overall increase in work at the microbiology laboratory and the need to become more cost-conscious and production oriented. New technologies and equipment were brought into the lab, including a new computer system. "Med techs" were required to become competent in performing a broader range of laboratory work.

Dr. Maroney became technical director of the microbiology department in 1994 or 1995. Ms. Zook was department supervisor until some time in 1995. At that time, annual performance appraisals (PAs) consisted of a safety quiz and negotiation over the scores one would receive. (6/17/99 Tr. 158, 177; 6/18/99 Tr. 71). Claimant's annual performance appraisals met or exceeded standards until that of February 19, 1995, when claimant was rated as "needs improvement" in subcategory 12: "Agrees to schedule changes as work flow demands." (Exs. 1 through 4; 5-5). Claimant formally objected to that rating. (Ex. 5-6, -7).

Some time in 1995, Ms. Scariano became department supervisor. Claimant did not receive a PA in 1996.

Prior to 1996, if a "med tech" had a technical problem, that person would go directly to the technical director for a solution. In 1996, Dr. Maroney required that the technologist develop a proposed solution to the problem and bring the problem and proposed solution to her. This involved more knowledge and better problem-solving skills than previously required.

Prior to January 1997, it was accepted procedure for "med techs" to document their literature review and required annual reading of the standard operating procedures (SOPs) at the time of their PAs. (6/17/99 Tr. 147, 177). In January 1997, Ms. Scariano held a department meeting in which it was

announced to the "med techs" that documentation of their continuing education would change. Henceforth, documentation was to be made in a departmental notebook as they completed each item. (Ex. 58; 7/2/99 Tr. 21). Claimant attended the meeting and read the minutes. (Ex. 58).

On August 28, 1997, the "med techs" were informed that each person must meet or exceed national standards in specified areas, and that regulations required annual performance competency measurement, which was to be implemented by means of proficiency testing, blind challenges, direct observation, and written quizes. Areas needing improvement were to be addressed in the PAs. (Ex. 7A).

On September 5, 1997, a "Performance Investigation Form" regarding a September 1, 1997 event in which claimant mismatched tests on two patients was given to claimant. Counselling was recommended. (Ex. 8-1).

On September 29, 1997, Ms. Scariano again instructed workers how to document their annual review of the standard operating procedures (SOPs). (Ex. 27-13).

On November 11, 1997, a "Performance Investigation Form" regarding a November 11, 1997 event was given to claimant. This form stated that claimant had not followed SOP by continuing to test without physician request and/or director or supervisor approval after the result had been confirmed and released by the director. (Ex. 9-1). For this, claimant received a verbal reprimand, a step in the disciplinary process. (Ex. 10-3). Claimant formally objected to this disciplinary action. (Ex. 10).

On December 12, 1997, claimant received her PA. Her work was evaluated by Ms. Scariano and Dr. Maroney and reviewed by the operations manager, Ms. Walden. The PA indicated that claimant needed improvement in multiple areas, including her knowledge of microbiology; computer skills; productivity; documentation of attendance at continuing education meetings, individual reading and annual review of SOPs; inability to work independently with minimal supervision; lack of cost-consciousness; jumping to conclusions; and inflexibility in regard to scheduling. (Ex. 11). Claimant raised issues about the PA; in a December 15, 1997 letter, Ms. Scariano (who was leaving her supervisory position at the end of the month) notified claimant that those issues would be handled by Ms. Walden. (Ex. 12).

In a December 20, 1997 letter to Ms. Walden regarding her PA, claimant objected to the "needs improvement" categories on the basis that they were not based on her full year's performance or on documented issues clearly made known to claimant in a timely manner, or were incorrect. (Ex. 13).

Ms. Schoof became interim supervisor until March or April 1998, when she accepted a position as lead technologist. Ms. Walden resigned in February 1998. Dr. Maroney was assigned the operational supervisory and managerial duties in addition to her duties as technical director of the department. Dr. Maroney also became directly involved in training.

Meanwhile, in February 1998, claimant and Ms. Walden met to discuss claimant's response to her PA. Ms. Walden counseled claimant as to what she could do to raise her ratings. Claimant was concerned that Ms. Walden did not address her concern that her PA was unfair because it was not based on her full year's performance or on documented issues clearly and timely made known to claimant. Claimant believed that there should be nothing new or surprising in a PA. She thought that the employer's policy was to make an employee aware of problems and to help work with the employee to achieve an acceptable level of performance. (Exs. 63, 64).

On March 9, 1998, Ms. Schoof informed the "med techs" of how competency assessments would be done for 1998. (Exs. 13F, 13G). Claimant began, but did not complete, some of her continuing education assignments. (Exs. 13E, 13I). Claimant began and completed job specific assignments. (Ex. 13H).

On March 24, 1998, claimant asked Dr. Maroney to discuss the issues she had raised in regard to the December 1997 performance evaluation. (Exs. 15, 72).

On May 13, 1998, claimant opted to participate in a Work Performance Improvement Plan (WIP) rather than receive an interim performance appraisal with future performance deficiencies being formally addressed with progressive discipline. The WIP required claimant to work full time (40 hours a week), to meet the performance standards of the laboratory by a weekly assessment of information from reading assignments, daily review of her work for accuracy and completeness, productivity, and computer entry. (Ex. 14).

On May 18, 1998, claimant wrote to Dr. Maroney regarding the WIP, stating that she had not failed to perform up to the laboratory standards and that she had not been notified of excessive errors in her work as they occurred. Claimant again raised the issue in regard to her PA that she had not been made aware of her deficiencies as they occurred. (Ex. 15).

On May 22, 1998, claimant sought medical treatment from Dr. Beam, complaining of increasing stress at work. Claimant reported that, after years of excellent performance reviews, concerns had been raised about her performance for which there was no basis but the supervisor's errors and misjudgments. Claimant reported difficulty in sleeping, which was affecting her clarity in thinking. Dr. Beam diagnosed psychological stress and insomnia, for which he prescribed lorazepam. He referred claimant to the occupational health clinic for the work issues. (Ex. 16).

On May 29, 1998, claimant began treating with Dr. Karty, osteopath, in the occupational health clinic. Claimant provided Dr. Karty with a detailed history of her employment issues. Dr. Karty reported that, starting from about October 1997, a series of harassing events led to a poor performance appraisal in December 1997 and a May 1998 work improvement plan that was issued based on unknown events. Dr. Karty also reported that claimant thought that her PA was the last step before she could be terminated for poor performance. Dr. Karty noted that claimant was well organized and credible. He noted that she was briefly tearful several times and then spontaneously became well controlled and logically organized. Dr. Karty diagnosed "Acute Reaction to Stress" and referred her to Dr. Lange, psychologist, for a psychological opinion. Dr. Karty released claimant to regular work. (Ex. 16).

On June 2, 1998, claimant discussed her fear of retaliation and her belief that Dr. Maroney intended to harass her out of her job with Ms. Allan in Human Resources. (Exs. 73, 75).

On June 8, 1998, Dr. Maroney prepared a Summary of Daily Observation for the week of June 1-5, which indicated that claimant had not demonstrated that she understood the microbiology on a bench where she had been working for a year; quick improvement was expected. (Ex. 19).

On June 8, 1998, claimant filed a claim for "job related stress" based on an October 15, 1997 reprimand that was allegedly referred to in the December 1997 performance appraisal. (Exs. 20, 21, 33-5).

On June 15, 1998, claimant was evaluated by Dr. Lange. Dr. Lange stated that claimant presented with symptoms of anxiety and depression because of conflicts with the laboratory director. He reported that claimant felt that the disciplinary actions were unjust and based on subjective evidence and that she was being singled out. He noted that claimant, as well as others, had come into conflict with the laboratory director. Dr. Lange noted that claimant's affect was somewhat restricted and she was having difficulty with sleep, appetite and energy. Dr. Lange diagnosed "Adjustment disorder with depression and anxiety." Dr. Lange also noted that claimant preferred not to use medication and was in contact with the Employee Assistance Program (EAP). Dr. Lange opined that, based on the evidence available to him, the major contributing cause of claimant's condition was due to the work environment. (Ex. 23).

On June 15, 1998, Dr. Maroney signed "Daily Observations/Week 2" of the WIP that documented some improvement in claimant's performance, but not enough to meet minimum standards. (Ex. 25-4). On June 23, 1998, Dr. Maroney signed "Daily Observations/Week 3" that again documented some, but insufficient, improvement. (Ex. 25-3).

Also on June 23, 1998, Dr. Maroney responded to claimant's May 18, 1998 letter. In it, Dr. Maroney outlined the times that claimant's deficiencies had been addressed by her former supervisor, the former manager, and herself, and concluded that claimant had had numerous opportunities for discussion of her work performance and deficiencies. (Ex. 25).

On June 23, 1998, Dr. Karty modified claimant's work, stating:

> "Due to stress [claimant] notes coming from the director of the micro lab, there should be no contact with [the director]; so that [claimant] should have restricted work which will be to exclude her from the micro lab." (Ex. 26-4).

On July 13, 1998, claimant returned to Dr. Karty. Claimant complained of having to meet with Dr. Maroney regarding her third evaluation, but reported that the employer had placed her in a different office as a file clerk where her hours had been reduced "more in keeping with what she had planned when first coming on as a hire." Dr. Karty noted that claimant was not on any specific prescription for her stress reaction and seemed to be improving with counseling and a change in her work situation. Dr. Karty continued claimant's work restrictions. (Ex. 31).

On July 13, 1998, claimant discussed the grievances with Ms. Hron, Human Resources consultant, that she filed in response to the Daily Summary of Observations prepared by her supervisor. Claimant was informed that performance appraisals are not grieved, but that statements of rebuttal can be attached to performance evaluations. Claimant's grievances were to be considered as rebuttals to the weekly evaluations. (Ex. 32).

On August 31, 1998, claimant was examined by Dr. Klecan. (Ex. 33). Dr. Karty concurred with Dr. Klecan's report, but with an area of disagreement that is illegible. (Ex. 38).

On September 4, 1998, Dr. Karty diagnosed claimant's condition as "Psychological Stress, V62.89." He continued claimant's restrictions related to contact with Dr. Maroney. He noted that claimant remained on no specific prescription for her condition and stated that claimant was fine with EAP counseling and modified duty. (Ex. 34).

On September 14, 1998, the employer denied claimant's mental disorder claim. (Ex. 35).

On September 15, 1998, claimant returned to Dr. Karty. Dr. Karty noted that the issues of stress were still present and continued claimant's work restriction of no contact with Dr. Maroney. (Exs. 36, 37, 40, 41A, 44, 52).

In a letter dated November 4, 1998, the employer notified claimant that her position would be eliminated as of January 4, 1999, due to budgetary restrictions. (Ex. 40A).

On November 18, 1998, Dr. Klecan reevaluated his August 18, 1998 report at the request of the employer's attorney. (Ex. 41).

Dr. Karty's deposition was taken on November 24, 1998. (Ex. 42).

Dr. Lange's deposition was taken on December 7, 1998. (Ex. 43).

On January 5, 1999, claimant filed for unemployment compensation. (Ex. 13C).

On May 19, 1999, Dr. Karty signed a letter from the employer's counsel regarding claimant's curative treatment from the onset of her claim. (Ex. 51).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant's occupational disease claim for an adjustment disorder was compensable. The ALJ concluded that claimant's performance appraisal (PA) and work improvement plan (WIP) were unreasonable corrective or job performance evaluations by the employer, and that the technical director's personality and management style and the turnover of claimant's other supervisors were not generally inherent in every working situation. On review, the employer's arguments can be summarized as follows: whether claimant has a mental disorder; and whether claimant proved by clear and convincing evidence that her alleged mental disorder arose out of and in the course of employment.

Claimant has the burden of proof. ORS 656.266. Claimant's mental disorder is not compensable unless she establishes all of the following: (a) that the employment conditions producing the mental disorder existed in a real and objective sense; (b) that the employment conditions producing the mental disorder are those other than conditions generally inherent in every work situation or reasonable disciplinary, corrective or job performance evaluation actions by the employer, or cessation of employment or employment decisions attendant upon ordinary business or financial cycles; (c) there is a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community; and (d) there is clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3).

We begin by addressing whether claimant sustained a diagnosable mental disorder. Claimant filed a claim for "job related stress." Claimant described the basis of her claim as follows:

> "Pneumocystitis tissue and touch preps were prepared per SOP by another technologist and both of us were reprimanded. This incident is cited against me and appears on my 12/97 performance appraisal." (Ex. 21).

Four doctors treated or examined claimant: Dr. Beam, M.D.; Dr. Karty, osteopath; Dr. Lange, clinical psychologist; and Dr. Klecan, psychiatrist.

Dr. Beam diagnosed claimant's condition as "psychological stress and insomnia" related to particular occurrences at work. (Ex. 16). Dr. Karty diagnosed claimant's condition as "Acute Reaction to Stress" and "Psychological Stress" and referred claimant to Dr. Lange, psychologist, for a psychological evaluation. Dr. Lange stated that, given claimant's presentation and history, diagnoses of DSM-IV categories "adjustment disorder with depression and anxiety" and "psychophysiological stress reactions" were suggested. (Exs. 23; 43-13, -16). Dr. Lange reported that claimant presented with symptoms of depression and anxiety because of conflicts with the laboratory director. Based on the history provided by claimant, Dr. Lange opined that the major contributing cause for her condition was her work environment. (Ex. 23).

Initially, Dr. Klecan agreed with the diagnosis of "adjustment disorder." Dr. Klecan explained that "adjustment disorder" means a reaction to an external stress that would likely cause distress to anyone. He also explained that his diagnosis was based on the credible report of symptoms and on the validation of claimant's complaints found in the written records, including the non-medical records. In his report, Dr. Klecan further noted that claimant's symptoms and medical diagnosis were complicated by the overriding impression of grievance, which she had extensively documented.

Dr. Klecan explained that grievances and medical/psychiatric diagnostics are generally separate issues, but in this case grievance and symptoms were intermingled and distinctions between the two were not so readily made. Dr. Klecan indicated that his view of claimant's case as more than a grievance matter was influenced by his reading of claimant's non-medical materials. Dr. Klecan opined that claimant's ability to work as a medical technologist was complete and unimpaired; however, he agreed with claimant's treating doctor's restrictions from working under the supervision of Dr. Maroney. Dr. Klecan stated that he based his conclusion less on claimant's statements or mental status than on the non-medical records, specifically the verbal warning dated November 22, 1997 and the December 1997 performance appraisal. (Ex. 33).

Subsequently, however, Dr. Klecan changed his diagnosis after meeting with the employer's attorney and being presented with additional evidence regarding claimant's work performance and disciplinary actions. Dr. Klecan observed that the disciplinary actions about which claimant complained were not different from those of other workers and were consistent with the employer's attempts to upgrade and improve the laboratory's work product, and, because Dr. Maroney was charged with implementing the improvements and upgrades, it was not surprising that she would be the focus of blame by resistant or unhappy workers.

Dr. Klecan also observed that the operations at the employer were being consolidated, leading to work force reductions and the necessity to reassign workers to shifts and duties they had not previously been hired for, and that these matters had probably been common knowledge to all the workers at the laboratory for some time.

Based on this new information, Dr. Klecan stated that he realized that he had been "pulled into a non-medical dispute," namely a dispute over the facts of claimant's disciplinary actions and whether those actions were fair. Dr. Klecan admitted that he had been persuaded by claimant's blending of grievance complaints with her assertions of psychological symptoms and complaints. After reviewing his original report, Dr. Klecan concluded that his original conclusions were erroneous from a psychiatric perspective, and changed his opinion regarding claimant's psychiatric condition.

Dr. Klecan then provided the following conclusions: That claimant had suffered upsetting emotions which were normally accompanied by physical responses, such as sleep disturbance, upset stomach or tears, and that these emotions were normal, and did not rise to a "mental disorder."

Dr. Klecan stated that the diagnosis of "adjustment disorder" implied that the subject patient was reacting in some abnormal, pathological way. Dr. Klecan pointed out that the DSM-IV has a recognized diagnostic code for those circumstances where there are distressing emotions and stressful conflict between a worker and employer or supervisor, namely "occupational problem" with a diagnostic code V62.2. Dr. Klecan explained that the V-code is used when the problem is brought to the attention of doctors and the patient seeks help, but no mental disorder is actually present.

In support of his changed view, Dr. Klecan reviewed his original report and noted the emphasis claimant placed on her grievances and how little she said about symptoms. Dr. Klecan found claimant's symptoms to be within the range of normal and understandable emotions. As part of his review, Dr. Klecan reevaluated claimant's presentation to him. He stated that claimant's chief complaint was not about her symptoms as much as about the forced change in her job assignment.

Dr. Klecan observed that claimant had repeatedly and convincingly emphasized that she had been hired to work part time, nights, and mostly on gram stains, and now she was being required to work full time, days, and at laboratory work quite beyond gram stains. Dr. Klecan opined that this was a central issue for claimant, but concluded that it was not plausible that such a grievance could lead to a mental disorder.

On this medical record, we do not find sufficient evidence to establish the presence of a "mental disorder." Dr. Beam diagnosed claimant's condition as "stress." However, "stress," in and of itself, does not qualify as a "mental disorder" because it is not recognized as such in the psychological community. *E.g., Ronald V. Dickson*, 42 Van Natta 1102, 1108 (1990), *aff'd Dickson v. Carolina Casualty*, 108 Or App 499 (1991).

Dr. Karty stated that, when he diagnosed "acute reaction to stress," he thought it was similar to psychological stress. (Ex. 42-43). Dr. Karty, who is an osteopath board certified in general practice and had no special training in psychology or psychiatry, admitted that he was unfamiliar with DSM-IV diagnoses. (Ex. 42-7, -14, -15, -42, -43). Because Dr. Karty is not a specialist, we give his opinion little weight when compared to the opinions expressed by physicians who specialize in psychology or psychiatry. *See Lynda J. Zeller*, 47 Van Natta 1581 (1995) (deferring to psychiatrist's specialized expertise).

We next turn to the expert opinions of Dr. Lange and Dr. Klecan. As noted above, Dr. Lange diagnosed claimant's condition as "adjustment disorder." He also stated that DSM-IV code V62.2 pertaining to occupational problems was assumed under his diagnosis. (Ex. 43-16, -17). However, Dr. Lange did not discuss the distinction between the two diagnoses, nor did he identify claimant's symptoms as being of any degree of severity. (Ex. 23).

In contrast, Dr. Klecan's changed opinion is unrebutted. Moreover, it is supported by the medical record. Claimant's reports to the treating and examining physicians primarily focused on her problems at work rather than on her psychological symptoms. Although claimant was prescribed lorezapam, she stopped taking it after taking only a few tablets. In addition, no physician prescribed psychological or psychiatric treatment. Instead, as noted by Dr. Karty, EAP counseling was sufficient.

On this record, we conclude that Dr. Klecan's changed opinion is the most persuasive. Dr. Klecan explained the reasons for his changed opinion. Moreover, that opinion is based on a complete and accurate history and is more well-reasoned than that of Dr. Lange. *See Somers v. SAIF*, 77 Or App (1986); *Miller v. Granite Construction Co.*, 28 Or App 473 (1977); *Abbott v. SAIF*, 45 Or App 657 (1980). Accordingly, we conclude that claimant has failed to prove that she has a mental disorder generally recognized in both the medical and psychological communities.[1]

Consequently, because claimant has failed to prove this element of her claim, she has also failed to prove, by clear and convincing evidence, that she has a mental disorder that arose out of and in the course of employment. ORS 656.802(3).

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[1] Moreover, the evidence indicates that claimant's PA and WIP were not unreasonable corrective or job performance evaluations by the employer. Therefore, even if claimant established a diagnosis of a mental or emotional disorder generally recognized in the medical or psychological community, her PA and WIP could not be considered in evaluating whether employment conditions were the major contributing cause of claimant's mental disorder. *Liberty Northwest Ins. Corp. v. Shotthafer*, 169 Or App 556 (2000).

ORDER

The ALJ's order dated March 31, 2000, as supplemented April 22, 2000, is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
ROBERT E. ANDERSON, Claimant
Own Motion No. 97-0438M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Willner, Wren, et al, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's April 14, 2000 Notice of Closure, which closed his claim with an award of temporary disability compensation from February 14, 1998 through April 4, 2000. The insurer declared claimant medically stationary as of March 8, 2000. Claimant requests a review of the dates for which temporary disability compensation was awarded in the Notice of Closure.

By Own Motion Order dated October 28, 1998, we authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant was hospitalized for the proposed surgery. ORS 656.278(1)(a).[1]

A claim may not be closed unless the claimants 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). 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 does not contend that his medically stationary date is incorrect or that he was not medically stationary when the insurer closed his claim. In any event, the record would not support such a contention.[2] Rather, claimant contends that: (1) temporary disability awarded by the insurer's Notice of Closure is incorrect; and (2) he is entitled to temporary disability compensation until April 11, 2000, the date of his last appointment with Dr. Hall.

Here, the evidence in the record supports the conclusion that claimant was medically stationary at the time of closure. Inasmuch as temporary disability benefits were paid through March 8, 2000, the date he was declared medically stationary, we conclude that claimant is not entitled to additional temporary disability and that it was appropriately terminated.[3] Therefore, we conclude that the employer's closure was proper.

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[1] On December 29, 1999, claimant requested enforcement of our October 28, 1998 order, contending that the insurer had unilaterally terminated his temporary disability benefits on August 17, 1999. On February 1, 2000, we found that the insurer had unreasonably terminated claimant's temporary disability benefits and directed the insurer to recommence temporary disability compensation beginning August 17, 1999 when it terminated compensation until it could lawfully terminate such benefits.

[2] In this regard, Dr. Hall, claimant's attending physician, provided the only medical evidence regarding claimant's medical stationary status. On March 8, 2000, Dr. Hall noted that "things are stable," and that he would follow-up with claimant periodically. On April 24, 2000, in response to a March 29, 2000 inquiry from the insurer, Dr. Hall he agreed that claimant was medically stationary at the time of the last examination, *i.e.* March 8, 2000. Dr. Hall further opined that there was no medical treatment that would likely to "change the course of [claimant's] situation." Dr. Hall's opinion is unrebutted. Furthermore, there is no evidence that claimant was not medically stationary at the time his claim was closed on April 14, 2000.

[3] Claimant argues that if his medically stationary date of March 8, 2000 is correct and he was paid time loss at least until March 21, 2000, then a "large overpayment" would exist. He contends therefore, that the closure is procedurally flawed and should be set aside. However, based on the record before us, there is no evidence demonstrating that the insurer has asserted or plans to assert an overpayment. Also, as noted above, we have determined that the closure was proper inasmuch as claimant was medically stationary when his claim was closed and temporary disability benefits were paid until they could be lawfully terminated.

Accordingly, we affirm the employer's March 29, 1999 Notice of Closure in its entirety.[4]

IT IS SO ORDERED.

[4] It appears from claimant's contentions and assertions contained in his request for review of the insurers closure, that he is unclear as to his rights and benefits under the Workers' Compensation laws. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot extend legal advice to either party. However, since claimant is unrepresented, he may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters. He may call free of charge at 1-800-927-1271,or write to:

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

In the Matter of the Compensation of
RITA K. COLLMAN, Claimant
WCB Case No. 99-03738
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Meyers, Radler, et al, Defense Attorneys

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the insurer's denial of her occupational disease claim for her bilateral carpal tunnel syndrome. In her appellant's brief, claimant contends that the ALJ erred in declining to continue the hearing in order for claimant to obtain additional medical evidence. With her brief, claimant submits a medical report not admitted at hearing. We treat the submission as a motion for remand. *See Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are continuance, remand and compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Continuance

On review, claimant argues that the ALJ erred in denying her motion to continue the hearing in order to obtain an additional medical report. We review the ALJ's ruling for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995).

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. Furthermore, OAR 438-006-0091 provides that continuances are disfavored. The rule permits a continuance, however, for any reason that would justify postponement of a scheduled hearing under OAR 438-006-0081. OAR 438-006-0091(4).[1]

[1] The postponement rule provides that hearings shall not be postponed unless extraordinary circumstances are shown. Extraordinary circumstances, however, do not include incomplete case preparation unless completion of the record could not be accomplished with due diligence. OAR 438-006-0081(4). Here, we agree with the insurer that the reason a continuance was requested in this matter is essentially incomplete case preparation. For the reasons expressed by the ALJ and in this order, we conclude that the record could have been completed with due diligence. Because we are unable to find that claimant acted with due diligence in this case, no extraordinary circumstances have been shown sufficient to justify a continuance.

Here, claimant requested a continuance in order to obtain a medical report from Dr. Young. Claimant began treating with Dr. Young shortly before the May 22, 2000 hearing. Claimant argues that she acted with due diligence because she requested a report two weeks prior to the hearing, but the report was not ready at the time of hearing.

Based upon the record, we do not find that the ALJ abused his discretion by denying the continuance requested by claimant. A hearing was first set for August 11, 1999, and was postponed three times prior to the May 22, 2000 hearing before the ALJ. Two of the postponements were at claimant's request.[2] Claimant obtained her present counsel on November 1999. However, the record does not show that any medical reports were generated by claimant since she was last seen by her former treating doctor, Dr. Amstutz, on May 4, 1999, which is almost a year before the hearing conducted by the ALJ. Moreover, there is no evidence that any attempts were made by claimant or her counsel to obtain such medical reports until shortly before the May 2000 hearing.

Accordingly, we disagree with claimant's contention that the ALJ abused his discretion in denying a continuance.[3] We therefore affirm the ALJ's ruling on that issue.

Remand

With her appellant's brief, claimant has submitted a report obtained after the hearing record closed. We treat claimant's submission as a request for remand. *Judy A. Britton*, 37 Van Natta at 1262.

We may remand a case to the ALJ if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); *Bailey v. SAIF*, 296 Or 41, 45 n. 3 (1983). To merit remand for the consideration of additional evidence, it must be clearly shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986).

Consistent with our holding above, we conclude that claimant has failed to show that the evidence she seeks to admit was not obtainable with due diligence at the time of hearing. Therefore, claimant's request for remand is denied.

Compensability

We adopt the ALJ's "Opinion," with the following supplementation.

The sole opinion in the record regarding causation is from Dr. Amstutz, claimant's former attending physician. Dr. Amstutz performed claimant's left carpal tunnel release on February 25, 1999. On March 4, 1999, Dr. Amstutz reported that he believed that claimant's carpal tunnel syndrome was primarily idiopathic and that her bus driving activity of three hours per day, five days per week was not the major cause of her condition. (Ex. 6-1). On May 4, 1999, Dr. Amstutz reported in a chartnote that he did not believe that work caused claimant's condition because he did not think the amount of time she spent performing her bus driving activities was sufficient to constitute the major cause of her condition. (Ex. 8).

Because the sole expert opinion that discusses causation of claimant's condition does not attribute the major cause of her condition to her work activity, we agree with the ALJ that claimant has failed to meet her burden of proof. ORS 656.802.

ORDER

The ALJ's order dated June 21, 2000 is affirmed.

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[2] The third postponement was due to a conflict in the ALJ's schedule.

[3] Claimant argues that the ALJ did not make a finding of material prejudice (on the part of the insurer) under OAR 438-007-0018(4), and therefore, the hearing should have been continued to allow additional medical reports. That rule, however, pertains to documentary evidence not properly disclosed, rather than continuances or postponements. Nevertheless, the ALJ did find material prejudice to the insurer based upon claimant's delay in case preparation. (Tr. 10).

In the Matter of the Compensation of
CAT LE, Claimant
WCB Case No. 99-01141
ORDER ON REVIEW
Kirkpatrick & Zeitz, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

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 chronic headache 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 July 1998, claimant sought medical treatment for chronic headaches. In August 1998, claimant was referred to Dr. Cassini, neurologist. Finding Dr. Cassini's opinion most persuasive, the ALJ concluded that claimant carried his burden of proving that the major contributing cause of his chronic headache condition was exposure to workplace chemicals.

On review, the insurer contends that Dr. Cassini's opinion is not sufficiently persuasive to prove compensability.[1] In particular, the insurer argues that the record contains no evidence that claimant was exposed to a *toxic* level of chemicals. We agree with the insurer.

Along with Dr. Cassini's opinion, the record contains a report from examining toxicologist, Dr. Burton. Dr. Burton found that the "constellation of symptoms described by [claimant], in addition to the industrial hygiene date, indicate that he is not experiencing significant exposures to the substances used at work." (Ex. 26-9). Instead, Dr. Burton thought that claimant's symptoms "suggest depression associated with chronic recurrent tension/muscle contraction headaches." (*Id.*)

Dr. Burton further explained that the solvents used at claimants work "will cause upper airway and ocular irritant symptoms" and, at higher concentrations, "symptoms similar to intoxication with alcohol." (*Id.* at 10). Dr. Burton found that claimant's symptoms were different and thus not consistent with exposure to chemicals used at his work. (*Id.*) Dr. Burton also relied on the lack of abnormal findings on physical examination, MRI brain scan, and an EEG as supporting his conclusion. (*Id.*)

Dr. Burton additionally attended the hearing and, after being present during testimony from claimant, claimant's former coworker, and an industrial hygienist, he adhered to the opinion provided in his report. In particular, Dr. Burton noted that an industrial hygiene study, conducted after his examination and finding that concentration levels of xylene, naphtha, and vinyl toluene were "very low," (Ex. 31), supported his conclusion that exposure to chemicals at work did not cause claimant's chronic headache condition.

Dr. Cassini found that claimant's chronic headaches were "secondary to work related chemical exposure." (Ex. 30-2). In particular, Dr. Cassini pointed to a "recent study" with people "occupationally exposed to solvent mixtures including xylene, toluylene, and other various hydrocarbons." (*Id.*) According to Dr. Cassini, this study showed that a common complaint from the participants included headache. (*Id.*)

Dr. Cassini added that a "13 year exposure with strict temporal relationship between onset of headache and exposure and slow progression of his symptoms are consistent with an exposure induced headache syndrome." (*Id.* at 3). Thus, Dr. Cassini found that claimant's condition was "the result of a gradual process of repeated injury." (*Id.*)

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[1] Following receipt of the parties' briefs, the insurer asked that we consider *SAIF v. Lewis*, 170 Or App 201 (2000), which issued after submission of the briefs.

Dr. Cassini submitted another report after reviewing Dr. Burton's testimony at hearing.[2] Dr. Cassini reiterated that claimant's cumulative exposure to chemicals resulted in the chronic headache condition. (Ex. 32-1). According to Dr. Cassini, his opinion was based "on clinical experience and my knowledge of headache." (*Id.*) Referring to the industrial hygienist's testing, Dr. Cassini found that it was not "relevant" because it reflected exposure "under very specific conditions at only one point in time." (*Id.* at 3).

In proving compensability, claimant must have some affirmative evidence that the condition is caused by the work exposure. ORS 656.266; *Bronco Cleaners v. Velazquez*, 141 Or App 295, 298 (1996). Here, as asserted by the insurer, what is missing is affirmative evidence that claimant was exposed to a sufficient level of chemicals that it resulted in his chronic headache condition. Rather, the only evidence concerning this issue is the industrial hygienist's study recording "very low" levels of exposure and concluding that there was no "overexposure" of workers. (Ex. 31-1).

Although claimant criticizes this study as having been undertaken during better conditions and, thus, does not reflect his actual working conditions, he does not provide any other proof concerning the level of chemicals to which he was exposed. Furthermore, Dr. Cassini provides little reasoning supporting his opinion that cumulative chemical exposure caused claimant's chronic headache condition. In particular, Dr. Cassini points to a study which he asserts supports his conclusion. Dr. Cassini does not explain, however, how the work conditions in the study are the same as those in claimant's employment; that is, Dr. Cassini does not state how the occupational exposure experienced by the workers in the study match those experienced by claimant since he does not show that he is knowledgeable concerning claimant's particular level of exposure.

Finally, Dr. Cassini did not persuasively rebut Dr. Burton's opinion that claimant's symptoms were not consistent with exposure to those chemicals present in his workplace. Along with a temporal relationship, Dr. Cassini relied on his clinical experience and "knowledge of headache" in asserting that chemical exposure caused claimants condition. We find such reasoning inadequate in that it does not specifically explain how claimant's chemical exposure resulted in his headache condition.

Thus, based on the absence of affirmative proof of overexposure, along with the evidence that chemical measurements were "very low" and the lack of reasoning in Dr. Cassini's opinion, we conclude that claimant failed to carry his burden of proof. Consequently, we conclude that he failed to prove compensability. *See* ORS 656.802(2).

ORDER

The ALJ's order dated April 4, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award also is reversed.

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[2] We note that the insurer objects to the admission of this report because it was submitted post-hearing and "there was no showing of surprise or due diligence by claimant." We find that we need not address this issue because, whether or not we consider the report, we find that it does not change our conclusion that claimant did not prove compensability.

In the Matter of the Compensation of
JUAN G. MACIAS, Claimant
WCB Case No. 99-08178
ORDER ON REVIEW
Preston, Bunnell & Stone, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Herman's order that upheld the self-insured employer's denial of a L4-5 herniated disc condition with left radiculopathy. On review, the issue is compensability.[1]

We adopt and affirm the ALJ's order with the following supplementation to address claimant's contention that the ALJ incorrectly found that the record did not support the compensability of the L4-5 disc condition as a "new medical condition" related to the accepted 1992 injury claim.

The ALJ concluded that because claimant's 1992 injury combined with a 1990 preexisting compensable and a preexisting congenital condition, the major contributing cause standard applied to this "new medical condition" claim. Neither party objects to the ALJ's conclusion. Consequently, we use the major contributing cause standard on review.

To satisfy the "major contributing cause" standard, claimant must establish that his work injury of March 1992 contributed more to the disability or need for treatment of the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disability or need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). The fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or its need for treatment. *Dietz*, 130 Or App at 401; *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997); *Elaine M. Baxter*, 51 Van Natta 1898 (1999).

Because of the possible alternative causes for claimant's current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

Claimant relies on the opinions of Dr. Fulser, the attending physician, and Dr. Gehling, a consulting neurosurgeon. However, we do not find those opinions to be persuasive. Although both doctors opined that claimant's L4-5 disc condition began with and relate to the 1992 work injury, neither doctor offers any persuasive evaluation of the relative contributions of the various causes of claimant's disability or need for treatment for the disc condition. (Exs. 26; 55-2; 58; 63A). In other words, neither doctor evaluates the contributions of the 1990 injury, the preexisting congenital condition, and the 1997 injury which together with the 1992 injury produce claimant's current condition. Nor did either doctor offer an opinion as to how much the 1992 work injury contributed to the overall disc problem. (Ex. 55-2; 63A-14).

Claimant has the burden of establishing the compensability of his L4-5 herniated disc condition. ORS 656.266. Based upon this record, we conclude that claimant has failed to establish that his work 1992 work injury was the major contributing cause of his current disability or need for treatment of the L4-5 disc condition. Accordingly, on this record, we agree with the ALJ that claimant has failed to establish the compensability of his L4-5 disc condition.

ORDER

The ALJ's order dated July 26, 2000 is affirmed.

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[1] The employer argues that the doctrines of claim preclusion and issue preclusion bar claimant from litigating the compensability of the L4-5 disc as a "new medical condition." Because we find on the merits that claimant has failed to establish the compensability the L4-5 disc condition, we need not address the preclusion issues.

In the Matter of the Compensation of
JAMES S. MEFFORD, SR., Claimant
WCB Case No. 00-02268
ORDER ON REVIEW
Kryger, et al, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler'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 injured his low back on January 27, 1999. SAIF initially denied the claim, but later accepted a herniated L5-6 disc on July 2, 1999. On March 20, 2000, SAIF modified its acceptance to include a "combined condition," consisting of the accepted disc herniation and preexisting spinal stenosis with degenerative disc disease. That same day, SAIF denied the compensability of the "combined condition" as of March 7, 2000, the date of a medical report by an examining physician, Dr. Anderson. Dr. Anderson opined that, as of March 7, 2000, the compensable injury was no longer the major contributing cause of the disability or need for treatment of the current combined condition. (Ex. 34-4). Claimant requested a hearing from the denial.

The ALJ set aside SAIF's denial, finding that claimant sustained his burden of proving the compensability of his current combined low back condition. In making this finding, the ALJ relied on the medical opinion of Dr. Lewis, an attending physician.

On review, SAIF disagrees with the ALJ's reliance on Dr. Lewis' opinion in setting aside its denial. SAIF argues that Dr. Lewis' opinion is not persuasive because it does not address claimant's low back condition as of March 7, 2000 and because it is inconsistent. For the following reasons, we agree.

Under ORS 656.005(7)(a)(B), claimant must prove that his compensable injury is the major contributing cause of the disability or need for treatment of the combined condition. *Chad H. Stonier*, 52 Van Natta 380 (2000).

Because of the presence of a preexisting degenerative condition, the medical causation issue is complex, requiring for its resolution expert medical opinion. *Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). Absent persuasive reasons, we generally give greater weight to the opinion of the attending physician. *Weiland v. SAIF*, 64 Or App 810, 814 (1983). In this case, we find persuasive reasons not to give greater weight to Dr. Lewis opinion.

Dr. Lewis initially agreed with Dr. Anderson's March 7, 2000 report, in which the latter physician concluded that the work injury was no longer the major contributing cause of claimant's disability or need for treatment. (Ex. 36). Yet, in a subsequent response to an inquiry from claimants counsel, Dr. Lewis concluded that the compensable injury was the major contributing cause of claimant's need for treatment. (Ex. 37). Dr. Lewis never explained the inconsistency or, if he had changed his opinion, the reasons for that change. For this reason, we find Dr. Lewis's most recent opinion unpersuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987); *George H. Gale*, 52 Van Natta 339, 341 (2000) (physician's opinion entitled to little weight because he did not explain his change of opinion from previous concurrence with an examining doctor's report).

In addition, as SAIF correctly observes, Dr. Lewis last treated claimant on November 2, 1999. (Ex. 33). Dr. Lewis, therefore, was not in an advantageous position to assess whether, as of March 7, 2000, the compensable injury was the major contributing cause of any need for treatment. Moreover, after reviewing Dr. Lewis' report (Ex. 37), we agree with SAIF that the report primarily addresses the

compensability of claimant's initial injury rather than the compensability of the combined condition as of March 7, 2000. *See Sherena M. Meagher*, 52 Van Natta 1479, 1480 (2000) (medical opinion that focused on compensability of original injury rather than current condition at issue found not persuasive).

For all of these reasons, we do not find Dr. Lewis' opinion sufficient to satisfy claimant's burden of proof. Instead, we conclude that Dr. Anderson's opinion is the most persuasive on this record. He directly addressed the compensability of claimants combined condition as of March 7, 2000 and concluded that the preexisting condition was the major contributing of any need for treatment of the combined condition. (Ex. 34-4). Accordingly, having reviewed this record *de novo*, we conclude that claimant failed to satisfy his burden of proof under ORS 656.005(7)(a)(B). Thus, we reverse.

ORDER

The ALJ's order dated July 11, 2000 is reversed. SAIF's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

November 2, 2000 Cite as 52 Van Natta 1984 (2000)

In the Matter of the Compensation of
JONNA M. MOORE, Claimant
WCB Case No. 99-06285
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Hoguet's order that upheld the insurer's denial of claimant's "new medical condition" claim for an L4-5 disc bulge. In her brief, claimant asks us to take administrative notice of the insurer's post-hearing acceptance of her claim for a lumbosacral strain. Alternatively, claimant requests remand for admission of proposed evidence regarding that acceptance. On review, the issues are administrative notice, remand, and compensability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Administrative Notice/Remand

Claimant asks us to take administrative notice of the insurer's "post-hearing" acceptance of her claim for a lumbosacral strain. Alternatively, claimant requests that we admit the proposed evidence regarding the "post-hearing" acceptance on review or remand to the ALJ for that purpose.[1] We decline claimant's requests based on the following reasoning.

Claimant contends that the proposed evidence would affect the outcome of the case because the insurer's "post-hearing" acceptance of claimant's lumbar strain seriously undermines the opinions of Drs. Yarusso and Jones. In this regard, claimant argues that these doctors based their conclusions that claimant's low back problems are not related to her accepted thoracic strain on a mistaken belief that claimant did not injure her low back when she strained her mid back. In claimant's view, the insurer's "post-hearing" acceptance of claimant's lumbosacral strain establishes that she did, in fact, injure her low back and the doctors' opinions are unpersuasive therefore, "as a matter of law."

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[1] Claimant describes the proposed evidence as the insurer's "post-hearing" updated notice of claim acceptance at claim closure and its "form 1503." Although claimant refers to these documents as being attached to her brief, we do not find them attached or otherwise present.

We agree with claimant that the opinions of Drs. Yarusso and Jones are not particularly persuasive (but for different reasons[2]), and we do not rely on them. However, based on the remaining medical opinions, we reach the same result regarding the compensability of the claim, without considering the opinions of Drs. Yarusso and Jones (see section entitled "Compensability," below), even assuming that the insurer accepted claimant's lumbosacral strain "post-hearing." Moreover, the proposed "post-hearing" evidence would not affect the outcome of this dispute. *See Compton v. Weyerhaeser Co.*, 301 Or 641, 646. Consequently, the case has not been improperly, incompletely, or otherwise insufficiently developed (without the proposed evidence) and it does not merit remand. *See* ORS 656.295(5).

Compensability

Drs. Huyssoon and Goering provide the medical evidence supporting claimant's claim for an L4-5 disc condition.

Dr. Huyssoon's opinion is not persuasive because it is based solely on a temporal relationship. (Ex. 42).

Dr. Goering opined that claimant's September 24, 1998 work injury, her subsequent work activities, and her preexisting leg length discrepancy caused her low back problems generally since the work injury, and her L4-5 disc bulge, in particular. (Exs. 46-14-20, -39, -62). The doctor described claimant's leg length discrepancy as a preexisting condition that interfered with her recovery from the work injury, contributed to her symptoms, and made her more vulnerable to re-injury. (Exs. 39, 43, 44, 46-26-31, -67-69, 47-4).

Based on Dr. Goering's opinion, we find that claimant probably had a preexisting condition, leg length discrepancy, that combined with her work injury and subsequent work activities to cause her L4-5 disc condition. *See* ORS 656.005(7)(a)(B). Therefore, claimant is subject to the "major contributing cause" standard of proof and she must establish that work related causes contributed more to her L4-5 disc condition that did her preexisting leg length discrepancy. Although Dr. Goering appears to reach that conclusion (*see* Ex. 47-1, 48-2), he does not explain why work related causes contribute more than the preexisting condition that he identified. Under these circumstances, Dr. Goering's opinion is insufficient to carry claimant's burden of proof.[3] ORS 656.266; *see Elizabeth M. Buitron*, 51 Van Natta 1768 (1999) (although doctor weighed off work causes, he did not explain why work related causes contributed more to the claimant's condition) (*citing Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995)). Accordingly, absent persuasive expert evidence supporting the claim, we uphold the insurer's denial.

ORDER

The ALJ's order dated April 20, 2000 is affirmed.

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[2] We find Dr. Yarusso's causation opinion unpersuasive because it changed materially, without explanation. (*See* Exs. 32-1, 50). We find Dr. Jones' opinions unpersuasive for the following reasons. To the extent that the doctor believes that claimant's L4-5 disc results from "age-related" degeneration, we find his opinion persuasively rebutted by Dr. Goering, who noted that claimant is only 31 years old, not old enough "to have this extent of the problem." (Ex. 47-1; *see* Ex. 45-10). And, to the extent that Dr. Jones believes that claimant's low back problems are of "unknown etiology," based on claimant's "functional" findings, we find his conclusion persuasively countered by Dr. Goering's examination findings, which he described as "substantiated." (*See* Exs. 45-8, -10-12; 46-73; 47-4, 48-1).

[3] We do not find Drs. Yarusso's and Jones' opinions persuasive, as explained above. (*See* n. 2). Yet, even discounting those examining physicians' opinions, the claim fails because the opinions of Drs. Huyssoon and Goering are insufficient to establish that claimant's work injury was the major contributing cause of her L4-5 disc condition. ORS 656.266.

In the Matter of the Compensation of
DOUGLAS L. SHUMWAY, Claimant
Own Motion No. 99-0310M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Mitchell & Associates, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Claimant requests review of the SAIF Corporation's August 4, 2000 "Notice of Closure Board's Own Motion Claim" that closed his claim with an award of temporary compensation from August 18, 1999 through July 9, 2000. SAIF declared claimant medically stationary as of August 2, 2000. Claimant opposes SAIF's closure because there are newly accepted conditions that [SAIF] has failed to close. In addition, claimant noted that he submitted a request for hearing before the Hearings Division, requesting the same relief before that forum.[1] We affirm SAIF's August 4, 2000 "Notice of Closure Board's Own Motion Claim."

FINDINGS OF FACT

On June 30, 1971, claimant compensably injured his right ankle. SAIF accepted the claim for a disabling right ankle injury and processed it to closure on August 30, 1972. Claimant's aggravation rights expired on August 30, 1977.

On July 15, 1999, Dr. Schader, claimant's attending physician, requested authorization to proceed with a "redo of the arthrodesis of [claimant's] right ankle." On August 16, 1999, SAIF submitted a "Carrier's Own Motion Recommendation" form recommending that the claim be reopened under the Board's Own Motion jurisdiction.

On August 25, 1999, the Board issued an Own Motion Order that authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant was hospitalized for surgery. When claimant's condition became medically stationary, SAIF was ordered to close the claim under the Board's own motion rules.

On June 22, 2000, Dr. Schader opined that claimant was "progressing well with his right ankle." He noted that claimant still complained of pain and discomforted and opined that an independent medical evaluation "would be beneficial" in claimant's case.

An insurer-arranged medical record review was conducted on July 20, 2000. The reviewing physician opined that based on claimant's medical records and the diagnostic test results, claimant's right ankle had reached medically stationary status. Dr. Schader concurred with the reviewing physician's medically stationary opinion on August 2, 2000.

On August 4, 2000, SAIF closed claimant's claim by Notice of Closure that awarded temporary disability benefits from August 18, 1999 through July 9, 2000, and declared claimant medically stationary as of August 2, 2000. Claimant requested Board review of that Notice of Closure. He also requested a hearing with the Hearings Division regarding claim closure.

CONCLUSIONS OF LAW AND OPINION

Claimant requests that the Board, in its own motion authority, review SAIF's August 4, 2000 closure challenging SAIF's failure to "close" newly accepted conditions. We interpret claimants request as a request to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268. In addition, claimant noted that he had requested a hearing before the Hearings Division, requesting the same relief before that forum. WCB Case No. 00-06447. Claimant makes no argument regarding the merits of the closure. Based on the following reasoning, we find that we have subject matter jurisdiction in our own motion capacity to review the August 4, 2000 closure.[2]

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[1] Specifically, claimant raises the following issues in his request for hearing: (1) "failure to closre [sic] claim"; and (2) attorney fees. Claimant's hearing request has been assigned WCB Case No. 00-06447. That hearing is scheduled before Administrative Law Judge (ALJ) Lipton on November 20, 2000.

[2] In addition, although we have no authority in our own motion capacity to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268, we note that claimant has made a request for that relief before another forum that has such authority *i.e.*, the Hearings Division.

In *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000), we issued orders in our own motion capacity and our "regular" capacity involving issues similar to those presented in the current case. In *Ledin*, the claimant had a new condition claim (a right knee meniscus tear condition) that had been validly reopened and subsequently closed pursuant to our own motion authority under ORS 656.278. There, the claimant disputed the closure, contending that his condition should be rated and processed under ORS 656.268 and not treated as an Own Motion claim. The claimant requested review of the Own Motion Notice of Closure both before the Hearings Division and before the Board in our Own Motion jurisdiction. We postponed action on the own motion matter pending resolution of the litigation before the Hearings Division.

The Administrative Law Judge (ALJ) held that, because our prior order authorizing the claim to be reopened in our Own Motion jurisdiction was not appealed, our determination of our Own Motion jurisdiction became final and was not subject to collateral attack before the Hearings Division. Therefore, the ALJ dismissed claimant's hearing request for lack of jurisdiction. Claimant requested Board review.

On review in our "regular" capacity, we agreed with the ALJ that the Hearings Division lacked jurisdiction to review the own motion closure of the claimant's claim because that was a matter within our Own Motion jurisdiction under ORS 656.278(1). Nevertheless, we held that, insofar as claimant's request pertained to the carrier's duty to process claimant's claim under ORS 656.262(7)(c), the ALJ was authorized to consider that matter. Therefore, we reinstated the claimant's hearing request.

In doing so, we explained that a condition found compensable after claim closure is entitled to reopening under ORS 656.262(7)(c) and processing under ORS 656.268, even if the aggravation rights have expired on the original claim. We noted that such a claim processing issue is a "matter concerning a claim" for which the claimant can request a hearing under ORS 656.283. Determining that the claimant's "new" condition was found compensable after claim closure, we held that the carrier was obligated to reopen the claim for processing of the condition in accordance with ORS 656.262(7)(c). In anticipation of the eventual "ORS 656.268" closure of the claim, we noted that the claimant would not be entitled to duplicate compensation for any time period coinciding with temporary disability benefits awarded pursuant to the carrier's Own Motion Notice of Closure.

Specifically addressing the carrier's Own Motion Notice of Closure, we also found that we had subject matter jurisdiction in our own motion capacity to review the closure. Because the claimant's aggravation rights had expired on his initial injury claim and his condition required surgery, we reasoned that we were authorized to reopen the claimant's claim pursuant to ORS 656.278(1)(a) and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. Thus, we found that we had subject matter jurisdiction to review the carrier's subsequent closure of that claim. *See Larry L. Ledin*, 52 Van Natta at 685; *Paul E. Smith*, 52 Van Natta 730 (2000).

The same reasoning applied to the current claim. There is no dispute that claimant's aggravation rights have expired on his initial injury claim. Furthermore, claimants condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the August 25, 1999 Own Motion Order[3] that authorized reopening claimant's claim pursuant to ORS 656.278(1) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review SAIF's subsequent closure of that claim.[4] Therefore, we proceed with that review.

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[3] We note that the August 29, 1999 Own Motion Order was not appealed and has become final by operation of law. *See* ORS 656.278(4). Had that order been appealed or not become final, our decision today may well have been different. However, resolution of cases based on those specific circumstances must await a future case.

[4] Although we have subject matter jurisdiction to determine entitlement to temporary disability benefits where an injured worker's aggravation rights have expired, we generally defer making such a determination if there is litigation before the Hearings Division that may result in the payment of benefits under another claim or under another statute such as ORS 656.262(7)(c). *See* OAR 438-012-0050(1)(a)-(c); *Craig Prince*, 52 Van Natta 108, 111 (2000).

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the August 4, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Here, claimant makes no argument that he was not medically stationary at the time of closure, nor does he argue that his medically stationary date was incorrect or his temporary disability compensation was incorrectly calculated. Instead, claimant's argument is solely procedurally based, *i.e.*, claimant essentially argues that there are newly accepted conditions that should have been processed under ORS 656.262(7)(c) and 656.268 rather than under the Board's own motion jurisdiction pursuant to ORS 656.278. However, as noted above, we have already concluded that we had subject matter jurisdiction to issue our August 29, 1999 Own Motion Order which authorized the reopening of claimant's claim pursuant to ORS 656.278 and its closure pursuant to our Own Motion rules. As such, we have subject matter jurisdiction to review SAIF's closure. Because claimant raises no substantive arguments, we affirm SAIF's August 4, 2000 Own Motion Notice of Closure in its entirety.

Accordingly, SAIF's August 4, 2000 Own Motion Notice of Closure is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
ERLA F. SQUIRE, Claimant
WCB Case No. 00-01932
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Gilroy Law Firm, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Crumme's order that set aside its 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 supplementation.

First, we agree with the ALJ's assessment of the medical opinion evidence and, in particular, his conclusion that claimant's treating physician, Dr. Karasek, provided the most persuasive opinion. On review, we address the employer's argument that Dr. Karasek's opinion is not sufficient to carry claimant's burden of proof because he indicated only that claimant's June 1999 injury precipitated her need for treatment.

Although Dr. Karasek stated that claimant's "need for treatment * * * was precipitated" by her June 1999 injury, he also indicated that the "majority of inflammatory change, and need for treatment, is probably related to the industrial injury" based on a history that claimant first had symptoms when she fell in June 1999, and those symptoms progressively worsened until she sought treatment in September 1999. (Ex. 36-2, 36-3). In particular, Dr. Karasek explained that claimant had "degenerative pathology in her discs" prior to June 1999 that was asymptomatic and an "inflammatory process" was "initiated by tearing or other traumatic injury to a degenerative disc at the time of the fall." (*Id.* at 1-2). Dr. Karasek added that "it is probable that the fall was responsible in a major sense for her need for treatment." (*Id.* at 2).

In proving compensability, claimant must prove that her compensable injury was the major contributing cause of her need for treatment or disability of the combined condition. *See* ORS 656.005(7)(a)(B). Showing that a work injury is the immediate or precipitating cause of a claimant's disability or need for treatment does not necessarily mean that the injury was the major contributing cause of the condition. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995). Instead, determination of the major contributing cause involves evaluating the relative contribution of different causes of claimant's need for treatment of the combined condition and deciding which is the primary cause. *Id.*

Although Dr. Karasek indicated that the need for treatment was "precipitated" by the June 1999 injury, based on his entire opinion, we find that he satisfied claimant's burden of proof. According to Dr. Karasek, although claimant has a preexisting condition, the compensable injury caused an "inflammatory process," which constitutes the "need for treatment." Thus, we conclude that claimant proved that her compensable injury was the major contributing cause of her need for treatment of the combined condition. *See* ORS 656.005(7)(a)(B).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $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 July 10, 2000 order is affirmed. For services on review, claimant's attorney is entitled to a fee of $1,200, to be paid by the self-insured employer.

November 3, 2000 Cite as 52 Van Natta 1989 (2000)

In the Matter of the Compensation of
FINIS O. ADAMS, Claimant
Own Motion No. 99-0118M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorneys
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable back condition. Claimant's aggravation rights expired on August 25, 1983. The insurer opposes authorization of temporary disability compensation on the grounds that claimant was not in the work force at the time of the current disability.

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

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

Claimant submits Dr. Pearson's April 14, 1999 medical report in support of his contention that he could not work due to the compensable condition and that it would have been futile for him to look for work because of his compensable condition. Dr. Pearson asserted that "[claimant] has been unable to work for the past 2-3 years due to recurrent back problems. He has required numerous surgical procedures for these over the past couple of years." Based on Dr. Pearson's statement, we conclude that claimant was unable to work at the time of his current worsening. *Bethel A. Lamping*, 50 Van Natta 883 (1998); *Barbara M. Johnson*, 50 Van Natta 882 (1998).

Further, in order to satisfy the third *Dawkins* criterion, claimant must also establish, along with the "futility" standard, that he was willing to work. Failing to demonstrate his willingness to work, then he is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Arthur R. Morris*, 42 Van Natta 2820 (1990); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

Claimant submitted an April 22, 1999 affidavit wherein he attests that "My last active workday was in May, 1997 and I have not worked since that time because my back condition made it futile for me to seek or obtain work. * * * It is my intention to return to work with my employer, * * *, immediately upon my recovery from my most recent surgery." Based on claimant's unrebutted affidavit, we are persuaded that claimant is willing to work but unable to do so because of his compensable condition. Therefore, on this record, we find that claimant has proved that he remained in the work force at the relevant time.

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

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
FINIS O. ADAMS, Claimant
Own Motion No. 97-0181M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Malagon, Moore, et al, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests reconsideration of our February 4, 1999 Own Motion Order Reviewing Carrier Closure, which affirmed the insurer's August 26, 1998 Notice of Closure in its entirety. On February 18, 1999, we abated our prior order to allow claimant sufficient time to respond to the insurer's motion. On reconsideration, we adhere to the conclusion reached in our February 4, 1999 order. We base this decision on the following reasoning.

In our February 4, 1999 order, we relied on Dr. Rosenbaum's August 4, 1998 insurer-arranged medical (IME) report in finding that claimant was medically stationary. As result of his report, the insurer declared claimant medically stationary as of August 4, 1998 and closed his claim on August 26, 1998. We concluded that Dr. Rosenbaum offered the most well-reasoned and fact-based opinion and set affirmed the Notice of Closure.

On reconsideration, claimant has submitted the following documents: (1) chart notes from Dr. Pearson dated from September 1998 through March 1999; (2) Dr. Karasek's November 1998 medical report as well as chart notes from December 1998 through January 1999; and (3) Dr. Pearson's June 1, 1999 rebuttal to Dr. Rosenbaum's February 9, 1999 follow-up report. In reply, the insurer submitted Dr. Rosenbaum's February 9, 1999 follow-up report and argues that none of the documentation submitted by claimant support his contention that he was not medically stationary when it closed his claim.

Claimant argued that we should defer to his treating physicians, Drs. Frank, Pearson and Karasek, regarding his medically stationary status. As noted in our February 4, 1999 order, 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). We further give most weight to opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Here the record contains the opinion of Drs. Frank and Pearson, claimant's longtime physicians, Dr. Karasek, a consulting physician, and Dr. Rosenbaum, the IME physician. We continue to find Dr. Rosenbaum's opinion more persuasive. Despite the additional reports from Drs. Frank, Pearson and Karasek, Dr. Rosenbaum continues to offer the same well-reasoned opinion as he did when the insurer closed claimant's claim.

Dr. Rosenbaum continues to provide objective, well-founded medical reasons as to why he believed claimant was medically stationary at the time of closure.

Dr. Karasek's November 1998 medical report as well as chart notes from December 1998 through January 1999 and Dr. Pearson's June 1, 1999 rebuttal to Dr. Rosenbaum's February 9, 1999 follow-up report are "post-closure" medical evidence. However, we may consider "post-closure" medical evidence regarding the question of whether a claimant was medically stationary at the time of claim closure, as long as that evidence relates to the claimant's condition at the time of closure, no subsequent changes in the claimant's condition. *Scheuning v. J.R. Simplot & Co.*, 84 Or App 622 (1987). In their reports, Drs. Karasek and Pearson address claimant's current complaints of pain and recommend further surgery in the form of screw removal. Claimant contended that those complaints of pain for which further surgery was recommended are the same complaints made during a January 1998 IME examination as well as in Dr. Rosenbaum's August 4, 1998 IME examination. Accordingly, claimant contends that since the complaints are the same as prior to his closure, it demonstrates that he was not medically stationary when his claim was closed because he needed additional surgery.

However, as noted by claimant, Dr. Rosenbaum took those complaints of pain into consideration when rendering his August 4, 1998 opinion declaring claimant medically stationary. As noted above, we have found Dr. Rosenbaum's opinion to be most persuasive in that it addresses claimant's condition at the time of closure. We do not find that Drs. Pearson's and Karasek's post-closure opinions address claimant's condition at closure, but rather address a subsequent worsening.[1]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our February 4, 1999 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] On April 6, 1999, the insurer submitted its own motion recommendation regarding claimant's current worsening. The insurer objected to reopening on the grounds that claimant was not in the work force at the time of the current disability. In an order issued concurrently with this order, we address the insurer's recommendation and contentions, and authorized the reopening of claimant's claim for the provision of temporary disability compensation beginning the date he was hospitalized for the proposed surgery.

November 3, 2000 Cite as 52 Van Natta 1991 (2000)

In the Matter of the Compensation of
STEVE R. BITZ, Claimant
WCB Case No. 00-00989
ORDER ON REVIEW
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mills' order that upheld the insurer's denial of his left knee condition. On review, the issue is compensability.[1]

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[1] We note that claimant is presently unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. Claimant may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

Workers' Compensation Ombudsman
350 Winter St NE, Room 160
Salem, OR 97301-3878

We adopt and affirm the order of the ALJ.[2]

ORDER

The ALJ's order dated July 26, 2000 is affirmed.

[2] Noting that it only recently received a copy of claimant's appellant's brief, the insurer seeks an extension of the briefing schedule. Inasmuch as the insurer's request was brought to our attention after our review began and because we have decided to affirm the ALJ's order, consideration of the insurer's extension request is unnecessary.

In the Matter of the Compensation of
EDWARD D. BLYSTONE, Claimant
WCB Case No. C002428
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On October 4, 2000, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, for payment of a stated sum, claimant released rights to future workers' compensation benefits, except medical services, for the compensable injury. For the following reasons, we disapprove the proposed disposition.

A claim disposition agreement shall not be approved if, within 30 days of submitting the disposition to us, the worker, insurer or self-insured employer requests that we disapprove the disposition. ORS 656.236(1)(c).

Here, the disposition was submitted to us on October 4, 2000. The statutory 30th day following the submission is November 3, 2000. SAIF Corporation filed a request for disapproval of the disposition on October 31, 2000. Accordingly, we disapprove the disposition. *Id.*

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(5)(k).

IT IS SO ORDERED.

In the Matter of the Compensation of
DENNIS D. HALL, Claimant
WCB Case No. 00-00824
ORDER ON REVIEW
Michael A. Bliven, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Martha Brown's order that directed it to process claimant's new medical condition claim pursuant to ORS 656.262(7)(c) and 656.268. In his brief, claimant asserts that he is entitled to an attorney fee pursuant to ORS 656.386(1). On review, the issues are claim processing and attorney fees.

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

SAIF argues that ORS 656.319(6)[1] bars a claim that it failed to process a new medical condition claim where the initial Notice of Acceptance issued more than two years prior to the request for hearing. We disagree. Because SAIF did not raise this issue at hearing, we decline to address it on review. *Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). In any event, because the alleged claim processing violation (*i.e.*, SAIF's failure to properly process claimant's "new medical condition") arose within 2 years from the filing of claimant's hearing request, that request was timely. *See Robert A. Olson*, 52 Van Natta 1540 (2000).

SAIF also argues that claim preclusion bars an award of disability benefits once they have been determined in a claim. More specifically, SAIF contends that a claimant is not entitled to further benefits under ORS 656.262 or 656.268 unless an express statutory provision allows further benefits after claim closure. SAIF is apparently arguing that a final disability award in an initial injury claim precludes an award in a subsequent new medical condition claim. We disagree.

ORS 656.262(7)(a) provides for the filing of a new medical condition claim and specifies that such a claim may be made "at any time."[2] A new medical condition claim, although distinct from an initial claim or an aggravation claim, is nonetheless a claim that must be processed as any other claim under ORS 656.262 and 656.268. *See Johansen v. SAIF*, 158 Or App 672, 680-681 (1998), *on recon* 160 Or App 579, *rev den* 329 Or 527 (1999). Thus, the statutory scheme provides for processing of new medical condition claims and payment of benefits if appropriate. Although a new medical condition claim is related to an initial claim, it is distinct and must be processed independently of the initial claim. *Id.* at 679-681. Accordingly, we disagree with SAIF's argument that claim preclusion bars the processing and payment of benefits in a new medical condition claim.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding claimant's entitlement to temporary disability benefits is $1,000, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 17, 2000, as reconsidered May 30, 2000, is affirmed. For services on Board review, claimant's attorney is awarded $1,000, to be paid by SAIF.

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[1] ORS 656.319(6) provides that 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.

[2] We have found that the legislature created an exception to claim preclusion in ORS 656.262(7)(a). *Olive M. Bonham*, 51 Van Natta 1710 (1999).

Board Member Meyers specially concurring.

If I were addressing the issue presented in this case on a clean slate, I would agree with SAIF's position. However, because of the doctrine of *stare decisis*, I am obligated to follow the Board's holding in *Larry L. Ledin*, 52 Van Natta 682 (2000) and the cases on which *Ledin* is based.

In *Ledin*, the Board held that because the claimant's right knee condition was found compensable after claim closure, he was entitled to have the claim reopened and processed under ORS 656.262(7)(c), even though the aggravation rights on the original claim had expired. As noted in Board Member Haynes special concurrence in *Ledin*, although the statute is unclear as to whether it is intended to apply after aggravation rights have expired, the legislative history is lacking in any discussion of the profound financial and procedural impact of such a drastic change in the statutory scheme. This suggests that the legislature did not intend that claims in which the aggravation rights had expired could be reopened for the payment of additional temporary and permanent disability benefits.

Because it was neither intended nor expected that claims would be reopened after the aggravation rights had expired, claim reserves were not set with this outcome contemplated, and consequently insurers did not take into account the financial impact when they established their rates.[1] Additionally, it is clear that mandated state reserve requirement levels will be impacted, as well as actuarial analyses for purposes of reinsurance and surety bonding.

The result of the decision in *Ledin* and its progeny is increased claims, allocated expense, and administrative costs in claims in which the 5-year aggravation rights have expired, but it additionally impacts the viability of insurers and future rates in Oregon. This clearly cannot have been the intention of the legislature in enacting ORS 656.262(7)(a) and (7)(c).

[1] While rates do contemplate "incurred but not reported" factors, those factors have quite obviously not included the costs associated with *Ledin's* holding.

November 3, 2000 Cite as 52 Van Natta 1994 (2000)

In the Matter of the Compensation of
DYONA J. POTTER, Claimant
Own Motion No. 97-0556M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Travelers Ins. Co., Insurance Carrier

Claimant requests review of the insurer's September 13, 2000 Notice of Closure, which closed her claim with an award of temporary disability compensation from June 5, 1999 through September 4, 2000.[1] The insurer declared claimant medically stationary as of August 14, 2000.

In her request for review, claimant contends that she has had multiple surgeries and injections for which further compensation should be awarded. We interpret such a contention that claimant was not medically stationary at claim closure.

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

[1] Claimant's December 9, 1988 claim was accepted as a disabling claim and was first closed on July 21, 1989. Thus, claimant's aggravation rights expired on July 21, 1994. ORS 656.273(4)(a). When claimant's condition worsened requiring surgery in March 1998, claimant's claim was under our Own Motion jurisdiction. ORS 656.278(1)(a). Consistent with our statutory authority, on January 13, 1999, we issued our Own Motion Order authorizing the payment of temporary disability compensation and noted that when claimant was medically stationary, the insurer should close the claim pursuant to OAR 438-012-0055.

The propriety of the closure turns on whether claimant was medically stationary at the time of the September 13, 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Typically, there are only two issues to be raised when a claimant requests review of an insurer's closure of his or her claim. The most common issue raised is that the claimant asserts that he or she was not medically stationary at claim closure. A second issue raised less often is that, although the claimant agrees that he or she was medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability compensation during the time the claim was open.

Here, claimant contends she is entitled to additional benefits because of the multiple back surgeries and injections she underwent. We interpret claimant's request as a challenge to the "closure" and timeloss awarded. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

In an August 14, 2000 chart note, Dr. Falk, claimant's treating physician, reported that claimant had decided against any further "procedures and thus does not want to move forward with stimulator placement." As a result of claimant's decision regarding further invasive procedures, Dr. Falk noted that, other than administration of pain medications, there was "nothing more that we can offer her." He prescribed a 30-day supply of pain medication and told her to follow-up with her primary care physician. This opinion is unrebutted.

Furthermore, although Dr. Falk indicates that claimant may need some pain management, this does not support the conclusion that she was not medically stationary when her claim was closed. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation, at claim closure, that further medical treatment would "materially improve" claimant's compensable condition. ORS 656.005(17); *Lois Brimblecom*, 48 Van Natta 2312 (1996). Thus, even if claimant was contesting her medically stationary date, based on uncontroverted medical evidence, we find that claimant was medically stationary on the date her claim was closed and that she is not entitled to additional temporary disability benefits.

Claimant notes that "you people said my case was closed from any other compensation other than time loss. * * * Would you please tell me why." We interpret claimant's statement as a request for other workers' compensation benefits (permanent disability). We are without authority to award further permanent disability in this claim. Effective January 1, 1988, the legislature removed our authority to grant additional permanent disability compensation in our Own Motion capacity. *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990). As noted in footnote 1, claimant's aggravation rights expired in 1994. Thus, she is not statutorily entitled to a permanent disability award under this reopening of her own motion claim.[2]

In conclusion, based on the uncontroverted medical evidence, we find that claimant was medically stationary on the date her claim was closed. Therefore, the insurer's closure was proper.

Accordingly, we affirm the insurer's September 13, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[2] It appears from claimant's request that she may not understand her rights and benefits under the Workers' Compensation Law. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board is an impartial body and cannot give legal advice to either party. However, since claimant does not have an attorney, she may wish to contact the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street NE
Salem, OR 97301
Telephone: 1-800-927-1271

In the Matter of the Compensation of
ALEXANDER CIARAMELLA, Claimant
WCB Case No. 00-02031
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its denial of claimant's injury claim for a low back condition; and (2) set aside its denial of claimant's current low back condition. On review, the issue is compensability.

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

The ALJ set aside SAIF's denials based on the opinion of claimant's treating physician, Dr. Davidson. On review, SAIF contends that Dr. Davidson's opinion is unpersuasive, because he engaged in an impermissible "temporal analysis." We disagree.

Both parties agree that claimant suffers from preexisting degenerative disk disease in his low back that has combined with his February 1999 work injury to cause his disability and need for treatment. Accordingly, claimant must prove that his work injury is the major contributing cause of his disability or need for treatment for the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997).

Where the medical evidence is divided, we generally rely on those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259 (1986). In addition, we defer to the opinion of claimant's treating physician, absent persuasive reasons not to do so. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no reasons not to defer to claimant's treating physician, Dr. Davidson.

Medical opinions based solely on a "temporal relationship" between the claimant's work injury and the onset of disability and need for treatment will generally not satisfy the claimant's burden of proof. *Allie v. SAIF*, 79 Or App 284, 289 (1986); *Marysol Harrit-Diaz*, 52 Van Natta 1903 (2000).

However, here, Dr. Davidson based his opinion on more than just a temporal relationship between claimant's injury and his L3-4 disc protrusion condition. At deposition, Dr. Davidson agreed somewhat with SAIF's "straw that broke the camel's back" analogy in describing the effect of claimant's injury in relation to his preexisting conditions in causing his disability and need for treatment. (Ex. 50-18, -33). However, Dr. Davidson also took into account claimant's prior injuries and surgeries[1], the history of claimant's February 1999 work injuries, and objective changes on his MRI scan after the injuries in arriving at his opinion on causation. (Ex. 46). Dr. Davidson stated that the work injury was "100 percent" responsible for the progression of claimant's L3-4 disc protrusion condition evident on a later (post-injury) MRI scan. (Ex. 50-24). The progression, according to Dr. Davidson, was a measurable change in claimant's disk pathology caused by the injury. (Ex. 50-22).

SAIF next contends that Dr. Davidson failed to consider claimant's accepted lumbar strain condition. We disagree. Dr. Davidson stated that claimant's work injury was "100 percent" of the cause of the progression in his L3-4 disc protrusion condition. (Ex. 50-24). Implicit in that reasoning is that the degenerative disk disease and lumbar strain conditions were not causative of the progression in the disc protrusion condition. However, Dr. Davidson expressly considered claimant's degenerative disk disease condition. (Ex. 46, 50-12).

Moreover, the issues before the ALJ[2] were compensability of claimant's L3-4 disc protrusion condition and compensability of claimant's current low back condition. Dr. Tesar and Dr. Mass, who

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[1] Dr. Davidson, in fact, performed surgery on claimant's low back in 1998, and is therefore in an advantageous position to render an opinion on causation. (Ex. 9); *Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 702 (1998).

[2] Among other issues that are not contested on Board review.

examined claimant at the request of SAIF, stated that claimant's lumbar strain condition had resolved somewhere between six to eight weeks after his February 1999 injury. (Exs. 39, 48). There is no other medical opinion on this issue in the record. Given the opinions of Dr. Tesar and Dr. Mass, we are not persuaded that Dr. Davidson was required to take into account a lumbar strain condition that had resolved by the time of his April 6, 2000 deposition. We are therefore satisfied that Dr. Davidson considered all potential causes of claimant's L3-4 disc protrusion condition. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995).

SAIF contends that Dr. Davidson's opinion is based on the incorrect history that claimant had "no disc bulge" prior to his February 1999 injury, whereas an April 3, 1998 MRI confirmed a "mild central disc bulge" at L3-4. (Exs. 5, 46). However, Dr. Davidson reviewed claimant's April 1998 and May 1999 MRI scans. (Ex. 46). Dr. Davidson also performed surgery on claimant's low back seven days after the April 3, 1998 MRI, and is therefore in the best position to evaluate claimant's "pre-injury" low back condition. (Ex. 5). Accordingly, we defer to Dr. Davidson's interpretation of the prior MRI scan over that of the radiologist. Moreover, a reasonable interpretation of Dr. Davidson's reference to a "progression" of the disc bulge is that the condition progressed since claimant's February 1999 injury. (Ex. 46).

SAIF next contends that Dr. Davidson did not explain how claimant developed one-sided symptoms "consistent with" a central disc bulge. (Ex. 46). However, in the absence of a medical opinion disputing this correlation, we are unwilling to fault Dr. Davidson's logic on this point.

Finally, on the issue of claimant's current low back condition, Dr. Davidson explained that the disc protrusion never ceased to be the major contributing cause of his disability and need for treatment, because of the irreversible anatomic change occasioned by the work injury. (Ex. 50, pp. 28-30). We rely on Dr. Davidson on this issue as well, especially given his position as claimant's treating physician and surgeon both before and after the injury. *Kienow's Food Stores v. Lyster*, 79 Or App 416, 421 (1986). As such, Dr. Davidson was in the best position to evaluate the effect of claimant's injury in conjunction with his MRI scans, prior injuries and surgeries.

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 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 issues, and the value of the interest involved.

ORDER

The ALJ's order dated July 24, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by SAIF.

In the Matter of the Compensation of
ALEXANDER NEWTON, Claimant
Own Motion No. 00-0264M
SECOND OWN MOTION ORDER ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our September 18, 2000 Own Motion Order, as reconsidered on October 13, 2000, which declined to authorize reopening of his 1985 injury claim for the payment of temporary disability compensation because he had not demonstrated that he was in the work force at the time of his disability. Claimant submitted additional information regarding the work force issue. Having received the SAIF Corporation's response and completing our reconsideration, we withdraw our prior orders and replace them with the following order.

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

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

In our prior orders, we found that the record did not demonstrate that it would have been futile for claimant to work or seek work at the time of the current worsening. With his request for reconsideration, claimant submitted a September 20, 2000 medical report from Dr. Auld, his attending physician. Dr. Auld opined that due to "genuine pain" resulting from a worsening of his compensable condition, claimant was not able to work. Based on Dr. Auld's unrebutted opinion, we find that claimant was unable to work at the time of his current worsening. Thus, the "futility standard" of the third *Dawkins* criterion has been satisfied.[1]

In order to satisfy the third *Dawkins* criterion, claimant must also establish, that he was willing to work. Failing to demonstrate his willingness to work, then he is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Arthur R. Morris*, 42 Van Natta 2820 (1990); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

Claimant submitted an October 21, 2000 statement wherein he asserts he is willing to work. Claimant's statement is unrebutted. Therefore, we are persuaded that claimant is willing to seek employment but unable to do so because of his compensable condition. *Michael D. Demagalski*, 51 Van Natta 1043 (1999) (uncontested statement that claimant was doing "odd jobs" for room and board sufficient to prove that claimant was in the work force). Therefore, on this record, we find that claimant has proved that he remained in the work force at the relevant time.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning June 12, 2000, the date claimant was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] Additionally, SAIF "supports" claimant's position that he is unable to work due to his 1985 injury.

In the Matter of the Compensation of
MARJORIE A. RAMIREZ, Claimant
WCB Case Nos. 99-08314, 99-03520 & 99-03053
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorney
Cavanagh & Zipse, Defense Attorney
Lundeen, et al, Defense Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Farmers Insurance Company (Farmers) requests review of those portions of Administrative Law Judge (ALJ) Fulsher's order that: (1) set aside its *de facto* denial of claimant's occupational disease claim for a bilateral trigger thumb condition; (2) upheld the SAIF Corporation's compensability/responsibility denial for the same condition; and (3) upheld Liberty Northwest Insurance Corporation's (Liberty) responsibility denial for the same condition. On review, the issues are compensability and responsibility.

We adopt and affirm the ALJ's order with the following supplementation to address Farmers' contentions that: (1) the ALJ incorrectly relied on the opinions of Drs. Van Allen and Button in finding claimant's bilateral thumb condition compensable; and (2) the ALJ incorrectly applied the "Last Injurious

Exposure Rule" (LIER) and determined that Farmers was responsible for claimant's bilateral thumb condition.

Compensability

The ALJ relied on the opinion of Dr. Van Allen, the attending physician, as supported by the opinion of Dr. Button, a SAIF-arranged medical examiner, to conclude that the major contributing cause of claimant's bilateral trigger thumb condition was her overall work activities as an apprentice electrician. Farmers contends that Dr. Fuller's opinion (stating that claimant's bilateral thumb condition is idiopathic) is more persuasive. We disagree with Farmers' contentions.

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

Dr. Van Allen has been claimant's attending physician since May 1997, when he began treating claimant for carpal tunnel syndrome.[1] (Ex. 13). In February 1998, approximately six months after the second carpal tunnel release, Dr. Van Allen noted that claimant was exhibiting "frank triggering of both thumbs." (Ex. 47). Dr. Van Allen explained that trigger thumb is a condition that develops secondary to a tendinitis that occurs at the base of the thumb involving the thumb flexor. (Ex. 56). He further indicated that the etiology of claimant's bilateral trigger thumb condition is the same as the etiology of her carpal tunnel syndrome, *i.e.* the labor-intense use of the hands due to her occupation as an electrician. (*Id.*). Dr. Van Allen also concluded that claimant had no factors, other than work, playing a role in the etiology of the trigger thumb condition. (*Id.*).

Dr. Button agreed with Dr. Van Allen that claimant's overall work activities as an electrical apprentice caused both her bilateral carpal tunnel syndrome and her bilateral trigger thumb condition. (Ex. 66-5). Like Dr. Van Allen, Dr. Button opined that claimant had no preexisting, predisposing or underlying conditions that would relate to the trigger thumb condition. (*Id.*).

In contrast, Dr. Fuller opined that claimant's bilateral trigger thumb condition is idiopathic and the result of nodule formation in all her fingers as the tendons cross the volar aspect of the metacarpal phalangeal joints. (Ex. 73-8). According to Dr. Fuller, this nodule condition is physiological and any major tendon that crosses a major joint develops this type of nodule. (*Id.*) Dr. Fuller stated that this nodular condition is most evident as the quadriceps tendon cross the knee forming the patella.[2] (*Id.*)

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the opinion of claimants treating physician, absent persuasive reasons to do otherwise. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find no persuasive reasons not to defer to the opinion of Dr. Van Allen, as supported by Dr. Button.

Moreover, we note that both Drs. Van Allen and Button specialize in surgery of the hand; Dr. Fuller does not. Because Drs. Van Allen and Button have more expertise in the cause and treatment of hand problems than Dr. Fuller, we find their opinions more persuasive than Dr. Fuller's. *See Abbott v. SAIF*, 45 Or App 657, 661 (1980). Accordingly, we agree with the ALJ that claimant established the compensability of her bilateral trigger thumb condition.

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[1] Dr. Van Allen performed carpal tunnel releases on both of claimants wrists. (Exs. 22; 33). By Opinion and Order of February 10, 1999, a prior ALJ determined that claimant's bilateral carpal tunnel syndrome was compensably related to her work as an apprentice electrician and was the responsibility of SAIF. (Ex. 63).

[2] Dr. Van Allen disagreed with Dr. Fuller and indicated that Dr. Fuller's statement about the nodularity of claimant's flexor tendons was inaccurate. (Ex. 76). Dr. Van Allen also opined that "the patella is a sesamoid bone and has nothing to do with soft tendon nodules presenting over the pulleys in the digits." (*Id.*).

Responsibility

The ALJ, applying the LIER, determined that Farmers was responsible for claimant's bilateral trigger thumb condition. Farmers does not contend that the LIER is not applicable. Rather, Farmers asserts that correctly applying the LIER places responsibility for claimant's bilateral thumb condition with SAIF.

In *Boise Cascade Corp. v. Starbuck*, 296 Or. 238, 241 (1984), the Court stated: "In an occupational disease context, the rule is this: If a worker establishes that disability was caused by disease resulting from causal conditions at two or more places of employment, the last employment providing potentially causal conditions is deemed to have caused the disease." The onset of disability is the "triggering date" for determining which employment is the last potentially causal employment. *Bracke v. Bazar*, 293 Or 239, 248 (1982). Where a claimant seeks or receives medical treatment for the compensable condition before experiencing time loss due that condition, it is appropriate to designate a triggering date based on either the seeking or receiving of medical treatment, whichever occurs first. *Agricomp Ins. v. Tapp*, 169 Or App 208, 213 (2000); *See Reynolds Metals v. Rogers*, 157 Or App 147, 153 (1998) (the date of the first medical treatment is the triggering date that dictates which period of employment is assigned initial responsibility for the treatment).

The triggering date has been described as "the date claimant first sought treatment for symptoms, even if not correctly diagnosed until later." *SAIF v. Kelly*, 130 Or App 185, 188 (1994). Alternatively, the triggering date has been described as "the date that the claimant first began to receive treatment." *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994). Because the purpose in designating a triggering date is to identify a point when a condition generally becomes a disability, the *Tapp* court has determined that the event (seeking or receiving medical treatment) used to establish the triggering date must have a sufficient objective relationship to the date of disability to make it an appropriate triggering date for assignment of initial responsibility under the LIER. *Tapp*, 169 Or App at 214-15.

Claimant testified that she was having problems with her thumbs when she started seeing Dr. Van Allen for carpal tunnel syndrome in May 1997, when SAIF was on the risk. (Tr. 14). However, Dr. Van Allen did not specifically chart a problem with claimant's thumbs until February 16, 1998, when Farmers was on the risk. (Ex. 47). Claimant's first medical treatment for the thumb condition was administered on February 16, 1998. (Ex. 47).

In discussing the onset of claimant's trigger thumb condition, Dr. Van Allen wrote:

> "I have reviewed my chart notes on [claimant] and do not find a reference to the trigger thumb specifically until 2-16-98.This was well into her treatment for her carpal tunnel, and I do make a reference at that point that she may have mentioned it to me previously. However, it was unlikely that I felt it was symptomatic enough to warrant any specific treatment and felt it might resolve on its own with her time off work following her carpal tunnel releases. I would find it difficult to estimate an exact time that this was diagnosed; however, I would have considered it very mild prior to February." (Ex. 71).

Prior to February 1998, Dr. Van Allen considered claimant's thumb condition mild enough to resolve on its own, without treatment, incident to claimant being off work for carpal tunnel releases. Under these circumstances, even though claimant described her thumb problem to Dr. Van Allen at various times before February 16, 1998, we do not consider that event to be of a sufficient objective relationship to the date of disability to make it an appropriate triggering date for the assignment of initial responsibility under the LIER.

Based on Dr. Van Allen's discussion and the fact that claimant first received treatment for her thumb condition on February 16, 1998, we conclude that February 16, 1998, is the appropriate triggering date for the assignment of initial responsibility under the LIER. *See Tapp*, 169 Or App at 214-15; *Kelly*, 130 Or App at 188. Accordingly, because the evidence does not establish that claimant's prior employments with Liberty's insured and SAIF's insured were the sole cause of claimant's bilateral thumb condition or that it was impossible for Farmers' insured to have caused the condition, we agree with the ALJ's determination that Farmers is responsible for claimant's bilateral trigger thumb condition. *Reynolds Meters v. Rogers*, 157 Or App at 153.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,800, to be paid by Farmers. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsels uncontested request for attorney fees), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated May 31, 2000 is affirmed. For services on review, claimant is awarded an $1,800 fee, payable by Farmers.

In the Matter of the Compensation of
MICHAEL W. WESTON, Claimant
WCB Case No. 99-03421
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Poland's order that: (1) set aside set its pre-closure current condition denial on procedural grounds; and (2) set aside its *de facto* denial of claimant's L2-3 and L4-5 herniated disc condition. On review, the issues are the validity of the pre-closure denial and compensability. We affirm in part, reverse in part, and modify in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Pre-closure denial

Claimant injured his back in June 1998 when he was knocked off an 8-foot scaffold. He was thrown about 20 feet as the result of a heavy steel panel, which fell, striking him and the scaffold on which he was standing. (Tr. 28). The claim was accepted on July 28, 1998 as a "disabling contusion/abrasion left forearm and low back strain." (Ex. 12).

On April 29, 1999, the employer issued a "pre-closure" partial denial, stating in part: "We believe that your accepted disabling conditions are no longer the major contributing cause of your current need for treatment."[1] (Ex. 52). Claimant requested a hearing.

The ALJ determined that the accepted conditions of "contusion/abrasion left forearm and low back strain" had not been accepted as "combined" conditions under the terms of ORS 656.005(7)(a)(B). Consequently, relying on *Croman v. Serrano*, 163 Or App 136 (1999) (carrier must have accepted a combined condition in order to properly issue a "pre-closure" denial pursuant to ORS 656.262(7)(b) and ORS 656.262(6)(c)), the ALJ concluded that the employer's "pre-closure" current condition denial was procedurally improper. Accordingly, the ALJ set aside the denial.

The employer argues that *Serrano* "does not apply to this case, in which the claimant's preexisting diagnosable conditions have combined with his compensable injury and have become the major contributing cause of his continued disability and need for treatment." (Appellant's Brief, 10). We disagree.

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[1] The denial letter also denied "degenerative disc disease at L3-4, L4-5, L5-S1, Spondylolysis, Spondylolisthesis L5-S1, and depression." (Ex. 52). The ALJ set aside that portion of the denial. Neither party contests that portion of the ALJ's order.

In *Serrano*, the court stated:

> "[I]n order for employer to have issued properly a preclosure denial under ORS 656.262(7)(b) and ORS 656.262(6)(c), it must have accepted a combined condition. Under ORS 656.005(7)(a)(B), a combined condition exists when a compensable injury combines at any time with a preexisting condition to cause or prolong disability or a need for treatment. When ORS 656.005(7)(a)(B) is read with the language of ORS 656.262(6)(c), it is clear that the combined condition must have been accepted before it may be denied under the statute." 163 Or App at 141.

The court's language is clear. If the employer believes that claimant's compensable injury has combined with a preexisting condition to cause or prolong disability or need for treatment, and has accepted a "combined condition," and if the employer also believes that the compensable injury is no longer the major contributing cause of claimant's disability or need for treatment, the employer can issue a "pre-closure" denial under ORS 656.262(7)(b) and (6)(c).

Here, the employer believed that the compensable injury combined with a preexisting condition. Consequently, from a procedural standpoint under ORS 656.262(7)(b) and (6)(c), the employer must have accepted a combined condition before it could subsequently issue a "pre-closure" "combined condition" denial. Instead, the employer issued a "pre-closure" "combined condition" denial without first accepting a "combined condition." Accordingly, we agree with the ALJ's conclusion that the employer's denial was procedurally improper.

Compensability

The employer also challenges the ALJ's conclusion that claimant proved the compensability of disc herniations at L2-3 and L4-5. The ALJ determined that claimant had preexisting degenerative changes in his spine that combined with the work injury to prolong his disability or need for treatment. *See* ORS 656.005(7)(a)(B). Consequently, the ALJ determined that the "major contributing cause" standard applied to this claim. Neither party contends otherwise. Therefore, we use the "major contributing cause" standard on review.

Because of the possible alternative causes for his herniated disc conditions, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

To satisfy the "major contributing cause" standard, claimant must establish that his work incident of June 1998 contributed more to the disability or need for treatment of the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimants disability or need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). The fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or its need for treatment. *Id.* at 401; *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997); *Elaine M. Baxter*, 51 Van Natta 1898 (1999).

The ALJ relied on the opinion of Dr. Lantsberger, the attending physician, to conclude that claimant had established the compensability of the herniated discs at L2-3 and L4-5. The employer contends that Dr. Lantsberger's opinion is insufficient to establish the compensability of the disc herniations because the opinion does not evaluate the relative contributions of the work injury and preexisting degenerative conditions in producing the herniated discs. We agree with the employer.

Based upon radiology studies, Dr. Lantsberger diagnosed a broad-based herniated disc on the left at L2-3 and a broad-based disc herniation and lateral herniation into the foramen at L4-5. (Ex. 56). Dr. Lantsberger opined that the major contributing cause of claimants disability and need for treatment of the herniated discs is the June 1998 work injury. (Ex. 56). Dr. Lantsberger based her opinion on claimant's pre-injury ability to perform, without difficulty, the heavy work duties of his occupation as a boilermaker. (Ex. 62). At best, we interpret Dr. Lantsberger's opinion as supporting a conclusion that the work injury of June 1998 is the precipitating cause, but not necessarily the major contributing cause, of claimant's disability or need for treatment for the L2-3 and L4-5 disc herniations.

Although her chart notes reflect that claimant has multilevel disc disease (Exs. 34; 37; 40; 43), Dr. Lantsberger offers no evaluation of the relative contributions of the preexisting degenerative disc disease and the work injury to produce claimant's disability from or need for treatment for the disc herniations at L2-3 and L4-5. Without such an evaluation, her opinion that the 1998 work incident is the major contributing cause of claimant's disability or need for treatment for the L2-3 and L4-5 disc herniations is merely an unsupported conclusion; as such, it is unpersuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

In conclusion, we find that claimant has not established that the 1998 work incident is the major contributing cause of his disability or need for treatment for those conditions. Accordingly, we conclude that claimant has failed to establish the compensability of his L2-3 and L4-5 herniated disc conditions. *See* ORS 656.266; ORS 656.005(7)(a)(B).

Attorney Fees

The ALJ awarded claimant's attorney an assessed attorney fee of $4,000, for claimant's counsel's services at hearing. Because we have reinstated the *de facto* denial of the L2-3 and L4-5 herniated disc conditions, we modify the ALJ's assessed attorney fee award.

Claimant's counsel is entitled to an assessed fee, payable by the employer, for services at the hearing associated with setting aside the April 29, 1999 denial. Time devoted to the case is but one factor we consider in determining a reasonable fee for these services. OAR 438-015-0010(4) instead requires consideration of numerous other factors besides time devoted to the case, such as the complexity of the issues, the value of the interest involved, skill of the attorneys, the nature of the proceedings, the benefits secured, and the risk that an attorney's efforts may go uncompensated. *See Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable). Moreover, a reasonable attorney fee is not based solely on a strict mathematical calculation. *See Cheryl Mohrbacher*, 50 Van Natta 1826 (1998); *Danny G. Luehrs*, 45 Van Natta 889, 890 (1993).

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $1,500 is a reasonable attorney fee for services at the hearings level. We reach this conclusion particularly because of factors such as the time devoted to the issue (as represented by the hearings record), the value of the interest involved, the complexity of the issue, and the risk that claimant's counsel might go uncompensated. Accordingly, we modify the ALJ's attorney fee award in view of the factors in OAR 438-015-0010(4).

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 April 29, 1999 denial is $1,000, 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.

ORDER

The ALJ's order dated April 9, 2000 is reversed in part, affirmed in part, and modified in part. That portion of the ALJ's order that set aside the employer's *de facto* denial of claimant's L2-3 and L4-5 herniated disc condition is reversed. In lieu of the ALJ's $4,000 assessed attorney fee award, claimant's attorney is awarded an assessed fee of $1,500, payable by the employer. The remainder of the order is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the employer.

In the Matter of the Compensation of
HENRY WILLIAMS, Claimant
Own Motion No. 00-0300M
OWN MOTION ORDER

The insurer has submitted claimant's request for temporary disability compensation for claimant's compensable right knee condition. Claimant's aggravation rights expired on April 10, 1985. The insurer opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

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

The insurer contends that claimant was not in the work force at the time of the current disability. Claimant has submitted a July 25, 2000 medical report from Dr. Finkel, his attending physician, and a July 18, 2000 affidavit in response to the insurers contentions.

In order to satisfy the third *Dawkins* criterion, claimant must first establish that he was willing to work. Failing to demonstrate his willingness to work, then he is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Arthur R. Morris*, 42 Van Natta 2820 (1990); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

In claimant's July 18, 2000 affidavit, he asserts that "I was unable to work during the last (2) years due to an injured right knee." Claimant also asserts that because he has ongoing physical therapy and pain complaints he has been "prevented from employment." In his July 25, 2000 medical report, Dr. Finkel states that claimant "remains disabled from any type of employment, which would require bending, stooping, lifting or walking on the leg for any period of time."

While Dr. Finkel's statement and claimant's affidavit *may* demonstrate claimant's physical inability to work, neither evinces his *willingness* to work. By claimant's own admission, he has not worked in the last two years prior to the current worsening. There is no evidence that claimant was working prior to that time period. If, before becoming unable to work due to the compensable injury, claimant was able to work but did not work or seek work, he has not proved his willingness to work. Claimant has submitted no persuasive evidence regarding whether he was willing to work. Consequently, we conclude that claimant has failed to meet his burden of proving hat he was in the work force at the time of disability. *SAIF v. Blakely* at 246-247.

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

Claimant's entitlement to medical expenses pursuant to ORS 656245 is not affected by this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRUCE A. DRUM, Claimant
WCB Case No. 99-01274
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the self-insured employer's denial of his syncope episode and cervical spinal injury claim. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

On review, claimant contends that the ALJ erred in upholding the employer's denial of his syncope episode and cervical condition. Claimant first notes that, at hearing, the issue of compensability of the cervical condition was withdrawn. After reviewing the transcript, we agree that claimant withdrew the issue of compensability of his current cervical condition. (Tr. 5). Claimant clarified that the conditions at issue consisted of the "syncope and rib and thigh contusions." (Tr. 5). The employer's counsel did not object to the framing of the issues. Accordingly, on review, we address only the compensability of claimant's syncope episode and rib and thigh contusions.

The ALJ found that, under *Phil A. Livesley Co. v. Russ*, 296 Or 25 (1983), claimant had not met his burden of proof. Specifically, the ALJ reasoned that it was as likely that claimant's fainting spell was idiopathic as it was that the episode was work-related.

The court recently discussed the *Livesley* case and ORS 656.266 in *McTaggart v. Time Warner Cable*, 170 Or App 491 (2000). In *McTaggart*, the court held that ORS 656.266, which provides that a claimant may not carry the burden of proving compensability merely by disproving other possible explanations of how the injury or disease occurred, did not affect the Supreme Court's decision in *Livesley*. Moreover, the court held that the essential holding of the *Livesley* case (which involved an unexplained fall) was that an injury arises out of employment if it arises from a neutral risk of the employment. Consequently, the court reasoned that a truly unexplained fall that occurs in the course of employment arises out of the employment as a matter of law, and the remaining question is whether claimant has adequately excluded idiopathic factors to establish that the fall is truly unexplained. *McTaggart*, 170 Or App at 491.

Here, as in *McTaggart*, it is clear that the accident arose out of employment. Claimant was driving while working for the employer as a long haul truck driver when he fainted and drove off the road. However, after reviewing the record, we do not find that claimant has adequately excluded idiopathic factors to establish that the syncope episode was unexplained. Specifically, at hearing, claimant testified that he had the flu a week before the accident. Claimant also testified that, at the time the accident occurred, he was still "more or less fatigued" from being ill. (Tr. 10). Dr. Kubac, who performed an evaluation of the syncope episode, took a history of the incident from claimant and performed numerous tests. Based upon his evaluation, Dr. Kubac reported that claimant's episode was most likely due to "flu-like illness, exhaustion and probable dehydration." (Ex. 57-A).

There is no evidence that rebuts Dr. Kubac's opinion with regard to the issue of the cause of claimant's syncope episode. Dr. Kubac's opinion that claimant's fainting episode was attributable to his prior illness is also consistent with claimant's testimony at hearing. Under the circumstances, we conclude that claimant has not excluded idiopathic factors, and has not established that the fainting spell, which resulted in the accident and injuries to claimant, is unexplained. Therefore, we affirm the ALJ's order.

ORDER

The ALJ's order dated June 21, 2000 is affirmed.

In the Matter of the Compensation of
LESTER GUYSE, Claimant
WCB Case No. 00-02492
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Thye's order that affirmed an Order on Reconsideration awarding claimant 35 percent (112 degrees) unscheduled permanent disability for his mental disorder claim. On review, the issue is extent of unscheduled permanent disability. We affirm.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ affirmed the Order on Reconsideration award based on the impairment findings of the medical arbiter, Dr. Edwards. On review, the employer contends that Dr. Edwards' opinion is not persuasive. We disagree.

Medical findings of impairment must be made by claimant's attending physician at claim closure or the medical arbiter, if any. ORS 656.245(2)(b)(B); ORS 656.268(7); *Lopez v. Agripac*, 154 Or App 155 (1998). Impairment findings from non-attending physicians may be considered only if the findings are ratified by the attending physician at claim closure. *Koitzsch v. Liberty Northwest Insurance Corp.*, 125 Or App 666 (1994)

On reconsideration, where a medical arbiter is used, the findings of the medical arbiter are used, except where a preponderance of medical opinion indicates a different level of impairment. OAR 436-035-0007(14) (WCD Admin. Order 98-055). We rely on the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. *Kenneth W. Matlack*, 46 Van Natta 1631 (1994). Here, we agree with the ALJ that Dr. Edwards' opinion is persuasive.

The employer argues that we should find the opinion of Dr. Klecan, who performed a psychiatric examination at the request of the employer, persuasive. However, we agree with the ALJ that claimant's attending physician, Dr. Peacock, did not concur with Dr. Klecan's impairment ratings, but rather only with the fact that claimant's condition was medically stationary. (Ex. 9). Accordingly, Dr. Klecan's findings cannot be used to rate impairment. OAR 436-035-0007(13); *Adam J. Delfel*, 50 Van Natta 1041 (1988).

The employer next contends that Dr. Edwards relied on an inaccurate history of claimant's being confined in a room with a "gun-carrying coworker who went 'berserk,'" which is contrary to the record that claimant was the only individual in the room with a gun. (Ex. 11-2). We agree with the ALJ that this is a distinction without a difference.

First, in her medical arbiter report, Dr. Edwards proceeds to recount the correct history of the sequence of events on March 3, 1998, during which claimant was not threatened by the co-worker, regardless of whether he had a weapon. (*Id.*) Moreover, claimant's condition has been determined to be compensably related to the work incident. The only issue presented to Dr. Edwards was the extent of claimant's permanent impairment. In this regard, Dr. Edwards performed a complete review of claimant's medical history and reported an accurate statement of claimant's current mental and physical symptoms. (Ex. 11). Accordingly, we are satisfied that Dr. Edwards relied on a complete and accurate history. *Somers v. SAIF*, 77 Or App 259 (1986).

The employer next draws our attention to an error in the ALJ's order. The ALJ referenced an "Exhibit 15-2" for the proposition that "an acute stress disorder may develop into an adjustment

disorder." (*O&O* at 4). We agree that there is no Exhibit 15 in the record, nor can we locate a citation for this precise statement elsewhere in the record. Nevertheless, Dr. Turco, who examined claimant at the request of the employer, stated that claimant had developed an acute stress disorder, "which basically is also an adjustment disorder with mixed emotional features." (Ex. 1-8). This opinion supports the general proposition advanced by the ALJ's aforementioned reference. Therefore, we are not persuaded that the ALJ's inaccurate citation undermines the ALJ's ultimate conclusion that claimant is entitled to permanent impairment related to his adjustment disorder condition.

In this regard, we also disagree with the employer's assertion that Dr. Edwards' impairment rating is inconsistent with a diagnosis of "acute stress disorder," which is presumed to last a maximum of four weeks, according to DSM-IV criteria. As we stated, Dr. Turco equated claimant's acute stress disorder to an adjustment disorder, which does not have such a "DSM-IV" limitation. (Ex. 1-8).

Dr. Edwards concluded that claimant's work incident had resulted in an "acute stress disorder," and also agreed with the accepted condition of "mental stress," which was responsible for claimant's current symptoms of anxiety, depression, and stomach pain. (Ex. 11-3). Although Dr. Edwards did not specifically mention a diagnosis of "adjustment disorder," her impairment findings are consistent with Dr. Turco's statement that claimant also suffered from an adjustment disorder with mixed emotional features. (Ex. 11-4); OAR 436-035-0400(5). Dr. Edwards expressly related claimant's permanent impairment to his compensable condition, and not to any non-work-related cause. (Ex. 11-3); *see generally SAIF v. Danboise*, 147 Or App 550, 553 (1997) (when a treating doctor or the medical arbiter makes impairment findings and describes those findings as consistent with a claimant's compensable injury, such findings may be construed as showing that the impairment is due to the injury); *Christopher S. Andersen*, 52 Van Natta 85 (2000).

Finally, the employer contends that Dr. Edwards' impairment findings do not fit the DSM-IV criteria for any recognized diagnosis, and are therefore unpersuasive. We disagree.

Through litigation, the employer accepted claimant's claim for "mental stress" (Ex. 10), which is an inexact term, and not itself a recognized "DSM-IV" diagnosis. *See Janenne R. Asti*, 48 Van Natta 2575, 2576 (1996). However, the preponderance of medical opinion indicates that claimant suffers from an "acute stress disorder with adjustment disorder." (Exs. 1, 1A(a), 2, 2A, 3, 4A, 8A). In addition, the amended denial issued by the employer's processing agent stated "* * *[W]e hereby deny the compensability of your claim for a condition diagnosed as acute reaction to stress and adjustment disorder with mixed anxiety and depression." (Ex. 1B). A prior ALJ set aside this denial, and directed the employer to process the denied conditions, which included the adjustment disorder with mixed anxiety and depression. (Ex. 3). The Board and the Court of Appeals affirmed the ALJ's order. Under such circumstances, we find that Dr. Edwards properly made impairment findings consistent with OAR 436-035-0400(5) ("[l]oss of function attributable to permanent symptoms of affective disorders, anxiety disorders, somatoform disorders, and chronic adjustment disorders.")

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,250, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated August 24, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the self-insured employer.

In the Matter of the Compensation of
GARY F. KENNADAY, Claimant
WCB Case No. 00-00106
ORDER ON REVIEW
Doblie & Associates, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Brazeau'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," but do not accept the finding that claimant's low back condition was "essentially asymptomatic" prior to his compensable injury of February 4, 1992. Instead, we find that claimant had significant low back pain prior to the compensable injury, as reflected by Dr. Powell's December 16, 1991 chart note in which it is reported that claimant requested an excuse from jury duty due to back pain from a prior non-work related back surgery in February 1991. (Ex. 5).

In addition, we do not accept the ALJ's finding that claimant experienced right leg pain within a few days of his compensable February 4, 1992 injury. Instead, we find that claimant did not experience right leg pain until March 1992, as noted in Dr. Powell's March 16, 1992 chart note. (Ex. 9-1).

CONCLUSIONS OF LAW AND OPINION

Claimant sustained a compensable injury on February 4, 1992 when he slipped and fell at work. Dr. Powell diagnosed an acute lumbar strain overlying previous discogenic disease. (Ex. 5). The insurer accepted the claim as a compensable lumbar strain. The claim was closed in October 1992 without an award of permanent disability.

On November 9, 1999, the insurer issued a denial of claimant's current low back condition on the grounds that the accepted low back strain had combined with a preexisting low back condition and that the compensable injury was no longer the major contributing cause of the need for treatment of the "combined" condition. (Ex. 31). Claimant requested a hearing.

The ALJ set aside the insurer's denial, finding that claimant had sustained his burden of proving that the compensable injury remained the major contributing cause of his current low back condition. In making this finding, the ALJ concluded that most physicians had related claimant's low back condition to the compensable injury and that the primary contrary evidence from examining physicians Woodward and Williams was based on an allegedly inaccurate history that claimant's right sided pain began in March 1992 rather than, as the ALJ found, within a few days of the February 4, 1992 injury.

On review, the insurer contends that the Woodward/Williams panel provided the most persuasive medical opinion. The insurer further asserts that the medical evidence establishes that claimant's current medical treatment is solely directed at the effects of a preexisting low back condition and that the compensable injury is no longer the major contributing cause of claimant's need for treatment. For the following reasons, we find that claimant's current low back condition is not compensable.

In evaluating the medical evidence on causation, we rely on those opinions that are both well-reasoned and based on complete information. *Somers v. SAIF*, 77 Or App 259 (1986). Absent persuasive reasons to do otherwise, we generally give greater weight to the opinion of claimant's attending physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to give greater weight to the opinion of claimant's treating physician, Dr. Keys.

Dr. Keys concurred with the report of Drs. Woodward and Williams, who stated that they could not attribute claimant's current low back condition and need for treatment to the February 4, 1992 injury. (Exs. 30-10, 32). Yet, in his deposition, Dr. Keys agreed that the February 4, 1992 injury was probably the major contributing cause of claimant's need for treatment. (Ex. 35-22). We do not find Dr. Keys opinion sufficient to satisfy claimant's burden of proof.

First, Dr. Keys did not explain why he initially agreed with an opinion that did not attribute claimant's current back condition to the compensable injury and then later apparently changed his opinion to reach the opposite conclusion. Such an insufficiently explained change of opinion is not persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987). Second, to meet claimant's burden of proving major contributing cause, a physician's opinion must consider the relative contribution of all potential causes. *Dietz v. Ramuda*, 130 Or App 397, 402 (1994), *rev dismissed* 321 Or 416 (1995). Having reviewed Dr. Keys' deposition testimony, we are not persuaded that his one-sentence conclusion reflects an adequate weighing of all potential causes of claimants' current low back condition, such as the significant preexisting low back condition that was symptomatic shortly before the compensable February 1992 injury.

Two other medical opinions address the compensability of claimant's current low back condition, those of Dr. Keiper, a consulting physician, and the Woodward/Williams panel. We find that Dr. Keiper's opinion is of little value. He declined to concur with the Woodward/Williams panel's report that could not attribute claimant's current condition to the 1992 injury. (Ex. 34). However, Dr. Keiper provided no explanation for his opinion other than to say his history was different from that in the Woodward/Williams report. We do not find Dr. Keiper's insufficiently explained refusal to concur with the Woodward/Williams report persuasive evidence that claimant's compensable injury remains the major contributing cause of claimant's current low back condition and need for treatment.

In contrast to the deficient opinions of Drs. Keys and Keiper, we find that the Woodward/Williams report reflects a careful weighing of the relative contribution of the preexisting low back condition and the compensable injury with respect to the cause of claimant's current low back condition and need for treatment. (Ex. 30). The ALJ discounted their report because of an allegedly inaccurate history that claimant did not develop right sided complaints until March 1992. Although claimant testified that it was his "educated guess" that he developed right leg pain with a few days of the February 1992 injury (Tr. 12), the contemporaneous medical records do not document right leg complaints until Dr. Powell's March 16, 1992 chart note. (Ex. 9-1). In this case, we rely on the contemporaneous records rather than claimant's testimony. *See Diann C. Harry*, 51 Van Natta 1540, 1541 (1999) (the claimant's contemporaneous reporting regarding the onset of symptoms found more likely accurate than her recollection at hearing).

Accordingly, we conclude that the Woodward/Williams panel had an accurate history of the onset of claimant's right leg symptoms. Because it is well reasoned and based on a complete and accurate history, we find the Woodward/Williams report the most persuasive on this record. Based on that report, we conclude that claimant's current low back condition is not compensable. Thus, we reverse.

ORDER

The ALJ's order dated July 24, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed.

November 14, 2000 Cite as 52 Van Natta 2009 (2000)

In the Matter of the Compensation of
JOSEPH D. BINGLEY, Claimant
Own Motion No. 99-0444M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Cole, Cary, et al, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requests review of the insurer's August 24, 2000 Notice of Closure, which closed his claim with an award of temporary disability compensation from January 4, 2000 through March 28, 2000. The insurer declared claimant medically stationary as of March 28, 2000. Claimant contends that he is entitled to additional benefits as he was not medically stationary on March 28, 2000, when the insurer terminated time loss payments.

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 of the passage of time. ORS 656.005(17). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

On May 31, 2000, Dr. Lanford, claimant's attending physician, concurred with the insurer that claimant was released to and had returned to regular fulltime work on April 12, 2000.

In a July 26, 2000 medical report, Dr. Lanford, opined that claimant had "reached maximum medical improvement." This opinion is unrebutted. Thus, on this record, we conclude that claimant was not medically stationary on March 28, 2000, when the insurer discontinued payment of temporary disability compensation. Claimant is substantively entitled to temporary disability benefits if the record establishes that he was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; *Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992). The insurer terminated temporary disability benefits on March 28, 2000. However, the record shows that claimant was not released to return to work until April 12, 2000 and was not medically stationary until July 26, 2000.

Accordingly, we modify the insurer's August 24, 2000 Notice of Closure to award claimant additional temporary disability compensation from March 28, 2000 through April 12, 2000, the date claimant returned to work.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
DALE A. DUNN, SR., Claimant
WCB Case No. 00-00969
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The insurer requests review of Administrative Law Judge (ALJ) Black's order that set aside its denial of claimant's injury claim for a C5-6 disc condition. On review, the issue is compensability.

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

The ALJ set aside the insurer's denial of claimant's C5-6 disc condition, finding that claimant had satisfied his burden of proof under ORS 656.005(7)(a)(B). In making this finding, the ALJ found the opinions of attending physicians, Drs. Koller and Newby, who supported compensability, more persuasive than that of a physician who reviewed medical records, Dr. White. Dr. White attributed the disputed condition in major part to a preexisting cervical condition. (Ex. 25).

On review, the insurer contends that the opinions of Drs. Koller and Newby are not persuasive because they both relied on an inaccurate history of the exact mechanism of the alleged October 30, 1999 injury and because Dr. Newby failed to adequately consider "pre-injury" C5-6 symptoms. The insurer argues that the ALJ should have relied, instead, on Dr. White's opinion, which it asserts was the best reasoned. We disagree.

Having reviewed the record *de novo*, we conclude that Drs. Koller and Newby had a sufficiently accurate understanding of the mechanism of injury. Moreover, we are persuaded that Dr. Newby adequately considered the significance of claimant's preexisting symptoms in concluding that the October 30, 1999 incident was the major contributing cause of claimant's need for treatment for the "combined condition" under ORS 656.005(7)(a)(B). (Ex. 28). Therefore, in the absence of persuasive reasons to do otherwise, we give greater weight to the opinions of the attending physicians. *See Weiland v. SAIF*, 64 Or App 810 (1983). Finally, we do not find more persuasive Dr. White's conclusion that a preexisting cervical condition was the major factor in claimant's current cervical condition, given his statement that a large cervical disc extrusion occurred on October 30, 1999. (Ex. 25-4).

Accordingly, we conclude that claimant satisfied his burden of proof under ORS 656.005(7)(a)(B). Thus, we affirm.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by 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 August 14, 2000 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
DEBRA J. ESCALERA, Claimant
WCB Case No. 00-01552
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the SAIF Corporation's denial of her occupational disease claim for a cervical spine condition. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation.[1] On page 1, we replace the second paragraph of the findings of fact with the following:

> "On May 21, 1997, claimant sought treatment from Dr. Benschoter, complaining of right-sided neck pain. (Ex. 1). Dr. Benschoter reported that claimant had a 'history of pain in her neck and shoulder area related to stress, but has had intermittent sharp pains on the right side, radiating up to the right side of her head for the last several weeks.' (Ex. 1-1). Claimant indicated she had muscular pain in a variety of locations that 'migrates from place to place,' but the recent neck pain was sharper than usual. (*Id.*) Dr. Benschoter diagnosed '[a]cute on chronic neck strain and pain.' (Ex. 1-2).
>
> "Claimant saw Dr. Pugsley on February 10, 1998 for an annual exam. (Ex. 2). Dr. Pugsley said that claimant mentioned some left neck pain and she noted that claimant talks on the phone a lot with her left ear. (Ex. 2-1). Dr. Pugsley diagnosed left neck pain, muscular in origin, but did not recommend any treatment at that time. (*Id.*)"

In the first paragraph on page 2, we change the physicians name to "Dr. Butt." In the second paragraph on page 2, we change the first sentence to read: "Claimant returned to Dr. Pugsley on January 14, 1999. (Ex. 3-1)."

Claimant argues that ORS 656.802(2)(a) applies to this case and she relies on the opinion of her attending physician, Dr. Pugsley. On the other hand, SAIF contends that ORS 656.802(2)(b) applies and the medical evidence is insufficient to establish compensability.

To establish a compensable occupational disease, claimant must prove that her employment conditions were the major contributing cause of the cervical spine condition. ORS 656.802(2)(a). If the occupational disease claim is based on the worsening of a preexisting disease or condition, claimant must prove that employment conditions were the major contributing cause of the combined condition

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[1] We modify the ALJ's order to note that Exhibit 9A was also admitted in evidence. (Tr. 1-2).

and pathological worsening of the disease. ORS 656.802(2)(b). In occupational disease claims, a disease or condition is "preexisting" if it contributes or predisposes the claimant to disability or a need for treatment, and precedes either the date of disability or the date when medical treatment is first sought, whichever occurs first. *SAIF v. Cessnun*, 161 Or App 367, 371 (1999).

Claimant first sought medical treatment for her cervical condition on May 21, 1997, when she went to Dr. Benschoter, complaining of right-sided neck pain. (Ex. 1). Dr. Benschoter said that claimant had a "history of pain in her neck and shoulder area related to stress, but has had intermittent sharp pains on the right side, radiating up to the right side of her head for the last several weeks." (Ex. 1-1). Claimant indicated she had muscular pain in a variety of locations that "migrates from place to place," but the recent neck pain was sharper than usual. (*Id.*) Dr. Benschoter diagnosed "[a]cute on chronic neck strain and pain." (Ex. 1-2). Similarly, Drs. Kirschner and Jones found that claimant had a chronic and preexisting tension and stress condition in the upper trapezii. (Ex. 8-6 to -8). Based on those medical opinions, we find that claimant had a cervical condition that preceded the date of first treatment in May 1997.

Furthermore, we find that claimant's preexisting cervical condition contributed or predisposed her to disability or a need for treatment. Dr. Pugsley reported on January 14, 1999 that claimant had right neck pain, similar to what she had experienced a couple of years ago on the left side. (Ex. 3-1). On June 30, 1999, Dr. Pugsley said that claimant had "[l]eft neck pain for a number of months, chronic, it started about two years ago." (Ex. 4-1). Dr. Pugsley noted that claimant's pain had been on both sides of her neck. (*Id.*) Based on Dr. Pugsley's chart notes, we find that claimant's neck pain in 1999 is similar to the neck pain she had in 1997 when she was treated by Dr. Benschoter. Therefore, we conclude that claimant's claim for a cervical condition is based on the worsening of a preexisting disease/condition and she must prove that her employment conditions were the major contributing cause of her combined condition and a pathological worsening of the disease. *See* ORS 656.802(2)(b); *Deborah J. Provost*, 52 Van Natta 1389 (2000).

We agree with the ALJ that Dr. Pugsley's opinion is not sufficient to establish compensability. On June 30, 1999, Dr. Pugsley reported that claimant's neck pain was "very much related to work and when it started it occurred exclusively when she was using the phone[.]" (Ex. 4-1). On May 18, 2000, Dr. Pugsley said that the major causative factor of claimant's neck pain was her phone use at work. (Ex. 12-1). She concluded that claimant's work activities were the major cause of her neck pain and headache. (Exs. 12-2, 14). Although Dr. Pugsley felt that claimant's employment conditions were the major contributing cause of her cervical spine condition, her opinion does not establish that claimant's work activities were the major contributing cause of a pathological worsening of the condition.

Furthermore, we are not persuaded that Dr. Pugsley had an accurate understanding of claimant's neck symptoms. Dr. Pugsley reported that claimant's neck pain "has only occurred when she was using the phone without a headset." (Ex. 14). In contrast, Dr. Benschoter reported that claimant had a "history of pain in her neck and shoulder area related to stress[.]" (Ex. 1-1). Although Drs. Kirschner and Jones reported that a long day at work increased claimant's neck symptoms, they noted "when [claimant] is on vacation, she has not noticed any significant difference, but she says she has stress on her vacations also with her teenage children." (Ex. 8-4). Thus, the reports from Drs. Benschoter, Kirschner and Jones indicates that claimant's neck symptoms do not occur "only" while using the phone without a headset, as reported by Dr. Pugsley. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive). For these reasons, we agree with the ALJ that Dr. Pugley's opinion is not sufficient to establish compensability.

ORDER

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

In the Matter of the Compensation of
ANTOINETTE GAINER, Claimant
WCB Case No. 00-02165
ORDER ON REVIEW
Martin L. Alvey, Claimant Attorney
J. Keene, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's injury claim for a right costrochondritis 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 works for the employer hand finishing airplane parts. On December 15, 1999, she returned to work after her first break at 9 A.M. When she resumed working, she felt a sudden onset of pain in her chest, on the right side. She reported the injury and sought medical treatment. Dr. Hirsch eventually diagnosed costrochondritis and claimant filed a claim, which the insurer denied.

The ALJ set aside the insurer's denial, finding that claimant's work activity was "at least a material cause of her injury[.]" The ALJ relied on Dr. Hirsch's causation opinion, reasoning that the doctor provided an adequate explanation of the mechanism and location of the injury in support of the claim. We disagree.

Claimant has had several prior incidents of chest pain and she sought treatment for these symptoms on three prior occasions. The medical experts agree that claimant's prior costrochondritis episodes predisposed her to experience recurrent similar problems. Under these circumstances, the case presents a complex medical question that requires expert evidence for its resolution. *See Uris v. Compensation Department*, 247 Or 420, 424-26 (1967); *William H. McCormick*, 52 Van Natta 1599 (2000) (whether a preexisting condition or an on-the-job injury is the major contributing cause of a worker's condition is a complex medical question that requires expert testimony).

In this regard, Dr. Hirsch, treating physician, explained that claimant's

> "prior complaints certainly have made her more susceptible to future problems in this area, particularly with continued work related aggravation by using the vibrating burring tool [at work]." (Ex. 19-2).

Based on Dr. Hirsch's opinion that claimant's preexisting costrochondritis predisposed her to recurrent episodes and combined with her work activities to cause her current condition, we find that claimant is subject to the major contributing cause standard of proof. ORS 656.005(7)(a)(B).

Dr. Hirsch provides the only expert evidence supporting the claim. She opined that claimant's "work injury of 12/15/99 was the major contributing cause of the disability or need for medical treatment of her acute right costrochondritis condition on 12/15/99." (Ex. 19-2). But Dr. Hirsch did not explain how claimant's work contributed more to her current condition (or disability or need for treatment therefore) than did claimant's predisposition. Under these circumstances, the doctor's opinion is insufficiently reasoned to establish "major causation." *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev den* 321 Or 416 (1995); *see also Somers v. SAIF*, 77 Or App 259 (1986); *Weiland v. SAIF*, 64 Or App 810 (1983). Consequently, we therefore reverse the ALJ's order and uphold the insurer's denial.

ORDER

The ALJ's order dated July 17, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
CHARLES M. HANEY, Claimant
Own Motion No. 98-0360M
OWN MOTION ORDER REVIEWING
CARRIER CLOSURE ON RECONSIDERATION
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 15, 2000 Own Motion Order, that affirmed the SAIF Corporation's February 1, 2000 Notice of Closure in its entirety.

In order to allow sufficient time to consider the motion for reconsideration, we abated our order on September 19, 2000. Having received the parties' written positions and additional documentation, we proceed with our review.

In our prior order, we relied on the opinion of Dr. Funk, claimant's attending physician at the time SAIF closed his claim. Dr. Funk had opined that claimant was medically stationary on January 28, 2000 and that he would achieve "no further improvement."

We declined to find the opinions of Drs. Randell and Hendrix as persuasive inasmuch as their medical reports did not address claimant's medically stationary status at the time of the claim closure, nor did they imply that he was not medically stationary on February 1, 2000, when SAIF closed his claim. *See Scheuning v. J.R. Simplot & Co.*, 84 Or App 622, 625 (1987). Rather, we concluded that Drs. Randell's and Hendrix' opinions focused on claimant current need for treatment.

On reconsideration, claimant submitted October 3 and October 10, 2000 medical reports from Dr. Hendrix. In his October 3, 2000 report, Dr. Hendrix opines that, after having reviewed all of claimant's previous medical records, claimant's "injury has never been solved or brought to a satisfactory medical stability." He also recommended claimant undergo an arthroscopic evaluation. In his October 10, 2000 medical report, Dr. Hendrix again opined that claimant's knee condition has continued to worsen and that one of his options is the proposed surgery. In an October 17, 2000 addendum to his October 10, 2000 report, Dr. Hendrix reiterated his opinion that claimant's injury has never been solved. He opined that the only treatment that will "materially improve" claimant's condition is surgery. This opinion is unrebutted.

In our prior order we found that Dr. Hendrix' July 24, 2000 medical report did not relate to claimant's knee condition when his claim was closed. As before, Dr. Hendrix' recent medical reports address claimant's current condition and not his medically stationary status at the time of closure, *i.e.* February 1, 2000. Although he does opine that claimant's "injury has never been solved or brought to a satisfactory medical stability, "because no explanation is provided for this opinion, we do not consider Dr. Hendrix' October 2000 reports to be persuasive regarding claimant's medically stationary status at closure.

However, claimant has submitted medical documentation regarding a worsening of his knee condition requiring surgery as of Dr. Hendrix' July 24, 2000 medical report. We interpret this submission as a request for own motion benefits as the worsening relates to his current knee condition. Accordingly, SAIF is required to make a written recommendation to the Board within 90 days of receiving claimant's own motion request. OAR 438-012-0030. That recommendation must include the information specified in OAR 438-012-0030.[1]

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 17, 2000 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.

IT IS SO ORDERED.

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[1] Concurrently with the issuance of this order, we have requested, by letter, that SAIF process claimant's request for own motion benefits in relation to his current knee worsening.

In the Matter of the Compensation of
CARL M. PRICE, Claimant
Own Motion No. 66-0218M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

On November 1, 2000, the SAIF Corporation submitted claimant's request for medical benefits relating to his July 11, 1953 work-related injury. SAIF recommends reopening of claimant's claim to obtain a professional evaluation regarding proposed home site modifications as well as Own Motion authority for the provision of the proposed modifications. In addition, SAIF recommends that the claim remain open until medical services are no longer required.

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

Because the requested professional evaluation is in regards to proposed home site modifications, we find that the professional evaluation is reasonable and necessary to enable SAIF to determine what home site modifications are needed.

In addition, in order to establish compensability of medical services, a claimant must prove both the necessary causal relationship between the medical services and the compensable injury and the reasonableness and necessity of the medical services. *See* ORS 656.245; *Van Blokland v. Oregon Health Services University*, 87 Or App 696, 698 (1987). Where reasonable and necessary, remodeling services to accommodate a claimants disabilities are compensable medical services. *SAIF v. Glubrecht*, 156 Or App 339, 349-50 (1998) (holding that text and context of ORS 656.245(1)(b) revealed legislatures intent to compensate, as "prosthetic appliances, braces and supports," a quadriplegic claimant for expenses of remodeling a house to accommodate a wheelchair and other quadriplegia-related devices); *see also Stoddard v. Credit Thrift Corporation*, 103 Or App 283 (1990) (holding that the fact that the claimant who was rendered a quadriplegic as a result of a work-related injury would require assistance of care givers after his house was remodeled to make it more accessible did not make remodeling costs noncompensable).

Here, claimant's compensable injury resulted in paraplegia, with resultant ulcers and bilateral carpal tunnel syndrome resulting from years of wheelchair use. These injuries resulted in a permanent total disability award. The modifications to claimant's home are required to assist with his everyday living and care. Considering such circumstances, we find that the requested medical services are reasonable and necessary and causally related to the compensable injury. Accordingly, claimant's claim is reopened to provide the above medical services. *See* OAR 438-012-0037.

This order shall supplement our August 24, 1992 order that previously reopened claimant's 1953 claim for the payment of office visits, medical services and supplies. Claimant's claim shall remain reopened to provide medical services that are found to be reasonable and necessary and causally related to the compensable injury. Authorization for these medical services shall continue on an ongoing basis for an indefinite period of time, until there is a material change in treatment or other circumstances. After those services are provided, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDWARD T. ROTHAUGE, Claimant
Own Motion No. 66-0410M
OWN MOTION ORDER
John C. DeWenter, Claimant Attorney
H. Thomas Andersen (Saif), Defense Attorney

On September 10, 1999, the SAIF Corporation submitted a request for medical services for claimant's compensable low back condition. Claimant's aggravation rights have expired. SAIF opposed reopening of the claim on the grounds that the requested medical services are unrelated to his November 31, 1950 injury.

On March 15, 2000, we referred claimant's claim to the Hearings Division for a fact-finding hearing. OAR 438-012-0040. We requested that the assigned Administrative Law Judge (ALJ) take evidence on the issue of whether the 1950 work injury is a material cause of claimant's current need for the requested medical services. In addition, the ALJ was directed to address the effect, if any, our June 1996 order may have on the current medical services issue.

On September 6, 2000, following a fact-finding hearing, ALJ Marshall issued his Own Motion Recommendation. The ALJ found that, while claimant's current treatment for his low back condition was similar to the treatment authorized by the Board under its June 4, 1996 Own Motion Order, claimant had not established that his condition remained the same. Noting that Dr. Goodwin (claimant's attending physician) was unable to affirmatively state whether claimant's compensable condition was a material contributing cause of claimant's need for the requested medical treatment, the ALJ concluded that claimant had not established the requisite causal relationship between his 1950 compensable low back injury and his current need for medical services for his low back condition. Accordingly, the ALJ recommended that the Board decline to reopen claimant's 1950 low back injury claim for the payment of the requested medical services pursuant to ORS 656.278.

Thereafter, we implemented a briefing schedule to allow the parties an opportunity to respond to the ALJ's recommendation. Claimant submitted his opening brief on September 27, 2000. To date, no response has been received from SAIF. Therefore, we proceed with our review.

Claimant raises the same issues as he did before the ALJ, including his argument that his low back condition is the same condition as the one which was addressed in our June 4, 1996 order. In other words, claimant contends that SAIF is precluded from denying medical services that had been previous awarded. However, all of claimant's contentions and arguments have already been were addressed in the ALJ's Own Motion Recommendation. After review of this record, we agreed with and adopt the ALJ's conclusion that the evidence does not establish a causal relationship between claimant's current condition and his compensable injury.

Accordingly, we decline to authorize payment for the requested medical services for claimant's current low back condition. However, claimant's claim shall remain open to provide medical services that are found to be reasonable and necessary and causally related to the compensable injury pursuant to our June 4, 1996 order. 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. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

In the Matter of the Compensation of
TONI A. WILSON, Claimant
WCB Case No. 00-00012
ORDER ON REVIEW
Glen J. Lasken, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Hazelett's order that upheld the SAIF Corporation's denials of her aggravation or new medical condition claims for L5-S1 disc herniation and L4-5 and L5-S1 mechanical instability. On review, the issues are aggravation and compensability.

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

In the first paragraph of the findings of fact on page 1, we change the date in the first sentence to "April 8, 1997." In the third full paragraph on page 2, we change the last sentence to read: "Dr. Malos did not believe surgery was appropriate and he recommended conservative treatment. (*Id.*)" We change the last paragraph on page 2 to read: "On January 29, 1998, Dr. Waldram reported that claimant was medically stationary and could return to full duty without limitation. (Ex. 17)." In the second paragraph on page 3, we replace the third sentence with the following:

> "Dr. Bald found that claimant did not have any limitations resulting from the accepted lumbosacral strain. (Ex. 22-4). He explained that claimant's reduced range of motion and inconsistencies during the examination were the result of psychogenic pain behavior and preexisting degenerative disc disease. (*Id.*)"

In the fourth paragraph on page 3, we change the first sentence to read:

> "On September 15, 1999, Dr. Kendrick performed a lumbar laminectomy and discectomy at L5-S1, and a fusion at L4-5 and L5-S1. (Ex. 30)."

In the sixth paragraph on page 3, we replace the second sentence with the following:

> "Dr. Farris found that claimant had preexisting degenerative joint disease of the lumbar spine and a preexisting somatoform personality disorder. (Ex. 36-4, -5). Dr. Farris concluded that claimant's somatoform pain behavior was the major contributing cause of claimant's extended treatment and disability. (Ex. 36-6)."

In the fourth paragraph on page 4, we delete the last sentence. In the last paragraph beginning on page 4 and continuing on page 5, we change the second sentence by deleting the phrase: "On what is basically the same information[.] In that same paragraph that continues on page 5, we delete the last sentence."

We supplement the ALJ's order with the following.

Claimant seeks to establish compensability of her L5-S1 disc herniation and L4-5 and L5-S1 mechanical instability as an aggravation or as new compensable conditions. For the following reasons, we agree with SAIF that claimant has failed to prove a compensable aggravation.

SAIF accepted an "L-S strain" resulting from claimant's April 1997 injury. (Ex. 4). On January 29, 1998, Dr. Waldram reported that claimant was medically stationary and could return to full duty without limitation. (Ex. 17). A March 19, 1998 Notice of Closure awarded only temporary disability benefits, which was affirmed by a July 27, 1998 Order on Reconsideration. (Exs. 20, 21).

On September 15, 1999, Dr. Kendrick performed a lumbar laminectomy and discectomy at L5-S1, and a fusion at L4-5 and L5-S1. (Ex. 30). In October 1999, Dr. Kendrick signed an aggravation form. (Ex. 34). In addition, claimant's attorney wrote to SAIF and requested that it process the aggravation claim. (Ex. 34a).

ORS 656.273(1) provides that a worsened condition resulting from the original injury is established by medical evidence of an actual worseningof the compensable condition supported by objective findings. *See SAIF v. Walker*, 330 Or 102 (2000). In *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995), we held that ORS 656.273(1) requires proof of two specific elements in order to establish a worsened condition: (1) "actual worsening," and (2) a compensable condition. Both elements must be satisfied in order to establish a "worsened condition resulting from the original injury." *Id.* If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7). *Id.*

Thus, to prove an aggravation of her 1997 accepted condition, claimant must establish an actual worsening of the "L-S" strain supported by objective findings. We agree with SAIF that there is no medical evidence that attributes claimant's worsened low back condition to her accepted strain. We conclude that claimant has failed to establish an "actual worsening" of her strain.

We also agree with the ALJ that claimant has failed to establish compensability of her L5-S1 disc herniation and L4-5 and L5-S1 mechanical instability conditions.[1] Claimant relies on Dr. Kendrick's opinion to establish compensability. The medical evidence establishes that claimant had preexisting degenerative disc disease in her lumbar spine that combined with the April 1997 injury to cause or prolong her disability or need for treatment. (Exs. 11-2, 16, 22-1, 29, 36-5, 40-1, -2, 42-3, 43-5, -6, 44-4). Therefore, ORS 656.005(7)(a)(B) applies and claimant must establish that her April 8, 1997 injury is the major contributing cause of her L5-S1 disc herniation and L4-5 and L5-S1 mechanical instability conditions.

We agree with the ALJ that Dr. Kendrick's opinion is not sufficient to establish compensability of claimant's L4-5 and L5-S1 disc conditions. In addition to the reasons discussed by the ALJ, we are not persuaded that Dr. Kendrick had an accurate understanding of claimant's original April 8, 1997 injury. When Dr. Kendrick initially examined claimant on March 23, 1999, he reported that she suffered the original injury when she was lifting a safe from the floor. (Ex. 23-1). In a letter to SAIF on September 10, 1999, Dr. Kendrick reported that claimant was originally injured "when she was lifting a safe[.]" (Ex. 29-1). He explained that "certainly lifting a heavy object such as a safe can put a very significant amount of force onto an area which has a predisposition to injury and has been heretofore asymptomatic." (Ex. 29-2).

In a January 12, 2000 report, Dr. Kendrick indicated that claimant's April 1997 injury had occurred when she was "squatting and lifting the lid to a safe." (Ex. 40-1). In his June 1, 2000 report, Dr. Kendrick opined that claimant "underwent a pretty clear-cut lifting injury while lifting a heavy object from the floor[.]" (Ex. 47-3).

Claimant testified that she was injured on April 8, 1997 when she was lifting a lid off a safe. (Tr. 8-10, Exs. 1, 3). She believed the lid weighed about 10 pounds. (Tr. 9). Claimant's testimony is inconsistent with Dr. Kendrick's understanding that she was injured while lifting a "heavy" object. Because Dr. Kendrick did not have an accurate understanding of the mechanism of claimant's original injury, his opinion on causation is entitled to little weight. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive). We agree with the ALJ that claimant has failed to establish compensability of her L5-S1 disc herniation and L4-5 and L5-S1 mechanical instability conditions.

ORDER

The ALJ's order dated August 14, 2000 is affirmed.

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[1] On review, SAIF contends that, to the extent claimant is arguing that the disputed conditions were "omitted conditions" under ORS 656.262(6)(d), she did not raise that issue at hearing. Claimant responds that the compensability issues were fully developed and litigated. We need not address that issue because we find that, in any event, claimant has not established compensability of the disputed conditions under ORS 656.262(7)(a) or ORS 656.262(6)(d).

In the Matter of the Compensation of
ERIC C. McKOWN, Claimant
Own Motion No. 00-0318M
OWN MOTION ORDER
Walsh & Associates, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his low back condition. Claimant's aggravation rights expired on December 29, 1998. SAIF opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of his current disability.

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

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

Here, SAIF contended that claimant's failure to provide proof of earnings demonstrated that he was not in the work force. In response to SAIF's contention, claimant has submitted copies of his 1998 and 1999 W-2 tax forms and a letter from his employer indicating that he was "an active employee * * * from January 1 through July 7." Based on claimant's submission, we find that he was in the work force at the time of his current worsening which requires surgery.[1]

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

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

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[1] On July 11, 2000, Dr. White, claimant's primary care physician, opined that claimant's low back condition had worsened and referred him to Dr. Buza, his treating orthopedic surgeon. Dr. Buza recommended that claimant undergo surgery to repair a rupture disc in his lower back. The "date of disability," for the purposes of determining whether claimant is in the work force under the Board's own motion jurisdiction, is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish he was in the work force is the time prior to July 11, 2000, when his condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

In the Matter of the Compensation of
DELBERT SHAY, Claimant
WCB Case Nos. 99-06917 & 99-06916
SECOND ORDER OF DISMISSAL
Allison Tyler, Claimant Attorney
Mustafa T. Kasubhai, Attorney

The Department of Consumer and Business Services (Department) requests reconsideration of our October 19, 2000 Order of Dismissal that dismissed for lack of appellate jurisdiction its request, and claimant's cross-request, for review of the Administrative Law Judge's (ALJ's) order that set aside a Proposed and Final Order (NCE order) declaring the employer, Michael G. and Carol L. O'Brion, to be noncomplying. Having received the employer's response, we proceed with our reconsideration.

Our Order of Dismissal found that, because the employer requested a hearing regarding the Department's NCE order and no party challenged the compensability of claimant's claim, we lacked appellate review authority of the ALJ's order. ORS 656.740(4)(c); *Ferland v. McMurty Video Productions*, 116 Or App 405 (1992), *Spencer House Moving, NCE*, 44 Van Natta 2522 (1992), *aff'd Miller v. Spencer*, 123 Or App 635 (1993). In requesting reconsideration, the Department asserts that the employer's request for hearing included a matter concerning a claim because it asserted that the "worker's claim is not valid" without subsequently withdrawing that issue at hearing. The employer responds that, during the hearing, compensability was not raised, thus showing that it was not an issue.

The employer submitted its request for hearing before retaining counsel. The document, entitled "Noncomplying Employer," states:

> "We believe the * * * worker's claim is not valid. We therefore request an evidentiary hearing. We object to the claim for the reasons that [claimant's] wages were under $500 per month and we are not required to having coverage pursuant to ORS 656.017. * * *"

At hearing, the ALJ asked the employer's attorney about the issues and he responded that the issue was "the noncomplying status of [the employer], specifically under 656.027(2) and (3)." (Tr. 10). Counsel argued that the "work involved was contracted in or about a private home" or, alternatively, the total cost of labor did not exceed $500 in any 30-day period. (*Id.*) When asked about cross-issues, claimant's attorney and the Department's attorney indicated that there were none. (*Id.*)

We find such evidence shows that the issue at hearing concerned only the NCE order and, specifically, whether the employer was noncomplying. Although the request for hearing asserted that claimant's claim "is not valid," as the subsequent language showed, the contention was made in the context that claimant was a casual worker. This construction of the request for hearing is supported by statements at hearing concerning the issues, where no party indicated that it was challenging compensability of the claim.

Thus, we continue to conclude that, because the request for hearing did not include a matter concerning a claim, we lack appellate jurisdiction. *See Trisha Clarke*, 48 Van Natta 505, *aff'd without op* 145 Or App 261 (1996).

Noting that the ALJ's order incorrectly stated that appeal was to the Board rather than the Court of Appeals, the Department alternatively asks us to remand the case to the ALJ "so the appropriate appeal rights can be reissued in that order."

In *Lankford v. Copeland*, 141 Or App 138, 143 (1996), after vacating the Board's order on the basis that the Board lacked jurisdiction to review an ALJ's order finding that the claimant was not a subject worker, the court noted that the ALJ's order provided an incorrect statement of the parties' appeal rights. The court found that the incorrect statement "affected a substantial right of [the] claimant" and remanded the case to the Board to dismiss the request for review and then "remand the order to the Director for the issuance of a corrected order." 141 Or App at 143. The court subsequently revisited its *Lankford* rationale in *Oldham v. Plumlee*, 151 Or App 402 (1997). Reasoning that the Board had no jurisdiction over an ALJ's order issued on behalf of the Director, the court concluded that the Board was not authorized to remand to the Director for the issuance of a new corrected order. Consequently, the

court overruled *Lankford* to the extent that *Lankford* held that the proper disposition is that the Board remand the order to the Director. Nonetheless, the *Oldham* court continued to adhere to the *Lankford* rationale that an ALJ's order giving incorrect "Notice of Appeal" rights is not final.

Here, because the ALJ's order incorrectly advises the parties to appeal the case to the Board rather than the Court of Appeals, the order is not final. *Oldham*, 151 Or App at 404. Because we have no appellate jurisdiction over the ALJ's order, we likewise are not authorized to remand the case to the ALJ. Nonetheless, because the ALJ's order is not final, we are returning the record to the ALJ to consider the issuance of another order containing the correct Notice of Appeal rights.

IT IS SO ORDERED.

November 15, 2000 Cite as 52 Van Natta 2021 (2000)

In the Matter of the Compensation of
VAUDA E. NOWOTNY, Claimant
Own Motion No. 00-0189M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorney
Steven T. Maher, Defense Attorney

The self-insured employer has submitted claimant's request for temporary disability compensation for claimant's 1991 right back condition. Claimant's aggravation rights expired on September 10, 1997. The employer issued a denial of the compensability of claimant's lumbar radiculopathy condition on May 31, 2000. Claimant timely appealed that denial. (WCB Case No. 00-04397). In addition, the employer recommends against reopening on the grounds that : (1) the carrier is not responsible for claimant's current condition; and (2) surgery or hospitalization is not reasonable and necessary for the compensable injury.

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

Here, claimant did appeal the May 31, 2000 denial; however, she withdrew her request for hearing. An Order of Dismissal issued on September 8, 2000. That order has not been appealed. Thus, the current lumbar radiculopathy condition and ensuing surgery for which claimant requests own motion relief remain in denied status. Consequently, we are not authorized to reopen claimant's claim at this time as the employer has not accepted claimant's current condition as compensable. Should claimant's circumstances change and the employer accept responsibility for claimant's condition, claimant may again seek own motion relief.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
SHERRY A. GOMES, Claimant
WCB Case No. 99-07107
ORDER OF DISMISSAL
James B. Northrop (Saif), Defense Attorney

On October 23, 2000, we withdrew our September 22, 2000 order that remanded this matter to the Administrative Law Judge (ALJ). We took this action to consider the SAIF Corporation's contention that we lacked authority to review the ALJ's order because claimant had neglected to provide timely notice of her request for Board review to the other parties. The time for submission of claimant's response has expired. Consequently, we proceed with our consideration of SAIF's argument. On reconsideration, because the record does not establish that the other parties received timely notice of claimant's request, we dismiss.

FINDINGS OF FACT

On May 25, 2000, the ALJ issued an Opinion and Order that dismissed claimant's request for hearing for failure to appear at hearing. Copies of the ALJ's order were mailed to claimant, the employer, the SAIF Corporation and SAIF's attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for review must be mailed to the other parties within the 30-day appeal period. The ALJ also gave claimant 30 days from the date of his order to request abatement and reconsideration should she believe that "extraordinary circumstances" prevented her attendance at hearing.

On June 26, 2000, the Board received a letter from claimant. Claimant stated that she was "not able to attend the hearing due to the fact I am incapacitated." Claimant's letter following the ALJ's Order of Dismissal was treated as request for Board review. Claimant's letter did not indicate that copies were provided to SAIF, its insured, or its attorney. On June 28, 2000, the Board mailed its computer-generated letter to all parties acknowledging its receipt of a request for review. SAIFs receipt of this acknowledgement letter constitutes SAIF's and its insured's first notice of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2).

Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983). The failure to timely file and serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992), except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or App 47, 51 (1985); *Argonaut Insurance Co. v. King*, 63 Or App at 853.

Here, the 30th day after the ALJ's May 25, 2000 order was June 24, 2000, a Saturday. Inasmuch as claimant's request for review was received by the Board on June 26, 2000 (the following Monday), it was timely filed.[1] *See* ORS 656.289(3); 656.295(2); OAR 438-005-0046(1)(b).

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[1] We have previously held that, when the last day of the 30-day appeal period falls on a Saturday or a legal holiday, including Sunday, the appeal period runs until the end of the next day that is not a Saturday or legal holiday. *E.g., James D. Hill*, 49 Van Natta 308 (1997); *Anita L. Clifton*, 43 Van Natta 1921 (1991); *Sharon D. Stephens*, 40 Van Natta 105 (1988). *See also* ORS 174.120; ORCP 10A. Inasmuch as the 30th day in this case fell on a Saturday and the following day (Sunday) was a legal holiday, *see* ORS 187.010(1)(a), claimant's appeal period ran until the end of Monday, June 26, 2000.

However, the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period.[2] Rather, based on SAIF's submission, the other parties' first notice apparently occurred when SAIF received a copy of the Board's June 26, 2000 letter acknowledging claimant's request for review. Under such circumstances, notice of claimant's appeal was untimely. *Stella T. Ybarra*, 52 Van Natta 1252 (2000).

Consequently, we conclude that notice of claimant's request was not provided to the other parties within 30 days after the ALJ's May 25, 2000 order.[3] Therefore, we lack jurisdiction to review the ALJ's order, which has become final by operation of law. *See* ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. *Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[2] Claimant's letter to the Board, which was enclosed in an envelope postmarked June 22, 2000, did not indicate that copies had been provided to the other parties to the proceeding.

[3] In the event that claimant can establish that she provided notice of her request for Board review to the other parties to the proceeding within 30 days after the ALJ's May 25, 2000 order, she may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Because our authority to reconsider this order expires within 30 days after the date of this order, claimant must file her submission as soon as possible.

In the Matter of the Compensation of
ROBERT WEST, Claimant
Own Motion No. 00-0293M
OWN MOTION ORDER ON RECONSIDERATION
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys

Claimant seeks Board authorization of an approved fee for attorney's services culminating in our October 16, 2000 Own Motion Order. We received the retainer agreement submitted by claimant's attorney. An amount of 25 percent of the increased temporary disability compensation is awarded under this order, not to exceed $1,500, payable by the carrier directly to claimant's attorney. *See* OAR 438-015-0080.

Accordingly, our October 16, 2000 order is abated and withdrawn. On reconsideration, as amended herein, we adhere to and republish our October 16, 2000 order in its entirety. The parties' rights of reconsideration and appeal shall run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
STEPHEN H. JOHNSON, Claimant
WCB Case Nos. 00-01335 & 99-08961
ORDER ON REVIEW
David C. Force, Claimant Attorney
Garrett, Hemann, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that: (1) declined to consider evidence not submitted to the Director during the reconsideration process; (2) declined to grant permanent total disability; and (3) upheld the self-insured employer's denial of an injury claim for an AC joint condition. On review, the issues are the ALJ's evidentiary rulings, compensability, and permanent total disability.

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

Evidentiary Rulings

At hearing, claimant sought to admit into evidence his own testimony and certain documents apparently not available during the Director's reconsideration proceeding.[1] The employer objected to the evidence and the ALJ ruled the evidence inadmissible.

ORS 656.283(7) provides that evidence on an issue regarding a notice of closure that was not submitted at the reconsideration required by ORS 656.268 is not admissible at hearing. The Board has interpreted the statute as excluding evidence (except for medical arbiter reports) not available to the Appellate Unit at the time of reconsideration. *See Joe R. Ray*, 48 Van Natta 325, *on recon* 48 Van Natta 458 (1996). Claimant contends that the ALJ's exclusion of the documents offered violates his constitutional due process rights pursuant to Amendment 14 of the U.S. Constitution and deprives him of a remedy without due course of law in violation of Article I section 10 of the Oregon Constitution.[2]

The Court of Appeals addressed a similar due process argument in *Koskela v. Willamette Industries, Inc.*, 159 Or App 229 (1999), *rev allowed* 329 Or 318 (1999) (Where the administrative process provides a meaningful process for adjudicating contested facts by allowing the claimant to present lay testimony by affidavit and offer affirmative written proofs and counter proofs, due process does not require a trial-type hearing with live witnesses). Because the Supreme Court has accepted review of *Koskela*, claimant invites us to revisit this issue. We decline to do so.

Claimant contends that his preexisting psychological disability, when considered in conjunction with his compensable shoulder injury, establishes an entitlement to permanent total disability. Claimant further contends that the Appellate Review Unit (ARU) rules preclude consideration of the preexisting psychological disability, contrary to the definition of permanent total disability under ORS 656.206(1)(a). Consequently, claimant reasons that the ALJ's failure to admit evidence of the preexisting condition allegedly precluded by the ARU's rules, deprives claimant of a remedy (permanent total disability) without due course of law in violation of Article I section 10 of the Oregon Constitution. We disagree.

Contrary to claimant's allegation, OAR 436-030-0055(2) directs the ARU to include disability existing prior to the compensable injury in determining permanent total disability. Even if OAR 436-030-0055(2) did not direct the ARU to include disability existing prior the compensable injury in determining permanent total disability, nothing prevents claimant from submitting evidence of such disability to the ARU in order to preserve the record should the matter come to hearing before an ALJ. Accordingly, the ALJ's refusal to admit the proffered evidence did not deprive claimant of a remedy without due course of law in violation of Article I section 10 of the Oregon Constitution.

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[1] The evidence in question pertains only to the permanent total disability issue which came to hearing via claimant's hearing request from an Order on Reconsideration. Evidence pertaining to claimant's AC joint was not limited as that issue arose out of the employer's compensability denial of the AC joint condition.

[2] Claimant raised this constitutional challenge at the hearing level. The ALJ did not address this issue.

Compensability

The ALJ concluded that claimant had not established the compensability of the AC joint condition.

Claimant seeks to establish the compensability of post-traumatic degeneration of the AC joint as either a "combined condition" under ORS 656.005(7)(a)(B) or a "consequential condition" under ORS 656.00(7)(a)(A). In either case, the major contributing cause standard applies.

To satisfy the "major contributing cause" standard, claimant must establish that his compensable injury contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). The fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or its need for treatment. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995); *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997).

Because of the possible alternative causes for his AC joint condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

The only medical provider to offer an opinion regarding the cause of claimant's AC joint condition was Dr. Roberts, the attending physician. Dr. Roberts opined that claimant had degenerative changes in the AC joint that preexisted the May 1998 compensable injury. (Ex. 24-1). He further concluded that claimant's compensable injury combined with the preexisting degenerative changes in the AC joint to create symptoms requiring treatment. (Ex. 24-2). However, he also opined that: (1) the compensable injury, which resulted in a glenoid labral tear, did little to affect the AC joint; and (2) the compensable injury did not pathologically worsen the degeneration of the AC joint. (Exs. 25-15; 25-18).

Claimant has the burden to establish the compensability of his AC joint condition. ORS 656.266. Dr. Roberts' opinion, which determined that claimant's compensability "did little to affect the AC joint," does not establish the compensability of claimant's AC joint condition. In other words, the medical evidence does not prove that claimant's May 1998 compensable injury was the major contributing cause of his disability or need for medical treatment for this AC joint condition (ORS 656.005(7)(a)(B)), nor that the May 1998 compensable injury was the major contributing cause of the AC joint condition (ORS 656.005(7)(a)(A)).

Permanent Total Disability

Claimant suffers from a psychological condition that predates his May 1998 compensable injury.[3] Claimant contends that he is permanently and totally disabled as a result of this condition and the residual problems from the May 1998 injury.[4]

"Permanent total disability" is defined as "the loss, including preexisting disability, 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). In order to establish permanent total disability (PTD), claimant must prove either that: (1) he is completely physically disabled and therefore precluded from gainful employment; or (2) his physical impairment, combined with a number of social and vocational factors, effectively prohibits gainful employment under the "odd lot" doctrine. ORS 656.206(1)(a); OAR 436-030-0055; *SAIF v. Simpson*, 88 Or App 638, 641, (1987), *rev den* 305 Or 273 (1988); *Welch v. Banister Pipeline*, 70 Or App 699, 701 (1984), *rev den* 298 Or 470 (1985).

The ALJ determined that claimant's preexisting condition was not disabling at the time of the compensable injury. Consequently, the ALJ declined to consider the preexisting condition in assessing whether claimant was permanently and totally disabled. *See Margie L. Garcia*, 46 Van Natta 1028, 1029 (1994) (in order to consider a preexisting disability in determining whether a claimant is permanently and totally disabled, the preexisting disability must be disabling at the time of the compensable injury).

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[3] Post traumatic stress related to the Vietnam War. (Ex. 8-11).

[4] The accepted condition is right shoulder glenoid labral. (Ex. 25).

The medical evidence does not establish that claimant is permanently precluded from gainful employment by either his psychological condition, his right shoulder condition, or a combination thereof. Additionally, there is no vocational evidence establishing claimant has an inability to work for non-medical reasons. Consequently, even if we assume that claimants preexisting psychological condition was disabling at the time of the compensable injury, we still are not able to conclude, on this record, that claimant is permanently incapacitated from regularly performing work at a gainful and suitable occupation.

ORDER

The ALJ's order dated June 5, 2000 is affirmed.

In the Matter of the Compensation of
DONNA R. MARTIN, Claimant
WCB Case No. 99-02795
ORDER ON REVIEW
Linerud Law Firm, Claimant Attorney
Wallace, Klor & Mann, Defense Attorney

Reviewed by Board Members Bock, Biehl, and Meyers.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Thye's order that set aside its partial denial of claimant's left chondromalacia patella condition. Claimant moves to strike the employer's appellant's brief as untimely. On review, the issues are motion to strike and compensability. We grant the motion to strike and affirm.

FINDINGS OF FACT

We adopt the "Findings of Fact" set forth in the ALJ's order.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

Claimant moves to strike the employer's appellant's brief on the basis that it was not timely filed. The employer did not respond to claimant's motion. We grant claimant's motion based on the following reasoning.

For purposes of appellate briefs, "filing" is defined as "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). An attorney's certificate that a thing was deposited in the mail on a stated date is proof of mailing on that date. OAR 438-005-0046(1)(c).

Here, the employer's appellant's brief was due on August 16, 2000. No certificate was attached to the brief stating when it was placed in the mail. However, the postmark on the envelope containing the brief was August 18, 2000. The employer offers no explanation for not filing its appellants brief by August 16, 2000. Under such circumstances, claimant's motion to strike the employer's appellant's brief is granted and the brief has not been considered on review.

Nevertheless, claimant submitted a respondent's brief that addressed the merits of her claim. The employer also timely filed a reply brief. Under these circumstances, we have considered both claimant's respondent's brief and the employer's reply brief on review. *See George T. Cooper*, 44 Van Natta 493 (1992) (the claimant failed to file an appellant's brief; however, because the insurer chose to file a "respondent's brief," the claimant was entitled to file a reply).[1]

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[1] *Compare Corrie M. Harp*, 50 Van Natta 212 (1998) (where the Board granted the claimant's motion to strike the carrier's appellant's brief as untimely and the claimant contended that her respondent's brief was only to be considered in the event that the Board did not grant her motion to strike the carrier's brief, the Board did not consider the claimant's respondent's brief).

Compensability

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

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

ORDER

The ALJ's order dated June 30, 2000 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,500, payable by the self-insured employer directly to claimant's counsel.

Board Member Meyers dissenting.

While I agree with the majority's decision regarding the motion to strike the employer's appellant's brief as untimely, I disagree with their decision that claimant has met her burden of proving compensability of her left chondromalacia patella condition. Therefore, I must respectfully dissent.

Claimant sustained a compensable injury to her *right* knee, and the employer accepted multiple conditions regarding the right knee. There is no dispute that claimant's claim for a *left* chondromalacia patella condition is a claim for a consequential condition resulting from the compensable right knee injury. As such, claimant must establish compensability under ORS 656.005(7)(a)(A), which 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."

Dr. Jones, orthopedist, examined claimant on behalf of the employer. (Ex. 36). In addition, he reviewed all of the medical records, including MRI scans and x-rays. Dr. Jones concluded that claimant's left chondromalacia patella condition was caused in major part by preexisting patellofemoral tilt lateralization and malalignment and a propensity for chondromalacia in both the patellofemoral and other compartments of the knee. He found that the transfer of weight from the right knee to the left knee due to the work injury to the right knee was a minor factor in the left knee condition. (Ex. 36-9). He explained that the preexisting degenerative changes in claimant's right knee were most likely present in her left knee as well, although treatment and diagnostic studies had been limited to her right knee. He concluded that, although transfer of some weight bearing to the left leg increased symptoms in the left knee, the majority cause of the left knee condition was claimant's preexisting constitutional changes. (Ex. 36-10).

Dr. Jones' opinion is consistent with the September 5, 1997 operative report that showed degenerative changes within claimant's right knee. (Ex. 6). This surgery occurred less than four months after claimant's right knee injury. Therefore, it clearly shows that claimant had preexisting degenerative changes. Only Dr. Jones addresses these degenerative changes in his causation opinion. Based on Dr. Jones' opinion, I would find that claimant has failed to establish compensability of her consequential left knee condition.

In the Matter of the Compensation of
JAVIER H. PATINO, Claimant
WCB Case No. 99-08656
ORDER ON REVIEW
Terrall & Terrall, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) dismissed his request for hearing from a September 7, 1999 Order on Reconsideration; and (2) affirmed an October 6, 1999 Order on Reconsideration, as amended, that awarded 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left knee (leg). On review, the issues are the propriety of the dismissal order, unscheduled permanent disability, and scheduled permanent disability. We affirm.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," including the ALJ's "Findings of Ultimate Fact."

CONCLUSIONS OF LAW AND OPINION

Dismissal Order

The ALJ held that claimant's hearing request was untimely insofar as it pertained to the issue of unscheduled permanent disability. On review, claimant challenges that decision.

We need not resolve the ALJ's procedural ruling because, for the reasons stated below, even if claimant's hearing request was timely regarding the unscheduled permanent disability issue, the record does not support his entitlement to such an award.

Unscheduled Permanent Disability

Claimant's disability is evaluated as of the date of the Order on Reconsideration. ORS 656.283(7). Impairment is established by a preponderance of medical evidence based upon objective findings. ORS 656.726(3)(f)(B). On reconsideration, where a medical arbiter is used, impairment is established by the medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14). Where a preponderance establishes a different level of impairment, the impairment is established by the preponderance of evidence. (*Id.*)

Here, a medical arbiter panel (Drs. Gripekovin, Marble, and Rich) found valid reduced ranges of motion in claimant's lumbar spine for flexion, as well as right and left lateral flexion. (Ex. 22-11). However, in specifically discussing the cause of the reduced ranges of motion, the arbiter panel opined:

> "This worker does have documented evidence of degenerative changes in his lumbar spine with a spondylolysis of L5. We feel that any soft tissue injuries sustained in June of 1998 have resolved by this point in time. Further impairment of range of motion would be related 100% to the preexisting degenerative process in his lumbar spine." (Ex. 22-8).

Claimant argues that the word "further" in above-quoted opinion should be interpreted as "future." In other words, claimant contends that the impairment from the valid reduced ranges of motion are caused by the accepted lumbar strain and that only impairment arising from a future reduction in ranges of motion would be attributable to the preexisting conditions. Because such an interpretation is inconsistent with the medical arbiter panels use of the word "resolved" to describe the accepted soft tissue injury, we decline to interpret the above-listed opinion as claimant requests.

Consequently, we conclude that the medical arbiter opinion does not attribute claimant's reduced ranges of motion in the lumbar spine to the compensable injury. Accordingly, we find that

claimant is not entitled to an award of unscheduled permanent disability as a result of this compensable injury.[1]

Scheduled Permanent Disability

The September 7, 1999 Order on Reconsideration, as amended on October 6, 1999, affirmed an April 20, 1999 Notice of Closure that awarded claimant 5 percent (7.5 degrees) scheduled permanent disability for loss of use or function of the left knee (leg), pursuant to OAR 436-035-0230(5)(b), for a left medial meniscectomy.[2] Claimant seeks an additional 8 percent (12 degrees) scheduled permanent disability for loss of use or function of the left knee (leg) for reduced ranges of motion.

The medical arbiter panel recorded varying ranges of motion in both of claimant's knees, described the range motion as "resisted," and noted "a great deal of pain behavior." (Ex. 22-4). They did not expressly declare their range of motion measurements as either valid or invalid.

The ALJ determined that, without consistent, specific range of motion findings, claimant had failed to establish his entitlement to an impairment value for reduced ranges of motion due to the compensable injury.

Claimant contends that because the medical arbiters did not expressly state the range of motion were invalid, those findings, variable or not, must be used to rate impairment. We disagree.

The criteria for the rating of disability is the permanent loss of use or function of the injured member due to the industrial injury. ORS 656.214(2). Here, we are unable to attribute the reduced range of motion in claimant's left knee to his industrial injury. The medical record does not indicate that claimant has a problem with his right knee. Nonetheless, in his closing exam, Dr. Heusch, the attending physician, reported that while claimant's left knee had a reduced range of motion, it was equal to the range of motion of claimant's right knee. (Ex. 15-2). Likewise, the medical arbiters also noted reduced ranges of motion in claimant's uninjured right knee. (Ex. 22-4). Consequently, even if we assume that the variable ranges of motion in claimant's left knee, as measured by the medical arbiters, are valid, we are unable to attribute those findings to the compensable injury. OAR 436-035-0007(23)[3]; *see generally, Donald J. Whisenant*, 52 Van Natta 808 (2000) (loss of range of motion must based upon a comparison to contralateral joint, when there is no medical evidence of injury or disease to the contralateral joint). Accordingly, we agree with the ALJ that claimant is not entitled to an award for ratable permanent impairment for loss of range of motion of the left knee.

ORDER

The ALJ's order dated March 15, 2000, as reconsidered April 26, 2000, is affirmed.

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[1] Claimant also requests an award of 5 percent for a chronic condition limiting the repetitive use of his spine. While the medical arbiter panel acknowledged that claimant's repetitive use of the spine was limited, the panel attributed the limitation to the preexisting condition. (Ex. 22-8). Because there is no medical evidence to the contrary, we conclude that claimant is not entitled to an award of 5 percent for a chronic condition related to his compensable injury.

[2] Neither party challenges claimant's entitlement to this 5 percent award for the left knee surgery.

[3] OAR 436-035-0007(23) provides: "The range of motion or laxity (instability) of an injured joint shall be compared to and valued proportionately to the contralateral joint except when the contralateral joint has a history of injury or disease or when either joint's range of motion is zero degrees or is ankylosed. The strength of an injured extremity, shoulder or hip shall be compared to and valued proportionately to the contralateral body part except when the contralateral body part has a history of injury or disease."

In the Matter of the Compensation of
LARRY V. TUCKER, Claimant
Own Motion No. 00-0332M
OWN MOTION ORDER
Bischoff, Strooband & Ousey, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation has submitted claimant's request for temporary disability compensation for his compensable cervical condition. Claimant's aggravation rights expired on May 22, 1995. SAIF opposes authorization of temporary disability compensation, contending that claimant has withdrawn from the work force.

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

On September 25, 2000, Dr. Dorsen, claimant's attending surgeon, recommended claimant undergo surgery to remove cervical hardware. On this record, we conclude that claimant's compensable injury worsened requiring surgery.[1]

However, in order to be entitled to temporary disability compensation, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in regular gainful employment; or (2) not employed, but willing to work *and* is seeking work; or (30 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 notes that claimant indicated in his request for reopening that he has not work for the last two years. Thus, SAIF contends that claimant was not in the work force at the time of the current worsening.

In response, claimant submitted a November 2, 2000 affidavit wherein he attests that he last attempted to work in January 2000, but was only able to work for a couple of days. He also asserts that he "would work if [he] could find a job that could accommodate my limitations." Based on claimant's unrebutted assertions, we conclude that he was willing to work.

However, in order to prove that he is a member of the work force, claimant must satisfy either the "seeking work" factor of the second *Dawkins* criterion or the "futility" factor of the third *Dawkins* criterion. Based on the following, we find that claimant failed to satisfy those factors.

As noted in footnote 1, the relevant time period to determine whether claimant was in the work force is at the time of disability. *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990). On this record, claimant's condition worsened requiring surgery on September 25, 2000, which is the date of disability. In his affidavit, claimant admits that he did not seek work because *he* thought it was futile inasmuch as he believed he was unemployable due to his "severe limitations."

Whether it would be futile for claimant to seek work is not a subjective test viewed through the eyes of claimant; it is an objective test determined from the record as a whole, especially considering persuasive medical evidence regarding claimants ability to work and/or seek work. *Jackson R. Scrum*, 51 Van Natta 1062 (1999) (Board denied request for Own Motion relief where the record lacked persuasive medical evidence establishing that claimant was unable to work and/or seek work due to the compensable injury). In short, the question is whether the work injury made it futile for claimant to make reasonable efforts to seek work, not whether claimant reasonably believes it to be futile.

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[1] The "date of disability," for the purpose of determining whether claimant is in the work force under the Board's own motion jurisdiction, is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996). The relevant period for which claimant must establish he was in the work force is the time prior to September 25, 2000, when his condition worsened requiring surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270 (1990); *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997).

Here, claimant does not offer a *medical* opinion that would support his "futility" contentions, nor does the record demonstrate that it would have been futile for him to work or seek work at the time of the current worsening. There is no medical evidence that demonstrates that it would have been futile for him to seek work prior to September 25, 2000. Accordingly, claimant has not established that he was a member of the work force at the time of the current disability.

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

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

IT IS SO ORDERED.

November 16, 2000 Cite as 52 Van Natta 2031 (2000)

In the Matter of the Compensation of
EARL W. ROOKHUIZEN, Claimant
WCB Case No. 00-01175
ORDER ON RECONSIDERATION
Michael B. Dye, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

On October 26, 2000, we withdrew our October 3, 2000 order that affirmed the Administrative Law Judge's (ALJ's) order upholding the SAIF Corporation's denials of claimant's "omitted" low back conditions and current low back condition. We took this action to consider claimant's motion for reconsideration and to grant SAIF an opportunity to respond. Having received SAIF's response, we proceed with our reconsideration.

Claimant contends that we did not address his argument that the denied low back conditions are compensable as part of a "combined condition," which was allegedly omitted from the Notice of Acceptance.

Initially, we note that this argument was not raised to the ALJ. In those circumstances, we generally decline to consider the argument on review. *See Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991).

Moreover, even if the issue were preserved, claimant never requested that any "combined condition" be accepted. *See* ORS 656.262(6)(d); ORS 656.262(7)(a). Consequently, no "combined condition" was ever processed by SAIF, and the issue of the compensability of a "combined condition" was neither identified nor litigated at hearing. (*see O&O* at 1).

Finally, the record does not establish that claimant's February 16, 1999 injury was or is the major contributing cause of his disability or need for treatment for any combined low back condition. ORS 656.005(7)(a)(B). *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997). Consequently, consideration of claimant's contention does not alter our ultimate conclusion to affirm the ALJ's decision.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our October 3, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
NANCY S. SPRATT, Claimant
WCB Case No. C002667
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Westmoreland & Mundorf, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

On November 1, 2000, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.

The CDA provides on page 2, number 7: "The claim has not been closed. The parties agree that claimant is medically stationary. Also, on the same page, number 8 provides: No permanent disability benefits have been awarded on the claim. The parties stipulate claimant is entitled to 5 percent scheduled permanent partial disability."

We have held that it is impermissible for a CDA to accomplish claim processing functions, including the status of whether a claimant is medically stationary or the awarding of permanent partial disability, because it is not one of the objectives to be resolved with such an agreement. *E.g., Kenneth R. Free*, 47 Van Natta 1537 (1995); *Debbie K. Ziebert*, 44 Van Natta 51 (1992).

Here, we do not interpret the present CDA, however, as impermissibly attempting claim processing functions. Instead, because the CDA expressly provides that the claim has not been closed and that no permanent disability benefits have been awarded on the claim, we interpret the agreement merely as stating that the parties believe that claimants condition is medically stationary and that, had the claim been closed, claimant would have been entitled to a 5 percent award of scheduled permanent disability.

The agreement, as interpreted herein, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $5,625, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
VICKI F. BROWN, Claimant
WCB Case No. 00-00606
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that upheld the self-insured employer's denial of her low back condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" except that we correct the statement that the "Board affirmed a judges decision that the claim was not compensable." (O & O at 3), replacing it with "The Board reversed an ALJ's order concluding that claimant proved the compensability of her injury or occupational disease claim for a low back strain."

We also do not adopt the first two full paragraphs on page 4.

CONCLUSIONS OF LAW AND OPINION

Claimant has numerous prior claims, including one filed in July 1998. In particular, claimant alleged that a compensable injury was the major contributing cause of her need for treatment or disability. An ALJ agreed with claimant and set aside a denial; the Board, however, reversed the ALJ's order and reinstated the denial.

On November 2, 1999, while working, claimant had the onset of low back pain and sought medical treatment. In December 1999, claimant began treating with Dr. Soldevilla, who eventually performed surgery on her low back for a herniated disc.

Considering the "law of the case" as providing that claimant's condition was not compensable before November 1999, the ALJ decided that claimant's "non-compensable back condition was still in existence and operative as of November 2, 1999." The ALJ concluded that claimant did not prove compensability because Dr. Soldevilla's opinion was not persuasive.

Claimant challenges the ALJ's order, asserting that, whether an injury or occupational disease, Dr. Soldevilla's opinion carried her burden of proof. The employer responds that claimant's present condition is the same as that found not compensable in prior litigation and, in any case, Dr. Soldevilla's opinion is not sufficiently persuasive to prove compensability.

Besides Dr. Soldevilla's opinion, the only other opinions are from Dr. Cook, claimant's prior treating orthopedist, and Dr. Hamby, an occupational medicine specialist who examined claimant in October 1998 on behalf of the employer. Both physicians concurred with letters from the employer's attorney stating that claimant's "current back problems are an aggravation of her preexisting injury and not related to a new injury." (Exs. 158, 159).

Dr. Soldevilla first indicated that his current diagnosis of left lumbar radiculopathy was not different from the diagnosis in 1998. (Ex. 160-2). Dr. Soldevilla further provided that claimant's November 2, 1999 injury combined with her preexisting degenerative disc disease and that claimant "had recovered from her 1998 episode and had a new exacerbation in 11/2/99." (*Id.*)

Dr. Soldevilla next indicated that claimant's herniated disc represented a pathological worsening of her preexisting degenerative disc disease. (Ex. 161-1). Dr. Soldevilla then provided estimates of contribution from potential factors, including prior work injuries, work history, off-work activities, degenerative disc disease, and the November 2, 1999 injury; he thought that the November 2, 1999 episode constituted 51 percent in claimant's need for surgery. (*Id.* at 2). Dr. Soldevilla added that this incident "caused her symptomatic disc herniation which required surgery[.]" (*Id.*)

Dr. Soldevilla was deposed. He reiterated that the November 2, 1999 event was the major contributing cause of claimant's condition. (Ex. 162-9). Although Dr. Soldevilla continued to believe that the diagnosis was no different than in 1998, he considered claimant's condition from the 1998 injury to have resolved and the 1999 event to be a reinjury. (*Id.* at 10, 11). Dr. Soldevilla explained that he considered claimant's 1998 injury to be resolved before November 1999 because she had returned to her regular work and was not seeking medical treatment. (*Id.* at 18). More specifically, according to Dr. Soldevilla, because no person totally recovers from an injury, that person can continue to have occasional symptoms; however, because claimant was performing her "normal activities," including her regular job, without medical treatment, he thought that her 1998 condition had resolved. (*Id.* at 19).

We first find that claimant's condition resulting from the noncompensable 1998 lumbar strain injury had resolved before the November 1999 episode. In coming to this conclusion, we rely on Dr. Soldevilla's opinion. Only the "check-the-box" opinions from Dr. Cook and Dr. Hamby rebut Dr. Soldevilla's opinion that claimant's 1998 condition had resolved. According to Drs. Cook and Hamby, claimant's condition was not related to a new injury but constituted an aggravation of a preexisting injury.

We find that this opinion does not overcome that of Dr. Soldevilla. First, Dr. Hamby last saw claimant in October 1998, well before the November 1999 episode, and there is no indication that he even reviewed medical records generated after his October 1998 evaluation. Thus, we give Dr. Hamby's opinion no weight.

Although Dr. Cook treated claimant following the November 1999 incident, he provides no reasoning to explain his conclusion. In contrast, Dr. Soldevilla outlined his reasons for considering claimant's condition to be a "reinjury." Consequently, we find Dr. Soldevilla's opinion more persuasive. *See Somers v. SAIF*, 77 Or App 259 (1986) (in evaluating medical opinion evidence, we rely on those opinions that are based on an accurate history and are well-reasoned).

Having found that claimant's condition from the November 1999 incident is not the same as the prior noncompensable low back condition, we find no preclusive effect from the prior litigation.[1] *E.g., Drews v. EBI Companies*, 310 Or 134, 139 (1990) (issue preclusion "precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached").

We also rely on Dr. Soldevilla's opinion to further conclude that claimant proved that the November 2, 1999 injury was the major contributing cause of her need for treatment or disability. For the same reasons stated above, we find Dr. Soldevilla's opinion in this regard more persuasive than the opinions from Drs. Cook and Hamby. According to Dr. Soldevilla, although other factors contributed, the November 2, 1999 episode was the major contributing cause of claimant's need for treatment. Thus, we conclude that claimant proved compensability. *See* ORS 656.005(7)(a)(B).

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 $4,500, 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 August 8, 2000 is reversed. The self-insured employer's denial is set aside and the claim is remanded to the employer for processing according to law. For services at hearing and on review, claimant's attorney is awarded an assessed fee of $4,500, to be paid by the self-insured employer.

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[1] In particular, the prior claim was limited to deciding if a compensable injury or employment conditions were the major contributing cause of the need for treatment, as opposed to the preexisting degenerative disc disease. (Ex. 148-2). Here, although claimant's preexisting degenerative disc disease also plays a role in her current condition, as a result of the November 1999 event, claimant has a herniated disc, which Dr. Soldevilla characterizes as a pathological worsening of her preexisting condition. We find such evidence shows that claimant's condition is not the same as that disputed and found not compensable during the prior litigation.

In the Matter of the Compensation of
STEVEN M. COOPER, Claimant
WCB Case Nos. 00-00044 & 99-06854
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorney
James B. Northrop (Saif), Defense Attorney
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Biehl, Bock, and Haynes.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Peterson's order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability.

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

The "Ultimate Findings of Facts" and the next-to-last sentence of the "Conclusions of Law and Opinion" are replaced as follows:

> "Claimant's work activities for the insured were the major contributing cause of his bilateral CTS and a pathological worsening of his left CTS."

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 August 9, 2000 is affirmed. For services on review, claimant is awarded a $1,200 attorney fee, to be paid by the insurer.

Board Member Haynes dissenting.

The majority finds claimant's CTS compensable based on Dr. Mara's opinion--even though claimant's history and clinical examinations are not reliable. I would uphold the insurer's denial, because Dr. Mara's reasoning and conclusions are unpersuasive.

Dr. Mara is not entitled to deference as claimant's attending physician, because his exposure to claimant gave him no advantage: The doctor acknowledged that claimant did not provide an accurate and complete history about his prior upper extremity problems (including left CTS symptoms just months before he worked for the insured). Moreover, Dr. Button, examining physician, described claimant's clinical examination as nonanatomic and dramatically inconsistent with objective nerve conduction studies. (*See* Ex. 28-4-6). Dr. Button also found the wear pattern on claimant's hands inconsistent with his "profound bilateral sensory impairment." (Exs. 28-7). And Dr. Mara *agreed* with Dr. Button that claimant's clinical presentation "indeed may have" included "training effect" and claimant "probably" did exaggerate some of his symptoms. (Exs. 29, 35-9-10). In other words, claimant's reporting was less than genuine. Under these circumstances, claimant's reporting is clearly unreliable and Dr. Mara was in no better position to assess causation than was Dr. Button.

I would also find Dr. Mara's conclusions unpersuasive because they are inadequately explained. The doctor admitted that claimants history *was* important to determine causation. (Ex. 35-11). But he did not explain why he apparently discounted causes preceding this work exposure, even after he learned that claimant had not divulged his prior upper extremity problems. Thus Dr. Mara's conclusion is inconsistent with his own reasoning.

Similarly, despite agreeing with Dr. Button that claimant's clinical findings "may indeed" represent learned responses, Dr. Mara persisted in relying on claimant's history *and* his clinical presentation.

Finally, I would note that Dr. Button viewed a videotape of claimant setting up a hunting camp and opined that claimant could not have performed those activities as effectively as he did with the symptoms he reported. (Ex. 29A). Dr. Mara disagreed, but he did not view the video, so his opinion is again inadequately informed and reasoned. (*See* Exs. 30C, 35-24-27).

In sum, Dr. Mara's opinion is unpersuasive because it is internally inconsistent and inadequately explained. Considering the doctor's admissions and unsupported conclusions, I would say that his causation opinion is ultimately so qualified that it is speculative. Under these circumstances, I must respectfully dissent.

In the Matter of the Compensation of
HAROLD G. OLDS, Claimant
WCB Case No. 00-02084
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Marshall's order that: (1) declined to admit Exhibit 16 into evidence; (2) awarded claimant temporary disability benefits from February 2, 2000 to April 3, 2000; and (3) assessed a penalty for the SAIF Corporation's allegedly unreasonable resistance to the payment of compensation. With his appellant's brief, claimant has attached several documents not admitted at hearing. We treat the submissions as a motion for remand. *See Judy A. Britton*, 37 Van Natta 1262 (1985). On review, the issues are remand, evidence, temporary disability benefits and penalties. We deny the motion to remand and affirm in part and modify in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Remand

With his appellant's brief, claimant has attached documents not admitted into evidence at the time of hearing. Because our review is limited to the record developed before the ALJ, we treat the submissions as a motion for remand. *Judy A. Britton*, 37 Van Natta at 1262.

We may remand a case to the ALJ if we find that the case has been improperly, incompletely, or otherwise insufficiently developed or heard by the ALJ. ORS 656.295(5); *Bailey v. SAIF*, 296 Or 41, 45 *n*.3 (1983). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, claimant has not offered any reason why the proffered evidence was unobtainable with due diligence at the time of hearing. In any event, we conclude that the proffered evidence would not likely affect the outcome of the case. Therefore, we deny claimant's request for remand.

Evidence

At hearing, the ALJ declined to admit an Administrative Decision from the Employment Department on the grounds that it was not relevant. An ALJ is not bound by common law or statutory rules of evidence or by technical or formal rules of procedure. The ALJ may conduct a hearing in any matter that will achieve substantial justice. ORS 656.283(7). The ALJ is given broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown* v. SAIF, 51 Or App 389, 394 (1991). We review the ALJ's evidentiary ruling for abuse of discretion. *James D. Brusseau II*, 43 Van Natta 541 (1991).

The ALJ's exclusion of Exhibit 16 was based on his reliance on Board precedent. Because we agree with that reliance, we find no abuse of discretion in the ALJ's decision to exclude the Employment Department decision. Accordingly, we adopt and affirm the ALJ's reasoning with respect to the issue of Exhibit 16. Alternatively, based on Board caselaw, we conclude that, even if we were to admit the

exhibit, it would not change the outcome of this case. *See, e.g., Kenneth A. Meyer*, 50 Van Natta 2302 (1998) (although the claimant argued that his termination was due to discrimination and/or retaliation, the record indicated that the employer fired the claimant because he did not take a drug test and, to the extent that the employer's act was not reasonable, the issue was not within the purview of workers' compensation law).

Temporary disability benefits

We adopt and affirm the ALJ's reasoning on the issue of temporary disability benefits.

Penalty

Claimant contends that the ALJ's order erroneously awarded a penalty based on temporary disability benefits owing between February 2, 2000 and April 3, 2000. Claimant argues that the penalty should be modified to base a penalty on amounts owing from February 2, 2000 through April 3, 2000. SAIF agrees that the order should be modified as suggested by claimant. (SAIF's respondent's brief, pg. 6.) We therefore modify the penalty assessment accordingly.

ORDER

The ALJ's order dated July 12, 2000 is modified in part and affirmed in part. In lieu of the ALJ's penalty, claimant is awarded a penalty based on amounts due from February 2, 2000 through April 3, 2000, to be shared equally by claimant and his attorney. The remainder of the ALJ's order is affirmed.

November 20, 2000 Cite as 52 Van Natta 2037 (2000)

In the Matter of the Compensation of
DARRELL H. SAMPSON, Claimant
Own Motion No. 00-0345M
OWN MOTION ORDER DENYING CONSENT TO
DESIGNATION OF PAYING AGENT (ORS 656.307)
Malagon, Moore, et al, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The Benefits Section of the Workers' Compensation Division is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer has acknowledged that the only issue is responsibility for claimant's otherwise compensable claim. Claimant's aggravation rights under his 1991 injury claim with Liberty Northwest Insurance Corporation expired March 3, 1997. Thus, the claim is subject to ORS 656.278.

Under OAR 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary. *Id.*

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

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

IT IS SO ORDERED.

In the Matter of the Compensation of
ANA M. AGUILA, Claimant
WCB Case Nos. 00-00265 & 97-04831
ORDER ON REVIEW
Hilda Galaviz, Claimant Attorney
Jerry Keene, Defense Attorney
Hoffman, Hart & Wagner, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) declined to award a penalty-related attorney fee for Royal Insurance/Geisy, Greer & Gunn, Inc.'s (GG&G's) allegedly unreasonable claim processing; (2) declined to set aside AIGC Claims Services, Inc's (AIGC's) allegedly invalid June 3, 1997 L5-S1 herniated disc denial; (3) declined to find that AIGC's August 20, 1997 responsibility denial was untimely and invalid; and (4) declined to award penalties or attorney fees for AIGC's allegedly unreasonable and invalid denials. AIGC cross-requests review of that portion of the ALJs order that awarded a $2,000 attorney fee regarding AIGC's August 20, 1997 denial. In her reply brief, claimant contends that the attorney fee should be increased and that she should be awarded an additional attorney fee for obtaining the rescission of AIGC's responsibility denial. On review, the issues are claim processing, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact and findings of ultimate fact, with the following exception. We do not adopt the third paragraph of the ALJ's findings of ultimate fact.

CONCLUSIONS OF LAW AND OPINION

Claimant initially injured her low back on January 22, 1993, when GG&G was on the risk. On April 7, 1993, GG&G accepted a nondisabling lumbar strain. (Ex. 16). Imaging studies subsequently revealed mild annular disc bulges at L4-5 and L5-S1, which were interpreted as degenerative disc disease. (Exs. 24, 35). In November 1994, the claim was closed with an award of temporary disability only. (Ex. 84). The closure was affirmed on reconsideration and after a hearing. (Exs. 86, 88).

On September 1, 1996, when AIGC was on the risk, claimant experienced progressive worsening of low back pain, aggravated by heavy lifting at work. (Ex. 94). She was diagnosed with an acute lumbar strain. *Id.*

On January 28, 1997, claimant was examined for AIGC by Drs. Dinneen and Platt, who declared claimant medically stationary and opined that claimant's current condition was a preexisting degenerative condition made symptomatic by the 1996 incident and that the work incident was no longer the major contributing cause of claimant's current need for treatment and disability. (Ex. 114).

On February 13, 1997, Dr. Wagner diagnosed an L5-S1 disc with radiculopathy. (Ex. 116).

On June 3, 1997, AIGC accepted a disabling low back strain. In the same document, AIGC stated:

> "[W]e have received medical reports with billing for L5-S1 disk, with radiculopathy. Medical information in our file indicates that this current condition and need for treatment in [sic] not related to your employment * * *. Our denial is based on the fact it does not appear your condition was worsened by or arose out of and in the course of your employment * * * ." (Ex. 120).

On June 9, 1997, claimant requested a hearing on the denial.

On August 20, 1997, AIGC denied responsibility for the "L5-S1 disc, with radiculopathy." (Ex. 123).

On August 21, 1997, AIGC issued an Updated Notice of Acceptance at Closure for a low back strain. On the same date, AIGC issued a Notice of Closure that found claimant medically stationary as of January 28, 1997 and awarded temporary disability through that date and no permanent disability. (Ex. 125). The closure was affirmed on reconsideration.

On October 15, 1997, Dr. Gritzka performed a medical arbiter examination. Dr. Gritzka reported a herniated disc at L4-5, left, which he attributed to claimant's 1993 injury. (Ex. 132).

In a letter dated January 22, 1998, AIGC wrote to a prior assigned ALJ, stating:

> "[A]s of no later than January 28, 1997, any benefits under the workers compensation laws * * * due claimant are the responsibility of [GG&G] on the January 22, 1993 claim. The claim that is being processed by AIGC * * * for the date of injury of September 1, 1996 was no longer the cause or a major contributing factor in claimant's condition as of January 28, 1997."

On April 2, 1999, claimant wrote to GG&G, informing it that a "claim" was being made under the January 22, 1993 date of injury claim. (Ex. 139A). GG&G did not respond to claimant's April 2, 1999 letter and never accepted or denied claimant's "claim."

On January 20, 2000, claimant requested a hearing, raising the issues of GG&G's alleged "de facto" responsibility denial, penalty and attorney fees. This request for hearing was consolidated with the request for hearing on AIGC's denial.

During a colloquy at hearing between the parties and the ALJ, claimant stated, "[W]e don't want to get to the compensability of an L5-S1 or an L4-5, because we believe that the denial was illegal." (Tr. 5). Claimant further asserted that her only claimed conditions were "the chronic lumbar strain, for one. That's what was originally accepted by both insurers. * * * And that's as far as we want to get to this point. We haven't made a claim for anything else." (Tr. 5). Claimant also asserted that "we're not litigating compensability and responsibility" of the disc condition(s). (Tr. 16). Based on claimant's representations, AIGC withdrew its June 3, 1997 and August 20, 1997 denials, as amended. (Tr. 16, 17).

The sole issues remaining before the ALJ were claimant's requests for penalties and attorney fees.

Penalties and Attorney Fees for Allegedly Unreasonable Claim Processing

The ALJ concluded that claimant was not entitled to penalties or penalty-related attorney fees for either carrier's allegedly unreasonable refusal to pay compensation or unreasonable delay in accepting or denying a claim. We agree.

Claimant asserted that her only claims against GG&G and AIGC were the accepted chronic lumbar strains, for which all benefits had been paid. Consequently, there were no "amounts then due" on which to base a penalty pursuant to ORS 656.262(11), and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee under ORS 656.382(1). *See Lloyd A. Humpage*, 49 Van Natta 1784 (1996) (citing *SAIF v. Condon*, 119 Or App 194, *rev den* 317 Or 162 (1993) (no entitlement to penalty or assessed fee under ORS 656.382(1) for untimely claims processing where no amounts due at time of unreasonable delay)).

Attorney Fees under ORS 656.386(1) for AIGC's Denials

The ALJ concluded that no attorney fee was appropriate under ORS 656.386(1) for prevailing over AIGC's denial of the L4-5 or L5-S1 disc conditions because no claim had been made for the denied conditions. We agree. *See Stephenson v. Meyer*, 150 Or App 300 (1997) (absent a claim, a denial is a nullity and is of no legal effect); *Ralph L. Morris*, 50 Van Natta 69, 71 (1998); *Ramona E. Hamilton*, 48 Van Natta 2438 (1996), *aff'd mem* 151 Or App 266 (1997).

However, the ALJ found that what had been causing claimant's "current condition" since January 1997 was not unequivocally separate from the accepted lumbar strain. Consequently, the ALJ concluded that the "pre-closure" denial was a current condition denial of an inseparable condition.

The ALJ awarded a fee under ORS 656.386(1) for prevailing over AIGC's denial. The ALJ reasoned that, even though withdrawn at the hearing, the basis for AIGC's denial was its assertion that the condition for which claimant was "currently" seeking compensation was not compensable. On review, AIGC contends that the ALJ erred in awarding a carrier-paid attorney fee under ORS 656.386(1) because claimant had made no claim for the denied conditions. We agree.

ORS 656.386(1) provides for a reasonable attorney fee in cases involving denied claims where an attorney is instrumental in obtaining a rescission of the denial prior to a decision by the ALJ. A "denied claim" requires three components: (1) a claim; (2) a refusal to pay compensation; and (3) an express denial. ORS 656.386(1)(b)(A).

Here, in its June 3, 1997 document, AIGC expressly stated that it had accepted claimant's lumbar strain. In the same document, AIGC stated: "[W]e have received medical reports with billing for L5-S1 disk, with radiculopathy. Medical information in our file indicates that *this* current condition and need for treatment in [sic] not related to your employment[.]" (Ex. 120; emphasis supplied). In its August 20, 1997 denial, AIGC expressly denied responsibility for the "L5-S1 disc, with radiculopathy." (Ex. 123).

AIGC's reference to "this" current condition was a reference to the "L5-S1 disc, with radiculopathy." Because AIGC's June 1997 denial letter accepted claimant's "lumbar strain" and specifically denied claimant's "L5-S1 disc, with radiculopathy," we interpret AIGC's denial to be a "partial denial" of that condition. *See Tattoo v. Barrett Business Service*, 118 Or App 348 (1993) (the express language of the denial controls the scope of the conditions denied); *Johnson v. Spectra Physics*, 303 Or 49, 58 (1987) (the insurer may partially deny a claim if it specifies which injuries or conditions it accepts and which it denies).

The August 1997 denial denies responsibility for the same specified condition. As such, the denials were limited to the L5-S1 disc with radiculopathy condition, not claimant's "current" low back condition, combined or otherwise, or symptoms other than any attributable to the denied condition. In other words, AIGC's denials are *not* general "current condition" denials, as they both specify that they are denying "L5-S1 disc, with radiculopathy."

As discussed above, claimant has withdrawn her claim for the "L5-S1 disc, with radiculopathy" condition. Moreover, AIGC never denied the accepted lumbar strain, either separately or as part of a "combined condition." Therefore, because there was no "denied claim," there is no entitlement to an attorney fee under ORS 656.386(1). We accordingly reverse the ALJ's attorney fee award.

ORDER

The ALJ's order dated July 24, 2000 is reversed in part and affirmed in part. That portion of the order that awarded a $2,000 attorney fee, to be paid by AIGC, is reversed. The remainder of the order is affirmed.

In the Matter of the Compensation of
PAULINE O. RODRIGUES, Claimant
WCB Case No. 99-06159
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Brazeau's order that upheld the self-insured employer's denials of claimant's sacroiliac joint dysfunction and L4-5 annular tear conditions. On review, the issue is compensability.

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

The ALJ concluded that claimant did not carry her burden of proving the compensability of her sacroiliac joint dysfunction condition and annular fissure condition. Claimant contends that the medical record shows that her December 26, 1997 injury caused both conditions and, thus, are compensable.

With regard to the sacroiliac joint dysfunction condition, we find that, whether or not claimant has the condition, she did not prove that it was caused by the December 26, 1997 event. Dr. MacRitchie, claimant's prior treating physician, first diagnosed the condition and indicated that it resulted from the December 26, 1997 injury. (Exs. 46, 55). Dr. MacRitchie subsequently agreed,

however, that she would expect the onset of symptoms from such a condition to occur within 72 hours of the injurious event and claimant did not report such symptoms until 18 days after her injury. (Ex. 67-1). Dr. MacRitchie further agreed that claimant's initial presentation was unusual and claimant's actions in a surveillance videotape was not consistent with her behavior during examinations. (*Id.* at 2).

Based on the latter report, we find that Dr. MacRitchie considered the onset of claimant's symptoms to be inconsistent with a sacroiliac joint dysfunction, thus rebutting her previous opinion that the December 26, 1997 episode caused the condition. Because the remaining physicians either found undetermined etiology (Ex. 32-6), or that claimant did not have the condition (Exs. 74-2, 78-7, 79), we conclude that claimant did not prove that the December 26, 1997 caused any sacroiliac joint dysfunction condition. *See* ORS 656.005(7)(a).

Turning to the annular fissure condition, we agree with the ALJ's assessment of the medical opinion evidence and, in particular, his conclusion that Dr. Karasek's opinion was not sufficiently persuasive to prove compensability. Along with the ALJ's reasons, we further note that Dr. Karasek did not base his opinion on an accurate history. Dr. Karasek thought that claimant had the onset of intensive back pain on December 26, 1997. (Exs. 80, 82-34). The record shows, however, that claimant did not report back pain until her examination with Dr. Matteri on January 15, 1998. (Ex. 15-1). We find Dr. Karasek's reliance on an inaccurate history significant because other physicians found that the gap between the injury and back symptoms showed that the annular fissure was not related to the December 26, 1997 episode (Exs. 71-2, 76-3) and Dr. Karasek himself emphasized that assessing causation relies heavily on the history (Ex. 82-58).

Thus, having found that Dr. Karasek's opinion was not based on an accurate history and, as explained by the ALJ, showed only that the December 26, 1997 event was a precipitating, rather than the major contributing cause, we conclude that claimant did not prove compensability of the annular fissure condition. *See* ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated June 19, 2000 is affirmed.

November 21, 2000 Cite as 52 Van Natta 2041 (2000)

In the Matter of the Compensation of
CHRISTINE J. AHRENDT, Claimant
WCB Case No. C002709
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Dobbins, McCurdy & Yu, Claimant Attorney
Stoel, Rives, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

On November 7, 2000, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for her compensable injury. We approve the proposed disposition.

Here, the first page of the proposed agreement provides a date of injury of May 19, 1999. Based on the Department of Consumer and Business Services' records, the May 19, 1999 claim is in denied status. Furthermore, the claim numbers recited in the CDA coincide with claimant's accepted April 1, 1998 injury claim. Because a CDA must pertain to an accepted claim, we conclude that the reference to a May 19, 1999 date of injury is a typographical error and that the parties intention is to release claimant's "non-medical service" rights under her accepted April 1, 1998 injury claim.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved. An attorney fee of $2,000, payable to claimant's counsel, is also approved.

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

IT IS SO ORDERED.

November 20, 2000 Cite as 52 Van Natta 2042 (2000)

In the Matter of the Compensation of
LASZLO TOTH, Claimant
WCB Case No. 99-04198
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's current right elbow condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following change. In the second full paragraph on page 2, we delete the last two sentences.

CONCLUSIONS OF LAW AND OPINION

On September 2, 1998, claimant was inspecting doors when he had an onset of pain in his right elbow and hand. (Ex. 1). The employer accepted a nondisabling claim for right elbow tendinitis. (Tr. 2-3).

On May 21, 1999, the employer issued a denial of claimant's current condition as of December 19, 1998, asserting that it was not related to the September 2, 1998 injury and did not arise out of or in the course and scope of his employment. (Ex. 18).

The ALJ found no medical information to suggest that claimant's current condition was different than the accepted condition. The ALJ relied on claimant's testimony that he had continued symptoms from mid-September to mid-December 1998, but he did not seek treatment because he did not want to incur further medical bills. The ALJ interpreted Dr. Casey's opinion to find that claimant's current condition in December 1998 and January 1999 through June 1, 1999 was a compensable continuation of the accepted September 1998 injury.

The employer argues that the ALJ erroneously interpreted Dr. Casey's opinion. The employer contends that there is no medical evidence to establish that claimant's current elbow condition is related to his accepted right elbow tendinitis.

We agree with the ALJ that there is no evidence that claimant had a preexisting elbow condition. Because the employer did not accept a "combined" condition, the provisions of ORS 656.005(7)(a)(B) or ORS 656.262(7)(c) do not apply. Claimant must establish that his September 2, 1998 injury is a material cause of the need for treatment or disability of his current right elbow condition. ORS 656.005(7)(a).[1] Because of the multiple possible causes of claimant's need for treatment, and considering the passage of time since the initial injury, we find that this case presents a complex medical question that depends on expert medical analysis for its resolution. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993).

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[1] We note that claimant raised the issue of "back-up" denial in closing arguments, but the ALJ declined to address that issue. *See Patricia M. McKinzey*, 51 Van Natta 1933 (1999) (Board would not consider a "back-up" denial issue raised for the first time during closing argument).

We begin by reviewing claimant's medical treatment for his right elbow condition. Claimant worked for the employer from June 24, 1998 until early September 1998. (Ex. 1; Tr. 17). He performed a variety of positions, including the inspection of doors. On September 2, 1998, claimant began having right elbow problems when he was inspecting doors. (Ex. 1; Tr. 13-15). On September 8, 1998, he sought treatment from Dr. Traina, who diagnosed right elbow tendinitis. (Ex. 3). She found that claimant was tender to palpation over the medial epicondylar region. (*Id.*) She recommended a sling, medication and light duty for one week. (*Id.*)

On September 15, 1998, Dr. Traina said that claimants elbow had been doing "very much better" until today. (Ex. 4). She found that claimant had full range of motion without difficulty and he was nontender to palpation. (*Id.*) She concluded that claimant's tendinitis was "improved" and she told him he could work regular duty as "tolerated." (*Id.*) Dr. Traina found that claimant was medically stationary on September 16, 1998. (Ex. 5).

Claimant returned to Dr. Traina on December 19, 1998, and she reported that his elbow "got better but never completely resolved." (Ex. 6). She noted that claimant had been fired approximately one week after he was released for regular duty. (*Id.*) Dr. Traina found that claimant was tender to palpation over the medial epicondyle region and she recommended a sling, light duty and medication. (*Id.*) On January 5, 1999, she reported that claimant's right elbow still hurt. (Ex. 7). Dr. Traina diagnosed chronic tendinitis of the right elbow and referred claimant to Dr. Casey. (*Id.*)

Dr. Casey examined claimant on January 13, 1999, finding that claimant had "[p]ossible" tardy ulnar nerve palsy. (Ex. 8). He recommended nerve conduction studies, which were normal. (Exs. 8, 10, 11). Dr. Casey prescribed various medications. (Ex. 11). On February 24, 1999, Dr. Casey recommended a cervical MRI, but it was negative. (Exs. 11-13). Claimant had some relief from an injection and one of the medications. (Ex. 15). Dr. Casey last treated claimant on August 10, 1999. (Ex. 24-5).

Claimant relies on Dr. Casey's opinion to establish compensability of his current right elbow condition. Dr. Casey has provided two medical reports on causation, as well as a deposition. On June 17, 1999, Dr. Casey said that claimant had a tendinitis or epicondylitis of the right elbow associated with intermittent ulnar nerve symptoms. (Ex. 22). He noted that claimant had related the symptoms to flipping doors for the employer and Dr. Casey felt those activities could initiate such symptoms. (*Id.*) Dr. Casey explained that, with overuse activities of that type, stopping the activity would not necessarily make the symptoms go away. (*Id.*) On August 31, 1999, Dr. Casey said he continued to believe that claimant's "epicondylitis" was primarily caused by the work activity of flipping doors and claimant continued to require treatment. (Ex. 23).

Claimant contends that, according to Dr. Casey's deposition testimony, if claimant did have ongoing symptoms from September 1998 through December 19, 1998 (and claimant asserts that he did), those ongoing symptoms would be related to the original injury. For the following reasons, we disagree with claimant's interpretation of Dr. Casey's deposition testimony.

In a deposition, Dr. Casey said he had not previously read any of Dr. Traina's reports, and he was not aware that claimant had an accepted tendinitis condition or that claimant had only worked for the previous employer for about two months before he was terminated. (Ex. 24-6, -9). In addition, Dr. Casey was not aware that Dr. Traina had released claimant to regular work or that claimant had not received medical treatment from September 15, 1998 until December 19, 1998. (Ex. 24-9, -14). Dr. Casey testified that the additional information that claimant had been released for regular work and that he had no medical treatment for three months affected his previous causation opinions.[2] (Ex. 24-15). He explained:

> "I think if one has a soft-tissue injury such as a sprain or strain, and it heals to the point that it requires no treatment for a significant period of time, that if it recurs in the future its not always related to the initial incident.

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[2] Based on Dr. Casey's testimony, we find that his June 17, 1999 and August 31, 1999 reports on causation were based on an inaccurate history and are entitled to little weight. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

"And I've tried reasonably hard over the years to stay consistent with that opinion. *And it is my opinion that if a patient goes for three months or longer without significant symptoms or treatment, then a recurrence of that symptom is not necessarily related to the prior incident.*" (Ex. 24-15, -16; emphasis supplied).

The employer's attorney asked Dr. Casey if he was "not able to state from a reasonable medical probability standpoint that [claimant's] complaints in January of 1999 when he saw you were causally related" to the September 1998 condition. (Ex. 24-16). Dr. Casey responded:

"I would state that unless there's some information that he had been seen somewhere, of which I'm unaware. Again, the history I recall obtaining was that he'd had some significant ongoing symptoms during that time. But that if he didn't have sufficient symptoms to require any treatment, it's my opinion that what and he'd been released, as Dr. Traina's records show, in September to do his regular work with no significant findings, that *I would state that a condition for which I treated him again in early 1999 was not related to a[n] incident in September.*" (Ex. 24-16; emphasis supplied).

Dr. Casey acknowledged that the gap in medical treatment "[c]ould be" explained by claimant's concern about paying for the treatment. (Ex. 24-20). He said that "if there's some record of which I was unaware that indicates that this patient had on-going symptoms that required treatment or attention from the time he was released by Dr. Traina until I evaluated him in January of 1999, that that could change my opinion on causation." (Ex. 24-21, -22).

Claimant's attorney questioned Dr. Casey about his changed opinion:

"Q. [Claimant's attorney]: In your experience, Doctor, I know you've indicated if somebody wasn't seen any time at all for about three months time, that the ongoing problem or the problem that they later on present with may not be related back to the original cause. Would that conclusion perhaps be more dispositive in a situation in which somebody does not provide history of ongoing problems to the doctor when they finally do present them as opposed to somebody who actual[ly] explains what's going on and what has happened in those three months time frame?

"A. [Dr. Casey]: There can be some extenuating circumstances obviously. But again, I think if they went for a three-month period with after being after having an exam with essentially no findings and then re-present, I think my own feeling is that it just increases the burden of associating it significantly to the point I wouldn't say it could never happen. *But I don't think it's probable that it related to something that long ago.*" (Ex. 24-23, -24; emphasis supplied).

We do not agree with claimant that Dr. Casey's deposition testimony establishes that, if claimant had ongoing symptoms from September 1998 through December 19, 1998, those ongoing symptoms would be related to the original injury. In *Benz v. SAIF*, 170 Or App 22 (2000), the court held that, although the Board may draw reasonable inferences from the medical evidence, it is not free to reach its own medical conclusions about causation in the absence of such evidence. *See also SAIF v. Calder*, 157 Or App 224, 227-28 (1998) ("[t]he Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge").

Here, Dr. Casey testified that if a patient went without significant symptoms or medical treatment for three months or longer, then a recurrence of symptoms was "not necessarily related to the prior incident." (Ex. 24-16). Based on the fact that Dr. Traina had released claimant to regular work with no significant findings in September 1998 and claimant did not have sufficient symptoms to require any further treatment, Dr. Casey said that claimant's condition in early 1999 "was not related to a[n] incident in September." (*Id.*) He noted that if there was some record of ongoing symptoms that required treatment, that "could" change his opinion on causation. That portion of Dr. Casey's opinion, however, is couched in terms of possibility rather than probability, which is not sufficient to sustain claimant's burden of proof. *See Gormley v. SAIF*, 52 Or App 1055, 1060 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive).

Moreover, upon further questioning from claimant's attorney, Dr. Casey explained that, after claimant's September 15, 1998 examination with essentially no findings and a three month period without treatment, he did not think it was probable that claimant's condition was related to the original

incident. (Ex. 24-23, -24). We conclude that Dr. Casey's opinion is not sufficient to establish that claimant's current right elbow condition was related, in material part, to the September 2, 1998 work incident.

The only other medical opinion is from Dr. Traina. Although Dr. Traina's December 19, 1998 and January 5, 1999 chart notes referred to the fact that claimant's elbow pain began in September 1998 (Exs. 6, 7), we find that her opinion lacks adequate explanation and is not sufficient to establish compensability. Dr. Traina did not explain how or why claimant's September 1998 injury was related to his current right elbow condition. In particular, Dr. Traina did not explain why claimant's elbow was tender on December 19, 1998, even though he had not been working for the employer since early September 1998. In addition, she did not explain why claimant's elbow was tender in December 1998 when he had no tenderness in his right elbow during her September 15, 1998 exam and she had declared him medically stationary the following day. (Exs. 4, 6). We find that Dr. Traina's opinion is not sufficient to establish compensability of claimant's current condition. In sum, we conclude that the medical evidence is insufficient to establish compensability and we therefore reverse that portion of the ALJ's order.

Finally, the ALJ found that claimant was not entitled to a penalty for the employer's allegedly unreasonable denial. In light of our disposition, there are no "amounts then due" on which to base a penalty and no unreasonable resistance to the payment of compensation to support a penalty-related attorney fee. *See Boehr v. Mid-Willamette Valley Food*, 109 Or App 292 (1991); *Randall v. Liberty Northwest Ins. Corp.*, 107 Or App 599 (1991). We therefore affirm the ALJ's conclusion that claimant is not entitled to a penalty.

ORDER

The ALJ's order dated June 15, 2000 is reversed in part and affirmed in part. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

November 21, 2000 Cite as 52 Van Natta 2045 (2000)

In the Matter of the Compensation of
JOHN COTAN, Claimant
WCB Case No. C001646
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Welch Bruun & Green, Claimant Attorney
Jeff Gerner (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

On July 10, 2000, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We disapprove the proposed disposition.

On July 19, 2000, the Board wrote the parties requesting an addendum to the CDA. On September 29, 2000, the Board sent a second request, reminding the parties that a failure to correct deficiencies in the CDA would result in the disapproval of the proposed agreement.[1] To date, the parties have not submitted the addendum as requested. Under the circumstances, we disapprove the proposed disposition as unreasonable as a matter of law. *See* OAR 438-009-0020(4)(b).

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of any temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(4)(i) and (6)(e).

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[1] Pursuant to OAR 438-009-0020(4)(b), the Board may disapprove the agreement as unreasonable as a matter of law if a deficiency noted in the Board's addendum letter is not corrected within 21 days.

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
DUANE WIMSATT, Claimant
WCB Case No. 99-05508
ORDER ON REVIEW
Doblie & Associates, Claimant Attorney
Schwabe, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the insurer's denial of claimant's injury claim for left back and leg pain symptoms. Claimant has moved for remand for admission of a "post-hearing" medical report that he received from the insurer and consolidation with another hearing that is presently pending between the parties (WCB Case No. 00-05648). On review, the issues are remand, consolidation and compensability.

We deny the motions for remand/consolidation and adopt and affirm the ALJ's order with the following supplementation.

Our review is limited to the record developed at hearing. ORS 656.295(5). We may only remand to the ALJ should we find that the hearings record has been "improperly, incompletely or otherwise insufficiently developed." *Id.* Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

In this case, the persuasive medical evidence indicates that claimant had preexisting degenerative disc disease and a non-symptomatic herniated disc at L5-S1 that combined with the work incident to cause left leg and back pain. The ALJ upheld the insurers denial because the record did not establish that claimant's March 18, 1999 work incident was the major contributing cause of his need for treatment /disability for his left leg and back pain condition.

Claimant submitted a "post-hearing" July 18, 2000 report, based on an insurer-arranged medical examination, from Drs. Parsons, Marble and Gripekoven, in which they diagnosed a protruded lumbosacral disc on the left with left S1 nerve root compression that they attributed to claimant's March 18, 1999 work injury, and degenerative lumbar disc disease that they attributed to idiopathic etiology. According to claimant, the insurer-generated medical report should be admitted into the record because it was not obtainable with due diligence prior to the hearing and would likely affect the outcome of the case because it provides an opinion contrary to those relied on by the insurer at hearing.

The insurer objects to claimant's request for remand, arguing that claimant did not exercise due diligence because he could have obtained medical opinion prior to the hearing to meet his burden of proof. The insurer also argues that the medical report in question would not likely affect the outcome of the case because the opinion in that report is based on a "precipitating cause" analysis and is cumulative of the other "precipitating cause" analyses claimant produced at hearing.

Here, the insurer did not generate Dr. Parsons' report until July 18, 2000, after the April 24, 2000 closure of the record. We conclude that Dr. Parsons' *report* itself was not obtainable with the exercise of due diligence at the time of the hearing. Nonetheless, there is no explanation why the substance contained in Dr. Parsons' report could not have been presented at the time of the hearing. Moreover, the substantive matter addressed in that report is already presented in the reports previously admitted into the hearing record.

In any event, if we further assume that the substance of Dr. Parsons' report was also not obtainable with due diligence prior to the hearing, we would, nevertheless, decline claimant's remand request. First, there are already reports in the record in support of compensability. (*See* Exhibits 28, 29A, and 36). Dr. Parsons' report states without explanation that claimant's protruded lumbosacral disc on the left was a result of his March 18, 1999 injury. The report also states that the degenerative disc disease at L4-5 and L5-S1 was not the major contributing cause of the disc. Because this submission is cumulative of other evidence in the record, it would likely not affect the outcome of the case. Thus, we find no compelling reason to remand to the ALJ for additional proceedings. Accordingly, claimant's motions are denied.[1]

ORDER

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

[1] Claimant also submitted an April 20, 2000 notice to the insurer that he was filing an occupational disease claim for posterolateral L5-S1 disc herniation with impingement on the left S1 nerve root, disc herniation at L4-5 and degenerative disc disease caused by [claimant's] work at [the employer]. This notice is provided in support of his request for consolidation. Because we have concluded that remand is not appropriate, we do not address claimant's request for consolidation.

In the Matter of the Compensation of
PAUL PEEK, Claimant
WCB Case No. C001674
ORDER DISAPPROVING CLAIM DISPOSITION AGREEMENT
Kirkpatrick & Zeitz, Claimant Attorney

Reviewed by Board Members Biehl and Haynes.

On July 12, 2000, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. For the following reason, we disapprove the proposed disposition.

On July 26, 2000, the Board's staff wrote the parties requesting an addendum to the CDA. On September 29, 2000, the Board's staff sent a second request, reminding the parties that a failure to correct this deficiency would result in the disapproval of the proposed CDA.[1] To date, the parties have not submitted the addendum as requested. Under the circumstances, we disapprove the proposed disposition as unreasonable as a matter of law. *See* OAR 438-009-0020(4)(b).

Inasmuch as the proposed disposition has been disapproved, the insurer or self-insured employer shall recommence payment of any temporary or permanent disability that was stayed by submission of the proposed disposition. OAR 436-060-0150(4)(i) and (6)(e).

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.

[1] Pursuant to OAR 438-009-0020(4)(b), the Board may disapprove the agreement as unreasonable as a matter of law if the deficiency noted in the Board's addendum letter is not corrected within 21 days.

In the Matter of the Compensation of
JAMES E. CRAFT, Claimant
WCB Case No. 00-02012
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
Jerry Keene, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Crummé's order that: (1) declined to admit Exhibit 48 into the record; and (2) increased claimant's award of scheduled permanent disability for the loss of use or function of his right leg from 15 percent (22.5 degrees), as awarded by an Order on Reconsideration, to 37 percent (55.5 degrees). The insurer cross-requests review of that portion of the ALJ's order that increased claimant's scheduled permanent disability award, contending that the reconsideration order award should be reinstated. On review, the issues are the ALJ's evidentiary ruling and extent of scheduled permanent disability. We reverse the ALJ's permanent disability award.

FINDINGS OF FACT

Claimant, a manager at a credit union, has preexisting post-polio syndrome with dysplasia of the left hip. He also experienced a right hip dislocation in 1980. On September 25, 1998, claimant compensably fractured his right hip. Dr. Davis performed surgery to repair the right hip fracture. The insurer accepted an "intertrochanteric fracture of the right hip."

Declaring claimant medically stationary on June 15, 1999, Dr. Davis opined that, because of his post-polio syndrome, it was difficult to evaluate functional assessment and limitations relative to his hip fracture. Instead, Dr. Davis thought claimant's evaluation should be related to his current functional status as compared to prior to his injury. (Ex. 34).

A September 22, 1999 Notice of Closure awarded 16 percent scheduled permanent disability for the right leg. (Ex. 38). Claimant requested reconsideration.

On October 25, 1999, Dr. Davis provided additional information regarding claimant's permanent impairment. Dr. Davis stated that, based on medical probability, claimant suffered permanent impairment of his ability to walk and stand with his right leg without the use of crutches. Dr. Davis compared claimant's present ability to walk and stand with his ability to do so without crutches prior to the injury. (Ex. 40). Dr. Davis also opined that claimant's persistent and permanent groin pain was the direct result of his injury and resulted in claimant's present difficulty in arising from his chair at work. (Exs. 42, 43).

Prior to the injury, claimant had ambulated with the use of a long left leg brace and was able to walk without using crutches anywhere except on uneven ground. Claimant rarely used a wheelchair, but did play wheelchair basketball. Following the injury to his right hip, claimant now walks with crutches all the time and can carry only small items and light paperwork. (Ex. 41).

On January 22, 2000, Drs. Tiley, Liu, and Rand performed a medical arbiter examination. (Ex. 45). On February 3, 2000, the Director requested clarification of the panel's examination report. The Director specifically asked whether all of claimant's impairment was due to the accepted condition only and noted that there was no apportionment for the worker's preexisting polio and right hip dislocation conditions. Dr. Rand subsequently indicated that 20 percent of claimant's impairment was due to the accepted condition and 80 percent to the preexisting conditions. (Ex. 46).

A February 10, 2000 Order on Reconsideration reduced claimant's total scheduled permanent disability award for his right leg (hip) to 15 percent. The appellate review specialist found that that claimant was entitled to 6.5 percent for loss of motion, 66 percent for loss of strength, 15 percent for inability to walk/stand for more than 2 hours in an eight hour period, and 5 percent for significant restriction in repetitive use of the right leg, for a combined value of 74 percent. The appellate review specialist apportioned the disability pursuant to Dr. Rand's report. (Ex. 47). Claimant requested a hearing.

On May 30, 2000, the insurer submitted an exhibit list. The parties agreed to have the case decided on the written record. On June 8, 2000, claimant submitted Exhibit 48, which consists of a "post-order on reconsideration" letter to Dr. Rand from claimant, dated February 22, 2000, and Dr. Rand's response dated March 1, 2000.

CONCLUSIONS OF LAW AND OPINION

Remand

The ALJ declined to admit Exhibit 48 into the record. Exhibit 48 consists of arbiter Dr. Rand's response to questions from claimant's attorney concerning claimant's impairment that was generated after the Order on Reconsideration issued. After claimant had submitted his closing argument, the insurer objected to admission of Exhibit 48 on the ground that it was a post-reconsideration report other than a supplemental arbiters' report requested by the Workers' Compensation Division. On review, claimant argues that we should admit and consider Exhibit 48 and increase claimant's scheduled permanent disability award to 59 percent.

ORS 656.283(7) provides that the ALJ is not bound by common law or statutory rules of evidence and may conduct a hearing in any manner that will achieve substantial justice. That statute gives the ALJ broad discretion on determinations concerning the admissibility of evidence. *See, e.g., Brown v. SAIF*, 51 Or App 389, 394 (1981). We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995). Based on the following reasoning, we find no abuse of discretion by the ALJ in declining to admit Exhibit 48.

Here, the proffered evidence was requested by claimant and was not part of the Department's reconsideration record. Thus, Exhibit 48 was inadmissible at hearing. *See Tinh Xuan Pham Auto v. Bourgo*, 143 Or App 73 (1996) (admission of a supplemental or clarifying report from the medical arbiter admissible if requested by the Department or when the initial report indicated that it was not complete); *Larry A. Thorpe*, 48 Van Natta 2608, 2610 (1996) (supplemental or clarifying reports requested by a party are not considered "medical arbiter" reports for purposes of ORS 656.268(6)(e) and, therefore, are not admissible). Consequently, we find no error in the ALJ's evidentiary ruling.

Based on this reasoning, there likewise is no compelling reason to remand this matter to the ALJ for further proceedings.[1] In other words, the consideration of this document would not affect the outcome of this case. *Compton v. Weyerhaeuser*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Talent*, 94 Or App 245, 249 (1988). Therefore, we also deny claimant's request for remand.

Extent of Scheduled Permanent Disability

The ALJ increased claimant's scheduled permanent disability award for claimant's right leg (hip) to 37 percent. On review, the insurer argues that the ALJ improperly apportioned claimant's disability and argues that the reconsideration orders award of 15 percent should be reinstated.

The ALJ concluded that apportionment under OAR 436-035-0007(4)(c) was not appropriate because the insurer had not accepted a combined condition. However, after rejecting Dr. Rand's clarifying report, the ALJ nevertheless apportioned claimant's impairment pursuant to ORS 656.214(2) and OAR 436-035-0007(1). In doing so, the ALJ reasoned that, because the record showed that claimant's work injury remained the cause of more than 50 percent "(but not how much more)" of his combined condition and related impairment as of February 10, 2000, the date of the arbiter panel examination, the apportionment value should be 50 percent. The ALJ accordingly apportioned the scheduled impairment rating of 74 percent and awarded 37 percent scheduled permanent disability for claimant's right leg.

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[1] Citing *Rosario Felix*, 45 Van Natta 1179 (1993) and *Georgia E. Wilson*, 47 Van Natta 387, *on recon* 47 Van Natta 627 (1995), claimant argues that, because we have previously corrected scrivener's errors when a review of the record demonstrated such an error, that we should treat Dr. Rand's "correction" the same as a scrivener's error. The record, however, does not demonstrate a "scrivener's error." The arbiters did not rate the wrong part of claimant's body, as occurred in the cases cited by claimant. Rather, the theory of a "scrivener's error" relies solely on the information contained in the excluded and inadmissible Exhibit 48.

Claimant's theory that the supplemental information should be allowed because it "arose out of" the reconsideration order is equally flawed. We rejected a similar argument in *Cecil L. Wilmarth, Jr.*, 48 Van Natta 325 (1996), when we stated that the effect of admitting "post-reconsideration" evidence pursuant to ORS 656.268(8) would be to eviscerate the provisions of ORS 656.268(8) and ORS 656.283(7) that explicitly limit the admissibility of post-reconsideration evidence.

The insurer argues that, given Dr. Rand's opinion that only 20 percent of claimant's permanent impairment was due to his compensable injury, the ALJ should not have declined to apportion claimant's scheduled permanent disability award accordingly. We agree.

The standard for determining whether impairment is related to a compensable injury is specifically set out by statute. ORS 656.214(2) provides that "the criteria for the rating of scheduled disability shall be the permanent loss of use or function of the injured member *due to the industrial injury.*" ORS 656.214(2) (emphasis added); *see* OAR 436-035-0007(1) (WCD Admin. Order 98-056).[2] Thus, the question before us is what impairment is "due to" the compensable intertrochanteric fracture of the right hip as opposed to claimant's noncompensable conditions.

When a medical arbiter is used, impairment is determined by a medical arbiter, except where a preponderance of medical opinion establishes a different level of impairment. OAR 436-035-0007(14). We rely on the most thorough, complete and well-reasoned evaluation of claimant's injury-related impairment. *Kenneth W. Matlack*, 46 Van Natta 1631 (1994).

Here, the ALJ relied on the arbiter panel's findings rather than those of Dr. Davis, because Dr. Davis' findings were less comprehensive than those of the panel and because Dr. Davis examined claimant nearly seven months prior to the reconsideration date. For those reasons, we also rely on the arbiter panel's findings.

However, the ALJ rejected Dr. Rand's opinion regarding the apportionment of claimant's impairment, concluding that Dr. Rand's report was not persuasive evidence that the panel found as Dr. Rand had indicated. In particular, the ALJ found the substance of the full panel's report to be inconsistent with Dr. Rand's apportionment findings. We turn to the panel's report.

The arbiter panel described the accepted condition as "intertrochanteric fracture of the right hip." The panel documented claimant's range of motion and strength loss findings. In response to the Director's question whether claimant had a loss of repetitive use of the knee/hip due to a diagnosed chronic and permanent medical condition arising out of the accepted condition, the panel replied:

> "It is our opinion based on [claimant's] clinical appearance today as well as review of the record as supplied at the time of the examination and his subjective history, he is significantly limited in his ability to repetitively use the right hip due to his diagnosed and accepted condition of right intertrochanteric hip fracture."

In response to the question from the Director regarding whether claimant was prevented from walking or standing for more than two hours in an eight hour period due to the accepted condition, the panel stated:

> "It is our opinion that [claimant] has sustained limitation in walking and standing for more than 2 hours cumulative in an 8-hour period due to the diagnosed intertrochanteric fracture of the right hip *as a result of the weakness sustained post injury superimposed on his previous condition now limiting his function.*" (Emphasis added.)

Finally, the Director asked the panel to provide, based upon its medical judgment, the percentage of impairment due to the accepted condition if findings were due to the condition and due to other unrelated causes and to include rationale for its decision. The arbiter panel responded as follows:

> "Findings are based on [claimant's] current ability subsequent to the injury of intertrochanteric fracture of the right hip and it is our opinion that apportionment is not appropriate in this case."

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[2] OAR 436-035-0007(1) provides, in part:

"Except for sections (4) and (5) of this rule, a worker is entitled to a value under these rules only for those findings of impairment that are permanent and were caused by the accepted compensable condition an accepted consequential condition and direct medical sequelea [sic]. Unrelated or noncompensable impairment findings shall be excluded and shall not be valued under these rules."

In its request for clarification, the Director asked:

> "With respect to your findings of impairment, including but not limited to, the severe strength loss, in the right leg/hip, is it your opinion that all impairment is due to the accepted condition only, and there is no apportionment for the worker's previous conditions of polio and right hip dislocation?"

Dr. Rand, the member of the arbiter panel who dictated the first report, circled "accepted condition" and indicated 20 percent, and circled "of polio and right hip" and indicated 80 percent.

As discussed above, the ALJ rejected Dr. Rand's report after finding that it was not persuasive evidence that it was the opinion of the three-member panel. We do not agree with the ALJ's analysis. First, Dr. Rand was the dictating member of the panel for the initial report and we find nothing in the Director's letter or Dr. Rand's response to indicate that Dr. Rand's clarification did not represent the opinion of the panel. Moreover, although the ALJ found that the substance of the full panel's report was inconsistent with Dr. Rand's findings, the full panel's report is no more detailed in its reasoning than Dr. Rand's, and in fact is internally inconsistent in that the panel itself noted that claimant's inability to walk for more than a two-hour period in eight hours was due to the injury "superimposed on the previous condition now limiting his function." Thus, the panel's response did not answer the Director's question.

In addition, Dr. Davis' reports support a conclusion that apportionment is appropriate in this case. At the time of his closing examination, Dr. Davis opined that, because of claimant's post-polio syndrome, it was difficult to evaluate functional assessment and limitations relative to his hip fracture. Instead, Dr. Davis thought claimant's evaluation should compare his present functional status as compared to his status prior to his injury. Dr. Davis made this comparison and concluded that claimant's ability to stand and walk with his right leg and his ability to rise from a chair had been permanently diminished by the injury. In other words, Dr. Davis acknowledged that claimant had some impairment due to his noncompensable conditions prior to his hip injury that continued to affect his ability to function, but that claimant's ability to function had diminished due to the injury.

Based on this medical record, we conclude that claimant's impairment as of the date the order on reconsideration issued was due both to the compensable fracture (and its sequelae) and to claimant's preexisting post-polio condition. Accordingly, because Dr. Rand's is the only medical report in the record that establishes the percentages of apportionment and is unrebutted, we rely on it.

The parties do not dispute the Order on Reconsideration's finding of a 74 percent value due to lost range of motion, lost strength, inability to walk more than two of eight hours, and loss of repetitive use of the right leg. Consequently, based on the medical arbiters' opinion, as clarified by Dr. Rand's report, we conclude that claimant is entitled to 20 percent of that value, for an award of 15 percent scheduled permanent disability for the loss of use or function of the right leg (hip). We accordingly reverse the ALJ's award and reinstate the Order on Reconsiderations award.

ORDER

The ALJ's order dated July 17, 2000 is reversed. The February 10, 2000 Order on Reconsideration that awarded claimant 15 percent (22.5 degrees) scheduled permanent disability for loss of use or function of claimant's right leg (hip) is affirmed. The ALJ's "out-of-compensation" attorney fee award is also reversed.

In the Matter of the Compensation of
CHARLES E. HOWELL, Claimant
Own Motion No. 00-0325M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for his low back condition. Claimant's aggravation rights expired on October 20, 1987. SAIF opposes authorization of temporary disability compensation, contending that claimant was not in the work force at the time of his current disability.

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

On August 28, 2000, claimant underwent a opiate pump implant for his low back condition. Thus, we conclude that claimant's compensable injury worsened requiring surgery.

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

Here, SAIF contended that claimant was not in the work force at the time of his current disability because claimant failed to provide proof of earnings. However, on November 14, 2000, SAIF forwarded copies of wage information which claimant had sent to it. That wage information includes a copy of claimants 1999 W-2 tax form, as well as paystubs demonstrating claimant's presence in the work force between August and October 2000. On this record, we conclude that claimant has established that he was in the work force at the time of his current disability.[1]

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning August 28, 2000, the date he was hospitalized for surgery. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

IT IS SO ORDERED.

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[1] The "date of disability" for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction, is the date he enters the hospital for the proposed surgery (the Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a)). *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was in the work force is the time prior to August 28, 2000, when he underwent the proposed surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App 410, 414 (1990); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

In the Matter of the Compensation of
ARGELIO C. SAENZ, Claimant
WCB Case Nos. 00-00043 & 98-08851
CORRECTED ORDER ON REVIEW (REMANDING)
Hilda Galaviz, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) upheld the SAIF Corporation's denial of claimant's claim for back pain as a consequence of his accepted June 1997 right knee injury; (2) upheld SAIF's denial of claimant's 1998 right knee injury claim; (3) upheld SAIF's denial of claimant's claim for back pain as a consequence of the 1998 right knee injury; and (4) imposed sanctions for claimant's counsels' allegedly frivolous hearing requests regarding the 1997 knee and back claims. Claimant also requests remand, contending that the ALJ erred in freezing the record as of the February 8, 2000 hearing. On review, the issues are the ALJ's procedural rulings, remand and, potentially, compensability and sanctions. We vacate the ALJ's order and remand.

FINDINGS OF FACT

Claimant injured his right knee on June 14, 1997. SAIF accepted claimant's claim for right knee subchondral bone bruise, osteochondral defect, and torn medial meniscus, posterior horn. On May 5, 1999, SAIF issued a partial denial of claimant's subsequent claim for consequential low back pain[1] and claimant requested a hearing. (WCB Case No. 98-08851).

Claimant filed another injury claim for a February 1998 right knee injury and consequential low back pain related to that injury. SAIF denied that claim on December 8, 1999 and claimant requested a hearing. (WCB Case No. 00-00043). On January 10, 2000, a hearing was set for March 28, 2000 regarding the February 1998 claim.

Meanwhile, the hearing on the 1997 injury claim (WCB Case No. 98-08851) was postponed three times before it convened on February 8, 2000. As of the third postponement, a prior ALJ "froze the record," pending admission of the depositions of Drs. Jones and Nicholson.

At the February 8, 2000 hearing, claimant[2] requested a consolidated hearing (on the 1997 and 1998 claims), to be "postponed" until March 28, 2000, the date already set for the 1998 claim. (*See* 1Tr. 16). Claimant argued that the cases should be heard at the same time because his low back strain was at issue in both cases, and the evidence was "the same," the only question being whether the 1997 or 1998 injury caused his low back pain. (1Tr. 2). Claimant also stated that he was not prepared for hearing on the 1998 claim. (1Tr. 11).

SAIF initially stated that it opposed consolidation, specifically objecting to any postponement of WCB Case No. 98-08851 and expressing concern that claimant should not be allowed to generate additional evidence for the 1997 claim. (1Tr. 1, 5, 12). SAIF also acknowledged that it had "assumed" that the cases *would* be consolidated, (1Tr. 9), but argued that consolidation would not serve administrative economy because there was no evidence relating the back claim to the 1997 injury. (1Tr. 10). SAIF also stated that it was prepared to litigate only the 1997 claim. (1Tr. 12).

Claimant replied that the two claims were not easily separated because SAIF had processed the 1998 claim as part of the 1997 claim. (1Tr. 10-11). Claimant also stated that he wished to question claimant's family doctor, Dr. Nicholson, regarding the recent deposition of Dr. Jones, examining physician. (Dr. Jones was deposed about a week previously, but the transcript of the deposition was "in the mail" as of the February 8, 2000 hearing). (1Tr. 8).

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[1] SAIF separately denied a claim for a consequential L4-5 disc bulge. Claimant requested a hearing on that denial, but withdrew it at the March 20, 2000 hearing.

[2] Claimant was not present at the February 8, 2000 hearing. This order attributes actions and arguments by claimant's attorney to claimant and actions and arguments by SAIF's attorney to SAIF.

The ALJ found: "Everybody wants consolidation, and for some reason nobody's ready today." (Tr. 13). The ALJ ruled that the parties had ample notice and offered them a choice to go forward on both claims, or continue the hearing on the consolidated cases, with the record frozen as developed (except for admission of Dr. Jones' deposition). (1Tr. 13-14). The parties chose the latter and the hearing was continued. (1Tr. 17).

The "continued" hearing actually convened on March 20, 2000. Claimant and his two attorneys appeared as witnesses.

The ALJ upheld SAIF's denials (based on the medical evidence) and imposed $100 sanctions against each of claimant's attorneys (reasoning that claimant had no colorable basis for challenging SAIF's November 1998 partial denial of the 1997 consequential low back claim). Claimant requested review.

CONCLUSIONS OF LAW AND OPINION

On February 8, 2000, a hearing convened regarding SAIF's denial of claimant's low back condition, claimed to be a consequence of his accepted 1997 right knee injury claim. (WCB Case No. 98-08851). At the outset, claimant requested consolidation with WCB Case No. 00-00043, a case arising out of SAIF's denial of claimant's claim for a new 1998 right knee injury and a low back condition, claimed to be a consequence of a 1998 right knee injury. A hearing on WCB Case No. 00-00043 had been previously scheduled for March 28, 2000, and claimant requested that the "consolidated" hearing convene on that date.

SAIF initially objected to consolidation, stating that it wished to proceed on the 1997 claim that day and it was not prepared to litigate the 1998 claim. However, SAIF also acknowledged that it had previously assumed that the two cases *would* be consolidated.[3]

The ALJ consolidated the cases,[4] continued the "consolidated" hearing to a later date, but ruled that the record would be frozen as developed, pending submission of Dr. Jones' deposition. Claimant objected. The "continued" hearing actually reconvened on March 20, 2000.

On review, claimant argues that the ALJ erred in freezing the record as of February 8, 2000. He contends that the ALJ should have granted his request to postpone the hearing when it was consolidated, because the issues were not identical in the two claims and he had not had time to sufficiently develop the record in the later claim regarding the 1998 injury. (WCB Case No. 00-00043). Specifically, claimant argues that he reasonably anticipated 49 days to prepare for the hearing on the 1998 claim (*i.e.*, until March 28, 2000, the hearing date scheduled for the 1998 claim), *after* the February 8, 2000 hearing date -- until the ALJ froze the record on February 8, 2000. Thus, because the ALJ's ruling abbreviated his time to prepare for litigating the later claim (without prior notice), claimant contends that the ALJ evidentiary ruling deprived him of a full and fair opportunity to be heard regarding the 1998 claim. Claimant requests remand for that purpose.

The issue on review is whether the ALJ abused her discretion[5] in refusing to allow claimant to present evidence on the 1998 claim after February 8, 2000, when a hearing on the 1998 claim was previously scheduled for March 28, 2000.

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[3] SAIF represented that it had inquired as to whether claimant would oppose consolidation, without response. (1Tr. 9, 11-12).

[4] The ALJ's "consolidation" ruling has not been challenged on review.

[5] An ALJ is not bound by technical or formal rules of procedure and may conduct the hearing in any manner that will achieve substantial justice--subject to applicable statutes and rules. ORS 656.283(7). We review the ALJ's evidentiary ruling for abuse of discretion. *See, e.g., Sandra L. Booker*, 48 Van Natta 2533 (1996) (Board reviews a continuance ruling for abuse of discretion).

Claimant was not required to be prepared for the March 28th hearing in February. Thus, the ALJ's February 8, 2000 freezing of the record amounted to an extraordinary circumstance, beyond claimant's control, and a "new issue," raised for the first time at the February 8, 2000 "consolidated" hearing. When claimant objected to the ALJ's "at hearing" ruling that no additional evidence would be admitted, he essentially requested a continuance[6] of the "consolidated" hearing in response to this new issue.[7]

This case turns on the fact that the hearing on the 1998 claim was already scheduled for 49 days later when the cases were consolidated at the February 8, 2000 hearing regarding the 1997 claim. We reiterate that claimant was not required to be prepared to litigate the 1998 claim when the ALJ consolidated the cases and froze the record. When the ALJ froze the record, claimant was denied a fair opportunity to be heard on the 1998 claim, by restricting the evidence without prior notice. Under these circumstances, we find that the ALJs evidentiary ruling was an abuse of discretion. *Compare Mika T. Poe*, 49 Van Natta 495 (1997) (no abuse of discretion where record frozen *as of* originally scheduled hearing date and hearing had been postponed due to unavailability of employer's representative, not for substantive reasons). Therefore, we conclude that the record is improperly developed on the 1998 injury claim and remand is appropriate. *See* ORS 656.295(5).

Accordingly, the ALJs order dated April 25, 2000, as amended June 8, 2000, is vacated. This case is remanded to ALJ Tenenbaum with instructions to reopen the record and conduct further proceedings consistent with this order and substantial justice. Thereafter, the ALJ shall issue a final appealable order reconsidering those issues raised at hearing.[8]

IT IS SO ORDERED.

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[6] Under ORS 656.283(4), a "hearing shall not be postponed except in extraordinary circumstances beyond the control of the requesting party." OAR 438-006-0091, regarding continuances, and 438-006-0081, regarding postponements, provide that postponements or continuances may be granted to allow preparation for new issues raised at hearing. Here, a hearing on the 1998 injury claim had been scheduled for almost a month when the hearing convened on the 1997 injury claim and the cases were consolidated.

[7] SAIF opposes remand on three grounds, none of which address the fact that claimant had 7 weeks remaining to prepare for the March 28, 2000 scheduled hearing on the 1998 claim, until February 8, 2000, when the ALJ consolidated the cases and froze the record. Neither SAIF nor the ALJ explain why claimant should have less time to prepare after case consolidation than he had before consolidation.

[8] Because we are remanding the case to the ALJ, we do not address the remaining issues. The parties may direct their arguments regarding those issues to the ALJ on remand.

In the Matter of the Compensation of
WALTER JONES, JR., Claimant
Own Motion No. 66-0356M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorney
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for medical benefits relating to his October 6, 1962 injury claim. SAIF recommends against the payment of the requested benefits, (*i.e.* November 24, 1999 low back surgery), on the grounds that the requested medical services are not related to the compensable injury.

Inasmuch as claimant sustained a compensable industrial injury prior to January 1, 1966, he does not have a lifetime right to medical benefits pursuant to ORS 656.245. *William A. Newell*, 35 Van Natta 629 (1983). However, for conditions resulting from a compensable injury occurring before January 1, 1966, the Board may authorize the payment of medical services. *See* ORS 656.278(1)(b). Claimant has the burden of proving that the requested medical services are causally related to the compensable injury. ORS 656.266; OAR 438-012-0037.

By letter dated October 19, 2000, we advised claimant of his burden of proof and requested his response within 21 days. The time allowed for response has passed and no response has been received from claimant. Therefore, we proceed with our review.

In a September 13, 2000 medical report, Dr. Parvin, claimant's attending surgeon, explained that claimant was taken to surgery in November 1999 because he was experiencing multiple fall incidents and difficulty with lower extremity coordination and strength. These symptoms were caused by spinal stenosis. Dr. Parvin explained that the stenosis was caused by a combination of factors including scar tissue (contributed from previous surgeries) and degenerative changes. He also noted that the spinal fractures claimant suffered as a result of his 1962 injury may have contributed "to a very slight degree." Dr. Parvin concluded that, although the fractures and scar tissue may have played a part in claimant's stenosis, the major contributing cause was "most likely the degenerative/aging process."

Based on Dr. Parvin's unrebutted opinion, the record does not establish that claimant's current need for treatment (*i.e.* the November 1999 surgery) is causally related to his October 6, 1962 work injury. Accordingly, the request to reopen the claim for medical services allegedly related to the 1962 work injury is denied.[1]

IT IS SO ORDERED.

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[1] We will reconsider this order if the required evidence is forthcoming within 30 days of the date of this order, *i.e.* medical evidence establishing that claimant's need for medical services is attributable to his 1962 work injury (rather than to degenerative/aging processes).

In the Matter of the Compensation of
JAMES G. EARNEST, Claimant
Own Motion No. 00-0130M
OWN MOTION ORDER ON RECONSIDERATION
Ransom & Gilbertson, Claimant Attorney
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our October 3, 2000 Own Motion Order, in which we reopened claimant's claim for the payment of temporary disability benefits commencing March 30, 2000, the date claimant was hospitalized for treatment for an inpatient detoxification program. Claimant contends that his temporary disability compensation benefits should begin October 25, 1999, when he was hospitalized for treatment for his compensable psychological condition. With his request, claimant also seeks a "penalty" for unreasonable claims processing.

On October 31, 2000, we abated our October 3, 2000 order in order to allow the parties sufficient to present their positions regarding claimant's request for reconsideration. Having received the parties' responses, we proceed with our reconsideration. After completing our reconsideration, we withdraw our prior order and replace it with the following order.

Entitlement to 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.*

In response to claimant's request for reconsideration, the SAIF Corporation contends that it does not object to the reopening of claimant's claim for the provision of temporary disability compensation beginning October 25, 1999, as long as claimant provided proof of his hospitalization on that date. Claimant submitted an October 26, 1999 Discharge Summary which documents that claimant was hospitalized on an overnight stay on October 25, 1999 for treatment for his compensable psychological condition. Inasmuch as this submission is not contested, we are persuaded that claimant's compensable condition worsened requiring the October 25, 1999 hospitalization. Thus, we withdraw our previous finding regarding the commencement of claimant's temporary disability. Instead, on reconsideration,

we authorize the reopening of claimant's claim to provide temporary total disability compensation beginning October 25, 1999, the date claimant was first hospitalized for treatment for his compensable psychological condition. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Penalties for Unreasonable Claims Processing

Claimant seeks a "penalty" apparently for SAIF's allegedly unreasonable delay in processing his own motion claim for temporary disability compensation beginning October 25, 1999.

Inasmuch as claimant is raising the issue of penalties for the first time on reconsideration, we are not inclined to address that issue at this late date. *See Vogel v. Liberty Northwest Ins. Corp.*, 132 Or App 7, 13 (1994); *Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). However, even if we were to address this issue, we would conclude that claimant is not entitled to a penalty. When a claim is under the Board's own motion jurisdiction, as this claim is, no compensation is due until the Board issues an order authorizing reopening of the claim. Therefore, prior to an order authorizing reopening, there are no amounts "then due" upon which to base a penalty. *John D. McCollum*, 44 Van Natta 2057 (1992). Under these circumstances, a penalty would not be warranted.

Accordingly, as supplement and modified, we republished our October 3, 2000 order. The parties' rights of appeal and reconsideration shall begin to run from the date of this order.

IT IS SO ORDERED.

November 22, 2000 Cite as 52 Van Natta 2057 (2000)

In the Matter of the Compensation of
KEVIN E. HANNA, Claimant
WCB Case Nos. 00-01337 & 99-10180
ORDER OF DISMISSAL
Lundeen, et al, Defense Attorney

Claimant has requested review of Administrative Law Judge (ALJ) Martha Brown's July 3, 2000 order that dismissed claimant's request for hearing. We have reviewed claimant's request for review to determine if we have jurisdiction to consider this matter. Because the record does not establish that the other parties received timely notice of claimant's request, we dismiss.

FINDINGS OF FACT

On July 3, 2000, the ALJ issued an Opinion and Order that dismissed claimant's request for hearing for failure to appear at hearing. Copies of the ALJ's order were mailed to claimant, the employer, the insurer and the insurers attorney. The order contained a statement explaining the parties' rights of appeal, including a notice that a request for review must be mailed to the Board within 30 days of the ALJ's order and that copies of the request for review must be mailed to the other parties within the 30-day appeal period.

On August 3, 2000, the Board received a letter from claimant, dated July 30, 2000. Claimant's letter was treated as request for Board review of the ALJ's Order of Dismissal. Claimant's letter did not indicate that copies were provided to the employer, the insurer or the insurer's attorney.

On August 8, 2000, the Board mailed its computer-generated letter to all parties acknowledging its receipt of a request for review. The insurer's receipt of this acknowledgement letter constitutes its and the employer's first notice of claimant's request for Board review.

CONCLUSIONS OF LAW AND OPINION

An ALJ's order is final unless, within 30 days after the date on which a copy of the order is mailed to the parties, one of the parties requests Board review under ORS 656.295. *See* ORS 656.289(3). Requests for Board review shall be mailed to the Board and copies of the request shall be mailed to all parties to the proceeding before the ALJ. ORS 656.295(2).

Compliance with ORS 656.295 requires that statutory notice of the request be mailed or actual notice be received within the statutory period. *Argonaut Insurance Co. v. King*, 63 Or App 847, 852 (1983). The failure to timely file and serve all parties with a request for Board review requires dismissal, *Mosley v. Sacred Heart Hospital*, 113 Or App 234, 237 (1992), except that a non-served party's actual notice of the appeal within the 30-day period will save the appeal. *See Zurich Ins. Co. v. Diversified Risk Management*, 300 Or App 47, 51 (1985); *Argonaut Insurance Co. v. King*, 63 Or App at 853.

"Filing" of a request for review is 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 the request is not mailed by registered or certified mail and the request is actually received by the Board after the date for filing, it shall be presumed that the mailing was untimely unless the filing party establishes that the mailing was timely. OAR 438-005-0046(1)(b).

Here, the 30th day after the ALJ's July 3, 2000 order was August 2, 2000. Claimant's request for review was not mailed by registered or certified mail. Because the request was received by the Board on August 3, 2000, a rebuttable presumption exists that the request was untimely filed. *See* OAR 438-005-0046(1)(b). This presumption is probably rebutted based on the August 2, 2000 postmark date of the envelope in which the request was contained. However, we need not resolve this question because the record fails to establish that the other parties to the proceeding before the ALJ were provided with a copy, or received actual knowledge, of claimant's request for review within the statutory 30-day period.[1] Thus, notice of claimant's appeal was untimely. *Stella T. Ybarra*, 52 Van Natta 1252 (2000). Under these circumstances, we lack jurisdiction to review the ALJ's order, which has become final by operation of law.[2] *See* ORS 656.289(3); 656.295(2).

Finally, we are mindful that claimant has requested review without benefit of legal representation. We further realize that an unrepresented party is not expected to be familiar with administrative and procedural requirements of the Workers' Compensation Law. However, instructions for requesting review were clearly stated in the ALJ's order. Moreover, we are not free to relax a jurisdictional requirement. *Alfred F. Puglisi*, 39 Van Natta 310 (1987); *Julio P. Lopez*, 38 Van Natta 862 (1986).

Accordingly, the request for Board review is dismissed.

IT IS SO ORDERED.

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[1] Claimant's letter to the Board, which was enclosed in an envelope postmarked August 2, 2000, did not indicate that copies had been provided to the other parties to the proceeding.

[2] In the event that claimant can establish that he provided notice of his request for Board review to the other parties to the proceeding within 30 days after the ALJ's July 3, 2000 order, he may submit written information for our consideration. However, we must receive such written information in sufficient time to permit us to reconsider this matter. Because our authority to reconsider this order expires within 30 days after the date of this order, claimant must file his submission as soon as possible.

In the Matter of the Compensation of
KIMBERLY M. NISWENDER, Claimant
WCB Case Nos. 98-08348 & 98-06145
ORDER ON REVIEW
Kryger, et al, Claimant Attorney
Lundeen, et al, Defense Attorney
Sheridan, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Paula Insurance Company requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that set aside its denial of claimant's new injury claim for her left shoulder and neck conditions. On review, the issue is compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

Claimant has a compensable low back injury claim with Employers Insurance of Wausau as a result of a work accident in January 1994.[1] Claimant continued to have chronic low back and leg pain after that injury.

In April 1998, while working for the same employer, claimant fell into an aisle while traveling on a minibus; she slid towards the front of the vehicle but was stopped when another passenger grabbed her ankle. When this incident occurred, Paula was providing coverage.

The ALJ concluded that claimant proved that the April 1998 injury was the major contributing cause of her neck and left shoulder conditions.[2] Paula challenges that conclusion, asserting that neither the neck nor the left shoulder conditions are compensable.

Following the April 17, 1998 incident, claimant first saw Dr. McDonald and then her treating physician, Dr. Olson. She reported to both physicians that she had pain in her cervical and lumbar spine. (Exs. 102-1, 106-1). Dr. Olson diagnosed back and neck strains. (Exs. 106-1, 110).

On May 11, 1998, claimant told Dr. Olson that, following a physical therapy session, she had right shoulder pain and some numbness in her left arm. (Ex. 114-1). Dr. Olson continued to diagnose only a cervical strain. (*Id.*, 117-3, 118-1). On June 10, 1998, Dr. Olson noted that, although claimants neck pain had improved, she still had "some trouble with her left shoulder." (Ex. 121-1). Dr. Olson found that range of motion in the left shoulder was limited and assessed "[l]eft shoulder injury of unclear etiology." (*Id.*)

On July 16, 1998, claimant saw consulting orthopedist, Dr. Corrigan, who diagnosed cervical strain, right shoulder contusion and strain, and lumbar strain. (Ex. 126-4). With regard to the neck and right shoulder, Dr. Corrigan noted that it was reasonable "to assume some element of strain and contusion considering the mechanics of her injury of April 17, 1998." (*Id.*) In view of the "normal cervical spine and left shoulder x-rays and a normal cervical spine study," however, Dr. Corrigan was "not convinced that there is any structural problem within the shoulder in terms of something like a rotator cuff tear." (*Id.* at 4-5).

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[1] The 1994 claim is not at issue in this proceeding.

[2] The ALJ's initial order issued on May 25, 1999. Paula requested Board review; after finding that the hearing transcript was not complete, the Board remanded the case to the ALJ. The ALJ convened another hearing. The ALJ then issued an Opinion and Order on Remand that, except for awarding an additional attorney fee, adhered to and republished the first order. That order is now before the Board on review.

Examining physicians Dr. Williams, neurosurgeon, and Dr. Fuller, orthopedic surgeon, diagnosed a "[c]hronic pain syndrome associated with the back, neck and left upper extremity, involving subjective complaints not supported by objective findings." (Ex. 130-4). In particular, after performing an internal examination of the left shoulder, Dr. Fuller "found no pathology to be clinically evident." (*Id.*) The panel noted only that claimant "possibly [had] some soft tissue injuries as a result of her underlying condition." (*Id.* at 5).

On August 19, 1998, Dr. Olson found "[n]eck pain and shoulder pain persisting post injury" and noted "an element of functionality to her symptomatology and limitations." (Ex. 130A-4). Dr. Olson then reported to claimant's attorney that the "diagnosed conditions stemming from the April 17, 1998 injury" included a "cervical strain, a right shoulder contusion and strain[.]" (Ex. 132-1). Dr. Olson further stated that the major contributing cause of the need for treatment of the cervical and left shoulder was the April 17, 1998 accident. (*Id.* at 2).

Dr. Olson's final "check-the-box" report stated that, based on neck complaints claimant made concerning her 1994 injury, "claimant's low back and neck conditions are pre-existing, and while she may have experienced a symptomatic flare-up from the April 17, 1998 incident, there was no pathological worsening of those condition, nor can the April 17, 1998 incident be construed as the major contributing cause of the claimant's need for medical treatment in light of her pre-existing conditions." (Ex. 134-2).

Dr. Neuberg then began treating claimant. In January 1999, Dr. Neuberg wrote to claimant's attorney that claimant had "left long thoracic nerve palsy." (Ex. 137-1). Dr. Neuberg explained that such a condition resulted from a "stretch injury" to the nerve and it was "consistent with her description of the accident, and it is consistent with all the findings on review of her chart." (*Id.*) Based on a "review of the literature, discussing this with Dr. Corrigan and Dr. Nelson [who examined claimant on September 28, 1998 (Ex. 131A)], and a review of the medical record," Dr. Neuberg thought that "the cause of [claimant's] left long thoracic nerve palsy is the accident of April 17, 1998." (*Id.* at 2).

Dr. Fuller then performed a second evaluation. He found a "[m]ild cervical strain relating to the 04/17/98 incident" and "[s]evere pain behavior and narcotic habituation." (Ex. 140-10). According to Dr. Fuller, the initial medical examinations after the April 1998 incident did not support a shoulder injury. (*Id.*) Dr. Fuller thought that, if claimant had injured her long thoracic nerve at that time, "she would have immediately presented with symptoms of 'my shoulder blade is sticking out', which is the presenting symptom of persons with scapular winging[.]" (*Id.*)

Furthermore, Dr. Fuller found that claimant had scapular winging at the time of his February 2, 1999 examination but continued to doubt the diagnosis of long thoracic nerve palsy because she had no winging "with the arm held in certain positions" or abnormal scapular motion when the arm was put through a complete range of motion. (*Id.* at 11).

In response to Dr. Fuller's report, Dr. Neuberg stated that, immediately after the injury, claimant "was suffering from the pain of the acute trauma of the injury, which focused on the back and neck" and any shoulder symptoms "were basically over shadowed by other symptoms." (Ex. 142A-1). Dr. Neuberg explained that the diagnosis of long thoracic nerve palsy was not considered until Dr. Nelson noticed scapular winging during his October 13, 1998 examination; the diagnosis was confirmed by a nerve conduction study in November 1998. (*Id.* at 2-3). Dr. Neuberg then stated that she did not concur with Dr. Fuller's report. (*Id.* at 3).

Dr. Fuller responded to Dr. Neuberg's opinion, reiterating that the April 1998 incident did not cause a long thoracic nerve palsy because "the onset of signs is immediate following the time of injury" and claimant did not show immediate left scapular dysfunction. (Ex. 143-1). Instead, according to Dr. Fuller, claimant "had normal shoulder evaluations by all of the examining physicians" without any indication of left shoulder girdle dysfunction. (*Id.*) Based on the chartnotes and his own examination on August 11, 1998, Dr. Fuller thought that claimant appeared to develop a traumatic nerve injury in late August 1998, according to Dr. Olson's August 19, 1998 chartnote. (*Id.* at 2).

In evaluating medical opinions, we rely on those that are based on an accurate history and are well-reasoned. *Somers v. SAIF*, 77 Or App 210 (1986). Based on this standard, we first find that the record is insufficient to prove the compensability of the long thoracic nerve palsy condition.

Dr. Neuberg is the only physician who supports a causal relationship between this condition and the April 17, 1998 accident. We find her opinion unpersuasive for several reasons. First, Dr. Neuberg

does not persuasively rebut Dr. Fuller's opinion that, if claimant had sustained such an injury from the accident, she would have immediately demonstrated scapular dysfunction and, instead, her initial medical examinations were normal concerning her left shoulder. In addressing the initial absence of scapular complaints, Dr. Neuberg states only that, apparently, claimant's shoulder symptoms were "over shadowed" by neck and low back pain.

Such a statement does not explain why, according to Dr. Fuller, claimant did not show scapular problems until late August, about four months after the April 1998 accident. Furthermore, it does little to respond to Dr. Fuller's point that claimant could not have engaged in such activities as swimming pool therapy and gym exercises if she was having difficulty in using her left arm.

Dr. Neuberg also does not provide any explanation for how the April 1998 accident caused a long thoracic nerve palsy. Dr. Neuberg states only that such condition was "consistent with [claimant's] description of the accident" without specifically explaining how the mechanics of the accident caused trauma to the nerve.

Finally, except for one examination on June 25, 1998, Dr. Neuberg did not start treating claimant until September 15, 1998, nearly five months after the accident.

In sum, with regard to the long thoracic nerve palsy condition, we find the medical opinions, at best, in equipoise. Because Dr. Neuberg's opinion is not sufficiently persuasive, claimant did not carry her burden of proving compensability of this condition.[3]

We come to a different conclusion, however, concerning the neck strain condition. Dr. Olson, who had extensive contact with claimant following the accident, diagnosed a neck strain and related it to the April 17, 1998 accident. (Ex. 132). Although Dr. Olson's final report found that the accident was not the major contributing cause, it was based on the assumption that claimant had a preexisting neck condition. We agree with the ALJ that the record does not support the existence of a preexisting neck condition. Although claimant may have reported some neck symptoms in during an examination for the 1994 low back claim, the record otherwise shows that claimant had no prior problems with her neck. Thus, we find insufficient evidence of a preexisting neck condition. Rather, we are more persuaded by Dr. Olson's prior report, which is based on a more accurate understanding of claimant's history. Consequently, claimant must establish that the April 1998 work incident was a material contributing cause of her need for medical treatment or disability for her neck condition. *See* ORS 656.005(7)(a); *Beverly Enterprises v. Michl*, 150 Or App 357 (1997).

Dr. Olson's opinion relating the neck strain to the April 17, 1998 incident is also supported by Dr. Corrigan, to some extent, the Williams/Fuller panels report, and Dr. Fuller's report. Consequently, we conclude that claimant carried her burden of proving the compensability of her neck condition. We turn to attorney fees. The ALJ assessed a total attorney fee award of $5,000 for claimant's attorney efforts in prevailing over the denial of claimant's neck and left shoulder conditions. Because we have found that only the neck condition is compensable, we modify the ALJ's attorney fee award, as well as award an attorney fee for services on review concerning this issue. ORS 656.386(1), 656.382(2).

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

ORDER

The ALJ's Opinion and Order on Remand dated May 31, 2000, as corrected June 1, 2000, is reversed in part and affirmed in part. That portion setting aside Paula's denial of claimant's left shoulder condition is reversed. The denial is reinstated and upheld. In lieu of the ALJ's attorney fee award, claimant's attorney is awarded an assessed fee of $4,500 for services at hearing (initial and on remand) and on Board review regarding the neck condition, to be paid by Paula. The remainder of the order is affirmed.

[3] We reach this conclusion whether the appropriate compensability standard is "major" or "material" contributing cause.

In the Matter of the Compensation of
KEITH G. BAKER, Claimant
WCB Case No. 98-08272
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its *de facto* denial of claimant's left shoulder impingement syndrome. In his brief, claimant argues that his subacromial bursitis condition is compensable. On review, the issue is compensability.[1] We reverse in part and affirm in part.

FINDINGS OF FACT

On January 20, 1998, claimant sought treatment from Dr. Blanche for left shoulder and upper left arm pain. (Ex. 8). He diagnosed left subacromial impingement syndrome and costochondritis. (*Id.*) Dr. Blanche prescribed medication and encouraged claimant to avoid repetitive motion while driving the hyster. (*Id.*)

Dr. Blanche next examined claimant on April 7, 1998. (Ex. 13). He said that claimant's symptoms had improved, but had not completely resolved. (*Id.*) He diagnosed "[m]uscular strain in his shoulders, particularly his trapezius muscles and his muscles of the rotator cuff bilaterally." (*Id.*) On April 10, 1998, Dr. Blanche wrote to the insurer and explained that claimant's pain was "primarily muscular" and not due to nerve impingement, but was "due to repetitive strain probably at work." (Ex. 17-2).

Shortly thereafter, the insurer accepted a nondisabling left shoulder muscle strain. (Ex. 18).

Dr. Peterson examined claimant on August 20, 1998 for complaints of neck and shoulder pain. (Ex. 25). He diagnosed possible cervical myelopathy and recommended a cervical MRI, which showed mild posterior disk bulges at C3-4 and C6-7. (Exs. 22, 25).

On September 14, 1998, claimant sought emergency room treatment for a neck injury. (Ex. 20). Claimant's symptoms included pain in both shoulders. (Ex. 20-1). He was diagnosed with a cervical strain. (Ex. 20-5).

On September 21, 1998, Dr. Peterson said that claimant's MRI showed multilevel disk desiccation, but he found no evidence of spinal cord or nerve root compression. (Ex. 25-2, -3). Dr. Peterson explained that, since claimant's August 20, 1998 visit, he had experienced an acute episode of neck pain and bilateral arm weakness. (Ex. 25-3). He noted that claimant's symptoms apparently developed after he drove a hyster across a rough road. (*Id.*)

Claimant filed a claim for a neck and upper back condition related to a September 14, 1998 injury. (Exs. 23). The insurer denied the claim on the basis there was insufficient evidence to indicate that claimant's neck and upper back condition was the result of a job-related injury or disease. (Ex. 24). The insurer later amended the denial to deny responsibility. (Ex. 28).

On October 15, 1998, Dr. Walters reported that claimant "apparently had a pump go out on his hyster and the steering is really hard." (Ex. 26). Claimant's shoulder had "flared up again" and Dr. Walters injected the shoulder. (*Id.*)

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[1] At hearing, the parties also raised an issue regarding the extent of claimant's permanent disability regarding the June 22, 1999 Order on Reconsideration, as amended on July 14, 1999. (Exs. 50, 52, Tr. II-1, -2, -10 to 14, -17). Because the ALJ did not address that issue in the order and neither party raises that issue, we do not address the extent of disability on review. We note further that, although the parties initially raised the issue of compensability of claimant's current left lateral epicondylitis, the insurer accepted that condition and claimant withdrew his request for hearing regarding that condition. (Tr. II-8).

Dr. Carlini examined claimant on November 3, 1998. He said claimant first developed left shoulder and neck soreness in January 1998. (Ex. 27-1). Dr. Carlini explained that claimant "redeveloped" soreness and weakness in his left shoulder a month ago, when his hyster had a problem with the power steering. (*Id.*) He diagnosed "[r]esolved cervical dorsal musculoskeletal sprain syndrome." (Ex. 27-4).

Dr. Peterson reviewed additional medical records and said that claimant's symptoms had been ongoing since January 1998. (Ex. 30). He found that claimant's symptoms were consistent with subacromial bursitis and cervical spondylosis, which were not work-related. (*Id.*)

On January 22, 1999, claimant's attorney requested that the insurer expand its acceptance to include left shoulder impingement and subacromial bursitis. (Ex. 32).

Claimant sought treatment from Dr. Townsend on March 11, 1999. (Ex. 35). He said that claimant had injured his left shoulder while driving a hyster in January 1998, when the power steering was not working. (*Id.*) Dr. Townsend explained that claimant's x-ray showed a type III acromion and he diagnosed "[r]ecurrent impingement of the left shoulder." (*Id.*) On April 5, 1999, Dr. Townsend injected claimant's left shoulder and said his condition was due to the repetitive nature of driving a hyster. (Ex. 38). Dr. Townsend subsequently reported that claimant had brief improvement from the injection, but the pain had recurred. (Ex. 40). He recommended a subacromial decompression. (Exs. 38, 41, 45, 54).

Dr. Cronin performed a medical arbiter examination on June 10, 1999 and diagnosed chronic/recurrent left shoulder impingement syndrome. (Ex. 48-2). He felt that claimant's impairment was related 90 percent to the "accepted condition" and 10 percent to the preexisting type II acromion. (*Id.*) He felt that driving the hyster was the major contributing cause of claimant's current condition. (*Id.*)

CONCLUSIONS OF LAW AND OPINION

Impingement Syndrome/Subacromial Bursitis

The ALJ found that the medical evidence established that claimant's accepted left shoulder strain was more appropriately identified as an impingement syndrome and he concluded that the condition was compensable. On the other hand, the ALJ found that claimant failed to prove compensability of subacromial bursitis.

The insurer argues that claimant cannot prove legal causation because he is not a credible historian and his testimony is inconsistent with the medical record. The insurer also contends that claimant has not established medical causation because the medical evidence is insufficient to establish that his work activities were the major contributing cause of his left shoulder impingement syndrome.

On review, claimant argues that his left shoulder impingement syndrome *and* subacromial bursitis are compensable. We first address compensability of the subacromial bursitis condition.

We agree with the ALJ that the only diagnosis of subacromial bursitis was from Dr. Peterson. Dr. Peterson initially examined claimant on August 20, 1998 and diagnosed cervical spondylosis. (Ex. 25-3). He subsequently reported that claimant's symptoms were consistent with subacromial bursitis and cervical spondylosis, neither of which was work-related. (Exs. 30, 44). There is no other medical evidence regarding claimant's alleged bursitis condition. Even if we assume that claimant has subacromial bursitis, we conclude that the medical evidence is insufficient to establish compensability under either a material or major contributing cause standard. We agree with the ALJ that claimant has failed to establish compensability of subacromial bursitis.

Claimant does not dispute the insurer's assertion that ORS 656.802 applies to the left shoulder impingement syndrome. To establish a compensable occupational disease, claimant must prove that his employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). If the occupational disease claim is based on the worsening of a preexisting disease or condition, 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). Because of the multiple possible causes of claimant's left shoulder condition, we find that this case presents a complex medical question that depends on expert medical analysis for its resolution. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993).

Claimant relies in part on the opinion of Dr. Blanche, who first treated him on January 20, 1998 for left shoulder and upper left arm pain. (Ex. 8). He said claimant had experienced pain for two weeks and had been driving a hyster. (*Id.*) He diagnosed left subacromial impingement syndrome and costochondritis. (*Id.*) On April 7, 1998, Dr. Blanche said that claimant's symptoms had improved. (Ex. 13). He diagnosed "[m]uscular strain in his shoulders, particularly his trapezius muscles and his muscles of the rotator cuff bilaterally." (*Id.*) He felt claimant's condition was related to repetitive motion at work. (*Id.*).

On April 10, 1998, Dr. Blanche wrote to the insurer and said that claimant's symptoms on January 20, 1998 seemed to be associated with driving a hyster. (Ex. 17). Dr. Blanche said his initial assessment was a subacromial impingement syndrome and inflammation of the muscles of the rotator cuff. (Ex. 17-1). He saw claimant on April 7, 1998 to "ostensibly close the case[,]" but claimant still had shoulder pain. (*Id.*) Dr. Blanche explained that claimant's pain was "primarily muscular" and not due to nerve impingement, but "rather due to repetitive strain probably at work." (Ex. 17-2).

Although Dr. Blanche initially said that claimant had left subacromial impingement syndrome and costochondritis (Ex. 8), he subsequently diagnosed "[m]uscular strain in his shoulders, particularly his trapezius muscles and his muscles of the rotator cuff bilaterally." (Ex. 13). In light of Dr. Blanche's later diagnosis of muscular strain and his April 10, 1998 report that claimant's symptoms were primarily muscular and due to repetitive strain, we find that his opinion lacks adequate explanation and is not sufficient to establish that claimant had left shoulder impingement syndrome. Furthermore, although Dr. Blanche associated claimant's muscular pain with repetitive strain "probably at work[,]" he did not express an opinion about the major contributing cause of the impingement syndrome. We conclude that Dr. Blanche's opinion is insufficient to establish compensability of claimant's left shoulder impingement syndrome.

For similar reasons, we are not persuaded by Dr. Cronin's opinion. Dr. Cronin examined claimant on June 10, 1999 and diagnosed chronic/recurrent left shoulder impingement syndrome. (Ex. 48-2). He opined that claimant had a "Type II" acromion, based on Dr. Townsend's March 11, 1999 chart note, and he said that could predispose an individual to an impingement syndrome. (*Id.*) We note that Dr. Townsend actually diagnosed a "Type III" acromion instead. (Ex. 35). Dr. Cronin said that "the activities of driving the Hyster and moving the arm through the impingement range of motion frequently is the major contributing cause to the current condition." (Ex. 48-2).

In a clarification letter from the Appellate Review Unit, Dr. Cronin was asked whether need for surgery was "due to or due to a direct medical sequela of the accepted left shoulder muscle strain[.]" (Ex. 49-2). Dr. Cronin checked "yes" and explained:

> "I refer you to Dr. Blanche's 9/10/98 letter[.] Initial diagnosis 'subacromial impingement syndrome & inflammation of muscles of [left] shoulder.' This is the <u>same</u> medical condition since injury. Perhaps you need to revise the accepted condition to include impingement syndrome. Also the 1st medical report 1/20/98 the diagnosis is 726.2 [left] shoulder impingement syndrome." (*Id.*; underline in original).

Thus, in recommending that the impingement syndrome should be accepted, Dr. Cronin relied on Dr. Blanche's initial diagnosis. As we discussed above, however, Dr. Blanche later diagnosed a shoulder muscular strain and said that claimant's pain was primarily muscular and due to repetitive strain. (Exs. 13, 17-2). We found that Dr. Blanche's opinion was not sufficient to establish that claimant had left shoulder impingement syndrome. For the same reasons, we find that Dr. Cronin's reliance on Dr. Blanche's initial report was misplaced. Because Dr. Cronin did not indicate if he was aware of Dr. Blanche's later reports, his opinion is entitled to little weight and is not persuasive. Moreover, Dr. Cronin's report is not persuasive because it is conclusory and does not adequately explain why claimant's work activities caused the impingement syndrome.

Claimant also relies on Dr. Townsend's opinion. Dr. Townsend reported that claimant had injured his left shoulder while driving a hyster in January 1998, when the power steering was not working. (Ex. 35). Dr. Townsend said that claimant's x-ray showed a type III acromion and he diagnosed "[r]ecurrent impingement of the left shoulder." (*Id.*) He said claimant's condition was due to the repetitive nature of driving a hyster. (Exs. 38, 40).

The insurer contends that Dr. Townsend's opinion is not persuasive because he had inaccurate history that claimant's shoulder complaints began when he lost the power steering in his hyster in January 1998. On the other hand, claimant argues that the medical evidence establishes that the repetitive motion of driving a hyster was the major contributing cause of his impingement syndrome. He asserts that there is no need to rely on the "added difficulty" of the shoulder motions when the power steering was lost.

Even if we assume, without deciding, that Dr. Townsend had an accurate understanding that claimant's power steering on the hyster went out in January 1998, we are not persuaded by his opinion on causation. Dr. Townsend initially diagnosed "[r]ecurrent impingement of the left shoulder" (Ex. 35), and diagnosed the same condition on July 19, 1999. (Ex. 54). Dr. Townsend did not explain why claimant's impingement was "recurrent." In his April 26, 1999 letter to claimant's attorney, Dr. Townsend explained:

> "I feel the pain in his shoulder is due to shoulder impingement. This has been temporarily relieved with subacromial injections. * * * Dr. Blanche felt that he had a shoulder strain. I feel that is consistent with the present condition. Again, I feel it is an impingement that is directly work related and was the condition evaluated by Dr. Blanche." (*Id.*)

Dr. Townsend's April 26, 1999 report indicates that he felt Dr. Blanche's diagnosis of a shoulder strain was consistent with claimant's present condition, which Dr. Townsend felt was shoulder impingement. It is not clear whether Dr. Townsend believed the shoulder strain and impingement syndrome were the same or similar conditions. Claimant's attorney attempted to clarify that question on April 27, 1999, when he wrote to Dr. Townsend, asking whether the diagnoses of impingement syndrome and subacromial bursitis were "merely an extension of the initial shoulder strain which was the diagnosis that Dr. Blanche had given him[.]" (Ex. 43). The record does not include a response from Dr. Townsend.

We find that Dr. Townsend's opinion is not persuasive because it lacks adequate explanation. In particular, his opinion does not explain whether or not claimant's impingement syndrome is separate and different from the left shoulder muscle strain already accepted by the insurer. Instead, Dr. Townsend apparently treated both conditions interchangeably. We are unable to determine from Dr. Townsend's opinion whether claimant has left shoulder impingement syndrome that is separate from the accepted left shoulder muscle strain. Furthermore, we agree with the insurer that Dr. Townsend failed to discuss the contribution of claimant's Type III acromion to his impingement syndrome. Dr. Cronin indicated that claimant had a preexisting "Type II" acromion that contributed to his impingement syndrome. (Ex. 48-2). We conclude that Dr. Townsend's opinion is insufficient to establish that claimant's work activities were the major contributing cause of the left shoulder impingement syndrome.

To the extent claimant relies on the opinion of Dr. Carlini to establish compensability, we are not persuaded by his opinion. Dr. Carlini examined claimant on one occasion in November 1998 and diagnosed "[r]esolved cervical dorsal musculoskeletal sprain syndrome." (Ex. 27-4). Dr. Carlini's opinion does not support either the diagnosis or compensability of left shoulder impingement syndrome.

Similarly, we are not persuaded by Dr. Walters' opinion. Dr. Walters reported on October 15, 1998 that claimant "apparently had a pump go out on his hyster and the steering is really hard." (Ex. 26). He said that claimant's shoulder had "flared up again[.]" (*Id.*) Dr. Walters did not refer to a diagnosis and his conclusory chart note is insufficient to establish compensability of claimant's left shoulder impingement syndrome.

The remaining medical opinion on causation is from Dr. Peterson, who diagnosed claimant with cervical spondylosis. (Ex. 25-2, -3). Dr. Peterson felt that claimant's symptoms were the result of subacromial bursitis and cervical spondylosis, neither of which was work-related. (Exs. 30, 44). Thus, Dr. Peterson's opinion does not support compensability. In sum, we conclude that the medical evidence is insufficient to establish compensability of claimant's left shoulder impingement syndrome. We therefore reverse that portion of the ALJ's order.[2]

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[2] Because we have found that claimant has failed to establish compensability under ORS 656.802(2)(a), we need not decide whether ORS 656.802(2)(b) applies to this case.

September 14, 1998 Injury

Because neither party discusses that portion of the ALJ's order that upheld the insurer's denials of claimant's September 14, 1998 injury claim for a neck and upper back injury (Exs. 24, 28), we do not address that issue.

ORDER

The ALJ's order dated June 22, 2000 is reversed in part and affirmed in part. The insurer's denial of claimant's left shoulder impingement syndrome is reinstated and upheld. The ALJ's attorney fee award is reversed. The remainder of the ALJ's order is affirmed.

November 24, 2000 Cite as 52 Van Natta 2066 (2000)

In the Matter of the Compensation of
DANIEL B. COVERT, Claimant
WCB Case No. 00-01535
ORDER ON RECONSIDERATION
Welch, Bruun & Green, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

The SAIF Corporation requested reconsideration of our September 14, 2000 order that affirmed the Administrative Law Judge's (ALJ's) order that modified an Order on Reconsideration to award temporary total disability benefits from March 2, 1998 through March 10, 1999. SAIF argues that in addition to ORS 656.262(4)(g), the ALJ (and Board) should have also analyzed the case under ORS 656.262(4)(d). On October 9, 2000, in order to consider SAIF's argument, we withdrew our September 14, 2000 order. Having received claimant's response to SAIF's motion, we proceed with our reconsideration.

In awarding temporary disability benefits from March 2, 1998 through March 10, 1999, both our order and the ALJ's order addressed the case under ORS 656.262(4)(g). That statute provides, in part, that temporary disability compensation is not due and payable pursuant to ORS 656.268 for any period of time not authorized by the attending physician.

On reconsideration, SAIF for the first time argues that the case should also have been analyzed under ORS 656.262(4)(d). That statute provides, in relevant part, that temporary disability compensation is not due and payable for any period of time for which the insurer "has requested from the worker's attending physician verification of the worker's inability to work resulting from the claimed injury or disease and the physician cannot verify the workers inability to work."

This case arose from SAIF's appeal of an Order on Reconsideration. No hearing was held and the case was submitted on the documentary record with written closing arguments. In its written argument, SAIF asserted that there was no authorization for time loss from the attending physician. The ALJ addressed SAIF's arguments relying on ORS 656.262(4)(g). In its briefs on review, SAIF again argued that temporary disability benefits were not authorized by claimant's attending physician.

As a general rule, we do not consider issues that are raised for the first time on review. *See Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991); *see also Fister v. South Hills Health Care*, 149 Or App 214 (1997) (absent adequate reason, Board should not deviate from its well-established practice of considering only those issues raised by the parties at hearing). However, alternative "legal theories," as opposed to new issues, can be considered for the first time on Board review if there is no prejudice to the adverse party. *See Martha E. Leyva*, 49 Van Natta 1177 (1997).

The issue before the ALJ and the Board was whether the Order on Reconsideration correctly awarded claimant temporary disability benefits. Thus, SAIF's argument does not raise a new issue. Instead, SAIF raises an alternative legal theory under a different subsection of the statute and argues on this additional basis that claimant is not entitled to temporary disability benefits. Because the type of evidence needed to establish entitlement to temporary disability benefits under ORS 656.262(4)(d) and (g) is similar (*i.e.*, evidence that the attending physician could verify the worker's inability to work and evidence that the attending physician had authorized temporary disability), and because the evidence in

this matter is limited to the reconsideration record,[1] we find no prejudice to claimant in addressing SAIF's argument. *See Anita A. Bade*, 36 Van Natta 1093 (1984) (new legal theory raised on Board review is not "new issue" and Board is free to address theory on review).

In June 1998, SAIF's claims examiner wrote to Dr. Rosenbaum and, among other things, asked him whether claimant "remained released to regular work" with regard to his sciatica condition. (Ex. 43-2). If claimant was not able to work, Dr. Rosenbaum was asked to explain the medical findings that prevented him from returning to regular work. In his June 11, 1998 response, Dr. Rosenbaum stated:

> "I am not aware at the present time of [claimant's] work activity. If he has indeed been performing regular work duty then I believe he could continue this activity. Frequently sciatic pain is of such severity that increased physical exertion increases the pain and precludes significant work activity. It would be dependent upon [claimant's] condition and since I have not evaluated him since March 2, 1998 I cannot make an adequate assessment. It was my understanding that he has not been employed since 8/5/96 but I do not have any recent work experience specifically noted in my medical records."

Here, SAIF requested verification from Dr. Rosenbaum of claimant's inability to work resulting from the injury and Dr. Rosenbaum could not verify that claimant was unable to work. Thus, under ORS 656.262(4)(d), temporary disability is not due and payable after June 11, 1998, the date of Dr. Rosenbaum's response.

On reconsideration, the ALJ's order dated May 16, 2000 is modified in part. The Order on Reconsideration is modified to award temporary disability benefits from March 2, 1998 through June 11, 1998. The remainder of the ALJ's order is affirmed. Because we have reduced claimant's compensation for temporary disability, no attorney fee under ORS 656.382(2) can be awarded. Consequently, our $1,050 attorney fee award is withdrawn. Accordingly, as modified herein, we republish our September 14, 2000 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Because the evidence that can be considered in this matter is limited to the reconsideration record, even if claimant had notice of SAIF's argument, he would not have been able to submit any new evidence not already in the reconsideration record. Thus, we are not persuaded that claimant has been prejudiced by the fact that the theory was not raised before the ALJ.

In the Matter of the Compensation of
ELEANOR NAGAI, Claimant
WCB Case No. 98-07355
ORDER OF ABATEMENT
Parker, Bush & Lane, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Claimant requests abatement and reconsideration of our October 31, 2000 Order on Review in which we reversed an Administrative Law Judge's order that had set aside the self-insured employer's denial of claimant's occupational disease claim for a mental disorder. Specifically, claimant contends that we failed to make adequate findings of fact regarding work force reductions, whether claimant was treated the same as other workers, whether corrective or job performance evaluations were reasonable, and in relation to the ALJ's credibility findings.

In order to consider this matter, we withdraw our October 31, 2000 order. The employer is granted an opportunity to respond. To be considered, the employer's response must be filed within 14 days from the date of this order. Thereafter, we will take this matter under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
CLARINDA S. KEYS, Claimant
Own Motion No. 98-0461M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE ON RECONSIDERATION
Doblie & Associates, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

Claimant requested reconsideration of our August 15, 2000 Own Motion Order, that affirmed the insurer's May 19, 2000 Notice of Closure. On September 15, 2000, we abated our prior order and established a briefing schedule. Having received the parties' submissions, we proceed with our reconsideration. On reconsideration, we adhere to our August 15, 2000 order, as supplemented below.

We previously relied on Dr. Jacob's April 25, 2000 medical report, finding that claimant was medically stationary on that date. In reaching this conclusion, we reasoned that Dr. Jacobs, one of claimant's treating physicians, offered the most well reasoned and fact-based opinion.

On reconsideration, claimant argues that we should defer to Dr. Breen, claimant's longtime attending physician. Specifically, she contends that there is no persuasive reason not to defer to Dr. Breen due to his experience with claimant. Claimant refers to Dr. Breen's opinion that claimant was not medically stationary because she had not reached her "maximum work level." Further, claimant argues that "through graduated return-to-work efforts, carefully monitored by the doctor, her condition can materially improve by becoming more functional." Thus, because her functional ability would improve with "graduated return-to-work efforts," claimant argues that she was not medically stationary when the insurer closed her claim.

To begin, after further consideration of this record, we continue to find Dr. Jacob's opinion more persuasive, which is well-reasoned and based on objective findings, regarding claimant's medically stationary status at the time of the insurer's May 19, 2000 closure. In addition, Dr. Breens observations do not persuade us that claimant's condition was not medically stationary when the insurer closed the claim.

We have previously found that when treatment is designed to primarily improve a claimant's functional abilities, and not to improve her compensable condition, this treatment is not determinative when establishing her medically stationary status under ORS 656.005(17). *Kelly J. Trussell*, 47 Van Natta 121 (1995); *Frank M. Douglas*, 46 Van Natta 1445 (1994). In reaching our conclusions in *Trusell* and *Douglas*, we relied on *Clarke v. SAIF*, 120 Or App 11 (1993).

In *Clarke*, the claimant argued that although his treating physician declared him medically stationary, his need for a leg brace to support his weak leg supported his contention that he was not medically stationary until his leg was fitted for the brace and he was released from medical care. The court paraphrased the claimant's argument as an argument that "ORS 656.005(17) is not limited to medical treatment prescribed for improving his physical condition, but also encompasses treatment prescribed solely for the improvement of his functional abilities given a particular condition." *Clarke*, 120 Or App at 13. The court rejected that argument and held that "medical treatment prescribed solely to improve a claimant's functional abilities is not pertinent to the determination of a claimants medically stationary date under ORS 656.005(17)." *Clarke*, at 120 Or App 13-14. Because there was no evidence that the leg brace was prescribed to improve the claimant's physical condition, the *Clarke* court concluded that the claimant was medically stationary when the carrier closed his claim.

Here, a "graduated return-to-work" program may improve claimant's functionality. However, as noted above, functional improvement alone is not pertinent to her medically stationary status. Instead, the deciding factor is that there is evidence that such a program is designed to improve claimant's compensable condition. Without such evidence, and given Dr. Jacobs' persuasive opinion that claimant was medically stationary as of April 25, 2000, we find that claimant was medically stationary when the insurer closed her claim and affirm the Notice of Closure.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our August 15, 2000 order in its entirety. The parties' rights of reconsideration and appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
MARLINE D. MILLER, Claimant
WCB Case No. 99-10158
ORDER ON REVIEW (REMANDING)
Cole, Cary, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Tenenbaum's order that: (1) declined to admit a medical arbiter's supplemental report; and (2) awarded 7 percent (13.44 degrees) scheduled permanent disability for loss of use or function of the right elbow (arm) and 6 percent (11.52 degrees) scheduled permanent disability for loss of use or function of the left elbow (arm), whereas an Order on Reconsideration had awarded no permanent disability. On review, the issues are the ALJ's evidentiary ruling and, potentially, extent of scheduled permanent disability. We vacate and remand.

FINDINGS OF FACT

Claimant, a records specialist, has an accepted claim for right wrist and right index finger tendinitis and "bilateral lateral epicondylitis." (Ex. 2B). On July 26, 1999, claimant's treating physician, Dr. Lin, performed a closing examination. Dr. Lin reported that claimant's symptoms were "essentially resolved," and that she had normal range of motion and "no residual deficits." (Ex. 5).

On August 20, 1999, SAIF issued a Notice of Closure awarding no permanent disability for claimant's accepted conditions. (Ex. 5AA). Claimant requested reconsideration with a medical arbiter.

On December 8, 1999, Dr. Filarski performed a medical arbiter examination. During that examination, Dr. Filarski found reduced elbow flexion bilaterally. (Ex. 6-2). However, Dr. Filarski diagnosed "resolved" tendinitis and epicondylitis. (*Id.*) Dr. Filarski further stated that "[t]he patient does not feel that there has been a change in her deficit of elbow extension through her symptomatic period, but that she has always had a mild degree of flexion contracture." (Ex. 6-3).

On December 20, 1999, the Department requested a clarifying report from the medical arbiter. (Ex. 7). That report was not received before the Order on Reconsideration, which issued on December 21, 1999. (Ex. 8). The Order on Reconsideration modified claimant's periods of temporary disability, but otherwise affirmed the Notice of Closure and awarded no permanent disability. (Ex. 8-3).

On December 29, 1999, Dr. Filarski authored a clarifying report in response to the Department's additional questions. (Ex. 9). Dr. Filarski stated that "[d]ecreased elbow flexion and extension are NOT due to accepted condition. Medically probable [secondary to] preexisting acquired contracture; exact etiology undetermined." (Ex. 9; emphasis in original).

Claimant requested a hearing from the Order on Reconsideration. The ALJ declined to admit the arbiters clarifying report and awarded 7 percent scheduled permanent disability for the right arm (elbow) and 6 percent scheduled permanent disability for the left arm (elbow). The ALJ relied on the findings in the initial medical arbiter report.

CONCLUSIONS OF LAW AND OPINION

The ALJ declined to admit Exhibit 9, the arbiters clarifying report, based on *Tinh Xuan Pham Auto v. Bourgo*, 143 Or App 73 (1996), *Melody R. Ward*, 52 Van Natta 241(2000), and *Timothy W. Trujillo*, 52 Van Natta 748 (2000). On review, SAIF contends that the ALJ erred in failing to admit the exhibit. SAIF relies on the rationale expressed in *Jason O. Olson*, 47 Van Natta 2192 (1995). We agree with SAIF's contention.

We review the ALJ's evidentiary rulings for abuse of discretion. *Terry W. Martin*, 52 Van Natta 161 (2000). Pursuant to ORS 656.283(7), "post-reconsideration order" evidence is generally not admissible at hearing. *Koskela v. Willamette Industries*, 159 Or App 229 (1999). However, ORS 656.268(6)(f) provides that "[a]ny medical arbiter report may be received at a hearing even if the report is not prepared in time for use in the reconsideration proceeding." If the Department seeks a clarifying or supplemental report from the arbiter, it is admissible at hearing. *Jason O. Olson*, 47 Van Natta at 2193.

The *Bourgo* court held only that a supplemental report *sought and obtained by one of the parties* was inadmissible at hearing. 143 Or App at 77, 78. The *Bourgo* court expressly did not decide the issue of the admissibility of a clarifying or supplemental arbiter report sought by the Department. *Id.* at 78 n5. However, in *Jason O. Olson,* we held that such a report, if requested by the Department, was admissible. 47 Van Natta at 2193. Similarly, in *Melody R. Ward* and *Timothy W. Trujillo,* we held only that the ALJ lacked authority to remand to the Department for a supplemental or clarifying report. Those cases are therefore distinguishable. Accordingly, we conclude that the ALJ abused her discretion in declining to admit the arbiters clarifying report.

Because the report should have been admitted, we vacate the ALJ's order and remand this case to the ALJ for further consideration of the issues raised by the parties.

ORDER

The ALJ's order dated August 23, 2000 is vacated. This matter is remanded to ALJ Tenenbaum for further proceedings consistent with this order. Those proceedings may be conducted in any manner that the ALJ deems achieves substantial justice. Following those proceedings, the ALJ shall issue a final, appealable order.

In the Matter of the Compensation of
BETTY J. MOEN, Claimant
WCB Case Nos. 00-01854 & 00-01667
ORDER ON REVIEW
Scott M. McNutt, Sr., Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer, on behalf of claimant's 1993 injury claim, requests review of those portions of Administrative Law Judge (ALJ) Brazeau's order that set aside its denial of claimant's current low back condition. The insurer, on behalf of claimant's 1999 claim, cross-requests review of those portions of the ALJ's order that: (1) found that claimant's left knee claim was timely filed; and (2) set aside its denial of her left knee condition. On review, the issues are timeliness of the claim and compensability. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the following changes and supplementation. We replace the first two paragraphs on page 2 with the following:

> "Claimant worked for the employer for 13 years in various positions, including operating a Skoog machine. (Tr. 8-9). In November 1992, x-rays of her lumbar spine showed minimal degenerative osteophytic spurring at multiple levels, but no evidence of significant disc space narrowing. (Ex. 1). She was diagnosed with left leg radiculopathy and probable L5 nerve root compromise. (Ex. 2-2).
>
> "On April 28, 1993, claimant filed a claim for low back and leg pain, asserting that it was related to operating the Skoog machine. (Exs. 4, 5). Dr. Boye, claimant's chiropractor, diagnosed a lumbosacral strain and gluteal strain. (Ex. 5). Claimant complained to Dr. Boye of pain in the posterior thigh going down into the left ankle. (Ex. 6-1). A May 25, 1993 lumbar MRI showed an L5-S1 disc with desiccation and a mild annular bulge, with slight left posterolateral prolapse in the left S1 nerve root sleeve. (Ex. 9-2)."

In the third paragraph on page 2, we change the sixth sentence to read: "On July 20, 1993, the insurer accepted a lumbosacral strain, left gluteal strain and mild annular bulge at L5-S1. (Ex. 19)." On page 3, we change the sixth full paragraph to read:

"Claimant completed an "801" form, stating that repetitive work had caused pain in her back and left knee. (Ex. 62). On December 1, 1999, claimant's attorney wrote to the insurer, requesting that it accept a left knee condition and amend its acceptance to include an L5-S1 disc herniation. (Ex. 75A)."

On page 4, we replace the first paragraph with the following:

"On February 25, 2000, the insurer issued a current condition denial of claimant's L5-S1 disc bulge/herniation, lumbosacral strain, gluteal strain and chronic degenerative left knee cruciate ligament tear. (Ex. 78A). On March 2, 2000, the insurer issued another denial, asserting that the claim was not timely filed and that neither the left knee condition nor the L5-S1 disc herniation arose out of or in the course and scope of employment. (Ex. 79)."

In the third paragraph on page 4, we delete the second sentence.

CONCLUSIONS OF LAW AND OPINION

Compensability - Left Knee Condition

The insurer argues that claimant's claim for a left knee condition is untimely. We need not address that issue because we conclude that, even if we assume that claimant's left knee claim was timely filed, the medical evidence is not sufficient to establish compensability.

The ALJ analyzed claimant's left knee claim as an occupational disease. The ALJ found there was persuasive evidence that claimant's left knee condition was degenerative in nature and preexisted her employment exposure and, therefore ORS 656.802(2)(b) applied. Both parties agree that ORS 656.802(2)(b) applies to the left knee claim.

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

Claimant relies on the opinion of her Dr. Bert, her treating physician, to establish compensability of her left knee condition. Dr. Bert first examined claimant on May 24, 1999. (Ex. 63). He said claimant had discomfort in her back and left leg, as well as locking and catching in her knee, which she indicated was related to operating the "Scoop" at work. (*Id.*) Dr. Bert felt that claimant had an internal derangement of the left knee. (*Id.*)

On August 16, 1999, Dr. Bert reported that claimant's left knee MRI showed poor visualization of the anterior cruciate, which probably meant that she had a chronic tear. (Ex. 66). In a later report, Dr. Bert said claimant had a "cruciate deficient" knee and "undoubtedly some degenerative changes." (Ex. 68).

Dr. Bert performed claimant's left knee surgery on September 21, 1999. (Ex. 70). His postoperative diagnosis was Grade IV chondromalacia of the patella and tibia with a partial tear of the anterior cruciate ligament and a partial tear of the lateral meniscus. (*Id.*)

In a May 24, 2000 report, Dr. Bert explained that claimant operated a skoog, which required repetitive use of her leg. (Ex. 82-2). He said claimant "has complained of some locking and catching in her knee, which is symptomatic when she operates the skoog." (*Id.*) He noted that the MRI revealed claimant had some intrasubstance degeneration of the horns of the medial and lateral menisci and he felt she had a chronic tear of her cruciate ligament. (*Id.*) Dr. Bert explained:

"These would certainly be related to repetitive use of the knee historically, and I suspect her knee complaints are directly related to the piece of equipment she is using at work. Therefore, reviewing her work activity with what she tells me she does off work, I believe the major cause of her knee problem is related directly to the skoog operation." (*Id.*)

For the following reasons, we do not find that Dr. Bert's causation opinion regarding claimant's left knee condition is persuasive. In his May 24, 2000 report, Dr. Bert said that claimant "has

complained of some locking and catching in her knee, which is symptomatic when she operates the skoog." (Ex. 82-2). Dr. Bert said that he "*suspect[ed]* her knee complaints are directly related to the piece of equipment she is using at work." (*Id.*; emphasis supplied).

There is no evidence that Dr. Bert had reviewed claimant's medical records to determine what, if any left knee symptoms she had at the time she was still working. Claimant testified that she had not been working since April 1998. (Tr. 12, 18). Dr. Manuele, who had treated claimant while she was still working, said that claimant had not complained to him about knee pain specifically and he had not performed any examination related to her left knee. (Ex. 83).

Dr. Boye had also treated claimant while she was still working. Although Dr. Boye occasionally mentioned claimant's left knee symptoms in his chart notes, he did not refer to any "locking and catching" in her knee. Instead, Dr. Boyes reports related claimants knee problems to her back condition and he did not refer to any ongoing knee symptoms. On March 28, 1997, Dr. Boye said that claimant's left knee had buckled and given way the day before, but he diagnosed only a low back condition, *i.e.*, lumbosacral strain. (Ex. 30-4). Three days later, Dr. Boye examined claimant, but did not refer to any knee symptoms. (*Id.*) In March 1998, Dr. Boye reported that claimant had back and leg pain when she was on her feet for prolonged periods. (Ex. 32-1). Later that month, he said that claimant's "left knee does not hurt as much and she can bend it more easily getting in and out of cars and going up and down steps, etc." (Ex. 32-2). By April 13, 1998, Dr. Boye said claimant did not have any pain or stiffness in her leg or knee. (*Id.*)

Thus, although Dr. Bert said that claimant "has complained of some locking and catching in her knee, which is symptomatic when she operates the skoog" (Ex. 82-2), the reports from Drs. Manuele and Boye are inconsistent with Dr. Bert's statement. We are not persuaded that Dr. Bert had an accurate understanding of claimant's left knee symptoms before she quit working in April 1998. Consequently, Dr. Bert's opinion that the major cause of claimant's left knee condition was directly related to the skoog operation is entitled to little weight. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977) (medical opinions that are not based on a complete and accurate history are not persuasive).

Furthermore, we are not persuaded by Dr. Bert's opinion because he did not evaluate the relative contribution of claimant's preexisting degenerative left knee condition. In his August 16, 1999 chart note, Dr. Bert said that claimant's left knee MRI showed poor visualization of the anterior cruciate, which probably meant that she had a "chronic" tear. (Ex. 66). On August 30, 1999, he said that claimant "undoubtedly" had some degenerative changes. (Ex. 68). Dr. Bert's postoperative diagnosis was Grade IV chondromalacia of the patella and tibia with a partial tear of the anterior cruciate ligament and a partial tear of the lateral meniscus. (Ex. 70). In his May 24, 2000 report, Dr. Bert explained that the MRI showed some "intrasubstance degeneration of the horns of the medial and lateral menisci" and he again noted that she had a "chronic tear" of her cruciate ligament. (Ex. 82-2).

In his opinion on causation, however, Dr. Bert discussed only claimant's work activities and did not explain the contribution, or lack thereof, of the degenerative knee condition. Although work activities that precipitate a claimant's injury or disease may be the major contributing cause of the condition, that is not always the case. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). The medical expert must take into account all contributing factors in order to determine their relative weight. *SAIF v. Strubel*, 161 Or App 516, 521 (1999). We are not persuaded by Dr. Bert's opinion because he did not take into account all the contributing factors in evaluating causation of claimant's left knee condition.

On the other hand, Dr. Williams explained that the reason the anterior cruciate did not show on the MRI was that it was a degenerative, chronic tear. (Ex. 78-7). Dr. Williams concluded that the degenerative changes were the major contributing cause of claimant's left knee condition. (*Id.*) Similarly, Drs. Geist and Melson believed that claimant's left knee condition was degenerative in nature. (Ex. 80-5).

In sum, we conclude that Dr. Bert's opinion is insufficient to establish that claimant's work activities were the major contributing cause of the combined condition and pathological worsening of her left knee condition. *See* ORS 656.802(2)(b). There are no other medical opinions that support compensability. Consequently, we reverse the ALJ's order regarding claimant's left knee condition.[1]

[1] In light of this decision, we also reverse the ALJ's $2,000 attorney fee award for claimant's counsel's services regarding the left knee condition.

Current Condition Denial - Low Back Condition

The ALJ relied on Dr. Bert's opinion to find that claimant had developed her low back condition as a result of work in 1993 and the degenerative process had progressed as a result of that injurious exposure. The ALJ found that the insurer's "1993 claim" remained responsible for claimant's low back condition.

To begin, we summarize claimant's low back claims and treatment. In April 1993, claimant filed a claim regarding her low back condition. (Ex. 4). In July 1993, the insurer accepted a disabling lumbosacral strain, gluteal strain (left) and mild annular bulge at L5-S1. (Ex. 19). An October 7, 1993 Determination Order awarded 9 percent unscheduled permanent disability for claimant's low back condition. (Ex. 23).

On April 21, 1998, Dr. Manuele signed an aggravation form concerning claimants low back condition, which was denied by the insurer. On November 20, 1998, a stipulation and order was approved that upheld the insurer's denial as to the aggravation claim. (Ex. 50-2). The parties agreed that the denial would not be construed as a denial of claimant's current condition. (*Id.*)

Claimant continued to have low back symptoms. She sought treatment from several physicians, including Dr. Bert. On August 30, 1999, Dr. Bert reported that the lumbar MRI showed an L5-S1 disc herniation. (Ex. 68). On December 1, 1999, claimant's attorney wrote to the insurer and requested that it amend its acceptance to include an L5-S1 disc herniation. (Ex. 75A).

On February 25, 2000, the insurer issued a current condition denial of claimant's L5-S1 disc bulge/herniation, lumbosacral strain and gluteal strain. (Ex. 78A). The insurer said that the medical evidence indicated that the major contributing cause of the combined condition was the progressive, preexisting degenerative spine and disc disease and not the April 20, 1993 injury. (*Id.*) On March 2, 2000, the insurer issued a denial of the L5-S1 disc herniation as a "new injury" claim, asserting that it did not arise out of or in the course and scope of employment and claimant's work at the employer was not the major contributing cause. (Ex. 79).

On review, the insurer relies on ORS 656.262(6)(c) and argues that claimant's current low back condition is no longer related in major part to the 1993 claim. The insurer contends that the medical evidence shows that claimant's preexisting degenerative changes were the major contributing cause of her current back condition.

Claimant argues that the medical evidence shows that the accepted disc bulge at L5-S1 *is* the current low back condition. She asserts that ORS 656.005(7)(a)(B) applies to the low back claim and she relies primarily on the opinion of Dr. Bert to establish compensability.

In April 2000, Drs. Geist and Melson diagnosed claimant's current condition as degenerative disc disease with radiculopathy. (Ex. 80-4). Although that was not one of the conditions originally accepted, they agreed that claimant's condition had been present since 1993 and her L5-S1 disc condition involved the same condition as that accepted in 1993. (*Id.*)

Dr. Williams diagnosed degenerative changes and a central bulging disc touching the S1 nerve root. (Ex. 78-6). He did not believe there had been a "clinically significant change" in claimant's condition since 1993. (Ex. 81-3).

Although Dr. Bert diagnosed claimant with an L5-S1 disc herniation, he explained that she had a disc bulge or herniation in 1993 that continued to require treatment. (Ex. 82-1). His opinion is consistent with 1993 medical reports referring to a herniated disc at L5-S1 and with Dr. Kirkpatrick's December 1998 report relating claimant's back symptoms to the 1993 injury. (Exs. 10, 13-4, 14, 17-3, 51-2).

Based on the foregoing medical reports, it appears that claimant's accepted mild annular bulge at L5-S1 is the essentially the same as her current low back condition. In any event, however, we find that her current low back condition is compensable for the following reasons.

The medical evidence establishes that claimant had a degenerative condition at L5-S1 that pre-existed and combined with the 1993 injury. Claimant's May 25, 1993 MRI showed an L5-S1 disc with desiccation, mild annular bulge and a "slight left posterolateral prolapse * * * in the area of the left S1 nerve root sleeve." (Ex. 9-2). Dr. Williams opined that those changes had taken years to develop. (Ex. 81-3). Dr. Bert agreed that claimant had a preexisting degenerative condition that was a factor in her current low back condition. (Ex. 82). We agree with claimant that ORS 656.005(7)(a)(B) applies and therefore, she must prove that her 1993 work injury is the major contributing cause of her disability or need for treatment of her L5-S1 disc herniation. She relies on the opinion of her treating physician, Dr. Bert.

Dr. Bert first examined claimant on May 24, 1999, explaining that claimant was having back and left leg pain, which she felt was related to operating the "scoop" at work. (Ex. 63). On August 30, 1999, Dr. Bert diagnosed an L5-S1 disc herniation. (Ex. 68). Based on claimant's history, he found that the herniation was directly related to her work injury. (*Id.*)

On January 4, 2000, Dr. Bert performed surgery on claimant's L5-S1 disc and found a "very large subligamentous disc herniation." (Ex. 76-5). After surgery, claimant was "very much improved" and her back pain had diminished greatly. (Ex. 77).

In a May 24, 2000 report, Dr. Bert said he had reviewed claimant's past history of injury in 1993 and her May 1993 MRI. (Ex. 82-1). He felt that claimant had a disc bulge or herniation at that time, which had continued to require treatment. (*Id.*) Based on claimant's history of a 1993 injury and continuing and progressive symptoms, Dr. Bert concluded that the 1993 injury was the major cause of her current need for medical treatment. (*Id.*) He acknowledged that claimant had some degree of degeneration, which he expected to progress after an injury. (*Id.*) Nevertheless, Dr. Bert believed that the initial injury and continuing work activity were the major factors in causing the disk to fail more completely and become more symptomatic. (Ex. 82-1, -2).

We find that Dr. Bert's opinion is persuasive because it is well-reasoned and based on an accurate history. Moreover, as claimant's treating surgeon, Dr. Bert's opinion is entitled to deference. *See Argonaut Insurance Company v. Mageske*, 93 Or App 698, 702 (1988) (treating physician's opinion was given greater weight because of his first-hand exposure to and knowledge of the claimant's condition). Dr. Bert's opinion is supported by Dr. Manuele, one of claimants treating physicians, who agreed that claimant's accepted 1993 condition was the major contributing cause of her L5-S1 disc herniation. (Ex. 83).

We agree with the ALJ that the contrary medical opinions are not persuasive. Drs. Geist and Melson opined that claimant's need for surgery resulted from progressive degenerative change aggravated by her job. (Ex. 80-4). They felt that claimant's job was a contributing cause, but was not the major contributing cause of her need for surgery. (*Id.*) They concluded that claimant's degenerative disc condition was the major contributing cause of her low back condition. (Ex. 80-5). We are not persuaded by their opinion because it is conclusory and lacks adequate explanation. The only discussion Drs. Geist and Melson provided regarding the nature of claimant's work activities was to say that she had worked as a "Skoog" operator for seven years. (Ex. 80-2).

Dr. Williams found that claimant's initial accepted conditions of a low back strain with mild annular bulge at L5-S1 had combined with progressive degenerative spine and disc disease. (Ex. 78-6). He did not believe claimant's work exposure led to a pathological worsening of her degenerative disc disease, but he said "the sequential x-rays and MRIs show progressive degenerative disc disease independent of work exposure." (Ex. 78-7). On the other hand, he concluded there had not been a clinically significant change in claimant's condition since 1993. (Ex. 81-3). Similarly, he did not believe claimant's mild annular bulge at L5-S1 had a material influence on her current condition. (*Id.*) Dr. Williams concluded that claimant's progressive degenerative changes were the major cause of her current low back condition. (*Id.*)

We do not find Dr. Williams' opinion persuasive. Although he said the x-rays and MRIs showed "progressive degenerative disc disease independent of work exposure[,]" he did not explain how he was able to determine from the x-rays and MRIs that the progressive degenerative condition was independent from claimant's work. Furthermore, Dr. Williams' opinion that claimant did not have a "clinically significant change" in her condition since 1993 and that the L5-S1 bulge did not have a material influence on her current condition is inconsistent with Dr. Bert's reports that claimant was

currently more symptomatic and had a "very large subligamentous disc herniation" at surgery. (Exs. 76-5, 82). In addition, Dr. Williams did not comment on Dr. Bert's report that claimant was "very much improved" after surgery and her back pain had diminished greatly (Ex. 77), or the report from Drs. Geist and Melson that claimant had improvement in her back pain and "virtually total relief of left leg pain." (Ex. 80-2). For the foregoing reasons, we discount the probative value of Dr. Williams' opinion.

Based on Dr. Bert's opinion, we conclude that claimant's 1993 injury is the major contributing cause of her need for treatment and disability for her current low back condition, as well as the condition itself. We therefore affirm that portion of the ALJ's order that found the insurer (under the 1993 claim) responsible for claimant's current low back condition.

Claimant's attorney is entitled to an assessed fee for services on review concerning the current low back 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 is $1,200, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 28, 2000 is affirmed in part and reversed in part. Those portions of the ALJ's order that set aside the insurer's denial of claimants left knee condition and awarded a $2,000 attorney fee are reversed. The insurer's denial of claimant's left knee condition is reinstated and upheld. The remainder of the ALJ's order is affirmed. For services on review regarding the low back condition, claimant's attorney is awarded $1,200, payable by the insurer.

In the Matter of the Compensation of
PETER A. ROY, Claimant
WCB Case No. 00-02361
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of his claim for a left thumb injury. In his brief, claimant moves for acceptance of his appellant's brief on the ground that it was untimely filed due to extraordinary circumstances. On review, the issues are the procedural motion, subjectivity and compensability.

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

Procedural Motion

Citing OAR 438-011-0030, claimant requests that the Board consider his appellant's brief. SAIF asserts that claimant's opening brief was due on September 8, 2000, and because it was not filed timely, it should not be considered on review.

Claimant's brief was mailed on September 11, 2000 and received by the Board on September 12, 2000. Claimant contends that the appellant's brief was not filed timely because claimant's attorney's former law clerk retained possession of the case files after leaving employment, "and did notify counsel of filing deadlines." (Claimant's motion at 1). We presume that claimant meant that the former law clerk did *not* notify counsel of filing deadlines. Claimant argues that the negligent action of a former employee constitutes "extraordinary circumstances" under OAR 438-011-0030.

Under OAR 438-011-0030, a motion to waive the rules may be allowed if the Board finds that extraordinary circumstances beyond the control of the moving party justify such action. *Id.* In previous cases, we have held that clerical errors and calendaring errors do not constitute extraordinary

circumstances beyond the control of the moving party. *Antonina Gnatiuk*, 50 Van Natta 976 (1998); *Lester E. Saunders*, 46 Van Natta 1153, 1154 (1994), *aff'd mem, Lester E. Saunders v. Preston Petty Products Co.*, 133 Or App 602 (1995). In *Charles E. Jesse*, 52 Van Natta 1504 (2000), the carrier asserted that the reason for the untimely filing was because of a recent transition in personnel. We found no extraordinary circumstances beyond the carrier's control and we granted the claimant's motion to strike the carrier's untimely filed brief.

Here, claimant did not file a request for briefing extension within the requisite time period. Furthermore, we are not persuaded that claimant's attorney's reason for untimely filing constitutes extraordinary circumstances that were beyond his control. In light of such circumstances, we are not inclined to grant claimant's motion and to consider the brief. In any event, however, our consideration of claimant's brief would not change our disposition of this case.

Subjectivity and Compensability

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated August 1, 2000 is affirmed.

November 24, 2000 Cite as 52 Van Natta 2076 (2000)

In the Matter of the Compensation of
MAYBELLE M. WERNER, Claimant
WCB Case No. 99-09820
ORDER ON REVIEW
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the insurer's denial of her occupational disease claim for a left shoulder rotator cuff tear. On review, the issue is compensability.

We adopt and affirm the ALJ's order with the following changes and supplementation. After the third full paragraph on page 3, we add the following paragraph:

> "On March 1, 2000, Dr. Blake reported that he was 'unable at this time to determine whether [claimant's] rotator cuff tear is related to her work.' (Ex. 8). Dr. Blake indicated he was waiting for an opinion from a shoulder specialist. (*Id.*)"

In the eleventh sentence in the first paragraph on page 4, we change the phrase "as you slide" to "as you raise." (Ex. 10-18).

On review, claimant asserts that the demonstration at hearing of how she performs her work activities (*i.e.*, dealing at a blackjack table) was an inaccurate representation. Claimant contends that the ALJ erroneously relied on that information. She also argues that she was prejudiced because of her age.

We begin by noting that, because of the multiple possible causes of claimant's left rotator cuff tear, we find that this case presents a complex medical question that depends on expert medical analysis for its resolution. *See Uris v. Compensation Dept.*, 247 Or 420 (1967); *Barnett v. SAIF*, 122 Or App 279 (1993). Claimant must establish that her employment conditions were the major contributing cause of her left rotator cuff tear. ORS 656.802(2)(a). She relies on the opinion of Dr. Blake to establish compensability.

We agree with the ALJ that Dr. Blake did not have an accurate understanding of claimant's job duties. Nevertheless, even if we assume that Dr. Blake had an accurate understanding of her work activities, we conclude, for the following reasons, that his opinion is insufficient to establish compensability of the left rotator cuff tear.

On March 1, 2000, Dr. Blake wrote to the insurer that he was "unable at this time to determine whether [claimant's] rotator cuff tear is related to her work." (Ex. 8). Dr. Blake indicated he was waiting for an opinion from a shoulder specialist. (*Id.*)

On May 1, 2000, Dr. Blake reported that he had another patient that worked for the same employer as claimant who had a "near identical problem with her shoulder" and "identical" job activities. (Ex. 9). Dr. Blake indicated that Dr. Switlyk had examined the other patient and found that the other patient's employment activity had a direct bearing on her shoulder problem. (*Id.*) Based on Dr. Switlyk's report of the other patient, Dr. Blake concluded that claimant's work activities were the major contributing cause of her rotator cuff tear. (*Id.*)

In a deposition, Dr. Blake explained that claimant had never been examined by Dr. Switlyk and he did not have any information directly from Dr. Switlyk that claimant's shoulder problem was work-related. (Exs. 9, 10-11). Dr. Blake explained that his opinion on causation was based on Dr. Switlyk's opinion regarding another patient. (Ex. 10-10, -11). Dr. Blake reasoned that, since both patients had identical jobs, he felt that Dr. Switlyk's opinion would be the same for claimant. (*Id.*) Dr. Blake assumed that claimant performed her job activity in the same manner as the other patient. (Ex. 10-11, -12).

We conclude that, even if we assume Dr. Blake had an accurate understanding of claimant's job duties, his opinion is entitled to little, if any, weight. In Dr. Switlyk's report regarding the other patient, Dr. Switlyk said that the other patient had "an intact rotator cuff tear" and he diagnosed her with "[c]hronic rotator cuff syndrome, left shoulder." (Ex. 8A-2, -3). The other patient had a type II acromion with some subchondral cyst formation at the greater tuberosity. (Ex. 8A-2). Dr. Switlyk said that the other patient's findings suggested she had some chronic rotator cuff tendinitis. (Ex. 8A-3).

In contrast, Dr. Blake diagnosed claimant with a "significant rotator cuff tear." (Ex. 1). Claimant's left shoulder arthrogram showed a complete tear of the rotator cuff tendon. (Ex. 2). Based on the fact that claimant had a complete tear of the rotator cuff tendon and the other patient examined by Dr. Switlyk had "an intact rotator cuff tear," Dr. Blake's opinion that both patients had "near identical problem[s]" with their shoulders requires additional explanation. Moreover, Dr. Switlyk diagnosed the other patient with a "[c]hronic rotator cuff syndrome" and chronic rotator cuff tendinitis, whereas Dr. Blake diagnosed claimant with a rotator cuff tear. Dr. Blake's opinion is not persuasive because it lacks adequate explanation.

Moreover, our findings must be based on the medical evidence in the record and reasonable inferences that can be drawn from that evidence. See *Benz v. SAIF*, 170 Or App 22 (2000); *SAIF v. Calder*, 157 Or App 224, 227-28 (1998). Dr. Blake's opinion is not persuasive because it is based on Dr. Switlyk's report *about another patient* and is not specific to claimant. *See Sherman v. Western Employer's Insurance*, 87 Or App 602 (1987) (physician's comments that were general in nature and not addressed to the claimant's situation in particular were not persuasive). We conclude that Dr. Blake's conclusory opinion on causation is insufficient to establish that claimant's work activities were the major contributing cause of her left rotator cuff tear.

Finally, claimant contends that there were "quite a few inaccuracies" in the deposition of Dr. Blake. She asserts that, if she had been allowed to attend the deposition, she could have cleared up any inaccuracies at that time. Claimant was represented by counsel at the time of Dr. Blake's deposition and at the time of hearing. Claimant does not dispute her former attorney's authority to act on her behalf. To the extent claimant is arguing about alleged inadequacies on the part of her former attorney, the Workers' Compensation Board is not the proper forum for litigating the adequacy of legal representation. *See, e.g., Lou E. Marks*, 52 Van Natta 118 (2000).

ORDER

The ALJ's order dated July 25, 2000, as corrected July 28, 2000, is affirmed.

In the Matter of the Compensation of
VIRGIL ADAMSON, JR., Claimant
WCB Case No. 00-02964
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Jerald Keene, Defense Attorney

Reviewed by Board Members Meyers and Bock.

The self-insured employer requests review of those portions of Administrative Law Judge (ALJ) Peterson's order that: (1) assessed a penalty for the employer's allegedly unreasonable delay of the payment of permanent disability awarded by an Order on Reconsideration; and (2) awarded a $500 attorney fee under ORS 656.382(1) for the employer's allegedly unreasonable resistance to the payment of compensation. On review, the issues are penalties and penalty-related attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we recap as follows. Claimant compensably injured his back on August 10, 1997 and the employer accepted a low back strain. (Ex. A-1). The claim was closed by a December 17, 1997 Notice of Closure. (*Id.*) Claimant requested reconsideration. (*Id.*) A March 13, 2000 Order on Reconsideration awarded 21 percent (67.2 degrees) unscheduled permanent disability for claimant's low back condition, as well as temporary disability. (Ex. A-4).

On April 17, 2000, claimant's attorney mailed a request for hearing to the Workers' Compensation Board, requesting a penalty and attorney fee for the employer's failure to pay compensation awarded by the March 13, 2000 Order on Reconsideration. The request for hearing was received by the Board on April 18, 2000. On April 18, 2000, the employer paid the compensation due claimant as ordered by the March 13, 2000 Order on Reconsideration. (Ex. 1).

CONCLUSIONS OF LAW AND OPINION

Relying on OAR 436-060-0150(7)(c), the ALJ found that an Order an Reconsideration was a "Department order" and, therefore, claimant's permanent disability award from the March 13, 2000 Order on Reconsideration was due within 30 days. Because the employer paid the compensation one week late, the ALJ assessed a 10 percent penalty under ORS 656.262(11)(a) for the employer's allegedly unreasonable delay of the payment of compensation. The ALJ also awarded a $500 attorney fee under ORS 656.382(1) for the employer's allegedly unreasonable resistance to the payment of compensation.

The employer argues that OAR 436-060-0150(7)(d) applies to this case, rather than subsection (7)(c). The employer contends that the March 13, 2000 Order on Reconsideration was not effective or enforceable until its appeal rights expired and, therefore, the employer had 30 days after that time period to pay claimant's permanent disability award.

OAR 436-060-0150(7) (WCD Admin. Order No. 96-070) provides:

"Permanent disability and fatal benefits shall be paid no later than the 30th day after:

"(a) The date of a notice of claim closure issued by the insurer;

"(b) The date of any determination or litigation order which orders payment of permanent total disability or fatal benefits;

"(c) The date of any department order which orders payment of compensation for permanent partial disability. A request for reconsideration of a determination order does not stay payment of permanent partial disability compensation ordered;

"(d) The date any litigation authorizing permanent partial disability becomes final; or

"(e) The date a claim disposition is disapproved by the Board, if permanent disability benefits are otherwise due."

In interpreting administrative rules, we apply the same rules that apply to the construction of statutes. *Gevers v. Roadrunner Construction*, 156 Or App 168, 172 (1998). Our first level of inquiry into the meaning of rules is examination of text and context. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993).

Here, the issue concerns the payment of claimant's unscheduled permanent disability that was awarded under the March 13, 2000 Order on Reconsideration. OAR 436-060-0150(7)(a) does not apply because the original Notice of Closure did not award any permanent disability. (Ex. A-3). Subsection (b) does not apply because neither permanent total disability nor fatal benefits are at issue. Similarly, because there is no claim disposition involved, subsection (e) does not apply.

OAR 436-060-0150(7)(c) refers to "[t]he date any department order which orders payment of compensation for permanent partial disability." Under ORS 656.005(9), "department" means the Department of Consumer and Business Services. The March 13, 2000 Order on Reconsideration is a "department order" that expressly "orders the compensation for temporary disability be modified and that the worker is entitled to an award of permanent disability." (Ex. A-4). Thus, the March 13, 2000 Order on Reconsideration meets the requirements of OAR 436-060-0150(7)(c) because it is a "department order" that "ordered" payment of compensation for permanent partial disability.

In contrast, OAR 436-060-0150(7)(d) refers to "[t]he date any litigation authorizing permanent partial disability becomes final[.]" At hearing, the employer argued that the March 13, 2000 Order on Reconsideration involved "litigation" because claimant filed a request for reconsideration to appeal the notice of closure. (Tr. 7). We are not persuaded by the employer's argument. We construe "litigation" in OAR 436-060-0150(7)(d) to mean something *other than* "any department order[,]" as provided in subsection (7)(c). Examples of "litigation authorizing permanent partial disability" would include ALJ orders, Board orders or court decisions. When the legislature or an agency uses a particular term in one provision of a statute or regulation, but omits that same term in a parallel and related provision, we infer that the legislature or agency did not intend that the term apply in the provision from which the term is omitted. *See* ORS 174.010 (in construing a statute, we are to ascertain and declare what is contained therein, not to omit what has been inserted or insert what has been omitted).

Furthermore, even if the March 13, 2000 Order on Reconsideration constitutes "any litigation," that order did not "authorize" permanent disability. Rather, the March 13, 2000 Order on Reconsideration expressly "ordered" payment of compensation for permanent partial disability, which is consistent with OAR 436-060-0150(7)(c). Under these circumstances, we agree with the ALJ that OAR 436-060-0150(7)(c) applies to this case.

Alternatively, the employer argues that the ALJ's interpretation of OAR 436-060-0150(7) contravenes ORS 656.313(1)(a). According to the employer, ORS 656.313(1)(a) explicitly excuses an employer from paying permanent partial disability ordered by a reconsideration order if it files a request for hearing challenging it.

ORS 656.313(1)(a) provides, in part:

> "Filing by an employer or the insurer of a request for hearing on a reconsideration order before the Hearings Division, a request for Workers' Compensation Board review or court appeal or request for review of an order of the Director of the Department of Consumer and Business Services regarding vocational assistance stays payment of the compensation appealed, except for: [certain listed exceptions]."

The employer is correct that the exceptions listed in ORS 656.313(1)(a) do not include orders awarding permanent partial disability. Nevertheless, ORS 656.313(1)(a) has no application in this case because there is no evidence that the employer requested a hearing on the March 13, 2000 reconsideration order. Instead, *claimant* requested a hearing on that reconsideration order. Furthermore, rather than disputing the March 13, 2000 Order on Reconsideration, the employer has paid the unscheduled permanent disability award. Because ORS 656.313(1)(a) does not apply here, we need not decide whether OAR 436-060-0150(7)(c) contravenes ORS 656.313(1)(a).

We agree with the ALJ that OAR 436-060-0150(7)(c) applies and, therefore, claimant's permanent disability benefits were due no later than the 30th day after the March 13, 2000 Order on Reconsideration. The employer paid the compensation due claimant on April 18, 2000, more than 30 days after the March 13, 2000 Order on Reconsideration.

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

Here, we find that the employer reasonably relied on OAR 436-060-0150(7)(d) as justification for not paying claimant's permanent disability award within 30 days after the March 13, 2000 Order on Reconsideration. Although we do not agree with the employer's interpretation of that rule, we do not find the issue to have been so clear that the insurer "unreasonably" delayed payment of compensation. *See, e.g., Annie L. Bounds*, 51 Van Natta 358 (1999) (although the administrative closure was improper, the Board did not find the issue to have been so clear that the insurer acted unreasonably by closing the claim); *Marie E. Kendall*, 46 Van Natta 2520 (1994), *on recon* 47 Van Natta 335 (1995) (carrier's conduct held reasonable where case law at the time supported propriety of that conduct); *cf. Vega v. Express Services*, 144 Or App 602, 608-10 (1996) (the carrier had a legitimate doubt about its obligation to pay the full amount in the reconsideration order because it was ambiguous), *rev den* 325 Or 446 (1997); *Dawes v. Summers*, 118 Or App 15, 19 (1993) (employer's failure to pay was based on a legitimate doubt as to its liability where language of determination order was ambiguous).

Under these circumstances, we conclude that claimant is not entitled to a penalty under ORS 656.262(11)(a) and we reverse the ALJ's assessment of a penalty. For the same reason, we find that the employer did not unreasonably resist the payment of compensation under ORS 656.382(1). We therefore reverse the ALJ's attorney fee award under ORS 656.382(1).

ORDER

The ALJ's order dated July 20, 2000 is reversed in part and affirmed in part. Those portions of the ALJ's order that assessed a 10 percent penalty and awarded a $500 attorney fee are reversed. The remainder of the ALJ's order is affirmed.

November 27, 2000 Cite as 52 Van Natta 2080 (2000)

In the Matter of the Compensation of
GEORGE L. ALLENBY, Claimant
WCB Case No. 97-02663
ORDER ON REMAND
Thomas Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *Liberty Northwest Insurance Corporation v. Allenby*, 166 Or App 331 (2000). The court has reversed our prior order, *George L. Allenby*, 50 Van Natta 1844 (1998), that held that a March 20, 1997 Second Order on Reconsideration (which found that claimant's injury claim was prematurely closed) was invalid and found that a February 6, 1997 Order on Reconsideration (that had found that the claim was not prematurely closed) was final by operation of law. Relying on its holding in *Boydston v. Liberty Northwest Ins. Corp.*, 166 Or App 336 (2000), the court has determined that DCBS had authority to withdraw and abate its first reconsideration order and that the second reconsideration order was authorized. Concluding that we erred in invalidating the second reconsideration order, the court has reversed and remanded for reconsideration.

In seeking review of the second reconsideration order, the insurer's sole challenge to the order was that DCBS lacked authority to issue it. Based on the court's decision, that argument has been rejected. In light of such circumstances, we affirm the March 20, 1997 Second Order on Reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM BECKER, Claimant
WCB Case No. 00-01978
ORDER ON REVIEW
James W. Moller, Claimant Attorney
VavRosky, MacColl, Olson, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its denial of claimant's injury claim for a low back condition; and (2) assessed a penalty under ORS 656.262(11) for the insurer's allegedly unreasonable denial. On review, the issues are compensability and penalties.[1]

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

The insurer denied claimant's claim on the basis of a lack of "objective findings." (Ex. 7B). At hearing, the insurer also contended that claimant was not credible, in that his claim was filed in "retaliation" for low performance reviews and disciplinary actions by the employer.[2] The ALJ set aside the insurer's denial, reasoning that claimant's treating physician Dr. Thomas' finding of reduced range of motion satisfied claimant's burden of proving "objective findings." ORS 656.005(7)(a); ORS 656.005(19). Moreover, the ALJ rejected the insurer's "retaliation" defense, and found that claimant had sustained a compensable injury to his low back on August 16, 1999, witnessed by a coworker, Mr. Addy.

On review, the insurer contends that claimant did not prove the requisite objective findings in support of his claim. We disagree.

"Objective findings" are verifiable indications of injury or disease that may include, but are not limited to, range of motion, atrophy, muscle strength, and palpable muscle spasm. ORS 656.005(19); *See SAIF v. Lewis*, 170 Or App 201 (2000) (requirement of objective findings is not satisfied by reports of symptoms not presently verified by the physician). At a minimum, during his examination of claimant on January 6, 2000, Dr. Thomas found reduced lumbar flexion and extension, which limitations he expressly determined to be objective and valid. (Exs. 6, 10).

The insurer next argues that claimant's testimony that he was injured on August 16, 1999 is not credible, and instead that claimant filed a claim in retaliation for certain disciplinary actions. However, the ALJ found that claimant credibly testified that he injured his back lifting an "edger" machine on August 16, 1999. (Tr. 14, 56). Although the ALJ's credibility finding in favor of claimant was not expressly demeanor-based, we agree with the ALJ that the substance of claimant's testimony was credible. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987) (when the issue of credibility concerns the substance of a witnesses' testimony, the Board is equally qualified to make its own determination of credibility); *James E. Board*, 52 Van Natta 442 (2000).

In this regard, we note that claimant consistently reported to his attending physicians a history of lifting an edger machine in August 1999. (Exs. 1B, 6). Claimant's testimony was also corroborated by a co-worker, Mr. Addy, who witnessed claimant's injury with the edger. (Tr. 56). Mr. Addy's testimony further strengthens the ALJ's credibility finding regarding claimant's version of events.

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[1] When two admitted exhibits were found to be missing from the record (Exhibits 12 and 13), the parties were notified and given the opportunity to submit authenticated reproductions of the missing exhibits. In response, the insurer provided reproduced copies of one missing exhibit. Claimant's attorney later furnished the Board with complete copies of the missing exhibits. Because the record now contains complete copies of all admitted exhibits, we have proceeded with our review.

[2] Claimant contends that the insurer did not timely raise this argument, as this issue was not contained in its denial, nor raised at the beginning of the hearing. We need not resolve this procedural matter because, even if the argument was considered, it would not alter the ALJ's and our ultimate conclusions.

Turning to the insurer's "retaliation" defense, we note that the documents introduced by the insurer to prove that claimant had been given poor performance reviews, along with a "final warning" about comments made to store employees, were both dated several weeks after claimant's August 16, 1999 injury, and after claimant had reported an injury to his supervisor on September 13, 1999. (Exs. 12, 13; Tr. 43). Accordingly, we agree with the ALJ that the insurer's "retaliation" defense is not persuasive.

Finally, the insurer contends that it had a "legitimate doubt" about claimant's claim sufficient to avoid assessment of a penalty for an unreasonable denial. We disagree.

The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in light of all the evidence available. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

At hearing, the insurer stipulated that it received Dr. Thomas' January 6, 2000 chart note (containing the finding of reduced lumbar range of motion), on February 23, 2000, before issuance of its March 7, 2000 denial, which was based on an alleged lack of objective findings. (Tr. 5). As we discussed above, Dr. Thomas reported reduced ranges of lumbar motion which constitute "objective findings" under ORS 656.005(19). (Ex. 6). Although Dr. Seymour stated on April 4, 2000 that he had found no "objective findings" on either of his two examinations of claimant, the insurer had already issued its denial by that date. (Ex. 11-1). Moreover, at the time of the insurer's March 7, 2000 denial, both Dr. Seymour and Dr. Thomas had concluded that claimant's August 1999 lifting injury was the major contributing cause of his disability and need for treatment for his low back condition. (Exs. 4, 7, 8). There is no contrary medical opinion on this issue in the record. Under these circumstances, we conclude that the ALJ properly assessed a penalty pursuant to ORS 656.262(11).

Claimant's attorney is entitled to an assessed fee for services on review regarding the compensability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $1,275, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and claimant's attorney's uncontested attorney fee request), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to a fee for services related to the penalty issue. *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

ORDER

The ALJ's order dated May 4, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,275, payable by the insurer.

In the Matter of the Compensation of
MICHAEL T. BERGMANN, Claimant
Own Motion No. 99-0177M
OWN MOTION ORDER
Mitchell & Associates, Claimant Attorney
Alice Bartelt (Saif), Defense Attorney

On May 4, 1999, the SAIF Corporation submitted a request for temporary disability compensation for claimant's compensable left knee condition. Claimant's aggravation rights expired on March 19, 1997. SAIF initially opposed reopening on the following grounds: (1) it was not responsible for that condition; and (2) claimant was not in the work force at the time of disability. Also on May 4, 1999, SAIF issued a denial of a 50 percent tear of the left knee ACL. Claimant filed a request for hearing with the Hearings Division, contesting SAIF's denial.

On November 17, 1999, the parties entered into a Stipulation and Order in which SAIF agreed to accept the "50% tear of the left knee ACL in addition to the previously accepted left knee horizontal tear of posterior horn & mid-sector of medial meniscus." The parties disagreed, however, as to whether this acceptance required a reopening of the claim, with claimant contending that it was an acceptance of a new condition requiring reopening under ORS 656.262(7)(c) and SAIF contending that the claim remained in Own Motion status. The parties explicitly preserved that issue. The Stipulation did not address the work force issue.

Pursuant to our March 30, 2000 Second Own Motion Order Referring for Consolidated Hearing, we postponed action regarding a request that we exercise our authority under ORS 656.278 to authorize temporary disability compensation under claimants 1991 left knee claim. We took this action to await resolution of litigation that was pending before the Hearings Division arising from claimant's contention that SAIF was obligated to reopen and process his current condition under ORS 656.262(7)(c) to closure under ORS 656.268. WCB Case No. 00-01126.

In our order referring the own motion for a consolidated hearing, we noted that, at the hearing, the Administrative Law Judge (ALJ) assigned to conduct the hearing would resolve the claim processing issue raised by claimant (as well as any other issues properly raised by the parties). In addition, the assigned ALJ would make findings of fact and conclusions of law and opinion regarding the effect of his or her decision on this claim processing matter on claimant's Own Motion claim. Finally, if it is determined that claims processing should proceed under ORS 656.278, the ALJ shall also make findings of fact and conclusions of law on the issue of whether claimant was in the work force at the time claimant's condition worsened. *See Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989); *SAIF v. Blakely*, 160 Or App 242 (1999).

On October 24, 2000, we affirmed an ALJ's order that directed SAIF to reopen the claim and process claimant's "new condition" (*i.e.* 50 percent tear of the left knee anterior cruciate ligament (ACL)) under ORS 656.262(7)(c) to closure under ORS 656.268. The ALJ further noted that, in light of such a determination, since the claim was not in Own Motion status with respect to the processing of the new condition claim, the workforce status issue was irrelevant.

Because we have affirmed the ALJ's order regarding the processing of claimant's claim for his current left knee condition, we decline to exercise our Own Motion authority to reopen the claim under ORS 656.278. *See Craig J. Prince*, 52 Van Natta 1658 (2000).

Accordingly, claimant's request for own motion relief is denied. 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
TIMMY L. FLOWERS, Claimant
WCB Case No. 00-00443
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Biehl and Bock.

The insurer requests review of those portions of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its denial of claimant's occupational disease claim for a left elbow condition; and (2) awarded a $3,750 assessed attorney fee pursuant to ORS 656.386(1). On review, the issues are compensability and attorney fees.

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

Claimant is a delivery driver for the employer. In August 1999, he experienced the onset of pain in both elbows and fingers, which he associated with repetitive lifting work activities. He filed a claim for bilateral elbow and wrist conditions which the insurer denied. Claimant requested a hearing.

Before hearing, claimant withdrew his claim for a bilateral carpal tunnel condition. The ALJ set aside the portion of the insurer's denial that related to a left elbow medial epicondylitis condition based on the opinion of Dr. Adams, claimant's treating physician.

On review, the insurer first contends that claimant's claim is not supported by objective findings. We disagree. This is an occupational disease claim, governed by ORS 656.802. To be compensable, existence of an occupational disease or worsening of a preexisting disease must be established by medical evidence supported by objective findings. ORS 656.005(19)[1]; ORS 656.802(2)(d); *Jeffrey L. Dennis*, 52 Van Natta 344 (2000). Here, there are objective findings of reproducible tenderness related to claimant's left medial epicondylitis condition.

Claimant's treating physician, Dr. Adams, performed two examinations. During claimant's first visit on October 26, 1999, Dr. Adams noted "tenderness directly over the ulnar notching in the epicondylar notch." (Ex. 6A). This finding is consistent with an October 11, 1999 examination, which reported that claimant was "tender to palpation along the medial epicondyle in the left arm." (Ex. 1-2). We have held that a finding of "tenderness" can constitute a requisite "objective finding," if it is shown to be "reproducible." *See, e.g., Sandra K. Mitchell*, 51 Van Natta 1837 (1999); *Betty L. Kneeland*, 51 Van Natta 1334 n1 (1999) (tenderness found to be "reproducible" in reference to two separate findings of tenderness on different dates). In light of these separate findings of tenderness in the same location, we are persuaded that claimant's tenderness is "reproducible" and that he has the requisite objective findings necessary to support his occupational disease claim. ORS 656.802(2)(d).

In *SAIF v. Lewis*, 170 Or App 201 (2000), the court held that the requirement of "objective findings" is not satisfied if a medical expert "merely listens to a patient's description of his or her symptoms and, believing the patient and without any verification process, relies on that description to form a diagnosis." *Lewis*, 170 Or App at 203. The court stated, with regard to the definition of "objective findings" in ORS 656.005(19), that "[t]he statutory emphasis is on findings made by a medical expert on the basis of a verification process involving trained observation, examination, or testing that produces results -- either physical *or subjective responses* -- that are witnessed, measured, or can be reproduced." (emphasis added) *Lewis*, 170 Or App at 212. Here, claimant's tenderness in the medial epicondyle region was presently "verified" on two separate occasions by different examiners. The medical examiners did not merely rely on claimant's report of prior symptoms of tenderness. For that reason, claimant's claim is supported by objective findings consistent with the *Lewis* decision.

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[1] 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."

The insurer next argues that claimant has a preexisting subluxing ulnar nerve condition in his left elbow and, therefore, claimant needed to prove his work activities for the employer were the major contributing cause of the combined condition and of a pathological worsening of the disease. ORS 656.802(2)(b). However, we note that the insurer did not raise this theory to the ALJ.[2] Under such circumstances, we are not inclined to address it on review. *Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991); *Nazario N. Solis*, 52 Van Natta 335 (2000).

In any event, even if we were to consider the insurer's argument, the record does not contain persuasive medical evidence that claimant's left medial epicondylitis condition combined with any preexisting condition. *See* ORS 656.802(2)(b). Dr. Adams acknowledged the presence of a chronic subluxing ulnar nerve condition, which may have been "partially contributory" to claimant's medial epicondylitis condition, but did not state that there was a "combining" of the two conditions. (*Id*). Moreover, Dr. Adams concluded that claimant's work activity was the major contributing cause of his epicondylitis condition rather than of a worsening of his subluxing ulnar nerve condition. (Ex. 13B-2); ORS 656.802(2)(a). Drs. Reimer and Fuller, who performed an examination of claimant at the request of the insurer, also diagnosed a preexisting, congenital subluxing ulnar nerve condition. (Ex. 12-4). However, these physicians similarly did not find a "combining" of the ulnar nerve condition with claimant's epicondylitis condition. (*Id.*)

Finally, the insurer argues that Dr. Adams did not consider the impact of claimant's off-work activities, specifically weight lifting in August and September 1999. We disagree. Although Dr. Adams did not take a direct history of claimant's weight lifting activities, he reviewed (and did not concur with) the report of Drs. Reimer and Fuller, who did take such a history. (Exs. 12-1, 13B). Accordingly, we are satisfied that Dr. Adams relied on a complete and accurate history of claimant's off-work activities in rendering his opinion on causation. (Ex. 13B-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 $100, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's attorney's response letter), the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated May 12, 2000 is affirmed. For services on review, claimant's attorney is awarded $100, payable by the insurer.

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[2] In making this determination, we reference the order, the hearing transcript and the transcript of closing arguments.

In the Matter of the Compensation of
WILLIAM L. GILBERT, Claimant
WCB Case No. 99-09439
ORDER ON REVIEW
Richard A. Sly, Claimant Attorney
Schwabe, Williamson & Wyatt, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Hoguet's order that: (1) admitted Exhibit 104 into evidence; and (2) set aside its denial of claimant;s claims for arachnoiditis and constipation. In his brief, claimant argues that his depression and elevated blood pressure are compensable consequences of his compensable injury. On review, the issues are evidence and compensability. We reverse in part and affirm in part.

FINDINGS OF FACT

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

Claimant sustained a compensable low back injury in 1963 with a previous employer. He underwent a lumbar laminectomy at L4-5 in December 1963 and a lumbar fusion at L4 through the sacrum in 1965. Claimant had a good result from the surgery and experienced no significant low back problems until January 1980.

Claimant again compensably injured his low back on January 2, 1980 when he slipped and fell while getting off his hyster. A Determination Order in 1981 and a Stipulation in 1982 awarded 62.5 percent unscheduled permanent partial disability. In the 1980s, claimant underwent several myelograms. In October 1980, he underwent lumbar laminectomy at L3-4 and L4-5 and a right lumbar sympathectomy and ganglionectomy at L2, 3, 4 in December 1980.

A 1986 myelogram and CT scan showed mild/minimal arachnoiditis. In a January 1980 myelogram, Dr. Newby noted evidence of arachnoiditis. (Ex. 10-3). The March 1980 and May 1981 myelograms did not mention findings of arachnoiditis. An October 1980 myelogram showed possible post-operative scar and /or mild arachnoiditis.

In 1987, the parties litigated the compensability of a claim for aggravation of the low back condition. An Opinion and Order issued which concluded that claimants low back condition had not worsened. The order did not address the compensability of claimant's arachnoiditis condition. In 1988, the parties entered into a stipulation and disputed claim settlement. In the document, the parties agreed that claimant's low back condition remained compensable, but that there had been no aggravation of the condition.

In July 1999, claimant's attorney requested that the employer amend its acceptance to include arthritis, constipation, depression, elevated blood pressure and arachnoiditis. In November 1999, the employer denied the request to accept the conditions.

CONCLUSIONS OF LAW AND OPINION

Evidentiary Issue

The employer argues that the ALJ erred in admitting Exhibit 104, a September 1998 record review by Dr. Trotter, into evidence. Dr. Trotter is an out-of-state physician, licensed in Illinois, who was employed by Intracorp. The employer solicited a medical opinion from Intracorp and submitted the record review by Dr. Trotter into evidence. The employer subsequently advised claimant's attorney on February 14, 2000, that it was going to withdraw Dr. Trotter's medical report. The report was withdrawn and resubmitted by claimant on February 28, 2000, the date of hearing.

The employer argued to the ALJ that Dr. Trotter had refused to submit to cross-examination and that the exhibit should therefore not be admitted. The ALJ found that the employer had tried to reach Dr. Trotter through Intracorp on four occasions between January 27, 2000 and February 22, 2000. The

ALJ noted that claimant did not argue that the employer had not made a good faith effort to contact Dr. Trotter, but instead argued that there were apparently no attempts to reach the doctor directly in Illinois and no evidence that Dr. Trotter had personally refused to submit to cross examination. In addition, the ALJ noted that the employer did not seek a continuance to cross-examine Dr. Trotter regarding Exhibit 104.

We need not decide the admissibility of Exhibit 104 because we conclude, for the reasons that follow, that even assuming that Dr. Trotter's opinion is admissible, it is not persuasive.

Compensability of Arachnoiditis/Constipation

The ALJ concluded that claimant's arachnoiditis condition was not included in the scope of the employer's acceptance. The ALJ, however, concluded that the compensability of claimant's arachnoiditis condition was assumed by the parties and the prior ALJ (then Referee) in 1987 litigation and that the employer was barred by issue preclusion from asserting that the arachnoiditis condition was not a part of the 1980 accepted low back claim. We agree with and adopt the ALJ's reasoning and conclusion regarding the scope of acceptance; however, we disagree with the ALJ's conclusion that the 1987 Opinion and Order actually decided the issue of compensability of the arachnoiditis condition. For the reasons which follow, we conclude that issue preclusion does not bar the employer from contending that the arachnoiditis condition is not compensable.

Issue preclusion "precludes future litigation on a subject issue only if the issue was 'actually litigated and determined' in a setting where 'its determination was essential to' the final decision reached." *Drews v. EBI Companies*, 310 Or 134, 139 (1990) (quoting *North Clackamas School Dist. v. White*, 305 Or 48, 53, *modified* 305 Or 468 (1988)).

In the 1987 litigation, the ALJ (then called Referee) upheld the employers denial of an aggravation of the accepted low back condition. The prior ALJ's decision was based on a conclusion that claimant's condition was not worse than it was at the time of the last arrangement of compensation. Thus, the 1987 order did not address or decide the issue of whether the arachnoiditis condition was materially related to the compensable injury. Under such circumstances, we are not persuaded that compensability of the arachnoiditis condition was actually litigated and determined.

The parties also entered into a "Stipulation and Order of Bona Fide Dispute Settlement" in 1988 in lieu of an appeal by claimant of the 1987 Opinion and Order. We also conclude that the settlement likewise does not bar the employer from contesting compensability of arachnoiditis. In the settlement, the parties agreed that the compensable low back condition remained compensable, but that there had been no worsening of the condition since the last arrangement of compensation. There was no agreement that claimant's arachnoiditis condition was compensable or that the employer was accepting his then current low back condition which included the arachnoiditis condition. Under such circumstances, we are not persuaded that the 1988 settlement actually litigated and determined compensability of the arachnoiditis.

Because neither the 1987 order nor the 1988 settlement established that the arachnoiditis condition was part of the compensable low back claim, we turn to the merits of the compensability issue. There are four medical opinions regarding the cause of the arachnoiditis.

Dr. Rosenbaum, neurosurgeon, examined claimant on behalf of the employer. Dr. Rosenbaum initially believed that the arachnoiditis was a consequence of the 1980 compensable injury. However, after reviewing medical records from January 14, 1980 by Dr. Newby that showed arachnoiditis already present, Dr. Rosenbaum changed his mind. Dr. Rosenbaum opined that since arachnoiditis is an inflammatory process that would take time to evolve, it was not reasonable to conclude that it was secondary to the January 2, 1980 compensable injury. (Ex. 122-3). Dr. Rosenbaum concluded that the arachnoiditis preexisted the industrial injury and occurred secondary to the myelographic studies from the prior injury in the 1960s.

In his deposition testimony, Dr. Rosenbaum explained that the current theory is that arachnoiditis is caused by a combination of pantopaque dye and blood (from the spinal needle). (Ex. 124-33 to 34).

Dr. Grimm, neurologist, has treated claimant for many years for his low back and arachnoiditis. In 1987, when asked if the cause of the arachnoiditis was unclear, he stated: "I cannot say. It certainly is." (Ex. 42-52). In a June 11, 1998 report, Dr. Grimm indicated that claimant's arachnoiditis was triggered by the surgical and diagnostic procedures in the 1980s. (Ex. 101). When asked about the cause of the arachnoiditis in February 2000, Dr. Grimm stated, in part:

> "Whether or not [claimant] in the mid 1960s was left with scarring at the lumbar fusion site is academic. The fact of the matter is, that his progressive, well-documented troubles arose after 1980, a decade in which there were 6 [sic] an additional 5-6 myelograms and other spine surgeries, including a cervical neck procedure by Dr. Rosenbaum himself.
>
> "It makes little difference whether or not the 1980 injury or Tesar myelogram kindled a pre-existing lumbar site scar into symptomatic arachnoiditis, or to what extent spinal surgeries or additional myelograms abetted the process. Arachnoiditis, which [claimant] has, is a chronic, miserable, debilitating, and intractable pain disorder, arising from an objective cause and for which there is no cure. In [claimant's] case, it arose after 1980, not before."
> (Ex. 126).

Dr. Trotter reviewed claimant's records on behalf of the employer. Dr. Trotter indicated that the arachnoiditis diagnosis continued to be related to the 1980 compensable injury. (Ex. 104-3).

We are not persuaded by the opinion of Dr. Trotter. Dr. Trotter apparently was not aware of Dr. Newby's belief that arachnoiditis was present on the January 1980 myelogram. In addition, it is unclear what medical records Dr. Trotter reviewed.

We are likewise not persuaded by Dr. Grimm's opinion. In 1987, Dr. Grimm indicated that the cause of the arachnoiditis was unclear. More recently, Dr. Grimm has indicated that the 1980 injury and procedures are the cause. No reason is given for Dr. Grimm's apparent change of opinion. Under such circumstances, we do not find his opinion persuasive. *See Kelso v. City of Salem*, 87 Or App 630 (1987).

On this record, we conclude that Dr. Rosenbaum's opinion is the most well reasoned and is based on complete information. Under such circumstances, we find his opinion persuasive. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). Thus, we conclude that claimant has not established compensability of his arachnoiditis condition.

With regard to claimant's constipation, the record does not establish whether the condition is related to claimant's medication for the compensable condition or for a noncompensable condition. Because the burden of proving the compensability of the condition rests with claimant (ORS 656.266), the record does not support a conclusion that the employer's denial should be set aside.

Compensability of Depression and Elevated Blood Pressure

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

ORDER

The ALJ's order dated May 18, 2000 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the self-insured employer's denial of arachnoiditis and constipation is reversed. The denial 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
DONNA R. GOODRICH, Claimant
WCB Case Nos. 00-00934, 00-00630 & 00-00629
ORDER ON REVIEW
Heather Hold, Claimant Attorney
David Wilson, Defense Attorney
Julie Masters (Saif), Defense Attorney
William J. Blitz, Defense Attorney
Mary Goebel Adams (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Liberty Northwest Insurance Corporation, on behalf of Merlin Pizza (Liberty/Merlin), requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its responsibility denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS); (2) upheld the SAIF Corporation's responsibility denial, on behalf of Ken-Wal Farms, Inc. (SAIF/Ken-Wal), of the same condition; and (3) upheld SAIF's responsibility denial, on behalf of Donna Deardorff (SAIF/Deardorff), of the same condition. On review, the issue is responsibility. We reverse in part and affirm in part.

FINDINGS OF FACT

Claimant began working for Ken-Wal Farms, Inc. (Ken-Wal) in January 1998 as a calf feeder. (Tr. 6, 13). Claimant began having right wrist pain in late February/early March 1998. (Tr. 13). When claimant avoided using her right hand, her left hand began hurting. (Tr. 14). On April 16, 1998, claimant sought treatment from Dr. Foutz, who diagnosed "[p]ossible CTS, likely tendinitis." (Ex. 1).

On April 27, 1998, Dr. Kho performed nerve conduction studies and EMG studies that were within normal limits. (Ex. 2-3). He diagnosed palmar flexor tendinitis at the carpal tunnel "with carpal tunnel symptoms without EDX correlation." (*Id.*)

Claimant quit working for Ken-Wal in May 1998 and began working for Merlin Pizza (Merlin), primarily as a waitress. (Tr. 14-15). Claimant's wrist pain worsened. (*Id.*)

Claimant returned to Dr. Kho on May 18, 1998, who diagnosed palmar flexion tendinitis with carpal tunnel symptoms. (Ex. 3).

On September 14, 1998, Dr. Foutz examined claimant, diagnosing "[c]linical stigmata of CTS." (Ex. 6). Dr. Kho performed further tests on September 23, 1998, but found no evidence of CTS. (Ex. 7). Dr. Kho diagnosed chronic palmar flexion tendinitis. (Ex. 8).

Claimant quit working for Merlin in February 1999. (Tr. 16). On March 17, 1999, Dr. Foutz reported that claimant had been unemployed for a month, but her wrist pain had not improved. (Ex. 9). He diagnosed chronic wrist tendinitis and prescribed medication. (*Id.*)

On June 30, 1999, claimant sought treatment from Dr. Williams who diagnosed "[w]rist pain, etiology unclear, possibly flexor tendinitis" and referred claimant to Dr. Appleby. (Ex. 10). Dr. Appleby reported that there might be a carpal tunnel factor that had not yet been revealed in nerve conduction studies. (Ex. 11-4). He recommended further testing in a "dynamic manner," *i.e.*, immediately after exercise. (*Id.*)

On September 1, 1999, claimant began working for Donna Deardorff (Deardorff) as a laundromat attendant. (Tr. 17). Claimant's duties involved sorting, washing and drying laundry, as well as ironing and cashier work. (Tr. 17-18). Her wrist symptoms increased with the additional activity. (Tr. 18).

Dr. Grant performed additional tests on October 1, 1999, finding that claimant had moderately severe bilateral CTS. (Ex. 14-2). Dr. Appleby performed bilateral carpal tunnel releases in December 1999. (Exs. 21, 22).

Claimant filed claims against Liberty/Merlin, SAIF/Deardorff, and SAIF/Ken-Wal regarding her CTS condition. (Exs. 16A, 17, 19). On November 30, 1999, SAIF/Deardorff denied responsibility of claimant's CTS. (Ex. 20). Liberty/Merlin also denied responsibility of claimant's condition. (Ex. 24A). SAIF/Ken-Wal denied compensability and responsibility of claimant's CTS. (Ex. 24). Claimant requested a hearing on the denials.

CONCLUSIONS OF LAW AND OPINION

SAIF/Ken-Wal withdrew its compensability denial of claimant's CTS on the day of hearing. (Tr. 1-2). The only issues at hearing were responsibility and attorney fees. (Tr. 2). The ALJ found that, because causation was established as to a specific employment, it was not necessary to rely on the last injurious exposure rule (LIER). The ALJ relied on Dr. Appleby's opinion and found that Liberty/Merlin was responsible for claimant's CTS.

Relying on *Safeco Ins. Co. v. Victoria*, 154 Or App 574, *rev den* 327 Or 621 (1998), Liberty/Merlin argues that the LIER applies. Liberty/Merlin contends that claimant's onset of disability was on May 18, 1998 or October 1, 1999. In either case, Liberty/Merlin asserts that it should not be assigned initial responsibility for claimant's CTS.

On the other hand, SAIF/Ken-Wal argues that this case was properly resolved based on actual causation, rather than the LIER. Relying on *Willamette Industries, Inc. v. Titus*, 151 Or App 76 (1997), SAIF/Ken-Wal contends that, because there is no reliable evidence that claimant's subsequent employment after Merlin contributed to a worsening of her CTS, Liberty/Merlin may not use the LIER defensively. SAIF/Deardorff agrees with SAIF/Ken-Wal and argues that the sole cause of claimant's CTS was her employment before September 1, 1999.

To begin, we do not agree with the ALJ that Dr. Appleby's opinion fixes actual responsibility with Liberty/Merlin. Dr. Appleby first examined claimant on July 22, 1999. (Ex. 11). Dr. Appleby also performed claimant's bilateral carpal tunnel releases in December 1999. (Exs. 21, 22).

In a "check-the-box" letter from SAIF/Deardorff's attorney, Dr. Appleby agreed that he had reviewed Dr. Kho's April 27, 1998 report and Dr. Grant's October 1, 1999 evaluation. (Ex. 26-1). Dr. Appleby was aware that claimant began working for Deardorff on September 1, 1999 and he agreed that her bilateral CTS condition was already in existence at that time. (Ex. 26-2). Dr. Appleby further agreed that claimant's need for medical treatment for CTS was caused by activities before September 1, 1999. (*Id.*) Dr. Appleby also supported the conclusion that claimant's work at Deardorff did not play a role in the cause or pathological worsening of her bilateral CTS. (*Id.*)

Although Dr. Appleby did not believe that claimant's work at Deardorff played a role in causing her CTS, he did not explain which of the two employments before September 1, 1999 (Ken-Wal from January to May 1998 or Merlin from May 1998 to February 1999) was the major contributing cause of her bilateral CTS. Considering such circumstances, Dr. Appleby's opinion is not sufficient to establish actual causation.

The other medical opinions likewise do not support an "actual causation" conclusion. Dr. Foutz first examined claimant on April 16, 1998 for right wrist pain. (Ex. 1). In a "check-the-box" letter from claimant's attorney, Dr. Foutz agreed that, when he initially treated claimant in April 1998, her "dairy work" was the major cause of her "upper extremity condition, initially right and then bilateral[.]" (Ex. 28). Because Dr. Foutz does not address the potential contributions to claimant's condition for her "post-dairy" work activities, we are not persuaded by Dr. Foutz's conclusory opinion for "actual causation" purposes.

Finally, Dr. Grant refers to several of claimant's employments as potential contributors to her current condition. In light of such circumstances, Dr. Grant's opinion does not support a conclusion that claimant's condition is attributable to a specific employment exposure. Because the medical evidence is insufficient to determine actual causation of claimant's CTS condition, we apply the LIER to determine which employer is responsible.[1]

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[1] In light of our conclusion that responsibility is not determined by actual causation, it is not necessary to address whether Liberty/Merlin may invoke the LIER defensively.

Under the LIER, initial or presumptive responsibility for a condition is assigned to the last period of employment where conditions could have caused claimant's disability. *Bracke v. Bazar*, 293 Or 239, 248-49 (1982). The "onset of disability" is the triggering date for determining which employment is the last potentially causal employment. *Id.* at 248. Where a claimant seeks or receives medical treatment for the compensable condition before experiencing time loss due that condition, it is appropriate to designate a triggering date based on either the seeking or receiving of medical treatment, whichever occurs first. *Agricomp Ins. v. Tapp*, 169 Or App 208, 213 (2000); *see Reynolds Metals v. Rogers*, 157 Or App 147, 153 (1998) (the date of the first medical treatment is the triggering date that dictates which period of employment is assigned initial responsibility for the treatment).

The "triggering date" has been described as "the date claimant first sought treatment for symptoms, even if not correctly diagnosed until later." *SAIF v. Kelly*, 130 Or App 185, 188 (1994). Alternatively, the "triggering date" has been described as "the date that the claimant first began to receive treatment." *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994). Because the purpose in designating a "triggering date" is to identify a point when a condition generally becomes a disability, the *Tapp* court has determined that the event (seeking or receiving medical treatment) used to establish the "triggering date" must have a sufficient objective relationship to the date of disability to make it an appropriate "triggering date" for assignment of initial responsibility under the LIER. *Tapp*, 169 Or App at 214-15; *Marjorie A. Ramirez*, 52 Van Natta 1998 (2000).

In accordance with the *Tapp* rationale, we turn to a determination of the "triggering date." "Possible" carpal tunnel syndrome (CTS) was diagnosed following Dr. Foutz's April 1998 exam. CTS symptoms were similarly noted during Dr. Kho's April 1998 nerve conduction and EMG studies, as well as following Dr. Kho's May 1998 exam. Although some subsequent exams and findings did not detect the presence of CTS, the record ultimately supports Dr. Appleby's July 1999 suspicion that there was a "carpal tunnel factor that had not yet been revealed in nerve conduction studies." (Ex. 11-4). That opinion was subsequently confirmed by additional tests on October 1, 1999 that found moderately severe bilateral CTS, as well as the December 1999 CTS release surgeries.

In light of such circumstances, it appears that the symptoms for which claimant sought treatment prior to July 1999 (at which time Dr. Appleby suspected the presence of an "unrevealed" carpal tunnel factor) were subsequently confirmed to be, in fact, CTS. Consequently, based on the *Tapp* rationale, the appropriate "triggering date" for the assignment of initial responsibility under the LIER (*i.e.*, the date that would have a sufficient objective relationship to the date of disability) would either be July 1999 (when Dr. Appleby examined claimant and offered his CTS suspicion) or June 1999 (when claimant sought treatment from Dr. Williams for her wrist complaints that resulted in Dr. Williams' referral to Dr. Appleby).[2]

Nonetheless, we need not specifically identify the precise date because if the "triggering date" occurred while claimant was working for Ken-Wal, the medical evidence (for the reasons expressed below) supports a conclusion that claimant's "Merlin" work activities contributed to a worsening of her underlying condition. *See Bracke v. Bazar*, 293 Or at 250; *Oregon Boiler Works v. Lott*, 115 Or App 70, 74 (1992); *Industrial Indemnity Co. v. Weaver*, 81 Or App 493, 497 (1986). Likewise, if the "triggering date" occurred while claimant was working for Merlin, the medical evidence does not establish that Ken-Wal was the sole cause or that it was impossible for claimants work at Merlin to have caused her condition. Thus, responsibility would not shift back to Ken-Wal. *See Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997). Consequently, under either analysis, presumptive responsibility would either rest with Merlin or responsibility would shift forward from Ken-Wal to Merlin.

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[2] Arguably, the "triggering date" occurred sometime before September 1, 1999, which was the date that Dr. Appleby agreed that claimant's CTS condition existed. Nevertheless, for the reasons that follow, we need not conclusively resolve the "triggering date" question because, in any event, ultimate responsibility for claimant's condition would be unaffected.

Finally, regardless of whether "presumptive" responsibility initially rested with Ken-Wal or Merlin, ultimate responsibility for claimant's condition would shift to Deardorff.[3] In reaching this conclusion, we are persuaded that claimant's "post-September 1, 1999" work activities for Deardorff contributed to her condition. This conclusion is supported by Dr. Grant, who agreed with the proposition that claimant's "Deardorff" work contributed independently to a worsening of her underlying condition.[4] (Ex. 27-2). Support for this conclusion is also found in Dr. Appleby's observation that claimant's "[w]orking laundry is a particular challenge" to her.[5]

In conclusion, based on the foregoing reasoning, we find that responsibility rests with Deardorff. Consequently, we reverse the ALJ's determination that Ken-Wal was responsible for the claim.

ORDER

The ALJ's order dated May 22, 2000 is reversed in part and affirmed in part. The portion of the ALJ's order that set aside Liberty/Merlin's responsibility denial is reversed. Liberty/Merlin's denial is reinstated and upheld. The portion of the ALJ's order that upheld SAIF/Deardorff's responsibility denial is reversed. SAIF/Deardorff's responsibility denial is set aside and the claim is remanded to it for processing according to law. SAIF/Deardorff is responsible for the ALJ's attorney fee award. The remainder of the ALJ's order is affirmed.

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[3] If the "triggering date" arose while claimant was working for Deardorff, responsibility would not shift to Merlin because the persuasive medical evidence does not support a conclusion that claimant's work activities for Merlin were the sole cause of her condition or that it was impossible for claimant's work at Deardorff to have caused or contributed to her condition. In reaching this conclusion, we acknowledge that Dr. Appleby agreed that claimant's Deardorff work "did not play a role in the cause or pathological worsening of her bilateral carpal tunnel syndrome." (Ex. 26-2). Yet Dr. Appleby further noted that claimant's "[w]orking laundry is a particular challenge." (Ex. 18-1). This latter observation is consistent with claimant's testimony that when she began working at Deardorff and had increased her activity, her complaints "went right back up again." (Tr. 18, 19). In light of Dr. Appleby's divergent observations, we are not prepared to conclude that it was impossible for claimant's "Deardorff" work activities to have caused or contributed to her condition or that either her "Merlin" or "Ken-Wal" work activities were the sole cause of her condition.

[4] Unlike the ALJ, we do not consider Dr. Grant's opinion to be "diametrically opposed." Dr. Grant initially stated that claimant's Ken-Wal work was "inconsistent with causing the moderately severe CTS" diagnosis in October 1999 and that the CTS "actually began" between September 1998 and October 1999. Dr. Grant also stated that it was medically probable that claimant's "Ken-Wal" work was the greatest single occupational contributor to her current CTS. (Ex. 27-1). Dr. Grant subsequently concluded that claimant's symptoms began while she was working for Ken-Wal and that the symptoms waxed and waned (but did not resolve) thereafter. When viewed in the context of claimant's evolving symptoms, we interpret Dr. Grant to be stating that claimant's *symptoms* originated with her work activities at Ken-Wal, which was probably the greatest single occupational contributor to her CTS. Nonetheless, Dr. Grant did not believe that claimant's ultimately diagnosed "moderately severe CTS" was *caused* by Ken-Wal. Rather, it was Dr. Grant's opinion tht claimant's symptoms that later culminated in that specific diagnosis began and waxed and waned without resolution while she was working for Ken-Wal and continued through her Merlin and Deardorff employments. When viewed from this perspective, Dr. Grant's opinion of an independent contribution to claimant's eventually diagnosed "moderately severe CTS" condition from her Deardorff work activities is supported by the record and persuasive.

[5] We acknowledge that Dr. Appleby submitted a concurrence letter agreeing that claimant's need for CTS medical treatment was caused by her pre-September 1, 1999 "activities" and that her Deardorff work did not play a role in the cause or pathological worsening of her bilateral CTS. As previously noted, Dr. Appleby had also observed that claimant's "[w]orking laundry is a particular challenge." Because this observation is inconsistent with Dr. Appleby's concurrence letter, we consider Dr. Appleby's opinion regarding the question of contribution to claimant's condition from her Deardorff work activities to be less probative than the opinion offered by Dr. Grant.

In the Matter of the Compensation of
KRIS P. LARSON, Claimant
WCB Case No. 98-05863
ORDER ON REVIEW
Furniss, Shearer & Leineweber, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

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

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

On page 3 of the order, we make the following change: "something happened with a client of the employer's on May 4, 1998 * * **"

The issue in this case is whether claimant, a residence care aide, was injured on May 4, 1998.[1] The ALJ set aside the insurer's denial, finding that claimant met the 90-day notice requirement of ORS 656.265(1). On review, the insurer contends that, even if the notice requirement has been met, inconsistencies in the record prove that claimant is not a credible witness. Specifically, the insurer contends that claimant's testimony that she reported her injury to her employer and requested an 801 form is not credible, based on contrary testimony from the employer's witnesses.

The ALJ made no express credibility findings. The ALJ's statement that "I am satisfied by claimant's testimony that something happened [on May 4, 1998] which caused claimant to fall onto a bed and feel the sudden onset of back pain" could be interpreted as an implicit credibility finding in favor of claimant. (*O&O* at 3). Nevertheless, even if the ALJ's statement cannot be so interpreted, our review of the substantive record confirms that claimant has proved that she suffered a compensable injury on May 4, 1998.

We are in as good a position as the ALJ to evaluate the credibility of a witnesses' testimony based on the substance of the record. *Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987); *Rob R. Hartley*, 49 Van Natta 2011 (1997). Here, claimant testified that she injured her low back moving a large patient on May 4, 1998. (Tr. 36). Unrebutted testimony proved that claimant told her partner, Mr. Cantley, about this work incident the day after the injury. (Tr. 14, 105). Claimant's coworker, Ms. Overholser, also confirmed that claimant reported the work injury to her "one or two days" after the injury and that she helped claimant look for an 801 form (unsuccessfully) at that time. (Tr. 105).

The insurer argues that several of the employer's witnesses contradicted claimant's testimony that she had reported her injury and attempted to file an 801 form in the several days after May 4, 1998. (*e.g.* Tr. II, p. 9). The insurer also contends that this testimony casts doubt on claimant's credibility in general. However, the testimony of Mr. Cantley and Ms. Overholser is sufficiently corroborative of claimant's suffering an injury on May 4, 1998. The employer's witnesses did not directly dispute Mr. Cantley's and Ms. Overholser's testimony that claimant reported her injury to them. That is the determinative issue; whether claimant was injured on May 4, 1998.

Moreover, even if the testimony of Mr. Cantley and Ms. Overholser is "canceled out" by the testimony of the employer's witnesses, we would still find claimant credible. In this regard, we note that the employer's witnesses did not necessarily dispute claimant's testimony that she had requested an 801 form - they testified only that they "could not recall" claimant's requesting the form. (Tr. 123, Tr. II, p. 9). Moreover, the insurer acknowledged on the June 2, 1998 801 form that it had notice of the injury at least as of May 29, 1998. (Ex. 21).

Claimant's medical record is also consistent with her testimony. During claimant's first medical treatment after the alleged work injury, lumbar and foot sprains were diagnosed. (Ex. 14). Claimant's initial visit with Dr. Edwards on June 3, 1998 reflects a history of a twisting back injury while lifting a

[1] There is no dispute that claimant required medical treatment for low back and foot conditions. (Tr. 10).

patient "approximately four weeks ago." (Exs. 22). Dr. Pribnow's June 29, 1998 chart note similarly reports a history of injury consistent with claimant's testimony. (Ex. 31-1). Accordingly, based on our review of the substantive record, we conclude that the preponderance of the persuasive evidence establishes that a material contributing cause of claimant's need for treatment or disability for her foot and low back injury was a May 4, 1998 work injury.

Claimant 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 July 21, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,500, payable by the insurer.

November 27, 2000 Cite as 52 Van Natta 2094 (2000)

In the Matter of the Compensation of
DONALD L. LAMB, Claimant
WCB Case No. 99-06228
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

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

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

First, in the first paragraph in the "Findings of Fact," we correct the reference to "1998" to "1988".

Furthermore, we agree with the ALJ's assessment of the medical opinion evidence and, specifically, his conclusion that the opinion of Dr. Keenen, claimant's treating physician, is not sufficiently persuasive to carry claimant's burden of proof. In response to claimant's argument on review that Dr. Keenen did not rely on an inaccurate history by referring to a specific injurious event, we point to Dr. Keenen's last report, where he stated that he understood "that there was a single event, while using a grinder, that resulted in his pain" and he attributed claimant's "current need for treatment to the above-mentioned injury in 1997." (Ex. 16).

Like the ALJ, we find this last report to be inconsistent with Dr. Keenen's previous reports correctly indicating that there was no specific work injury (Exs. 11, 14); Dr. Keenen thought that claimant's repetitive bending and twisting activities at work were the major contributing cause of his degenerative disc disease, (*Id.*). In sum, because Dr. Keenen first points to repetitive activities and then a specific work injury as the cause of claimant's condition, we agree that his opinion is not persuasive. *See Weiland v. SAIF*, 64 Or App 810 (1983).

ORDER

The ALJ's order dated August 8, 2000 is affirmed.

In the Matter of the Compensation of
BARBARA MOHL, Claimant
WCB Case No. 99-04677
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorney
Sheridan, et al, Defense Attorney

Reviewed by Board Members Meyers and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Hoguet's order that set aside its denial of claimant's occupational disease claim for right trapezius and latissimus dorsi muscle strains. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant performed repetitive, often heavy, lifting activities for the employer for about a year, beginning September 29, 1997. She usually loaded packages from a moving belt into trailer trucks, 25 to 30 hours per week.

Claimant sought treatment for thoracic pain on January 10, 1998. (Exs. 12,13, 14). In February 1998, Dr. Berselli diagnosed right trapezius and latissimus dorsi muscle strains. He treated claimant for mid back symptoms on about 15 occasions thereafter.

Claimant filed several prior injury claims during this employment, including a November 21, 1997 low back/right hip injury, a January 9, 1998 low back injury, a March 3, 1998 latissimus dorsi and trapezius muscle strain, and an April 17, 1998 hearing loss claim. These claims were denied and the denials upheld after hearing and on Board review.[1]

The prior ALJ found claimant an unreliable historian based on her "attitude, demeanor, and appearance, and also considering psychosocial factors discussed in the medical records[,]" and upheld the denials of the back injury claims. (Ex. 65). On review, the Board adopted the prior ALJ's order regarding claimant's back injuries and further concluded that the hearing loss claim was not compensable.

CONCLUSIONS OF LAW AND OPINION

The ALJ found that claimant established a compensable occupational disease claim for right trapezius and latissimus dorsi muscle strains. The ALJ relied on the opinion of Dr. Berselli, treating physician.

The insurer argues that the ALJ erred in evaluating the claim as an occupational disease, rather than an injury, citing *Joseph R. Huff*, 48 Van Natta 731 (1996). In *Huff*, we held that the disputed shoulder condition was properly analyzed as an injury, because the claimant knew precisely when his symptoms began and his condition developed suddenly and unexpectedly on a specific date.

The ALJ found *Huff* inapplicable, reasoning that "a prerequisite is acceptance of claimant's testimony at hearing." (Opinion and Order, p.2). Further reasoning that claimant was not a reliable historian, the ALJ disregarded claimant's testimony completely, analyzed the claim as an occupational disease, and found the claim compensable based on the documentary record. We reach the opposite result.

We need not resolve whether the claim should be analyzed as an occupational disease, as opposed to an injury, because we conclude that the claim fails in any event, based on the medical evidence. *See Uris v. Compensation Department*, 247 Or 420 (1967) (complex medical question must be resolved by expert medical opinion).

Dr. Berselli, treating physician, provides the only medical evidence relating claimant's current mid back problems to her work. Although we generally rely on the opinion of a worker's treating physician, we do not do so when we find persuasive reasons to discount that opinion. *See Weiland v. SAIF*, 64 Or App 810 (1983). In this case, we find such reasons.

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[1] The prior ALJ also noted that the parties agreed that claimant's claim for an upper body occupational disease "would not be adjudicated" as part of the prior case. (Ex. 65-2; *see* Ex. 63a-3-5).

When Dr. Berselli first examined claimant on March 5, 1998, he recorded an injury "a few days ago * * * secondary to being struck over the right lateral ribcage while at work." (Exs. 26, 27, 28; *see* Exs. 36, 37). After treating claimant for mid back symptoms, Dr. Berselli filed a claim for a March 1998 injury on claimant's behalf, on August 19, 1998. (Ex. 42). Then, as of early September 1998, Dr. Berselli concurred with an "overuse injury" explanation for claimant's right trapezius and latissimus dorsi muscle strains. (Exs 44, 45, 50).

Dr. Berselli ultimately opined that claimant's work activities, "not one discrete incident,"[2] caused her thoracic muscle strains. (Ex. 73-2). Thus, the question is whether the doctors final opinion is sufficient to carry claimant's burden. We conclude that it is not, because it is based on a questionable history and inadequately explained.

Claimant testified that her mid back problems began in *January* 1998, with "hooping" activities at work.[3] (Tr. 1-12; 28-29; 35). No doctor recorded that history. Instead, contemporaneous medical reports indicate that claimant's symptoms began when she lifted some moderately heavy boxes and/or when she slipped and fell against a countertop or box, while lifting heavy boxes. (Exs. 12-16). Moreover, although Dr. Berselli reported that claimant had a history of low and mid back problems, he believed that she suffered a mid back muscle strain with a *March* 1998 lifting incident. (Exs. 26, 28). In other words, Dr. Berselli's history differs from claimant's contemporaneous reporting *and* her testimony regarding her symptoms and their circumstances. Considering the variations in claimant's reporting, we cannot say that Dr. Berselli's causation opinion is based on an accurate and complete history.

Moreover, when questioned about the specific injuries she reported during this time, claimant explained that her mid back strain symptoms differed from those associated with the injury claims. (Tr. 23-25, 40-42; *see* Tr. 27-28). No such distinction is reflected in the medical evidence. On this basis as well, we cannot say that the expert evidence is based on an accurate and complete information.

We also find Dr. Berselli's opinion inconsistent regarding the nature and reliability of claimant's clinical findings.

On September 7, 1999, Dr. Berselli concurred with a statement that claimant's tenderness complaints were consistently identified, reproducible, and related to her thoracic muscle strains. (Ex. 67). The next day, the doctor concurred with statements that his diagnosis and treatment was based on claimant's subjective complaints and therefore the validity of her complaints necessarily depends on her reliability as an historian. Dr. Berselli also agreed that he had been "unable to find anything objective to substantiate [claimant's] subjective complaints of pain." (Ex. 68). About nine months later, Dr. Berselli agreed with statements that claimant's findings were "consistently identifiable and reproducible" and "clearly caused" by her work related mid back strain. (Ex. 73). We are unable to reconcile Dr. Berselli's various descriptions of claimant's findings as both unsubstantiated[4] and "consistently identifiable." Moreover, as we have explained, we find claimant's reporting unreliable.

Under these circumstances, we cannot say that Dr. Berselli's ultimate opinion is persuasive, because it is based on a questionable history and inadequately explained. Accordingly, absent persuasive medical evidence supporting the claim, we reverse the ALJ's order and uphold the insurer's denial.

ORDER

The ALJ's order dated July 21, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

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[2] We note that the prior claimed injuries, including the "March 1998 mid back injury" are not compensable as a matter of law. (*See* Exs. 65, 72).

[3] Claimant testified that she first noticed a burning sensation, some numbness, and a little soreness in her mid back in January 1998 while "hooping" plastic bags of small packages. Claimant "hooped" the bags from a sitting position, throwing them over her head, and over a hoop, at a rate of 200 to 300 per hour.

[4] We also note that, when Dr. Yarusso examined claimant in January 1998, he recorded that claimant demonstrated "significant amplification of symptoms and pain behavior, without reproducible, palpable back tenderness." (Ex. 17).

In the Matter of the Compensation of
DOUGLAS R. BARNES, Claimant
WCB Case Nos. 99-08756 & 99-02911
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) set aside its responsibility denial for claimant's right shoulder injury claim; and (2) upheld Johnston and Culberson, Inc.'s (JCI's) responsibility denial of claimant's claim for the same condition. On review, the issue is responsibility. We reverse.

FINDINGS OF FACT

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

At all relevant times, claimant worked for the employer (Sally A. Marshall, Trustee [Marshall]), an auto body shop. On October 6, 1998, claimant injured his right shoulder while helping a coworker load tools into a truck. At that time, Marshall was insured by SAIF. Although claimant had ongoing symptoms in his right shoulder, he continued to work and did not seek medical treatment.

On November 11, 1998, Marshall became a noncomplying employer.

On December 8, 1998, claimant sustained a second injury to his right shoulder while at work when a bolt he was loosening gave way and he struck his shoulder in the same location that had been symptomatic since the October 1998 incident.

On December 10, 1998, claimant first sought medical treatment from Dr. Koch, M.D., for his right shoulder condition. (Ex. 3). Dr. Koch referred him to Dr. Casey, orthopedist, who diagnosed rotator cuff tendinitis. (Ex. 9). Claimant did not respond to conservative treatment, and Dr. Casey subsequently performed a distal claviculectomy and acromioplasty.

Claimant's claim with Marshall in its noncomplying capacity was assigned to JCI. Both JCI and SAIF denied compensability of and responsibility for claimant's right shoulder condition. (Exs. 5, 16, 18, 25, 26).

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant's right shoulder injury claim was compensable. That determination is not challenged on review. Regarding the responsibility issue, the ALJ concluded that where there is no accepted injury, as here, the assignment of responsibility portion of the last injurious exposure rule is no longer viable and has been supplanted by ORS 656.005(7)(a)(B).[1] Applying ORS 656.005(7)(a)(B), the ALJ assigned responsibility for claimant's right shoulder injury to SAIF. On review, SAIF argues that: (1) the last injurious exposure rule applies to determine responsibility in this case; and (2) under that rule, JCI is responsible for claimant's right shoulder injury. Based on the following reasoning, we agree with SAIF.

In reaching his conclusion regarding the applicable responsibility law, the ALJ relied on *Thomas L. Hinson*, 51 Van Natta 1942 (1999), *Terry J. Rasmussen*, 51 Van Natta 1287 (1999), *Albert H. Olson*, 51 Van Natta 685 (1999), and *Michael C. Reddin*, 50 Van Natta 1396 (1998). These cases, in turn, relied on the courts decision in *Conner v. B & S Logging*, 153 Or App 354 (1998). Relying on these same cases, JCI contends that the ALJ's legal reasoning is correct, *i.e.*, ORS 656.005(7)(a)(B) applies to determine responsibility under the circumstances of this case. We disagree.

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

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

The cases relied on by the ALJ and JCI are distinguishable. The claimants in those cases all had prior injuries that had been *accepted* by separate carriers before the unaccepted current condition claims arose. Because the prior *accepted* claims did not include the current condition claims, ORS 656.308(1)[2] did not apply to determine responsibility. Under the facts of those cases, the issue was which of multiple prior *accepted* injuries was responsible for the claimant's current conditions. Based the court's decision in *Conner*,[3] we determined that, if the medical record established that a specific previously *accepted* injury was the major contributing cause of the current condition, then ORS 656.005(7)(a)(A)[4] would apply to assign responsibility for the current condition to the carrier with that previously *accepted* injury. On the other hand, if the medical record established that a combination of the previously *accepted* injuries caused the current condition, then the last injurious exposure rule and the "rebuttable presumption" in *Industrial Indemnity Co. v. Kearns*, 70 Or App 583 (1984),[5] would apply to assign responsibility. *Hinson*, 51 Van Natta at 1942; *Rasmussen*, 51 Van Natta at 1287; *Olson*, 51 Van Natta at 686-87; *Reddin*, 50 Van Natta at 1398-99.

Here, there are no previously accepted claims. Furthermore, as previously noted, compensability has been established. Therefore, the above reasoning does not apply under the circumstances of this case. In addition, because there is no previously accepted claim for claimant's right shoulder condition (rotator cuff tendinitis), ORS 656.308(1) does not apply to determine responsibility. *SAIF v. Yokum*, 132 Or App at 23. Under such circumstances, we generally resort to the judicially created rules governing the initial assignment of responsibility in successive employment cases, *e.g.*, the last injury rule (for injury claims) and the last injurious exposure rule (for occupational disease claims). *See James A. Hoyt*, 52 Van Natta 346 (2000); *John J. Saint*, 46 Van Natta 2224 (1994).

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[2] ORS 656.308(1) provides:

"When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. The standards for determining the compensability of a combined condition under ORS 656.005(7) shall also be used to determine the occurrence of a new compensable injury or disease under this section."

ORS 656.308(1) does not apply to initial claim determinations. *SAIF v. Yokum*, 132 Or App 18 (1994). Instead, ORS 656.308 only applies where there is an earlier accepted claim and a later injury involves the same condition as did the earlier accepted claim. *Sanford v. Balteau Standard/SAIF Corp.*, 140 Or App 177, 181 (1996); *Smurfit Newsprint v. DeRosset*, 118 Or App 368, 371-72 (1993). In this context, a "new injury involves the same condition as the earlier accepted injury when it has the earlier compensable injury within or as part of itself." *MultiFoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999).

[3] *Conner* involved a claimant who had an accepted 1985 claim with one carrier and an accepted 1991 claim with a second carrier. The Board determined that the second carrier was responsible for the current condition claim (which had not been accepted) pursuant to the rebuttable presumption in *Kearns*. After finding that the medical evidence established that the second injury was the major contributing cause of the compensable portion of the current condition, and citing ORS 656.005(7)(a)(A), the court affirmed the Board's conclusion that the second carrier was responsible. 153 Or App at 162.

[4] ORS 656.005(7)(a)(A) provides:

"No injury or disease is compensable as a consequence of a compensable injury unless the compensable injury is the major contributing cause of the consequential condition."

[5] In *Kearns*, the court examined responsibility in the context of successive accepted injuries involving the same body part. The court held that there was a rebuttable presumption that the last carrier with an accepted claim remains responsible for subsequent conditions involving the same body part. 70 Or App at 585-87. In *Raymond H. Timmel*, 47 Van Natta 31 (1995), we held that, encompassed in the "*Kearns* presumption" is the "last injury rule," which fixes responsibility based on the last injury to have independently contributed to the claimant's current condition. The carrier with the last accepted injury can rebut the "*Kearns* presumption" by establishing that there is no causal connection between the claimant's current condition and the last accepted injury. 70 Or App at 588. In *Timmel*, we decided that the enactment of *former* ORS 656.308(1) did not overrule *Kearns* and, where a claimant has several accepted claims for injuries involving the same body part, but not the same condition as that for which the claimant currently seeks compensation, *Kearns* remained valid law. 47 Van Natta at 32.

JCI argues that the medical record establishes actual causation against claimant's employment while SAIF was on the risk. Therefore, JCI argues that we should assign responsibility to SAIF without resorting to judicially created rules. However, "[i]t is well established that [a carrier] * * * may assert the rule of responsibility as a defense even when a claimant has chosen to prove actual causation." *Willamette Industries, Inc. v. Titus*, 151 Or App 76, 79 (1997) (citation and footnote omitted); *see Spurlock v. International Paper Co.*, 89 Or App 461, 464-65 (1988) (same) (citing *Runft v. SAIF*, 303 Or 493, 501-2 (1987)); *Donna M. Johnston*, 51 Van Natta 1414 (1999), *Rick J. Pickrell*, 51 Van Natta 453 (1999).

In *Safeco Ins. Co. v. Victoria*, 154 Or App 574, 577, *rev den* 327 Or 621 (1998), the court explained the applicability of this defense. The court noted that the last injurious exposure rule is both a rule of proof and a rule of assignment of responsibility. In *Victoria*, there was no dispute that the claim was work related and the only dispute was responsibility. Therefore, the court found that only the latter aspect of the rule was relevant. *Id.* The court rejected the claimant's assertion that the rule should be applied only to cases where it was impossible to determine which employment was the major contributing cause of a claimant's compensable injury. The court found that that assertion as "not apposite here because it employs a principle of the last injurious exposure rule when it is used as a rule of proof." *Id.* Finally, quoting *Titus*, 151 Or App at 82, the court stated that "[p]roof that the subsequent employment independently contributed to the current disability is required before the [last injurious exposure] rule of responsibility can be invoked defensively by the targeted employer." *Id.*

Here, as in *Victoria*, there is no dispute that the claim is work related and the only dispute is responsibility. Therefore, only the rule of assignment of responsibility portion of the last injury rule is relevant. In addition, here, the medical opinions attribute claimant's right shoulder condition to both the injury that occurred while SAIF was on the risk and the subsequent injury that occurred when the employer was noncomplying. (Exs. 11-5-6, 17, 17A, 25B, 29-6, 29-10-11, 29-14, 29-16). That is sufficient to invoke defensive use of the last injury rule as a rule of responsibility. *Safeco Ins. Co. v. Victoria*, 154 Or App at 577-78. Consequently, we turn to the responsibility assignment portion of the last injury rule to resolve the responsibility dispute.

Here, claimant initially injured his right shoulder in October 1998 while working for SAIF's insured. By the time he injured his right shoulder again in December 1998, the employer was noncomplying and claim processing was eventually assigned to JCI. Claimant first sought treatment for his right shoulder condition while working for the employer in its noncomplying status; therefore, JCI is initially (or presumptively) responsible. *Reynolds Metals v. Rogers*, 157 Or App 147,153 (1998); *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994) (if a claimant received medical treatment before experiencing time loss, the date the claimant first received treatment is the triggering date for the initial assignment of responsibility).

An employer that otherwise would be responsible under the last injury rule may avoid responsibility if it proves either: (1) that it was impossible for conditions at its workplace to have caused the condition in this particular case; or (2) that a prior period of employment was the sole cause of the condition. *See Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997). We find no such evidence in this case.

The medical opinions establish that both the October 1998 and December 1998 injuries contributed to claimants right rotator cuff tendinitis condition. (Exs. 11-5-6, 17, 17A, 25B, 29-6, 29-10-11, 29-14, 29-16). Dr. Casey provided the most comprehensive causation opinion and opined that both work injuries were the direct cause of claimant's right shoulder condition. (Ex. 17A). When pressed for a major contributing cause opinion and notified that claimant rated his shoulder pain as 5 out of 10 after the October 1998 injury, and 8 out of 10 after the December 1998 injury, Dr. Casey stated that "since 5 is 62.5 percent of 8, that the first injury caused 62.5 percent of his symptoms, and the second injury caused 37.5 percent of his symptoms, and therefore the first injury, under those criteria, has to be the reason for his surgery, unless [claimant] says he could have tolerated a level 5 forever." (Ex. 25B). In his deposition, Dr. Casey acknowledged this formula was his best estimate in responding to an impossible question. (Ex. 29-5). However, he continued to find that: (1) a combination of the two injuries caused claimant's right shoulder condition; and (2) the first injury was not the sole cause. (Exs. 29-6, -10-11, -14). Therefore, on this record, JCI failed to transfer responsibility back to SAIF, the carrier on the risk at the time of the prior injury. Accordingly, we conclude that responsibility for claimant's right rotator cuff tendinitis condition rests with JCI.

Claimant's attorney is entitled to an assessed fee for his services. After considering the 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 is $1,000, payable by JCI. In reaching this conclusion, we have particularly considered the time devoted to the case, the complexity of the issues, and the value of the interest involved.

ORDER

The ALJ's order dated May 19, 2000 is reversed in part and affirmed in part. That portion of the order that upheld JCI's responsibility denial is reversed. JCI's responsibility denial is set aside and the claim is remanded to it for processing according to law. Claimant's attorney is awarded an assessed fee of $1,000, payable by JCI directly to claimant's attorney. That portion of the order that set aside SAIF's responsibility denial is reversed. SAIF's responsibility denial is reinstated and upheld. JCI, rather than SAIF, is responsible for the ALJ's award of an insurer-paid attorney fee of $3,600. The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
JUDITH C. WHITE MUNRO, Claimant
WCB Case No. 98-09202
ORDER ON REVIEW
Preston, Bunnell & Stone, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Kekauoha's order that upheld the SAIF Corporation's denial of her claim for hepatitis C infection. On review, the issue is compensability.

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

The ALJ found that under ORS 656.266, claimant had not met her burden of proof. Specifically, the ALJ reasoned that claimant was relying on deductive reasoning in order to prove her claim.

Subsequent to the ALJ's order, the court issued its decision in *McTaggart v. Travelers Insurance*, 170 Or App 491 (2000), in which it discussed ORS 656.266 and its relationship to the Supreme Court's decision in *Phil A. Livesley Co. v. Russ*, 296 Or 25 (1983). In *McTaggart*, the court held that ORS 656.266, which provides that a claimant may not carry the burden of proving compensability merely be disproving other possible explanations of how the injury or disease occurred, did not affect the Supreme Court's decision in *Livesley*. Moreover, the court held that the essential holding of the *Livesley* case (which involved an unexplained fall) was that an injury arises out of employment if it arises from a neutral risk of employment. Consequently, the court reasoned that a truly unexplained fall that occurs in the course of employment arises out of the employment as a matter of law, and the remaining question is whether the claimant has adequately excluded idiopathic factors to establish that the fall is truly unexplained. *McTaggart*, 170 Or App at 504-05.

This case, unlike *McTaggart*, does not involve an unexplained fall. Rather, the issue is whether claimant has established the necessary causal relationship between her hepatitis C condition and her work exposure. Although claimant was exposed to blood as a result of her work duties, there is no evidence that any of the blood that claimant was exposed to was infected with hepatitis C. Moreover, as noted by the ALJ, the medical experts acknowledged that hepatitis C may not manifest itself for many years or even decades after infection. In light of this, we agree with the ALJ that claimant has not carried her burden of proving compensability.

ORDER

The ALJ's order dated July 5, 2000 is affirmed.

In the Matter of the Compensation of
MICHAEL A. KREGER, Claimant
WCB Case No. 99-07471
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

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

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

The ALJ set aside the insurer's denial of claimant's left leg injury that allegedly occurred on March 1, 1999, when claimant was struck on the left lower leg by a load of freight weighing 30 to 40 pounds. The ALJ first determined that ORS 656.005(7)(a)(B) applied because the alleged injury had "combined" with a preexisting left leg condition arising out of a previous left leg fracture in 1987. Applying *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998), the ALJ then determined that the March 1, 1999 incident was the major contributing cause of claimant's need for treatment of the "combined condition."

On review, the insurer contends that the ALJ incorrectly determined that an otherwise compensable injury "combined" with claimant's preexisting left leg condition. Alternatively, the insurer asserts that, even if ORS 656.005(7)(a)(B) is applicable, the ALJ should have held that claimant failed to prove a compensable claim. We disagree with the insurer's contentions.

Initially, we examine whether the medical evidence establishes the presence of a "combined condition." Dr. Bracis, an examining physician, opined that the work-related trauma and the preexisting condition "must be assessed together clinically." (Ex. 22). Moreover, in his deposition, Dr. Bracis testified that there was no way of separating the 1987 fracture and the inflammation and drainage resulting from the 1999 injury. (Ex. 23-17).

"[I]n order for there to be a 'combined condition,' there must be two conditions that merge or exist harmoniously." *Luckhurst v. Bank of America*, 167 Or App 11 (2000) (discussing *Multifoods Specialty Distribution v. McAtee*, 164 Or App 652 (1999). On this record, we find that the medical evidence does establish the presence of two conditions that merged or exist harmoniously. Therefore, we conclude that the ALJ properly applied the major contributing cause standard of ORS 656.005(7)(a)(B).[1]

Accordingly, in order to establish that his left leg condition is compensable, claimant must show that his March 1999 work injury was the major contributing cause of the disability or need for treatment of the combined condition. Having reviewed this record *de novo*, we are persuaded that, viewed as a whole, the medical evidence from Dr. Bracis and Dr. Krieg, claimant's surgeon, establish that the March 1, 1999 injury was the major contributing cause of the disability or need for treatment of the combined condition.[2] Therefore, we agree with the ALJ that claimant satisfied his burden of proving a compensable claim.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

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[1] Indeed, contrary to its position on review, the insurer at hearing argued that this is "a combined condition case." (Tr. 3).

[2] In this regard, we particularly note Dr. Bracis' testimony that the March 1, 1999 incident was the major contributing cause of an aggravation of the underlying preexisting condition. (Ex. 23-12). Moreover, Dr. Bracis testified that the March 1999 injury was the major contributing cause of the "disruption" of claimant's preexisting left leg condition that in turn led to claimant's need for treatment. (Ex. 23-29). For his part, Dr. Krieg agreed in his deposition that the traumatic 1999 injury "converted a situation that was in equipoise or in a state of equilibrium" to a state of "disequilibrium that required treatment." (Ex. 24-7).

ORDER

The ALJ's order dated August 16, 2000, as amended on August 18, 2000, 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
RICHARD L. PLUMMER, Claimant
WCB Case No. 00-02195
ORDER ON RECONSIDERATION
Bernt A. Hansen, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

The self-insured employer requests reconsideration of our October 30, 2000 order that adopted and affirmed the Administrative Law Judge's order setting aside its denial of claimant's low back injury claim. The employer argues that we erred by finding that: (1) there was no persuasive medical evidence that claimant suffered from a preexisting condition that combined with his work injury; (2) the standard of proof was material contributing cause; (3) claimant was credible; (4) Dr. Ullrich supported claimant's claim; and (5) there were no other suggested causes for claimant's disability and treatment after January 13, 2000.

After reviewing the employer's motion for reconsideration, we adhere to our previous conclusion. We write only to address the employer's argument regarding the applicability of ORS 656.005(7)(a)(B). The employer argued on review that ORS 656.005(7)(a)(B) applies because claimant's back strain of January 3 & 4, 2000 combined with the January 13, 2000 incident. In our previous order, we agreed with the ALJ's conclusion that there was no persuasive medical evidence that claimant had a preexisting condition that combined with his work injury to cause his disability and need for treatment. For the following reasons, we adhere to that conclusion on reconsideration.

Claimant had the flu in early January 2000 and suffered back pain as a result of the nausea and vomiting. (Tr. 10, 11). Dr. Ullrich treated claimant on January 7, 2000 for low back pain caused by vomiting. (Exs. A-1, B). Dr. Ullrich's chart note indicated that claimant had nausea and vomiting on January 3rd and 4th, 2000. (Ex. B). Dr. Ullrich wrote: "Suspect muscle strain induced by retching." (*Id.*) Claimant testified that Dr. Ullrich did not perform a back examination on January 7, but he prescribed a muscle relaxant. (Tr. 12). Claimant took the medication for about four days and felt fine. (Tr. 13). He was not experiencing back pain prior to the January 13, 2000 incident at work.[1] (Tr. 13, 14, 40).

On January 13, 2000, claimant was assisting three other coworkers as they maneuvered a truck hood into place. As claimant helped lift the hood in place, he stepped sideways and felt a sharp pain for an instant in his low back, slightly above his belt line. (Tr. 15-16). One of claimant's coworkers later told a supervisor that he had seen claimant during that incident and it appeared to him that claimant was in bad pain. (Tr. 70). The incident occurred at the end of a work shift and his back hurt that evening. (Tr. 17-18). By the next morning, claimant had difficulty getting up because of low back pain. (Tr. 18).

On January 14, 2000, claimant sought treatment from Dr. Ullrich, who diagnosed a low back strain, took claimant off work and recommended physical therapy. (Exs. A, 3, 4,). Claimant filed a claim related to the January 13, 2000 incident and indicated on both the "801" and the "827" forms that he had previously injured the same body part 1 to 2 weeks ago due to illness. (Exs. 1, 4).

In a June 7, 2000 report, Dr. Ullrich agreed that claimant's work exposure lifting a hood had caused his need for treatment on January 14, 2000. (Exs. 23, 24). Dr. Ullrich did not believe that claimant's degenerative condition played any role in the diagnosis. (*Id.*) Dr. Ullrich said that the

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[1] In reaching this conclusion, we reject the employer's argument that claimant had called Dr. Ullrich on January 12, 2000 to ask whether a back brace or kidney belt would help his back problems. We find that claimant made that phone call on January 17, 2000, which was *after* the January 13, 2000 work incident. (Exs. A-2, 5, Tr. 54-55, 58).

conditions he observed on January 14th were more consistent with the work injury rather than the prior flu episode, but he could not "state that complete healing had occurred after the back condition described on January 7." (*Id.*) Nevertheless, Dr. Ullrich said that when he treated claimant on January 14, 2000, he was *only* treated for the pain that arose after the January 13th injury. (*Id.*)

In a later letter, the employer asked Dr. Ullrich to agree with this statement: "In your medical opinion, you cannot say that the January 7, 2000 muscle strain is unrelated to the January 14, 2000 muscle strain." (Ex. 25-1). Dr. Ullrich responded that he disagreed and he referred to an attached letter. (Ex. 25-2). Dr. Ullrich explained that his opinion varied "from some aspects of your summary." (Ex. 26). Dr. Ullrich clarified the location of claimant's pain on January 7, 2000 and January 14, 2000 and stated: "[o]therwise my opinion, so far as it is expressed in your letter, does not substantially differ." (*Id.*)

In *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999), the court held that a "combined condition" under ORS 656.005(7)(a)(B) may constitute either an integration of two conditions or the close relationship of those conditions, without integration. In other words, in order for there to be a "combined condition," there must be two conditions that merge or exist harmoniously. *Luckhurst v. Bank of America*, 167 Or App 11 (2000).

We are not persuaded that Dr. Ullrich's statement that he "cannot" say that the January 7, 2000 muscle strain was "unrelated" to the January 14, 2000 muscle strain is sufficient to establish that the two strains combined to cause claimant's disability and/ or need for treatment, particularly in light of Dr. Ullrich's previous statement that on January 14, 2000, claimant was only treated for the pain that arose after the January 13th injury. (Ex. 24). As previously noted, Dr. Ullrich did not believe that claimant's degenerative condition played any role in the diagnosis. (Exs. 23, 24). There are no other medical reports that establish that claimant had a "combined condition." Under these circumstances, we agree with the ALJ that that there is no persuasive medical evidence that claimant had a preexisting condition that combined with his work injury to cause his disability and need for treatment We conclude that the ALJ correctly applied a material cause standard of proof.[2]

After reviewing the remaining arguments in the employer's motion for reconsideration, we find that the employer essentially raises the same arguments that it raised on review and we have nothing further to add to our prior order or the ALJ's order.

Accordingly, our October 30, 2000 order is withdrawn. On reconsideration, as supplemented, we republish our October 30, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[2] Alternatively, we find that Dr. Ullrich's statement that claimant's treatment on January 14, 2000 was only for the pain from the January 13, 2000 work injury satisfies the major contributing cause standard under ORS 656.005(7)(a)(B). (Ex. 24). *See SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309, 311-312 (1997), *rev den* 326 Or 389 (1998).

In the Matter of the Compensation of
MARTHA NAVARRO, Claimant
WCB Case No. 00-02528
ORDER ON REVIEW
Coughlin, Leuenberger & Moon, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that declined to award claimant temporary total disability (TTD) payable after October 1999. On review, the issue is the rate of temporary disability.

We adopt and affirm the ALJ's order. *See Alfredo R. Hernandez*, 51 Van Natta 71 (1999) (a carrier was entitled to reduce the claimant's TTD benefits to TPD under ORS 656.325(5)(c) and 656.212(2) when the claimant's treating physician released the claimant (a person present in the United States in violation of federal immigration law an illegal alien) to a modified job with his former employer with wages equal to his "at-injury" job).

ORDER

The ALJ's order dated July 27, 2000 is affirmed.

In the Matter of the Compensation of
PETER ABAH, Claimant
WCB Case No. 99-07692
ORDER ON RECONSIDERATION
Bottini Bottini & Oswald, Claimant Attorney
Jerald Keene, Defense Attorney

Claimant requests reconsideration of our October 30, 2000 Order on Review that affirmed the Administrative Law Judge's (ALJ's) order that upheld the self-insured employer's denial of his right wrist injury claim.

With his reconsideration request, claimant has enclosed a copy of a July 31, 2000 "Complaint Dismissal Memo" from the Civil Rights Division of the Bureau of Labor and Industries. In submitting this information, claimant contends that this report shows that his employer "lied under oath by testifying that 'I was supposed to go to train and supposed to be at the site before 05.00pm' on the day of [his] injury which was different from their earlier testimony during the first hearing."[1]

We note the memo was not included in the record before the ALJ. Because our review is limited to the record developed before the ALJ under ORS 656.295(5), we treat claimant's submission as a motion for remand for admission of memo. We decline to grant the motion because admission of the document is not reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986). We base this conclusion on the following reasoning.

We do not consider the comments contained in the submitted report to be significantly different from the testimony offered by the employer witness at the hearing. In any event, assuming for the sake of argument that we disregarded the employer's witness' testimony, the remaining evidence would still fail to persuasively establish that claimant's need for medical treatment or disability was materially related to a work incident on September 9, 1999. Consequently, consideration of claimant's submission would not alter the ultimate decision that his claim is not compensable.

Accordingly, we withdraw our October 30, 2000 order. On reconsideration, as supplemented herein, we adhere to and republish our order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

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[1] Because it is unclear whether copies of this submission were provided to claimant's attorney and to the self-insured employer, copies have been included with the attorneys' copies of this order.

In the Matter of the Compensation of
TRUMAN MILLER, Claimant
WCB Case No. 99-08237
ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorney
VavRosky, MacColl, Olson, et al, Defense Attorney

On October 31, 2000, we modified that portion of an Administrative Law Judge's (ALJ's) order that awarded temporary total disability (TTD) benefits for the period from November 13, 1998 through December 3, 1998. Specifically, we awarded temporary partial disability (TPD) benefits for that period and modified the ALJ's "out-of-compensation" attorney fee award accordingly. In addition, because we had reduced the compensation awarded by the ALJ, we found that claimant's attorney was not entitled to an assessed fee for services on review under ORS 656.382(2). We also affirmed that portion of the ALJs order that awarded TPD benefits for the period from December 4, 1998 until termination is allowed by law. Thus, our order awarded TPD benefits for the period from November 13, 1998 until termination is allowed by law.

Both claimant and the insurer request reconsideration of our October 31, 2000 order. Claimant requests reconsideration of our decision not to award an assessed attorney fee for services on review under ORS 656.382(2). The insurer requests reconsideration of our decision that claimant is entitled to TPD for the period from November 13, 1998 until termination is allowed by law. We respond to these requests for reconsideration separately.

Claimant's request for reconsideration

In her request for reconsideration, claimant contends that: (1) the insurer did not raise the distinction between TTD and TPD at hearing; therefore, we erred in making that distinction in our order; and (2) the benefits due for the period from November 13, 1998 through December 3, 1998 will result in the same amount of compensation whether classified as "TTD" or "TPD" benefits. The insurer responds that a modification of a claimant's award from TTD benefits to TPD benefits is a reduction of benefits. Based on the following reasoning, we find that, under the circumstances of this case, the rate for TPD benefits will be less than the rate for TTD benefits. Therefore, contrary to claimant's argument, our October 31, 2000 order will result in a reduction of benefits compared to those awarded by the ALJ.

In the first place, we find that the insurer did raise the distinction between TTD and TPD. At hearing and on review, the insurer argued, in part, that reports from Dr. Cox, claimant's attending physician, did not establish entitlement to any temporary disability because those reports did not release claimant from *all* work. (Tr. 4-8; Appellant's Brief, page 15; Reply Brief, page 3). In addition, claimant responded to that argument, disagreeing with the insurer's interpretation of Dr. Cox's reports. (Respondent's Brief, page 2). We find that the insurer's arguments raised the distinction between TTD and TPD. Addressing that distinction in our initial order, we found that, although Dr. Cox ultimately did not release claimant from all work, he did release him to modified work beginning November 13, 1998, which entitled claimant to *TPD* benefits as of that date.

Second, claimant argues that he is entitled to an assessed attorney fee under ORS 656.382(2) because his compensation was not reduced by our order. Specifically, claimant argues that, because he performed no work during the period from November 13, 1998 through December 3, 1999, TPD benefits for that period will be the same as TTD benefits.

To the extent that claimant's argument relies on calculation of the rate of temporary disability benefits, we note that the parties stipulated at hearing that they would preserve the issue of claimant's temporary disability rate for future litigation, if any. Thus, the issue of the rate of temporary disability compensation was not raised or developed at hearing. Instead, the issue at hearing and on review was limited to claimant's entitlement to procedural temporary disability benefits, not the rate at which any such benefits would be paid. Thus, on reconsideration, we will not address the calculation of the specific rate to be paid for claimant's temporary disability benefits.

Nevertheless, without calculating the specific rate for temporary disability benefits, we find that the general principles used to determine the proper TPD rate do not support claimant's argument. In this regard, as we found in our initial order, Dr. Cox ultimately released claimant to modified work as of

November 13, 1998, and continued that modified work release throughout the period in question. Thus, claimant was not released from all work and was not entitled to procedural TTD benefits. Instead, he was entitled to procedural *TPD* benefits throughout the period in question. Furthermore, after leaving employment with the insured due to the CTS condition, claimant earned wages by performing several jobs for his landlord. (Ex. 16-1). Thus, claimant had "post-injury" wages.

Where, as here, there are "post-injury" wage earnings, the TPD rate will necessarily be lower than the TTD rate. *See* OAR 436-060-0030(a) and (b). Therefore, because we reduced the ALJ's award of *TTD* benefits for the period from November 13, 1998 through December 3, 1998 to *TPD* benefits for that period, and claimant had "post-injury" wage earnings, we reduced the compensation the ALJ awarded claimant.[1] Therefore, claimant's attorney is not entitled to an assessed fee under ORS 656.382(2).

The insurer's request for reconsideration

In its request for reconsideration, the insurer contends that we did not consider the following arguments it made on review that it contends warrant reversal of the ALJ's order: (1) claimant's testimony was not credible; (2) claimant left work for reasons unrelated to the "injury;" and (3) claimant was not in the work force at the time of disability. We disagree.

The ALJ set forth findings of fact and explained why she rejected the insurer's arguments that claimant was not credible and did not leave work for reasons related to the "injury." After our "de novo" review of the record, including the testimony of claimant and Mr. Eagle, upon whose testimony the insurer urges us to rely, we adopted the ALJ's findings of fact and her reasoning and conclusions, except to the extent that the ALJ found claimant entitled to TTD benefits from November 13, 1998 through December 4, 1998. By doing that, we have set forth the facts and conclusions relied on in this case. *See Jorge Pedraza*, 49 Van Natta 1019 (1997); *George v. Richard's Food Center*, 90 Or App 639 (1998) (an order on review need not set forth its own findings of fact and conclusions if it affirms or adopts an administrative law judge's order that is itself sufficient for substantial evidence review). Accordingly, we have previously considered the insurer's arguments prior to adopting the reasoning and conclusions of the ALJ on these matters. Furthermore, the insurer raises no new arguments on reconsideration regarding these matters. After reconsideration, we continue to agree with the ALJ that claimant is credible and left work due to the compensable bilateral CTS condition.

Finally, as for the insurer's third argument, *i.e.*, that claimant was not entitled to temporary disability benefits because he was not in the work force at the time of disability, we agree with claimant that the insurer first raised this issue on review. In this regard, at hearing, the insurer raised several legal grounds in support of its contention that claimant was not entitled to temporary disability. (Tr. 1-2, 4-9). The ALJ addressed each of those arguments in her order. However, at hearing, the insurer did not raise the issue of whether claimant was in the work force at the time of disability.

As a general rule, we do not consider issues that are raised for the first time on review. *See Stevenson v. Blue Cross*, 108 Or App 247, 252 (1991); *Gunther H. Jacobi*, 41 Van Natta 1031, 1032 (1989) (new issues or legal theories presented for the first time on review are not considered where prejudice would result to one of the parties); *see also Fister v. South Hills Health Care*, 149 Or App 214 (1997) (absent adequate reason, Board should not deviate from its well-established practice of considering only those issues raised by the parties at hearing). In this case, we find no reason to deviate from our general rule. Consequently, we decline to consider the work force issue raised by the insurer for the first time on review. *See Nazario N. Solis*, 52 Van Natta 335 (2000) (Board declined to consider "instrumentality" issue under ORS 656.386(1) raised by the insurer for the first time on review).[2]

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[1] We stress that in making this finding regarding the attorney fee issue, we are not making a specific calculation of claimant's temporary disability rate. Instead, we are finding that, as a result of claimant's "post-injury" wages, the TPD rate will not be the same as the TTD rate.

[2] In any event, the "post-injury" wages referred to in the above discussion regarding TTD/TPD benefits supports a conclusion that claimant did not leave the work force. Therefore, even if the work force issue were addressed, it would not alter our prior decision that claimant is entitled to TPD benefits.

Therefore, as supplemented herein, we republish our October 31, 2000 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM M. LIGHTNER, Claimant
WCB Case No. C002753
ORDER APPROVING CLAIM DISPOSITION AGREEMENT
Starr & Vinson, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

On November 14, 2000, the Board received the parties' claim disposition agreement (CDA) in the above-captioned matter. Pursuant to that agreement, in consideration of the payment of a stated sum, claimant releases certain rights to future workers' compensation benefits, except medical services, for his compensable injury. We approve the proposed disposition.

On page 4, lines 22-23, the CDA provides in part:

> "The parties agree that the sums paid under this Claim Disposition Agreement shall be in lieu of all previous awards of Permanent Partial Disability, not in addition thereto."

It is well settled that temporary and permanent disability benefits legally due and payable prior to submission of the CDA may not be considered an "advancement" of the CDA proceeds. *See Robert Derderian*, 45 Van Natta 1042 (1993). Stated more simply, temporary or permanent disability benefits that are legally due and payable prior to the submission of the CDA to the Board cannot be included in the consideration for the CDA.

Here, the parties' CDA states that the sums paid under the CDA are in lieu of previous awards of permanent partial disability. However, the agreement also provides that claimant has entered into a third party settlement for $900,000. The parties further agree that the SAIF Corporation's statutory share of that settlement is $366,666 and that the consideration for the CDA is SAIF's waiver of $315,551.01 of its statutory share. Thus, the consideration to claimant is actually the reduction of SAIF's statutory share of the third party settlement proceeds from $366,666. to $51,114.99, *i.e.*, the waiver of $315,551.01 from the recoverable third-party settlement. Accordingly, we conclude that the "in lieu of" provision most reasonably means that "post-CDA" permanent disability payments have been replaced by the above-noted consideration for the CDA.

The agreement, as clarified by this order, is in accordance with the terms and conditions prescribed by the Board. *See* ORS 656.236(1). Accordingly, the parties' claim disposition agreement is approved.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
KRISTINA L. PARKS, Claimant
WCB Case No. 99-09218
ORDER ON REVIEW
Lavis & Dibartolomeo, Claimant Attorney
Sather, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

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

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

In setting aside the insurer's denial, the ALJ analyzed the claim as one for an accidental injury involving a "combined condition" under ORS 656.005(7)(a)(B). Relying on the opinion of an attending physician, Dr. Buuck, the ALJ determined that claimant had satisfied her burden of proving that an incident at work in early April 1999 when claimant lifted a milk crate was the major contributing cause of the need for treatment of the "combined condition."

On review, the insurer contends that the ALJ should have analyzed the claim as one for an occupational disease and that, under the applicable legal standard for that kind of claim, claimant failed to sustain her burden of proof. Alternatively, the insurer asserts that Dr. Buuck's opinion is not persuasive under any theory of causation.

Having reviewed this record *de novo*, we agree with the ALJ's reasoning that this claim should be analyzed as one for an accidental injury. We further agree with the ALJ that, because the medical evidence establishes that an otherwise compensable injury combined with a preexisting right shoulder condition, the appropriate framework for determining the compensability of the alleged April 1999 injury is the "combined condition" standard in ORS 656.005(7)(a)(B).

Accordingly, to establish that a compensable injury occurred in April 1999, claimant must prove that the milk crate lifting incident was the major contributing cause of the disability or need for treatment of the "combined condition." *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997); *Gregory C. Noble*, 49 Van Natta 764, 767 (1997), *aff'd mem Liberty Northwest Insurance Corporation v. Noble*, 153 Or App 125 (1998). Here, we are persuaded that the medical evidence from Dr. Buuck and from an examining physician, Dr. Woodward, establish that claimant's injury in early April 1999 was the major contributing cause of at least her initial need for medical treatment. In this regard, we note Dr. Woodward's opinion that claimant suffered a right shoulder strain in April 1999 that was responsible for claimant's medical treatment in April and May 1999. (Ex. 50).

Accordingly, we conclude that the ALJ properly set aside the insurer's denial of claimant's threshold injury claim.[1] Thus, we affirm.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 18, 2000 is affirmed. For services on review, claimant's attorney is awarded an assessed fee of $1,000, to be paid by the insurer.

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[1] In reaching this conclusion, we emphasize that we are not determining the compensability of claimant's current right shoulder condition. Instead, our holding is limited to a determination that claimant suffered an injury in April 1999 that was the major contributing cause of a need for treatment of a "combined" right shoulder condition.

In the Matter of the Compensation of
VERA TANNENBAUM, Claimant
WCB Case No. 00-0229M
OWN MOTION ORDER ON RECONSIDERATION
Fontana & Takaro, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer requests reconsideration of our October 30, 2000 Own Motion Order that authorized the reopening of claimant's claim to provide temporary disability compensation beginning the date of claimant's surgery to implant a morphine pump. Having received claimant's response, we proceed with our reconsideration.

As a preliminary matter, after reconsideration, we noticed a scrivener's error in our initial order. Although finding that claimant's compensable condition worsened requiring surgery as of *June 2, 2000*, we authorized the reopening of the claim for temporary disability compensation beginning *July 12, 2000*, which is the date of a second surgery that claimant underwent to repair the malfunctioning morphine pump. We correct our initial order to authorize the reopening of claimant's claim to provide temporary disability compensation beginning *June 2, 2000*, the date of the initial surgery.

On reconsideration, citing ORS 656.273(1)(a) and (b), the insurer argues that a worsening is not established by either the worker's absence from work or inpatient treatment of the worker for the compensable condition at a hospital. In addition, the insurer repeats its argument that the opinions of Dr. Grewe, claimant's treating surgeon, do not meet claimant's burden of proving a worsening of her compensable condition requiring surgery or hospitalization as required under ORS 656.278(1)(a).

The insurer's reliance on ORS 656.273(1)(a) and (b) is misplaced. ORS 656.273(1)(a) and (b) are not applicable because claimant's 1979 claim is in the exclusive jurisdiction of our Own Motion authority under ORS 656.278. *See Stephen G. Ramberg*, 51 Van Natta 1461 (1999); *Jody Crompton*, 48 Van Natta 1183 (1996). Pursuant to ORS 656.278(1)(a), we may reopen a claim for temporary disability benefits 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."

Regarding the insurer's second argument, after reconsideration, we have nothing to add to our prior finding that, read as a whole, Dr. Grewe's opinions establish that the need for the surgical procedure was caused by a worsening of claimant's compensable condition. *See Durwood McDowell*, 47 Van Natta 2370 (1995) ("worsening" requiring hospitalization under ORS 656.278(1)(a) found where the claimant's condition worsened to the extent that it could only be managed by treating the compensable condition during inpatient hospitalization); *Earl Prettyman*, 46 Van Natta 891 (1994) (although "worsening" requiring surgery under ORS656.278(1)(a) found where the claimant's condition worsened to the extent that it required diagnostic arthroscopy to determine whether total knee replacement necessary, reopening denied because the claimant had voluntarily removed himself from the work force).

Finally, we note that claimant's attorney is not entitled to an assessed fee for services on reconsideration of this Own Motion matter. *See Efren Quintero*, 50 Van Natta 86 (1998).

Accordingly, we withdraw our October 30, 2000 order. On reconsideration, as supplemented herein, we republish our October 30, 2000 Own Motion Order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOHN J. BAN, Claimant
WCB Case No. 97-08233
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Tenenbaum's order that awarded a $3,750 attorney fee for services at hearing. On review, the issue is attorney fees. We modify.

FINDINGS OF FACT

Claimant requested a hearing regarding the insurer's October 9, 1997 and September 24, 1998 denials of claimant's claim for a July 1997 mid and low back injury. The issue was compensability, specifically whether the injury occurred and whether the claim was supported by objective findings.

After several postponements and two cancelled mediations, the case went to hearing on December 14, 1999. The hearing lasted just over an hour and the transcript is 46 pages long. Four witnesses testified, including claimant and two others on his behalf.

The record consists of 70 exhibits, with at least 13 submitted by claimant. The insurer requested the deposition of Dr. Peters, treating physician. The deposition was originally scheduled for January 12, 1998, the day before the hearing, in Portland (requiring claimant's counsel to travel from Eugene). The deposition and hearing were cancelled and rescheduled due to inclement weather. Dr. Peters was deposed in Portland on February 19, 1998.

After the hearing, claimant's counsel submitted an affidavit to the ALJ attesting to about 40 1/2 hours of legal time and 11 ¼ hours of paralegal time. Counsel requested a fee of $15,000.

CONCLUSIONS OF LAW AND OPINION

The ALJ awarded a $3,750 attorney fee for claimant's counsel's services at the hearing level, considering the rule-based factors discussed below.

On review, claimant argues that the ALJ's attorney fee award is not adequate compensation for the time expended or the risk of going uncompensated. Claimant contends that the ALJ improperly refused to consider time spent corresponding with Dr. Karasek regarding claimant's diagnosis and findings, because that time was reasonably spent substantiating claimant's objective findings in order to prove compensability. Claimant requests a fee of $15,000, for 40.5 hours of legal time and 11.25 hours of paralegal time, based in part on a rate of $250 per hour for attorney time.

The employer contends that the ALJ's attorney fee award should not be increased. In support, the employer argues that the value of the interest involved is undetermined, paralegal time should not be considered because there is no way to determine whether this work was subject to attorney supervision,[1] and claimant's fee request includes an unsupported "contingency multiplier" of 210%.

We review the attorney fee issue *de novo*, considering the specific contentions raised on review, in light of the factors set forth in OAR 438-015-0010(4) to the circumstances of this case. Those factors are: (1) the time devoted to the case; (2) the complexity of the issue(s) involved; (3) the value of the interest involved; (4) the skill of the attorneys; (5) the nature of the proceedings; (6) the benefit secured for the represented party; (7) the risk in a particular case that any attorney's efforts may go uncompensated; and (8) the assertion of frivolous issues or defenses.

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[1] Because there is no contention that the paralegal services in this case involved "research and investigation" subject to attorney supervision, we have not included them in our attorney fee consideration. *See Jamie J. Boldway*, 52 Van Natta 755 (2000); *Candace L. Spears*, 47 Van Natta 2393, 2394 n. 1 (1995).

Our review of the record reveals the following information. The issues in dispute at the hearing were the compensability of claimant's back injury claim and penalties. The hearing lasted just over an hour and the transcript is 46 pages long. Four witnesses testified, including claimant and two others on his behalf.

The record consists of 70 exhibits, with about 13 submitted by claimant, including at least two "claimant-generated" medical reports which were of significant probative value in establishing the compensability of his claim. One physician was deposed "pre-hearing" and the deposition required claimant's counsel to travel from Eugene to Portland.[2]

The case involved issues of average medical and legal complexity, considering the range of cases generally submitted to this forum. The claim's value and the benefits secured are above average, considering the medical services, including physiotherapy, required. Claimant's attorneys devoted over 40 hours of legal services to the case.[3] The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. Finally, there was a significant risk that claimant's counsel's efforts might have gone uncompensated, particularly considering the employer's vigorous defense.[4]

Based upon our application of each of the previously enumerated factors and considering the parties' arguments, we conclude that $5,500 is a reasonable attorney fee for services at the hearings level. In reaching this conclusion, we have particularly considered the time devoted to the compensability issue (as represented by the record and evaluating claimant's counsel's submission in light of the insurer's objection), the value of the interest involved, and the risk that claimant's counsel might go uncompensated. Finally, we note that claimant is not entitled to an attorney fee for services expended at the hearing level or on Board review that were related to the penalty or attorney fee issues. *See Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986); *Dotson v. Bohemia, Inc.*, 80 Or App 233, *rev den* 302 Or 35 (1986).

ORDER

The ALJ's order dated August 3, 2000, as reconsidered August 22, 2000, is modified in part and affirmed in part. In lieu of the ALJs attorney fee award, claimant is awarded a $5,500 attorney fee, to be paid by the insurer. The remainder of the order is affirmed.

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[2] *See Marilyn M. Keener*, 49 Van Natta 110, 113 (1997) (attorney's time preparing for, traveling to, and attending depositions considered in assessing a reasonable attorney fee).

[3] Claimant's counsel devoted a significant number of hours skillfully advocating claimant's claim in the face of a vigorous defense. Nonetheless, the amount of time expended in litigating a claim is but one of many factors to be considered in determining a reasonable attorney fee award under OAR 438-015-0010(4).

[4] *See Schoch v. Leupold & Stevens*, 144 Or App 259 (1996) (The risk in a particular case that an attorney's efforts may go uncompensated is a factor to be considered in setting a reasonable attorney fee under OAR 438-015-0010(4)). Nevertheless, we do not apply a contingency factor or "multiplier" in a strict mathematical sense. *E.g., Lois J. Schoch*, 49 Van Natta 788, 790, n 1 (1997). Rather, in accordance with OAR 438-015-0010(4)(g), in arriving at our determination of a reasonable attorney fee award, we have taken into consideration the risk (particularly in light of the nature of the proceedings, and the employer's vigorous defense) that claimant's attorney's efforts might have gone uncompensated for the services rendered in this case.

In the Matter of the Compensation of
SHAWN E. MORGAN, Claimant
WCB Case Nos. 99-04725 & 98-09323
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Crummé's order that: (1) set aside its denial of claimant's combined L5-S1 disc condition; and (2) upheld Hartford's partial denial of claimant's claim for the same condition. Claimant cross-requests review of that portion of the ALJs order that assigned responsibility for the L5-S1 disc condition to SAIF. Hartford cross-requests review of that portion of the ALJ's order that: (1) set aside its current condition denial as procedurally invalid; and (2) awarded an assessed attorney fee of $1,000, payable by Hartford. On review, the issues are compensability, responsibility and attorney fees. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact with the exception of the third and fifth sentences of Finding of Fact number 17, on page 4 of the ALJ's order.

We briefly summarize the facts as follows.

Claimant has an accepted claim with SAIF for a low back injury that occurred on April 21, 1993. The claim was accepted by SAIF for an acute lumbar sprain. After the 1993 injury, claimant had continuing symptoms of back pain, but did not see a doctor until a March 20, 1997 back injury at work. SAIF denied a claim for aggravation on June 25, 1997. The denial denied claimant's "March 20, 1997 low back strain and degenerative disc disease at L5-S1." (Ex. 9C).

On October 6, 1997, the employer's then workers' compensation carrier, Hartford, accepted claimant's claim for the March 20, 1997 injury as a disabling "low back strain." On July 27, 1998, claimant sought treatment for a flare up of the low back symptoms. An MRI on July 29, 1998 revealed degenerative disease at L3-4, L4-5 and a protruding disc at L5-S1.

On November 4, 1998, Hartford issued a denial of claimant's current low back condition, although the claim had not yet been closed. In February 1999, claimant requested that Hartford accept his low back condition, including degenerative disc disease at L4-5 and L5-S1. Also in February 1999, claimant wrote SAIF requesting that it accept the degenerative disc conditions at L4-5 and L5-S1. On May 26, 1999, claimant requested that SAIF accept "5-1 discal pain with radiculalgia." On May 27, 1999, SAIF partially denied claimant's L4-5 degenerative disc disease and in a separate letter stated that the L5-S1 condition had already been denied on June 25, 1997. On July 20, 1999, Hartford issued a partial denial of claimant's low back condition, including his degenerative disc disease at L4-5 and L5-S1.

Claimant requested a hearing on Hartford's November 4, 1998 and July 20, 1999 denials and SAIF's May 27, 1999 denial.

CONCLUSIONS OF LAW AND OPINION

The ALJ found claimant's L5-S1 disc condition, described as L5-S1 annular tears, discal pain syndrome and secondary radicular irritation, compensable as a combined condition. The ALJ further found SAIF responsible for the L5-S1 condition. In addition, the ALJ set aside, as procedurally invalid, Hartford's November 4, 1998 denial of claimant's current condition and assessed a $1,000 attorney fee payable by Hartford.

SAIF argues on review that "discal pain" is not a condition, that its 1997 denial of degenerative disease at L5-S1 encompassed "discal pain" and that the evidence does not establish compensability of "discal pain." Hartford argues that claimant's L5-S1 condition is not compensable. Hartford also asserts that the ALJ erred in finding that its November 4, 1998 current condition denial was an invalid preclosure denial. Claimant argues that the ALJ correctly found the L5-S1 condition compensable, but asserts that Hartford, instead of SAIF, should be found responsible.

Several physicians address the cause of the L5-S1 condition. Drs. Tsai and Rand examined claimant in May 1997 on behalf of SAIF. They opined that the major contributing cause of claimant's condition and need for treatment was degenerative disc disease at the L5-S1 level. (Ex. 9A).

Dr. Dinneen examined claimant on behalf of Hartford on July 13, 1998. Dr. Dinneen opined that claimant's impairment and symptoms were attributable to claimants preexisting chronic lumbar sprain problem. (Ex. 16-5).

Claimant's attending physician, Dr. Howison, concurred with Drs. Tsai, Rand and Dinneen's opinions.

Dr. Van Pett, neurologist, saw claimant on referral from Dr. Howison on August 22, 1998. Dr. Van Pett's impression was that claimant's current symptoms and clinical findings correlated with "the reported on the job injury." (Ex. 20-3). Dr. Van Pett did not specify whether she was referring to the 1993 or the 1997 injury.

Dr. Neumann examined claimant, on behalf of Hartford, on October 13, 1998. Dr. Neumann stated that claimant had degenerative disc disease and that the March 1997 injury was not a contributing factor at the time of his evaluation. Dr. Neumann indicated that claimant's findings were based on his preexisting condition solely and that claimant had a propensity for a chronic sprain/strain condition. (Ex. 24-6). Dr. Howison concurred with Dr. Neumann's report. (Ex. 22).

Dr. Karasek, neurologist, saw claimant on referral from Dr. Howison. Dr. Karasek noted that claimant's L5-S1 disc could be described as mildly abnormal on an April 21, 1993 x-ray. Dr. Karasek stated that it was hard to know what changes were present before 1993 since the first MRI was not performed until July 1998. Nevertheless, Dr. Karasek opined that the "work injury" was the major cause of claimant's disability and need for treatment. Dr. Karasek believed that claimant traumatically tore a disc that had early degradation changes in it. Dr. Karasek indicated that the tears were the predominant pathology and that the evidence suggested that these were traumatic, but recommended a discography to clarify this. (Ex. 30). Dr. Karasek did not specify whether he was attributing claimant's condition to the 1993 or 1997 injury.

Only Drs. Van Pett and Karasek attribute claimant's L5-S1 condition to a work injury. Neither physician is specific about whether the 1993 or 1997 injury is the cause of the condition. The ALJ discounted Dr. Van Pett's opinion because the doctor did not indicate that she was aware that claimant had preexisting pathology and symptoms at L5-S1 prior to 1993. In addition, we note that her opinion is conclusory and is unclear about which injury allegedly caused claimant's problem. Accordingly, we are not persuaded by Dr. Van Pett's opinion.

The ALJ relied on Dr. Karasek's opinion in his Order on Reconsideration. We do not find Dr. Karasek's opinion persuasive on this record. Although Dr. Karasek saw a 1993 x-ray that indicated claimant had some preexisting disease at L5-S1, he was unaware that claimant was treated in 1989 for problems with the L5 disc and had pain into the left leg. (Ex. A). This information may have affected Dr. Karasek's opinion regarding the contribution of the preexisting disease. Because we are persuaded that Dr. Karasek did not have an accurate history, we do not find his opinion persuasive.

Consequently, on this record, we conclude that compensability of an L5-S1 disc condition has not been established. Because the condition is not compensable, we do not reach the preclusion arguments or the issue of responsibility.

Accordingly, we reverse the ALJ's decision to set aside SAIF's denial of claimant's L5-S1 disc condition. SAIF's denial of that condition is reinstated and upheld.

Procedural Validity of Hartford's November 4, 1998 Current Condition Denial.

The ALJ found that Hartford's current condition denial was an invalid preclosure denial. The ALJ reasoned that claimant's conditions were not clearly separate from his accepted strain.

Hartford accepted the March 20, 1997 injury claim for a low back strain on October 6, 1997. (Ex. 10A). On November 4, 1998, Hartford issued a current condition denial. The denial acknowledged that the claim was accepted for low back strain, but indicated that the current condition appeared to be due to lumbar degenerative disc disease and the compensable injury was no longer the major contributing cause of claimant's current need for treatment and disability. (Ex. 23).

Generally, preclosure denials are disfavored but, if they pertain to a condition separate or severable from the accepted condition, they are procedurally valid.[1] *See Corinne L. Birrer*, 51 Van Natta 163 *on recon* 51 Van Natta 467 (1999); *Zora A. Ransom*, 46 Van Natta 1287 (1994) (preclosure denial was proper where the medical evidence "unequivocally" indicated that the claimant's current condition was not related to the accepted condition). Given our conclusion that the L5-S1 condition is not compensable, we are persuaded that the current condition is separate and unrelated to the accepted 1997 strain injury with Hartford. Under such circumstances, we conclude that the November 4, 1998 denial was not an invalid preclosure denial and that the denial is also substantively valid.

ORDER

The ALJ's order dated February 22, 2000, as reconsidered on June 22, 2000 is reversed. SAIF's May 27, 1999 denial is reinstated and upheld. Hartford's November 4, 1998 and July 20, 1999 denials are upheld. The ALJ's attorney fee awards are also reversed.

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

In the Matter of the Compensation of
TRUMAN MILLER, Claimant
WCB Case No. 99-08237
SECOND ORDER ON RECONSIDERATION
Craine & Love, Claimant Attorney
VavRosky, MacColl, Olson, et al, Defense Attorney

On November 29, 2000, we issued an Order on Reconsideration that republished, as supplemented, our October 31, 2000 Order on Review that: (1) modified that portion of an Administrative Law Judge's (ALJ's) order that awarded temporary total disability (TTD) benefits for the period from November 13, 1998 through December 3, 1998; and (2) declined to award an insurer-paid attorney fee under ORS 656.382(2) for claimant's counsel's services on Board review. After the issuance of our November 29, 2000 order, claimant's November 28, 2000 letter was brought to our attention. We treat this submission (which contends that our modification of claimant's TTD benefits to TPD benefits does not result in a reduction of his compensation and, as such, claimant is entitled to an insurer-paid attorney fee under ORS 656.382(2)) as a request for reconsideration.

We withdraw our October 31, 2000 and November 29, 2000 orders. After considering claimant's contentions and further reviewing the disputed issues, we adhere to the reasoning expressed and conclusions reached in our prior orders.

Accordingly, our October 31, 2000 Order on Review, as supplemented by our November 29, 2000 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
ROBERT F. MARTINOT, Claimant
WCB Case No. 99-02696
ORDER ON REMAND
Nicholas M. Sencer, Claimant Attorney
Scheminske, et al, Defense Attorney

This matter is before the Board on remand from the Court of Appeals. Pursuant to the court's November 8, 2000 order, we have been directed to consider the parties' settlement. The parties have submitted a proposed Disputed Claim Settlement that is designed to resolve all issues raised or raisable at this time.

Pursuant to the settlement, the parties agree that the insurer's denial, as supplemented by this agreement, "shall forever remain in full force and effect" and that "the execution of this document shall constitute a full and final waiver of claimant's right to challenge or appeal from the denial." The parties further agree that "all Requests for Hearing shall be dismissed with prejudice as to all issues which were raised by claimant."

We approve the parties' settlement, thereby fully and finally resolving the parties' dispute, in lieu of all prior orders.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] A provision in the parties' settlement states that a portion of claimant's share of the proceeds shall be provided to claimant's union "Oregon Bakers Trust" in reimbursement of sums that it paid to medical providers on claimants behalf. Inasmuch as the parties' compensability dispute is being resolved by means of a Disputed Claim Settlement (DCS), only medical service providers may be directly reimbursed from the settlement proceeds. ORS 656.313(4)(c). (Health insurance providers may be directly reimbursed by the workers' compensation carrier when "the services are determined to be compensable." ORS 656.313(4)(b)). Nonetheless, because proceeds from a DCS are not considered "compensation," a claimant's assignment of all or a portion of his share of the proceeds is not prohibited by ORS 656.234. *Robert D. Surina*, 40 Van Natta 1855 (1988); *Theodule Lejeune, Jr.*, 40 Van Natta 493 (1988).

Here, we do not interpret the aforementioned settlement provision to represent that a non-workers' compensation entity will receive reimbursement directly from the workers' compensation carrier. Rather, in granting our approval of the settlement, we have interpreted the settlement as stating that claimant has assigned a portion of his share of the settlement proceeds to the non-workers' compensation entity. Pursuant to *Lejeune* and its progeny, such an assignment is not contrary to ORS 656.234. Finally, the agreement provides that no outstanding medical bills from medical service providers were in the insurers possession on the date the settlement terms were agreed on. In light of such circumstances, the proposed settlement is approvable. OAR 438-009-0010(2)(g); *Robert E. Wolford*, 46 Van Natta 522 (1994).

In the Matter of the Compensation of
DARRELL H. SAMPSON, Claimant
Own Motion No. 00-0345M
SECOND INTERIM OWN MOTION ORDER CONSENTING
TO DESIGNATION OF PAYING AGENT (ORS 656.307)
Malagon, Moore, et al, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

On November 20, 2000, we declined to consent to the Department designating a paying agent under ORS 656.307 because the record contained no evidence that surgery or hospitalization was requested for claimant's current condition. Since the issuance of our order, claimant has submitted further information regarding his need for surgery. Claimant's aggravation rights under his 1991 Liberty Northwest Insurance Corporation (Liberty Northwest) claim expired on March 3, 1997.

In addition, the Benefits Section of the Workers' Compensation Division (WCD) has further provided notification that it is prepared to issue an order designating a paying agent under ORS 656.307 and OAR 436-060-0180. Each insurer (including Liberty Northwest under claimant's 1991 claim) has provided its written acknowledgment that the only issue is responsibility for claimant's otherwise compensable claim. Under such circumstances, WCD seeks our response to its request for consent to an order designating a paying agent under ORS 656.307.

Under 438-012-0032, the Board shall notify the Benefits Section that it consents to the order designating a paying agent if it finds that the claimant would be entitled to own motion relief if the own motion insurer is the party responsible for payment of compensation. The Board may exercise its own motion jurisdiction if there is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. ORS 656.278(1)(a). In such cases, the Board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the workers condition becomes medically stationary. *Id.*

Here, on June 27, 2000, claimant underwent a right elbow release with periosteal stripping. Because the record establishes that claimant's current condition required surgery, and, thus, has met the requirements of ORS 656.278 for authorization of temporary disability compensation, we conclude that claimant would be entitled to own motion relief if the own motion carrier (Liberty Northwest) should be ultimately found responsible for the payment of compensation. *See Gary W. Yeager, Sr.*, 48 Van Natta 2293 (1993); *Steven M. Rossiter*, 47 Van Natta 34 919950; *Robyn Byrne*, 47 Van Natta 213 (1995).

Inasmuch as claimant would be entitled to own motion relief if the own motion insurer (Liberty Northwest) is found responsible for claimant's current condition, the Board consents to the order designating a paying agent for temporary disability compensation under claimant's 1991 own motion claim, beginning June 27, 2000, the date claimant was hospitalized for surgery. ORS 656.278(1)(a).

The Board emphasizes that this is not a final order or decision authorizing a reopening of the claim under ORS 656.278 and the Board's rules. Instead, this is an interim order consenting to the designation of paying agent under ORS 656.307.

When the responsible carrier has been determined, the Board will either: (1) issue an order reopening an own motion claim, if the own motion carrier (Liberty Northwest) is ultimately found to be the responsible carrier; and/or (2) issue an order denying reopening of an own motion claim, if the own motion carrier (Liberty Northwest) is ultimately not found responsible, or if a non-own motion carrier is ultimately found to the responsible carrier. Furthermore, if the own motion carrier (Liberty Northwest) is ultimately determined to be responsible for claimant's current condition, the parties are requested to submit their respective positions regarding own motion relief.[1]

IT IS SO ORDERED.

[1] This order, which is based on a record supporting a conclusion that claimant's undisputed compensable condition required surgery, replaces our November 20, 2000 order.

In the Matter of the Compensationm of
JAMES E. TEMPLETON, Claimant
WCB Case No. 00-01389
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Howell's order that affirmed an Order on Reconsideration awarding no unscheduled permanent disability. On review, the issue is extent of unscheduled permanent disability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated July 6, 2000 is affirmed.

Board Member Biehl dissenting.

At hearing, claimant asserted that he was entitled to unscheduled permanent disability for his compensable thoracic strain. The ALJ concluded that claimant failed to satisfy his burden of proving that he sustained permanent impairment. In reaching this conclusion, the ALJ relied on the opinion of the medical arbiter, Dr. Anderson, who opined that range of motion measurements taken by an occupational therapist (Bottomley) in conjunction with the arbiter examination were not valid. (Ex. 40-4). The majority affirms the ALJ's decision without opinion. Because I disagree with the majority's action, I dissent.

On review, citing *Justeen L. Parker*, 49 Van Natta 334 (1997), claimant contends that the range of motion findings of Bottomley, as adopted by the medical arbiter, provide an appropriate basis for finding that he has 4 percent impairment for reduced thoracic range of motion. For the following reasons, I agree that claimant is entitled to unscheduled permanent disability.

In declining to award unscheduled permanent disability, the ALJ rejected claimant's argument that, under OAR 436-035-0007(28), Dr. Anderson's opinion that range of motion findings were invalid was insufficient to invalidate the impairment findings.[1] That rule provides:

> "Validity shall be established for findings of impairment according to the criterion noted in the AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990 , unless the validity criterion for a particular finding is not addressed in this reference, is not pertinent to these rules, or is determined by physician opinion to be medically inappropriate for a particular worker. Upon examination, findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, *based on sound medical principles*, explaining why the findings are invalid. When findings are determined invalid, the findings shall receive a value of zero. If the validity criterion are not met but the physician determines the findings are valid, the physician must provide a written rationale, based on sound medical principles, explaining why the findings are valid." (emphasis added)

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[1] In determining claimant's permanent impairment, I, like the ALJ, rely on Dr. Anderson's December 14, 1999 arbiter's report. Permanent disability is rated as of the date of the January 18, 2000 Order on Reconsideration. ORS 656.283(7); *Lori Kowalewski*, 51 Van Natta 13 (1999). The fact that the medical arbiter's examination was performed closer in time to the issuance date of the reconsideration order is not always decisive. *Charlene L. Vinci*, 47 Van Natta 1919 (1995). However, we have previously held that a medical arbiter's report may be more probative when there is a significant time gap between the closing examination and the medical arbiter's examination. *See, e.g., Kelly J. Zanni*, 50 Van Natta 1188 (1998); *Ronald L. Tipton*, 48 Van Natta 2521, 2522 n. 5 (1996). Here, I find that the time gap between Dr. Yarusso's closing examination (March 23, 1998) and the medical arbiter examination on December 14, 1999 was significant. I, therefore, would conclude that the medical arbiter report provided more probative evidence of claimant's disability as of the January 18, 2000 reconsideration order.

In *Parker*, we applied that rule in a case where the medical arbiter stated that range of motion measurements did not meet AMA (American Medical Association) validity standards, but he did not identify the validity standards that were not satisfied, nor did he provide a written explanation of why the range of motion measurements did not meet validity standards. *See Labor Force of Oregon v. Frierson*, 169 Or App 573 (2000) (a physician is permitted to explain why findings that do not comply with AMA guidelines should nonetheless be used and to explain why findings that do comply with the guidelines should nonetheless not be used); *see also Roseburg Forest Products v. Clemons*, 169 Or App 231 (2000) (interpreting *former* OAR 436-035-0007(27)). Thus, we concluded in *Parker* that the arbiter's range of motion findings must be rated as impairment. *Justeen Parker*, 49 Van Natta at 335.

In this case, Dr. Anderson opined that "the less than normal motion demonstrated by inclinometer fails to meet the validity criteria and we do not feel that it is valid for purpose of rating impairment." (Ex. 40-4). As previously noted, Dr. Anderson did not actually take range of motion measurements himself, but instead relied on those taken by the occupational therapist, Bottomley. Bottomley measured range of motion in claimant's cervical and lumbar spines, as well as in the thoracic spine, even though the Department instructed Dr. Anderson to examine claimant with respect to the thoracic strain condition only. (Ex. 35A-2). Bottomley concluded that it was "our opinion that there is a lot of guarding exhibited by the patient during range of motion measurements and do not feel that they are necessarily valid for rating impairment. We note that many of the validity measures were not met including straight leg raise validity check, and sitting straight leg raise at 80 [degrees] is inconsistent with supine straight leg raise."

However, Bottomley's range of motion findings for the thoracic spine satisfied the Director's validity criteria in that, over three consecutive measurements of mobility, individual measurements were within plus or minus five degrees of each other.[2] (Ex. 40-10). While Bottomley commented that there was a "lot" of guarding by claimant during the measurements, she never clarified whether the guarding occurred during the thoracic measurements, which are the only measurements at issue in this case, or whether the guarding happened during lumbar and cervical measurements. Moreover, Bottomley noted that the straight leg raising validity checks were not met. However, claimant correctly observes that straight leg raise validity checks apply to the validity of lumbar spine measurements, which are irrelevant to impairment in the thoracic spine. (Ex. 40-10). Thus, Bottomley's comments regarding straight leg raising validity do not cast doubt on the reliability of the thoracic measurements, which satisfied the Director's validity criteria.

Accordingly, I would conclude that neither Dr. Anderson nor Bottomley provided a written opinion, *based on sound medical principles*, explaining why the range of motion findings in the thoracic spine are invalid. Applying OAR 436-035-0007(28) to the facts of this case, I would conclude that Bottomley's ROM measurements, as adopted by the arbiter, Dr. Anderson, must be rated as impairment.[3] Because the majority apparently concludes otherwise, I respectfully dissent.

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[2] In this regard, I note that one of the five measurements of thoracic flexion was not within 5 degrees of the others. (Ex. 40-10). However, at least three consecutive measurements of mobility were, which satisfies the Department's Bulletin 239 criteria for validity.

[3] I acknowledge that we have held that, regardless of whether the ranges of motion might satisfy a portion of the Director's validity criteria, where a physician expressly questions the validity of the findings, those findings are not sufficient to establish permanent disability. *Dana M. Peterson*, 50 Van Natta 1554 (1998). I find *Peterson* distinguishable, however. In that case, the medical arbiter stated that measurements of range of motion in the claimant's lumbar spine were valid and reproducible individually, but did not meet the criteria for validity based on the straight leg raising validity test. Accordingly, because we found that the medical arbiter questioned the validity of the claimant's range of motion measurements, we agreed with the ALJ that the record presented no valid range of motion measurements on which to rate impairment. *Id.* at 1555. In contrast to *Peterson*, however, here neither the medical arbiter, nor the occupational therapist on whose measurements the arbiter relied, provided a persuasive reason to discount the range of motion findings in claimant's thoracic spine. As previously noted, Bottomley's comments regarding the straight leg raise validity test in this case, unlike the comments of the arbiter in *Peterson*, have no relevance to the validity of the thoracic range of motion measurements. Because there is no medical opinion in this case that, based upon sound medical principles, explains why the thoracic spine measurements are not valid, the impairment measurements obtained by Bottomley should be used to determine permanent disability.

In the Matter of the Compensation of
THOMAS M. THORSON, Deceased, Claimant
WCB Case No. 99-07930
ORDER ON REVIEW (REMANDING)
Whitehead & Klosterman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Dianna Thorson, the widow of the deceased worker (hereinafter referred to as claimant) requests review of Administrative Law Judge (ALJ) Black's order that: (1) excluded Exhibit 13; and (2) upheld the SAIF Corporation's denial of survivor's benefits. In her brief, claimant moves for remand for further evidence taking. On review, the issues are the ALJ's evidentiary ruling, remand and compensability. We vacate and remand.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we summarize and supplement as follows.

On June 14, 1999, the deceased worker was fatally injured when he was driving the employer's log truck. SAIF denied claimant's claim for survivor's benefits on the ground that the work accident was not the major contributing cause of death. Claimant timely requested a hearing. The hearing was scheduled for January 4, 2000. Exhibits were exchanged. On the day of hearing, claimant's attorney received a report from Mr. Webb, a certified accident reconstruction expert. Claimant offered the exhibit at hearing, which was marked Exhibit 13. Mr. Webb was available for cross-examination at the hearing.

SAIF objected to admission of the exhibit on the basis that claimant failed to give notice of an expert witness as required by OAR 438-007-0016, and that admission of the report would be unfair and prejudicial. The ALJ excluded Exhibit 13 as it did not fall under the exception in ORS 656.310(2) for medical reports that "constitute prima facie evidence as to the matter contained therein[.]" (Tr. 7, 8). In other words, the ALJ reasoned that the opinion of a non-medical or non-vocational expert witness could not be offered through a report. Because claimant's counsel failed to give timely notice of an expert witness, the ALJ also excluded Mr. Webb's testimony, but allowed the testimony to be taken as an offer of proof. The ALJ continued the hearing to permit depositions and rebuttal evidence. The record was closed on July 19, 2000.

On the merits, the ALJ concluded that the medical evidence was in equipoise and upheld SAIF's denial because claimant failed to establish that the accident was the major contributing cause of death.

CONCLUSIONS OF LAW AND OPINION

In his order, the ALJ noted that he had excluded Exhibit 13 because it was the report of an expert that did not fall under the exception in ORS 656.310(2). (Tr. 8). ORS 656.310(2) provides that the contents of *medical* reports presented by a claimant for compensation shall constitute *prima facie* evidence as to matters contained therein, provided that the doctor rendering the reports consents to submit to cross-examination. *Melvin O. Roberts*, 44 Van Natta 33 (1992); *Harold T. Bird*, 43 Van Natta 1732 (1991). Exhibit 13 is not a medical report containing a doctor's opinion. It is a report prepared by an accident reconstruction expert at claimant's attorney's request. Therefore, ORS 656.310(2) is inapplicable.

Similarly, OAR 438-007-0016[1] permits an ALJ to exclude the *testimony* of an expert witness whose identity has not been disclosed within the times prescribed under OAR 438-007-0018. Exhibit 13

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[1] OAR 436-007-0016 provides:

"Within the times provided for the initial exchanges of exhibits and indexes under OAR 438-007-0018 each party shall disclose to all other parties the identity of each expert witness the party will call to testify at the hearing. A statement by a party that the party reserves the right, or similar language, to call as a witness any expert whose opinion has been included in the documents filed in the case is not compliance with this rule. At the hearing the Administrative Law Judge may, in his or her discretion, allow the testimony of expert witnesses not disclosed as required by this rule. In the exercise of this discretion, the Administrative Law Judge shall determine whether material prejudice has resulted from the timing of the disclosure and, if so, whether there is good cause for the failure to timely disclose that outweighs the prejudice to the other party or parties."

is a *report* by an expert accident reconstruction specialist, not testimony. Therefore, OAR 438-007-0016 is inapplicable. Rather, the issue is whether the report was timely disclosed under OAR 438-007-0015 and OAR 438-007-0018.

OAR 438-007-0015, which sets forth general disclosure requirements, requires the parties to disclose claims documents within 15 days of initial request and to disclose subsequently obtained documents within 7 days of receipt.

Claimant received Exhibit 13 on January 4, 2000. Therefore, claimant's disclosure of the document at the January 4, 2000 hearing was timely. Where disclosure of a document is timely, the ALJ does not have discretion to exclude it. *E.g., Phyllis J. Wheeler*, 44 Van Natta 970, 971 (1992); *Oliver F. Coon*, 42 Van Natta 1845 (1990). If the disclosure is late in the sense that it was disclosed at hearing but was not untimely under the rules, but the other party is put at a disadvantage by the delay in obtaining the report, then the remedy for potential prejudice to the opposing party is not to exclude the exhibit but rather to allow time for cross-examination or rebuttal. *(Id.)* The ALJ may not simply exclude the report.

In light of this legal authority, we find that the ALJ abused his discretion in not admitting Mr. Webb's accident reconstruction report. In addition, because Mr. Webb's report should have been admitted, this case has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5).

Accordingly, the ALJ's order dated October 11, 2000 is vacated. The matter is remanded to ALJ Black for further proceedings consistent with this order. The ALJ is directed to admit Mr. Webb's report and to consider any other evidentiary requests from either party that arise for the admission of that report. Those proceedings may be conducted in any manner that the ALJ determines achieves substantial justice. The ALJ, upon receipt of this additional evidence and the eventual reclosure of the record, shall reconsider the merits of the issues raised by the parties. Following those proceedings, ALJ Black shall issue a final, appealable order.

IT IS SO ORDERED.

In the Matter of the Compensation of
WILLIAM M. CASHELL, Claimant
WCB Case No. 99-06120
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Lipton's order that upheld the self-insured employer's denial of his occupational disease claim for bilateral ganglion cysts. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact" with the exception of the second sentence of the last paragraph.

CONCLUSIONS OF LAW AND OPINION

The ALJ determined that claimant had failed to prove compensability of his occupational disease claim for ganglion cysts on the left ring and right middle fingers. In making this determination, the ALJ found that the opinion of claimant's attending physician, Dr. Layman, was insufficient to satisfy claimant's burden of proof because he had an inaccurate history of claimant's work activities and because Dr. Layman's reasoning on the causation issue was inconsistent with the legislature's purpose in adopting ORS 656.266.

On review, claimant contends that the ALJ should have set aside the employer's denial based on Dr. Layman's opinion. For the following reasons, we agree.

To prove a compensable occupational disease, claimant must prove that his work activities were the major contributing cause of the claimed disease, *i.e.* the bilateral ganglion cyst condition. ORS 656.802(2)(a). Because of the medical evidence indicating that the condition may be not be due to work activities, but rather to idiopathic causes, the causation question is medically complex and resolution of the issue requires expert medical evidence. *Uris v. Compensation Department*, 247 Or 420, 424 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105, 109 (1985). Medical opinions that are well-reasoned and based on complete and accurate histories are given greater weight. *Somers v. SAIF*, 77 Or App 259 (1986). Additionally, we generally give greater weight to the opinion of a worker's treating physician, absent persuasive reasons to do otherwise. *See Weiland v. SAIF*, 64 Or App 810 (1983). In this case, we do not find persuasive reasons for not giving greater weight to the opinion of claimant's attending physician, Dr. Layman.

Dr. Layman opined on several occasions that claimant's work activities as a teamster maintenance worker were the major contributing cause of his ganglion cysts. (Exs. 9-1, 11A-1, 14-1, 24-20). The ALJ discounted the persuasiveness of Dr. Layman's opinion because his written reports recited a history that claimant pulled on a chain to hoist tires, when claimant did not testify that was a part of his work activity or provide that history to an examining physician, Dr. Woodward.

The ALJ is correct that the history of hoisting tires was not part of the testimony that claimant provided regarding the nature of his work duties nor does it appear as part of the work activities described in Dr. Woodward's report, a report that claimant confirmed at hearing accurately described his work activity. (Ex. 10-2; Tr. 9). Nevertheless, we do not find that this inaccuracy in Dr. Layman's written reports renders his opinion unpersuasive.

In his deposition, Dr. Layman testified that claimant told him that his ganglion cyst arose after "pulling on some chains." (Ex. 24-11). Claimant's counsel provided Dr. Layman with the accurate description of claimant's work activities contained in Dr. Woodward's report, which included the history of pulling chains out of a large pile. (Ex. 10-2). Dr. Layman testified that the history in Dr. Woodward's report was consistent with his understanding of claimant's work activities. (Ex. 24-17, 18). Dr. Layman then reiterated his opinion that claimant's work activities were the major contributing cause of the ganglion cyst condition. (Ex. 24-20). In light of his deposition testimony, we are persuaded that Dr. Layman had an accurate understanding of claimant's work activities, including pulling on chains, in concluding that they were the primary factor in claimant's occupational disease.

The ALJ also criticized Dr. Layman's reasoning as violating ORS 656.266, which provides that a claimant cannot carry the burden of proving a compensable occupational disease merely by disproving other possible explanations of how the disease occurred. As part of his reasoning that claimant's occupational disease claim was caused in major part by his work activities, Dr. Layman opined that, if one could exclude work activities as a causal agent, then one would have to conclude that claimant's ganglion cysts were idiopathic. (Exs. 9-1, 11A-1). Because he was unable to exclude work activities as a causative agent, Dr. Layman used this as one basis for concluding that claimant's condition was not idiopathic.

Unlike the ALJ, we see no inconsistency between this reasoning and ORS 656.266 because Dr. Layman's opinion that claimant's condition was work related was not based on disproving other (*i.e.*, non work-related) possible explanations for claimant's condition. Moreover, Dr. Layman provided other reasoning to support his causation opinion, such as claimant's history of inflammation prior to the development of the ganglion cysts. (Exs. 9-1, 11A-1). In addition, Dr. Layman cited the history of claimant's employment, the history of his symptoms and the specific nature of his employment. (Ex. 24-19). Finally, Dr. Layman conceded that he was unaware of epidemiological studies or medical literature to support his opinion (Ex. 24-23), but explained in a written report that his opinion that ganglion cysts can be work related was grounded in considerable clinical experience, consisting of 16 years of hand surgery, including his observation of patients who have had a history of work activity causing inflammation along the tendon flexor sheath, followed by the development of ganglion cysts. Dr. Layman reiterated this position at his deposition and emphasized that his opinion was based on more than merely a temporal relationship between the onset of claimant's symptoms and his work activities. (Ex. 24-8, 9).

Having reviewed Dr. Layman's opinion as a whole, we conclude that it is well-reasoned and based on a complete and accurate history. Thus, we find it persuasive.

The only other opinion that addresses the causation of claimant's ganglion cysts is from Dr. Woodward. He explained that his "understanding" was that ganglion cysts are idiopathic and that he was unaware of a higher incidence of such lesions in people whose work resembled claimant's. (Ex. 10-6). Later, in a supplemental report, Dr. Woodward provided three medical articles to support his contention that claimant's cysts were not related to his employment. (Ex. 12-2).

We acknowledge that there is medical literature supporting Dr. Woodward's position. However, Dr. Layman makes a persuasive case for his position based on his extensive clinical experience. When comparing the reasoning contained in the respective opinions, we find that Dr. Layman provides substantially more explanation of his position, an explanation we conclude is more cogent than Dr. Woodward's. In light of this, as well as the customary deference we accord the opinion of an attending physician, we find Dr. Layman's opinion the most persuasive. Therefore, we hold that claimant has sustained his burden of proving a compensable occupational disease claim. Accordingly, we reverse.

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 $4,900, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by the record, 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 orders dated June 28, 2000 and July 11, 2000 are reversed. The employer's denial is set aside and the claim is remanded to the employer for processing in accordance with law. For services on review, claimant is awarded an assessed fee of $4,900, to be paid by the employer.

In the Matter of the Compensation of
REBECCA R. COLLINS, Claimant
WCB Case No. 99-03788
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's aggravation claim for a C5-6 disc condition. With its appellant's brief, the employer seeks "administrative notice" of photocopies of selected portions of the *International Classification of Diseases*, 9th Revision, 4th Edition, Volumes 1 & 2 (1992). In her respondent's brief, claimant contests that portion of the ALJ's order that upheld the employer's compensability denial of the same cervical spine condition as a "new injury" claim. On review, the issues are administrative notice, aggravation, and compensability.

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

With its respondent's brief, claimant challenges that portion of the ALJ's order that upheld the employer's compensability denial of the C5-6 disc condition as a "new injury" claim. The employer objects to claimant's raising the issue because she did not file a formal cross-request for review. In other words, the employer contends that we lack jurisdiction to consider this issue. We treat the employer's objection as a motion to strike.

We have previously held that we have authority to consider issues which are not raised via formal cross-requests for review. *Petronilo Lopez*, 45 Van Natta 1136 (1993); *Cameron D. Scott*, 44 Van Natta 1723, 1724 (1992); *Kenneth Privatsky*, 38 Van Natta 1015 (1986). We adhere to our previous rulings and deny the employer's motion to strike.

Reasoning that the employer had, in effect, previously accepted claimant's degenerative cervical condition, the ALJ concluded that claimant's current C5-6 condition represents a compensable aggravation claim. The employer requests review, contesting the ALJ's reasoning. In addition, the employer submits photocopies of selected portions of the *International Classification of Diseases*, 9th Revision, 4th Edition, Volumes 1 & 2 (1992), which lists various medical diagnoses by numeric diagnostic codes. Some of the diagnoses contained therein are described in a manner similar to definitions in a dictionary; others are not. From this submission, the employer seeks "administrative notice" that the term "cervicalgia" (emphasis added) means "neck pain."

The Board may take administrative notice of facts "[c]apable of accurate and ready determination by resort to sources whose accuracy cannot reasonably be questioned." *SAIF v. Calder*, 157 Or App 224, 227 (1998); *Jesse R. Walker*, 45 Van Natta 974 (1993); *Rodney J. Thurman*, 44 Van Natta 1572, (1992); *Susan Teeters*, 40 Van Natta 115 (1988). A medical dictionary, when used to define medical terms, is such a source. *Calder*, 157 Or App at 227. However, the Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within specialized knowledge. Consequently, our findings must be based on medical evidence in the record. *Calder*, 157 Or App at 228; *Glen D. Oetken*, 52 Van Natta 1528 (2000).

Here, the record contains three uncontested medical opinions (Drs. Silver, Engstrom and Long) stating that the term "cervalgia" means "neck pain."[1] (Exs. 26A-14; 26-1; 27-21; 28-21 to 22). The photocopies submitted by the employer do not contain a listing or definition of the term "cervalgia." In essence, the employer asks us to take "administrative notice" that "cervicalgia" (emphasis added) means "neck pain," and to thus take "administrative notice" that "cervalgia" is excluded from also meaning "neck pain." We decline to do so.

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[1] On January 28, 1998, the employer issued its notice of acceptance, specifically accepting, right lateral epicondylitis, right forearm tenosynovitis and cervalgia. (Ex. 7A-1).

First, we note that even if "cervicalgia" (emphasis added) does mean "neck pain," that fact alone does not automatically exclude "cervalgia" from also meaning "neck pain." Moreover, the employer requests that we make a technical finding, based upon specialized knowledge, contrary to all the medical evidence in the record. We are not permitted to make such a factual finding. *Calder*, 157 Or App at 228; *Glen D. Oetken*, 52 Van Natta at 1528. Consequently, we do not take "administrative notice" that "cervalgia" is defined contrary to the definition given that term by Drs. Silver, Engstrom and Long. Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $2,000, to be paid by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 10, 2000 is affirmed. For services on review, claimant is awarded a $2,000 attorney fee, payable by the employer.

December 4, 2000 Cite as 52 Van Natta 2124 (2000)

In the Matter of the Compensation of
TROY W. CARTER, Claimant
WCB Case Nos. 98-05457 & 98-04936
ORDER ON RECONSIDERATION
Walsh & Associates, Claimant Attorney
Jerald Keene, Defense Attorney
Lundeen, et al, Defense Attorney

Claimant has requested reconsideration of our October 12, 2000 Order on Review that adopted and affirmed an Administrative Law Judge's (ALJ's) order that: (1) found that claimant's injury and occupational disease claims for a left shoulder condition were untimely; (2) upheld Crawford & Company's (Crawford's) denial of that condition; and (3) upheld Liberty Northwest Insurance Corporation's (Liberty) denial of the same condition. On reconsideration, claimant contended that we did not review or address the merits of his case and that the claim should be analyzed as an occupational disease, not an injury. On November 9, 2000, we withdrew our October 12, 2000 order and allowed the carriers an opportunity to respond. Having received the carriers' responses, we proceed with our reconsideration.

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

Therefore, as supplemented herein, we republish our October 12, 2000 order in its entirety. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
PHILLIP W. FROST, Claimant
WCB Case No. 99-08634
ORDER ON REVIEW
J. R. Perkins III, Claimant Attorney
Reinisch, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) declined to award temporary disability benefits from November 1, 1999 to February 29, 2000; (2) declined to award a penalty for an allegedly unreasonable resistance to the payment of compensation; and (3) denied claimant's request for mileage reimbursement. On review, the issues are temporary disability benefits, penalties and mileage reimbursement. We affirm in part and vacate in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact. We also adopt the ALJ's Findings of Ultimate Fact, with the exception of the ALJ's Finding that the employer had a legitimate doubt regarding its liability for claimant's mileage reimbursement.

CONCLUSIONS OF LAW AND OPINION

Temporary disability benefits and penalties

We adopt and affirm the ALJ's Conclusions of Law and Opinion with respect to the issues of temporary disability benefits and penalties.

Mileage reimbursement

The ALJ denied claimant's request for mileage reimbursement for traveling to and from his doctor while outside the state of Oregon. Based on the following reasoning, we vacate this portion of the ALJ's decision.

We have previously held that reimbursement for mileage expenses concerning medical treatment for a compensable claim constitutes medical services, for which the Director has jurisdiction. *Ralph I. Pringle*, 47 Van Natta 2155 (1995); *Thurman M. Mitchell*, 47 Van Natta 1971 (1995). In 1999, ORS 656.704(3)(b) was enacted which addresses jurisdiction regarding medical services disputes between the Board and the Director. Subsection (3)(b)(C) provides that any dispute that requires a determination of whether a sufficient causal relationship exists between medical services and an accepted claim to establish compensability is a matter concerning a claim (in which case jurisdiction would rest with the Board's Hearing Division under ORS 656.283(1)).

Here, the mileage reimbursement dispute does not involve a "causation" issue between the mileage and claimant's accepted claim. Consequently, the authority to resolve the propriety of claimant's mileage reimbursement request based on his accepted claim rests with the Director. ORS 656.704(3)(b)(B). We therefore vacate the ALJ's decision concerning the medical services issue.

ORDER

The ALJ's order dated June 1, 2000 is vacated in part and affirmed in part. That portion of the ALJ's order that addressed the medical services issue is vacated and claimant's request for hearing regarding that issue is dismissed. The remainder of the ALJ's order is affirmed.

Board Member Biehl dissenting in part.

The majority affirms that portion of the ALJ's order that found that the employer properly terminated claimant's temporary total disability (TTD) when claimant declined to accept the employer's modified job offer. Because I disagree with that finding, I respectively dissent.

ORS 656.268(4)(c) provides for the continuation of TTD until the "attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

The employer's offer of a modified job and its subsequent termination of claimant's TTD was premised on Dr. Krieg's September 29, 1999 response to the employer's description of the proposed modified job. In that response, Dr. Krieg placed an x in the blank preceding the following sentence: "[Claimant] can return to light duty work, as indicated above, on October 4th, 1999." (Ex. 48).

Standing alone, this notation could support a conclusion that Dr. Krieg approved the modified job offer. However, Dr. Krieg added this further clarification: "[Claimant] can perform this [position] as it pertains to his right arm. He needs to be released by his physiatrist and/or neurosurgeon." *(Id.)*

When his entire response is viewed in its full context, Dr. Krieg was in effect, *not* releasing claimant to the proposed modified job. Rather, Dr. Krieg was recommending a further evaluation and testing by either a physiatrist or a neurosurgeon. In the event that these additional studies did not detect any concerns regarding claimant's condition and his capacity to perform the proposed job, Dr. Krieg's approval would become effective.

The later physiatric and neurological opinions requested by Dr. Krieg did not support claimant's release to the proposed modified job. Raising concerns regarding claimant's physical capacity to perform desk work and answering a phone, Ms. Richardson, an occupational therapist, did not believe that claimant was "ready to return to work even for a desk job at this time." (Ex. 54a). Subsequent neurological evaluations performed by Dr. Cobasko echoed these concerns, recommending further testing to determine whether surgical exploration would be necessary. (Ex. 55-4).

In light of such circumstances, the record does not support a conclusion that Dr. Krieg's September 29, 1999 response constituted an approval of the employer's proposed modified job. Because ORS 656.268(3)(c) expressly requires an attending physician's written documentation that a worker is released to modified employment, I am not persuaded that the statutory prerequisite for the employer's termination of claimant's TTD was satisfied until February 29, 2000 (when Dr. Krieg unequivocally approved the modified job offer). Because the majority holds otherwise, I respectfully dissent from that portion of their opinion.

In the Matter of the Compensation of
DOUGLAS L. SHUMWAY, Claimant
Own Motion No. 99-0310M
OWN MOTION ORDER OF ABATEMENT
Mitchell & Associates, Claimant Attorney
Alice Bartelt (Saif), Defense Attorney

Claimant requests reconsideration of our November 2, 2000 Own Motion Order Reviewing Carrier Closure, that affirmed the SAIF Corporation's August 4, 2000 Notice of Closure.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order and implement the following briefing schedule. SAIF's response to claimant's motion must be filed within 14 days of the date of this order. Claimant's reply must be filed within 14 days of the date from the date of mailing of SAIF's response. Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
JOSEPH A. HULSE, Claimant
WCB Case Nos. 99-07427, 99-02669 & 99-00493
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Thomas J. Dzieman, Defense Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Barrett Business Services (Barrett) requests review of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) affirmed the Director's nonsubjectivity determination for Scott Van Wey, dba Scott Van Wey Construction; (2) affirmed the Director's nonsubjectivity determination for Van Wey Homes, Inc.; (3) set aside Barrett's denial of claimant's left thumb injury claim; and (4) awarded claimant's counsel a $5,600 assessed attorney fee. In its brief, Van Wey Homes contends that the ALJ erred by declining to dismiss it as a party pursuant to ORS 656.308(2)(c). On review, the issues are dismissal, subjectivity, responsibility, and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the "Findings of Fact" set forth in the ALJ's order with the following supplementation.

In August 1998, claimant was hired by Scott Van Wey to perform framing work. He reported to Scott Van Wey, or another worker, every morning and his work activities for the day were directed by Scott Van Wey. Claimant was paid every two weeks by Scott Van Wey at an agreed upon rate per hour. The tools claimant used were furnished by Scott Van Wey. Scott Van Wey had the right to fire claimant and in fact the employment relationship was terminated following claimant's accident.

CONCLUSIONS OF LAW AND OPINION

Dismissal

On February 26, 1999, the Director issued a nonsubjectivity determination under ORS 656.740(2) that found that claimant was not a subject worker of Van Wey Homes. Claimant requested a hearing concerning that determination. Prior to the hearing, Van Wey Homes filed a motion to dismiss it as a party under ORS 656.308(2)(c). The ALJ declined to grant the motion to dismiss and determined on the merits that Van Wey Homes was not a subject employer. The ALJ affirmed the Director's nonsubjectivity determination regarding Van Wey Homes. On review, Van Wey Homes contends that the ALJ incorrectly failed to grant its motion to dismiss. We disagree.

ORS 656.308(2)(c) provides for dismissal of an insurer or self-insured employer, in the context of a responsibility dispute, if the record does not contain substantial evidence to support a finding of responsibility against that insurer or self-insured employer. Here, Van Wey Homes was a party to this proceeding by virtue of claimant's appeal of the Director's nonsubjectivity determination under ORS 656.740(2). ORS 656.308(2) is not applicable to the issue of subjectivity. Accordingly, the ALJ correctly denied the motion.

Subjectivity

Van Wey Homes

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

Scott Van Wey

The ALJ found that claimant was not a subject worker of Scott Van Wey, reasoning that Barrett was responsible for providing workers' compensation coverage for claimant's injury. We disagree.

As a preliminary matter, the record does not contain any evidence that establishes an employment relationship between claimant and Barrett. While Barrett did provide other workers for Scott Van Wey, *claimant* was not one of those workers. Therefore, claimant was not directly employed by Barrett.

However, ORS 656.850(3) provides that a worker leasing company may be responsible for providing workers' compensation coverage for both leased workers and other subject employees of the leasing company's client when the client does not have an active guaranty contract on file with the Director. Consequently, if it is determined that claimant was a subject employee of Scott Van Wey, the application of ORS 656.850(3) may fix responsibility for claimant's injury with Barrett. Therefore, it is first necessary to determine whether claimant was a subject worker of Scott Van Wey.[1]

When deciding whether a claimant comes under workers' compensation law, the first inquiry is whether the claimant is a "worker" under ORS 656.005(30) and the judicially created "right to control" test. *See S-W Floor Cover Shop v. Natl. Council on Comp. Ins.*, 318 Or 614, 630-631 (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 principal factors 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. *See Castle Homes, Inc. v. Whaite*, 95 Or App 269, 272 (1989). None of these factors are dispositive; rather, they are to viewed in their totality. *See Cy Investment, Inc. v. Natl. Council on Comp. Ins.*, 128 Or App 579, 583 (1994).

Claimant was introduced to Scott Van Wey by Nick Goodman, who worked for Scott Van Wey. (Ex. 63A-24). Claimant was instructed by Scott Van Wey to report to a job site to begin working as a framer. (*Id.*). Claimant reported to Scott Van Wey, or another worker, every morning and claimant's work activities for the day were directed by Scott Van Wey. (Ex. 63A-118). Claimant was paid every two weeks by Scott Van Wey at an agreed upon rate per hour. (Ex. 63A-31-45). The tools claimant used were furnished by Scott Van Wey. (Ex. 63A-35-68). Finally, Scott Van Wey had the right to fire claimant and in fact the employment relationship was terminated following claimant's accident. (Ex. 63A-103).

On this record, all of the factors considered in the "right to control" test weigh in favor of finding claimant was an employee of Scott Van Wey. Under these circumstances, the Director's nonsubjectivity determination, as to Scott Van Wey, must be set aside.[2]

Responsibility

We adopt the conclusions and reasoning set forth in the ALJ's order with the following supplementation.

The ALJ determined that Barrett was a "worker leasing company" rather than a "temporary service provider" under the terms of ORS 656.850. Consequently, pursuant to ORS 656.850(3), the ALJ assigned responsibility for claimant's injury to Barrett. We agree.

The determination of an entity's status as either a "worker leasing company" or a "temporary service provider depends upon whether the workers provided by the entity to a client are provided on a "temporary basis" as defined in ORS 656.850(1)(b).[3] At the time of claimant's injury, a worker named

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[1] ORS 656.850(3) provides in relevant part: "[w]hen a worker leasing company provides workers to a client, the worker leasing company shall satisfy the requirements of ORS 656.017 and 656.407 and provide workers' compensation coverage for those workers and *any subject workers employed by the client* unless during the term of the lease arrangement the client has an active guaranty contract on file with the director that extends coverage to subject workers employed by the client and any workers leased by the client. . ." (Emphasis supplied). It is clear from the emphasized portion of the statute that the determination of whether a claimant is a subject worker of the client is a necessary prerequisite to the application of ORS 656.850(3). That is, the provision does not apply if it is determined that the claimant is not a subject worker of the client.

[2] In light of this determination, the Director will presumably proceed to a determination of whether Scott Van Wey was a noncomplying employer under ORS 656.054 and ORS 656.740.

[3] ORS 656.850(1)(b) provides that: "'[t]emporary basis' means providing workers to a client for special situations such as to cover employee absences, employee leaves, professional skill shortages, seasonal workloads and special assignments and projects with the expectation that the position or positions will be terminated upon completion of the special situation. Workers also are provided on a temporary basis if they are provided as probationary new hires with a reasonable expectation of transitioning to permanent employment with the client and the client uses a preestablished probationary period in its overall employment selection program."

"Mark Sweitzer" was the only worker provided by Barrett to Scott Van Wey. Therefore, Barrett's status as either a working leasing company or a temporary service provider depends on whether Barrett provided Mark Sweitzer (hereinafter "Sweitzer") on a "temporary basis."[4]

Sweitzer first applied for work with Barrett in September 1995. (Ex. 6-2). On July 1, 1997, after assignments with two other Barrett clients, Sweitzer was assigned to Scott Van Wey. (*Id.*). Barrett's initial work order assigning Sweitzer to Scott Van Wey indicated the duration of the assignment as "Dec 97." (Ex. 15). The assignment to Scott Van Wey ended when Sweitzer quit on September 30, 1998. (Ex. 6-2). Between January 1, 1998 and June 1, 1998, Sweitzer missed only two pay periods, the week of January 3, and the week of March 15. (Ex. 8-2; 8-3). Between June 1, and September 30, he missed a three-week consecutive period beginning June 28. (Ex. 8-2).

Barrett does not assert that Sweitzer was assigned to Scott Van Wey to cover employee absences, employee leaves, or professional skill shortages. Rather, Barrett contends that Sweitzer was provided to cover a seasonal workload or to cover a special project, *i.e.*, the house on Fairway Drive.

The evidence does not support a conclusion that Sweitzer was assigned to Scott Van Wey to cover a special project with the expectation that the assignment would be terminated upon the completion of the house on Fairway Drive. To the contrary, the evidence shows that Scott Van Wey had six houses under construction in the summer of 1998, and that Sweitzer worked on at least two of the houses. (Ex. 63A-28; 63A-30). Moreover, none of Barrett's records indicated that Sweitzer was working on a special project or that Sweitzer's work for Scott Van Wey would terminate at a specified time.

Additionally, the evidence does not support a conclusion that Sweitzer was provided to Scott Van Wey to cover a seasonal workload. Sweitzer was assigned to Scott Van Wey for approximately 15 months. Although Sweitzer did not have continuous work during that time period, there is no evidence suggesting that the time he did work coincided with any type of cyclical business pattern. In other words, there is no evidence showing that Scott Van Wey's workloads varied with the time of year.[5]

Consequently, on this record, we agree with the ALJ that Sweitzer was not provided to Scott Van Wey on a "temporary basis" as that term is used in ORS 656.850(1)(b). Therefore, we conclude that Barrett did not provide Sweitzer's services to Scott Van Wey as a "temporary service provider", but instead provided Sweitzer's services as a "worker leasing company."

Inasmuch as we have found that claimant was a subject employee of Scott Van Wey, and having concluded that Barrett, as a working leasing company provided Mark Sweitzer as a leased employee, ORS 656.850(3) assigns responsibility to provide coverage for claimant's injury to Barrett. Accordingly, we agree with the ALJ's conclusion that Barrett's denial of responsibility must be set aside.

Attorney Fees

The ALJ awarded claimant's attorney a $5,600 attorney fee, pursuant to ORS 656.386(1), payable by Barrett. Barrett contends that because the compensability of claimant's injury was not an issue, the ALJ erred in awarded a fee under ORS 656.386(1). We agree that claimant is not entitled to an attorney fee under ORS 656.386(1), but find that claimant is entitled to the ALJs $5,600 assessed fee award under other statutory provisions.

ORS 656.308(2)(d) provides: "[n]otwithstanding 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 special circumstances."

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[4] Barrett's agreement with Scott Van Wey originated in 1995. (Ex. 3). There is no writing memorializing the actual terms of the agreement between Barrett and Scott Van Wey. Their agreement was done on a "handshake." (Tr. Vol II, p. 106). Neither party contends that Barrett was not paid a fee for providing workers to Scott Van Wey.

[5] "Seasonal workload" is not defined by statute or by OAR Division 436. However, OAR 437-004-0240, which deals with worker safety, defines "seasonal worker" as "a person employed in a job tied to certain time of year by an event or pattern and for not more than 10 months in a calendar year."

Here, Barrett did not deny compensability; rather it only contested responsibility. (Ex. 65). Consequently, if claimant is entitled to an assessed attorney fee payable by Barrett, he is entitled to the fee under the terms of ORS 656.308(2), not ORS 656.386(1). Therefore, the attorney fee award, if any, is limited to $1,000, absent a showing of extraordinary circumstances. *See Liberty Northwest v. Gordineer*, 150 Or App 136, 139 (1997).

The hearing transcript in this matter consists of two volumes with a total of 180 pages; seven witnesses testified. The record consists of 87 exhibits. One deposition of about three hours in length was taken. The hearing itself, exclusive of closing arguments, took a full day to complete. The legal issues, when compared to responsibility disputes generally presented to the Hearings Division, were more complex than average, specifically with regard to the application of the worker leasing statutes. The parties' respective counsels presented their positions in a thorough and professional manner. No frivolous issues or defenses were presented.

After considering the factors set forth in OAR 438-015-0010(4), we find that extraordinary circumstances exist to warrant an attorney fee in excess of the $1,000 statutory limit. *See Janice K. Gonzalez*, 49 Van Natta 638 (1997) (extraordinary circumstances found where issues were legally and procedurally complex involving substantial research by the claimant's counsel). Based on our application of the factors, and considering the parties arguments, we conclude that $5,600 is a reasonable attorney fee, for services at hearing and on review relating to the issue of responsibility. *See* ORS 656.308(2)(d); *Liberty Northwest v. Gordineer*, 150 Or App at 139; *Paul Huddleston*, 48 Van Natta 4, *on recon* 48 Van Natta 203 (1996); *Julie M. Baldie*, 47 Van Natta 2249 (1995). We reach this conclusion because of factors such as time devoted to the case, the value of the interest involved, and the complexity of the issues. Accordingly, in view of the factors set forth in OAR 438-015-0010(4), we award claimant an attorney fee, payable by Barrett, in the amount of $5,600, under ORS 656.308(2)(d).

In addition to an attorney fee under ORS 656.308(2)(d), claimant is entitled to an attorney fee under ORS 656.740(6)(c) for prevailing over the nonsubjectivity determination relating to Scott Van Wey. After considering the factors set forth in OAR 438-015-0010(4), we find that $1,000 is a reasonable attorney fee for services (at hearing and on review) relating to the issue of nonsubjectivity, payable from the Workers' Benefit Fund.

ORDER

The ALJ's order dated May 11, 2000 is reversed in part and affirmed in part. That portion of the ALJ's order that affirmed the Director's nonsubjectivity determination as to Scott Van Wey, dba Scott Van Wey Construction, is reversed and the Director's determination is set aside. For services associated with prevailing over the Director's nonsubjectivity determination, claimant is awarded an attorney fee of $1,000, payable by the Workers' Benefit Fund pursuant to ORS 656.740(6)(c). The remainder of the ALJ's order is affirmed.

In the Matter of the Compensation of
HENRY WILLIAMS, Claimant
Own Motion No. 00-0300M
OWN MOTION ORDER OF ABATEMENT

Claimant requests reconsideration of our November 7, 2000 Own Motion Order, that declined to reopen his claim for the payment of temporary disability compensation because he failed to establish that he was in the work force at the time of disability.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. The 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
EDGAR L. TJADEN, Claimant
WCB Case No. 99-08179
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Jerald Keene, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's occupational disease claim for a mental disorder. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

The employer manufactures hydraulic machine tools. Claimant has worked for the employer as a machine tool assembler and a tester for approximately 24 years. He performed his work without significant disruptions until March 1999.

In his job as a tester, claimant tested tools assembled by other workers. In early 1999, he was reassigned to a work area that occasionally required him to work with Mr. Schreiber, a coworker. Prior to that reassignment, claimant had not worked with Mr. Schreiber. (Tr. 17). When working with Mr. Schreiber, claimant's job was to test motors assembled by Mr. Schreiber. Mr. Schreiber was not claimant's supervisor. Instead, at all relevant times, Mr. Hill was claimant's supervisor.

In March 1999, claimant had been working on the motor line for a couple of weeks. (Tr. 16). Claimant did not know the rules and regulations governing that line. (*Id.*). One day, he was working with Mr. Schreiber and adjusted a pull saw motor. Mr. Schreiber did not say anything to claimant about this adjustment, but subsequently spoke with Mr. Hill about it. The next day, Mr. Schreiber yelled at claimant, saying that claimant was dumb, did not listen to him, and was not supposed to take a tool like that apart without asking. (Tr. 16, 18). Claimant saw Mr. Hill walk by while Mr. Schreiber was yelling. (*Id.*). However, claimant testified that Mr. Hill did not hear Mr. Schreiber's remarks. (Tr. 18).

Claimant immediately went to Mr. Hill and told him that Mr. Schreiber was "yelling" at him, although he did not tell Mr. Hill what Mr. Schreiber had said or the words he had used. (*Id.*). Mr. Hill told claimant that Mr. Schreiber had discussed this machine adjustment with him. Mr. Hill told claimant that he was not supposed to take the machine apart. (Tr. 16, 18). Claimant apologized, stating that nobody had instructed him on how to do it and he used to test this "the old way." (Tr. 18). Mr. Hill informed claimant that they were changing. (Tr. 19). Claimant apologized to Mr. Schreiber for making a mistake. (*Id.*).

Although claimant felt that Mr. Schreiber was being very aggressive during this March encounter, it did not scare him because it was his first encounter with Mr. Schreiber. (Tr. 17).

In May 1999, claimant was again working with Mr. Schreiber when claimant made a mistake (claimant did not know what his mistake was) and Mr. Schreiber blew up at him. (Tr. 20). Mr. Schreiber was about a foot away from claimant and began loudly yelling and swearing at him and questioning his intelligence. (Tr. 20-21, 88, 89). Claimant testified that he went and got Mr. Hill and told him about the situation, telling him that Mr. Schreiber was yelling at him, but not telling him the words he used. (Tr. 21).

Mr. Hill heard the verbal argument on the floor and asked Mr. Schreiber and claimant to separate from one another and calm down while he contacted Mr. Hofer, the Human Resources Director, for advice on how to handle the matter. (Tr. 138-39, 149-50). Mr. Hofer advised him to attempt to mediate the problem, *i.e.*, "sit the two of them down together and work out the differences." (Tr. 139, 142, 171-72). Mr. Hill had undergone mediation training, although this was his first attempt to mediate a dispute. (Tr. 142, 167).

After consulting with Mr. Hofer, Mr. Hill took claimant and Mr. Schreiber to the shop conference room. Mr. Hill asked Mr. Schreiber to explain what the problem was, then he asked claimant to do the same, then he returned to Mr. Schreiber. (Tr. 139). Mr. Schreiber explained in an excited, somewhat accusatory fashion, that claimant was not doing his job. (Tr. 139-40, 151). When Mr. Hill gave claimant an opportunity to explain his side, claimant responded that he "just want[ed] to get along." (Tr. 140). Mr. Hill encouraged claimant to participate, explaining that this was the format to take care of the situation and they needed to resolve the matter. Claimant responded that he had "no problem." (*Id.*, Tr. 58-59). Mr. Hill then went back to Mr. Schreiber, who had said he had other things to say. When Mr. Schreiber went on in the same vein, claimant got up, said he was not going to listen to this, and walked out.[1] (Tr. 61, 140-41).

Claimant left before the mediation was completed. Mr. Hill continued to talk with Mr. Schreiber and discussed the appropriate way to voice his concerns. (Tr. 151-52). Following this mediation, everything seemed to be working fine until an incident in September 1999 between Mr. Schreiber and claimant. (Tr. 142).

Mr. Hill reported back to Mr. Hofer that Mr. Schreiber had aired some of his concerns but claimant basically had no comment. (Tr. 61, 172). Claimant went to Mr. Hofer after he left the mediation and asked for his advice. (Tr. 24, 172). Claimant basically told Mr. Hofer that he had been having some problems with Mr. Schreiber, that he had tried to be a nice guy but he had been having difficulty getting Mr. Schreiber to respond to him. Claimant told Mr. Hofer that Mr. Schreiber did not like him and did not talk to him. (Tr. 173). Claimant told Mr. Hofer that he had purchased some things for Mr. Schreiber to facilitate the relationship without success. (*Id.*). During their working relationship, claimant gave Mr. Schreiber a radio and a candy bar in an attempt to befriend him.

Mr. Hofer told claimant that the "reality is[,] not everybody is going to like one another" but the employer expected people to respect each other and work with each other. (*Id.*). Mr. Hofer told claimant that, if he felt the incident was not resolved and felt like he needed somebody else to facilitate the dispute, he (Mr. Hofer) would help with that. (*Id.*). He also told claimant that, if he was not comfortable with his supervisor's mediation skills, he (claimant) could escalate it to the next level, which was part of the employer's normal appeals process. (Tr. 174). Claimant did not avail himself of these offers, and Mr. Hofer thought that claimant considered the incident a "done deal." No other incidents between claimant and Mr. Schreiber were reported until September 17, 1999. (*Id.*). Mr. Hill did not decide to keep Mr. Schreiber and claimant apart in the plant. (Tr. 154, 158).

Claimant testified that Mr. Hofer advised him to "yell right back" at Mr. Schreiber and to "deal with it." (Tr. 24, 26). Claimant went back to work because he thought he was not getting any help. (Tr. 24).

Following the May incident, claimant attempted to avoid Mr. Schreiber and was assigned work that usually kept him from contact with Mr. Schreiber. (Tr. 59-60).

On September 16, 1999, Mr. Hill assigned claimant to work on Mr. Schreiber's line. (Tr. 27). No events occurred that day. (Tr. 27-28). The next day, claimant noticed that Mr. Schreiber's mood had changed. Claimant thought he had made a mistake on a job card because the card did not match up with the motors he had put away. (Tr. 29). When he told Mr. Schreiber that he had a problem with a job card, Mr. Schreiber got very angry and started yelling and swearing at him. (Tr. 29-30). For the first ten seconds or so, Mr. Schreiber was yelling within inches from claimant's face. (Tr. 31-32). By the time Mr. Hill got to the scene, Mr. Schreiber was still yelling at claimant, but he was not in claimant's face. (Tr. 32).

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[1] We note that claimant's version of the mediation parallels Mr. Hill's version in several ways. In this regard, claimant testified that he told Mr. Hill that the matter with Mr. Schreiber was "[w]ater under the bridge -- no problem." (Tr. 23). Claimant testified that when Mr. Hill asked Mr. Schreiber if he had any problems with claimant, Mr. Schreiber responded that "[claimant's] got his thumb up his butt[,] I don't want to baby-sit him anymore" and started swearing. (*Id.*). At that point, claimant testified that he said that he did not want to be at the meeting, and walked out. (*Id.*).

At the time of the disturbance, Mr. Hill was in his cubicle on the shop floor when he heard yelling. (Tr. 142). He went to check it out and could tell it was serious, with Mr. Schreiber yelling at claimant. (Tr. 142-43). Mr. Schreiber was the aggressor and claimant was not yelling back. Mr. Hill intervened by asking what the problem was. (Tr. 143, 160). Claimant said he would not work with Mr. Schreiber anymore and walked away. (Tr. 143). Mr. Schreiber proceeded to tell Mr. Hill what the problem was. (*Id.*). This discussion included Mr. Schreiber telling Mr. Hill that he was upset because claimant was talking to him while he was trying to do his job and the distraction was causing him to make mistakes. (Tr. 161). Mr. Hill discussed with Mr. Schreiber the appropriate manner to voice his concerns about these matters. (*Id.*).

Mr. Hill went to Mr. Hofer to find out how to handle the situation, since the mediation had not worked. (Tr. 143, 160). Mr. Hofer told him to tell the individuals that they must get along in order to continue to be employed there. (*Id.*, Tr. 175). Mr. Hofer considered this a personality conflict and if the workers did not want help to facilitate the issue or if they chose not to work out their differences, they should find work elsewhere. (Tr. 175).

Mr. Hill asked claimant, Mr. Schreiber, and his lead man to come with him outside for a meeting. (Tr. 161). Mr. Hill told claimant and Mr. Schreiber that they either got along or they should find work elsewhere. (Tr. 144). Mr. Schreiber responded that the employer might as well fire him now because he would yell at claimant any time claimant made a mistake. (Tr. 33). During that meeting Mr. Schreiber also said he would come to Mr. Hill if claimant did something wrong and let Mr. Hill handle it. (Tr. 161).

Claimant went to Mr. Hofer and told him that he was working at his line when Mr. Schreiber began yelling at him for no reason and making threatening postures. (Tr. 176). Claimant said he felt he was being harassed and threatened. He felt the situation was escalating and did not want it to go any further. (*Id.*). Claimant felt that Mr. Schreiber may strike him. In discussing this situation, Mr. Hofer told claimant that he was glad that claimant did not escalate the situation because if people starting hitting each other, both would be terminated. (Tr. 176-77). Claimant was concerned about his safety and requested the remainder of the day off. Mr. Hofer granted that request.

On September 20, 1999, claimant sought medical services. Dr. Rambousek, D.O., examined claimant and diagnosed anxiety, depression, insomnia, and stress reaction. Dr. Rambousek authorized one week of time loss and prescribed medication. (Ex. 2, 3).

Mr. Voyd, the health and safety manager, contacted Dr. Rambousek to find out if claimant could return to light duty work. (Tr. 178-79). Dr. Rambousek imposed a limitation that claimant not have contact with Mr. Schreiber. The employer followed this limitation, and claimant returned to work in an engineering section making prints of engineering designs. (Tr. 179). Claimant had a panic attack while performing this work and paramedics were called, although they elected not to transport him to a medical facility. (*Id.*, Tr. 42-43). Mr. Voyd drove claimant home.

On September 23, 1999, claimant sought psychological counseling from Dr. Sullivan, Ph.D. (Ex. 3A). Claimant had a panic attack while consulting with Dr. Sullivan, who diagnosed an acute stress disorder. Dr. Sullivan provided counseling services from September 23, 1999, through the beginning of 2000. (Ex. 3B).

On September 27, 1999, Dr. Rambousek examined claimant again, noting that he had sustained a severe panic attack after returning to light duty work. (Ex. 4). After reviewing Dr. Sullivan's chart note, Dr. Rambousek took claimant off work for one month and changed his medication. Dr. Rambousek diagnosed depression and severe anxiety with panic.

On September 29, 1999, the employer completed an 801 claim form without claimant's signature. (Ex. 1). On October 8, 1999, the employer denied compensation for a mental disorder. (Ex. 5).

On November 22, 1999, claimant met with Dr. Sullivan, who noted that claimant reported himself 98 percent improved and ready to return to work. (Ex. 3B-7).

On November 23 or 24, 1999, Dr. Klein, psychiatrist, examined claimant on behalf of the employer. (Ex. 6). Dr. Klein noted that her only source of information was claimant's report and, assuming this history was correct, it was consistent with a generalized anxiety disorder secondary to stress on the job. (Ex. 6-6). She suggested some alternative methods of coping with stressful situations, including some brief counseling to develop skills to handle his feelings more directly. She found claimant entirely recovered from the anxiety disorder and released for work without restrictions. (*Id.*).

The night following his examination by Dr. Klein, claimant's anxiety worsened and he resumed treatment with Dr. Sullivan. (Exs. 3B-7-13).

On January 11, 2000, Dr. Rosales, psychiatrist, examined claimant at Dr. Sullivan's request. (Ex. 8). She diagnosed major depression, single episode, and post traumatic distress disorder.

Dr. Sullivan reported that the work situation reported by claimant was the major and sole cause of his diagnoses of post traumatic distress syndrome, depression, and anxiety disorder. (Ex. 9-2). Dr. Rosales checked a box indicating that she concurred with Dr. Sullivan's conclusion. (Ex. 10).

Although claimant was under the impression that Mr. Hill and Mr. Schreiber were friends outside of work, they were not. (Tr. 76-77, 79, 137-38). By November 24, 1999, Mr. Hill had fired Mr. Schreiber for attendance problems. (Tr. 146, Ex. 6-3).

Although claimant reported to the medical providers that Mr. Schreiber physically threatened him during the confrontations in May and September 1999, he testified that Mr. Schreiber did not physically threaten him, although he felt threatened by Mr. Schreiber's verbal aggression. (Tr. 55, 62, 70). Witnesses to these incidents also testified that Mr. Schreiber did not physically threaten claimant. (Tr. 92, 108, 126, 146).

There is no evidence to support claimant's reports to Drs. Sullivan and Rosales that the Human Resources Director accused claimant of being a threat to the other workers. Nor is there any evidence to support claimant's reports to physicians that he did a better job and was more reliable than other workers who were better rewarded by the employer.

CONCLUSIONS OF LAW AND OPINION

To establish the compensability of a mental disorder, claimant must prove that employment conditions were the major contributing cause of the disorder. 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 mental disorder arose out of and in the course of employment. ORS 656.802(3)(a)-(d). In order to be clear and convincing, the truth of the facts asserted must be "highly probable." *E.g., Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 402 (1987).

The ALJ found that claimant met his burden of proof under these standards. On review, the employer argues that claimant failed to prove that employment conditions were the major contributing cause of the mental condition by clear and convincing evidence because the medical evidence supporting claimant's claim is not based on an accurate history. ORS 656.802(2)(a) and (3)(d). We agree.[2]

The issue of the cause of claimant's mental condition presents a complex medical question that must be answered by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967); *Kassahn v. Publishers Paper Co.*, 76 Or App 105 (1985); *Barnett v. SAIF*, 122 Or App 279, 283 (1993). In evaluating the medical evidence concerning causation, we rely on those opinions which are both well-reasoned and based on accurate and complete information. *Somers v. SAIF*, 77 Or App 259 (1986).

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[2] The employer also argues that claimant failed to prove that the employment conditions producing the mental disorder: (1) exist in a real and objective sense; and (2) are conditions other than conditions generally inherent in every working situation or reasonable disciplinary actions. ORS 656.802(3)(a) and (b). Because we agree that the medical evidence fails to meet claimant's burden of proof under ORS 656.802(2)(a) and (3)(d), we need not address the employer's other arguments.

There is no dispute that claimant has a diagnosis of a mental disorder which is generally recognized in the medical or psychological community. In this regard, claimant has been variously diagnosed with depression, acute stress disorder, severe anxiety disorder with panic, generalized anxiety disorder, and post-traumatic distress syndrome. (Exs. 3, 3A-3, 4, 6-6, 9). The question is whether claimant has met his burden of proving by clear and convincing evidence that his mental disorder was caused in major part by work. Based on the following reasoning, we find that he has not.

Claimant first sought treatment for his mental disorder from Dr. Rambousek, D.O., his treating physician, on September 20, 1999. (Ex. 3). Dr. Rambousek took a history from claimant that included claimant's account of: (1) the supervisor's May 1999 mediation attempt, which claimant described as the co-worker (Mr. Schreiber) being unwilling to attempt to resolve the differences between claimant and Mr. Schreiber; (2) a September 17, 1999 incident where Mr. Schreiber yelled profanities and "threatening statements" at claimant; (3) working for the employer for 24 years without any advancement, despite other employees "working up the ladder, then leaving after a few years;" and (4) when claimant did Mr. Schreiber's job, the supervisors felt that claimant was doing a good job, whereas Mr. Schreiber was not getting the work done and produced inadequate quality. (Ex. 3).

The only other record from Dr. Rambousek is a chart note dated September 27, 1999, in which he states that claimant was following up with Dr. Sullivan, Ph.D., who directed him to Dr. Rambousek to start on antidepressant therapy. (Ex. 4). Neither of these records from Dr. Rambousek provide any causation opinion.

On September 23, 1999, Dr. Sullivan first examined claimant and took the following history regarding the "presenting problem:"

> "[Claimant] reports, over the past several months, an increasing escalation of hostility from a co-worker. He describes, for example, being chewed-out by this co-worker for no reason and, at one point, physically threatened. [Claimant] has attempted to resolve this with the co-worker as well as their boss and the Human Resources Dept. at work - apparently, with little results. [Claimant] describes the company as basically telling him that both of them have to work things out or both will be fired. [Claimant] feels that this is unfair, particularly because he has been a loyal worker for 24 years and also because he can't figure out what he has done that is wrong. In the past, [claimant] describes at least one incident of racial harassment and [claimant] wonders if this is the reason for his current difficulties."[3] (Ex. 3A-1).

Dr. Sullivan noted that claimant was "afraid that perhaps this co-worker will come by his house and spray him with bullets." (Ex. 3A-2). Numerous handwritten chart notes from Dr. Sullivan are also in the record. (Ex. 3B). However, with the exception of a few isolated words, these chart notes are illegible. Therefore, they do not provide any information regarding Dr. Sullivan's analysis or history.

Dr. Sullivan presents his causation opinion in a January 12, 2000 report. (Ex. 9). He noted that claimant's history indicated no significant psychiatric problems until the current workplace difficulties and no other stresses that would account for claimant's symptoms. He recorded claimant's history of the work incidents as follows. Claimant "reported significant and substantial verbal harassment and, at one time, a physical threat from a fellow employee on the worksite." (Ex. 9-1). Claimant also reported that "he had seen this individual punch out this individual's girlfriend at a Christmas party and that this person has a reputation for volatile behavior." (*Id.*). Based on these reports from claimant, Dr. Sullivan concluded that "[c]onsequently, [claimant] had legitimate reasons to believe that there was a threat to his physical integrity." (*Id.*).

In addition, Dr. Sullivan noted that claimant's supervisor and the Human Resources Director "were not supportive when [claimant] approached him and, in fact, either failed to intervene or told him to 'yell back.'" (*Id.*). Dr. Sullivan also noted that there were "intimations that [claimant] might lose his job." (*Id.*). He found that, after treatment with medication and therapy, claimant had been ready to return to work by the end of November 1999.

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[3] Claimant is Dutch-Indonesian; his family immigrated to the United States from Holland when he was six years old. There is no reasoning/analysis in the medical records that would support a contention that his mental disorder was brought on by racial harassment at work.

However, Dr. Sullivan stated that claimant had a relapse after a psychiatric examination by Dr. Klein, M.D., who examined claimant on behalf of the employer on November 23 or 24, 1999. Dr. Sullivan noted that this relapse was further exacerbated when the Human Resources Director told claimant that he was unable to "accommodate" claimant [presumably this refers to claimant's request that he have little contact with his former supervisor] and that "the director had to worry about whether [claimant] was a threat to the other workers." (*Id.*).

Given this history, Dr. Sullivan concluded that "[c]onsistent with the research, the direct trauma as well as the abandonment/lack of support from management reported by [claimant] both contributed to the development of [claimant's] conditions of post traumatic distress syndrome, depression, and anxiety disorder and are the major and only cause of these diagnosis." (Ex. 9-1-2). Dr. Sullivan noted that Dr. Klein and he disagreed on the exact nature of claimant's anxiety disorder. In this regard, Dr. Klein diagnosed a "generalized anxiety disorder," whereas Dr. Sullivan diagnosed an "anxiety disorder." (Exs. 6-6, 9-2). In support of his diagnosis of an "anxiety disorder," Dr. Sullivan stated that he believed that claimant "did have reason to fear bodily harm" and he was "not sure Dr. Klein appreciated this fact." (Ex. 9-2).

On January 11, 2000, Dr. Rosales, M.D., examined claimant at the request of Dr. Sullivan. (Ex. 8). She recorded a history of a transfer within the company to a different type of work, with seniority disregarded. (Ex. 8-2). She also reported that claimant had received no salary raises, whereas others had received raises. She reported a racial slur with no consequences about four years ago, and "lots of 'small' harassments - tire slashing, etc." (*Id.*). Regarding the current situation, she reported that, in May 1999, claimant began to receive degrading harassment at the hands of a coworker and management did not take it seriously. She noted that claimant was being bullied with no relief from the workplace. She also noted that claimant was accused of being a "threat to all the others" in a consultation with Human Resources at work. (*Id.*).

Dr. Rosales offered no independent causation opinion. However, she checked a box indicating that she concurred with Dr. Sullivan's causation opinion. (Ex. 10).

The only other medical opinion is from Dr. Klein. (Ex. 6). She recorded a history of problems at work beginning after claimant was transferred to a new location and began working with a coworker (Mr. Schreiber), whom claimant claimed hated him for unknown reasons. (Ex. 6-1). She noted an incident about a week after the transfer when claimant changed the set up on a machine and Mr. Schreiber blew up at him the next day. Claimant reported that the supervisor walked by during this confrontation and did not do anything. Later, claimant went to the supervisor about this and was told that he should not have changed the set up on the machine. (Ex. 6-2). Dr. Klein reported that claimant disagreed with this and felt that he changed it properly because it would have been dangerous to operate as originally set up. Besides, claimant stated that he had never been told not to change a set up and no rules forbidding such a change had ever been given to him. (*Id.*). Claimant stated that he did not confront Mr. Schreiber because "he had once seen him assault him [sic] at a party." (*Id.*). Claimant also stated that he "knew [Mr. Schreiber] and [the supervisor] 'partied together,' and he felt 'I had no chance.'" (*Id.*).

Dr. Klein had no history of the mediation attempt made by the supervisor in May 1999. Instead, her next report of a work incident dealt with events on September 17, 1999, when Mr. Schreiber "blew up" and began cursing at claimant when claimant attempted to approach him about a problem with some motors. Claimant reported that Mr. Schreiber came an inch from claimant's nose with his fists raised and told claimant, "I don't care how nice you are, I'm going to get you." (*Id.*).

Claimant reported that he went to the Human Resources Director and told him that he could not work with Mr. Schreiber anymore because he was afraid that Mr. Schreiber would "go postal." (*Id.*). Claimant reported that he was told that he had to work with Mr. Schreiber or he (claimant) would be fired. Claimant reported that he was afraid to work with Mr. Schreiber because of his temper. (*Id.*).

Claimant also stated that, although he had worked for the company for 24 years, he felt that he had always been treated rather poorly. (Ex. 6-3). He reported that he had never been given a promotion, although he is an extremely competent worker and never misses any time. On the other hand, he reported that other employees that miss time and are not as careful as he is seem to fare better with the company. (*Id.*). Claimant reported that he has no stress outside of work, and has a very supportive family. (Ex. 6-4).

Dr. Klein noted that she did not have any records to review and was lacking information from the employer and coworkers that would either corroborate or contest his perceptions of what happened on the job. (Ex. 6-5). Nevertheless, based solely on claimant's history, Dr. Klein concluded that claimant gave "a history consistent with a generalized anxiety disorder secondary to stress on the job." (Ex. 6-6).

On this record, we find that the physicians rendering causation opinions had an inaccurate history on several matters. First, claimant reported to the medical providers that he was physically threatened by Mr. Schreiber and had actually seen Mr. Schreiber strike another person at a party. However, in his testimony at hearing, claimant stated that Mr. Schreiber had not physically threatened him or raised his fists, and he had not witnessed Mr. Schreiber striking anyone, although he had heard rumors about Mr. Schreiber striking his girlfriend at a coworker's Christmas party that both claimant and Mr. Schreiber attended. Moreover, claimant's testimony regarding these matters was supported by that of witnesses to the confrontations between Mr. Schreiber and claimant.

Second, claimant gave the medical providers a history of the employer failing to intervene in the problem he was having with Mr. Schreiber. However, testimony at hearing established that the supervisor attempted to mediate the dispute between claimant and Mr. Schreiber in May 1999.[4] In this regard, Mr. Hill testified that he heard the May incident and intervened. He asked Mr. Schreiber and claimant to separate from one another and calm down while he contacted Mr. Hofer, the Human Resources Director, for advice on how to handle the matter. (Tr. 138-39, 149-50). Mr. Hofer advised him to attempt to mediate the problem, *i.e.*, "sit the two of them down together and work out the differences." (Tr. 139, 142). Mr. Hill had undergone mediation training, although this was his first attempt to perform a mediation. (Tr. 142, 167).

After consulting with Mr. Hofer, Mr. Hill took claimant and Mr. Schreiber to the shop conference room. Mr. Hill testified that he asked Mr. Schreiber to explain what the problem was, then he asked claimant to do the same, then he returned to Mr. Schreiber. (Tr. 139). Mr. Hill testified that Mr. Schreiber explained in an excited, somewhat accusatory fashion, that claimant was not doing his job. (Tr. 139-40, 151). When he gave claimant an opportunity to explain his side, claimant responded that he "just want[ed] to get along." (Tr. 140). Mr. Hill encouraged claimant to participate, explaining that this was the format to take care of the situation and they needed to resolve the matter. Claimant responded that he had "no problem." (*Id.*). Mr. Hill then went back Mr. Schreiber, who had said he had other things to say. When Mr. Schreiber went on in the same vein, claimant got up, said he was not going to listen to this, and walked out.[5] (Tr. 140-41).

When claimant left, the mediation was not over. Mr. Hill talked to Mr. Schreiber about the appropriate way to voice his concerns. (Tr. 151-52). Mr. Hill testified that, following this mediation, everything seemed to be working fine until the September 1999 incident between Mr. Schreiber and claimant. (Tr. 142).

Where their testimony differs, we find Mr. Hill's perception of the mediation more persuasive than that of claimant. Mr. Hill provides more detailed testimony regarding what went on during the entire mediation process. Thus, we find that the employer tried to intervene in the dispute between claimant and Mr. Schreiber and claimant refused to participate.

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[4] There is some dispute as to when this mediation occurred. Claimant testified that it occurred about two weeks after the May 1999 incident with Mr. Schreiber, when Mr. Hill returned from vacation. (Tr. 20, 22). Mr. Hill testified that the it occurred the day of the May 1999 incident, not days or weeks later. (Tr. 150, 141-42, 166). Mr. Hofer testified that it occurred within a day of the incident. (Tr. 187-88). In any event, claimant does not dispute that a mediation was attempted. Moreover, those medical providers who rendered causation opinions were not aware of this mediation.

[5] We note that claimant's version of the mediation parallels Mr. Hill's version in several ways. In this regard, claimant testified that he told Mr. Hill that the matter with Mr. Schreiber was "[w]ater under the bridge -- no problem." (Tr. 23). Claimant testified that when Mr. Hill asked Mr. Schreiber if he had any problems with claimant, Mr. Schreiber responded that "[claimant's] got his thumb up his butt[,] I don't want to baby-sit him anymore" and started swearing. (*Id.*). At that point, claimant testified that he said that he did not want to be at the meeting, and walked out. (*Id.*).

In addition, claimant reported several factors to his physicians regarding lack of support from the employer that are not supported by the record. In this regard, there is no evidence to support claimant's reports to Drs. Sullivan and Rosales that the Human Resources Director accused claimant of being a threat to the other workers. Nor is there any evidence to support claimant's reports that he did a better job and was more reliable than other workers who were better rewarded by the employer.

In reaching their conclusion that the work incidents were the major contributing cause of claimant's mental disorder, the medical providers relied, in part, on these inaccurate factors. They especially relied on claimant's history that the employer failed to intervene in the dispute between claimant and Mr. Schreiber[6] and his history that Mr. Schreiber physically threatened him and he had actually seen Mr. Schreiber strike another person. (Exs. 3A, 6, 8, 9, 10). Dr. Sullivan particularly stressed the importance that claimant had reason to fear "bodily harm." (Ex. 9-2). However, as explained above, these histories were not accurate. Moreover, we cannot say that the physicians would have rendered the same causation opinions if they had an accurate history of the work conditions. Therefore, we find that claimant has failed to prove that employment conditions were the major contributing cause of the mental condition by clear and convincing evidence. ORS 656.802(2)(a) and (3)(d).

ORDER

The ALJ's order dated April 5, 2000 is reversed. The employer's denial of claimant's occupational disease claim for a mental disorder is reinstated and upheld. The ALJ's attorney fee award is reversed.

[6] Although Dr. Rambousek's history contains a report of the mediation, it is not accurate in that it states that the other worker was unwilling to resolve the problem, whereas it was claimant who refused to participate and walked out on the mediation. (Ex. 3). In any event, Dr. Rambousek did not render a causation opinion.

In the Matter of the Compensation of
CHRISTINA E. VAUGHN, Claimant
WCB Case Nos. 99-05470, 99-01753 & 98-08739
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Liberty Northwest, on behalf of Integral Youth Services (Liberty/Integral), requests review of those portions of Administrative Law Judge (ALJ) Mongrain's order that: (1) set aside its denial of responsibility for claimant's left wrist condition; and (2) upheld the responsibility denial of Liberty Northwest/Taco Time (Liberty/Taco Time) of the same condition. On review, the issue is responsibility.

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

Liberty/Integral argues that Dr. Hanesworth's opinion is more persuasive than the opinions of Nurse Practitioners Bergeron and Matuk and that Liberty/Taco Time should be held responsible for claimant's left wrist condition. Liberty/Taco Time argues that all of Dr. Hanesworth's reports should have been excluded from the record due to his failure to consent to cross-examination. (The ALJ excluded Dr. Hanesworth's most recent opinion, Exhibit 55, from the record because the doctor had left the state and could not be located for cross-examination regarding Exhibit 55). Although the ALJ excluded Exhibit 55 from evidence, counsel for Liberty/Taco Time quoted a portion of Dr. Hanesworth's opinion in Exhibit 55 during the deposition of Nurse Matuk. The ALJ relied on the quoted opinion in determining that Dr. Hanesworth's opinion was unpersuasive. The ALJ reasoned:

> "Dr. Hanesworth stated that the claimant's 1995 injury was the major contributing cause of her acute condition in 1998, but according to [counsel for Liberty/Taco Times] reference in the deposition of [Nurse] Matuk, which was admitted without objection, Dr. Hanesworth also stated that considering the acute nature of the claimant's problem in August 1998 he would be unable to say what, if any, part the claimant's 1995 Taco Time injury played in her 1998 left wrist complaints and treatment. Therefore, Dr. Hanesworth's two opinions appear to be directly contrary and cancel each other out, leaving the opinions of the two nurse practitioners that the cause of the claimant's acute problem in 1998 was her work activity at that time * * *." (Opinion and Order, page 5).

Based on the opinions of the two nurse practitioners, the ALJ concluded that claimant sustained a new compensable injury at Liberty/Integral and that responsibility for the left wrist condition shifted from the first employer, Liberty/Taco Time to Liberty/Integral under ORS 656.308(1).

Like the ALJ, we also find Dr. Hanesworth's opinion unpersuasive and rely on the opinions of the nurse practitioners, but we base our opinion on the following reasoning.

First, it is unclear whether Dr. Hanesworth had the chart notes or opinions of the nurse practitioners, Matuk and Bergeron, when he gave his opinions in the record. Under such circumstances, we are not persuaded that Dr. Hanesworth's opinion was based on complete information. In addition, because the nurse practitioners saw claimant in early August, soon after the work incident, we conclude that their opinions are entitled to more weight. Dr. Hanesworth did not examine claimant until October 1998, two months after the work incident.

Because we conclude that Dr. Hanesworth's opinions are unpersuasive, we need not determine whether all of his reports should have been excluded from the record, rather than only Exhibit 55. Likewise, because of our decision that Dr. Hanesworth's opinion is unpersuasive on other grounds, we need not determine whether Dr. Hanesworth's opinion from Exhibit 55, as summarized by counsel for Liberty/Taco Time during Nurse Matuk's deposition, is admissible.

Because the ALJ's order addressed the compensability of claimant's condition, claimant's attorney is entitled to an assessed fee under ORS 656.382(2) for services on Board review regarding the compensability issue which was potentially at risk by virtue of our *de novo* review of the ALJ's order. After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $300, payable by Liberty/Integral. In reaching this conclusion, we have particularly considered the time devoted to the issue (as demonstrated by claimants respondents brief that was limited to one page and only briefly addressed compensability). *See Dennis Uniform Manufacturing v. Teresi*, 115 Or App 252-53 (1992), *mod* 119 Or App 447 (1993).

ORDER

The ALJ's order dated August 4, 2000 is affirmed. For services on Board review, claimant's attorney is awarded $300, payable by Liberty/Integral.

In the Matter of the Compensation of
JANET L. SCHELL, Claimant
WCB Case No. 00-02401
ORDER ON REVIEW
Brothers & Ash, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

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

The insurer requests review of Administrative Law Judge (ALJ) Brazeau's order that found that claimant's left elbow claim was prematurely closed. On review, the issue is premature closure.

We adopt and affirm the ALJ's order with the following supplementation to address the insurer's contentions that claimant's accepted left lateral epicondylitis condition became medically stationary on January 7, 2000. In particular, the insurer asserts that the ALJ incorrectly relied on the opinion of Dr. Thayer, the attending physician, rather than the opinions of Drs. Courogen and McKillop, insurer-arranged medical examiners.

Claimant's left lateral epicondylitis condition was accepted on June 9, 1999. (Ex. 20-1). The claim was closed on February 8, 2000, by Notice of Closure, declaring, among other things, that claimant's condition became medically stationary on January 7, 2000. (Ex. 64).

Claimant requested reconsideration, contending that she was not medically stationary and that the claim should remain in open status. (Ex. 66). On March 22, 2000, the Department issued an Order on Reconsideration, which rescinded the February 2000 Notice of Closure and ordered that the claim remain in open status. (Ex. 67-2).

The insurer requested a hearing. The ALJ, relying on the opinion of Dr. Thayer, determined that claimant was not medically stationary on January 7, 2000, and affirmed the Order on Reconsideration.

On review, the insurer contends that the opinions of Drs. Courogen and McKillop are more persuasive than the opinion of Dr. Thayer.

"Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). The propriety of the closure turns on whether claimant was medically stationary at the time of the February 2000 Notice of Closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1965). Claimant bears the burden of proving that she was not medically stationary at claim closure, based on competent medical evidence. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981); *Harmon v. SAIF*, 54 Or App 121, 125 (1981).

The issue of claimant's medically stationary status is primarily a medical question to be decided on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980); *Louis L. Haron*, 52 Van Natta 1833, 1834 (2000). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Thayer, an orthopedist, has been the attending physician since April 1999. On September 24, 1999, Dr. Thayer suggested that claimant go to work hardening to either get better or to determine if surgery was necessary.[1] (Ex. 47). In his chart note of November 29, 1999, Dr. Thayer: (1) was uneasy with operating as claimant was showing improvement (Ex. 54); (2) suggested a PCE II (*Id.*); and (3) opined that claimant was not medically stationary (Ex. 56). His assessment regarding claimant's medically stationary status did not subsequently change. On February 18, 2000, Dr. Thayer indicated the claim had been closed without his knowledge and without the previously requested PCE II. (Ex. 66-5).

[1] By letter of October 14, 1999, Dr. Thayer was informed that the insurer would hold off on work hardening until after an IME. (Ex. 48).

Here, Dr. Thayer, as claimant's attending physician, has opined that claimant's medical condition was not stationary. He has also recommended further studies/programs/options (work hardening and PCE II). Dr. Thayer does not attribute these recommendations as merely an attempt to address fluctuating symptoms. To the contrary, considering the reference to surgery, the record supports a conclusion that the recommendations were, at least partially, designed to evaluate claimant's need for surgery in addition to her capacity for performing physical activities. Under these circumstances, we conclude that Dr. Thayer's recommendations for work hardening and a PCE II are evidence of a reasonable expectation of material improvement of claimant's condition from treatment when the claim was closed. *See Rosendo M. Valencia*, 51 Van Natta 1034 (1999), *on recon*, 51 Van Natta 1293 (1999).

In contrast to Dr. Thayer, both Drs. Courogen and McKillop have concluded that claimant's condition is stationary. (Ex. 52-6; 60-11). However, Dr. Courogen's examination was performed on November 9, 1999. Consequently, he was unaware of the improvement in claimant's condition as observed by Dr. Thayer on November 29, 1999. Because Dr. Courogen's opinion is based upon incomplete information, we do not find it persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998). We similarly find Dr. McKillop's opinion unpersuasive because he did not appear to have been informed of Dr. Thayer's requests for work hardening and a PCE II.[2]

In conclusion, we find no persuasive reason not to defer to the opinion of Dr. Thayer. Consequently, we agree with the ALJ's decision to affirm the Order on Reconsideration.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, to be paid by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated March 22, 2000 is affirmed. For services on review, claimant is awarded a $1,000 attorney fee, payable by the insurer.

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[2] Even if not discounted, on this record, the opinions of Drs. Courogen and McKillop are insufficient to overcome the "attending physician" deference given to Dr. Thayer's opinion.

Board Member Meyers dissenting.

Because I conclude that claimant was medically stationary at claim closure, I respectfully dissent.

We have previously found that when treatment is designed to primarily improve a claimant's functional abilities, rather than to improve the compensable condition, the treatment is not determinative in establishing claimants medically stationary status under ORS 656.005(17). *Kelly J. Trussell*, 47 Van Natta 121 (1995); *Frank M. Douglas*, 46 Van Natta 1445 (1994). In reaching our conclusions in *Trussell* and *Douglas*, we relied on *Clarke v. SAIF*, 120 Or App 11 (1993).[1]

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[1] In *Clarke*, the claimant argued that although his treating physician declared him medically stationary, his need for a leg brace to support his weak leg supported his contention that he was not medically stationary until his leg was fitted for the brace and he was released from medical care. The court paraphrased the claimant's argument as an argument that "ORS 656.005(17) is not limited to medical treatment prescribed for improving his physical condition, but also encompasses treatment prescribed solely for the improvement of his functional abilities given a particular condition." *Clarke*, 120 Or App at 13. The court rejected that argument and held that "medical treatment prescribed solely to improve a claimant's functional abilities is not pertinent to the determination of a claimant's medically stationary date under ORS 656.005(17)." *Id.* Because there was no evidence that the leg brace was prescribed to improve the claimant's physical condition, the *Clarke* court concluded that the claimant was medically stationary when the carrier closed his claim.

Here, Dr. Thayer's recommendations for work hardening and a PCE II appear to be designed to evaluate and possibly improve claimant's functionality as opposed to exploring treatment options to improve the compensable condition. As noted above, evaluating functional improvement alone is not pertinent to claimant's medically stationary status. Rather the deciding factor is whether such programs are designed to improve claimant's compensable condition.

Absent such evidence, and given the opinions of Drs. Courogen and McKillop that claimant was medically stationary as of January, 2000, I am persuaded that claimant was medically stationary when the insurer closed the claim. Consequently, I would reverse the ALJ's order, set aside the Order on Reconsideration, and reinstate and affirm the Notice of Closure.

In the Matter of the Compensation of
TERRANCE C. WALSTON, Claimant
WCB Case No. 00-03418
ORDER ON REVIEW
Philip H. Garrow & Janet H. Breyer, Claimant Attorneys
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

The SAIF Corporation requests review of that portion of Administrative Law Judge (ALJ) Black's order that assessed SAIF a penalty under ORS 656.268(5)(e). On review, the issue is penalties. We reverse.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," except that the first sentence is corrected to indicate that claimant's compensable injury occurred on July 10, 1998.

CONCLUSIONS OF LAW AND OPINION

SAIF accepted claimant's injury claim for a July 10, 1998 right ankle calcaneous fracture. The claim was closed on November 24, 1999 with a 14 percent scheduled permanent disability award. An Order on Reconsideration increased the award to 27 percent, or 36.45 degrees, for claimant's right foot (ankle).

SAIF requested a hearing regarding the extent of claimant's permanent disability, and claimant filed a cross-request seeking a penalty under ORS 656.268(5)(e).[1]

The ALJ held that claimant was entitled to a penalty under the statute, reasoning that the reconsideration orders increased permanent disability award was not due to new information or new rating criteria "and claimant is over 20 percent disabled." (Opinion and Order, p. 5).

SAIF argues that claimant is not entitled to a penalty because claimant is not at least 20 percent disabled.[2] We agree.

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[1] ORS 656.268(5)(e), formerly 656.268(4)(g), provides:

"If, upon reconsideration of a claim closed by an insurer or self-insured employer, the director orders an increase by 25 percent or more of the amount of compensation to be paid to the worker for either a scheduled or unscheduled permanent disability and the worker is found upon reconsideration to be at least 20 percent permanently disabled, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant. If the increase in compensation results from new information obtained through a medical arbiter examination or from the adoption of a temporary emergency rule, the penalty shall not be assessed."

[2] Claimant does not oppose SAIF's argument.

In *SAIF v. Cline*, 135 Or App 155, *rev den* 321 Or 560 (1995), the court held that the statute permits an award of penalties only if the entire worker, not just a body part, has been determined to be at least 20 percent disabled.[3] Thus, a worker must receive at least 64 degrees of scheduled and/or unscheduled permanent disability to be considered "at least 20 percent permanently disabled" for purposes of determining whether the worker is entitled to a penalty based on the carrier's underrating permanent disability at claim closure. *See* OAR 436-030-0175(3).

Here, because claimant's total award is less than 64 degrees (*i.e.*, 36.45 degrees), he is not entitled to a penalty under ORS 656.268(5)(e). Consequently, we reverse that portion of the ALJ's order. *See Daniel M. Valencia, on remand*, 48 Van Natta 1524 (1996).

ORDER

The ALJ's order dated August 18, 2000 is reversed in part and affirmed in part. That portion of the order that assessed a penalty is reversed. The remainder of the order is affirmed.

[3] The court applied former ORS 656.268(4)(g), since renumbered as 656.268(5)(e). *See* note 1, *supra.*

In the Matter of the Compensation of
KEITH R. WEAVER, Claimant
Own Motion No. 00-0336M
OWN MOTION ORDER ON RECONSIDERATION

Claimant requests reconsideration of our November 21, 2000 Own Motion in which we declined to authorize the reopening of claimant's claim to provide temporary disability compensation because claimant had not provided proof that he was in the work force at the time of disability. Specifically, on reconsideration, claimant contends that he would have been in the work force had he not been "forced" to retire.

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

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

Claimant has the burden of proof on this issue and must provide evidence, such as copies of paycheck stubs, income tax forms, unemployment compensation records, a list of employers where claimant looked for work and dates of contact, a letter from the prospective employer, or a letter from a doctor stating that a work search would be futile because of claimants compensable condition for the period in question. *See Ben L. Davis*, 47 Van Natta 2001 (1995); *Earl J. Prettyman*, 46 Van Natta 1137 (1994).

The "date of disability" for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction,[1] is the date he enters the hospital for the proposed surgery and/or inpatient hospitalization for a worsened condition. *Fred Vioen*, 48 Van Natta 2110 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). The relevant time period for which claimant must establish he was

[1] The Board in its own motion jurisdiction can only authorize temporary disability from the time of surgery or hospitalization. *See* ORS 656.278(1)(a).

in the work force is the time prior to his October 19, 2000 hospitalization when his condition worsened requiring that hospitalization. *See generally Wausau Ins. Companies v. Morris*, 103 Or App at 273; *SAIF v. Blakely*, 160 Or App 242 (1999); *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997); *Michael C. Batori*, 49 Van Natta 535 (1997); *Kenneth C. Felton*, 48 Van Natta 725 (1996).

On reconsideration, claimant contends that, although he was willing work to for his employer at a job that incorporated his medical limitations, he was "forced to retire for medical reasons (right shoulder, right knee and lower back conditions)." We interpret claimant's statement to mean that he was willing to work, but that it is futile for him to work and/or seek work due to his medical condition. Thus, claimant contends that he remained in the work force under the third *Dawkins* criteria.

The self-insured employer contends that claimant was not in the work force at the time of the current disability because claimant had "officially retired as of August 23, 2000 and is receiving full medical retirement benefits." We have previously found that a finding that claimant has retired does not irrevocably commit the claimant to retirement for purposes of workers' compensation benefits. In other words, a claimant may retire and subsequently reenter the work force. However, in order to prove that he is in the work force under the third *Dawkins* factor, claimant must show that he is presently willing to seek work and that it is presently futile to seek work due to the work injury.

In his request for reconsideration, claimant asserts that he did not want to retire and wanted to continue to work within his physical limitations. Claimant's statement is unrebutted. We are persuaded that his statement demonstrates claimant's willingness to work.

However, claimant must also satisfy the "futility" standard of the third *Dawkins* criterion, in order to be found in the work force. Claimant contends that he could not work at his job because of his physical limitations. He noted that his doctor had written to his employer requesting that he be placed in a job that was less physically demanding. When the employer could not accommodate him, he was forced to retire "for medical reasons." Whether it would be futile for claimant to seek work is not a subjective test viewed through the eyes of claimant; it is an objective test determined from the record as a whole, especially considering persuasive medical evidence regarding claimants ability to work and/or seek work. *Jackson R. Scrum*, 51 Van Natta 1062 (1999) (Board denied request for Own Motion relief where the record lacked persuasive medical evidence establishing that the claimant was unable to work and/or seek work due to the compensable injury). In short, the question is whether the work injury made it futile for claimant to make reasonable efforts to seek work, not whether claimant reasonably believes it to be futile.

Claimant does not offer a *medical* opinion that would support his "futility" contentions, nor does the record demonstrate that it would have been futile for him to work or seek work at the time of the current worsening. There is no medical evidence that demonstrates that it would have been futile for him to seek work prior to his October 2000 surgery. Consequently, we find that claimant has failed to meet his burden of proof regarding his work force status. Therefore, we conclude that claimant was not in the work force at the time of the October 2000 worsening for his compensation condition.

Accordingly, on reconsideration, as supplemented herein, we adhere to and republish our November 21, 2000 order in its entirety. The parties' rights of appeal and reconsideration shall run from the date of this order.[2]

IT IS SO ORDERED.

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[2] It appears from claimant's request for reconsideration, that he is unclear as to his rights under the Workers' Compensation system. Because claimant is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in such matters. He may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

DEPT OF CONSUMER & BUSINESS SERVICES
WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE
SALEM OR 97301-3878

In the Matter of the Compensation of
STEVEN R. AZORR, Claimant
Case No. 00-02760
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Hazelett's order that: (1) directed it to process claimant's "new medical condition" claim for a right-sided L5-S1 disc herniation under ORS 656.262 and 656.268; and (2) assessed a penalty for SAIF's allegedly unreasonable failure to pay temporary disability compensation for the period from February 14, 2000 through February 29, 2000. On review, the issues are jurisdiction, claim processing, and penalties. We affirm.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Jurisdiction and Claim Processing

We adopt the ALJ's reasoning and conclusions on these issues, with the following supplementation.

SAIF argues that the ALJ did not have jurisdiction because claimant's aggravation rights have expired. SAIF contends that the claim is within the Board's Own Motion jurisdiction under ORS 656.278. We disagree.

Because claimant's request pertains to SAIF's duty to process his claim under ORS 656.262(7)(c), the ALJ had jurisdiction over the matter. ORS 656.283(7); *Robert A. Olson*, 52 Van Natta 1540 (2000); *Larry L. Ledin*, 52 Van Natta 682 (2000); *Craig J. Prince*, 52 Van Natta 108 (2000).

Relying on our decision in *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999), the ALJ found that SAIF was required to process claimant's L5-S1 disc herniation condition as a "new medical condition" pursuant to ORS 656.262(7)(c) and 656.268. We agree.

On review, SAIF raises several arguments asserting that benefits for claimant's "new medical condition" claim are limited to the benefits available under ORS 656.278. These arguments are based on SAIF's premise that ORS 656.262(7)(c) provides no basis for benefits regarding new medical condition claims accepted after a claimant's aggravation rights have expired on the initial claim. We rejected that premise in *Graham*, relying, in part, on the reasoning in *Johansen v. SAIF*, 158 Or App 672, *adhered to on recon*, 160 Or App 579, *rev den*, 329 Or 528 (1999).

SAIF contends that *Graham* and *Johansen* were wrongly decided. We have no authority to decide whether *Johansen* was wrongly decided and continue to rely on it as controlling precedent. We also decline to revisit our decision in *Graham* and continue to rely on it as controlling precedent. *See Michael T. Bergmann*, 52 Van Natta 1931 (2000) (rejected SAIF's arguments *Graham* was wrongly decided and, after reexamining the text of ORS 656.262(7)(c), continued to adhere to our conclusion in *Graham* that "new medical condition" claims accepted after claim closure must be reopened under ORS 656.262(7)(c) for payment of benefits and processing to closure under ORS 656.268, even if aggravation rights have expired on initial claim); *see also Larry L. Ledin*, 52 Van Natta at 684-85; *Craig J. Prince*, 52 Van Natta at 110-11.

SAIF also argues that claimant is barred from requesting a hearing under ORS 656.319(6),[1] which imposes a two year limit on requests for hearing regarding claims processing issues. We disagree.

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[1] ORS 656.319(6) provides:

"A hearing for failure to process or an allegation that the claim was processed incorrectly shall not be granted unless the request for hearing is filed within two years after the alleged action or inaction occurred."

Because SAIF did not raise this issue at hearing, we are not inclined to address it on review.[2] *Stevenson v. Blue Cross of Oregon*, 108 Or App 247 (1991). In any event, we reject SAIF's argument that, under ORS 656.319(6), claimant was required to request a hearing on the failure to process the disc herniation claim within two years of the February 9, 1993 closure. The two year deadline in ORS 656.319(6) runs from the time the "alleged action or inaction occurred," which is not necessarily the date of claim closure.

Claimant's dispute is not with the February 9, 1993 claim closure. Instead, the alleged claim processing violation was SAIF's failure to process the new medical condition under ORS 656.262(7)(c) and 656.268. In this regard, the herniated disc condition was not diagnosed until early 2000. On February 29, 2000, claimant requested that the herniated disc condition be both accepted and processed as a "new medical condition." (Exs. 11, 12, 13, 14, 15). On April 4, 2000, SAIF issued a modified acceptance that accepted a "right-sided L5-S1 disc herniation." (Ex. 21). However, SAIF did not process this new medical condition under ORS 656.262(7)(c) and 656.268. On April 10, 2000, claimant submitted a hearing request that raised the following issues: (1) "[f]ailure to pay interim time loss on [a] newly accepted condition;" and (2) penalty and attorney fees. Thus, claimant's hearing request on the alleged claim processing violation was made well within two years of the "alleged inaction." ORS 656.319(6); *Robert A. Olson*, 52 Van Natta 1540, 1541 (2000).

Finally, we note that, by a separate Own Motion Order issued on today's date, we affirmed SAIF's June 14, 2000 Own Motion Notice of Closure that closed claimant's Own Motion claim with an award of temporary disability benefits from March 1, 2000 through May 7, 2000, and declared claimant medically stationary as of June 5, 2000. Inasmuch as claimant is not entitled to receive more than the statutory sum of benefits for a single period of temporary disability benefits, the temporary disability benefits paid pursuant to the Own Motion Notice of Closure should be considered in processing claimant's new medical condition claim under ORS 656.262 and 656.268. *See Billy W. Washington*, 52 Van Natta 734 n5 (2000).

Penalty

At hearing, claimant requested that the ALJ assess penalties for SAIF's failure to pay temporary disability compensation from February 14, 2000 through February 29, 2000.[3] The ALJ granted that request and assessed a 25 percent penalty on that period of unpaid temporary disability compensation for SAIF's allegedly unreasonable claim processing. ORS 656.262(11). On review, SAIF contends that such a penalty is unwarranted, given its challenge to the existing state of the law. We disagree.

The standard for determining an unreasonable resistance to the payment of compensation is whether, from a legal standpoint, the carrier had a legitimate doubt as to its liability. *International Paper Co. v. Huntley*, 106 Or App 107 (1991). If so, the refusal to pay is not unreasonable. "Unreasonableness" and "legitimate doubt" are to be considered in the light of all the evidence available. *Brown v. Argonaut Insurance Company*, 93 Or App 588 (1988).

Our decision in *Graham* issued on October 14, 1999. *Graham*, 51 Van Natta at 1740. On February 29, 2000, claimant made a claim for a new medical condition for a L5-S1 disc herniation, provided copies of time loss authorizations, and requested that the claim be processed as a new medical

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[2] It is possible SAIF raised this issue during closing arguments, which although recorded, were not transcribed. It is well-settled, however, that an issue raised for the first time in closing argument will not be considered. *Cindy M. Penturf*, 50 Van Natta 1718 (1998), *Lawrence E. Millsap*, 46 Van Natta 2112, 2112-13 (1995) ("[w]e have consistently held that we will not consider an issue raised for the first time during closing argument" (citations omitted)); *see also Felipe A. Rocha*, 44 Van Natta 797 (1992); *Leslie Thomas*, 44 Van Natta 200 (1992); *Karel L. Nelson*, 42 Van Natta 1206 (1990).

[3] Although Dr. Lee, claimant's attending physician, authorized time loss beginning February 14, 2000, SAIF did not begin paying time loss until March 1, 2000, the date claimant was hospitalized for surgery. In doing so, SAIF contended that, because claimant's aggravation rights had expired and his initial claim was in the Board's Own Motion jurisdiction, the "new medical condition" claim was entitled only to those benefits allowed under ORS 656.278, which authorizes payment of temporary disability benefits "from the time the worker is actually hospitalized or undergoes outpatient surgery." However, as discussed above, under *Graham*, "new medical condition" claims accepted after claim closure must be reopened under ORS 656.262(7)(c) for payment of benefits and processing to closure under ORS 656.268, even if aggravation rights have expired on an initial claim.

condition under our decision in *Graham*. (Ex. 15). On March 1, 2000, claimant underwent surgery for the disc herniation condition. On April 4, 2000, SAIF issued a modified acceptance that accepted a right-sided L5-S1 disc herniation. (Ex. 21). That same date, SAIF submitted a "Carrier's Own Motion Recommendation" recommending that the claim be reopened under the Board's Own Motion jurisdiction pursuant to ORS 656.278. (Ex. 22). On April 11, 2000, we issued an Own Motion Order reopening the claim under ORS 656.278. (Ex. 25). That order was not appealed.

Thus, at the time SAIF accepted the new medical condition, our decision in *Graham* had issued and required SAIF to reopen and process the new medical condition under ORS 656.262(7)(c) and 656.268. Furthermore, claimant had requested processing of the claim under *Graham* when he submitted his request for acceptance and processing of the new medical condition. Nevertheless, when it accepted the new medical condition claim, SAIF processed that claim under ORS 656.278. Under these circumstances, we find that SAIF had no legitimate doubt as to its liability and affirm the ALJ's penalty assessment.

In reaching this conclusion, we distinguish our decisions in *Robert A. Olson*, 52 Van Natta 1540 (2000), and *Camilla S. Kosmoski*, 52 Van Natta 1573 (2000). In *Olson* and *Kosmoski*, unappealed Own Motion orders that allegedly involved new medical conditions had been issued under ORS 656.278 prior to the carriers' allegedly unreasonable failure to process the new medical condition claims under ORS 656.262 and 656.268. We held that penalties were not appropriate under those circumstances. We reasoned that it was not until issuance of our decision in *Larry L. Ledin*, 52 Van Natta 682 (2000), which was issued on April 14, 2000, that it became clear that, notwithstanding the submission of an Own Motion recommendation (and issuance of an unappealed Own Motion order), a carrier was still obligated to reopen, process, and close a claim for a new medical condition pursuant to ORS 656.262 and 656.268 and, as such, it was not unreasonable for the carriers to fail to process the claims under ORS 656.268. *Kosmoski*, 52 Van Natta at 1574, *Olson*, 52 Van Natta at 1542.

In contrast, here, the request for processing of the new medical condition under ORS 656.262, 656.268, and *Graham* occurred before any Own Motion recommendation was submitted or unappealed Own Motion order issued. Therefore, at the time SAIF accepted the new medical condition claim, it had no legitimate doubt as to its liability. Consequently, we affirm the ALJ's penalty assessment.

Attorney Fees

Claimant is entitled to an attorney fee for his counsel's services on review regarding the jurisdiction and claim processing issues. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review concerning the jurisdiction and claim processing issues is $100, to be paid by SAIF. In reaching this conclusion, we have particularly considered the time devoted to these 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 July 19, 2000 is affirmed in part and reversed in part. That portion of the order that assessed a penalty is reversed. For services on review regarding the jurisdiction and claim processing issues, claimant's attorney is awarded $100, payable by the SAIF Corporation.

Board Member Meyers specially concurring.

If I were addressing the issue presented in this case on a clean slate, I would agree with SAIF's position. However, because of the doctrine of *stare decisis*, I am obligated to follow the Boards holding in *Larry L. Ledin*, 52 Van Natta 682 (2000), and the cases on which *Ledin* is based. Nevertheless, I direct the parties to my recent concurrence in *Dennis D. Hall*, 52 Van Natta 1993 (2000), a decision that was also compelled by the doctrine of *stare decisis* and that explains the impact of the unintended consequences of reopening claims after aggravation rights have expired. Such consequences which I would continue to submit could not have been the intention of the legislature in enacting ORS 656.262(7)(a) and (7)(c).

In the Matter of the Compensation of
STEVEN R. AZORR, Claimant
Case No. 00-0119M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Ransom & Gilbertson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of the SAIF Corporation's June 14, 2000 "Notice of Closure Board's Own Motion Claim" that closed his claim with an award of temporary disability benefits from March 1, 2000 through May 7, 2000,[1] and declared claimant medically stationary as of June 5, 2000. Claimant makes no argument regarding the merits of the closure other than to state that he does not believe that this case is in Own Motion jurisdiction. He also contends that, "under current case law," SAIF "must reopen this claim and reclose it as a new medical condition."

In addition, claimant attaches a copy of Administrative Law Judge (ALJ) Hazelett's July 19, 2000 Order and Opinion that resulted from claimant's request for hearing regarding: (1) claim processing of his newly accepted right-sided L5-S1 herniated disc condition; and (2) penalties for SAIF's failure to pay temporary disability benefits on that claim from February 14, 2000 through February 29, 2000. (WCB Case No. 00-02760). In that order, the ALJ relied on *John R. Graham*, 51 Van Natta 1740, 51 Van Natta 1746 (1999), and held that claimant was entitled to temporary disability benefits for the period before he was hospitalized. The ALJ also assessed a penalty under ORS 656.262(11) for SAIF's allegedly unreasonable failure to pay the pre-hospitalization temporary disability benefits. Finally, the ALJ remanded the claim to SAIF to process the right L5-S1 herniated disc condition "as a newly accepted condition." SAIF requested review of that order. By a separate order issued today's date in our "regular" jurisdiction, we affirmed ALJ Hazelett's order.

Regarding the issue before us in our Own Motion capacity, *i.e.*, claimant's request for review of SAIF's June 14, 2000 "Notice of Closure Board's Own Motion Claim," we affirm SAIF's closure based on the following reasoning.

FINDINGS OF FACT[2]

On September 22, 1992, claimant sustained a compensable low back injury, which SAIF accepted as a disabling lumbar strain injury. The claim was closed on February 9, 1993. Claimant's aggravation rights expired five years later, on February 9, 1998.

On February 14, 2000, Dr. Lee, D.O., claimant's treating physician, filed an "aggravation" claim on claimant's behalf. Dr. Lee authorized time loss from February 14, 2000 through February 21, 2000. On February 21, 2000, Dr. Lee authorized time loss "until further notice" based on claimant's worsening condition. Further medical testing revealed a disc protrusion at L5-S1 on the right.

On February 29, 2000, claimant submitted a formal claim for acceptance of a right-sided L5-S1 disc herniation condition.

On March 1, 2000, claimant underwent a right L5-S1 hemilaminotomy and microdiskectomy performed by Dr. Calhoun, claimant's treating surgeon. On March 4, 2000, claimant submitted work force information in response to SAIF's inquiry and requested that SAIF reopen his claim.

On April 4, 2000, SAIF issued a "Modified Notice of Acceptance" that accepted the right-sided L5-S1 disc herniation. That same date, SAIF submitted a "Carrier's Own Motion Recommendation" that recommended claimant's claim be reopened in Own Motion.

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[1] The Own Motion Notice of Closure awarded claimant temporary total disability (TTD) benefits from March 1, 2000 through March 26, 2000, and temporary partial disability (TPD) benefits from March 27, 2000 through May 7, 2000. The closure notice also indicated that the TPD rate was zero because the employer paid claimant's full wages during the period he was entitled to TPD benefits.

[2] Some of these findings of fact are derived from the findings in ALJ Hazelett's order in WCB Case No. 00-02760.

On April 11, 2000, we issued an Own Motion Order authorizing the reopening of claimant's claim to provide temporary total disability compensation beginning March 1, 2000, the date claimant was hospitalized for surgery. SAIF was also directed to close the claim pursuant to OAR 438-012-0055 when claimant was medically stationary. That Own Motion Order was not appealed.

On June 5, 2000, Dr. Calhoun examined claimant and declared him medically stationary. He noted that claimant was working at his regular job without restrictions.

On June 14, 2000, SAIF issued an Own Motion Notice of Closure that closed claimant's claim with an award of temporary disability benefits from March 1, 2000 through May 7, 2000, and declared claimant medically stationary as of June 5, 2000.

On June 23, 2000, claimant requested that the Board in its Own Motion capacity review SAIF's Own Motion Notice of Closure, contending that his claim was not in Own Motion jurisdiction.

Claimant had also requested a hearing regarding processing of the newly accepted condition. (WCB Case No. 00-02760). The hearing on that matter was held on July 10, 2000. On July 19, 2000, ALJ Hazelett issued an order, as summarized above, which was appealed by SAIF. By a separate order issued today's date in our "regular" jurisdiction, we affirmed ALJ Hazelett's order.

CONCLUSIONS OF LAW AND OPINION

Claimant requests that the Board, in its Own Motion authority, review SAIF's June 14, 2000 "Notice of Closure Board's Own Motion Claim," contending that "this case is not in [O]wn [M]otion jurisdiction." We interpret claimant's request as a request to order SAIF to process the claim pursuant to ORS 656.262(7)(c)[3] and 656.268. In addition, claimant requested a hearing before the Hearings Division, requesting the same relief before that forum. (WCB Case No. 00-02760). As discussed above, ALJ Hazelett granted this relief to claimant. Moreover, on today's date, we affirmed ALJ Hazelett's order in our "regular" jurisdiction. As for the Own Motion matter, claimant makes no argument regarding the merits of SAIF's closure.

As a preliminary matter, we find that we have subject matter jurisdiction in our Own Motion capacity to review the June 14, 2000 closure. In this regard, we previously addressed the bifurcated authority of the Board in *John R. Graham*, 51 Van Natta 1740 (1999), 51 Van Natta 1746 (1999),[4] *Craig J. Prince*, 52 Van Natta 108 (2000), and *Larry L. Ledin*, 52 Van Natta 680, 52 Van Natta 682 (2000). In *Graham*, we held that a "new medical condition" claim qualifies for reopening and closure under ORS 656.268 pursuant to ORS 656.262(7)(c), even if the original claim is in the Board's Own Motion jurisdiction. 51 Van Natta at 1745.

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

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[3] ORS 656.262(7)(c), as amended in 1997, provides, in relevant part: "[i]f a condition is found compensable after claim closure, the insurer or self-insured employer shall reopen the claim for processing regarding that condition." This amendment applies retroactively to all claims existing or arising on or after the July 25, 1997 effective date, regardless of the date of injury or the date a claim is presented. *See Mario R. Castaneda*, 49 Van Natta 2135 (1997).

[4] SAIF makes several arguments that *Graham* and *Johansen v. SAIF*, 158 Or App 672, *on recon*, 160 Or App 579, *rev den* 329 Or 528 (1999), a court case relied on in *Graham*, were wrongly decided. We recently rejected these same arguments in *Michael T. Bergmann*, 52 Van Natta 1931 (2000). Therefore, we continue to rely on those cases as controlling precedent.

Finally, in *Ledin*, we determined that we had subject matter jurisdiction in our Own Motion capacity to review a carrier's Own Motion Notice of Closure. Specifically, we found that, where a claimant's aggravation rights had expired on the initial injury claim and the condition worsened requiring surgery, we were authorized to reopen the claimant's claim pursuant ORS 656.278(1)(a)[5] and to direct the carrier to close the claim under our Own Motion rules when the claimant's condition became medically stationary. We also reasoned that we had subject matter jurisdiction in our Own Motion capacity to review the carrier's subsequent closure of that claim. *Larry L. Ledin*, 52 Van Natta at 685; *see also Paul E. Smith*, 52 Van Natta 730 (2000); *Robert A. Olson*, 52 Van Natta 1540 (2000); *Camilla S. Kosmoski*, 52 Van Natta 1573 (2000).

This same reasoning applies to the current claim. There is no dispute that claimant's aggravation rights have expired on his initial injury claim. Furthermore, claimant's condition required surgery. Thus, applying the reasoning in *Ledin*, we had subject matter jurisdiction to issue the April 11, 2000 Own Motion Order[6] that authorized reopening claimant's claim pursuant to ORS 656.278(1)(a) and its closure pursuant to our Own Motion rules. Accordingly, we now have subject matter jurisdiction to review the insurer's subsequent closure of that claim.[7] Therefore, we proceed with that review.

A claim may not be closed unless the claimant's condition is medically stationary. *See* ORS 656.268(1); OAR 438-012-0055(1). "Medically stationary" means that no further material improvement would reasonably be expected from medical treatment or the passage of time. ORS 656.005(17). Claimant bears the burden of proving that he was not medically stationary at claim closure. *Berliner v. Weyerhaeuser Corp.*, 54 Or App 624 (1981). The propriety of the closure turns on whether claimant was medically stationary at the time of the June 14, 2000 closure, considering claimant's condition at the time of closure and not of subsequent developments. *See* ORS 656.268(1); *Sullivan v. Argonaut Ins. Co.*, 73 Or App 694 (1985); *Alvarez v. GAB Business Services*, 72 Or App 524 (1985). The issue of claimant's medically stationary status is primarily a medical question to be decided based on competent medical evidence. *Harmon v. SAIF*, 54 Or App 121, 125 (1981); *Austin v. SAIF*, 48 Or App 7, 12 (1980).

Here, the only medical evidence regarding the medically stationary issue is provided by claimant's treating surgeon, who opined that claimant was medically stationary as of June 5, 2000. That is the date SAIF declared claimant medically stationary when it closed the claim.

Claimant makes no argument that he was not medically stationary at the time of closure, nor does he argue that his medically stationary date was incorrect. He also does not contest the temporary

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[5] ORS 656.278(1)(a) provides:

"(1) Except as provided in subsection (6) of this section, the power and jurisdiction of the Workers' Compensation Board shall be continuing, and it may, upon its own motion, from time to time modify, change or terminate former findings, orders or awards if in its opinion such action is justified in those cases in which:

"(a) There is a worsening of a compensable injury that requires either inpatient or outpatient surgery or other treatment requiring hospitalization. In such cases, the board may authorize the payment of temporary disability compensation from the time the worker is actually hospitalized or undergoes outpatient surgery until the worker's condition becomes medically stationary, as determined by the board[.]"

[6] We note that the April 11, 2000 Own Motion Order was not appealed and has become final by operation of law. *See* ORS 656.278(4). Had that order been appealed or not become final, our decision today may well have been different. However, resolution of cases based on those specific circumstances must await a future case.

[7] Although we have subject matter jurisdiction to determine entitlement to temporary disability benefits where an injured worker's aggravation rights have expired, we generally defer making such a determination if there is litigation before the Hearings Division that may result in the payment of benefits under another claim or under another statute such as ORS 656.262(7)(c). *See* OAR 438-012-0050(1)(a)-(c); *Craig Prince*, 52 Van Natta at 111.

disability compensation award before this forum.[8] Instead, claimant's argument is procedurally based, *i.e.*, claimant essentially argues that review of SAIF's Own Motion Notice of Closure should be under ORS 656.268 rather than the Board's Own Motion jurisdiction. Because we have rejected that argument and claimant raises no substantive arguments, we affirm SAIF's June 14, 2000 Own Motion Notice of Closure in its entirety.[9] *See Harold G. Mangum*, 52 Van Natta 1824 (2000); *John P. Adkins*, 52 Van Natta 708 (2000).

Finally, we turn to claimant's request that we order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268. As we have previously explained, where a claimant disputes the carrier's processing of a claim and contends that the claim should be processed under ORS 656.262(7)(c), the claimant may request a hearing to resolve that dispute. *See Prince*, 52 Van Natta at 111.

In other words, in our Own Motion jurisdiction, we do not have authority to grant claimant's request to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and 656.268. Claimant's relief, if any, regarding his request for additional benefits for his low back condition lies with the Hearings Division, not the Board in our Own Motion jurisdiction. As previously noted, claimant has pursued that relief through the Hearings Division. Moreover, the matter has been reviewed in our "regular" jurisdiction. WCB Case No. 00-02760.[10]

Accordingly, SAIF's June 14, 2000 Own Motion Notice of Closure is affirmed.

IT IS SO ORDERED.

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[8] We note that, at hearing, claimant contended that he was entitled to temporary disability compensation before the date of surgery. Such compensation may be due under processing pursuant to ORS 656.262(7)(c) and 656.268. Nevertheless, as discussed above, entitlement to benefits under ORS 656.262(7)(c) and 656.268 is not before us in our Own Motion capacity. Instead, the issue before us is claimant's entitlement to benefits pursuant to ORS 656.278. Under that statute, a worker is entitled to temporary disability compensation beginning the date he is "actually hospitalized or undergoes outpatient surgery." ORS 656.278(1)(a). Claimant underwent surgery on March 1, 2000. Therefore, he is entitled to temporary disability benefits beginning March 1, 2000, which is the date SAIF's temporary disability award began. ORS 656.278(1)(a).

[9] To the extent that claimant's request may be interpreted as a request that we grant additional permanent disability in our Own Motion jurisdiction, we do not have authority to grant such a request. *See* ORS 656.278(1); *Independent Paper Stock v. Wincer*, 100 Or App 625 (1990) (effective January 1, 1988, the legislature removed the Board's authority to grant additional permanent disability compensation in its Own Motion capacity).

[10] As we discussed in *Ledin*, a claimant is not entitled to receive any more than the statutory sum of benefits for a single period of temporary disability. *See Fischer v. SAIF*, 76 Or App 656, 661 (1985). Thus, consistent with the *Ledin* rationale, inasmuch as we have herein affirmed SAIF's Own Motion Notice of Closure, temporary disability benefits paid pursuant to that closure order will need to be taken into consideration should the litigation pending before us in our "regular" jurisdiction eventually result in claim closure pursuant to ORS 656.268.

In the Matter of the Compensation of
LAURIE COLEMAN, Claimant
WCB Case No. 00-03369
ORDER ON REVIEW
Bottini Bottini & Oswald, Claimant Attorney
Bruce A Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Podnar's order that upheld the SAIF Corporation's denial of her right knee injury claim. On review, the issue is compensability.

We adopt and affirm the ALJ's order.

ORDER

The ALJ's order dated August 15, 2000 is affirmed.

Board Member Phillips Polich concurring.

I agree with the conclusion that the medical evidence is insufficient to establish compensability. I write separately to explain that claimant failed to meet her burden of proof because there is no explanation of Dr. Rusch's changed and inconsistent opinions.

Dr. Rusch initially concurred with Dr. Thompson's April 12, 2000 report. (Ex.22). Dr. Thompson had reported that he could not explain claimant's symptoms and physical findings based on the alleged mechanism of injury. (Ex. 19-4, -5, -6). He found that claimant's knee pain was too diffuse to be explained by the type of injury. (Ex. 19-6). In light of claimant's history of fibromyalgia and the diffuseness of the tenderness, Dr. Thompson felt it was necessary to consider some other underlying problem such as fibromyalgia or inflammatory arthritis. (*Id.*) He recommended further x-rays to help diagnose claimant's condition. (*Id.*)

In contrast, Dr. Rusch reported on July 24, 2000 that claimant's work injury was the major contributing cause of her knee condition and need for treatment. (Ex. 24). He explained that the mechanism of injury from jumping down from the back of a trailer was consistent with claimant's right knee condition and findings. (*Id.*) Dr. Rusch also said that claimant's fibromyalgia and history of arthralgia were not contributing factors in her current knee condition. (*Id.*)

Dr. Rusch never explained the inconsistency between his concurrence with Dr. Thompson's report and his July 24, 2000 report, or his reasons for changing his opinion. Consequently, Dr. Rusch's opinion is entitled to little weight. *Compare Kelso v. City of Salem*, 87 Or App 630 (1987) (medical opinion that provided a reasonable explanation for the change of opinion was persuasive).

In the Matter of the Compensation of
CHARLES F. KLUTSENBEKER, JR., Claimant
WCB Case Nos. 98-06559, 98-04553 & 97-07040
ORDER ON REVIEW
Black, Chapman, et al, Claimant Attorney
Cummins, Goodman et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Stephen Brown's order that: (1) upheld the self-insured employer's denial of claimant's "new medical condition" claim for degenerative lumbar spine disease; and (2) upheld the employer's denial of claimant's "new medical condition" claim for L3-4 and L5-S1 herniated disc conditions. On review, the issue is compensability. We affirm.

FINDINGS OF FACT

Claimant worked as a heavy equipment operator for the employer from 1973 until his retirement in January 1998. In 1977, claimant experienced a compensable low back injury when the SAIF Corporation (not a party to this claim) was on the risk.

On August 1, 1985, claimant experienced low back pain with radiation in the left leg. (Ex. 3). He was initially diagnosed with a lumbosacral strain and left sciatica. His condition did not improve. A December 1985 CT scan revealed a large central disc herniation at L4-5, a slight central bulge at L5-S1, and bony overgrowth of the facet joints at each level from the lower body of L4 to the upper body of S1. This bony overgrowth slightly compressed the lateral aspects of the thecal sac at L4-5. (Ex. 9). Dr. Dunn diagnosed a large central herniated disk at L4-5. (Ex. 10). Claimant was treated conservatively and, on January 28, 1986, Dr. Dunn declared claimant medically stationary and released him to regular work. (Ex. 10-2).

After litigation, an August 27, 1987 Opinion and Order by a prior ALJ upheld SAIF's aggravation denial and set aside the employer's compensability and responsibility denial. (Ex. 20). Relying on the opinion of Dr. Dunn, the ALJ found that claimant had sustained a new injury that contributed to claimant's low back disc condition. (*Id.*).

Meanwhile, on June 16, 1986, claimant slipped and fell at work, injuring his low back. (Ex. 11). Claimant experienced pain in his low back and down both legs, with numbness and tingling into his foot. (Ex. 12-1). The employer accepted the claim as a disabling injury on a Form 801. (*Id.*) Claimant was declared medically stationary as of July 7, 1986. (Ex. 12). An August 29, 1986 Determination Order closed the claim with an award of temporary disability only. (Ex. 16).

On November 3, 1987, claimant returned to Dr. Dunn for persistent symptoms in his low back and left leg. (Ex. 21). An MRI revealed central disc herniations at L2-3 and L4-5 and disc bulges at L3-4 and L5-S1. (Exs. 22, 23). A CT scan revealed disc herniations at L3-4 and L4-5 and a bulge at L5-S1. (Ex. 24). The disc herniations at L3-4 and L4-5 were confirmed by myelogram. (Ex. 25). On February 12, 1988, Dr. Dunn performed a diskectomy at L4-5. (Ex. 29).

The employer reopened the June 16, 1986 claim. A June 15, 1988 Determination Order reclosed that claim with an award of 10 percent unscheduled permanent disability. (Ex. 40).

In August and September 1988, claimant sought treatment for low back symptoms. (Exs. 41, 42, 44). The employer reopened the June 16, 1986 claim.

A September 29, 1988 Determination Order closed the August 1, 1985 claim with an award of temporary disability only. (Ex. 46).

A November 17, 1988 Determination Order reclosed the June 16, 1986 claim with an award of 16 percent unscheduled permanent disability and 5 percent scheduled permanent disability for the loss of the left foot. (Ex. 51).

Between 1989 and 1996, claimant returned to Dr. Dunn's office annually, reporting periodic exacerbations of pain, generally activity related. He received symptomatic treatment. (Exs. 52, 54).

On April 16, 1997, claimant's low back symptoms increased while working. (Ex. 64). Dr. Zelaya suspected a recurrent disc and, on April 28, 1997, filed a claim based on the June 16, 1986 claim. (Exs. 61, 62). Dr. Louie became the treating physician; he diagnosed lumbar strain with possible radiculopathy. (Exs. 70, 73). The employer accepted a disabling lumbar strain and denied degenerative lumbar spine disease at multiple levels. (Exs. 85, 86).

On August 28, 1997, claimant requested the employer to expand its acceptance of the June 16, 1986 claim to include herniated discs at L3-4, L4-5 and L5-S1. (Ex. 92A). On September 4, 1997, the employer responded to the request, asking if claimant wanted the acceptance on the June 16, 1986 claim or on the later accepted new injury claim. (Ex. 93). On February 5, 1998, the employer denied claimant's requests. (Ex. 109).

On March 6, 1998, claimant requested the employer to expand its acceptance of the August 1, 1985 claim to include degenerative lumbar spine disease. (Ex. 114A).

CONCLUSIONS OF LAW AND OPINION

The ALJ upheld the employer's denials related to the 1985 and 1986 compensable claims. On review, claimant makes two arguments, the first directed to the 1985 injury and the second to the 1986 injury. We shall address each in turn.

August 1, 1985 Injury

Claimant argues that his degenerative lumbar spine disease preexisted his 1985 injury, as supported by the opinions of Dr. Farris and Dr. Schilperoort, and was encompassed by the August 27, 1987 Opinion and Order, in which the employer was found responsible for claimant's "low back condition." The employer contends that claimant's degenerative disease is not compensable because no medical treatment was directed toward that condition.

Claimant experienced a low back injury in 1977 when SAIF was on the risk. On August 1, 1985, when the employer was self-insured, claimant injured his low back while bending and pulling at work. SAIF and the employer each denied the 1985 claim. After an August 1987 hearing, a prior ALJ found that claimant's 1985 injury independently contributed to claimant's 1985 low back disc condition. The prior ALJ set aside the employer's denial and ordered the employer to accept responsibility and compensability for claimant's "low back condition." By virtue of the August 27, 1987 Opinion and Order directing the employer to accept the claim, claimant's "low back condition" claim was in "accepted" status. *See, e.g., Richard L. Markum*, 48 Van Natta 2204 (1996) (holding that the carrier had involuntarily accepted the claimant's psychiatric condition pursuant to a prior litigation order finding the condition compensable).

Here, however, the crux of the argument between the parties is whether the accepted "low back condition" is specific to claimant's L4-5 herniated disc condition (as advocated by the employer) or includes both the L4-5 disc condition and claimant's degenerative lumbar spine condition (as advocated by claimant).

The contemporary medical reports indicate that claimant complained of low back and left leg symptoms. Dr. Gilmour initially diagnosed a lumbosacral strain and left sciatica. Because of claimant's left leg involvement, Dr. Gilmour referred claimant to a neurologist for evaluation. In August 1985, Dr. Schwartz, neurosurgeon, differentially diagnosed claimant's condition as a probable herniated disc L4-5 or possible L5-S1. Because claimant had improved with conservative therapy, Dr. Schwartz recommended a trial return to work.

In December 1985, Dr. Dunn noted that claimant had continued to have recurrent episodes of pain in his back and down his leg. He diagnosed an occult or recurrent herniated disk in remission at that time. He ordered a CT scan, which he read as a large central herniated disk at L4-5, extending down over the body of L-5. Claimant continued to receive conservative treatment for his low back and leg symptoms. On January 28, 1986, Dr. Dunn declared claimant medically stationary and released him to regular work. Finally, after reviewing claimant's history and medical records, Dr. Dunn opined that claimant's work activity during which he rode on a poor seat on rough roads in July 1985 was an independent contributing factor to the rupture of his disk and subsequent treatment.

The issue, as framed by the prior ALJ, was whether claimant had sustained a new injury to his low back or had suffered an aggravation of the prior low back injury. (Ex. 20). Relying on the opinion of Dr. Dunn, the prior ALJ found that claimant had sustained a new injury that contributed to claimants low back disc condition. (Ex. 20). The prior ALJ further concluded that work activities with the employer were a "material contributing cause in the protrusion of and damage to the disc." (*Id.*).

Because the contemporaneous medical reports relating to claimant's 1985 injury indicated that claimant's low back condition involved a herniated disk at L4-5, and because the prior ALJ relied on Dr. Dunn's opinion to reach his conclusion (which referred to a disc condition), we find that the employers acceptance resulting from that litigation order was limited to that condition and did not include a degenerative lumbar spine condition.[1]

June 16, 1986 Injury

In June 1986 claimant slipped and fell on his buttocks. Claimant reported pain in his back down both legs, worse on the left and sometimes worse on the right with radiation, numbness and tingling into his foot. Dr. Dunn opined that claimant had a definitive exacerbation from a new incident and took him off work. Claimant filed a "new injury" claim, which the employer accepted on the 801 Form. (Ex. 11).

On July 2, 1986, Dr. Dunn declared claimant medically stationary and released him to regular work. An August 29, 1986 Determination Order closed the claim with an award of temporary disability only.

Responding to claimant's argument that, under *Georgia Pacific v. Piwowar*, 304 Or 494 (1988), the employer's acceptance of claimant's back condition in 1986 constituted acceptance of the conditions causing his symptoms at that time, the ALJ concluded that there was no convincing evidence that claimant's degenerative disc disease, other than the L4-5 herniation, was causing symptoms. The ALJ relied on the opinions of Drs. Farris and Schilperoort. Claimant raises the same argument on review. Specifically, claimant contends that, by accepting a low back injury, the nature of which was "not known at this time," the employer accepted claimant's herniated discs at L3-4 and L5-S1.

If a carrier accepts a claim for symptoms, that acceptance encompasses the causes of the symptoms. *Piwowar*, 305 Or at 501-02. In *Piwowar*, the carrier accepted a claim for a "sore back." Later, the carrier learned that the claimant's back problems may have arisen from ankylosing spondylitis, and the carrier issued a partial denial of that condition. *Id.* at 497. The Supreme Court explained that an employer is required "to compensate the claimant for the specific condition in the notice of acceptance regardless of the cause of that condition." *Id.* at 501. The Court concluded that, because the carrier had accepted a claim for a symptom of the underlying disease, and not a separate condition, it was precluded from denying the underlying condition. *Id.* at 501-02.

Here, there is no formal acceptance in the record. Instead, the employer accepted a disabling injury on an 801 Form. Claimant filed a claim for a lower back injury. In Box 14, the nature of the injury or disease is indicated as "Not known at this time." Based on this record, we find that the employer's acceptance is unclear.

As discussed above, when the carrier does not identify the specific condition accepted, we look to contemporaneous medical records to determine what condition was accepted. Thus, we examine the contemporaneous medical records to determine whether the acceptance of a lower back injury described as "not known at this time," was an acceptance of a symptom of claimant's herniated discs at L3-4 and L5-S1.

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[1] We do not find that Dr. Farris' 1998 interpretation of the December 26, 1985 CT scan is persuasive for the following reasons. First, Dr. Farris' interpretation of the CT scan was not contemporaneous with the 1985 injury and was, therefore, not considered by the parties at that time. Second, although Dr. Farris indicated that claimant suffered from degenerative lumbar spine disease as evidenced by the December 26, 1985 CT scan finding of bony overgrowth of the facet joints at each level, she also opined that the L4-5 herniated disc was part of claimant's degenerative lumbar spine disease. (Ex. 113-5, -8, -9, -12, -16, -18, -19, -20, -27 through -31). That opinion is directly at odds with the law of the case and is therefore unpersuasive. *See, e.g., Kuhn v. SAIF*, 73 Or App 768 (1985) (when claimant had, in earlier extent of disability proceeding, established that permanent disability arose out of industrial accident, doctor's opinion in subsequent aggravation proceeding that disability was result of congenital condition was held contrary to law of the case).

After the June 16, 1986 injury, claimant continued to work until he experienced pain in his back down both legs, worse on the left and sometimes worse on the right with radiation and numbness and tingling into his foot. Dr. Dunn opined that claimant had a "definitive exacerbation from a new incident as he was totally asymptomatic from his previous incident." There are no other medical reports prior to the employer's June 30, 1986 acceptance. Although Dr. Dunn provided no definitive diagnosis, he did not attribute claimant's symptoms to herniated discs at L3-4 or L5-S1. Under these circumstances, we agree with the ALJ that the rule in *Piwowar* does not apply to this case. Therefore, the ALJ properly upheld the employer's denial.

ORDER

The ALJ's order dated May 30, 2000 is affirmed.

December 8, 2000 Cite as 52 Van Natta 2156 (2000)

In the Matter of the Compensation of
RIMM L. BEER, Claimant
WCB Case No. 00-03910
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Randy Rice, Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Fitzwater's order that awarded no scheduled permanent disability award for loss of use or function of claimant's left arm, whereas an Order on Reconsideration had awarded 26 percent (49.92 degrees). On review, the issue is extent of scheduled permanent disability.[1]

We adopt and affirm the ALJ's order regarding claimant's entitlement to permanent disability compensation for loss of left arm strength, with the following modification and supplementation.

The sentence running from page 4 to page 5 of the Opinion and Order is modified as follows: Mr. Ross, PCE evaluator, documented a statistically *varying* left arm strength deficit and enumerated several possible non-injury related explanations for the *variations* among claimant left arm strength test responses. (Ex. 89-6).

In addition, we offer the following supplementation.

Mr. Ross opined that claimant's varying left arm strength test results indicated varying effort and Dr. Kieper, attending physician, concurred with Ross' PCE evaluation. Because claimant's left arm strength test results reflect varying effort and therefore suggest non-injury related contributing causes, (Ex. 89-6), we agree with the ALJ that claimant's lost left arm strength is not ratable under the standards. *See e.g., Margo A. Readye, Jr.*, 50 Van Natta 177 (1998) (standards may not be applied loosely or by analogy, because they are specific and precise).

ORDER

The ALJ's order dated August 15, 2000 is affirmed.

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[1] The insurer argues that the ALJ erred in refusing to admit the post-reconsideration deposition of Mr. Ross. We do not reach this issue, because we would reach the same result if we considered the disputed evidence.

In the Matter of the Compensation of
DONNA R. GOODRICH, Claimant
WCB Case Nos. 00-00934, 00-00630 & 00-00629
ORDER ON RECONSIDERATION
Heather Hold, Claimant Attorney
Lundeen et al, Defense Attorney
David Wilson, Defense Attorney
Julie Masters (Saif), Defense Attorney
William J. Blitz, Defense Attorney
Mary Goebel Adams (Saif), Defense Attorney

On November 27, 2000, we issued an Order on Review that: (1) set aside a denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome issued by the SAIF Corporation, on behalf of Donna Deardorff; and (2) upheld denials of the same condition issued by Liberty Northwest Insurance Corporation, on behalf of Merlin Pizza, and SAIF, on behalf of Ken-Wal Farms, Inc. Our order further provided that SAIF / Deardorff was responsible for the ALJ's attorney fee award. SAIF / Deardorff seeks clarification of our order. Noting that the ALJ awarded a $1,800 attorney fee (payable by SAIF / Ken-Wal) for a "compensability" denial withdrawn at the hearing (in addition to a $1,000 attorney fee payable by Liberty Northwest / Merlin Pizza (the insurer found responsible for the claim at hearing), SAIF / Deardorff asks whether it is obligated to pay *all* of the ALJ attorney fee awards or only the award granted by the ALJ for the responsibility issue.

As set forth in the opening paragraph of our order, the issues on review pertained to the responsibility for the claim. Thus, neither the compensability of the claim, nor the accompanying attorney fee awarded to claimant for SAIF / Ken-Wal's concession of its compensability denial were addressed in our order. Under such circumstances, the final sentence in the "Order" portion of our decision (which stated that "[t]he remainder of the ALJ's order is affirmed."), in effect, republished the ALJ's $1,800 attorney fee award to be paid by SAIF / Ken-Wal. Furthermore, the preceding sentence in the "Order" portion of our decision (which provided that "SAIF / Deardorff is responsible for the ALJ's attorney fee award."), in effect, only pertained to the responsibility denial (the sole issue in dispute on Board review).

In any event, to avoid any potential misunderstanding, we withdraw our November 27, 2000 order and offer the following clarification. As the responsible insurer, SAIF / Deardorff is responsible for the ALJ's $1,000 attorney fee award. SAIF / Ken-Wal remains obligated to pay the ALJ's $1,800 attorney fee award regarding SAIF / Ken-Wal's "hearing" rescission of its compensability denial.

Accordingly, on reconsideration, as supplemented herein, we republish our November 27, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
CARL C. ROTEN, Claimant
WCB Case No. 00-00570
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Livesley's order that directed it to recalculate claimant's rate of temporary disability benefits. On review, the issue is rate of temporary disability. 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 suffered a compensable injury on May 6, 1998. In the year prior to the injury, claimant had been laid off for a continuous period of two weeks.

The ALJ determined that claimant was unemployed during the two-week lay off. Consequently, the ALJ reasoned that in the year prior to his injury, claimant had been employed for less than 52 weeks, and therefore his average weekly wage should be calculated by dividing his earnings in the year prior to injury by 50 (the actual weeks of employment).

The insurer contends that claimant has been continuously employed with the employer at injury for approximately ten years. Consequently, the insurer argues that the two-week period in which claimant was laid off can only be excluded from the calculation of claimant's average weekly wage, if the two-week period is an "extended gap" under the terms of OAR 436-060-0025(5)(a)(A). The insurer further contends that the two-week period at issue here is not an "extended gap." Therefore, the insurer argues, claimant's average weekly wage should be calculated by dividing his earnings in the year prior to injury by 52, not by 50, as calculated by the ALJ. We disagree with the insurer's contentions.

The record establishes that during the two-week lay off, which occurred approximately 5 months prior to the compensable injury, claimant filed a claim for unemployment compensation and was looking for work. (Tr. 8). The insurer does not contend otherwise. Consequently, we conclude that claimant was not employed by the employer at injury during the period of lay off.[1]

OAR 436-060-0025(5)(a)(A) provides in pertinent part:

> "Insurers shall use the worker's average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist, insurers shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks. For workers employed less than four weeks, insurers shall use the intent of the wage earning agreement as confirmed by the employer and the worker."

Having concluded that claimant was not employed with the employer at injury during the two-week lay off period, we further conclude that claimant's average weekly wage should be determined using his "actual weeks of employment" (here 50, not 52). *See Ken T. Dyer*, 49 Van Natta 2089 (1997) (the plain meaning of actual weeks of employment refers only to those weeks when the claimant was actually employed; that is, earning remuneration for services performed for the employer); *Cheryl A. Lamb*, 52 Van Natta 676, 677-8 (2000). Accordingly, we agree with the ALJ's determination that, to correctly calculate claimants average weekly wage, claimant's earnings in the year prior to injury should be divided by 50 (the actual weeks of employment).

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[1] Having concluded that claimant was unemployed during the two-week lay off period, we do not need to determine whether or not such a period is an "extended gap."

Having resolved the "lay-off" question, we address the insurer's argument regarding the inclusion of claimant's vacation pay in his rate of temporary disability. It is undisputed that claimant was paid $1,308.96 in "vacation pay" in December 1998. The ALJ determined that because this amount was earned in association with work performed between December 1, 1997 and May 6, 1998 (within the 52 weeks prior to the May 6, 1998 injury), it should be included in the calculation of claimant's weekly wage.

The insurer contends that because the $1.306.98 was not paid until December 1998, about seven months after injury, it should not be included in the calculation of claimant's weekly wage. We agree with the insurer.

According to the employer's Hourly Employee Booklet:

> "The Company provides paid vacation for qualified employees as a reward for their efforts. Qualified employees will be paid for their vacation in December. To qualify for vacation, an employee must be employed on December first, and work at least six hundred forty hours in the year prior to that December first. The amount of vacation earned depends upon the number of hours worked." (Ex. 10).

In order for claimant to qualify for "vacation pay" two things had to occur: (1) he must have worked at least 640 hours in the year prior to December first; and (2) he had to be employed on December first. Because the "vacation pay" was contingent upon claimant being employed on December first, he had no present right to receive the "vacation pay" (that was payable on December 1, 1998) at the time of his injury on May 6, 1998. In other words, claimant's right to the vacation pay had not vested at the time of his injury.

In this regard, the facts here are analogous to *Nelson v. SAIF*, 302 Or 463, 469 (1987), where the Court held that insurance premiums and pension contributions need not be included in calculation of temporary disability benefits because the worker never received the premium payments and the pension payments could only be received under certain limited circumstances. Because at the time of the injury, claimant's "vacation pay" could only be received under limited circumstances, we conclude that the December 1998 "vacation pay" should not be included in the calculation of claimant's average weekly wage.[2]

Having concluded that the $1,308.96, of "vacation pay" received by claimant in December 1998 should not be included in the calculation of claimant's weekly wage, we find that claimant's total wages in the actual weeks of his employment prior to injury equal $32,357.84. Dividing this sum by the actual weeks worked (50) yields an average weekly wage of $647.16.

Consequently, the ALJ's order is modified to direct the insurer to calculate claimant's average weekly wage according to the formula set forth in this decision.

ORDER

The ALJ's order dated May 18, 2000 is affirmed in part and modified in part. The ALJ's calculation of claimant's average weekly wage is modified to $647.16. The ALJ's award of an "out-of-compensation" attorney fee is modified accordingly. The remainder of the ALJ's order is affirmed.

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[2] The circumstances here are distinguishable from the circumstances in *SAIF v. Ekdahl*, 170 Or App 193 (2000). In *Ekdahl*, the claimant received both an hourly wage and patronage dividend. The patronage dividend was calculated annually, was dependent on the number of hours worked, and was paid at some point in the year following the year in which it was earned. The court determined that because the patronage dividend was a type of "wage" as defined in ORS 656.005(29), it should be included in the calculation of the claimant's average weekly wage as it had been earned (even if not paid) at the time of the claimant's injury. Because the claimant in *Ekdahl* had a present right at the time of her injury to receive the patronage dividend (the money was hers and she was entitled to it), we find *Ekdahl* distinguishable.

In the Matter of the Compensation of
BERNARD MONTGOMERY, Claimant
Own Motion No. 00-0347M
OWN MOTION ORDER
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer submitted claimant's request for temporary disability compensation for claimant's compensable left knee condition. Claimant's aggravation rights on that claim expired on June 3, 1993. The insurer opposed authorization of temporary disability compensation, contending that it has been unable to determine if claimant was in the work force at the time of his current disability.

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

In a July 10, 2000 medical report, Dr. Baldwin, claimant's attending physician, recommended that claimant undergo a total knee arthroplasty. Thus, we conclude that claimant's compensable condition has worsened requiring surgery or hospitalization.

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

We have previously found that the "date of disability," for the purpose of determining whether claimant is in the work force, under the Board's own motion jurisdiction, is the date he enters the hospital for the proposed surgery. *Fred Vioen*, 48 Van Natta 2100 (1996); *John R. Johanson*, 46 Van Natta 2463 (1994). Here, the relevant time period for which claimant must establish he was in the work force is the time prior to July 10, 2000, when his condition worsened requiring that surgery. *See generally Wausau Ins. Companies v. Morris*, 103 Or App 270, 273 (1990); *Weyerhaeuser v. Kepford*, 100 Or App at 414; *Paul M. Jordan*, 49 Van Natta 2094 (1997); *Jeffrey A. Kyle*, 49 Van Natta 1331 (1997).

Here, the insurer contends that it is unable to determine if claimant was in the work force because he has failed to submit documentation demonstrating his work force status.

In response, claimant submitted various documents supporting his self-employment as a owner/operator of a business including: (1) a November 24, 2000 paystub from his business; (2) an April 14, 2000 invoice for equipment; (3) a November 15, 2000 State of Oregon Notice of Tax Rate; and (4) a September 25 and 30, 2000 invoices (with payments marked) for inventory. We have previously found that self-employment may constitute regular gainful employment, and claimant need not prove a particular loss in wages to be entitled to temporary disability benefits. *Carlos C. Santibanez*, 43 Van Natta 2685 (1991), *citing International Paper v. Hubbard*, 109 Or App 452 (1991). We find that claimant's submissions demonstrate that he is engaged in gainful employment through his self-employment business. Thus, we find that he was in the work force at the time of his current worsening which requires surgery.

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

IT IS SO ORDERED.

In the Matter of the Compensation of
RONALD E. ROGERS, Claimant
WCB Case Nos. 99-09834 & 99-09831
ORDER ON REVIEW
Preston, Bunnell & Stone, Claimant Attorney
Lundeen, et al, Defense Attorney
Cobb & Woodworth, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Liberty Northwest Insurance Corporation (Liberty) requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) directed it to pay a $17,050 attorney fee granted by a prior unappealed final litigation order; (2) directed it to pay temporary disability benefits; and (3) awarded claimant an assessed attorney fee. On review, the issues are temporary disability and attorney fees. We modify in part, reverse in part, and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Prior Litigation Award of Attorney Fees

A prior ALJ's order set aside both Liberty's and CIGNA Insurance Company's (CIGNA's) denials of compensability for claimant's right shoulder condition. The prior ALJ also found CIGNA responsible for claimant's compensable right shoulder condition and awarded a $17,050 fee to claimant's attorney, payable by CIGNA. (Ex. 1-15). The portions of the prior ALJ's order that set aside the compensability denials of Liberty and CIGNA, assigned responsibility to CIGNA, and awarded the $17,050 fee were in separate sections of the order.[1] CIGNA requested Board review, raising all issues decided adversely to it.[2]

On October 7, 1996, we issued our Order on Review reversing the prior ALJ's assessment of a penalty against Liberty, awarding claimant's attorney a fee of $1,000 for services on review (payable by CIGNA), and affirming the remainder of the ALJ's order. *Ronald E. Rogers*, 48 Van Natta 2107 (1996). On our own motion, the Order on Review was abated on October 11, 1996. (Ex. 3). Our Order on Reconsideration was issued on March 12, 1997, affirming, in its entirety, the prior ALJ's order and awarding claimant's attorney a fee of $1,000 for services on review (payable by CIGNA). *Ronald E. Rogers*, 49 Van Natta 267 (1997).

On November 14, 1998, the Court of Appeals remanded the case for reconsideration. (Ex. 5). *Reynolds Metals v. Rogers*, 157 Or App 147 (1998). On June 14, 1999, we issued our Order on Remand. *Ronald E. Rogers*, 51 Van Natta 937 (1999). We found Liberty responsible for claimant's compensable shoulder condition. Our order expressly stated as follows:

> "The ALJ's order dated September 29, 1995 is reversed in part, modified in part, and affirmed in part. That portion of the ALJ's order which set aside Cigna's June 17, 1994 denial of responsibility is reversed. Cigna's denial is reinstated and upheld. That portion of the ALJ's order which upheld that portion of Liberty Northwest Insurance

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[1] With regard to WCB Case 93-11544 (CIGNA's denials) the prior ALJ's order reads as follows: "IN WCB CASE NO. 93-11544, IT IS HEREBY ORDERED that the denial letters dated September 22, 1993, and June 27, 1994, are set aside. The claim is remanded to CIGNA for acceptance and processing in accordance with Oregon Workers' Compensation Law. In addition to compensation benefits, the insurer shall pay assessed fees of $17,050 to claimant's attorneys for services related to obtaining an award of compensation benefits. In addition to compensation benefits, the insurer shall also pay assessed fees of $1,000 to claimant's attorneys for services related to the assignment of responsibility." (Ex. 1-15).

[2] CIGNA did not specifically challenge the amount of the assessed fee. In challenging the prior ALJ's determination that the claim was compensable and that CIGNA was responsible, we acknowledge that it necessarily challenged the ALJ's determination that it should pay an assessed fee at all.

Corporation's January 30, 1995 denial which denied responsibility is reversed. Liberty Northwest's denial is set aside and the claim is remanded to Liberty Northwest for processing according to law. That portion of the ALJ's order which awarded an $1,000 assessed attorney fee, payable by Cigna, for services related to the assignment of responsibility is modified to be payable by Liberty Northwest. The remainder of the ALJ's order is affirmed." (Ex. 8-4).

On July 12, 1999, we issued our Second Order on Remand, in which we republished our June 14, 1999 Order on Remand. (Ex. 9-1).

On December 13, 1999, claimant requested a hearing. At that hearing, he specifically sought payment of the attorney fees and penalties awarded in the prior ALJ's order.[3] (Tr. 4).

The ALJ recognized that the Board's prior order setting aside Liberty's denial and finding Liberty, rather that CIGNA, responsible for claimant's compensable shoulder condition did not expressly reverse the prior ALJ's order that directed CIGNA to pay claimant's attorney an assessed fee of $17,050. Nonetheless, concluding that the Board had intended the assessed attorney fee to be paid by the responsible carrier, the ALJ directed Liberty to pay the $17,050 assessed fee.

Liberty contends that, because our prior order did not specifically reverse that portion of the prior ALJ's order directing CIGNA to pay the assessed fee, the assessed fee is payable by CIGNA. In contrast, CIGNA contends that, because Liberty was ultimately determined to be responsible for claimants compensable condition, Liberty is also responsible for the $17,050 assessed fee.[4] We agree with Liberty.

The Board's Order on Remand neither expressly addressed nor reversed the prior ALJ's award of a $17,050 assessed attorney fee payable by CIGNA. Instead, after reversing the prior ALJ's order on the responsibility issue, the order specifically affirmed the remainder of the ALJ's order. Inasmuch as claimant's attorney fee payable by CIGNA was a remaining portion of that ALJ's order, we conclude that the prior ALJ's award of a $17,050 attorney fee payable by CIGNA was affirmed, not reversed or modified. The Board's June 14, 1999 Order on Remand, as republished on July 14, 1999 by the Second Order on Remand, has not been appealed and has become final.

While the prior Board order may well have been in error, CIGNA's remedy was to either seek reconsideration of that order, or petition the court for judicial review. Because the Board's June 14, 1999 Order on Remand, as republished on July 14, 1999 by the Second Order on Remand, has become final, neither the ALJ nor this Board has authority to alter it. Consequently, CIGNA, not Liberty, is responsible for the payment of the $17,050 attorney fee award. *See William A. Burt*, 46 Van Natta 270 (1994) (Board's order directing a non-responsible carrier to pay an assessed attorney could not be collaterally challenged after it had become final).

Temporary Disability, Penalties, and Assessed Attorney Fee

Finding that Liberty's claim processing had been unreasonable, the prior ALJ's order directed Liberty to pay an assessed penalty of 25 percent of all benefits for medical services and disability due through the date of hearing. That portion of the prior ALJ's order was also affirmed by the Board's June 14, 1999 Order on Remand, as republished on July 14, 1999 by the Second Order on Remand. Liberty has not paid that penalty. (Tr. 25).

To enforce the prior ALJ's order, the ALJ in this case directed Liberty to pay: (1) temporary disability from September 18, 1993 to June 12, 1995 (the date of the continued hearing in the prior proceeding); (2) a 25 percent penalty on the amount of benefits due on February 24, 1995 (the date of the initial hearing in the prior proceedings); and (3) an assessed fee of $3,000, pursuant to ORS 656.382(1). (O&O, 5).

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[3] Claimant's counsel expressly stated: "We're not here on any other issues." (Tr. 5).

[4] CIGNA argues that because the prior ALJ's order states the "insurer shall pay assessed fees of $17,050," we should interpret it to mean "the responsible insurer shall pay assessed fees of $17,050." (Ex. 1-15). We reject that argument because: (1) that portion of the order specifically references the case number dealing only with CIGNA's denials; and (2) that portion of the order specifically remanded the claim to CIGNA in the sentence immediately preceding the one that delineated what the "insurer" was to pay.

Liberty contests the ALJ's temporary disability award and the assessed attorney fee under ORS 656.382(1), asserting that neither of those issues were raised at the hearing. Because the hearing issues were specifically limited to the enforcement of the prior ALJ's award of penalties and the aforementioned $17,050 attorney fee, we agree with Liberty.

Claimant argues that the temporary disability issue was necessarily included as part of his efforts to enforce the prior ALJ's order. We disagree on two grounds: (1) claimant specifically limited the hearing issues to the prior ALJ's award of penalties and the $17,050 attorney fee (Tr. 4, 5); and (2) the temporary disability issue and the assessed attorney fee issues were raised for the first time post-hearing.[5]

We have consistently held that we will not consider issues raised for the first time post-hearing. *See Lawrence E. Millsap*, 47 Van Natta 2112 (1995) (Board refused to consider issue raised for first time in closing argument); *Larry L. Schutte*, 45 Van Natta 2085 (1993). Because the temporary disability issue and the ORS 656.382(1) attorney fee issue were not raised until after the hearing, they were not within the ALJ's scope of review. Accordingly, we reverse those portions of the ALJ's order.[6]

ORDER

The ALJ's order dated April 20, 2000 is modified in part, reversed in part, and affirmed in part. Cigna, not Liberty, is responsible for the prior ALJ's $17,050 assessed attorney fee. In lieu of the ALJ's penalty assessment, Liberty is directed to pay claimant the penalty assessed by the prior ALJ's September 29, 1995 order. The ALJ's temporary disability award and attorney fee award under ORS 656.382(1) are reversed. The remainder of the ALJ's order is affirmed.

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[5] In a March 13, 2000 "post-hearing" letter, claimant's counsel stated: "In case it was not entirely clear at hearing, claimant remains entitled to temporary disability benefits that became payable by Liberty following the Board's Order on Remand. Should you order Liberty to pay the compensation due pursuant to that order, for the period between June 10, 1993 and June 12, 1995, claimant also seeks carrier-paid attorney fee pursuant to ORS 656.382(1) for counsel's services in securing that compensation."

[6] In reversing the portion of the ALJ's order that awarded temporary disability, we do not imply that claimant is not entitled to such temporary disability. Instead, we reverse the ALJ's order because that issue was not properly within his scope of review. Liberty remains responsible for compliance with the prior ALJ's order (as affirmed the Board's prior orders) which necessarily included the compensation due and payable as a result of those decisions, as well as the penalty assessed by the prior ALJ's order. "Due and payable" necessarily includes the consideration of such factors as time loss authorizations, as well as any wages or other benefits received during the period in question.

Board Member Phillips Polich specially concurring:

I agree with the conclusion that we do not have jurisdiction to revisit and change the result of the Board's prior order, *i.e.*, that CIGNA, rather than Liberty, is responsible for the payment of the $17,050 assessed attorney fee. I write separately to express my concern that we are unable to correct the unjust result of an inartfully drafted order.

The ALJ correctly concluded that Board did not intend for CIGNA, (a carrier the Board determined was not responsible for the payment of benefits resulting from any portion of claimant's compensable right shoulder condition) to be saddled with the payment of claimant's attorney fees. Nevertheless, through imprecise wording, the prior order inadvertently failed to place the burden of paying claimant's attorney fee on Liberty. Now, because the prior order has become final, we are powerless to correct the unintended and unjust result.

While today's Order is legally correct, it does not purport to do substantial justice. If we had jurisdiction to revisit this matter, we would change the Board's prior order to reflect what was intended, *i.e.*, that Liberty should pay claimant's attorney fee.

In the Matter of the Compensation of
HAROLD G. OLDS, Claimant
WCB Case No. 00-02084
ORDER ON RECONSIDERATION
Dale C. Johnson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests reconsideration of those portions of our November 17, 2000 Order on Review that affirmed an Administrative Law Judge's (ALJ's) order that: (1) denied claimant's motion to remand; and (2) declined to award temporary disability benefits beyond April 3, 2000. Specifically, claimant argues that we erred in failing to remand this case to the ALJ to consider evidence not admitted at hearing. Additionally, claimant argues that there is no evidence in the record to support the ALJ's finding that claimant was offered a light duty job of 6 1\2 hours per day, at a rate of $8 per hour.

With respect to the remand issue, claimant disagrees with our contention that there has been no showing that the evidence offered on review was unobtainable with due diligence at the time of the hearing. Claimant argues that it should be clear that the workers' compensation hearing before the ALJ was held and the record closed prior to the Employment Department decision.

On review, however, two of the documents submitted by claimant were in existence prior to the workers' compensation hearing, and we find no explanation for claimant's failure to submit them at the time of hearing. With regard to claimant's submission of the Employment Department decision that issued after the hearing, we apply the same reasoning expressed by the ALJ (as affirmed and adopted in our Order on Review) regarding the prior Administrative Decision by that same agency. Specifically, we do not find the document to be relevant and, alternatively, even if the document was to be admitted, it would not change the outcome of this case. *See, e.g., Kenneth A. Meyer*, 50 Van Natta 2302 (1998). Accordingly, we continue to conclude that the proffered evidence does not meet the criteria for remand to the ALJ.

Claimant also argues that the ALJ misconstrued Exhibit 5, an offer of employment. However, after reviewing the exhibit and the ALJ's order, we agree with the ALJs interpretation of that exhibit.

We withdraw our November 17, 2000 order for reconsideration. On reconsideration, as supplemented herein, we adhere to and republish our November 17, 2000 order. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
LARRY W. KEITH, Claimant
Own Motion No. 00-0257M
OWN MOTION ORDER
Cole, Cary, et al, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

The self-insured employer submitted claimant's request for temporary disability compensation for his 1971 cervical claim. Claimant's aggravation rights on that claimant expired on June 22, 1977. The employer opposed reopening on the following grounds: (1) no surgery or hospitalization has been requested; and (2) claimant was not in the work force at the time of disability.

However, a December 3, 1999 Opinion and Order reversed the employer's denial of claimant's current cervical condition and need for treatment, which we subsequently affirmed. Following said orders, claimant requested that the employer process the "new condition" claim. Claimant also filed a request for hearing with the Hearings Division and raised the issue of "[f]ailure to process [a] new condition." (WCB Case No. 00-05783).

On August 24, 2000, we consolidated the own motion action regarding the request that we exercise our authority under ORS 656.278 to authorize temporary disability compensation under claimants 1971 cervical claim. We took this action to await resolution of litigation pending before the Hearings Division arising from claimant's contention that the employer was obligated to reopen and process his current condition under ORS 656.262(7)(c) to closure under ORS 656.268.

An Order of Dismissal issued on November 6, 2000, following claimant's withdrawal of his request for hearing. In response to the Board's inquiry, claimant announced that the employer had issued an "updated Notice of Acceptance" for the new cervical condition and a Notice of Closure, which is presently on reconsideration before the Director. As a result, claimant asserts that his new condition claim is not within our Own Motion jurisdiction pursuant to ORS 656.278 and requests that we dismiss the request for own motion relief. Claimant's statements are unrebutted.

After of the review of the record, we agree with claimant that the employer has reopened the claim and processed his current cervical degenerative disc disease under ORS 656.262(7)(c) to closure under ORS 656.268. In light of such circumstances, we decline to exercise our Own Motion authority to reopen his 1971 claim under ORS 656.278. *See Craig J. Prince*, 52 Van Natta 1658 (2000).

Accordingly, claimant's request for own motion relief is denied. The parties' rights of appeal shall begin to run from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
JAMES KING, JR., Claimant
WCB Case No. 99-09878
ORDER ON REVIEW
Bischoff, Strooband & Ousey, Claimant Attorney
Hornecker, Cowling, et al, Defense Attorney

Reviewed by Board Members Biehl, Bock, and Meyers.

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

We adopt and affirm the ALJ's order with the following change.[1] On page 4, we change the fourth paragraph of the Ultimate Findings of Fact to read: "Claimant's September 2, 1999 work event was a material cause of his disability and need for treatment for the right medial meniscus tear."

Claimant's attorney is entitled to an assessed fee for services on review regarding the right medial meniscus tear. 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 right medial meniscus tear 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 August 9, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,200, payable by the employer.

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[1] We modify the ALJ's order to note that Exhibit 13A was also admitted in evidence. (Tr. 23).

Board Member Meyers dissenting.

The majority adopts and affirms the portion of the ALJ's order that found claimant probably had a torn medial meniscus, which was caused, in material part, by the September 2, 1999 work injury. Because I do not agree with the standard of proof or the majority's interpretation of the medical evidence, I respectfully dissent.

Claimant had a serious right knee injury in August 1997 and an MRI showed, among other things, a degenerative signal in the posterior horn and posterior body of the medial meniscus. (Ex. 2). Dr. Webb noted that claimant had some thinning of the medial cartilage space and might require surgery for possible meniscectomy versus repair. (Ex. 3).

The issue in this case is compensability of claimant's September 2, 1999 right knee injury. I agree with the employer that the medical evidence does not persuasively establish the existence of a right knee medial meniscus tear, within reasonable medical probability. To the contrary, the medical reports show only a possibility that claimant has a medial meniscus tear. Dr. Hofstetter interpreted claimant's October 1999 right knee MRI as showing some "slight fraying involving the undersurface of the posterior horn of the medial meniscus." (Ex. 8). He noted that the signal characteristics were "more consistent with degenerative type change rather than the presence of an acute tear." (*Id.*)

Dr. Staver said the recent MRI showed a "suggestion of degenerative tear of the medial meniscus." (Ex. 14-5). It was unclear to him whether claimant had a meniscal tear that needed treatment, although he agreed that claimant needed surgery for a torn anterior cruciate ligament. (Ex. 14-7). Although Dr. Weinman said claimant had a medial meniscus tear, he noted that was "not confirmed absolutely by MRI scanning." (Ex. 22).

In a March 31, 2000 report, Dr. Galt explained:

"There is a question of a *possible* medial meniscal tear that has not been confirmed either by MRI scan or surgery; but, I believe that there is a strong *possibility* that [claimant] does have a medial meniscal tear." (Ex. 23; emphasis supplied).

I believe the medical evidence shows, at most, a possibility that claimant has a medial meniscal tear, which is not sufficient to sustain his burden of proof. *See Gormley v. SAIF*, 52 Or App 1055 (1981) (opinions in terms of medical possibility rather than medical probability are not persuasive); *George H. Gale*, 52 Van Natta 339 (2000); *Connie J. Barrs*, 51 Van Natta 1338, *on recon* 51 Van Natta 1500 (1999).

Even if I assume that claimant does have a medial meniscal tear, the ALJ and the majority erroneously applied a material contributing cause standard of proof. As discussed above, claimant's August 1997 MRI showed a degenerative signal in the posterior horn and posterior body of the medial meniscus and Dr. Webb felt that claimant might require surgery for "possible meniscectomy versus repair." (Exs. 2, 3). Thus, claimant clearly had a preexisting degenerative condition in his right medial meniscus. I believe the medical evidence is sufficient to establish that the preexisting degenerative knee condition combined with the September 1999 work injury. *See Luckhurst v. Bank of America*, 167 Or App 11 (2000); *Multifoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999).

Furthermore, I agree with the employer that the opinions of Drs. Galt and Weinman are not persuasive because they do not explain why the meniscal tear is due to the 1999 injury when the 1997 evidence showed a degenerative condition, particularly since Dr. Hofstetter interpreted the recent MRI as showing the medial meniscus was "more consistent with degenerative type change rather than the presence of an acute tear." (Ex. 8). *See SAIF v. Strubel*, 161 Or App 516, 521 (1999) (medical expert must take into account all contributing factors in order to determine their relative weight); *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 321 Or 416 (1995).

Finally, if the employer accepts the torn meniscus condition and no such tear is evident during subsequent surgery, the employer will have accepted a condition that does not exist.[1] Even if the material contributing cause standard applies, the employer should not be required to accept a medial meniscus tear based on this insufficient medical record. *See* ORS 656.005(7)(a) (requiring medical services, disability or death in order for an injury to be "compensable").

For the foregoing reasons, I dissent.

[1] This matter could have been clarified with a diagnostic arthroscopy.

In the Matter of the Compensation of
WILLIAM M. LIGHTNER, Claimant
WCB Case No. C002753
ORDER OF ABATEMENT
Starr & Vinson, Claimant Attorney
Gary Wallmark (Saif), Defense Attorney

Reviewed by Board Member Haynes and Phillips Polich.

On November 29, 2000, we approved the parties' claim disposition agreement (CDA) in the above-captioned matter. On December 6, 2000, on behalf of the parties, claimant asked that we abate our November 29, 2000 order.

Because the parties motion was filed within 10 days of our November 29, 2000 approval order, the request is granted and our approval is withdrawn. *See* ORS 438-009-0035(1) and (2). On receipt of the parties' submission of further information regarding their request, we shall proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
VERNON T. SMITH, Deceased, Claimant
WCB Case No. 99-00865
ORDER ON REVIEW
Kryger, et al, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Meyers, Bock, and Biehl.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Kekauoha's order that set aside its denial of survivor's benefits. On review, the issue is entitlement to survivor's benefits. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

We begin by briefly summarizing the facts.

Claimant (Willa Allen) and the deceased worker, Smith, lived together from at least 1983 until Smiths death in an industrial accident in 1998. Both claimant and Smith had been married previously to other people and divorced. Claimant's divorce became final in 1985. Smith paid alimony to his ex-wife and claimant received house payments from her ex-husband.

In 1986, Chris, a 6-year old, who was the son of claimant's cousin, began living with claimant and Smith. The State of Oregon conducted home studies. Smith understated his contribution to the household. In actuality, Smith was the primary wage earner and paid most of the households bills.

Claimant adopted Chris in 1987. Smith did not adopt Chris. In the adoptive home study, claimant and Smith indicated that they were a couple in a long-term relationship and that they would have married but for financial concerns. Smith indicated that he considered himself a father figure to Chris and that he was committed to raising Chris.

Chris lived in the home continuously thereafter and Smith discharged the duties of a parent toward Chris and supported him financially. The record establishes that Smith stood *in loco parentis*[1] to Chris.

In September 1998, Smith was killed in an industrial accident. The insurer accepted the claim for Smith's fatal injury, but denied claimant's claim for survivor's benefits under ORS 656.226. Claimant appealed the denial.

The ALJ held that claimant was entitled to survivor's benefits pursuant to ORS 656.226. The ALJ reasoned that claimant and Smith had cohabited in Oregon for more than a year prior to Smith's death. In addition, the ALJ found that Chris, claimant's adopted son, satisfied the statutory requirement that there be a child "living as a result of the relation." In this regard, the ALJ reasoned that Smith stood in *loco parentis* to Chris, claimant's adopted son, and that Chris therefore met the definition of a child contained in ORS 656.005(5). On this basis, the ALJ found that claimant was entitled to survivor's benefits pursuant to ORS 656.226.

On Board review, the insurer argues that claimant does not qualify for benefits under the statute because there are no "children living as a result" of her relationship with the decedent.

ORS 656.226 provides:

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[1] Under ORS 656.005(5), a "child" includes a "child toward whom the worker stands in loco parentis." A person is said to stand *in loco parentis* when the obligations of parenthood have been voluntarily assumed and discharged. *Linda V. Greenslitt, Deceased*, 48 Van Natta 24 (1996).

> "In case an unmarried man and an unmarried woman have cohabited in this state as husband and wife for over one year prior to the date of an accidental injury received by one or the other as a subject worker, and children are living as a result of that relation, the surviving cohabitant and the children are entitled to compensation under this chapter the same as if the man and woman had been legally married."

Pursuant to ORS 656.005(5), a "child" includes a child toward whom the worker stands in *loco parentis*.

The insurer argues that the requirement of ORS 656.226 that "children are living as a result of that relation" means that survivors benefits are restricted to cohabitants who had biological (*i.e.*, birth) children with the deceased worker. Claimant argues that Chris is a child of the relationship because Smith stood *in loco parentis* to Chris and voluntarily assumed the duties of parenting Chris.

In construing ORS 656.226,[2] our task is to discern legislative intent. *See* ORS 174.020. We begin by examining the text and context of the statute. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610 (1993). The context includes other provisions of the same statute and other related statutes. *Id.* at 611. If the legislature's intent is clear from those inquiries, further inquiry is unnecessary. *Id.*

There is no case directly on point. However, the phrase, "and children are living as a result of that relation" has been addressed twice by the Court of Appeals. In *Kempf v. SAIF*, 34 Or App 877 (1978), the claimant (a cohabitant of a deceased worker) argued that the statute was unconstitutional because it distinguished between surviving partners with children and those without children. The court held that the statute was not unconstitutional. It reasoned:

> "The legislature was entitled to reason that the surviving partner of a substantial relationship was more likely to be financially dependent than the surviving partner of a casual relationship. The legislature was entitled to distinguish the substantial from the casual by way of the two-pronged test of ORS 656.226: cohabitation for more than one year (which claimant does not question) plus the *birth of a child or children.*" (Emphasis added).

Thus, the court, in concluding that the statute was not unconstitutional, interpreted the second prong of the statute as requiring the birth of a child or children. The second prong of the statute was also addressed in *Thomas v. SAIF*, 8 Or App 414 (1972).

In *Thomas*, the claimant, while cohabiting with the worker, gave birth to a child who was released for adoption in California prior to the worker's death. The court found that the adoption proceeding terminated all the couple's responsibilities for, duties toward, or rights over, the child under the laws of California. Thus, the court concluded that the claimant did not have "children * * * living as a result of that relation" as required by ORS 656.226.[3]

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[2] In *Cottrell v. EBI Companies*, 304 Or 187 (1987), the Supreme Court noted that no legislative history of ORS 656.226 survives from the statutes original enactment in 1927.

[3] Claimant argues that the holdings of *Kempf* and *Thomas* do not support a conclusion that ORS 656.226 restricts benefits to cohabitants who have birth children with deceased workers. In making this argument, claimant asserts that this interpretation of the statute would completely ignore the multiple definitions of child in ORS 656.005(5). First, we note that the definition of child applies to ORS 656.226, but also to ORS 656.204, the death statute. The broader definition of child also applies when determining whether a child of the worker is entitled to death benefits. ORS 656.204(4)(a) provides for benefits for a child of the worker under 18 where the worker leaves no spouse. Thus, this statute arguably provides an alternate route for a child of the worker to receive benefits independent of ORS 656.226. Secondly, ORS 656.226 does not merely state that cohabitants of deceased workers with children shall receive benefits. As discussed in this order, the statute limits benefits to those situations where children are living as a result of the cohabitation relationship. Thus, in addition to a child, the child must be living as a result of the relationship. Claimant also argues that because the statute refers to children rather than child, a strict reading of the statute would require that more than one child be born to qualify for benefits under the statute. This argument lacks merit. ORS 174.110 allows the singular number to include the plural and the plural number the singular. Therefore, the statutes reference to children includes a single child.

In the present case, the issue is whether the child, Chris, is a child "living as a result of" the relationship between claimant and Smith, the deceased worker. We conclude, based on the text and context of the statute, that he is not a child "living as a result of" the relationship between claimant and Smith. Although ORS 656.005(5) defines "child" broadly to include a child toward whom the worker stands *in loco parentis*, ORS 656.226 adds a requirement in addition to the existence of a child when a cohabitant seeks survivor's benefits. It requires that the child be "living as a result of" the relationship between the cohabitant and the worker. Based on the plain meaning of the phrase, we conclude that the statute requires that there be a living, biological child or children of the worker and the cohabitant.

Here, the child at issue, Chris, was not "living as a result of" the relationship between claimant and Smith. Based on the text of the statute and the prior court cases interpreting the statute, we are persuaded that the legislature intended to limit benefits under ORS 656.226 to cohabitants who had birth children with the deceased worker. To interpret the statute otherwise would be to ignore the phrase "living as a result of the relation" and render it meaningless. *See* ORS 174.010 (in interpreting a statute, court is not "to omit what has been inserted").

We find this reading of the statute to be consistent with the statutory context of ORS 656.226. In this regard, ORS 656.204(3)(a) provides for a lump sum final payment to the surviving spouse of a deceased worker upon remarriage. Subsection (b) of that statute provides that if, after the date of the workers death, the surviving spouse cohabits with another person for an aggregate period of more than one year and a "child has resulted from the relationship" the surviving spouse shall be paid a lump sum as final payment of the claim. We find that this statute supports a conclusion that the legislature in ORS 656.226, as in ORS 656.204(3)(b), equated cohabitation for a year and the birth of a child as evidencing a relationship that is equivalent to a marital relationship.

The ALJ relied, in part, on *Mell v. W.C. Ranch, Inc.*, 108 Or App 105 (1991), to conclude that Chris was a "child" living as a result of the relationship between claimant and Smith. In *Mell*, the worker began living with the claimant and her daughter Katie while still married to another woman. More than a year prior to his fatal injury, he was divorced. The deceased and the claimant lived together until the decedent's accident and the claimant gave birth to their child, Ashley, after the worker's death.

Citing ORS 656.204(4) for the proposition that a minor child of a deceased worker was entitled to workers' compensation benefits, the court concluded that Katie was not a "child" under the definition of ORS 656.005(5) because the worker did not stand *in loco parentis* to her. On this basis, the court concluded that Katie was not entitled to benefits.

The insurer argues that *Mell* is distinguishable because there was a child "living as a result of" the relationship between the deceased and the claimant. We agree that *Mell* is distinguishable. In *Mell*, there was a child born to the worker and the claimant (Ashley). In addition, the court in *Mell* did not address or interpret the language in ORS 656.226 that is at issue in this case.

For the reasons given above, we conclude that claimant does not qualify for benefits under ORS 656.226. Based on the statutes text, the legislature intended to limit benefits under ORS 656.226 to those who cohabited in Oregon with the deceased worker for more than a year prior to the injury and who have living, biological children with the deceased worker.

ORDER

The ALJ's order dated May 11, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's award of an attorney fee is also reversed.

Board Member Biehl dissenting.

I disagree with the majority's analysis of ORS 656.226 and agree with the ALJ held that claimant is entitled to survivor's benefits pursuant to ORS 656.226. At hearing, the insurer argued that claimant does not qualify for benefits under the statute because there are no "children living as a result" of her relationship with the decedent. The ALJ found that Chris, claimant's adopted son, satisfied the statutory requirement that there be a child "living as a result of the relation." The ALJ reasoned that Smith stood *in loco parentis* to Chris, claimant's adopted son, and that Chris therefore met the definition of a child contained in ORS 656.005(5). On this basis, the ALJ found that claimant was entitled to survivor's benefits pursuant to ORS 656.226. I agree.

ORS 656.226 provides:

> "In case an unmarried man and an unmarried woman have cohabited in this state as husband and wife for over one year prior to the date of an accidental injury received by one or the other as a subject worker, and children are living as a result of that relation, the surviving cohabitant and the children are entitled to compensation under this chapter the same as if the man and woman had been legally married."

Pursuant to ORS 656.005(5), a "child" includes a posthumous child, a child legally adopted prior to the injury , a child toward whom the worker stands in *loco parentis*, an illegitimate child and, under certain circumstances, a stepchild.

The insurer argues that the requirement of ORS 656.226 that "children are living as a result of that relation" means that survivor's benefits are restricted to cohabitants who had biological (*i.e.*, birth) children with the deceased worker. Claimant argues that Chris is a child of the relationship because Smith stood *in loco parentis* to Chris and voluntarily assumed the duties of parenting Chris. I agree. The record contains persuasive evidence that Smith stood *in loco parentis* to Chris and supported him financially. Chris was legally Smith's "child" as that term is defined in ORS 656.005(5). I conclude that the record establishes that Chris was a child of the relationship between claimant and Smith.

In *Mell v. W.C. Ranch, Inc.*, 108 Or App 105 (1991), the court looked to whether a worker stood *in loco parentis* to a child in order to determine whether the child was entitled to benefits. The court concluded that Katie, who was the daughter of the claimant (the deceased worker's cohabitant), did not qualify for benefits because the worker did not stand *in loco parentis* to her. Although Katie was not entitled to benefits, the court concluded that Katie's mother qualified for benefits under ORS 656.226. The insurer argues that *Mell* is distinguishable because in addition to Katie, the worker and the claimant had a natural child, Ashley, who was born after the worker's death.

According to the insurer, the only reason the court reached the issue of whether the worker stood *in loco parentis* to Katie in *Mell* was that the couple already had a birth child so that the requirement of a child living as a result of the relationship was already met. I disagree. *Mell* suggests that a child toward whom the worker stands *in loco parentis* qualifies as a child of the relationship for the purposes of ORS 656.226. In addition, to interpret the statutes otherwise would ignore the multiple definitions of "child" contained in ORS 656.005(5). Accordingly, I would affirm the ALJ's order finding that claimant is entitled to benefits under ORS 656.226.

In the Matter of the Compensation of
CHARLES M. HANEY, Claimant
Own Motion No. 98-0360M
OWN MOTION ORDER OF ABATEMENT
Saif Legal Department, Defense Attorney

Claimant requests reconsideration of our August 15, 2000 Own Motion Order, as reconsidered November 14, 2000, that affirmed the SAIF Corporation's February 1, 2000 Notice of Closure in its entirety.

In order to allow sufficient time to consider the motion for reconsideration, we abate our order. Before proceeding with its review, the Board implements the following briefing schedule. SAIF's response to claimant's request, including any supporting documents, must be filed within 14 days from the date of this letter. Claimant's reply, including any further supporting documents, must be filed within 14 days from the date of mailing of SAIF's. (Claimant is reminded to send a copy of any document filed with the Board to the carrier.) Thereafter, the matter shall be taken under advisement.

IT IS SO ORDERED.

In the Matter of the Compensation of
BRAD J. NORMAN, Claimant
WCB Case No. 99-09078
ORDER ON REVIEW
Dennis O'Malley, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Fulsher's order that upheld the self-insured employer's denial of claimant's injury claim for a left shoulder condition. On review, the issue is compensability.

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

The second sentence of the third paragraph of the section entitled "Conclusions of Law and Opinion" is modified to indicate that the claim is properly analyzed as an injury because claimant's left shoulder *symptoms* (rather than his condition) arose over a discrete, identifiable period of time.

In addition, we agree with the ALJ that the medical evidence supporting the claim is insufficient to carry claimant's burden of proof because it is inadequately reasoned.

The medical experts agree that claimant's recent left shoulder problems involve his work activities, shoulder anatomy, and preexisting degeneration acromioclavicular joint prominence and/or tendinitis, probably due to both aging and "wear and tear"). (*See* Exs. 19, 22, 28, 29). Therefore, claimant bears the burden of proving that his work contributed more to his disability or need for treatment for his "combined condition" than did all other causes.

Dr. Adams described claimant's work as "aggravating" and Dr. Tilson opined that claimant's work caused his need for treatment primarily because claimant said it did.[1] However, neither Dr. Adams nor Dr. Tilson explained why claimant's work activities contributed more to his disability or need for treatment for his condition, than did the identified nonwork related contributors. Under these circumstances, absent adequately reasoned expert evidence establishing major causation, we agree that claimant has not carried his burden of proof under ORS 656.005(7)(a)(B).

ORDER

The ALJ's order dated June 13, 2000 is affirmed.

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[1] Dr. Tilson also stated that claimant's explanation "made sense" to him, (Ex. 29-45), and he would reach the same conclusion if claimant's degenerative changes were more pronounced, because many people have similar or worse changes without pain. (*Id.* at 50-51).

In the Matter of the Compensation of
MANFRED M. SMETANA, Claimant
WCB Case No. 00-03196
ORDER ON REVIEW
Jerry Keene, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Marshall's order that upheld the self-insured employer's denial of claimant's back injury claim. On review, the issue is compensability.

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

We do not find that claimant did not seek medical treatment until March 29, 2000 because he did not think he had insurance coverage. Also, we do not adopt the last three sentences of the second paragraph on page 3.

In addition, we offer the following supplementation regarding the medical evidence.[1]

The medical evidence indicates that claimant's current back condition is a "combined condition," involving preexisting degeneration and the claimed injury. Therefore, claimant is subject to the "major contributing cause" standard of proof under ORS 656.005(7)(a)(B). The statute requires evaluation of the relative contribution of different causes, including the precipitating cause, to determine which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 321 Or 416 (1995). Whether a preexisting condition or an on-the-job injury is the major contributing cause of a worker's need for medical treatment or disability for his "combined condition" is a complex medical question that requires expert evidence for its resolution. *See Uris v. Compensation Department*, 247 Or 420, 424-26 (1967).

Dr. Bert provides the medical evidence supporting this claim. (Exs. 20, 23A, 23B). Although Dr. Bert opined that claimant's "fall" at work was "the major aggravating factor" of his combined back condition, he did not explain why he believes that the work incident contributed more than the preexisting condition that he identified. (*See* Ex. 23A-2). Under these circumstances, Dr. Bert's opinion is insufficient to carry claimant's burden of proof. *See Jonna M. Moore*, 52 Van Natta 1984 (2000). Therefore, we would reach the same result even if claimant provided Dr. Bert with an accurate history regarding events on March 6, 2000 and thereafter.

ORDER

The ALJ's order dated August 14, 2000 is affirmed.

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[1] For purposes of evaluating the medical evidence, we assume, but do not decide, that claimants reporting to Dr. Bert was reliable.

In the Matter of the Compensation of
JOSEPH M. ARDITO, Claimant
WCB Case No. 99-08358
ORDER ON REVIEW
Steven M. Schoenfeld, Claimant Attorney
Steven T. Maher, Defense Attorney

Reviewed by Board Members Biehl, Bock, and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Kekauoha's order that: (1) awarded claimant additional temporary total disability benefits from October 5, 1999 to January 5, 2000; and (2) awarded claimant a penalty for an allegedly unreasonable resistance to the payment of compensation. On review, the issues are temporary disability and penalties. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Finding that the insurer had not strictly complied with the requirements for unilateral termination of temporary disability, the ALJ awarded claimant temporary disability from October 5, 1999 to January 5, 2000. The ALJ also found that the insurer did not have a legitimate doubt as to its obligation to pay temporary disability after receiving Dr. Puziss' report of January 14, 2000, and awarded a penalty based on the unpaid compensation. We agree with the ALJ's determination to award additional temporary disability, but reverse the penalty award.

Temporary disability

An insurer may terminate temporary disability benefits when "[t]he attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker, and the worker fails to begin such employment." ORS 656.268(3)(c). Strict compliance with the terms of the statute, and its accompanying administrative rule, OAR 436-060-0030(5), is required. *Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986). Substantial compliance with the administrative rule is not sufficient to authorize the carrier to terminate temporary disability benefits. *Fairlawn Care Center v. Douglas*, 108 Or App 698 (1991).

Here, based on photographs accurately depicting the employer's modified duty position, claimant's attending physician, Dr. Puziss, retracted his earlier approval of the position and stated that, given the severity of his knee condition, claimant could not perform the elements of the position that involved sitting on a stool. (Ex. 51). In those circumstances, we find that the attending physician has not "agree[d] the employment appears to be within the worker's capabilities." OAR 436-060-0030(5)(b). We therefore conclude that the ALJ correctly awarded temporary disability for the period in dispute.

The insurer contends that claimant cannot be awarded benefits because he was terminated on October 12, 2000 for "insubordination," citing to *Leo A. Montgomery*, 50 Van Natta 2237 (1998). We disagree. Unlike the claimant in *Montgomery*, claimant was not performing his modified duty position when he was terminated. Rather, claimant refused to perform certain duties until he could clear the position with his attending physician, Dr. Puziss. Dr. Puziss eventually declined to approve the modified position. (Ex. 51). Claimant was terminated at least in part due to his inability to perform a position later declared unacceptable by his attending physician. Claimant's termination is therefore not a barrier to his receiving temporary disability benefits. *See Peggy J. Baker*, 49 Van Natta 40 (1997).

The insurer next contends that the employer was willing to "accommodate" claimant by altering the modified duty position to meet his needs once he reported to work. However, we agree with the ALJ that the rule contemplates *medical* approval of the exact physical requirements of any proposed modified duty job, rather than "onsite" adjustment of the requirements of any given position. *See* OAR 436-060-0030(5)(b).

Penalty

A penalty may be assessed when a carrier "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 the insurer had a "legitimate doubt" as to its liability for payment of additional compensation. *Brown v. Argonaut Insurance Co.*, 93 Or App 588 (1988). The reasonableness of the carrier's refusal to pay additional temporary disability is judged in light of the circumstances existing at the time of its termination. *Eduardo O'Campo*, 48 Van Natta 432, 434 (1996).

Here, as the ALJ acknowledged, when the insurer initially terminated temporary disability benefits on October 5, 1999, its termination was supported by Dr. Puziss' approval of the modified job described in Exhibit 39. (Exs. 39, 40-2). Although Dr. Puziss later retracted that approval based on additional information about the physical requirements of the position, the insurer did not receive this information until after January 5, 2000, when it had resumed payment of temporary disability. (Ex. 51, Tr. 8).

In these circumstances, evaluating the reasonableness of the insurer's actions by all of the information available at the time of its termination of temporary disability, we conclude that a penalty is not appropriate. Accordingly, we reverse the portion of the ALJ's order that awarded a penalty on unpaid temporary disability.

Claimant's attorney is entitled to an assessed fee for services on review regarding the temporary disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the temporary disability 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 June 6, 2000 is affirmed in part and reversed in part. That portion of the ALJ's order that awarded claimant and his attorney a 25 percent penalty pursuant to ORS 656.262(11) is reversed. The remainder of the order is affirmed. For services on review, claimant's attorney is awarded $1,000, payable by the insurer.

Board Member Meyers dissenting in part.

I agree with the majority's decision to reverse the ALJ's penalty award. Because I also would have reversed the ALJ's decision to award claimant additional temporary disability, I respectfully dissent from that portion of the majoritys holding.

First, I do not believe that Dr. Puziss necessarily "retracted" his earlier approval of the modified duty position. Rather, I believe a more reasonable inference is that Dr. Puziss' January 5, 2000 letter to the insurer and his January 14, 2000 note restricting claimant from grinding drill bits at most *reinstated* claimant's authorization for time loss benefits as of those dates. (*See* Exs. 49-2, 53-2). In this regard, I believe this situation is analogous to the 14-day limitation on the retroactive authorization of temporary disability in ORS 656.262(4)(g). *See Fred Meyer v. Bundy*, 159 Or App 44, *rev dismissed* 329 Or 503 (1999). It is inequitable here to force the insurer to pay temporary disability for a period of time beginning nearly two months prior to the attending physician's new authorization.

Next, I note that during at least some of the relevant period for which he sought time loss benefits (because he allegedly could not work) claimant evidently was also representing to the Unemployment Department that he was eligible for benefits, *i.e.* that he was able to, and actively seeking, work. (Ex. 49-1). *See* ORS 657.155(1)(c).

Finally, I agree with the insurer that it is bad public policy to reward behavior such as claimant's, where the employer has done everything in its power to comply with the rules regarding return to work, including obtaining approval from the attending physician for the modified position. (Ex. 39). Despite his attending physician's approval of a modified job, and despite the employer's additional onsite efforts to accommodate claimant's restrictions, claimant simply refused to do any work when he returned to the job site on October 12, 1999. (Tr. 82, 84). Although some of the tasks claimant was asked to do were later disapproved by his attending physician, claimant himself acknowledged that he could perform other tasks that were never disapproved. (Tr. 40; Tr. II, pp. 30-31). It was only several months later that claimant's attending physician disapproved *some* of the tasks in the employer's modified duty position. (Ex. 53-2).

In light of these points, I would have reversed the ALJ's award of additional temporary disability. I respectfully dissent from that portion of the majoritys decision that declines to do so.

In the Matter of the Compensation of
VICTOR J. CERVANTES, Claimant
WCB Case No. 99-07541
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of that portion of Adminstrative Law Judge (ALJ) Peterson's order that declined to award a penalty for the self-insured employer's allegedly unreasonable claim processing. On review, the issue is penalties.

We adopt and affirm the ALJ's order, with the exception of the last paragraph on page 2 and all but the last sentence of the first paragraph on page 3. In place of the first sentence of the ALJ's "Ultimate Findings of Fact," we substitute the following: Claimant did not challenge the Order on Reconsideration's temporary disability award at hearing.

On review, claimant contends that he should receive a penalty for the employer's allegedly unreasonable refusal to pay procedural temporary disability (TTD) while the claim was in open status. We disagree.

The ALJ concluded, and we agree, that claimant was not entitled to any further temporary disability than that awarded by the November 18, 1999 Notice of Closure and affirmed by the January 31, 2000 Order on Reconsideration. Consequently, there were no "amounts then due" on which to base a penalty pursuant to ORS 656.262(11). *Spivey v. SAIF*, 79 Or App 568 (1986).[1]

ORDER

The ALJ's order dated July 26, 2000 is affirmed.

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[1] Claimant submitted a number of documents with his appellant's brief, which we consider a request for remand. These documents were provided in support of the procedural temporary disability issue that claimant abandoned in his reply brief. Therefore, in light of claimant's withdrawal of that issue and our disposition of the penalty issue, we need not address claimant's request for remand.

In the Matter of the Compensation of
DARREN D. BUCKLEY, Claimant
WCB Case No. 00-03846
ORDER ON REVIEW
Parker, Bush & Lane, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Poland's order that set aside its denial of claimant's occupational disease claim for his bilateral carpal tunnel condition. On review, the issue is compensability.

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

On review, the insurer contends that the ALJ correctly concluded that claimant had a preexisting condition. Opinion and Order, pg. 3. However, the insurer argues that it was therefore inconsistent for the ALJ to rely on Dr. Puziss, who found that claimant did not have a preexisting condition.

We agree with the ALJ's reliance on Dr. Puziss' opinion for the reasons stated in the Opinion and Order. As a result, on review, we find that the persuasive medical evidence establishes that claimant did not have a preexisting condition. (Exs. 12,13).

The insurer further contends that claimant is an unreliable historian and that his doctor did not have an accurate history. Finally, the insurer argues that Dr. Puziss' opinion is based on a temporal analysis and therefore is unpersuasive.

After reviewing Dr. Puziss' opinions, we find that he had an accurate history of claimant's work history and symptoms. (Exs. 12, 13). Furthermore, we disagree that Dr. Puziss' opinion is based solely upon a temporal analysis. While Dr. Puziss did point out that claimant's symptoms decreased following the cessation of heavy and repetitive work, Dr. Puziss also noted that claimant was young and had no preexisting conditions. (Ex. 13-3). Dr. Puziss further reported that claimant's history was negative for carpal tunnel syndrome; claimant had no major weight gain, edema problems or hypothyroidism; claimant had not participated in sports activities during the past year; and claimant had never had carpal tunnel syndrome before. (Ex. 13-2). Under the circumstances, we do not find that Dr. Puziss' opinion was based merely on a temporal analysis.

Claimant's counsel is entitled to an assessed attorney fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's counsel's services on review is $1,200, to be paid by the 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 16, 2000 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the insurer.

In the Matter of the Compensation of
SCOTT D. DORRY, Claimant
WCB Case Nos. 00-03773 & 99-06251
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Claimant requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) declined to remand claimant's facial nerve condition claim to the Director for promulgation of a temporary rule; and (2) affirmed an Order on Reconsideration that awarded no additional permanent disability beyond that which claimant had been previously awarded. On review, the issues are issue preclusion, remand, and extent of unscheduled permanent disability.[1] We affirm.

FINDINGS OF FACT

We adopt the ALJ's Findings of Fact.

CONCLUSIONS OF LAW AND OPINION

Claimant's claim for a newly accepted facial nerve condition was closed by a March 26, 1999 Notice of Closure awarding no additional permanent disability. (Ex. 29). An August 4, 1999 Order on Reconsideration affirmed the March 26, 1999 Notice of Closure and found that claimant's permanent disability was addressed by "the standards." (Ex. 30-3).

Claimant requested a hearing from the August 4, 1999 Order on Reconsideration. The issues were extent of unscheduled permanent disability and promulgation of a temporary rule. A prior ALJ set aside the August 4, 1999 Order on Reconsideration and remanded the claim to the Appellate Unit of the Workers' Compensation Division for the promulgation of a temporary rule addressing claimant's permanent disability. (WCB Case No. 99-06251).

On January 12, 2000, (within 30 days of the initial order), the prior ALJ issued an abatement order, placing the record in "open status." On the same day, the prior ALJ issued an "Interim Order Remanding to Director for Promulgation of a Temporary Rule," with directions for the parties to return to the ALJ after the Director's promulgation of the temporary rule.

On April 28, 2000, the Director issued an "Order Refusing Remand," asserting that the Hearings Division lacked authority to remand for promulgation of a temporary rule because the Director had already made an express finding that the worker's impairment was addressed by the standards. Claimant requested a hearing from the "Order Refusing Remand." This request for hearing was assigned WCB Case Number 00-03733 and consolidated with WCB Case No. 99-06251.

On August 25, 2000, the current ALJ issued the order which gave rise to this request for review. The ALJ declined to remand to the Department for promulgation of a temporary rule, and affirmed the August 4, 1999 Order on Reconsideration.

Issue Preclusion

Claimant contends that the ALJ should have been bound by the prior ALJ's determination that "the standards do not address the worker's disability." (December 23, 1999 order at page 3).[2] On

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[1] Pursuant to ORS 656.726(4)(h), the Department has participated in these proceedings, contending that the earlier ALJ lacked the authority to remand the claim to the Department, because the Appellate Unit had already found that claimant's permanent disability was addressed by the existing standards.

[2] Like SAIF's "issue preclusion" argument, this argument was not raised to the ALJ. In any event, we disagree with claimant's argument.

January 12, 2000, the prior ALJ abated his initial order[3], and issued an "Interim Order Remanding to Director for Promulgation of a Temporary Rule." The Interim Order repeated the finding that claimant's disability was not addressed by the standards. However, the August 4, 1999 Order on Reconsideration had expressly found that claimant's disability *was* addressed by the standards. (Ex. 30-3).

Claimant contends that the Interim Order Remanding was a "final, appealable order," and was therefore conclusive as to the issue of whether claimant's disability is addressed by the standards. We disagree.

A final order is one that disposes of a claim so that no further action is required. *Price v. SAIF*, 296 Or 311 (1984). A decision that neither denies the claim, nor allows it and fixes the amount of compensation, is not a final appealable order. *Lindamood v. SAIF*, 78 Or App 15, 18 (1986); *Leroy A. Friend*, 44 Van Natta 775 (1992).

In *Leroy A. Friend*, we held that a referee's[4] "Interim Order Remanding" to the Director for consideration of a medical arbiter report was a final order, because the claimant's entitlement to temporary and permanent disability was "impacted" by the order. 44 Van Natta at 776. However, *Friend* did not involve the issue of remand for promulgation of a temporary rule, as here, but rather the "validity" of an order on reconsideration. *Id.* at 775. Moreover, the underlying reason for remand in *Friend* was rejected in *Pacheco-Gonzalez v. SAIF*, 123 Or App 312 (1993). In *Pacheco-Gonzalez*, the court held that the referee had jurisdiction to review an appeal from an "invalid" order on reconsideration, which would be contrary to the referee's rationale in *Friend* for remanding to the Department. 123 Or App at 315. Therefore, we find *Friend* distinguishable from this case.

In *Merry E. Franklin*, 46 Van Natta 1637 (1994), we held that a prior Board remand order to the Director for consideration of adoption of a "vocational assistance" rule was not a final order. 46 Van Natta at 1637. We reasoned that the remand order neither determined the claimant's entitlement to compensation nor fixed the amount thereof. *Id.* Thus, in *Franklin*, we held that we were authorized to "reconsider" the earlier "remand" order even though more than 30 days had expired since the "remand" order issued. *Id.*

Similarly, here, the ALJ's Interim Order Remanding did not finally determine claimant's right to, or the amount of, his claim for permanent disability benefits. Rather, the ALJ expressly left the record open and directed the parties to return to the ALJ after promulgation of a temporary rule. Accordingly, we conclude that neither the prior ALJ's December 23, 1999 initial order, nor the January 12, 2000 Interim Order Remanding, were final orders which could have preclusive effect on this proceeding.

Remand to the Director

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 the promulgation of a temporary rule amending the standards to address a worker's disability. *Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538 (1993). Claimant has the burden of proving that his disability is not addressed by the standards. ORS 656.266; *Susan D. Wells*, 46 Van Natta 1127 (1994).

In *Terry Hockett*, 48 Van Natta 1297 (1996), we reversed an ALJ's order that remanded to the Director for a temporary rule for the claimant's hypersensitivity of the foot condition. We noted that, in the Order on Reconsideration, the Director had made an express finding that the worker's disability was addressed by the standards. 48 Van Natta at 1288. *See also Katie J. Opdenweyer*, 52 Van Natta 92 (2000). Similarly, here, the Department has made an express finding that claimant's disability relating to his "right facial nerve, frontal zygomatic branch" condition is addressed by the standards. (Ex. 30-3). Nevertheless, claimant contends that the standards do not address his motor loss attributable to the right facial nerve. We disagree.

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[3] The ALJ had the authority to abate his order within 30 days. Because he did so, the order did not become final. *See Geer v. SAIF*, 121 Or App 647 (1993); *Lyday v. Liberty Northwest Insurance Corp.*, 115 Or App 668, 671 (1992).

[4] Referees are now termed Administrative Law Judges. ORS 656.724(1).

We agree with the Appellate Unit and the current ALJ that claimant's impairment is addressed by the existing standards. The applicable administrative rule provides a value for "complete" motor loss on either side of the face. OAR 436-035-0390(6). Because the standard contemplates the "complete" motor loss on either or both sides of the face, by implication, any impairment of the facial nerve that is less than "complete" is addressed by the standards, but does not meet the level required for an impairment value. *See, e.g., Daniel L. Carter*, 50 Van Natta 1145 (1998) (the claimant's impairment was addressed by the existing standards because the claimant's lung volume was greater than 70 percent and therefore was in Class I (zero impairment) as opposed to a Class II impairment under OAR 436-035-0385(2)).

The medical evidence details dysfunction and motor loss of the right facial nerve, but only with respect to the upper portion of the zygomatic branch, in claimant's forehead. (Exs. 10, 18). There is no evidence that claimant's facial nerve loss is "complete" on either or both sides of the face, the threshold for impairment contemplated by the administrative rule.

Finally, we disagree with claimant's contention that remand is necessary to address his alleged impairment related to his accepted tinnitus condition. OAR 436-035-0390(7)(b) provides an impairment value for tinnitus which, by a preponderance of medical opinion, "requires job modification." The rule further provides that "[n]o additional impairment value is allowed for bilateral tinnitus." (*Id.*) There is no medical evidence that claimant's tinnitus condition has required job modification. The rule specifically states that no additional value is allowable (in the absence of such proof). The rule addresses claimant's permanent disability. Accordingly, remand for promulgation of a temporary rule is not appropriate with regard to claimant's tinnitus condition.

In sum, we are not persuaded that the standards did not address claimants disability. *See Katie J. Opdenweyer*, 52 Van Natta at 92. Remand is therefore inappropriate. (*Id.*)

Extent of Unscheduled Permanent Disability

We adopt and affirm the ALJ's order on the issue of extent of unscheduled permanent disability as related to claimant's right facial injury condition.[5]

ORDER

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

[5] In light of our conclusion that claimant is not entitled to an additional permanent disability award, it is unnecessary to address SAIF's contention that claimant is precluded from seeking an additional award.

In the Matter of the Compensation of
DONALD R. CAMP, Claimant
WCB Case Nos. 00-00497 & 99-09894
ORDER ON REVIEW
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

Claimant, *pro se*, requests review of that portion of Administrative Law Judge (ALJ) Otto's order that upheld the insurer's denial of claimant's occupational disease claim for low back osteoarthritis.[1] On review, the issue is compensability.

[1] The insurer argues that claimant's occupational disease claim is precluded. We do not address this issue because, for the reasons expressed by the ALJ, the persuasive medical evidence does not lead to a conclusion that work activities were the major contributing cause of claimant's lumbosacral osteoarthritis.

We adopt and affirm the ALJ's order entitled "Compensability of claimant's lumbar spine osteoarthritis."[2]

ORDER

The ALJ's order dated August 21, 2000 is affirmed.

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[2] It appears, from his arguments, that claimant may not understand his rights and benefits under the Workers' Compensation Law. The Workers' Compensation Board is an adjudicative body that addresses issues presented to it by disputing parties. Because of that role, the Board cannot give legal advice. Because claimant does not have an attorney, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers regarding workers' compensation matters. He may contact the Workers' Compensation Ombudsman, at (503)-378- 3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

Workers' Compensation Ombudsman
Dept. of Consumer & Business Services
350 Winter Street, NE
Salem, OR 97301

In the Matter of the Compensation of
RANDY McCUTCHEN, Claimant
WCB Case No. 00-01233
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Reinisch, et al, Defense Attorney

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

The insurer requests review of Administrative Law Judge (ALJ) Crumme's order that increased claimant's unscheduled permanent disability award for his low back condition from zero to 32 percent (102.4 degrees). In its brief, the insurer contends that the ALJ erred in excluding the reports of the medical arbiter. In his brief, claimant contends that the ALJ erred in admitting a report from an insurer-arranged examination. On review, the issues are evidence and extent of unscheduled permanent disability.

We adopt and affirm the order of the ALJ. We decline the insurer's request that we disavow our prior decision in *Ramiro Pelayo*, 52 Van Natta 363 (2000).[1]

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

ORDER

The ALJ's order dated June 12, 2000 is affirmed. For services on review, claimant's counsel is awarded an assessed attorney fee of $1,200, to be paid by the insurer.

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[1] Despite the dissent's assertions, we are not necessarily convinced that a carrier's request that the Director obtain an arbiter exam is distinguishable from the carrier directly requesting such an exam. However, because the issue is not before us, we do not need to resolve that question at this time.

Board Member Meyers dissenting.

The majority has affirmed the ALJ's decision to exclude an arbiter's exam based on a prior Board decision, *Ramiro Pelayo*, 52 Van Natta 363 (2000). In that case, the Board held that, where a claimant requests reconsideration of a notice of closure, the insurer has no statutory right to seek appointment of a medical arbiter. However, ORS 656.268(7)(b) provides that, if neither party requests a medical arbiter and the Director determines that insufficient medical information is available to determine disability, the director may refer the claim to a medical arbiter appointed by the director.

Here, the Order on Reconsideration issued on February 9, 2000. The Board's decision in *Pelayo* did not issue until March 8, 2000. Although the insurer in this case did seek to request an arbiter exam, the statute does not permit an exam on that basis. Consequently, I would conclude that the request for an arbiter in this case was effectively made by the Director, which is permissible under the statutes. Therefore, because the Director made the request, the report can be considered.

Finally, I note that, because the *Pelayo* case now controls, an insurer expressly asking the Director to request an arbiter based upon insufficient medical information, rather than contending that it has a right to make such a request on its own behalf, may avoid similar situations in the future.

In the Matter of the Compensation of
BILLY G. WHALEY, Claimant
WCB Case Nos. 99-09331, 99-09330 & 99-06048
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Lundeen, et al, Defense Attorney
William J. Blitz, Defense Attorney
Hettle & Martin, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Liberty Northwest Insurance Corporation (Liberty) (on behalf of BMI Contractors, Inc.) requests review of those portions of Administrative Law Judge (ALJ) Howell's order that: (1) set aside its denial of claimant's occupational disease claim for a right shoulder condition; and (2) upheld the denials of the same condition issued by the SAIF Corporation (on behalf of O & S Contractors and Triplett-Wellman, Incorporated). On review, the issue is responsibility.

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

The ALJ determined, based on claimant's demeanor at hearing, that claimant was not a reliable historian regarding the mechanics of a work-related fall that occurred in October 1997, while he was employed by SAIF's insured, O & S Contractors. As a result, the ALJ found persuasive (because they were not dependent on a history supplied by claimant) those medical opinions that concluded that claimant's overall work activities were the major contributing cause of his current right shoulder condition. Consequently, the ALJ applied the "Last Injurious Exposure Rule" (LIER) and assigned responsibility for claimant's shoulder condition to Liberty.[1]

LIER provides that where a worker establishes that an occupational disease is caused when two or more carriers are at risk, the last employment providing the potentially causal conditions is deemed responsible for the disease. *Boise Cascade Corp. v. Starbuck*, 296 Or 238 (1984). The onset of disability is the "triggering date" for determining which employment is the last potentially causal employment. *Bracke v. Bazar*, 293 Or 239, 248 (1982). Where a claimant seeks or receives medical treatment for the compensable condition before experiencing time loss due that condition, it is appropriate to designate a

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[1] The parties agree that claimant's current right shoulder condition is not the same condition accepted by SAIF (O&S Contractors) in 1997. Consequently, they also agree that ORS 656.308 does not apply.

triggering date based on either the seeking or receiving of medical treatment, whichever occurs first. *Agricomp Ins. v. Tapp*, 169 Or App 208, 213 (2000); *see Reynolds Metals v. Rogers*, 157 Or App 147, 153 (1998) (the date of the first medical treatment is the triggering date that dictates which period of employment is assigned initial responsibility for the treatment).

The triggering date has been described as "the date claimant first sought treatment for symptoms, even if not correctly diagnosed until later." *SAIF v. Kelly*, 130 Or App 185, 188 (1994). Alternatively, the triggering date has been described as "the date that the claimant first began to receive treatment." *Timm v. Maley*, 125 Or App 396, 401 (1993), *rev den* 319 Or 81 (1994). Because the purpose in designating a triggering date is to identify a point when a condition generally becomes a disability, the *Tapp* court determined that the event (seeking or receiving medical treatment) used to establish the triggering date must have a sufficient objective relationship to the date of disability to make it an appropriate triggering date for assignment of initial responsibility under the LIER. *Tapp*, 169 Or App at 214-15.

Here, the record establishes that claimant first sought medical treatment for his current right shoulder condition (subacromial impingement syndrome/rotator cuff tendinitis) on May 19, 1999, when Liberty was on the risk. (Exs. 28; 30-3). The record further establishes that claimant had not missed work for that condition prior to May 19, 1999. (Ex. 30-5). Consequently, we conclude that May 19, 1999 is the appropriate triggering date for the assignment of initial responsibility to Liberty under the LIER. *See Tapp*, 169 Or App at 214-15; *Kelly*, 135 Or App at 188.

In order for responsibility to shift to SAIF (a carrier providing coverage for an earlier employer), Liberty must establish that: (1) it was impossible for claimant's work under its term of coverage to contribute to claimant's current need for treatment; or (2) claimant's work during SAIF's term of coverage was the sole cause of claimant's current shoulder condition. *See Roseburg Forest Products v. Long*, 325 Or 305, 313 (1997); *Reynolds Metals v. Rogers*, 157 Or App at 153; *Robert W. Banks*, 51 Van Natta 1707 (1999).

Even if we assume (as Liberty suggests) that claimant landed on his outstretched right arm during the 1997 work incident for SAIF's insured (O&S Contractors), the medical record does not support the conclusion that the 1997 work incident was the sole cause of claimant's current shoulder condition or that it was impossible for claimant's work, while Liberty was on the risk, to contribute to claimant's current need for treatment.[2] To the contrary, while the medical evidence most favorable to Liberty tends to establish the 1997 work incident for SAIF's insured as the major cause of claimant's current right shoulder problem, it does not eliminate claimant's work for Libertys insured as a causal agent of claimant's current right shoulder condition or his current need for treatment. (Exs. 43A; 52).

Accordingly, we agree with the ALJ's conclusion that Liberty is responsible for claimant's right shoulder condition.[3]

ORDER

The ALJ's order dated August 17, 2000 is affirmed.

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[2] The initial "801" form and the contemporaneous medical records from that incident indicate that claimant fell backward onto his right shoulder. (Exs. 2-1; 4). At hearing, claimant testified that he fell forward onto his right arm. (Tr. 15). Based upon claimant's demeanor, the ALJ determined that claimant was an unreliable historian, and consequently did not rely on claimant's testimony regarding the mechanics of the 1997 work incident. (O&O p. 6). We agree with that determination. *Bush v. SAIF*, 68 Or App 230, 233 (1984).

[3] We acknowledge Liberty's assertion that the ALJ incorrectly concluded that claimant had unabatedly performed his regular strenuous work from October 1997 through May 1999, when the record establishes claimant missed significant work time due to an injury not associated with his right shoulder and due to employment layoff. Assuming Liberty's assertion is correct, the medical evidence most favorable to Liberty does not establish that: (1) it was impossible for claimant's work with Libertys insured to contribute to claimant's current need for treatment; or (2) claimant's work for SAIF's insured was the sole cause of claimant's current shoulder condition.

In the Matter of the Compensation of
KATHY J. CAWLEY, Claimant
WCB Case No. 99-00954
ORDER ON REVIEW
Kryger, et al, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that upheld the self-insured employer's denial of claimant's C5-6 disc condition. In its brief, the employer moves to strike claimant's brief on the ground that it was untimely filed, On review, the issues are motion to strike and compiensability.

We adopt and affirm the ALJ's order, with supplementation to address the employer's motion to strike.

The employer moved to strike claimant's appellant's brief, which was due on or before September 14, 2000, on the ground that the brief was untimely served.

OAR 438-005-0046(2)(b) provides that anything delivered for filing shall include proof of service in the form of a certificate showing deposit in the mails together with the names and addresses of the persons served. Here, claimant's attorney included such a certificate with his appellant's brief certifying that a copy of the brief had been mailed to the Board and to the employer's attorneys on September 14, 2000, the day the brief was due. In light of such circumstances, we conclude that the brief was timely filed and served. Furthermore, even if the brief was received by the employer one day late, as the employer argues, the employer was still able to timely file its respondent's brief. *See David F. Weich*, 39 Van Natta 468 (1997) (motion to strike brief where no prejudice resulted from the claimant's failure to fully comply with briefing procedures).[1]

ORDER

The ALJ's order dated June 22, 2000 is affirmed.

[1] Alternatively, even if we did not consider claimant's brief, we would continue to reach the same ultimate conclusions regarding the ALJ's order.

In the Matter of the Compensation of
TERRY L. DAVIS, Claimant
WCB Case Nos. 00-02088 & 00-01776
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney
Jerald Keene, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests, and the SAIF Corporation, on behalf of Triple B Trucking (SAIF/Triple B), cross-requests, review of Administrative Law Judge (ALJ) Thye's order that: (1) set aside SAIF/Triple B's responsibility denial for claimant's recurrent L5-S1 herniated disc condition; and (2) upheld SAIF's responsibility denial, issued on behalf of Clearwater Concrete (SAIF/Clearwater), of the same condition. On review, the issue is responsibility.

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

The ALJ applied the presumption in *Industrial Indemnity v. Kearns*, 70 Or App 583 (1984), in deciding that SAIF/Triple B was responsible for claimant's recurrent herniated disc. On review, SAIF/Triple B argues that this case "may be resolved" under *Kearns* or, alternatively, "may properly be resolved" under ORS 656.308(1). According to SAIF/Triple B, "should the Board be inclined to choose the *Kearns* rule over the legislatively enacted rule from ORS 656.308(1), it should consider the following: ORS 656.308(1) is a later legislative enactment that supersedes the judicially created rule."

If SAIF/Triple B is arguing that this case is more properly decided pursuant to ORS 656.308(1) than the presumption in *Kearns*, then we reject its contention. As we have previously held, in deciding responsibility, we first determine whether the current condition has been previously accepted; if so, then responsibility is decided under ORS 656.308(1). If not, then responsibility is resolved under the *Kearns* presumption or ORS 656.005(7)(a)(A), depending on whether the medical evidence establishes that a prior accepted injury is the major contributing cause of a consequential condition. *E.g., Thomas L. Hinson*, 51 Van Natta 1942 (1999).

Here, there is no dispute that the recurrent herniated disc condition was not previously accepted. Consequently, we determine responsibility under the *Kearns* presumption or ORS 656.005(7)(a)(A), rather than ORS 656.308(1).

We further agree with the ALJ's analysis of the medical evidence and, in particular, his conclusion that examining neurosurgeon, Dr. Parsons, provided the most persuasive opinion because it was well-reasoned and based on an accurate history. According to Dr. Parsons, claimant's recurrent herniated disc condition "was not related" to his accepted October 1998 injury with SAIF/Clearwater. (Exs. 82-4, 84-1). Instead, Dr. Parsons thought that the 1986 claim with SAIF/Triple B caused the condition. (Exs. 82-5, 84-2).

Thus, based on Dr. Parsons' opinion, SAIF/Clearwater's October 1998 accepted injury did not independently contribute to the recurrent herniated disc. Consequently, whether under the *Kearns* presumption or ORS 656.005(7)(a)(A), SAIF/Triple B is responsible for the condition.

ORDER

The ALJ's order dated September 1, 2000 is affirmed.

In the Matter of the Compensation of
TERRY L. DAVIS, Claimant
Own Motion No. 00-0054M
OWN MOTION ORDER
Malagon, Moore, et al, Claimant Attorney
Julie Masters (Saif), Defense Attorney
Jerald Keene, Defense Attorney

The SAIF Corporation, on behalf of Triple B Trucking (SAIF/Triple B) initially submitted claimant's request for temporary disability compensation for his low back condition. Claimant's aggravation rights under his 1986 injury claim with SAIF/Triple B have expired. SAIF/Triple B opposed reopening on the grounds that claimant's current low back condition was not causally related to his compensable low back condition. In addition, SAIF/Triple B denied the responsibility for claimant's current low back condition. Claimant requested a hearing with the Hearings Division. (WCB Case No. 00-01776).

On April 10, 2000, we issued an Own Motion order consenting to the designation of a paying agent pursuant to ORS 656.307. In addition, we postponed action until the litigation pending before the Hearings Division had been resolved.

On September 1, 2000, Administrative Law Judge (ALJ) Thye issued an Opinion and Order, which set aside SAIF/Triple B's responsibility denial. Claimant requested, and SAIF/Triple B cross-requested Board review of ALJ Thye's order, and by an order issued on today's date, the Board affirmed ALJ Thye's order.

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

On April 19, 2000, claimant underwent a left foraminotomy and discectomy for a recurrent left disc herniation. Thus, we conclude that claimant's compensable injury has worsened requiring surgery.

Accordingly, we authorize the reopening of claimant's 1986 injury claim to provide temporary disability compensation beginning April 19, 2000, the date claimant was hospitalized. When claimant is medically stationary, SAIF shall close the claim pursuant to OAR 438-012-0055.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,500, payable by SAIF directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
JEFFREY J. McHENRY, Claimant
WCB Case No. 00-04314
ORDER ON REVIEW
McGinty & Belcher, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Martha Brown's order that dismissed for lack of jurisdiction his request for hearing regarding the classification of his claim. On review, the issues are jurisdiction and (potentially) claim classification, penalties and attorney fees.

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

Claimant contended at hearing that the insurer improperly refused to reclassify his accepted bilateral carpal tunnel claim from "nondisabling" to "disabling." The insurer asserted that the Department, not the Hearings Division, had jurisdiction over the matter, citing ORS 656.277(1).[1] The ALJ agreed with the insurer, rejecting claimant's argument that the use of the word "may" in ORS 656.277(1) was intended to permit a worker either to proceed before the Director or to request a hearing before the Board's Hearings Division. The ALJ reasoned that, when read in its entirety, the statute indicates that a claimant's initial avenue of appeal is through the Director and that the word "may" merely suggests that it is claimant's choice whether or not to contest classification of the claim. We agree with the ALJ's reasoning.

On review, however, claimant contends that ORS 656.283(1) gives a worker an alternative, discretionary course of action in claim classification disputes and that, therefore, this statute provides appropriate authority for requesting a hearing before the Hearings Division. ORS 656.283(1) provides:

> "Subject to ORS 656.319, any party or the Director of the Department of Consumer and Business Services may at any time request a hearing on any matter concerning a claim, except matters for which a procedure for resolving the dispute is provided in another statute, *including* ORS 656.245, 656.248, 656.260, 656.327 and subsection (2) of this section." (Emphasis added).

Claimant notes that the statutes listed in ORS 656.283(1) that provide exceptions to the rule that a party may at any time request a hearing on a "matter concerning a claim" deal with medical and vocational disputes. Because claim classification is not such a dispute, claimant argues that this statute allowed him to request a hearing before the Hearings Division in this case. We disagree with claimant's argument.

When there is a conflict between two statutes, both of which would otherwise have equal force and effect, and the provisions of one are particular, special and specific in their directions, and those of the other are general in their terms, the special provisions prevail over the general provisions. *Smith v. Multnomah County Board of Commissioners*, 318 Or 302, 309 (1994) (citing *State v. Preston*, 103 Or 631, 637 (1922)). In such a case, the specific statute is considered an exception to the general statute. *Id.* at 309.

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[1] That statute provides:

"A request for reclassification by the worker of an accepted nondisabling injury that the worker believes was or has become disabling must be submitted to the insurer or self-insured employer. The insurer or self-insured employer shall classify the claim as disabling or nondisabling within 14 days of the request if the request is received within one year after the date of acceptance. A notice of such classification shall be mailed to the worker and the worker's attorney if the worker is represented. The worker may ask the Director of the Department of Consumer and Business Services to review the classification by the insurer or self-insured employer by submitting a request for review within 60 days of the mailing of the classification notice by the insurer or self-insured employer. If any party objects to the classification of the director, the party may request a hearing under ORS 656.283 within 30 days from the date of the director's order."

Here, ORS 656.283(1) applies generally to parties' rights to request a hearing regarding a "matter concerning a claim." On the other hand, ORS 656.277(1) is the more specific statute and applies to situations involving classification of a claim. Application of each provision would lead to a different result. This leads us to conclude that the more specific provisions of ORS 656.277(1) should control. *See* ORS 174.020; *Smith*, 318 Or at 309-10. Therefore, we conclude that ORS 656.277(1) provides an exception to the general rule in ORS 656.283(1).

Moreover, the legislature's use of the word "including" in ORS 656.283(1) indicates that the list of statutory exceptions to a party's general right to request a hearing before the Hearings Division is not exhaustive. *Cf. State v. Burton*, 114 Or App 84, 87 (1992) (inclusive language of statute requiring drivers to provide reasonable assistance, "including" conveying injured persons to a physician, surgeon or hospital, if medical treatment is necessary or requested, indicated that other types of assistance may be reasonable). Therefore, because ORS 656.277(1) provides a procedure for resolving the classification dispute in this case, we conclude that ORS 656.283(1) does not allow claimant to directly request a hearing before the Board's Hearings Division to contest the insurer's claim classification.[2]

Claimant argues alternatively that the insurer failed to strictly comply with the notice requirements of ORS 656.277(1) because it failed to send notice of its claim classification to claimant. (Ex. 34). Thus, claimant contends that he had no alternative but to request a hearing pursuant to ORS 656.283(1) because a condition precedent to the Director's jurisdiction under ORS 656.277(1) was not satisfied. Once again, we disagree.

While it appears that the insurer did not send a copy of its response to claimant's reclassification request to claimant as required by ORS 656.277(1), we decline claimant's invitation to hold that such an error allows him to bypass the statutory procedure in ORS 656.277(1) for contesting claim classification and instead proceed directly to the Hearings Division via ORS 656.283(1). Instead, we agree with the insurer that the appropriate remedy for a violation of the notice provision in ORS 656.277(1) is a civil penalty. *See* OAR 436-030-0580(2) (allowing assessment of a civil penalty where an insurer fails to meet requirements of various administrative rules, including OAR 436-030-0045, which pertains to disabling/nondisabling reporting requirements).[3]

In conclusion, we find that the ALJ properly dismissed claimant's hearing request. Thus, we affirm.

ORDER

The ALJ's order dated September 18, 2000 is affirmed.

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[2] We note that claimant is not precluded from eventually requesting a hearing. But before that can occur, claimant must follow the specific statutory process set forth in ORS 656.277(1) (first requesting Director review of the insurer's classification decision and then seeking a hearing before the Hearings Division if he is dissatisfied with the Director's decision).

[3] We acknowledge that the court in *Long v. Argonaut Insurance Co.*, 169 Or App 625 (2000), held that a Notice of Closure was ineffective if a copy of the closure notice was not mailed to the claimant's attorney as required by statute and administrative rule. It could be argued that, by analogy, the insurer's reclassification notice was likewise ineffective here when it did not send a copy to claimant as required by ORS 656.277(1) and, thus, the insurer must reissue a valid reclassification notice from which claimant may seek Director review. Under those circumstances, clamant could request a hearing that would result in the ALJ directing the insurer to reissue its reclassification notice to claimant so he could then seek Director review. Claimant, however, does not contest the effectiveness of the insurer's reclassification notice, but rather argues that this omission allows him to directly request a hearing before the Board's Hearings Division challenging the insurer's claim classification. Nevertheless, the *Long* court did not hold that the claimant in that case could directly request a hearing before the Hearings Division, instead of complying with the mandatory reconsideration process. We, therefore, decline to allow claimant to directly request a hearing in this case.

In the Matter of the Compensation of
DANIEL B. PROUD, Claimant
WCB Case No. 00-03833
ORDER ON REVIEW
Vick & Conroyd, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Haynes and Bock.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we summarize and supplement as follows.

In 1997, claimant injured the anterior cruciate ligament (ACL) in his right knee in an off-the-job incident. (Ex. 1). ACL debridement was performed; reconstruction of the ACL was deferred. (Exs. 2, 3).

Claimant compensably injured his right knee on January 28, 1999, when he was working for the employer as a carpenter. (Exs. 4 through 7). The insurer accepted a disabling right knee strain, lumbosacral strain, anterior cruciate ligament (ACL) insufficiency, and right lateral meniscus tear. (Exs. 10, 17, 24). On May 11,1999, Dr. Zirschky reconstructed the ACL and repaired the lateral meniscus using multiple surgical darts. (Ex. 21).

On September 10, 1999, Dr. Zirschky released claimant to regular work with use of a knee brace. (Ex. 26). Claimant was laid off on October 6, 1999, when the employer restructured its business. (Ex. 27). Claimant then worked for a different employer for several weeks, during which period he experienced lateral right knee pain as he knelt to pull off a baseboard. (Ex. 30).

On October 22, 1999, claimant was seen by Dr. Yamata, who found a possible disruption of the meniscus repair. Claimant followed up with Dr. Zirschky on October 25, 1999, who noted the same history and findings. Dr. Zirschky also noted a sharp projection in the soft tissue, which he thought was one of the meniscal darts. He told claimant that the dart would gradually dissolve with time. (Ex. 30-4).

On November 8, 1999, Dr. Zirschky released claimant to modified work, forbidding climbing ladders, carrying items up or down stairs, and limiting squatting and stair climbing. (Ex. 28). On November 16, 1999, claimant requested resumption of temporary disability benefits. (Ex. 29).

On February 18, 2000, Dr. Fuller examined claimant for the insurer. Dr. Fuller opined that claimant had not sustained an anterior cruciate ligament injury in the January 1999 incident, and that he had had an excellent result from the ACL reconstruction. Dr. Fuller also opined that the meniscus repair may not have worked and that claimant's current knee complaints appeared to be related to the meniscal repair injury/surgery. (Ex. 30). Dr. Zirschky concurred in this report.

On February 25, 2000, claimant returned to Dr. Zirschky, complaining of soreness and swelling in the knee and discomfort with squatting, twisting or climbing. Dr. Zirschky indicated that claimant could be performing modified work with no squatting or climbing. (Ex. 31).

The insurer did not pay temporary disability benefits for the period beginning February 25, 2000. Claimant's January 28, 1999 injury claim remained open as of February 25, 2000.

On April 4, 2000, the insurer denied the right ACL insufficiency/tear conditions. (Ex. 34). This denial was not appealed. (Tr. 3).

On May 1, 2000, Dr. Zirschky reported that, due to the meniscal problem, claimant could perform light duty work. (Ex. 36). On May 3, 2000, Dr. Zirschky signed a modified work release form. (Ex. 37).

CONCLUSIONS OF LAW AND OPINION

The ALJ found that, because claimant was released to regular work in September 1999, OAR 436-060-0030(8) did not require the employer to resume temporary total disability benefits upon receipt of the February 25, 2000 chart note indicating that claimant was capable only of modified work. The ALJ also reasoned that, because claimant had been laid off prior to the change in the work release, his time loss was not due to his disability but to "his failure to engage in subsequent suitable work prior to the withdrawal or cessation of the modified work."

On review, claimant contends that he is entitled to temporary total disability benefits beginning February 25, 2000, based on Dr. Zirschky's chart note stating that claimant could perform modified work. We disagree.

Claimant's prior entitlement to temporary disability benefits ended when he was released to his regular work as of September 10, 1999.[1] Because claimant was performing regular work at the time he was laid off on November 6, 1999, we agree with the ALJ that OAR 436-060-0030(8) is inapplicable here. Therefore, claimant is not entitled to the resumption of temporary *total* disability benefits under that rule.[2]

Claimant's entitlement to temporary disability benefits for periods after he was laid off on November 6, 1999 depends on whether he was subsequently disabled as a result of his compensable injury. *See Gray v. SAIF*, 70 Or App 313 (1984); *Lisa R. Angstadt*, 47 Van Natta 981 (1995) (where the claimant suffered diminished earning capacity after being terminated, she became entitled to interim compensation as of the date her diminished earning capacity began).

Dr. Zirschky's "post-lay off" release to modified work is evidence that claimant became partially disabled due to his compensable injury on November 8, 1999. Moreover, since that date, claimant has not been released to regular work, has not returned to regular work, and remains released only to modified work. Therefore, because this is an open claim, claimant would be entitled to temporary *partial* disability from November 8, 1999 until one of the criteria under OAR 436-060-0030(9) is met.[3] Thus,

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[1] Claimant does not dispute the ALJ's finding that claimant had been released to regular work on September 10, 1999. Because there is no contention that claimant's previous temporary disability benefits were improperly terminated, the provisions of ORS 656.268(4) are inapplicable.

[2] We agree with claimant that he was in the work force at the time he again became disabled. Claimant was working until he sought treatment for increased knee symptoms. Thus, when Dr. Zirschky placed claimant on modified work, he was still in the work force. Since that time, claimant has not been released to regular work, has not returned to regular work, and remains released only to modified work. Consequently, there is no ground for a refusal to reinstate temporary partial disability benefits because claimant was not in the work force.

[3] OAR 436-060-0030(9) (WCD Admin. Order No. 96-070) provides:

"When the worker's disability is partial only and temporary in character, temporary partial disability compensation pursuant to ORS 656.212 shall continue until:

"(a) The attending physician verifies that the worker can no longer perform the modified job and is again temporarily totally disabled;

"(b) The compensation is terminated by order of the Department or by claim closure by the insurer pursuant to ORS 656.268;

"(c) The compensation has been paid for an aggregate period of two years. For the purpose of this rule, each opening of the claim is considered a separate claim and establishes a new two year period; or

"(d) The compensation is lawfully suspended, withheld or terminated for any other reason."

We note that the ALJ's citation to *Darrell L. Kreier*, 51 Van Natta 1478, 1483 fn3 (1999), is inapposite, as the interpretation of OAR 436-060-0030(9) in the footnote was from the dissenting member in that case.

only if the attending physician verifies that claimant is no longer able to perform the modified job and is again temporarily totally disabled could temporary partial disability be increased to temporary total disability. Because Dr. Zirschsky did not indicate that claimant was again temporarily totally disabled on February 25, 2000 or subsequently, claimant is not entitled to the resumption of temporary *total* disability benefits.[4]

ORDER

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

[4] We do not interpret claimant's arguments at hearing or on review as a request for reinstatement of temporary partial disability benefits.

In the Matter of the Compensation of
DONNA M. VIRNIG, Claimant
WCB Case No. 99-05675
ORDER ON REVIEW
Hollander & Lebenbaum, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The SAIF Corporation requests review of those portions of Administrative Law Judge (ALJ) Lipton's order that: (1) set aside its partial denial of claimant's consequential condition claim for a reflex sympathetic dystrophy/chronic regional pain syndrome condition; and (2) awarded an attorney fee for setting aside SAIF's partial denial of a somatoform pain disorder as premature and void. On review, the issues are compensability and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Compensability

We adopt and affirm the ALJ's reasoning and conclusions regarding the compensability issue.

Attorney Fees

The ALJ found that claimant had not filed a claim for a somatoform pain disorder and, in the absence of a claim, SAIF's partial denial of a somatoform pain disorder was "void." Nevertheless, the ALJ awarded a $2,000 assessed attorney fee because "claimant's counsel is entitled to an assessed fee for obtaining a rejection of the denial." SAIF argues that, without a claim, its partial denial of the somatoform pain disorder was null and void. Citing *Robert W. Stephenson*, 48 Van Natta 2287 (1996), SAIF argues that, because claimant did not "prevail" over a "denied claim," she is not entitled to an assessed attorney fee regarding the somatoform pain disorder denial. We agree.

Our decision in *Stephenson* was affirmed by the court in *Stephenson v. Meyer*, 150 Or App 300 (1997). The court relied on ORS 656.005(6), which defines "claim" as a "written request for compensation from a subject worker or someone on the worker's behalf[.]" Consistent with that definition, the court concluded that the term "denied claim" in ORS 656.386(1)[1] means an insurer's refusal to pay in response to a written request for compensation. The court reasoned that the legal

[1] ORS 656.386(1) authorizes an assessed fee in "cases involving denied claims where the claimant prevails finally" in a hearing before an ALJ.

predicate for an award of attorney fees under ORS 656.386(1) did not exist because no claim was ever made within the meaning of ORS 656.005(6). The court rejected the claimant's argument that the phrase "denied claim" in ORS 656.386(1) must be read broadly enough to allow attorney's fees "when insurer's force litigation by issuing a formal express denial without first having received a claim." The court noted that neither it nor the Board had the authority to expand the language of ORS 656.386(1) to embrace circumstances not covered by it, even though an inequity could result.

We conclude that the court's decision in *Stephenson* is controlling in the present case. We reject claimant's argument (first raised on review) that SAIF's denial is a "current condition" denial. As argued at hearing and found by the ALJ, it is, instead, a premature denial of a somatoform pain disorder, a condition for which a claim has not been filed. (Ex. 77, Tr. 11, 16). As SAIF's premature denial is a "nullity" and without effect, it has no preclusive effect. Moreover, even assuming that claimant's litigation of the premature denial was necessary to protect claimant's interests, that is not a basis for an award of attorney fees under ORS 656.386(1). The authority to award an assessed fee under that provision is limited to situations where the claimant has prevailed over a "denied claim." An assessed fee is not authorized in the present case because claimant has not made a "claim" for a somatoform pain disorder within the meaning of ORS 656.005(6). *Robert E. Johnson*, 50 Van Natta 7 (1998).

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 $2,550, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by claimant's respondent's brief and claimant's attorney's affidavit), the complexity of the issue, and the value of the interest involved.[2]

ORDER

The ALJ's order dated July 20, 2000 is affirmed in part and reversed in part. That portion of the order that awarded assessed attorney fees in the amount of $2,000 regarding the denial for a somatoform pain disorder condition is reversed. The remainder of the ALJ's order is affirmed. For services on review regarding the compensability issue, claimant's attorney is awarded an assessed fee of $2,550, payable by SAIF directly to claimant's attorney.

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[2] Claimant is not entitled to a fee on review for services devoted to the attorney fee issue. *See Dotson v. Bohemia Inc.*, 80 Or App 233 (1986). In his "Affidavit in Support of Attorney's Fees" claimant's attorney requests a fee of $2,750 for services on review. Those services included arguments in support of the ALJ's award of an attorney fee regarding SAIF's premature denial. The affidavit did not indicate that the requested fee did not include payment for those attorney fee related services. Thus, because claimant is not entitled to a fee on review for services devoted to the attorney fee issue, we have adjusted the requested fee accordingly. As noted above, applying the factors set forth in OAR 438-015-0010(4), we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $2,550.

In the Matter of the Compensation
SHIRLEY CHARTRAND, Claimant
Own Motion No. 99-0330M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
EBI Ins. Co., Insurance Carrier

Claimant requests review of the insurer's November 6, 2000 Notice of Closure, which closed her claim with an award of temporary disability compensation from September 2, 1999 through October 27, 2000. The insurer declared claimant medically stationary as of October 27, 2000.

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

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

In a letter dated November 20, 2000, we requested that the insurer submit copies of materials considered in closing the claim. Having received the parties' responses, we proceed with our review.

Typically, there are only two issues to be raised when a claimant requests review of an insurer's claim closure. The most common issue raised is that the claimant was not medically stationary at claim closure. A second issue raised less often, is that, although medically stationary at claim closure, the claimant asserts entitlement to additional temporary disability compensation during the time the claim was open.

Here, claimant initially simply requested review of the insurers November 6, 2000 Notice of Closure. With her December 6, 2000 submission, claimant raises issues regarding temporary disability payments and the need for further medical treatment. We interpret claimant's request for review and submission as a challenge to both the medically stationary determination and the temporary disability compensation award. The evidence in the record supports the conclusion that claimant was medically stationary at the time of closure and temporary disability compensation was appropriately terminated.

On October 27, 2000, claimant underwent a closing examination conducted by her treating physician, Dr. Cook. Dr. Cook opined that, although claimant required continued use of a knee brace and medications, she was otherwise medically stationary and could return to moderate to sedentary work. This opinion is unrebutted.

In her request for review of the insurer's closure, claimant states that she is not medically stationary because she has not received further the medical treatment noted by Dr. Cook in the form of a knee brace and medication. She offers no medical documentation to support her contention. However, even if we were to consider claimant's assertion that she requires further medical treatment, this does not support the conclusion that she was not medically stationary when her claim was closed. The term "medically stationary" does not mean that there is no longer a need for continuing medical care. *Maarefi v. SAIF*, 69 Or App 527, 531 (1984). Rather, the record must establish that there is a reasonable expectation, at claim closure, that further medical treatment would "materially improve" claimant's compensable condition. ORS 656.005(17); *Lois Brimblecom*, 48 Van Natta 2312 (1996).[1]

Based on the uncontroverted medical evidence, we find that claimant was medically stationary on October 27, 2000. Inasmuch as temporary disability compensation was paid through October 27, 2000, and the claim was closed on November 6, 2000, we conclude that claimant is not entitled to additional temporary disability compensation and that the insurer's claim closure was proper.

Accordingly, we affirm the insurer's November 6, 2000 Notice of Closure in its entirety.

IT IS SO ORDERED.

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[1] In her December 6, 2000 submission, claimant raises issues which relate to medical issues. Pursuant to ORS 656.245, these medical issues are within the Director's jurisdiction. Because we are not authorized to address such matters, claimant may wish to refer her questions to the Director. Regarding the medical issues, claimant may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers. Claimant may contact the Workers' Compensation Ombudsman, free of charge, at 1-800-927-1271, or write to:

DEPT OF CONSUMER & BUSINESS SERVICES
WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE
SALEM OR 97301-3878

In the Matter of the Compensation of
SHELLY COLE, Claimant
WCB Case No. 99-08462
ORDER ON REVIEW
Willner, Wren, Hill & Uren, Claimant Attorney
Wallace, Klor & Mann PC, Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The insurer requests review of Administrative Law Judge (ALJ) Mills' order that: (1) set aside its denial of claimant's occupational disease claim for her bilateral carpal tunnel syndrome; and (2) awarded a penalty for the insurer's allegedly unreasonable discovery violation. On review, the issues are compensability and penalties.

We adopt and affirm the order of the ALJ,[1] with the following supplementation.

On review, the insurer argues that the ALJ erred in awarding claimant a penalty for the insurer's unreasonable failure to provide claimant's counsel with a copy of a videotape showing claimant's work activities. The insurer contends that the tape may have impeached claimant if she did not testify accurately about her work activities.

In *Herbert L. Lockett*, 50 Van Natta 154 (1998), we held that the test in such a case is whether the insurer reasonably believed that the documents in question were relevant and material for impeachment purposes (*i.e.*, that the evidence tended to impair or destroy the claimant's credibility). Furthermore, we noted that the determination of whether evidence has impeachment value comes not at the hearing, but rather at the time the duty to provides discovery arises. We reasoned that a carrier could not withhold evidence properly discoverable on the suspicion that a claimant or another witness may testify in a certain manner at hearing or on speculation that evidence might eventually become impeachment evidence. *Lockett*, 50 Van Natta 156, fn 2.

Here, the insurer has not pointed to anything in the record that suggests that claimant at some point inaccurately or untruthfully described her work activities. Accordingly, its decision to withhold the video until the time of hearing on the speculation that claimant might testify untruthfully about her work activities was not reasonable. Therefore, we agree with the ALJ's conclusion that a penalty was proper.

Claimant's counsel is entitled to an assessed attorney fee for services on review concerning the issue of compensability. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the compensability issue is $750, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the issue (as represented by that portion of claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. We have also considered that claimant is not entitled to a fee for defending the ALJ's decision on the penalty issue. *See Saxton v. SAIF*, 80 Or App 631 (1986).

ORDER

The ALJ's order dated June 2, 2000 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] In light of our decision to affirm the ALJ on the issue of compensability, we need not address claimant's alternative argument regarding remand.

In the Matter of the Compensation of
DAVID R. STRUBLE, Claimant
WCB Case No. 98-07942
ORDER ON REVIEW
Roy Miller (Saif), Defense Attorney

Reviewed by Board Members Phillips Polich and Haynes.

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

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

On October 10, 2000, the ALJ issued an "Order of Show Cause/Dismissal." The ALJ explained that he had spoken to claimant on October 6, 2000 and, although claimant was aware of the hearing scheduled for October 9, 2000, he did not plan to attend the hearing. Indeed, claimant did not appear at the October 9th hearing, although the SAIF Corporation appeared on behalf of the employer.

At the October 9, 2000 hearing, SAIF's attorney asserted that, because this case had been set for hearing and postponed at claimant's request on several occasions, and because claimant was well aware of the scheduled hearing, it requested that the ALJ dismiss claimant's requests for hearing. (Tr. 2-3).

Based on claimant's failure to appear or otherwise prosecute his requests for hearing, and in response to SAIF's motion to dismiss claimant's requests for hearing, the ALJ concluded that claimant's requests for hearing were deemed abandoned and were dismissed with prejudice. The ALJ's order, however, provided that if claimant requested reconsideration within 15 days and could show good cause for his failure to appear at hearing, the dismissal order would be set aside.[1]

On October 23, 2000, claimant mailed a request for reconsideration and Board review, which was received on October 26, 2000. The ALJ denied reconsideration, finding that claimant's request did not demonstrate good cause for his failure to appear at hearing and he did not discuss his October 6, 2000 statement to the ALJ that he had not planned to attend the hearing.

OAR 438-006-0071 provides:

> "(1) A request for hearing may be dismissed if an Administrative Law Judge finds that the party that requested the hearing has abandoned the request for hearing or has engaged in conduct that has resulted in an unjustified delay in the hearing of more than 60 days.
>
> "(2) Unjustified failure of a party or the party's representative to attend a scheduled hearing is a waiver of appearance. If the party that waives appearance is the party that requested the hearing, the Administrative Law Judge shall dismiss the request for hearing as having been abandoned unless extraordinary circumstances justify postponement or continuance of the hearing."

On review, claimant asserts that he is "dissatisfied" with the ALJ's order. Nevertheless, he does not address the only issue on review, *i.e.*, whether the ALJ properly dismissed the hearing request pursuant to OAR 438-006-0071. Claimant does not explain why the ALJ should not have dismissed his hearing request, particularly in light of claimant's statement to the ALJ that he did not plan to attend the October 9, 2000 hearing.[2] Under these circumstances, we conclude that claimant's failure to attend

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[1] The "combined" nature of this 15-day "show cause" order and 30-day "dismissal" order was in accordance with our suggested approach when dealing with "non-appearance" cases. *See Teresa Marion*, 50 Van Natta 1165, 1166 n. 1 (1998).

[2] Because the ALJ had an opportunity to consider claimant's "post-show cause" reason for his failure to appear at the scheduled hearing, we are likewise able to consider claimant's response to the "show cause" order without the necessity of remanding to the ALJ. *See Tobin E. Weymiller*, 50 Van Natta 2184, 2185 n. 2 (1998).

the scheduled hearing was unjustified and we find that the ALJ properly dismissed claimant's hearing request.[3]

ORDER

The ALJ's orders dated October 10, 2000 and October 30, 2000 are affirmed.

[3] We note that claimant is presently unrepresented. Because he is unrepresented, he may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. Claimant may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

Workers' Compensation Ombudsman
Department of Business and Consumer Services
350 Winter St NE, Room 160
Salem, OR 97301-3878

In the Matter of the Compensation of
JAMES P. TEAGUE, Claimant
WCB Case No. 00-00695
ORDER ON REVIEW
Mustafa T. Kasubhai, Claimant Attorney
Schwabe, Williamson & Wyatt, Defense Attorney

Reviewed by Board Members Haynes and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of claimant's injury claim for a left shoulder and neck condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

Claimant compensably injured his back and right knee on November 13, 1995. (Ex. 1). The claim was accepted for a low back strain and right knee medial meniscus tear. (Ex. 36). Claimant was also treated for neck pain. (Exs. 4, 6). Claimant's cervical x-rays showed marked degenerative changes, particularly at C5-6 and C6-7. (Ex. 6). A February 13, 1996 cervical MRI showed moderately advanced cervical spondylosis at C4 through C7 with disc space narrowing and posterior osteophyte formation, which was contributing to borderline spinal stenosis. (Ex. 11). There was no evidence of disc herniation or significant neural foraminal narrowing. (*Id.*)

On October 8, 1999, claimant filed a claim for neck, arm, shoulder and groin pain related to a September 22, 1999 incident at work when he was lifting two boards that were stuck together. (Ex. 40). Claimant testified that the boards were one inch thick, two feet wide and eight feet long and each weighed about 50 pounds. (Tr. 7, 14). After he pulled the boards, he felt pain in his left neck and groin. (Tr. 9-10). He sought treatment on October 8, 1999 from Dr. Moore, who diagnosed a left inguinal hernia and a torn rotator cuff on the left.[1] (Ex. 39). She reported that claimant had progressive pain in his left shoulder from his left neck into his upper arm. (*Id.*) Claimant did not have numbness in his arm during the exam, but he said that his arm had been numb off and on for the past two weeks. (*Id.*)

Dr. Balme examined claimant on October 15, 1999 for left shoulder and upper extremity pain. (Ex. 43). He said claimant's cervical x-rays showed marked degenerative changes at C5-6 and C6-7, with disc space narrowing and osteophytic spurring. He suspected a herniated disc and recommended a cervical MRI. (*Id.*) Dr. Tamplen, radiologist, interpreted the October 15, 1999 MRI as showing degenerative disc narrowing and spurring from C3 to C7, most pronounced from C4 to C7. (Ex. 44). Dr. Tamplen said that no disc herniations were present. (*Id.*)

[1] The employer subsequently accepted a disabling left inguinal hernia and claimant had surgery for that condition. (Exs. 45, 56).

Claimant was referred to Dr. Amstutz, neurosurgeon. (Ex. 47). Dr. Amstutz interpreted the recent cervical MRI as showing a large disc herniation at C4-5, with osteophytic and disc changes at C5-6 and C6-7. (Ex. 47-3). He diagnosed a cervical intervertebral disc displacement at C4-5 and cervical radiculitis at C5. (*Id.*)

On November 8, 1999, Dr. Amstutz performed a C4 through C6 laminectomy with lateral recess relief and foraminotomies. (Ex. 49). His postoperative diagnosis was C4-5 and C5-6 stenosis with lateral recess and neural foraminal encroachment, and left C5 and C6 radiculopathy. (*Id.*) He found that the C5 and 6 nerve roots were "significantly compromised" on the left side, but there did not appear to be an "acute" disc herniation. (*Id.*)

Dr. Schilperoort, orthopedic surgeon, examined claimant on January 5, 2000, on behalf of the employer. (Ex. 55). Dr. Young, radiologist, reviewed claimant's imaging studies and medical records on behalf of the employer. (Ex. 63).

On January 6, 2000, the employer denied claimant's left neck, shoulder and arm condition on the basis that the work injury was not the major contributing cause of his need for medical treatment and the condition did not compensably arise out of or in the course of his employment. (Ex. 57).

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Amstutz's opinion and concluded that claimant's September 22, 1999 injury was the major cause of the need for treatment of his left shoulder and neck condition.

On review, the employer argues that the persuasive medical evidence establishes that claimant's preexisting degenerative cervical condition was the major contributing cause of his need for treatment. The employer contends that Dr. Amstutz's opinion is not sufficient to sustain claimant's burden of proof.

Claimant's theory of compensability is that the September 22, 1999 injury was the major contributing cause of the need for treatment of his shoulder/neck condition, rather than the condition itself. The medical evidence establishes that claimant has preexisting degenerative cervical changes that combined with his compensable injury to cause his need for treatment. (Exs. 47, 58, 55, 60, 63). Therefore, in order to establish compensability of his neck/shoulder/arm condition, claimant must show that his work injury was the major contributing cause of the need for treatment of the combined condition. *See* ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309, 311-312 (1997), *rev den* 326 Or 389 (1998). We agree with the employer that the issue is not whether claimant has cervical nerve root compression. Rather, the primary dispute is whether the need for treatment of the nerve root compression was caused, in major part, by claimant's work injury or his preexisting degenerative cervical condition. Claimant relies on the opinion of Dr. Amstutz, his treating physician and surgeon, to establish compensability.

Based on Dr. Amstutz's own statements, we find that his opinion is not entitled to any deference as the treating surgeon. *Compare Argonaut Insurance Co. v. Mageske*, 93 Or App 698, 702 (1988) (treating physician's opinion was given greater weight because of his first-hand exposure to and knowledge of the claimant's condition). In a January 13, 2000 report, Dr. Amstutz said that "[t]he observations that I made at surgery, I think, are distinctly the least valuable in this particular situation." (Ex. 58). At hearing, he testified that, at surgery, he could not specifically identify something that had happened recently. (Tr. 26). He felt that the MRI scan was a "better piece of information in that specific regard," because it showed the underlying anatomy. (*Id.*) Dr. Amstutz could not determine by looking at the disc during surgery whether it was old or new. (Tr. 50-51).

Thus, Dr. Amstutz placed little reliance on his surgical findings in determining causation and relied instead on claimant's history, the examination findings of weakness of the left deltoid and biceps, as well as the MRI scan. (Ex. 58, Tr. 26, 50). Under these circumstances, we find that Dr. Amstutz's opinion is not entitled to any deference as claimant's surgeon. Moreover, because the record shows Dr. Amstutz examined claimant on only one occasion before performing surgery, we find that his opinion is not entitled to any deference as claimants attending physician. *Compare Weiland v. SAIF*, 64 Or App 810 (1983) (the claimant's treating physician's opinion was more persuasive because of his greater opportunity to evaluate the claimant over a period of two years).

Dr. Amstutz's opinion on causation is complicated by the terminology he has used to describe claimant's neck and left shoulder condition. At hearing, Dr. Amstutz explained that whether a disc is characterized as bulging, herniating, displacing, prolapsing or protruding was not a valuable distinction to him in terms of caring for the problem. (Tr. 30, 49). He said that the medical profession does not describe those terms consistently. (Tr. 30-31). Dr. Amstutz himself has not described claimant's cervical condition consistently. He initially said that the 1999 MRI showed a "large disc herniation" at C4-5 that compromised the C5 nerve root, as well as C5-6 and C6-7 osteophytic and disc changes. (Ex. 47-3).

In his surgical report, Dr. Amstutz's postoperative diagnosis was C4-5 and C5-6 stenosis with lateral recess and neural foraminal encroachment, and left C5 and C6 radiculopathy. (Ex. 49). In a January 13, 2000 report, he again referred to a disc herniation at C4-5. (Ex. 58). At hearing, Dr. Amstutz said there was "certainly a bulge in the disc annulus, and the posterior longitudinal ligament." (Tr. 26). He also said that claimant "quite obviously had a disc herniation in terms of a large bulging of the disc annulus that was compromising the nerve." (Tr. 27). He explained that claimant had a "tear" in the disc annulus, which allowed the disc to protrude into the neural foramen and compromise the nerve. (Tr. 48).

In performing claimant's cervical surgery, Dr. Amstutz did not find an "acute" disc herniation (Ex. 49, Tr. 50), and did not find any free fragments of disc material. (Tr. 26, 27). He explained that, if he had found free fragments of disc material, he could have declared it "a more acute thing to a reasonable degree of certainty." (Tr. 27). Rather, Dr. Amstutz could not specifically identify something that had happened recently. (Tr. 26).

Dr. Amstutz acknowledged that claimant had degenerative changes that contributed to his cervical problem, but he concluded that the September 1999 work injury was the major contributing cause of claimants need for medical treatment of the left shoulder/neck condition. (Exs. 47-4, 58; Tr. 33, 43). He said that the C4-5 level on the MRI scan did not show the significant osteophytic changes that the C5-6 and C6-7 discs showed, which he felt was "consistent with a much more recent disc herniation phenomenon." (Ex. 58). Dr. Amstutz said that claimant's osteophytes had contributed to his cervical condition because they narrowed the size of the canal and provided less room for the nerve. (Tr. 29). His surgical report said there was "dense bone compromising the C5 and the C6 nerve roots." (Ex. 49-1).

In comparing claimant's cervical MRI scans, Dr. Amstutz explained:

> "I would say that these scans look pretty much identical except for the C4-5 level on the left hand side. What we saw that I described as moderate degenerative findings in 96 didnt seem to be any different in 99, which is kind of what one would expect. The -- the degenerative findings dont generally progress that abruptly. At the C4-5 level I believe there is a distinct difference, and in three years time, as I said, I wouldn't expect that there would be a distinct difference, based just on a degenerative basis. That's -- that is something that I would categorize as a consideration strongly suggestive of an acute intervening event, although its not absolutely proof of that." (Tr. 40-41).

Dr. Amstutz believed the extra disc bulging was more likely caused by the work incident than the progression of osteophytes, particularly when he considered claimant's symptoms after the injury. (Tr. 43). He explained that claimant's symptoms and findings correlated with the increased mass and provide a "very potent argument that this mass has increased in size abruptly[.]" (*Id.*)

Thus, Dr. Amstutz believed that claimant had an "abrupt change" in his spine at the time of the work injury (Tr. 31), and the bulging was caused by the work incident rather than the osteophytes. (Tr. 43). Dr. Amstutz, however, did not respond to Dr. Schilperoort's opinion that claimant's symptoms following the September 22, 1999 injury were not consistent with finding that a disc herniation had occurred on that date. (Ex. 60-2). When claimant sought treatment from Dr. Moore on October 8, 1999, she said claimant did not have numbness in his arm at that time, but his arm had been "numb off and on for the past two weeks." (Ex. 39). Dr. Schilperoort reviewed that chart note and said that, if a disc herniation had occurred at the time of the September 1999 injury, claimant would have had complaints of consistent and constant numbness of the arm, not numbness off and on for the past two weeks. (Ex. 60-2). We find that Dr. Schilperoort's opinion casts serious doubt on the persuasiveness of Dr. Amstutz's opinion.

Furthermore, we are not persuaded by Dr. Amstutz's statement that the October 1999 MRI showed a "large disc herniation" at C4-5 (Ex. 47-3), or his view that the 1999 MRI scan showed a "distinct difference" at C4-5. (Tr. 41). In comparing the two MRI scans, Dr. Amstutz explained that, "[a]t the C4-5 level I believe there is a distinct difference, and in three years time, as I said, I wouldn't expect that there would be a distinct difference, based just on a degenerative basis." (Tr. 41). Dr. Amstutz said that was "strongly suggestive of an acute intervening event[.]" (*Id.*)

Dr. Amstutz's finding of a "distinct difference" in claimant's 1999 cervical MRI scans at the C4-5 level contrasts sharply with the other medical opinions. Dr. Tamplen, radiologist, interpreted claimant's October 15, 1999 cervical MRI as showing degenerative disc narrowing and spurring from C3 to C7. (Ex. 44). He specifically noted that no disc herniations were present and he referred to "mild diffuse bulging and spurring" at C4-5, C5-6 and C6-7. (*Id.*) In a later report, Dr. Tamplen agreed that, after comparing the 1996 and 1999 MRIs, the films were almost identical except for the slight progression of arthritic changes on the 1999 MRI. (Ex. 62-1). He said that no traumatic event could be identified between the dates of the two MRIs. (*Id.*) He found no disc herniations on either MRI. (*Id.*)

Dr. Schilperoort's interpretation of claimant's October 15, 1999 MRI was the same as the February 13, 1996 MRI "with the addition of degenerative disease at C3-4, disc bulges at all levels and facet degenerative changes." (Ex. 60-1). He agreed that the differences between the two MRIs was due to degenerative changes. (*Id.*) Dr. Schilperoort relied on Dr. Amstutz's operative finding that there was "dense bone compromising the C5 and the C6 nerve roots" and concluded that claimant's nerve root compromise was caused in major part by the preexisting multilevel spinal spondylosis. (Ex. 55-6). He explained that claimant's work injury was "not unlike the last straw that broke the camel's back." (*Id.*) Dr. Schilperoort believed that claimant's preexisting degenerative spine changes were the major contributing cause of his need for surgery and his current condition. (Ex. 60-2).

Dr. Young, radiologist, reviewed claimant's imaging studies and found there was essentially no interval change. (Ex. 63-3). He explained that the only difference was a slightly different technique that allowed more detail to be visible on the 1999 study. (*Id.*) Dr. Young said the findings at C4-5 and C5-6 remained unchanged and showed no measurable differences. (*Id.*) He agreed with Dr. Schilperoort that claimant's substantial, preexisting degenerative disease was the major contributing cause of his disability and need for treatment. (Ex. 63-4). Dr. Young also referred to Dr. Amstutz's surgical finding of dense bone compromising the C5 and C6 nerve roots and concluded that the C5 and C6 nerve roots were compromised because of degenerative arthritis involving the end plates and uncinate spurs, as well as the facet joints. (Ex. 63-3).

After reviewing the reports from Drs. Tamplen, Young and Schilperoort, we are not persuaded by Dr. Amstutz's opinion that the MRI scans showed a distinct difference after the 1999 injury that was "strongly suggestive of an acute intervening event[.]" (Tr. 41).

In addition, we find that Dr. Amstutz's opinion about the need for treatment of claimant's C5-6 disc is inconsistent and confusing. In his surgical report, Dr. Amstutz referred to C5-6 stenosis and C6 radiculopathy. (Ex. 49). At hearing, he said there was a contribution to C5 and C6 nerve root compression from bone spurs and disc bulging that had formed in the area. (Tr. 25). Dr. Amstutz testified there was "some" disc herniation at C5-6, which was "beyond the realm of the normal disc" and associated with some osteophytic formation, as well. (Tr. 55). He found that the C6 nerve root was compromised and he did a decompression at C5-6. (Tr. 55, 60, 65, 68). On the other hand, when he was asked whether the C5-6 disc was responsible for claimant's symptoms, Dr. Amstutz said "[n]o." (Tr. 57). He testified that claimant's C5-6 disc looked "pretty much the same" on the 1996 and 1999 MRI scans. (Tr. 59). Thus, although Dr. Amstutz performed a decompression at C5-6 and he felt claimant's C6 nerve root was compromised, he did not believe the C5-6 disc was responsible for claimant's symptoms. We find that Dr. Amstutz's inconsistent opinion is entitled to little weight.

In sum, we conclude that Dr. Amstutz's opinion is not sufficient to establish compensability of claimant's left shoulder/neck condition. For the reasons discussed earlier, Dr. Amstutz's opinion is not entitled to deference as a treating physician or surgeon. He explained that his surgical findings were not particularly helpful in determining causation. (Ex. 58, Tr. 26, Tr. 50). Instead, he relied on claimant's history, the examination findings and the MRI scan. (Ex. 58, Tr. 26). Although Dr. Amstutz found that claimant's MRI scans showed that the work injury caused his need for surgical treatment, we

find that his opinion lacks adequate explanation, particularly in light of the contrary medical evidence. We find that Dr. Amstutz relied mainly on a "precipitating cause" analysis, which is not sufficient to establish compensability. (Ex. 58; Tr. 31, 33, 41, 43). *See Dietz v. Ramuda*, 130 Or App 397, 401 (1994), *rev dismissed* 320 Or 416 (1995) (although a work event may precipitate the symptoms or need for treatment, that does not necessarily mean that it was the major contributing cause of the condition or its need for treatment). We therefore reverse the ALJ's order.

ORDER

The ALJ's order dated August 21, 2000 is reversed. The self-insured employer's denial of claimant's left shoulder/neck condition is reinstated and upheld. The ALJ's attorney fee award is also reversed.

December 19, 2000 Cite as 52 Van Natta 2200 (2000)

In the Matter of the Compensation of
ANITA CHARPENTIER, Claimant
WCB Case No. 00-04117
ORDER ON REVIEW
McGinty & Belcher, Claimant Attorney
Jerald Keene, Defense Attorney

Reviewed by Board Members Meyers and Bock.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Nichols' order that upheld the insurer's denial of her left hand cellulitis condition. Claimant also seeks remand for admission of additional documents not admitted at hearing. On review, the issues are remand and compensability.

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

Claimant has a compensable left hand hematoma condition that resulted when she pinched her finger at work on February 6, 2000. The ALJ found that the medical evidence was not sufficient to carry claimant's burden of proving that her compensable injury was the major contributing cause of her cellutis condition. *See* ORS 656.005(7)(a)(A). Specifically, the ALJ concluded that medical opinions from Dr. Nisbet, claimant's treating physician, did not clarify whether the doctor believes that the accepted hematoma condition was the major cause of the resulting infection in claimant's right index finger.

The record admitted at hearing includes a June 13, 2000 report from Dr. Nisbet stating that the "injury on February 6th is the first mention of an injury in the exact location where the infection occurred, and certainly there is every reasonable possibility or probability that the injury, which did cause a bruise or hematoma formation in the area, went on to become infected, leading to the ultimate diagnosis" of cellulitis. (Ex. 18-1). The report pointed to other "potential causes," including "a cat scratch or any scratch on the pre-existing injury could easily have introduced bacteria, resulting in infection," an "increased risk of infection from being a diabetic and cigarette smoker," and "seeding of bacteria from a site somewhere else in her body to the bruise or hematoma[.]" (*Id.* at 1-2).

Claimant's attorney then submitted to Dr. Nisbet a July 3, 2000 report stating that he had considered all potential causes and had "ruled out these other causes as the most probable cause of the infection because, based upon the history provided to you, the work injury is the most probable cause of the infection." (Ex. 18A-1). Instead of signing the report, however, Dr. Nisbet submitted his own report "to clarify some of my comments," stating that it was "true that the bruise ultimately became infected, and this was the same location as the injury * * *, however, to my knowledge the skin surface was not compromised or broken or cut at the time of the initial injury." (Ex. 19-1). According to Dr. Nisbet, the "bacteria arrived there as a result of an injury in the same location, *i.e.* a cat scratch or seeding from an infection at some other site, and certainly [claimant] is at increased risk of infection due to her diabetes and to her history of smoking." (*Id.*) Dr. Nisbet ended the report by agreeing that "the infection happened on the same injured hand, the same location as her injury that occurred at work, or that the original injury at work with bruising established the right medium or milieu for the infection to occur after the introduction of bacterial at another time." (*Id.*)

Dr. Nisbet's final report stated that he and consulting physician Dr. Girod "are in total agreement that if [claimant] has documented her original injury to this hand, the specific location which caused the initial bruising, there is no question that the original injury was the initiating event that ended up being compounded by infection," thus resulting in "a direct association" between the original injury and the hand infection. (Ex. 20).

On review, claimant submits two additional documents that were generated after the ALJ's order. The more recent document is written by claimants attorney and signed by Dr. Nisbet. It states that Dr. Nisbet disagrees with the ALJ that his opinion expressed in previous reports was "not clear" and "that the injury of February 6, 2000 was the major contributing cause of the infection on [claimants] right index finger." The report further states that Dr. Nisbet did not sign the July 3, 2000 report because he believed that his remaining reports "better explained, and more fully supported, [claimant's] work related medical condition" and he had signed and submitted the July 3, 2000 report.

The second document submitted by claimant on review is another copy of the July 3, 2000 report, now containing Dr. Nisbet's signature. Claimant argues that we should remand the case to the ALJ for admission of the additional reports. The insurer objects, asserting that there is no compelling reason to remand because the reports were available at the time of hearing. We agree with the insurer.

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). There must be a compelling reason for remanding; a compelling reason exists when the evidence: (1) concerns disability; (2) was not obtainable at the time of hearing; and (3) is reasonably likely to affect the outcome of the case. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988). Although evidence that is not generated until after the hearing is "unavailable," it may still have been "obtainable" at the time of hearing. *Compton*, 301 Or at 648-49 (neither erroneous factual foundation nor change of opinion creates unobtainable evidence; thus, even though certain medical reports were not available at the time of hearing, the substance of the reports was obtainable).

Here, Dr. Nisbet's opinion clearly was "obtainable" at the time of hearing inasmuch as he submitted several reports that were admitted at hearing. Thus, because the documents provided by claimant on review relate to Dr. Nisbet's opinion concerning causation of the cellulitis condition, they could have been admitted at hearing and were obtainable at that time.

We also find that the additional documents are not likely to change the outcome in this case. We agree with the ALJ that Dr. Nisbet's reports admitted at hearing were not sufficient to prove that the compensable hematoma injury was the major contributing cause of the cellulitis condition. At best, Dr. Nisbet indicated that there was a "direct association" between the hematoma and cellulitis because both conditions were in the same location; Dr. Nisbet also demonstrated, however, that he considered the bacteria causing the cellulitis to be from another source and that the condition was also affected by claimants diabetes and cigarette smoking.

Although the additional reports state that the compensable injury is the major contributing cause, they do not explain this change in Dr. Nisbet's opinion or provide any explanation why the other potential causes are not as great as the compensable injury. Given these deficiencies, we find it unlikely that the additional reports would allow claimant to carry her burden of proof.

For these reasons, we deny the motion for remand.

ORDER

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

In the Matter of the Compensation of
NABEEH MUSTAFA, Claimant
WCB Case No. 99-09689
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Davis' order that set aside its denial of claimant's occupational disease claim for bilateral carpal tunnel syndrome (CTS). On review, the issue is compensability.

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

The employer relies on *Billie W. Gale*, 52 Van Natta 192 (2000), in support of its contention that Dr. Ackerman's opinion supporting this claim is inadequate. Specifically, the employer contends that the doctor's opinion is based solely on exclusionary analysis and therefore it is legally insufficient. We disagree.

In *Gale*, two doctors offered causation opinions. The first doctor's entire causation opinion consisted of the following statement: "Bilateral carpal tunnel syndrome presumably related to overuse. No obvious risk factors otherwise." *Gale*, 52 Van Natta at 192. We did not rely on the opinion, noting that probability, not possibility, is the requisite standard of proof. We also reasoned that the claimant could not prove compensability "merely by disproving other causes of how the injury or disease occurred." *Id.* We declined to rely on the second doctors opinion in *Gale*, because she offered no reasoning to support her statement that the claimant's work activities were the major contributing cause of the CTS. *Id.*

Here, unlike the opinions in *Gale*, Dr. Ackermans opinion that claimant's work caused his CTS is based on a negative medical history regarding predisposing contributors *and* the doctors evaluation of claimant's production line work activities. Thus, the causation evidence in this case is not based solely on an exclusionary analysis. On the contrary, Dr. Ackerman found it "medically probable" that claimant's work activities were the major cause of his CTS, "based on the tasks. And that is the crux of it." (Ex. 15-22). Dr. Ackerman also reasoned that work was the major cause of the condition, because he was expressly unable "to find any other reason for it occurring." (*Id; see* Ex. 15-13).

The employer further argues that Dr. Ackerman's opinion is unpersuasive because it is based on an inaccurate understanding of the nature and extent of claimant's work activities. However, the doctor visited the plant where claimant worked twice and he knew that claimant worked in the "engine build-up room" for about 40 days, was laid off for 4 days, then rehired on August 4, 1999 to work in the "cab pre-paint area," for a total work exposure of about 100 days. (*See* Exs. 13, 15-21). Dr. Ackerman was aware that claimant operated air driven screw drivers and drills and he did extensive gripping and grasping with vibratory tools at work.[1] (Ex. 13; *see* Ex. 15-8-9). There is no evidence that this history is materially inaccurate or incomplete.

Dr. Ackerman clearly considered the nature of claimant's work and the nature of his condition and found them not only consistent, but causally related. Considering claimants work activities and the lack of evidence of predisposing contributors, Dr. Ackerman attributed "the majority of [claimant's] carpal tunnel syndrome to his workplace activities." (Ex. 13-4). There is no contrary evidence. Under these circumstances, we find Dr. Ackerman's causation opinion persuasive and we rely on it.

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.

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[1] He was also aware that claimant did "taping" activities at work. (Ex. 15-10).

ORDER

The ALJ's order dated August 28, 2000 is affirmed. For services on review, claimant is awarded a $1,500 attorney fee, to be paid by the self-insured employer.

In the Matter of the Compensation of
LISA A. HINER, Claimant
WCB Case No. 00-00492
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Mannix, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Crumme's order that declined to direct the self-insured employer to reopen claimant's claim under ORS 656.262(7)(c).[1] On review, the issue is claim processing.

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

On the claim processing issue, we agree with the ALJ that the employer was not required to reopen claimant's 1990 claim, because the claim for conditions accepted in 1993 was not an "existing claim" on the effective date of the 1997 amendments to ORS 656.262(7).[2] *See SAIF v. Wolff*, 151 Or App 398 (1997) (claim pending on appeal is a claim "existing" on effective date of 1997 statutory amendments); *Bay Area Hospital v. Landers*, 150 Or App 154 (1997) (same).

ORDER

The ALJ's order dated June 23, 2000, as reconsidered on July 28, 2000, is affirmed.

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[1] Claimant has moved to strike the employer's respondent's brief as improperly served. OAR 438-005-0046(2). Because claimant had an opportunity to reply to the employer's timely-filed respondent's brief, the record does not support a conclusion that claimant was prejudiced by the employer's delay of service. *See Charles J. Williams*, 49 Van Natta 601 (1997); *David F. Weich*, 39 Van Natta 468 (1987). Therefore, we are not inclined to reject the employer's brief. Nonetheless, we need not resolve this issue because the ultimate result regarding the substantive issue raised by claimant's appeal would be the same regardless of whether the employer's brief was considered.

[2] *Compare Fleetwood Homes v. VanWechel*, 164 Or App 637 (1999) (amended ORS 656.262(7)(c) required reopening of claim for processing where "post-closure accepted" claim was in litigation on effective date of statutory amendment to ORS 656.262(7)(c)); *Larry L. Ledin*, 52 Van Natta 682 (2000) (same); *Douglas G. Abbott*, 50 Van Natta 1156 (1998) (same).

In the Matter of the Compensation of
DENISE G. FLETCHER, Claimant
WCB Case Nos. 00-02017 & 00-00148
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Jerald Keene, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of that portion of Administrative Law Judge (ALJ) Hazelett's order that set aside its denial of claimant's occupational disease claim for a right shoulder impingement syndrome condition. On review, the issue is compensability.

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

Claimant need not prove that her work activities were the major contributing cause of a pathological worsening of her preexisting right shoulder condition, because her claim is not *based on* a worsening of that condition. *See* ORS 656.802(2)(b); *Michael D. Cessnun, on remand*, 51 Van Natta 1737 (1999) (where no evidence indicated that the claimant's preexisting acromial spur worsened and his occupational disease claim for a left rotator cuff tear was not based such worsening, ORS 656.802(2)(b) did not apply.).[2]

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,800, payable by the insurer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's counsel's statement of services and claimant's respondent's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 12, 2000 is affirmed. For services on review, claimant is awarded a $1,800 attorney fee, to by paid by the insurer.

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[1] However, we do not discount the examining physicians opinions for failing to address claimant's partial rotator cuff tear diagnosis. Although Dr. Rask diagnosed a possible tear, based on claimant's MRI and examination, surgery revealed no such condition. (*See* Exs. 20a, 26, 38, 41, 45ab, 45a). *See* Opinion and Order, p.5.

[2] The insurer relies on *Loretta K. Fountain*, 52 Van Natta 213 (2000), in support of its contention that claimant must prove that her work activities were the major contributing cause of a pathological worsening of her preexisting right shoulder hooked acromion or degenerative osteophyte conditions. *See* ORS 656.802(2)(b). In *Fountain*, the claimant's occupational disease claim was based on a worsening of her preexisting acromion condition (and she failed to prove that work activities caused that worsening). Here, the persuasive medical evidence does not indicate that claimant's preexisting right shoulder condition worsened. Instead, it establishes that claimant's "unusual impingement" (inflammatory tendinitis and bursitis) resulted from her work activities--without a worsening of the preexisting conditions. Accordingly, because this claim is not based on a worsening of preexisting conditions, *Fountain* is distinguishable and ORS 656.802(2)(b) does not apply.

In the Matter of the Compensation of
CHERYL M. GATCHELL, Claimant
WCB Case No. 00-00301
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Scheminske, et al, Defense Attorney

Reviewed by Board Members Meyers and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Black's order that: (1) set aside its denial of claimant's aggravation claim for her left ankle condition; and (2) set aside its denial of her "new medical condition" claims for a left knee lateral meniscal tear and an anterior cruciate ligament rupture. On review, the issues are aggravation and compensability. We reverse.

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we summarize as follows.

On August 22, 1997, claimant compensably injured her left ankle. The employer accepted a "chip fracture, medial malleolus, left ankle." (Ex. 4). A January 23, 1998 Determination Order awarded only temporary disability benefits. (Ex. 6).

On March 10, 1998, claimant sought treatment for pain in her left ankle. (Exs. 7, 8). The claim was reopened, and, on April 15, 1998, Dr. Gordin performed debridement of the left posterior malleolus. (Ex. 11). A September 29, 1998 Determination Order awarded only temporary disability benefits. (Ex. 15). On January 25, 1999, Dr. Stanley performed a medical arbiter examination. (Ex. 16). Dr. Stanley found no instability of the left ankle. *Id.* A February 16, 1999 Order on Reconsideration awarded 7 percent scheduled permanent disability for claimant's left foot (ankle). (Ex. 19).

Claimant sought no further treatment for her left ankle until September 9, 1999, when she returned to Dr. Gordin. Claimant reported that she had begun to have ankle pain in the same area in about June or July 1999. (Ex. 20). Claimant also reported that she had stepped off a curb and twisted her left ankle. *Id.* Dr. Gordin treated her with an injection, heat, massage and stretching. *Id.*

On November 22, 1999, claimant turned her left ankle and fell on her left knee when she was getting into her van. (Ex. 21). Dr. Hindmarsh diagnosed a left ankle sprain and a left knee injury. (Ex. 21). A week later, Dr. Gordin found swelling and tenderness over the peroneal tendons. She diagnosed functional instability of the left ankle, which, she opined, "may represent insufficient rehab from her previous ankle problems," and peroneal tendonitis of the left ankle, and a torn lateral meniscus and subluxation of the patella in her left knee. (Exs. 22, 24, 25). Dr. Gordin submitted an aggravation form. (Ex. 23).

On January 7, 2000, Dr. Gordin repaired a left lateral meniscal tear and anterior cruciate ligament rupture in the knee and explored the left ankle. She found a nodule on the peroneus longus tendon, which she debrided. (Ex. 27AA). On July 10, 2000, claimant's attorney wrote to the employer confirming a consequential condition claim for a left lateral meniscal tear and left anterior cruciate ligament rupture. (Ex. 39).

CONCLUSIONS OF LAW AND OPINION

The ALJ concluded that claimant had established an aggravation of her left ankle condition and the compensability of her new left knee conditions (anterior cruciate ligament rupture and and left lateral meniscal tear) as a consequence of her left ankle instability condition. For the following reasons, we agree with the employer that claimant has failed to prove a compensable aggravation or that her new left knee conditions are compensably related to her left ankle condition.

ORS 656.273(1) provides that a worsened condition resulting from the original injury is established by medical evidence of an actual worsening of the compensable condition supported by objective findings. *See SAIF v. Walker*, 330 Or 102 (2000). In *Gloria T. Olson*, 47 Van Natta 2348, 2350 (1995), we held that ORS 656.273(1) requires proof of two specific elements in order to establish a

worsened condition: (1) "actual worsening," and (2) a compensable condition. Both elements must be satisfied in order to establish a "worsened condition resulting from the original injury." *Id.* If the allegedly worsened condition is not a compensable condition, compensability must first be established under ORS 656.005(7). *Id.*

We begin our analysis with a determination of whether claimant's current left ankle condition is a compensable condition. As a result of the compensable injury, the employer accepted "chip fracture, medial malleolus." The medical record does not establish that the accepted medial malleolus chip fracture condition has worsened. Instead, the evidence indicates that claimant's current left ankle condition consists of peroneal tendonitis and functional instability. (Exs. 22, 24). These are not accepted conditions. Therefore, in order to establish a worsened condition resulting from the original injury, claimant must first establish that the peroneal tendonitis and functional instability are compensable conditions.

Relying on Dr. Gordin's opinion and claimant's testimony, the ALJ concluded that claimant's ankle instability arose directly from the original injury. On review, the employer contends that the medical record does not support claimant's aggravation claim. We agree.

Dr. Gordin opined that claimant had most likely injured the peroneal tendons with the lateral force and internal twisting that occurred at the time of the August 1997 injury, then had a slow progressive course of tendinitis that culminated in the 1999 boggy tendons. Dr. Gordin explained that claimant had tried to strengthen the peroneal muscles and to regain proprioception with physical therapy, but had been unable to prevent functional instability due to the peroneal tendinitis. (Exs. 22, 24, 33).

The contemporary medical record, however, does not mention any peroneal tendonitis. (Exs. 7, 8, 9, 11, 11A, 12, 13, 13A, 13B). Moreover, on August 3, 1998, claimant's physical therapist reported that claimant demonstrated good proprioceptive and balance on the left lower extremity. (Ex. 13B). Dr. Gordin approved claimant's discharge from physical therapy. *Id.* Dr. Gordin also opined that claimant would have no permanent impairment from her injury and surgery other than some stiffness in the ankle. In addition, when Dr. Gordin examined claimant in September 1999, after claimant stepped off a curb and twisted her ankle, she reported that claimant "did very well until about two or three months ago," when claimant started having pain in the same area. (Ex. 20).

On January 25, 1999, Dr. Stanley reported that claimant did not complain of ligament laxity and he found no instability of the left ankle. Subsequently, Dr. Stanley opined that ligament laxity, not the tendons, would cause instability and would cause one's ankle to spontaneously turn. Dr. Stanley affirmed that, in January 1999, claimant did not complain of laxity and he found none. Dr. Stanley also stated that one could turn ones ankle without a prior injury, and that claimant's July and November 1999 incidents were of the type that could independently have caused her ankle problems. (Ex. 29).

Dr. Schilperoort, who had examined claimant for the employer on August 29, 1998, performed a record review. He noted the January 25, 1999 evaluation by Dr. Stanley had found no instability, normal strength, and some decreased range of motion. In comparing Dr. Stanley's evaluation with the November 1999 chart notes, Dr. Schilperoort opined that the November 1999 incident was a new injury and not a continuation of the prior injury. (Ex. 28). Subsequently, after reviewing Dr. Gordin's surgical report, Dr. Schilperoort further opined that the nodularity Dr. Gordin excised from claimant's peroneal tendon was unrelated to any ankle instability.

Where the medical evidence is divided, we give more weight to those opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986). In addition, absent persuasive reasons to the contrary, we generally defer to the opinion of claimant's attending physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we find persuasive reasons not to defer to claimant's attending physician.

As noted above, Dr. Gordin's opinion that claimant's original injury never healed is unsupported by the contemporaneous medical reports. A physical therapy discharge report shows that, on August 3, 1998, claimant had successfully completed physical therapy. At that time she had good proprioception and balance on the left ankle. Dr. Gordin approved the discharge. On August 31, 1998, Dr. Gordin reported that claimant was medically stationary, with no expected permanent impairment.

She made no report of any left ankle instability or tendon problem. In January 1999, Dr. Stanley reported that claimant had normal gait and no instability of the ankle by his findings and claimant's report.

The first medical evidence of "functional instability" is Dr. Gordin's November 29, 1999 report, in which she thought that claimant's instability may have been a result of insufficient rehabilitation of her previous problems. However, Dr. Gordin did not address the possible causative effect of claimant's misstep off a curb in September 1999. In her September 1999 report, Dr. Gordin noted that claimant had been doing "very well" until she began to feel pain in her ankle in June or July 1999. Thus, Dr. Gordin's opinion that claimant had had continued left ankle instability since the August 1997 injury and that the instability caused the November 1999 injury is not well explained, is inconsistent with her own chart notes, and is therefore unpersuasive.

Moreover, Dr. Gordin based her causation opinion upon the assumption that claimant had had no preexisting injury or ankle problems. (Ex. 38). However, claimant had stated on her claim form that she had twisted her left ankle previously. (Ex. 2). She also told Dr. Schilperoort that she had had multiple sports-related sprains. (Ex. 13-3). Because Dr. Gordin's opinion assumes an incorrect history, we give it little weight. *See, e.g., Miller v. Granite Construction Co.*, 28 Or App 473 (1977) (a physician's opinion based on a patient's history is only as reliable as the history is accurate). Accordingly, we conclude that claimant has failed to establish that her left ankle instability condition is compensable.

Under these circumstances, we conclude that claimant has failed to establish the compensability of her left ankle aggravation claim. Moreover, because claimant's left ankle instability condition is not compensable, claimant's alleged consequential left knee conditions are also not compensable. Thus, we reverse the ALJ's decision setting aside the employer's denials.

ORDER

The ALJ's order dated August 28, 2000 is reversed. The self-insured employer's denials are reinstated and upheld. The ALJ's attorney fee is reversed.

December 18, 2000 Cite as 52 Van Natta 2207 (2000)

In the Matter of the Compensation of
JOSEPH A. HULSE, Claimant
WCB Case Nos. 99-07427, 99-02669 & 99-00493
ORDER ON RECONSIDERATION
Black, Chapman, et al, Claimant Attorney
Thomas J. Dzieman, Defense Attorney
Terrall & Terrall, Defense Attorney

Claimant requests reconsideration of our December 5, 2000 Order on Review. Specifically, claimant asks for clarification of the attorney fees awarded by our order.

The ALJ awarded claimant's counsel a $5,600 attorney fee, pursuant to ORS 656.386(1), payable by Barrett Business Services (Barrett), for services at hearing pertaining to Barrett's denial of responsibility. In our order, we explained that claimant remained entitled to a $5,600 attorney fee, payable by Barrett, however, we awarded that fee pursuant to ORS 656.308(2)(d). In addition, the attorney fee we awarded was for both services at hearing, and on review. We also awarded a $1,000 attorney fee to claimant's counsel, for services at hearing and on review, payable from the Workers' Benefit Fund under ORS 656.740(6)(c). In order to clarify this award, we withdraw our December 5, 2000 order.

On reconsideration, as supplemented and clarified herein, we republish our December 5, 2000 Order on Review. The parties' rights of appeal shall begin running from the date of this order.

IT IS SO ORDERED.

In the Matter of the Compensation of
ALLEN MOONEY, Claimant
WCB Case No. 99-00987
ORDER ON REVIEW
Heiling & Associates, Claimant Attorney
Jerald Keene, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The insurer requests review of Administrative Law Judge (ALJ) Peterson's order that set aside its *de facto* denial of claimant's right medial meniscus condition. On review, the issue is compensability.

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

The ALJ relied upon the opinion of Dr. Benz (claimant's attending physician) as supported by Dr. Tesar and concluded that the work injury of August 1997 was the sole cause of claimant's torn right medial meniscus.

The insurer challenges the ALJ's conclusion regarding the cause of claimant's meniscal tear. Specifically, the insurer contends claimant's meniscal tear is a residual condition of a basketball injury that predated claimant's work injury of August 1997.[1] Because of the possible alternative causes for the medial meniscus condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). Here we find Dr. Benz' opinion to be persuasive.

The record establishes that, in December 1994, claimant suffered a complete tear of the anterior cruciate ligament while playing basketball. (Ex. 5; 6; 7). In January 1995, the ligament was surgically reconstructed by Dr. Benz. During surgery, Dr. Benz also examined the condition of the medial meniscus and reported:

> "The medial meniscus was normal in appearance on the surface. There were some areas of weakness that I demonstrated in the posteromedial area but I did not deliberately try to break through these. I did not feel that the weakness justified further exploration." (Ex. 10-1).

On September 30, 1997, Dr. Benz performed a medical meniscectomy on claimant's right knee to repair the disputed medical condition. (Ex. 34). It is Dr. Benz' operative report description of the condition of claimant's medial meniscus in September 1997 that is the source of the present controversy. In noting the condition of claimant's medial meniscus, Dr. Benz indicated: "There was diffuse weakness and fraying of the medial meniscus. Most of it was intrasubstance." (Ex. 34-1).

The insurer reasons that because Dr. Benz did not use the word "acute" in the 1997 operative report, the "weakness and fraying" Dr. Benz observed in 1997 must be the same as the "weakness" he observed in 1995. Therefore, the insurer argues that the meniscus damage repaired by Dr. Benz in 1997, was caused by the 1995 basketball injury. We disagree.

Dr. Benz was deposed after the hearing. During his deposition he described in detail how he probed the meniscus in both 1995 and in 1997. (Ex. 97-12). He explained the difference he noticed upon such probing and how that represented a substantial change in the consistency and character of the meniscus. (*Id.*). Those observations together with the sudden onset of claimant's symptoms immediately following the August 1997 work injury, led Dr. Benz to conclude that the damage to claimant's meniscus was caused by the 1997 work injury. (Ex. 96-4; 97-13).

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[1] The insurer does not dispute that claimant injured his right knee as a result of a work incident in August 1997. The insurer has accepted a "sprain, right knee" as a result of that incident. (Ex. 32).

Dr. Benz has had the opportunity to examine claimant's knee before and after his current claim for medical services for the medial meniscus condition. We find that such an opportunity places him in an advantageous position to offer an opinion. *See Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). When such an opinion is also based, as it is here, upon the physician's actual surgical observations, we give that opinion great weight. *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988).

Consequently, we agree with the ALJ that claimant has established the compensability of his right medial meniscus 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 $3,000, 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 and his counsel's uncontested request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated September 6, 2000 is affirmed. For services on review, claimant is awarded a $3,000 attorney fee, payable by the insurer.

[2] We acknowledge that the record contains the opinions of medical examiners who support the insurer's contentions. However, because each of those opinions is based upon the wording of Dr. Benz' operative reports as opposed to the detailed explanation of his surgical observations as set forth in Exhibits 96 and 97, we find those opinions less persuasive than the opinion and observations offered by Dr. Benz. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977)(medical opinion based upon incomplete information is not persuasive).

In the Matter of the Compensation of
ALLEN B. EHR, Claimant
WCB Case No. 00-00244
ORDER ON REVIEW
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Mongrain's order that upheld the SAIF Corporation's denial of his claim for a head injury. Claimant also moves for remand for a new hearing with a different ALJ. On review, the issues are remand and compensability.

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

Claimant contends that the case should be remanded for a new hearing before a new ALJ because of ALJ's "obvious bias" in favor of SAIF.[1] For the reasons set forth below, we deny claimant's motion to remand.

Claimant was represented by an attorney at hearing. If claimant believed that the ALJ was biased in favor of SAIF, it was incumbent upon claimant's attorney to have objected at that time and requested a change of ALJ. *See* OAR 438-006-0095(2).[2] In effect, claimant's current challenge and

[1] Claimant has sought information regarding the ALJ. We treat this as part of claimant's formal motion for remand for a new hearing and change of ALJ.

[2] OAR 438-006-0095(2) provides, in pertinent part, that any party may request that the ALJ be removed from the case on grounds of personal bias by promptly filing an affidavit with the Presiding ALJ setting forth the matters believed to constitute the grounds for disqualification.

request for a new hearing is a motion for a change of an ALJ. Such a request at this stage of litigation is neither timely nor in accordance with the applicable administrative rule. *See Philip G. Michael*, 46 Van Natta 519 (1994); *Virginia L. Baker*, 44 Van Natta 217 (1992). In other words, such a request must be filed before or during the hearing, prior to the issuance of the ALJ's order.

In any event, even assuming claimant's objection to the ALJ was timely filed, we are statutorily authorized to make our own appraisal of the documentary and testimonial evidence (irrespective of the ALJ's order). *See Sueyen A. Yang*, 48 Van Natta 1626 (1996). Thus, we are authorized to review this record without consideration of the ALJ's findings and conclusions. Under such circumstances, there is no compelling reason to remand for a new hearing before a new ALJ. *See Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986) (remand is appropriate upon a showing of good cause or other compelling basis).

Claimant also asserts that the ALJ incorrectly proceeded with the hearing without SAIF's investigator being present. Claimant argues that he did not have the opportunity to cross-examine the investigator. We note, however, that it was claimant's attorney that offered the investigator's report into evidence. (Trs. 57-58). In doing so, claimant's counsel did not seek continuation of the hearing for the further examination of the investigator. If claimant had desired the testimony of the investigator, his attorney could have called the investigator as a witness or requested a continuance of the hearing for further development of the record. Neither action was taken. In light of this, we perceive no error in the ALJ's conduct of the hearing.

Finally, claimant asserts that the ALJ erred in not finding him a credible witness. The ALJ, however, based his credibility finding on an observation of claimant's demeanor, which the ALJ described as "evasive." We generally defer to an ALJ's demeanor based findings and do so here. *See International Paper Co. v. McElroy*, 101 Or App 61, 64 (1990). Based on such a finding, the record does not establish that claimant's need for medical treatment and/or disability was materially related to an alleged work injury.[3]

ORDER

The ALJ's order dated June 29, 2000 is affirmed.

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[3] In any event, even if we reviewed the record without deference to the ALJ's express demeanor-based credibility finding, the record is still insufficient to satisfy claimant's burden of proving the compensability of his claim.

In the Matter of the Compensation of
CHRISTINA R. GAVLIK, Claimant
WCB Case No. 00-02540
ORDER ON REVIEW
Heather Holt, Claimant Attorney
Bostwick, et al, Defense Attorney

Reviewed by Board Members Haynes, Bock, and Biehl.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Howell's order that set aside its denial of claimant's current low back condition. In her respondent's brief, claimant seeks reversal of that portion of the ALJ's order that upheld the employers denial of her L5-S1 disc condition. The employer moves to strike the portions of claimant's brief addressing compensability of the L5-S1 disc condition. On review, the issues are compensability and motion to strike. We deny the motion and reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The employer moves to strike portions of claimant's respondent's brief. The employer argues that because claimant did not formally cross-appeal the portion of the ALJ's order that upheld the denial of the L5-S1 disc condition, the portion of claimant's respondent's brief that addresses compensability of the L5-S1 disc condition should be stricken.

We deny the motion to strike. By virtue of our *de novo* review, we have authority to consider matters decided by the ALJ that are raised by the parties' briefs in the absence of a formal cross-request for review. *See Destael v. Nicolai Co.*, 80 Or App 596 (1986); *Denise N. Brown*, 51 Van Natta 836 (1999).

Compensability of Current Low Back Condition

The employer denied claimant's current low back condition on the ground that it had combined with claimant's preexisting psychological status and that the major contributing cause of the combined condition was no longer the compensable injury. The ALJ found that claimants psychological "status" did not constitute a "preexisting condition" under ORS 656.005(24). Finding no "preexisting condition," the ALJ concluded that there was no combined condition for purposes of ORS 656.005(7)(a)(B). Finally, the ALJ concluded that claimants lumbosacral strain condition remained materially related to the compensable injury.

Pursuant to ORS 656.005(24), a preexisting condition is:

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

Here, Dr. Grant, who specializes in physical medicine and rehabilitation, concurred with the following statement:

> "As noted by both yourself and Dr. Visser, [claimant] has a significant psychologic overlay to her pain problem, which was likely the result of a preexisting psychologic status. This status has combined with her January 4, 1999 lumbosacral strain to prolong disability and the need for medical treatment." (Ex. 28-1).

Dr. Grant had previously indicated that claimant has some chronic muscular/myofascial low back difficulties, but was very somatically focused. He further noted a significant component of anxiety/adjustment reaction with mixed emotional features with somatic preoccupation, over-dramatized pain behavior, functional overlay and subjective complaints outweighing objective findings.

After reviewing this evidence, we conclude, based on the context of his opinion, that Dr. Grant believed that claimant had a preexisting condition that combined with the injury and is now the major contributing cause of the back condition. Based on the remainder of his opinions in the record that suggest claimant had a predisposing condition, we find that the doctors use of the term psychologic "status" refers to an "injury, disease, congenital abnormality, personality disorder or *similar condition that contributes or predisposes a worker to disability or need for treatment,*" such that this "status" constitutes a "preexisting condition" under ORS 656.005(7)(a)(B).

The only other physician who examined claimant in the relevant time period was Dr. Phillips, medical arbiter. Dr. Phillips found no evidence of a preexisting psychological problem and attributed claimant's low back impairment findings to her accepted condition. Dr. Phillips did not directly address the compensability of claimant's current low back condition. To the extent that Dr. Phillips' opinion can be read to support compensability of claimant's current low back condition, we defer to Dr. Grant, who was claimant's attending physician and who had greater familiarity with claimant's condition. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Under the circumstances, we conclude that there is a preexisting condition that combined with claimant's injury to prolong her disability and need for treatment. Consequently, based on Dr. Grant's opinion, we conclude that claimant's current low back condition is not compensable under ORS 656.005(7)(a)(B) because the compensable injury is not the major contributing cause of the disability or need for treatment of the combined condition.

Compensability of L5-S1 Disc Protrusion

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

ORDER

The ALJ's order dated July 12, 2000 is reversed in part and affirmed in part. That portion of the ALJ's order that set aside the portion of the employer's denial that denied claimant's current condition is reversed. The denial is reinstated and upheld in its entirety. The ALJ's award of an attorney fee is also reversed. The remainder of the ALJ's order is affirmed.

Board Member Biehl dissenting.

I would affirm the ALJ's conclusion that Dr. Grant's opinion regarding claimant's psychological status does not meet the definition of a preexisting condition for purposes of ORS 656.005(24).

After reviewing this record, I am not persuaded by Dr. Grant's unexplained statement that claimant's psychological "status" combined with the injury and is now the major contributing cause of the back condition. It is not clear from the doctor's opinion whether his use of the word "status" rises to the level of an "injury, disease, congenital abnormality, personality disorder or similar condition" under ORS 656.005(24), such that this "status" constitutes a preexisting condition for purposes of ORS 656.005(7)(a)(B). Under such circumstances, I agree with the ALJ that the evidence does not persuasively establish a preexisting condition. Accordingly, I disagree with the majority's analysis and would affirm the ALJ's order which sets aside the employer's denial of claimant's current low back condition.

December 21, 2000 Cite as 52 Van Natta 2212 (2000)

In the Matter of the Compensation of
DAVE A. HUMPHREY, Claimant
WCB Case No. 00-02887
ORDER ON REVIEW
Malagon, Moore, et al, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Crummé's order that: (1) directed it to process claimant's "new medical condition" claim for a herniated disc at L5-S1 under ORS 656.262 and ORS 656.268; (2) awarded a penalty under ORS 656.268(5)(d) for SAIF's allegedly unreasonable claims processing; and (3) awarded an attorney fee under ORS 656.382(1) for SAIF's allegedly unreasonable resistance to compensation. On review, the issues are claim processing, penalties and attorney fees. We affirm in part and reverse in part.

FINDINGS OF FACT

Claimant compensably injured his low back on October 20, 1987. (Exs. 6-1, 13-1). SAIF initially accepted a disabling dorsal lumbar strain. (*Id.*)

Claimant subsequently developed a herniated disc at L5-S1. On November 5, 1997, Dr. Gallo performed low back surgery. (Ex. 1). Dr. Gallo released claimant to regular work on February 2, 1998. (Ex. 5).

SAIF's denial of claimant's L5-S1 disc herniation was set aside by a February 2, 1999 Opinion and Order, which was affirmed by the Board on June 22, 1999. (Exs. 6, 7). The Board's order was not appealed. (Ex. 13-2).

On September 2, 1999, SAIF submitted a Carrier's Own Motion Recommendation that recommended reopening claimant's claim for Own Motion relief. (Ex. 13-2). On September 24, 1999, the Board issued an Own Motion Order that authorized reopening the claim to provide temporary total disability beginning November 5, 1997, the date claimant was hospitalized for surgery. (Ex. 9). The Board subsequently reconsidered its order on October 12, 1999 and amended it to include an attorney fee. (Ex. 11).

An October 6, 1999 Notice of Closure Board's Own Motion Claim awarded temporary disability benefits from November 5, 1997 through January 18, 1998. (Ex. 10). Claimant's attorney wrote to the Board on November 3, 1999, requesting that the October 6, 1999 Notice of Closure Board's Own Motion Claim be remanded to SAIF for processing as a new medical condition.

On December 21, 1999, SAIF issued a modified notice of acceptance, which referred to the accepted conditions as a dorsal lumbar strain and a disc herniation at L5-S1. (Ex. 12).

On April 20, 2000, the Board issued an Own Motion Order Reviewing Carrier Closure. (Ex. 13). The Board interpreted claimant's request for remand of the October 6, 1999 Notice of Closure Board's Own Motion Claim as a request to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and ORS 656.268. (Ex. 13-2). The Board treated claimant's request as a request for hearing before the Hearings Division as a "matter concerning a claim" and it referred the matter to the Hearings Division. (Ex. 13-3, -6). In addition, the Board affirmed the October 6, 1999 Notice of Closure Board's Own Motion Claim. (Ex. 13-6).

CONCLUSIONS OF LAW AND OPINION

Claim Processing

The ALJ relied on *John R. Graham*, 51 Van Natta 1740 (1999), and directed SAIF to process claimant's L5-S1 disc herniation as a new medical condition under ORS 656.262 and ORS 656.268. We adopt and affirm the portion of the ALJ's order that directed SAIF to process claimant's "new medical condition" claim for a herniated disc at L5-S1, and provide the following supplementation.

SAIF argues that claimant is not entitled to additional claim processing under ORS 656.262 and 656.268 because claimant's aggravation rights have expired and the claim is subject to the Board's Own Motion authority. SAIF contends that the Board lacks jurisdiction to direct processing under ORS 656.262(7)(c) once a claim is in Own Motion. In previous cases, we have concluded that the ALJ had jurisdiction over the matter because the claimant's request pertained to the carrier's duty to process his or her claim under ORS 656.262(7)(c). *Michael T. Bergmann*, 52 Van Natta 1931 (2000); *Robert A. Olson*, 52 Van Natta 1540 (2000); *Larry L. Ledin*, 52 Van Natta 682 (2000); *Craig J. Prince*, 52 Van Natta 108 (2000). We reach the same conclusion in this case.

SAIF relies on *Orman v. SAIF*, 131 Or App 653 (1994), and *Harsh v. Harsco Corp.*, 123 Or App 383 (1993), *rev den* 318 Or 661 (1994), to argue that the Hearings Division did not have original jurisdiction to award benefits. Similarly, SAIF argues that ORS 656.278 limits benefits that can be awarded once aggravation rights expire.

We addressed similar arguments in *Camilla S. Kosmoski*, 52 Van Natta 1573, 1574 n.2 (2000), explaining:

> "In light of the Board's bifurcated authority discussed above, we agree with SAIF that the Board has no authority to award benefits under ORS 656.262 and 656.268 under its Own Motion jurisdiction. *Independent Paper Stock v. Wincer*, 100 Or App 625, 627-628 (1990). Similarly, we agree with SAIF that the Board's Hearings Division lacks original jurisdiction to enforce a Board's Own Motion order, *Orman v. SAIF*, 131 Or App 653, 656-657 (1994), and that the Board under its Own Motion jurisdiction has no authority to order vocational assistance, *Harsh v. Harsco Corp.*, 123 Or App 383 (1993).
>
> "However, under the procedural posture of this case, SAIF's reliance on those cases is misplaced. The issues in this case are claim processing under ORS 656.262(7)(c) and claim closure under ORS 656.268, which arise under the Hearings Division's jurisdiction over 'matters concerning a claim,' and not under the Board's Own Motion jurisdiction."

In the present case, we adhere to our conclusion in *Kosmoski*.

Next, SAIF argues that ORS 656.262(7)(c) applies only to conditions in existence and omitted at closure, and does not apply to new medical conditions under ORS 656.262(7)(a). We rejected that argument in *Michael T. Bergmann*, 52 Van Natta at 1931, concluding that ORS 656.262(7)(c) was intended to apply to all conditions found compensable after claim closure.

SAIF also relies on ORS 656.319(6) and argues that claimant had to request a hearing regarding the failure to process the L5-S1 disc herniation within two years of the closure, and he did not.

We rejected a similar argument in *Camilla S. Kosmoski*, 52 Van Natta at 1574 n. 3, and *Robert A. Olson*, 52 Van Natta at 1541. In *Olson*, we found that the alleged claims processing violation was SAIF's failure to process the claimant's February 2, 2000 omitted medical condition claim. We reasoned that the period between the alleged failure to process the medical meniscus and patellar conditions under ORS 656.262(6)(d) and the claimant's request for hearing was well within the two year limitation of ORS 656.319(6). *Olson*, 52 Van Natta at 1541. In *Kosmoski*, we found that the period between the alleged failure to process the claim under ORS 656.262(7)(c) and the request for hearing was less than four months, which was well within the two year statutory period allowed under ORS 656.319(6). 52 Van Natta at 1574 n. 3.

SAIF's argument regarding ORS 656.319(6) is not clear. SAIF contends that "[a]n argument under ORS 656.262(7)(c) that the L5-S1 disc herniation was omitted from the closure would have to have been made within two years." (SAIF's br. at 7). SAIF is apparently basing its argument on its previous assertion that ORS 656.262(7)(c) applies only to conditions omitted at closure, not new medical conditions. This case, however, applies to a new medical condition claim under ORS 656.262(7)(a). For the following reasons, we find that SAIF's reliance on ORS 656.319(6) is misplaced.

SAIF's denial of claimant's L5-S1 disc herniation was set aside by a February 2, 1999 Opinion and Order, which was affirmed by the Board on June 22, 1999. (Exs. 6, 7). The Board's order was not appealed. (Ex. 13-2). An October 6, 1999 Notice of Closure Board's Own Motion Claim awarded temporary disability benefits from November 5, 1997 through January 18, 1998. (Ex. 10). Claimant's attorney wrote to the Board on November 3, 1999, requesting that the October 6, 1999 Notice of Closure be remanded to SAIF for processing as a new medical condition. The Board interpreted claimant's request as a request to order SAIF to process the claim pursuant to ORS 656.262(7)(c) and ORS 656.268, and treated that request as a request for hearing. (Ex. 13). Thus, claimant's hearing request on the alleged claim processing violation was made well within two years of the "alleged inaction." *See Steven R. Azorr*, 52 Van Natta 2145 (2000); *Dennis D. Hall*, 52 Van Natta 1993 (2000).

SAIF also argues that claim preclusion bars the award of additional disability benefits once those benefits have been determined in a claim. SAIF is apparently relying on the October 6, 1999 Notice of Closure Board's Own Motion Claim that awarded temporary disability benefits from November 5, 1997 through January 18, 1998. (Ex. 10). Claimant requested Board review of that Notice of Closure and the Board issued an "Own Motion Order Reviewing Carrier Closure" on April 20, 2000 that affirmed the October 6, 1999 Notice of Closure. (Ex. 13).

In *Larry L. Ledin*, 52 Van Natta at 683, we held that the claimant was not barred by an earlier Own Motion Order from seeking reopening and processing of his right knee torn meniscus condition. We found that the Board's Own Motion Order authorizing time loss for his right knee surgery did not eliminate his right to have his right torn meniscus condition processed under ORS 656.262(7)(c). *Id.*, *see also Errol L. Schrock*, 52 Van Natta 1888 (2000); *Robert A. Olson*, 52 Van Natta at 1540; *Craig J. Prince*, 52 Van Natta at 108. We reach the same conclusion in this case. Claimant is not barred from seeking reopening of his L5-S1 disc herniation because of the October 6, 1999 Notice of Closure Board's Own Motion Claim. Furthermore, claim preclusion does not apply to this case, which involves a new medical condition claim under ORS 656.262(7)(a). *See Dennis D. Hall*, 52 Van Natta at 1993; *Olive M. Bonham*, 51 Van Natta 1710 (1999) (ORS 656.262(7)(a), which allowed the claimant to "initiate a new medical condition claim at any time" created an exception to claim preclusion).

Finally, SAIF argues that *Graham* was wrongly decided, and that *Johansen v. SAIF*, 158 Or App 672, *on recon* 160 Or App 579, *rev den* 329 Or 527 (1999), was decided incorrectly. Because the court has not yet reached a decision addressing the rationale expressed in *Graham*, we adhere to our decision in that case and continue to rely on it. We have no authority to decide whether *Johansen v. SAIF* was wrongly decided and we continue to rely on that case as precedent.

Penalties and Attorney Fees

The ALJ found that SAIF's failure to process claimant's new L5-S1 herniated disc condition under ORS 656.262 and ORS 656.268 had been unreasonable since the Board issued *John R. Graham*, 51

Van Natta at 1740, on October 14, 1999. The ALJ assessed a penalty under ORS 656.268(5)(d) of 25 percent of the increased compensation due upon closure of the herniated disc claim. The ALJ also directed SAIF to pay an assessed attorney fee under ORS 656.382(1) for the unreasonable resistance to compensation.

SAIF contends that the ALJ erred by awarding a penalty for unreasonable claims processing under ORS 656.268(5)(d) and an assessed attorney fee under ORS 656.382(1). SAIF argues that those statutes do not allow both a penalty and an attorney fee to be awarded for the same alleged misconduct. In addition, SAIF argues that claimant is not entitled to an attorney fee under ORS 656.382(1) because there are no amounts due and it did not resist the payment of compensation.

Claimant responds that SAIF is subject to an assessed penalty and attorney fee for its refusal to follow the *Graham* case. Claimant asserts that SAIF's failure to follow established law constitutes an unreasonable resistance to the payment of compensation.

Under ORS 656.262(11)(a), if a carrier unreasonably delays or unreasonably refuses to pay compensation, the carrier shall be liable for an additional amount up to 25 percent of the amounts then due. ORS 656.268(5)(d) provides:

> "If an insurer or self-insured employer has closed a claim or refused to close a claim pursuant to this section, if the correctness of that notice of closure or refusal to close is at issue in a hearing on the claim and if a finding is made at the hearing that the notice of closure or refusal to close was not reasonable, a penalty shall be assessed against the insurer or self-insured employer and paid to the worker in an amount equal to 25 percent of all compensation determined to be then due the claimant."

In the present case, we need not determine whether there are any "amounts then due" because we find that SAIF had a legitimate doubt about its claim processing obligations when it issued a Notice of Closure Board's Own Motion Claim on October 6, 1999. (Ex. 10). In *Camilla S. Kosmoski*, 52 Van Natta at 1574, which was issued subsequent to the ALJ's order, we found that it was not until issuance of *Larry L. Ledin*, 52 Van Natta at 682, that it became clear that, notwithstanding the submission of an Own Motion recommendation (as well as the issuance of an unappealed Own Motion order), a carrier was still obligated to reopen, process and close a claim for a new medical condition pursuant to ORS 656.262 and ORS 656.268. In *Kosmoski*, we reasoned that, because *Ledin* issued after the carrier's claim processing actions, it had a legitimate doubt regarding its liability for processing the new condition claim. *Id.; see also Robert A. Olson*, 52 Van Natta at 1543.

We reach a similar conclusion in this case. We find that, at the time SAIF issued the October 6, 1999 Notice of Closure Board's Own Motion Claim, which was before issuance of the October 14, 1999 *Graham* decision, and also before the April 14, 2000 issuance of *Ledin*, SAIF had a legitimate doubt regarding its liability for processing the new medical condition claim under ORS 656.262 and ORS 656.268. Therefore, we are not persuaded that SAIF's failure to process the new L5-S1 herniated disc condition under ORS 656.262 and ORS 656.268 was unreasonable. *Compare Steven R. Azorr*, 52 Van Natta at 2147 (penalty was assessed where the claimant's request for processing of the new medical condition under ORS 656.262, 656.268, and *Graham* occurred before any Own Motion recommendation was submitted or unappealed Own Motion order had issued). Likewise, claimant is not entitled to an assessed attorney fee under ORS 656.382(1) for the unreasonable resistance to compensation. Accordingly, we reverse the portions of the ALJ's order that assessed a penalty and awarded an attorney fee under ORS 656.382(1).

Claimant's attorney is entitled to an assessed fee for services on review regarding the claim processing issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review concerning the claim processing issue is $1,000, payable by SAIF. In reaching this conclusion, we have particularly considered the time devoted to the claim processing issue (as represented by claimant's respondent's brief), the complexity of the issue, and the value of the interest involved. Claimant's attorney is not entitled to an attorney fee for services on review regarding the penalty or penalty-related attorney fee issues.

ORDER

The ALJ's order dated July 28, 2000 is affirmed in part and reversed in part. The portions of the ALJ's order that assessed a penalty and awarded an attorney fee under ORS 656.382(1) are reversed. For services on review regarding the claim processing issue, claimant's attorney is awarded $1,000, payable by SAIF.

In the Matter of the Compensation of
GARY R. JONES, Claimant
WCB Case Nos. 99-08363 & 98-07040
ORDER ON REVIEW
David C. Force, Claimant Attorney
Garrett, Hemann, et al, Defense Attorney

Reviewed by Board Members Phillips Polich and Bock.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brazeau's order that set aside its denials of claimant's occupational disease claim for a stress-related mental disorder. On review, the issue is compensability.

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

The ALJ determined that claimant suffered from a major depressive reaction, a diagnosis recognized by and set forth in DSM-IV. The ALJ also determined that two employment related stressors (exposure to toxic chemicals in 1997 and a "group-think" phenomenon) were the cause of claimant's mental disorder. Finding that the two employment-related stressors existed in a real and objective sense and were also not generally inherent in every working situation, the ALJ concluded that claimant's major depressive reaction was compensable.

Claimant has the burden to prove that employment conditions were the major contributing cause of the disease. ORS 656.802(2)(a). Existence of the disease must be established by medical evidence supported by objective findings. ORS 656.802(2)(d). Additionally, pursuant to ORS 656.802(3)(a)-(d), 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, corrective or job performance evaluation actions by the employer, or cessation of employment. Furthermore, there must be a diagnosis of a mental or emotional disorder which is generally recognized in the medical or psychological community and there must be clear and convincing evidence that the mental disorder arose out of and in the course of employment. ORS 656.802(3)(c)and(d); *see Leonard R. Terrible*, 51 Van Natta 1375 (1999).

The employer does not dispute that claimant suffers from a major depressive reaction. Nor does the employer contest claimant's exposure to toxic chemicals in 1997. Rather the employer contends that because the exposure was *de minimus* and thus not hazardous, claimant's emotional reaction to the exposure (fear and anger) was irrational. Consequently, the employer argues that claimant's major depressive disorder does not stem from a real and objective work event. In other words, the employer asserts that because the 1997 exposure event was not severe enough to be a "health hazard," the event did not exist in a real and objective sense. (Appellant's Brief, p. 13). We disagree.

In deciding if the employment conditions exist in a real and objective sense, we determine whether the events underlying claimant's mental condition are real, as opposed to imaginary, and are capable of producing stress. *Duran v. SAIF*, 87 Or App 509, 513 (1987). This question does not include whether claimant's perception of the events is reasonable or not, because the medical effect of the events is measured by the actual reaction rather than by an objective standard of whether the conditions would have caused disability of an average worker. *Peterson v. SAIF*, 78 Or App 167, 170, *rev den* 301 Or 193 (1986); *Lester Guyse*, 51 Van Natta 180, 181 (1999).

Here, it is undisputed that claimant was exposed to toxic chemicals in 1997 as the result of his employment as a sewer worker. Although the exposure may not have affected other persons the way it affected claimant, the incident (chemical exposure) did in fact occur. In other words, claimant's perception of the situation was based on a real event which was capable of causing stress. Therefore, claimant has satisfied the "real and objective" requirement of ORS 656.802(3)(a). *Guyse*, 51 Van Natta at 181.

Additionally, the employer asserts that the "group think" phenomenon was a volitional group dynamic in which claimant participated with two co-workers and which became a "self-fulfilling" prophecy. Consequently, the employer argues that claimant's mental disorder (depression) is intentionally self-inflicted, and thus not compensable under ORS 656.156(1).[1]

ORS 656.156(1) provides: "If injury or death results to a worker from the deliberate intention of the worker to produce such injury or death, neither the worker * * * shall receive any payment whatsoever under this chapter." In interpreting an earlier version of the statute, dealing with injuries intentionally inflicted on workers by employers, the Supreme Court said:

> "We think by the words 'deliberate intention to produce the injury' that the lawmakers meant to imply that the employer must have determined to injure an employe and used some means appropriate to that end; that there must be a specific intent, and not merely carelessness or negligence, however gross." *Jenkins v. Carman MFG. Co.*, 79 Or 448, 453 (1916).

In applying the present version of ORS 656.156(1), the court held the claimant's suicide compensable where a mental disorder rendered the claimant incapable of forming a deliberate intent to commit suicide. *McGill v. SAIF*, 81 Or App 210 (1986).

Here, while the record suggests that claimant volitionally engaged in certain activities with his co-workers, the record does not support a conclusion that claimant acted with the specific intent to cause his depression. To the contrary, the medical evidence supports the conclusion that claimant did not act with the specific intent to cause harm to himself. When asked if claimant chose to be depressed, Dr. Telew (an employer-arranged psychiatrist) replied: "No, not at all, no. I think he has evidence of a biological depression." (Ex. 45B-19). Dr. Telew further described claimant as being "more of a passive follower" and "torn between the job he loved and liked, and having to work with these two guys, and that he felt sort of caught in the middle." (Ex. 45B-23). Consequently, we conclude that claimant's mental disorder (depression) did not result from his deliberate intention to produce that condition.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $5,512.50, payable by the employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief and his counsels uncontested request), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated June 13, 2000 is affirmed. For services on review, claimant's attorney is awarded a $5,512.50 fee, payable by the self-insured employer.

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[1] We note there is a rebuttable presumption that injury is not occasioned by the willful intention of the injured worker to commit self-injury or suicide. ORS 656.310(1)(b).

In the Matter of the Compensation of
CHARLES MARSING, Claimant
WCB Case No. 00-03086
ORDER ON REVIEW
Brothers & Ash, Claimant Attorney
Meyers, Radler, et al, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The insurer requests review of Administrative Law Judge (ALJ) Otto's order that: (1) awarded temporary total disability from May 22, 2000 through June 9, 2000; and (2) declined to award sanctions for claimant's allegedly frivolous request for hearing. On review, the issues are temporary disability and sanctions. We reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant compensably injured his low back on November 30, 1999. Dr. Newby took claimant off work until March 3, 2000, then released him to sedentary work with restrictions.

The employer offered claimant modified work, without obtaining Dr. Newby's approval of the job description. Claimant did not begin working at the modified job.

On April 19, 2000, claimant requested a hearing, seeking temporary disability benefits. On June 9, 2000, Dr. Newby found claimant medically stationary.

A June 15, 2000 Notice of Closure closed claimant's back injury claim with awards of temporary disability (total and partial) from December 4, 1999 through May 21, 2000. Claimant did not challenge the Notice of Closure. When a dispute arose regarding claimant's entitlement to temporary disability beyond May 21, 2000, claimant requested a hearing.

The ALJ held that the Hearings Division had jurisdiction to address claimant's entitlement to temporary disability benefits. We agree and adopt his opinion on this issue, through the first full paragraph on page four.

The ALJ noted that the June 15, 2000 Notice of Closure awarded substantive temporary disability benefits from December 4, 1999 through May 21, 2000. He acknowledged that the Hearings Division lacked authority to determine claimants entitlement to procedural temporary disability benefits from April 21, 2000 through May 21, 2000, "because such a determination would create an overpayment beyond what was authorized by the closure order." (Opinion and Order, p.4.) However, because the closure order did not award substantive temporary disability benefits from May 22, 2000 through June 9, 2000, the ALJ concluded that he had authority to "authorize procedural temporary disability benefits" for that period. *Id.* We disagree.

The June 15, 2000 Notice of Closure awarded temporary disability benefits, ending May 21, 2000, and the closure notice became final. Thus, claimant's substantive entitlement to temporary disability benefits prior to the June 15, 2000 Notice of Closure was determined to end on May 21, 2000.

Neither the Hearings Division nor the Board has authority to impose a procedural overpayment by awarding temporary disability beyond the date determined by the closure notice. *Alfredo Martinez*, 49 Van Natta 67, 69 (1997); *see Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992) (Board not authorized to award procedural temporary total disability beyond medically stationary date determined by final closure order). We reach the same conclusion in this case. Moreover, claimant is barred from challenging the Notice of Closure, because he did not first request Department reconsideration. *Joan L. Fisher, deceased*, 51 Van Natta 959, 960 (1999); *Edmund D. Moore*, 49 Van Natta 1426, 1427 (1997) (where

no one requested reconsideration of a Notice of Closure's temporary disability award, the parties were barred from "further litigating" that award under ORS 656.283(7) and 656.268(8)).[1]

Accordingly, claimant is not entitled to temporary disability beyond May 21, 2000, the end of his substantive entitlement under the unappealed closure notice.[2]

Finally, we adopt the ALJ's reasoning and conclusion regarding the insurer's request for sanctions for claimant's allegedly frivolous request for hearing.

ORDER

The ALJ's order dated September 25, 2000 is reversed in part and affirmed in part. That portion of the order that awarded temporary disability compensation for the period from May 22, 2000 through June 9, 2000 is reversed. The ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

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[1] Under ORS 656.268(8), no hearing shall be held on any issue not raised and preserved before DCBS at reconsideration. Under ORS 656.283(7), issues regarding claim closure cannot be raised at hearing if not raised before DCBS. If claimant was dissatisfied with the Notice of Closure, his remedy was to request Department reconsideration. ORS 656.268(5)(b).

[2] In *Candice Marsden*, 50 Van Natta 1361 (1998), the claimant was entitled to procedural temporary disability beyond that awarded by a final Determination Order and Order on Reconsideration, where the claim was reopened under ORS 656.262(7)(c) for processing of new medical conditions that were found compensable after claim closure. Here, unlike *Marsden*, claimant does not seek additional temporary disability based on a new medical condition. Rather, he is seeking an increased award based on the condition for which his claim was previously closed. Because that closure (and its accompanying award) have become final, claimant is precluded from obtaining additional temporary disability for a period that preceded the closure notice.

In the Matter of the Compensation of
GLEN D. OETKEN, Claimant
WCB Case No. 99-08825
ORDER ON REVIEW
Dale C. Johnson, Claimant Attorney
Julie Masters (Saif), Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant[1] requests review of Administrative Law Judge (ALJ) Marshall's order that: (1) denied his request to reopen the record for additional "post-hearing" evidence; and (2) upheld the SAIF Corporation's denial of claimant's injury claim for a lumbar strain and lumbar disc conditions. On review, the issues are the ALJ's evidentiary ruling and compensability.

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

After the ALJ issued his initial, May 22, 2000 order, claimant moved for reconsideration. Along with other arguments on the compensability issue, claimant requested that the ALJ take administrative notice of certain legal documents reflecting additional accepted conditions related to claimant's work injury. Claimant sought to have admitted a March 28, 2000 order by a different ALJ, finding claimant's C5-6 disc herniation condition compensable, and a September 23, 1999 Order on Stipulation documenting SAIF's acceptance of a bilateral temporomandibular joint syndrome (TMJ) condition. By Order on Reconsideration dated July 17, 2000, the ALJ declined to take administrative notice of the documents and adhered to his prior order upholding SAIF's denial of claimant's low back conditions.

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[1] Claimant passed away during the pendency of our review. His surviving spouse is pursuing the appeal pursuant to ORS 656.218(3).

We review the ALJ's evidentiary rulings for abuse of discretion. *Rose M. LeMasters*, 46 Van Natta 1533 (1994), *aff'd mem* 133 Or App 258 (1995); *Ramiro Pelayo*, 52 Van Natta 363 n3 (2000). Because claimant sought to admit additional evidence after the hearing, OAR 438-007-0025 (relating to reconsideration requests) applies. Claimant must explain why the proposed evidence could not reasonably have been discovered and produced at the time of the hearing. OAR 438-007-0025(2)(b). Claimant has failed to offer an explanation consistent with the rule.

The Board may take administrative notice of ALJ's orders and prior approved stipulations, as they are "capable of accurate and ready determination by resort to sources whose accuracy cannot be readily questioned." ORS 40.065(2); *see Rodney J. Thurman*, 44 Van Natta 1572, 1573 (1992); *Carmen Mendoza*, 51 Van Natta 1956 (1999). However, here, the documents claimant seeks to have admitted were both available before the record closed on April 25, 2000. (*O&O* at 1). Claimant did not move for a continuance at hearing to offer the documents at a later time. In these circumstances, we are not persuaded that the documents could not have been discovered and produced at the time of the hearing. OAR 438-007-0025; *Ricardo O. Valenzuela*, 51 Van Natta 1852 (1999).

Furthermore, we agree with the ALJ that the admission of these documents would not affect the outcome of the case. The administrative documents involve conditions unrelated to the conditions at issue here. The documents have little, if any, relevance to this claim. Moreover, with regard to the Order on Stipulation reflecting SAIF's acceptance of the TMJ syndrome, SAIF's September 15, 1999 Modified Notice of Acceptance of that condition is already in the record. (Ex. 31). Admission of the Order on Stipulation would therefore be duplicative of existing evidence. Accordingly, we find that the ALJ did not abuse his discretion in denying claimant's motion to reopen the record. *Ricardo O. Valenzuela*, 51 Van Natta at p. 1852.

ORDER

The ALJ's order dated May 22, 2000, as reconsidered July 17, 2000, is affirmed.

In the Matter of the Compensation of
FRANCESCA R. RABER, Claimant
WCB Case No. 00-02185
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
Paul Louis Roess, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant requests review of Administrative Law Judge (ALJ) Black's order that upheld the self-insured employer's denial of her current low back condition. On review, the issue is the procedural validity of the denial.

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

The ALJ upheld the employer's denial on both procedural and substantive grounds. As to the procedural validity of the denial, the ALJ concluded that the employer's acceptance of a lumbar strain condition prior to denying claimant's "current combined condition" satisfied its obligations under ORS 656.262(7)(b). On the merits, the ALJ found that there was no medical evidence to support the compensability of claimant's current low back condition.

On review, claimant contends that the employer's March 8, 2000 "current condition" denial is procedurally invalid because the employer failed to accept a "combined condition" prior to issuing the denial. We disagree.

We find that the employer never accepted or denied a "combined condition." Instead, the employers March 8, 2000 denial merely: (1) accepted a lumbar strain condition ("to the extent that"

claimant sustained a new strain in October or November, 1999); and (2) denied claimant's current low back condition, diagnosed as either degenerative disc disease or degenerative arthritis, as well as a "developmental anomaly."[1] (*See* Ex. 17). Thus, the employer denied specifically identified and separate conditions, which it generally referred to as claimant's current low back condition. Because it did not attempt to deny a "combined condition," the employer need not have first accepted a "combined condition," pursuant to ORS 656.262(6)(c).[2] *See Blamires v. Clean Pak Systems*, 171 Or App 263 (2000) ("under the wording of ORS 656.262(6)(c), the acceptance of a combined condition must precede the denial of a combined condition").

ORDER

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

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[1] The employer also never accepted any of these conditions separately or as part of a combined condition.

[2] In light of this conclusion, we need not address claimant's contention that the employer cannot both accept and deny a combined condition in the same document.

In the Matter of the Compensation of
JESSE F. ROBERTSON, SR., Claimant
WCB Case No. 00-00059
ORDER ON REVIEW
Johnstone, et al, Claimant Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Meyers, Bock, and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Johnson's order that set aside its denial of claimant's occupational disease claim for a bilateral plantar fasciitis condition. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

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

CONCLUSIONS OF LAW AND OPINION

The ALJ found Dr. Wellikoff's opinion persuasive and consequently concluded that claimant had established the compensability of his bilateral plantar fasciitis condition.

The insurer contends that the opinion of Dr. Fuller persuasively shows that the major contributing cause of claimant's bilateral plantar fasciitis condition are factors not associated with claimant's work. Consequently, the insurer asserts that claimant has failed to establish the compensability of his bilateral plantar fasciitis condition. We agree with the insurer.

Because claimant seeks to establish the compensability of bilateral plantar fasciitis condition as an occupational disease, he must prove that his work activities are the major contributing cause of the disease itself. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000). To satisfy the "major contributing cause" standard, claimant must establish that his work activities contributed more to the claimed condition than all other factors combined. *see, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983).

A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimants disease and deciding which is the primary cause. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994); *see Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

The record contains two medical opinions regarding causation. One is from Dr. Wellikoff, the attending physician. The other is from Dr. Fuller, an insurer-arranged examiner. Dr. Wellikoff's opinion supports the compensability of claimant's bilateral plantar fasciitis condition. Dr. Fuller's opinion does not.

When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). However, in cases which require expert medical analysis rather than expert observation, the opinion of the treating physician is not entitled to deference. *Allie v. SAIF*, 79 Or App 284, 287 (1986).

Upon examination, Dr. Fuller noted that claimant had severe pitting edema in both legs with pitting extending to the patella. (Ex. 7-4). Dr. Fuller opined that claimant had idiopathic plantar fasciitis with the etiology relating to severe weight gain, claimant's overall general health, and his walking activities.[1] (Ex. 7-5).

Dr. Fuller further opined that while walking activities (both on and off the job) precipitated claimant's symptoms, nothing at work was the major contributing cause of claimant's bilateral plantar fasciitis condition. (*Id.*).

Dr. Wellikoff, like Dr. Fuller, believes that claimant's bilateral plantar fasciitis condition is multifaceted. (Ex. 14-1). Dr. Wellikoff opined that three factors have contributed to the problem; the structural mechanics of claimant's foot, the amount of walking required as a part of claimant's work, and claimant's weight gain over the last ten years. (*Id.*). However, in ultimately concluding that the work related walking was the major contributing cause of the bilateral fasciitis problem, Dr. Wellikoff does not appear to have considered the relative contributions of claimant's general health (diabetes mellitus, and congestive heart failure) or claimant's off-work walking activities (hunting and fishing). Because it does not appear that Dr. Wellikoff considered the relative contributions of all the factors contributing to claimant's bilateral plantar fasciitis condition, we do not find his opinion persuasive.[2] *Stacy v. Corrections Div.*, 131 Or App at 614; *Dietz v. Ramuda*, 130 Or App at 402.

In conclusion, we find Dr. Fuller's opinion to be the most complete, and the better reasoned of the two opinions in this record. Consequently, we conclude that claimant has failed to establish the compensability of his bilateral plantar fasciitis condition.[3] We therefore reverse the ALJ's order.

ORDER

The ALJ's order dated August 14, 2000 is reversed. The insurer's denial is reinstated and upheld. The ALJ's award of an assessed attorney fee is also reversed.

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[1] Among other conditions, claimant has diabetes mellitus and probable congestive heart failure. (Ex. 7-4)

[2] Moreover, to the extent that Dr. Wellikoff reasoned that claimant would have remained asymptomatic without the walking activities, he appears to have engaged in a but for analysis. (Ex. 14-1); *see Marlys M. Vick*, 52 Van Natta 1944 (2000); *Joanne C. Broyles*, 51 Van Natta 1250 (1999); *Alec E. Snyder*, 47 Van Natta 838 (1995) (persuasive medical opinion must weigh the relative contribution of different causes; "but for" analysis not well reasoned). Such reasoning is another factor in our determination that Dr. Wellikoff's opinion is not persuasive.

[3] We acknowledge the dissents comments regarding Dr. Fuller's apparent failure to explain how claimants diabetes or congestive heart failure contribute to a strain of the plantar fascia. However, even if we agreed with those comments, our conclusion to reinstate and uphold the insurer's denial would not change because we have found Dr. Wellikoff's opinion insufficient to meet claimant's burden of proof.

Board Member Biehl dissenting.

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

According to Dr. Wellikoff, claimant's condition resulted from excessive strain on the plantar fascia. (Ex. 14-1). Dr. Wellikoff explained that three factors contributed to the problem: (1) the structural mechanics of claimant's foot; (2) the amount of walking required as a part of claimant's work; and (3) claimant's weight gain over the last ten years. (*Id.*). In ultimately concluding that the work related walking was the major contributing cause of the bilateral fasciitis problem, Dr. Wellikoff placed significance on: (1) claimant's lack of prior foot problems; and (2) the lack of bone spurs in the feet. (*Id.*) According to Dr. Wellikoff, the lack of bone spurs supports the conclusion that the plantar fascia problem is of recent onset, rather than longstanding. (Ex. 14-2). I find his opinion well-reasoned and persuasive.[1]

In contrast, Dr. Fuller opined that claimant has idiopathic plantar fasciitis with the etiology relating to severe weight gain, claimants overall general health, and his walking activities. (Ex. 7-5). He then, without further explanation, opined that nothing work related was the major contributing cause. (*Id.*). Without such an explanation, I consider his opinion to be merely an unsupported conclusion, and as such, not persuasive.[2] *Moe v. Ceiling Systems, Inc.*, 44 Or App 429 (1980).

In conclusion, I find no persuasive reason not to defer to Dr. Wellikoff's well-reasoned opinion.[3] Accordingly, I agree with the ALJ that claimant has established the compensability of his bilateral plantar fasciitis condition.

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[1] I acknowledge the insurer's argument that Dr. Wellikoff's opinion is based upon a precipitating cause analysis rather than a major contributing cause analysis. However, because Dr. Wellikoff indicated that the major contributing cause represented more than 50 percent considering all other medical conditions coexisting, I conclude that his opinion is not based upon a precipitating cause standard. (Ex. 12). The insurer also suggests that Dr. Wellikoff did not have an accurate history regarding claimant's weight, *i.e.*, gradual weight gain over the last ten years. I note however, that the history recorded by Dr. Wellikoff (Exhibit 14), is consistent with claimant's testimony that he has had gradual weight gain over a ten year period. (Tr. 12).

[2] I also note that Dr. Fuller does not explain how claimant's diabetes or congestive heart failure contribute to a strain of the plantar fascia. Without such an explanation, I am not willing to conclude, as the majority does, that those two conditions contribute to claimant's bilateral plantar fasciitis problem. Consequently, I do not fault Dr. Wellikoff's opinion for not addressing the diabetes and congestive heart failure conditons.

[3] The insurer argues that because the determination of "major contributing cause" involves expert analysis, as opposed to expert observation, that Dr. Wellikoff's opinion is not entitled to any special weight. I find Dr. Wellikoff's opinion to be the most complete and best reasoned opinion in this record. Accordingly, I find it the most persuasive absent any special weight.

In the Matter of the Compensation of
KATHLEEN SANDERS, Claimant
WCB Case No. 99-10137
ORDER ON REVIEW
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Black's order that upheld the self-insured employer's denials of her aggravation or new medical condition claims for herniated discs at C2-3, C4-5 and C6-7. With her brief, claimant submitted additional documents, which we treat as a request for remand to the ALJ for the admission of additional evidence. On review, the issues are remand, aggravation and compensability.

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

Claimant submitted a number of documents on review. These include copies or partial copies of the following exhibits: 101E, 37, 65, 72, 87, 85, 76, 71, 100, 95, 65, 85, 97, 89, 90, 36, 32, 60, 50, 98, and 102. Because all of these documents were actually admitted into the hearings record, there is no need for remand relating to these exhibits. Moreover, to the extent that claimant requests remand to consider Dr. Corso's December 16, 1999 letter to the employer, this letter was generated well before the August 15, 2000 hearing. Therefore, it was obtainable with due diligence at the time of the hearing. *See Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986) (it must clearly be shown that the evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case). More importantly, Dr. Corso's comments do not address the issue at hand, that is, whether claimant's 1997 injury was the cause of her C2-3, C4-5 and C6-7 disc conditions (in contrast to the accepted C5-6 disc condition). Thus, those comments are not reasonably likely to affect the outcome of this case.

Claimant also raises the theory of compensability of her new medical conditions claim as an occupational disease. Whether her new medical conditions are analyzed as an injury or occupational disease, we agree with the ALJ that the medical evidence is insufficient to establish compensability of claimant's new medical conditions.

In his November 23, 1999 letter responding to the insurer-arranged medical examination, Dr. Belza concluded that he was unable to determine causality of claimant's then-present condition, stating that causality was "unclear." (Ex. 98). Shortly thereafter, on January 11, 2000, Dr. Belza concluded that claimant's work conditions were not the major contributing cause of her need for treatment related to the C3-4, C4-5 or C6-7 disc conditions. (Ex. 102). Dr. Belza concluded that the major contributing cause of claimant's current condition was her preexisting degenerative changes. *Id.* He thought that claimant's work duties may have had some contributory role, but that role was "minor in comparison with the significant preexisting condition that existed at C6-7." *Id.*

Because neither Dr. Belza, claimant's treating physician, nor the insurer's examiners support the compensability of claimant's claim, we affirm the ALJ's opinion upholding the employer's denials.[1]

ORDER

The ALJ's order dated September 14, 2000 is affirmed.

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[1] We note that claimant is presently unrepresented. Because she is unrepresented, she may wish to consult the Workers' Compensation Ombudsman, whose job it is to assist injured workers in workers' compensation matters. She may contact the Workers' Compensation Ombudsman at (503) 378-3351 or 1-800-927-1271 (V/TTY) (within the State of Oregon), or write to:

WORKERS' COMPENSATION OMBUDSMAN
350 WINTER ST NE, ROOM 160
SALEM OR 97301-3878

In the Matter of the Compensation of
ROBERT A. WILSON, Claimant
WCB Case No. 00-00026
ORDER ON REVIEW
Wallace, Klor & Mann PC, Defense Attorney

Reviewed by Board Members Biehl and Haynes.

Claimant, *pro se*, requests review of Administrative Law Judge (ALJ) Johnson's order that upheld the insurer's denial of his occupational disease claim for a bilateral foot condition. With his request for review, claimant also asks for an opportunity to present additional testimony. We treat claimant's request as a motion for remand. On review, the issues are compensability and remand.

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

Remand

Our review must be based on the record certified to us. *See* ORS 656.295(5). Consequently, we treat claimant's request to present additional testimony on review as a motion to remand to the ALJ for the taking of additional evidence. *Tamara J. Fleshman*, 52 Van Natta 1918 (2000); *Judy A. Britton*, 37 Van Natta 1262 (1985).

We may remand to the ALJ if the record has been improperly, incompletely or otherwise insufficiently developed. ORS 656.295(5). Remand is appropriate upon a showing of good cause or other compelling basis. *Kienow's Food Stores v. Lyster*, 79 Or App 416 (1986). To merit remand for consideration of additional evidence, it must clearly be shown that material evidence was not obtainable with due diligence at the time of the hearing and that the evidence is reasonably likely to affect the outcome of the case. *Compton v. Weyerhaeuser Co.*, 301 Or 641, 646 (1986); *Metro Machinery Rigging v. Tallent*, 94 Or App 245, 249 (1988).

Here, there is no evidence that the testimony claimant would submit for the first time on review was unavailable with due diligence at the time of the hearing. *See Tamara J. Fleshman*, 52 Van Natta at 1918. Moreover, in light of the existing documentary and testimonial evidence already present in the record, we find that consideration of this additional evidence would not likely affect the outcome. *See Compton v. Weyerhaeuser Co.*, 301 Or at 646. Under these circumstances, we conclude that the case has not been improperly, incompletely, or otherwise insufficiently developed. Accordingly, it does not merit remand. ORS 656.295(5).

Compensability

The ALJ upheld the insurer's denial based on the opinions of Drs. Peterson and Cook. On review, claimant contends that we should defer to the opinion of his attending physician, Dr. Gauntt. We disagree.

The cause of claimant's bilateral plantar fasciitis condition is a complex medical question, the resolution of which requires expert medical opinion. *Uris v. Compensation Dept.*, 247 Or 420 (1967).

We rely on those medical opinions that are well-reasoned and based on complete and accurate information. *Somers v. SAIF*, 77 Or App 259, 263 (1986). Absent persuasive reasons to the contrary, we generally defer to the opinion of claimant's attending physician. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, we agree with the ALJ that there are persuasive reasons not to defer to claimant's attending podiatrist, Dr. Gauntt.

Because claimant's claim is for an occupational disease, he must prove that his work activities are the major contributing cause of his plantar fasciitis condition. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000). When determining major contributing cause, all potentially causative factors must be considered to determine which one contributes more to the claimed condition than all other conditions combined. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed*, 321 Or 416 (1995).

Here, Dr. Gauntt did not discuss the potential effect of claimant's unusual foot structure on his condition. Dr. Peterson identified claimant's "pes cavus foot structure with a rigid plantar flexed first ray bilaterally," along with "mild pronation" as the predominant contributing factor in the development of claimant's bilateral foot condition. (Exs. 8-2). Lacking an explanation from Dr. Gauntt regarding the possible contribution to claimant's current condition from his foot structure, we agree with the ALJ that Dr. Gauntt's opinion is unpersuasive.

Claimant next contends that the ALJ erred in relying on Dr. Cook, who performed an examination of claimant at the request of the insurer. Dr. Cook concluded that he could not establish a "cause and effect" relationship between claimant's work and his plantar fasciitis condition. (Ex. 9-2). Specifically, claimant contends that Dr. Cook took an inaccurate history of his work activity, in terms of the time that claimant spent on his feet in the warehouse as opposed to his truck driving duties. We disagree.

Consistent with claimant's testimony, Dr. Cook's report reflects an accurate history of claimant's working "at relatively heavy labor working on the docks about three days a week and driving a good part of the remaining work week." (Ex. 9-1, Tr. 12, 13). In any event, even if Dr. Cook relied on an incorrect history, his opinion does not support compensability, which claimant has the affirmative burden to prove. ORS 656.266.

Finally, claimant contends that the ALJ failed to adequately consider the difficulty of performing his work duties of maneuvering bread racks on rubberized floors in extreme heat. We disagree.

As we stated above, this case represents a complex medical question, the resolution of which turns on the opinion of medical experts. Claimant has the burden of proving the compensability of his bilateral foot condition through such expert medical evidence. We agree with the ALJ's conclusion that, because no physician considered the impact of claimant's working on these rubberized mats, we cannot independently consider its potential effect.

ORDER

The ALJ's order dated August 28, 2000 is affirmed.

In the Matter of the Compensation of
JAMES L. BITTLE, Claimant
WCB Case No. 00-02965
ORDER ON REVIEW
Cole, Cary, et al, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

Reviewed by Board Members Biehl and Meyers.

The SAIF Corporation requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) awarded claimant additional temporary disability; and (2) assessed a penalty for SAIF's allegedly unreasonable claim processing. On review, the issues are temporary disability and penalties.

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

Claimant, a truck driver who lives in Keizer, Oregon, compensably injured his right shoulder in December 1999. Claimant came under the care of Dr. Ballard, who restricted him to modified work. (Ex. 14).

In a March 10, 2000 letter, the employer offered claimant a modified duty job at an alternate worksite in Albany, to begin on March 13, 2000. (Ex. 16-1). Dr. Ballard had earlier approved the job as appropriate for claimant's restrictions. (Ex. 15). On March 12, 2000, claimant declined this job offer, alleging that he could not drive to Albany because he had been restricted to no more than 15 minutes driving. (Ex. 16-2).

On March 17, 2000, Dr. Ballard approved a second modified job description, which was identical to the description contained in the March 10, 2000 letter. (Ex. 17). On March 21, 2000, the employer sent claimant the second modified job offer, to begin at the same Albany worksite on March 22, 2000. (Ex. 18). Claimant did not receive this offer until March 27, 2000. (Ex. 19).

Thereafter, SAIF terminated claimant's temporary disability. Claimant requested a hearing, seeking reinstatement of his temporary disability effective March 31, 2000.

The ALJ awarded claimant additional temporary disability, finding that claimant did not "fail to begin" a valid offer of modified employment, because he did not receive the modified job offer until after the position's starting date. *See* ORS 656.268(4)(c).[1] Furthermore, the ALJ assessed a penalty on the unpaid temporary disability, finding that SAIF's termination of temporary disability was an unreasonable resistance to the payment of compensation. ORS 656.262(11).

On review, SAIF first contends that the ALJ disregarded its first offer of modified employment on March 10, 2000. (Ex. 16). We disagree.

The issues at hearing were framed as entitlement to temporary disability from March 31, 2000 until properly terminated under law, and penalties for failure to pay such compensation. (Tr. 2). By March 31, 2000, the employer had expressly made a second offer of modified employment, through its letter of March 21, 2000. (Ex. 18). Dr. Ballard had specifically approved this offer on March 17, 2000. (Ex. 17). Moreover, unlike the first job offer (which was scheduled to begin on March 13, 2000), the second job offer was scheduled to start on March 22, 2000. (Ex. 18-1). Thus, although the duties of the second modified duty position were identical to the duties described in the March 10, 2000 offer, the

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[1] ORS 656.268(4)(c) provides:

"(4) Temporary total disability benefits shall continue until whichever of the following events first occurs:

"* * * * *

"(c) The attending physician advises the worker and documents in writing that the worker is released to return to modified employment, such employment is offered in writing to the worker and the worker fails to begin such employment."

March 21, 2000 offer was separate and distinct from the first job offer. (Ex. 18-1). Finally, because the second offer was more recent in time, it contained the most updated medical authorization from Dr. Ballard.[2] (Ex. 17).

At most, claimant's failure to begin the first offer of employment would potentially affect claimant's entitlement to "pre-March 31, 2000" temporary disability. However, as we discussed above, that period of temporary disability was not at issue at hearing.

Turning to the merits of the temporary disability issue, we agree with the ALJ's reasoning that claimant did not "fail to begin" the employer's second modified job, which was offered on March 21, 2000. *See* ORS 656.268(4)(c). In reaching this conclusion, we find that claimant did not receive the March 21, 2000 letter containing the offer of employment until March 27, 2000, which was after the March 22, 2000 starting date for the modified job. (Exs. 18, 19).

The employer must strictly comply with the requirements set forth in ORS 656.268(4) in order to terminate a claimant's temporary disability benefits. *Eastman v. Georgia Pacific Corp.*, 79 Or App 610 (1986). Strict compliance includes following the sequence of events contemplated by ORS 656.268(4)(c). *See Anthony R. Holder*, 50 Van Natta 1760 (1998) (insurer must obtain approval from attending physician *before* making offer of modified employment under *former* ORS 656.268(3)(c), even if approval is obtained later). Similarly, it is implicit in the statute that in order for a claimant to "fail to begin" a modified job, such employment must first be "offered in writing to the worker," *i.e.* the claimant must first be notified of that job before its starting date.[3] ORS 656.268(4)(c).

As previously noted, claimant received the second modified job offer after the job was scheduled to begin. In light of such circumstances, SAIF's termination of claimant's temporary disability based on this improper sequence of events was unreasonable. Consequently, the assessment of a penalty for such conduct was warranted.

Claimant's attorney is entitled to an assessed fee for services on review relating to the temporary disability issue. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review regarding the temporary disability issue is $2,000, 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, claimant's attorney's fee request, and SAIF's response to the attorney fee request), the complexity of the issue, and the value of the interest involved.[4] Claimant's attorney is not entitled to a fee for services related to the penalty issue. *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

ORDER

The ALJ's order dated August 15, 2000 is affirmed. For services on review, claimant's attorney is awarded $2,000, payable by SAIF.

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[2] Although he had earlier approved the March 10, 2000 offer of modified employment on March 9, 2000, Dr. Ballard again reviewed and approved the job description associated with the March 21, 2000 offer on March 17, 2000. (Exs. 15, 17).

[3] In light of our disposition of the temporary disability issue on this basis, we need not address claimant's argument that the employer's modified job offer at an "alternate worksite" does not satisfy the requirement of a "return to modified employment" under ORS 656.268(4)(c), nor SAIF's argument that claimant's need for transportation to the alternate worksite was not a "job-related restriction," which would excuse claimant's failure to begin the modified work. *See Robert E. Dixon*, 48 Van Natta 46 (1996).

[4] Claimant's attorney asserts 18 hours of preparation regarding claimant's respondent's brief. However, time expended is but one of the factors to be considered among those enumerated in the administrative rule. Moreover, in reaching our determination, we note that we are not bound by a strict mathematical calculation. *See Jamie L. Boldway*, 52 Van Natta 755 n2 (2000); *Cheryl Mohrbacher*, 50 Van Natta 1826 (1998). Finally, contrary to claimant's assertion, we do not find that any frivolous issues were raised by SAIF in this request for review. OAR 438-015-0010(4)(h).

In the Matter of the Compensation of
RICHARD J. HINKLEY, Claimant
WCB Case No. 00-02534
ORDER ON REVIEW
Ransom & Gilbertson, Claimant Attorney
Lundeen, et al, Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

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

FINDINGS OF FACT

We adopt the ALJ's findings of fact, which we summarize and supplement as follows.

On July 22, 1992, claimant sustained a compensable injury when he was struck by a falling tree. The insurer accepted an "acute thoracolumbar strain, left hand contusion, left ilium contusion."

On January 28, 1997, Dr. Durkan filed an aggravation claim, stating that claimant needed repair of a left rotator cuff tear. On May 18, 1997, the insurer accepted a disabling aggravation of "left rotator cuff, thoracic & lumbar strain." (Ex. 4). On July 14, 1997, Dr. Durkan performed a partial acromioplasty and excision of the subacromial bursa. (Ex. 5).

On July 15, 1997, the parties entered into a stipulation in which the insurer agreed to accept claimant's claim for "left rotator cuff tear." (Ex. 5A). On July 29, 1997, the insurer issued a Notice of Acceptance for a disabling aggravation of "left rotator cuff tear." (Ex. 6). On November 4, 1998, Dr. Switlyk performed diagnostic arthroscopy of the glenohumeral joint and revision acromioplasty and lysis of adhesions, left shoulder. (Ex. 7).

On November 10, 1999, the insurer closed claimant's claim by a Notice of Closure that declared claimant medically stationary as of May 3, 1999, and awarded temporary disability benefits through that date. (Exs. 9, 10).

Claimant requested reconsideration, asserting, among other things, that his medically stationary date was incorrect. (Ex. 12). On March 2, 2000, an Order on Reconsideration issued that, among other things, affirmed the time loss dates as authorized by the attending physician. (Ex. 14). Claimant requested a hearing, raising the issue of additional temporary disability.

CONCLUSIONS OF LAW AND OPINION

The ALJ relied on Dr. Switlyk's May 3, 1999 medical report, finding that claimant was medically stationary[1] on that date. On review, claimant contends that the correct medically stationary date should be October 8, 1999, the date Drs. Bald, Green and Duncan examined claimant for the insurer.[2] Claimant argues that, even though Dr. Switlyk stated that he thought claimant was medically stationary on May 3, 1999, claimant's condition materially improved after that date, as shown by claimant's increased range of motion findings at the October 8, 1999 examination. Claimant also relies on the insurer's examiners' statement that claimant was "currently" medically stationary.

After considering the record, we find Dr. Switlyk's opinion to be persuasive regarding claimant's medically stationary status. Although the insurer's examiners stated that claimant was "currently" medically stationary, their comment does not persuade us that claimant's condition was not medically stationary on May 3, 1999.

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[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).

[2] Claimant does not maintain that the claim was prematurely closed, noting that, even if the medically stationary date is redetermined to be October 8, 1999, the November 10, 1999 claim closure would not be premature. Thus, the issue before the ALJ was whether claimant qualified for additional temporary disability.

Moreover, we have previously found that when treatment is designed to primarily improve a claimant's functional abilities, and not to improve the compensable condition, this treatment is not determinative when establishing medically stationary status under ORS 656.005(17). *Kelly J. Trussell*, 47 Van Natta 121 (1995); *Frank M. Douglas*, 46 Van Natta 1445 (1994).[3] Here, on May 3, 1999, Dr. Switlyk noted that claimant was continuing to experience myofascial pain and spasm around his shoulder girdle, neck and rib cage. Dr. Switlyk stated that claimant was stationary as far as any separate problem with the shoulder, "but it is all interrelated to his overall neck and shoulder condition." Dr. Switlyk referred claimant's ongoing care to Dr. Brauer and recommended continuing physical therapy for palliative care.

The physical therapy reports indicate that that treatment was focused on maintaining low levels of pain with daily activities and in improving claimant's functional capabilities. (Exs. 7B, 8AC, 8AD). Although physical therapy may improve claimant's functionality, functional improvement alone is not determinative of claimant's medically stationary status. Instead, there must be evidence that such a program is designed to improve claimant's compensable condition. Without such evidence, and given Dr. Switlyk's persuasive opinion that claimant's left shoulder condition was medically stationary as of May 3, 1999, we do not find medical evidence that claimant's medically stationary date should be changed.[4]

ORDER

The ALJ's order dated August 24, 2000 is affirmed.

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[3] In reaching our conclusions in *Trusell* and *Douglas*, we relied on *Clarke v. SAIF*, 120 Or App 11 (1993). In *Clarke*, the claimant argued that although his treating physician declared him medically stationary, his need for a leg brace to support his weak leg supported his contention that he was not medically stationary until his leg was fitted for the brace and he was released from medical care. The court paraphrased the claimant's argument as an argument that "ORS 656.005(17) is not limited to medical treatment prescribed for improving his physical condition, but also encompasses treatment prescribed solely for the improvement of his functional abilities given a particular condition." *Clarke*, 120 Or App at 13. The court rejected that argument and held that "medical treatment prescribed solely to improve a claimant's functional abilities is not pertinent to the determination of a claimant's medically stationary date under ORS 656.005(17)." *Clarke*, at 120 Or App 13-14. Because there was no evidence that the leg brace was prescribed to improve the claimant's physical condition, the *Clarke* court concluded that the claimant was medically stationary when the carrier closed his claim.

[4] We contrast the circumstances of this case with those in *Janet L. Schell*, 52 Van Natta 2140 (2000). In *Schell*, the claimant's attending physician opined that the claimant's medical condition was not stationary. He also recommended work hardening and a PCE II. He did not attribute those recommendations as a mere attempt to address fluctuating symptoms, but, as we found, those recommendations were, at least partially, designed to evaluate the claimant's need for surgery in addition to her capacity for performing physical activities, and, as such, were evidence of a reasonable expectation of material improvement of the claimant's condition.

Here, in contrast, claimant's attending physician opined that claimant's medical condition was stationary and he considered his recommendation for physical therapy to be palliative care. The physical therapy notes establish that it was performed merely to control pain and improve claimant's functional capacity, which is insufficient to show a reasonable expectation of material improvement in claimant's condition itself.

In the Matter of the Compensation of
GEORGE L. ALLENBY, Claimant
WCB Case No. 97-02663
ORDER OF ABATEMENT
Thomas Dzieman, Claimant Attorney
Lundeen, et al, Defense Attorney

On November 27, 2000, we issued an Order on Remand that affirmed a March 20, 1997 Second Order on Reconsideration which had found that claimant's injury claim was prematurely closed. Announcing that the parties have agreed to settle all issues related to our recent order, the insurer seeks abatement of our decision to await our eventual consideration of their written agreement.

Based on the insurer's representation, we withdraw our November 27, 2000 order. On receipt of the parties' proposed agreement, we will proceed with our review of the settlement. In the meantime, the parties are requested to keep us apprised of further developments regarding this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
GREGORY C. HUNTER, Claimant
WCB Case No. 99-06237
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

Reviewed by Board Members Meyers and Bock.

The self-insured employer requests review of that portion of Administrative Law Judge (ALJ) Stephen Brown's order that set aside its denial of deQuervain's tenosynovitis and right lateral epicondylitis. The employer also moves to strike claimant's "reply" brief on the ground that it raises issues not previously raised at hearing. On review, the issues are compensability and motion to strike. We deny the motion to strike, reverse in part and affirm in part.

FINDINGS OF FACT

We adopt the ALJ's "Findings."

CONCLUSIONS OF LAW AND OPINION

Motion to Strike

The employer moves to strike claimant's respondent's brief (designated by claimant as a "reply" brief) on the ground that it raised for the first time the issue of the compensability of a psoriatic arthritis condition. The insurer asserts that claimant never filed a claim for this condition or raised the compensability of this condition at hearing. The ALJ, however, specifically found that claimant had failed to prove that his psoriatic arthritis was caused or worsened by his work activity. (Opinion and Order P. 4). Moreover, the condition was specifically mentioned in the employer's denial. (Ex. 21). Thus, we conclude that compensability of that condition was at issue at the hearing. Accordingly, we deny the motion to strike.

Compensability

Claimant filed a workers' compensation claim after being awakened at night by right hand pain after a particularly vigorous day of work performing the duties of a city's utility worker. Claimant eventually came under the care of Dr. Murdock on May 13, 1999 and was given several diagnoses: subacute right lateral epicondylitis, subacute right carpal tunnel syndrome, subacute stenosing tenosynovitis of the right thumb and small finger, and subacute right wrist deQuervain's tenosynovitis. (Ex. 17).

The employer later arranged for an examining physician, Dr. Radecki, to evaluate claimant's right upper extremity complaints. Dr. Radecki reported on June 24, 1999 that claimant demonstrated no evidence of the conditions Dr. Murdock diagnosed and that the only condition present was preexisting psoriatic arthritis affecting the right hand and foot. (Ex. 19).

On July 7, 1999, the employer issued a denial of claimant's right hand and elbow "problems," noting that the medical evidence suggested that his current problems may be due to psoriatic arthritis and not to employment. (Ex. 21). Claimant request a hearing from the denial.

In deciding the compensability issue, the ALJ separately analyzed the compensability of each of the conditions diagnosed by Dr. Murdock. The ALJ determined that claimant sustained his burden of proving that two of the diagnosed conditions were compensable: the lateral epicondylitis and deQuervain's tenosynovitis conditions. According to the ALJ, claimant failed to prove, however, the existence of the thumb and little finger tenosynovitis and carpal tunnel syndrome conditions. Finally, the ALJ determined that claimant had failed to prove that his psoriatic arthritis was caused or worsened by his work activity.

In determining that the epicondylitis condition was compensable, the ALJ found that Dr. Murdock had testified that the condition was likely due to the microtrauma of heavy physical work and that Dr. Murdock's opinion was unrebutted. The ALJ also reasoned that the deQuervain's condition was compensable based on Dr. Murdock's opinion.

On review, the employer contends that the ALJ incorrectly determined that the epicondylitis and deQuervain's conditions were compensable based on Dr. Murdock's opinion. The employer argues that Dr. Murdock's opinion is not sufficient to satisfy claimant's burden of proof with respect to these conditions. For the following reasons, we agree.

The parties agree that the compensability of claimant's disputed conditions is subject to ORS 656.005(7)(a)(B). Therefore, in order to establish the compensability of those conditions, claimant must show that his work injury was the major contributing cause of the disability or need for treatment of the combined conditions. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, 106 (1997), *aff'd as modified on recon*, 149 Or App 309, 315 (1997), *rev den*, 326 Or 389 (1998).

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

Because claimant's preexisting psoriatic arthritis may be responsible for claimant's need for treatment, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263 (1986).

On May 13, 1999, Dr. Murdock initially opined that claimant's deQuervain's and epicondylitis conditions were related to a day of strenuous work. (Ex. 17-2). After Dr. Radecki attributed claimant's right upper extremity conditions to preexisting psoriatic arthritis, Dr. Murdock qualified his earlier assessment to state that, if psoriatic arthritis was ruled out by a consulting physician, Dr. Basin, claimant's condition was "secondary" to a workplace injury. (Ex. 22).

Dr. Basin diagnosed probable psoriatic arthritis. (Ex. 25-2). On September 15, 1999, Dr. Murdock acknowledged that claimant had psoriatic arthritis, but he continued to diagnose right lateral epicondylitis, as well as carpal tunnel syndrome. (Ex. 28-2). Dr. Murdock opined that the latter conditions likely had a "workplace relationship," while the psoriatic arthritis did not. Dr. Murdock was subsequently deposed.

In his deposition, Dr. Murdock testified that psoriatic arthritis was contributing to claimant's upper extremity conditions. Dr. Murdock further testified that he was unable to determine whether a workplace injury or the psoriatic arthritis was the major contributing cause owing to his lack of expertise with respect to psoriatic arthritis. (Ex. 32-13). Dr. Murdock also testified that he would defer to rheumatologists with respect to the causation issue. (Ex. 32-23).

Having reviewed Dr. Murdock's opinion as a whole, we are not persuaded that it establishes to a degree of medical probability that claimant's epicondylitis and deQuervain's conditions are work related. Therefore, we look to the opinions of other physicians who addressed the causation issue.

As previously noted, Dr. Radecki diagnosed only psoriatic arthritis in claimant's right upper extremity and stated that the condition was preexisting and not work related. (Ex. 19). Accordingly, Dr. Radecki's opinion does not prove compensability.

Dr. Basin opined that claimant's right hand symptoms seemed to arise following an injury at work, but acknowledged that was not proof of cause. (Ex. 25-2). Dr. Basin later agreed in a concurrence letter that she could not find objective evidence of epicondylitis or deQuervain's tenosynovitis. (Ex. 35). In her deposition, Dr. Basin was asked whether she would defer to Dr. Murdock's diagnoses of deQuervain's and lateral epicondylitis. Dr. Basin, however, did not answer the question. (Ex. 36-11, 12). After considering Dr. Basin's opinion, we also conclude that it does not satisfy claimant's burden of proof.

The final opinion is from an examining physician, Dr. Sultany. Dr. Sultany opined that claimant had some evidence of mild right-sided epicondylitis, as well as psoriatic arthritis. However, Dr. Sultany stated that the psoriatic arthritis was not caused by work. Dr. Sultany did not comment on whether the epicondylitis was work related. (Ex. 30). As is true with the other medical evidence, Dr. Sultany's medical opinion does not establish the compensability of the disputed conditions.

Given the state of the medical evidence, we conclude that it does not prove that the disputed epicondylitis and deQuervain's conditions are compensable. Thus, we reverse that portion of the ALJ's order that determined that they are compensable.

ORDER

The ALJ's order dated June 8, 2000, as reconsidered on July 31, 2000, is reversed in part and affirmed in part. The employer's denial is reinstated and upheld in its entirety and the ALJ's attorney fee award is also reversed. The remainder of the ALJ's order is affirmed.

December 22, 2000 Cite as 52 Van Natta 2233 (2000)

In the Matter of the Compensation of
ALAN KUCERA, Claimant
Own Motion No. 00-0268M
OWN MOTION ORDER ON RECONSIDERATION (POSTPONING ACTION)
Martin J. McKeown, Claimant Attorney
Liberty Northwest Ins. Corp., Insurance Carrier

The insurer requests reconsideration of our August 30, 2000 Own Motion Order, that authorized reopening of this claim for the payment of temporary disability compensation. Specifically, the insurer contends that, when appropriate, this claim should be closed under OAR 438-012-0055 and ORS 656.278 rather than ORS 656.262.

In order to allow sufficient time to consider the insurer's motion for reconsideration, we abated our order and established a briefing schedule on September 22, 2000. Having received the parties' responses, we proceed with our reconsideration.

FINDINGS OF FACT

On September 16, 1987, claimant compensably injured his right wrist while working for the insured. The insurer accepted the injury claim as a disabling arthrodesis, right wrist. On October 5, 1988, the insurer closed the claim with an award of permanent partial disability compensation. Claimant's aggravation rights expired five years later, on October 5, 1993.

On September 2, 1998, claimant saw Dr. Dietrich for right wrist and elbow pain. Dr. Dietrich opined that the wrist pain probably originated from the open joints, which were intended to be fused, and the elbow pain probably originated from osteochondroses of the insertion of the triceps tendon.

On October 26, 1998, claimant sought treatment with Dr. Horn, who injected his lateral extensor musculature. In a November 4, 1998 medical report, Dr. Dietrich noted that surgery had been recommended.

On December 9, 1998, the Board authorized the reopening of claimant's claim for the payment of temporary disability compensation commencing the date claimant underwent the proposed surgery.

On December 15, 1999, Dr. Welch, hand specialist and plastic surgeon, examined claimant on behalf of the insurer. Dr. Welch opined that claimant had reached a "fixed and stable state with regarding to the right wrist." He noted that claimant was also being treated for tendonitis of the extensor muscle group in the right forearm, or "tennis elbow," which "apparently . . . has not been accepted at this time."

On February 3, 2000, the insurer issued a "Notice of Closure Board's Own Motion Claim" that closed claimant's claim with an award of temporary total disability compensation from December 17, 1998 through December 15, 1999. The insurer declared claimant medically stationary as of December 15, 1999. On February 14, 2000, Dr. Horn concurred with the Dr. Welch's findings.

On February 17, 2000, claimant requested "reconsideration" of the insurer's February 3, 2000 closure. The Board affirmed that closure on May 23, 2000. That order was not appealed.

On March 23, 2000 and June 7, 2000, claimant requested that the insurer accept additional diagnoses as "new medical conditions." On June 16, 2000, the insurer issued a Modified Notice of Acceptance for the "new medical conditions" as requested by claimant. Those conditions were processed under ORS 656.262(7)(c) to closure on July 6, 2000 pursuant to ORS 656.268. Claimant requested review of the insurer's July 6, 2000 closure.[1]

On August 24, 2000, the insurer submitted a "Carrier's Own Motion Recommendation" form that recommended that claimant's September 16, 1987 wrist injury claim be reopened. On this form, the insurer noted that claimant's "accepted" condition regarding the 1987 injury was "right wrist fracture, tendonitis, avascular necrosis/degenerative changes, c[h]ondromalacia right elbow" and his current condition was "same."

By Own Motion Order dated August 30, 2000, we authorized the reopening of claimant's September 16, 1987 injury claim to provide temporary disability compensation beginning the date claimant was hospitalized for surgery. We also ordered the insurer to close the claim ORS 656.268 when claimant was medically stationary.

On September 20, 2000, the insurer requested reconsideration of our August 30, 2000 Own Motion Order. Specifically, the insurer contended that it had already processed claimant's "new condition" claim to closure pursuant to ORS 656.268 and that, by accepting the "new condition" claim and processing to closure, claimant is not entitled to a "new set of aggravation rights for each accepted condition under the claim."

CONCLUSIONS OF LAW AND OPINION

The Board, in its Own Motion jurisdiction, may authorize monetary benefits in the form of temporary disability benefits from the time a worker is hospitalized or undergoes surgery for a worsening of a compensable injury until the worker becomes medically stationary. ORS 656.278(1)(a). Here, claimant's aggravation rights have expired on his September 16, 1987 claim and surgery has been recommended regarding that claim. Thus, under his 1987 injury claim, claimant is entitled to have his claim reopened under ORS 656.278 for the payment of temporary disability compensation beginning the date of his hospitalization.

However, in his response to the insurer's motion, claimant asserts that his claim should be reopened pursuant to ORS 656.262(7)(c).

Here, the issue of whether the claim should be processed under ORS 656.262(7)(c) is a "matter concerning a claim" and under ORS 656.283, any party "may at any time request a hearing on any matter concerning a claim," with certain exceptions not applicable here. In addition, our Own Motion rules provide for circumstances in which matters normally within our "Own Motion" authority interrelate with matters within the authority of other levels of workers compensation system, *e.g.* claims for own motion relief that involve medical service disputes within the Director's jurisdiction and/or compensability disputes with the Hearings Division's jurisdiction. *See* OAR 438-012-0050.

Specifically, OAR 438-012-0050 provides that the Board will act promptly upon a request for relief under the provisions of ORS 656.278 and our rules unless: (1) the claimant has available administrative remedies under the provisions of ORS 656.273; (2) the claimant's condition is subject of a contested case under ORS 656.283 to 656.298, ORS 656.307 or ORS 656.208; or (3) the claimant's request for payment of temporary disability compensation is based on surgery or hospitalization that is the subject of a Director's medical review under ORS 656.245, 656.260, 656.327. Under any of those circumstances, the Board may postpone its review of the merits of claimant's request for Own Motion relief if the available remedies set forth above could affect the Board's authority to award compensation under the provisions of ORS 656.278. That is the case here.

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[1] We make these findings of fact based on the parties' briefs to the Board regarding the reconsideration request currently before us. Both briefs refer to claimant's March and June 2000 requests that the insurer expand/amend its acceptance to include new medical conditions.

We treat claimant's request that this claim be reopened under ORS 656.262(7)(c) as a request for hearing on a "matter concerning a claim" pursuant to ORS 656.283. Consequently, we have referred the matter to the Hearings Division. We postpone action on claimant's request for Own Motion relief pending resolution of this related litigation.

At the hearing, the Administrative Law Judge (ALJ) assigned to conduct the hearing shall resolve the claim processing issue raised by the insurer's and claimant's contentions (as well as any other issues properly raised by the parties). In addition, the assigned ALJ shall make findings of fact and conclusions of law and opinion regarding the effect of his or her decision on this claim processing matter on claimant's Own Motion claim.

At the conclusion of the hearing, the ALJ shall forward to the Board a separate, unappealable recommendation with respect to this Own Motion matter and a copy of the appealable order issued in the WCB Case (number to be assigned). In addition, if the matter is resolved by stipulation, the ALJ is requested to submit a copy of the settlement document to the Board. After issuance of the order or settlement document, the parties should advise the Board of their respective positions regarding Own Motion relief.

Accordingly, we withdraw our August 30, 2000 Own Motion Order. Further action on this case shall be postponed pending resolution of the dispute pending before the Hearings Division.

IT IS SO ORDERED.

In the Matter of the Compensation of
MICHAEL A. NELSON, Claimant
WCB Case Nos. 99-07959 & 99-00582
ORDER OF DISMISSAL
Glen J. Lasken, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney
Reinisch, MacKenzie, et al, Defense Attorney

Argonaut Insurance Company, on behalf its insured, Discount Tires, requested review of Administrative Law Judge (ALJ) Thye's order that: (1) set aside its compensability and responsibility denial of claimant's current low back condition; and (2) upheld the *de facto* denial of CNA Insurance on behalf of its insured, Regal Wheel, of the same condition. Claimant and Argonaut have submitted a "Disputed Claim Settlement" designed to resolve all issues raised or raisable between them.

Pursuant to the settlement, the parties agree that Argonaut's denial "shall remain forever affirmed, and that the June 7, 2000 Opinion and Order shall be permanently set aside." The agreement further provides that "each Request for Hearing shall be dismissed with prejudice."

We approve claimant's and Argonaut's settlement, thereby fully and finally resolving this dispute, in lieu of the ALJ's order.[1] Accordingly, this matter is dismissed with prejudice.

IT IS SO ORDERED.

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[1] A provision in the settlement states that a portion of claimant's share of the proceeds shall be provided to a "non-workers' compensation" insurance provider in satisfaction of its lien for health insurance. Because the compensability dispute is being resolved by a Disputed Claim Settlement (DCS), only medical service providers may be directly reimbursed from the settlement proceeds. ORS 656.313(4)(c). (Health insurance providers may be directly reimbursed by the workers' compensation carrier when "the services are determined to be compensable." ORS 656.313(4)(b).) Nonetheless, because proceeds from a DCS are not considered "compensation," a claimant's assignment of all or a portion of his share of the proceeds is not prohibited by ORS 656.234. *Robert D. Surina*, 40 Van Natta 1855 (1988); *Theodule Lejeune, Jr.*, 40 Van Natta 493 (1988). Here, we do not interpret the aforementioned settlement provision to represent that a non-workers' compensation insurance carrier will receive reimbursement directly from the workers' compensation carrier. Rather, in granting our approval of the settlement, we have interpreted the settlement as stating that claimant has assigned a portion of his share of the settlement proceeds to the non-workers' compensation carrier. Pursuant to *Lejeune* and its progeny, such an assignment is not contrary to ORS 656.234.

In the Matter of the Compensation of
PEDRO L. PERERA, Claimant
WCB Case Nos. 00-05451 & 00-03346
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Julie Masters (Saif), Defense Attorney
Cavanagh & Zipse, Defense Attorney

Reviewed by Board Members Phillips Polich and Meyers.

Farmers Insurance Company requests review of those portions of Administrative Law Judge (ALJ) Otto's order that: (1) set aside its responsibility denial of claimant's aggravation claim for a bilateral wrist condition; (2) upheld the SAIF Corporation's responsibility denial of claimant's new injury claim for the same condition; and (3) assessed a penalty for Farmers' allegedly unreasonable denial. On review, the issues are responsibility and penalties.

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

We substitute the last paragraph of the ALJ's "Findings of Fact" with the following: "On July 7, 2000, Dr. Button concurred with Farmers' attorney's summary of his opinion that claimant's work activities at WW Truck Trailer were the major contributing cause of the worsening of claimant's bilateral carpal tunnel syndrome. (Ex. 22)."

Responsibility

Claimant is a trailer mechanic. On March 2, 1998, claimant began working for Young Trailer Company, Farmers' insured. (Ex. 11). Claimant's work duties involved heavy use of his hands and wrists. (Tr. 9). Claimant began to develop bilateral hand symptoms of tingling, numbness and pain, worse on the right. (Tr. 9, 10). He sought treatment with Dr. Thomas on March 4, 1998, who diagnosed bilateral carpal tunnel syndrome (CTS) and trigger finger conditions. (Exs. 4, 5). On March 27, 1998, Dr. Cobasko performed nerve conduction studies, which revealed a very mild right carpal tunnel syndrome. (Ex. 6-2).

On September 21, 1999, Farmers accepted claimant's claim for non-disabling "probable bilateral carpal tunnel syndrome." (Ex. 14).

On September 27, 1999, claimant began working for WW Truck Trailer, insured by SAIF. His job duties were essentially the same as at Young Trailer. On March 3, 2000, claimant returned to Dr. Thomas with worsened bilateral hand and wrist symptoms. Dr. Thomas diagnosed bilateral carpal tunnel syndrome, pathologically worsened since 1998. (Ex. 15). On March 17, 2000, repeat nerve conduction studies confirmed a pathological worsening of the condition bilaterally. (Ex. 17-2). The condition was now worse on the left. (*Id.*)

On April 17, 2000, Farmers denied responsibility for claimant's bilateral carpal tunnel syndrome. (Ex. 20). Claimant then filed a claim with WW Truck Trailer/SAIF. SAIF issued a responsibility denial on July 14, 2000. (Ex. 24).

The ALJ set aside Farmers' denial, finding that Farmers had not met its burden of proof to shift responsibility for claimant's bilateral carpal tunnel syndrome condition to SAIF, the insurer for claimant's current employer. On review, Farmers contends that the ALJ erred in failing to defer to Dr. Button. We disagree.

Because Farmers originally accepted claimant's bilateral carpal tunnel syndrome condition, it "remains responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition." ORS 656.308(1). Responsibility remains with Farmers unless the record establishes that claimant has sustained a new occupational disease involving the same condition. To establish a new occupational disease, the record must establish that claimant's employment conditions with WW Truck Trailer were the major contributing cause of the combined condition and pathological worsening of the disease. *See* ORS 656.802(2)(b); *Douglas L. Wilson*, 51 Van Natta 1473 (1999); *Pamela T. Smith*, 50 Van Natta 2162 (1998).

In *Douglas L. Wilson*, the insurer for the claimant's earlier employer accepted the claimant's claim for bilateral CTS condition. 51 Van Natta at 1474. That insurer later denied responsibility for the condition, alleging that the claimant's work at a later employer was the major contributing cause of the condition. Through the opinion of a physician, the earlier insurer proved only that the later work activity was the major contributing cause of the *worsening* of the claimant's CTS condition, not of the entire combined condition. ORS 656.802(2)(b). *Id.* The Board set aside the earlier insurer's denial, reasoning that it had not met its burden of proving that the later work activity was the major contributing cause of the combined condition and pathological worsening of the disease. *Id.*

This case is indistinguishable from *Douglas L. Wilson*. Here, Dr. Button examined claimant at the request of Farmers on August 20, 1999. (Ex. 13). Dr. Button diagnosed "probable bilateral carpal tunnel syndrome" and reasoned that the major contributing cause of claimant's "ongoing symptoms" was his work activity at Young Trailer. (Ex. 13-4). On July 7, 2000, after reviewing additional medical records and nerve conduction studies, Dr. Button concluded that the "worsening which has now taken place" was related in major part to claimant's work activity "since leaving Young Trailer Company in September, 1999." (Ex. 22-1).

Because Dr. Button did not state that the later work activity at WW Truck Trailer was the major contributing cause of both a pathological worsening of the CTS condition *and* of the combined condition,[1] we agree with the ALJ that Farmers did not meet its burden to shift responsibility to SAIF. ORS 656.308(1); *Douglas L. Wilson*, 51 Van Natta at 1475; *see also Dale A. Hargadine*, 51 Van Natta 428 (1999).[2] Responsibility remains with Farmers. Accordingly, Farmers' responsibility denial was properly set aside.

Penalties

We adopt and affirm the ALJ's order on the penalties issue.

ORDER

The ALJ's order dated August 21, 2000 is affirmed.[3]

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[1] Dr. Button represents the only medical opinion arguably supportive of Farmers' position.

[2] We decline Farmers' invitation to disavow *Wilson* and *Hargadine*.

[3] Claimant's attorney is not entitled to an additional fee for services on review under ORS 656.382(2), as the only issues were responsibility and penalties. *See* ORS 656.308(2)(d); *Saxton v. SAIF*, 80 Or App 631, *rev den* 302 Or 159 (1986).

In the Matter of the Compensation of
VICTOR SCHUNK, Claimant
Own Motion No. 98-0383M
OWN MOTION ORDER REVIEWING CARRIER CLOSURE
Floyd H. Shebley, Claimant Attorney
Kemper Ins. Co., Insurance Carrier

Claimant requests review of the insurer's September 21, 2000 Notice of Closure, which closed his claim with an award of temporary disability compensation from January 13, 1999 through August 27, 2000. Claimant contends that he is entitled to additional benefits as he was not medically stationary on August 27, 2000, when the insurer terminated time loss payments.

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). 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).

Dr. Keenen, claimant's attending physician, provided the only medical evidence regarding claimant's medical stationary status. On September 11, 2000, Dr. Keenen noted that claimant's "pain was largely unchanged." He took some back measurements and noted that he would see claimant back in three months. He also ordered new diagnostic studies. On October 2, 2000, following receipt of the diagnostic studies, Dr. Keenen noted that claimant was "medically stationary at this point." He also noted that his September 11, 2000 physical exam was "acceptable for the closing exam." Inasmuch as Dr. Keenen did not perform a physical examination on October 2, 2000 but rather simply reviewed the diagnostic studies, we interpret his statement regarding the September 11, 2000 exam to mean that claimant was medically stationary at that time.

Claimant is substantively entitled to temporary disability benefits if the record establishes that he was disabled due to the compensable injury before being declared medically stationary. ORS 656.210; *Lebanon Plywood v. Seiber*, 113 Or App 651, 654 (1992). The insurer terminated temporary disability benefits on August 27, 2000. However, the record shows that claimant was not medically stationary until September 11, 2000.

Accordingly, we modify the insurer's September 21, 2000 Notice of Closure to award claimant additional temporary disability compensation from August 27, 2000 through September 11, 2000, the date claimant was declared medically stationary.

Finally, claimant's attorney is allowed an approved fee in the amount of 25 percent of the increased temporary disability compensation awarded under this order, not to exceed $1,050, payable by the insurer directly to claimant's attorney. *See* OAR 438-015-0010(4); 438-015-0080.

IT IS SO ORDERED.

In the Matter of the Compensation of
FOREST C. STALNAKER, Claimant
Own Motion No. 00-0308M
OWN MOTION ORDER
Saif Legal Department, Defense Attorney

The SAIF Corporation submitted claimant's request for temporary disability compensation for claimant's compensable low back condition. Claimant's aggravation rights expired on January 21, 1997. SAIF recommended against reopening on the grounds that: (1) surgery or hospitalization is not appropriate for the compensable injury; and (2) claimant was not in the work force at the time of disability. Claimant requested Director's review of the requested medical treatment. (Medical Review Case No. 5706).

On October 27, 2000, we postponed action pending resolution of medical issues which were before the Director. On December 11, 2000, the Director issued its Order of Dismissal (MTX 00-837) because SAIF provided information which indicated that the Managed Care Organization (MCO) in which claimant was enrolled found the proposed surgery medically necessary and appropriate. Additionally, the Director noted SAIF's agreement with that finding. Accordingly, the Director concluded that there is no longer a dispute regarding medical issues and dismiss the review. Thus, although SAIF no longer contests the appropriateness of the recommended surgery, it continues to contend that claimant was not in the work force at the time of his current worsening.

Inasmuch as the medical dispute has been resolved, we proceed with our review of claimant's request for own motion relief and his work force status at the time of the current worsening.

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

It is undisputed that claimant's compensable condition requires surgery or hospitalization. However, in order to be entitled to temporary disability compensation upon a worsening of a work-related injury, a claimant must be in the work force at the time of disability. *SAIF v. Blakely*, 160 Or App 242 (1999). A claimant is in the work force at the time of disability if he or she is: (1) engaged in

regular gainful employment; or (2) not employed, but willing to work and is seeking work; or (3) not working but willing to work, and is not seeking work because a work-related injury has made such efforts futile. *Dawkins v. Pacific Motor Trucking*, 308 Or 254, 258 (1989).

Claimant submits Dr. Heder's, his primary care provider, October 20, 2000 report in support of his contention that he could not work due to the compensable condition and that it would have been futile for him to look for work because of his compensable condition. Dr. Heder opined that claimant "continues fully disabled for any significant amount of employment." He further opined that, although claimant is participating in a program of chronic pain management, his discomfort is not relieved sufficient that "he can expect to seek or carry our employment." Dr. Heder's opinion is unrebutted. Thus, we conclude that claimant has provided a persuasive medical opinion demonstrating that he was unable to work at the time of his current worsening and that it would have been futile for him to seek work due to the compensable condition.

Further, in order to satisfy the third *Dawkins* criterion, claimant must also establish, along with the "futility" standard, that he was willing to work. Failing to demonstrate his willingness to work, then he is not considered a member of the work force, and thus, is not entitled to temporary disability compensation. *See Arthur R. Morris*, 42 Van Natta 2820 (1990); *Stephen v. Oregon Shipyards*, 115 Or App 521 (1992); *Judith R. King*, 48 Van Natta 2303 (1996); *Marlene J. Andre*, 48 Van Natta 404 (1996).

Claimant submitted an October 22, 2000 affidavit wherein he asserts that he was willing to work. He attests that "[a]lthough my injury has made searching for work futile, I still have the desire to work and would do so if it were possible." We are persuaded that claimant is willing to seek employment but unable to do so because of his compensable condition.

Accordingly, we authorize the reopening of claimant's claim to provide temporary disability compensation beginning the date claimant 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.

December 27, 2000 Cite as 52 Van Natta 2239 (2000)

In the Matter of the Compensation of
CARLA K. CHURCHILL, Claimant
WCB Case No. 99-09760
ORDER ON REVIEW
Westmoreland & Mundorff, Claimant Attorney
Hettle & Martin, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

The self-insured employer requests review of Administrative Law Judge (ALJ) Johnson's order that set aside its denial of claimant's low back injury claim. On review, the issue is compensability. We reverse.

FINDINGS OF FACT

On August 5, 1999, claimant, a retail clerk, allegedly injured her low back while retrieving a 13-inch television set for a customer. Claimant alleged that, while doing so, she inadvertently tripped on an piece of "blister pack," losing her balance and twisting her body. The alleged injury was unwitnessed. Claimant did not file a claim until two days later, on August 7, 1999. The form 801 indicates that claimant had not previously injured her lower and middle back. (Ex. 29).

Claimant sought treatment from Dr. Handley on August 7, 1999, who diagnosed a lumbar strain. (Ex. 30). For objective findings, Dr. Handley listed tender lumbosacral area and decreased range of motion. Claimant again represented that the affected body part had not been previously injured. *Id.*

Claimant came under the care of Dr. Oksenholt on August 11, 1999. Like Dr. Handley, he also diagnosed a low back strain. (Ex. 34). Claimant once again denied prior injuries or trauma. *Id.*

The employer eventually denied the claim on October 26, 1999. Claimant requested a hearing.

Claimant has had a history of prior injuries to body parts other than the low back. However, on July 8, 1994, Dr. Borman reported that claimant had previously suffered an injury while working for the employer but had a complete recovery from her low back symptoms. (Ex. 7-2). On July 17, 1996, claimant had x-rays of the lumbar spine. The report stated after the words "CLINICAL INFORMATION": "chronic low back pain." (Ex. 21). On August 27, 1996, Dr. Soot noted that claimant had a history of low back pain but that it had not been a problem to her at the time. (Ex. 23).

CONCLUSIONS OF LAW AND OPINION

The ALJ set aside the employer's denial of claimant's low back injury claim. Although not making an express credibility finding, the ALJ determined that claimant had an injurious incident of "some magnitude" on August 5, 1999. The ALJ then determined that the injury claim was supported by "objective findings," consisting of reproducible tenderness and reduced range of motion. Thus, the ALJ held that claimant had proved a compensable injury claim.

On review, the employer contends that claimant has not carried her burden of proving that this unwitnessed injury is compensable. Specifically, the employer argues that medical and legal causation turns on claimant's credibility, and that, because claimant is not a credible witness, her claim must fail.

To begin, we infer that the ALJ found claimant a credible witness because of his finding that claimant proved that an injurious event of "some magnitude" occurred at work. However, we are in as good a position as the ALJ to evaluate claimant's credibility based on an objective review of the substance of the record (especially in the absence of a demeanor-based credibility finding). *See Coastal Farm Supply v. Hultberg*, 84 Or App 282 (1987); *Davies v. Hanel Lumber Co.*, 67 Or App 35 (1984). Following our *de novo* review of the record, we find that claimants testimony was not credible.

First, as previously noted in our factual findings, claimant has a preexisting history of a low back injury and prior chronic low back pain. Claimant denied the presence of previous low back injuries in contemporaneous medical records. In a statement given to the employer, claimant's denial of prior back problems was even broader. Not only did claimant deny prior back injuries, but she also denied prior medical treatment and "any problems" with the back, including pain. (Ex. 41A-8). At the hearing, claimant was asked if she had ever previously complained of low back pain. She replied "no." (Tr. 12).

Claimant also alleged in her recorded statement that she had a large swollen area in her lower back after her injury. (Ex. 41A-19). At hearing, claimant testified that she could feel a swollen area in her low back after her injury and was also experiencing numbness. (Tr. 17-18). Claimant further testified that her back stayed that way after she sought treatment and that the swelling was observable. (Tr. 18). The contemporaneous medical records, however, do not contain any notation of swelling. (Exs. 30, 34).

Finally, claimant testified that during her "post-injury" vacation she lifted nothing heavier than a "pocket book" or items less than two pounds. Moreover, she denied any significant gardening activities. (Trs. 22, 25). However, surveillance videotape (and the accompanying testimony of the investigator) establishes that claimant assisted in the lifting of two bags at a garden store. (Ex. 43; Tr. 46). Claimant later conceded that she had performed active gardening activities in her yard. (Tr. 52).

In summary, we do not find the substance of claimant's testimony credible. For that reason, we give little weight to the opinion of Dr. Oksenholt, who attributed claimant's need for treatment by history to her alleged work-related injury. *See Miller v. Granite Construction Co.*, 28 Or App 473 (1977) (a medical opinion is no better than the history on which it is based). Therefore, we conclude that claimant has failed to establish a compensable claim.

ORDER

The ALJ's order dated September 18, 2000 is reversed. The self-insured employer's denial is reinstated and upheld. The ALJ's attorney fee award is reversed.

In the Matter of the Compensation of
BARBARA F. COOPER, Claimant
WCB Case No. 00-04164
ORDER ON REVIEW
Michael B. Dye, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Meyers and Phillips Polich.

Claimant requests review of Administrative Law Judge (ALJ) Tenenbaum's order that decreased claimant's scheduled permanent disability award for loss of use or function of the right forearm (wrist) from 13 percent (19.5 degrees), as awarded by an Order on Reconsideration, to 8 percent (12.0 degrees). On review, the issue is extent of scheduled permanent disability.

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

The sole issue at hearing was the SAIF Corporation's challenge to the 5 percent impairment awarded by the Order on Reconsideration under OAR 436-035-0010(5), which provides for a chronic condition impairment value when a worker is "significantly limited in the repetitive use" of one or more body parts. In her reply brief, claimant requests that, if we agree with the ALJ that the medical arbiters report does not support a chronic condition award, we remand the matter to the Director for promulgation of a temporary rule to determine her disability "as her disability is not addressed by the standards."

We have the authority to remand a claim to the Director for promulgation of a temporary rule when a disability is not addressed by the existing standards. *See Gallino v. Courtesy Pontiac-Buick-GMC*, 124 Or App 538, 541-42 (1993); *Gevers v. Roadrunner Construction*, 156 Or App 168 (1998) (court held that, if a claimant's disability is not addressed by the standards, the Board is required, under ORS 656.726(3)(f)(C) to remand to the Director for adoption of a temporary rule that assesses the claimant's disability, regardless of whether the adoption of a temporary rule has been requested). Thus, the threshold issue in determining whether to remand to the Director for promulgation of a temporary rule is a determination that a disability is not addressed by the existing standards. As explained below, that threshold issue is not met here, *i.e.*, claimant's disability is addressed by the existing standards. Therefore, remand to the Director is not appropriate.

Claimant has the burden of proving that her disability is not addressed by the standards. *See Katie J. Opdenweyer*, 52 Van Natta 92 (2000); *Terry Hockett*, 48 Van Natta 1297 (1996), *Susan D. Wells*, 46 Van Natta 1127 (1994) (no remand to the Director for temporary rules where the claimant failed to meet her burden of proving that her disability was not addressed by the standards); *compare Peter Gevers*, 51 Van Natta 32 (1999) (where Board determined that the claimant's disability was not ratable under the standards, it remanded the claim to the Director for promulgation of a temporary rule, even though the claimant had not requested such relief). The standards include a rule that addresses impairment for limitation of repetitive use of a body part, which is the type of impairment for which claimant seeks an award. OAR 436-035-0010(5). In addition, the Director specifically found that claimant's disability was addressed by the current standards. (Ex. 26-3). While we agree with the ALJ's reasoning and conclusions that the medical arbiter's report[1] does not meet the requirements of proving chronic condition impairment under OAR 436-035-0010(5), that does not mean that claimant's disability was not addressed by the standards. Therefore, because the standards address claimant's disability, we find that remand is not appropriate.

Claimant also argues that the ALJ failed to apply the correct burden of proof, noting that the burden of proof was upon SAIF, as the party seeking to reduce the permanent disability award made by the Order on Reconsideration. We disagree and find that the ALJ applied the correct burden of proof.

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[1] Because claimant's attending physician did not perform a closing examination, only the medical arbiter's report may be used to determine impairment.

The court has clarified the role of burden of proof in proceedings where a carrier seeks reduction of a permanent disability award made by an Order on Reconsideration. *Marvin Wood Products v. Callow*, 171 Or App 175 (2000). Relying on ORS 656.283(7)[2] and the statutory scheme regarding the reconsideration process, the court determined that, apart from possibly supplementing the record with a medical arbiter report, the statute no longer contemplates that a party seeking review of a reconsideration order disability award has the ability to introduce new "evidence" showing that the disability standards were misapplied.

Rather than a burden of "proof" to convince the factfinder based on new evidence, the court concluded that the party requesting a hearing from a reconsideration order had a "burden of establishing error in the prior resolution," which involved persuading the reviewing body of the correctness of its position that the disability standards had been misapplied in the reconsideration order based on the record made at reconsideration. The court summarized the "burden" on a party dissatisfied by a reconsideration order as follows: (1) a burden of going forward by proposing in what way the determination below was erroneous; and (2) a burden of establishing the correctness of that position.

Here, in persuasively arguing that the medical arbiter's report did not meet the requirements of proving a chronic condition impairment under the standards, SAIF met its "burden of establishing error in the prior resolution," as explained by the court in *Callow*. In this regard, as the ALJ found, although finding that claimant had "some difficulty with repetitive use," the medical arbiter was unable to determine what repetitive use impairment was due to the accepted right wrist contusion and what was due to the noncompensable carpal tunnel syndrome condition. In addition, as the ALJ reasoned, "some difficulty with repetitive use" does not meet the requirement under OAR 436-035-0010(5) of being "significantly limited in the repetitive use" of a body part. *See Daralynn Nevett*, 52 Van Natta 1856 (2000).

ORDER

The ALJ's order dated August 29, 2000 is affirmed.

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[2] ORS 656.283(7) provides, in part:

"Evidence on an issue regarding a notice of closure 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."

In the Matter of the Compensation of
THOMAS M. THORSON, Deceased, Claimant
WCB Case No.99-07930
ORDER OF ABATEMENT
Whitehead & Klosterman, Claimant Attorney
James B. Northrop (Saif), Defense Attorney

On November 30, 2000, we vacated the Administrative Law Judge's (ALJ's) order that had: (1) excluded Exhibit 13 (an accident reconstruction report); and (2) upheld the SAIF Corporation's denial of claimant's claim (as the widow of the deceased worker) for survivor's benefits. Concluding that it was an abuse of discretion for the ALJ to have excluded the exhibit, we remanded for further proceedings. Asserting that we "misunderstood the basis for the ALJ's evidentiary ruling," SAIF seeks reconsideration of our prior decision.

In order to further consider this matter, we withdraw our November 30, 2000 order. Claimant is granted an opportunity to respond. To be considered, claimant's response must be filed within 14 days from the date of this order. Thereafter, we will proceed with our reconsideration.

IT IS SO ORDERED.

In the Matter of the Compensation of
EMMETT G. DeHART, Claimant
WCB Case Nos. 99-04686 & 99-03863
ORDER ON REVIEW
Popick & Merkel, Claimant Attorney
Jerald Keene, Defense Attorney
Sather, Byerly & Holloway, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Kemper Insurance Company (Kemper) requests review of the portions of Administrative Law Judge (ALJ) Herman's order that: (1) set aside its compensability/responsibility denial of claimant's "new injury" claim for a left shoulder condition; and (2) upheld EBI Insurance Companies' (EBI) denial of claimant's aggravation claim for the same condition. On review, the issues are compensability and responsibility.

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

Compensability

The ALJ determined that claimant's work injury of January 1999 (Kemper) combined with claimant's ongoing left shoulder condition from a work injury of December 1997 (EBI) to produce a "combined" condition diagnosed as bursitis and impingement syndrome.[1] Relying on Dr. Dales, the attending physician, the ALJ further determined that the major contributing cause of the "combined" condition, as well as the major contributing cause of the disability and need for treatment of the combined condition was the January 1999 work injury. Consequently, the ALJ concluded that claimant had established the compensability of his current left shoulder condition.

Kemper agrees that claimant's current left shoulder condition is a "combined" condition, but asserts that Dr. Dales' opinion is not persuasive. Rather, Kemper contends that Dr. Fuller's opinion persuasively establishes that the major contributing cause of this "combined" condition is not the 1999 work injury.

Because of the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967). When there is a dispute between medical experts, more weight is given to those medical opinions which are well reasoned and based on complete information. *See Somers v. SAIF*, 77 Or App 259, 263, (1986). In evaluating medical opinions, we generally defer to the treating physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983).

Dr. Fuller opined that the January 1999 injury caused, if anything, only a temporary exacerbation of symptoms in the left shoulder, but not any pathological or material worsening of that condition. (Ex. 158-6). The basis for his opinion is his belief that there is no specific diagnosis in claimant's left shoulder.[2] (Ex. 158-5). The wording of his opinion suggests he was not aware of Dr. Dales' specific surgical finding of "significant bursitis" in the subacromial space of claimant's left shoulder. (Ex. 144-1). Because Dr. Fuller's opinion appears to rest on incomplete information, we do not find the opinion persuasive. *See Miller v. Granite Construction Co.*, 28 Or App 473, 476 (1977); *William R. Ferdig*, 50 Van Natta 442, 443 (1998).

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[1] Claimant has worked at the same job since April 1997. In April 1998, the ownership of the employer changed and the insurance coverage changed from EBI to Kemper. The 1997 work injury resulted in EBI accepting a left "shoulder tendonitis." (Ex. 65).

[2] Specifically, Dr. Fuller indicated: "The differential diagnosis at this time is between a cervical condition producing referred pain in the shoulder, a primary shoulder condition such as one might find on MRI or arthrogram, and lastly, a non-organic complaint only condition, paced by his psychosocial problems." (*Id.*).

In contrast to the opinion of Dr. Fuller is the opinion of Dr. Dales. As the treating surgeon, Dr. Dales had the opportunity to view the interior of claimant's shoulder first hand. Because his opinion is based upon his actual surgical observations it is entitled to great weight. *Argonaut Ins. Co. v. Mageske*, 93 Or App 698, 702 (1988). Consequently, we find it persuasive.[3]

Responsibility

The ALJ determined that the 1999 work injury (bursitis and impingement syndrome) involved the same condition as the 1997 work injury (tendonitis) and therefore concluded that responsibility should be analyzed under ORS 656.308(1).[4] Applying ORS 656.308(1), the ALJ concluded that Kemper was responsible for claimant's current left shoulder condition.

Kemper agrees that ORS 656.308(1) applies to this case, but contends that a correct analysis under that statute assigns responsibility to EBI. EBI contends that the last injury rule, rather than ORS 656.308(1), applies, and that a correct analysis under the last injury rule assigns responsibility to Kemper.

ORS 656.308(1) only applies if the later injury involves the same condition as did the earlier accepted claim. *Sanford v. Balteau Standard/SAIF Corp.*, 140 Or App 177, 181 (1996); *Smurfit Newsprint v. DeRosset*, 118 Or App 368, 371-72 (1993); *James A. Hoyt*, 52 Van Natta 346, 347 (2000). Under ORS 656.308(1), a new injury involves the "same condition" as the earlier accepted injury when it has the earlier compensable injury within or as part of itself. *MultiFoods Specialty Distribution v. McAtee*, 164 Or App 654, 662 (1999); *Bobby Bradburry*, 52 Van Natta 1560, 1563 (2000). If ORS 656.308(1) applies, Kemper is responsible for claimant's current left shoulder condition only if the 1999 injury constitutes the major contributing cause of his disability or need for treatment for the current combined condition. *See SAIF v. Britton*, 145 Or App 288, 291-92 (1996); *Bradburry*, 52 Van Natta at 1563.

If, however, ORS 656.308(1) does not apply, then because the 1997 and 1999 injuries were "successive injuries" involving the same body part (*i.e.*, the left shoulder), responsibility is determined under the "last injury rule." *Hoyt*, 52 Van Natta at 347; *See John J. Saint*, 46 Van Natta 2224, 2226 (1994). Larson's last injury rule provides:

> "The 'last injurious exposure' rule in successive injury cases places full liability upon the carrier covering the risk at the time of the most recent injury that bears a causal relation to the disability * * [I]f the second incident contributes independently to the injury, the second insurer is solely liable, even if the injury would have been much less severe in the absence of the prior condition, and even if the prior injury contributed the major part to the final condition." *Hensel Phelps Const. v. Mirich*, 81 Or App 290, 293-94 (1986) (quoting *Smith v. Ed's Pancake House*, 27 Or App 361, 364-65 (1976) (quoting 4 *Larson, Workmen's Compensation Law* sec, 95.12 (1976))); *Hoyt*, 52 Van Natta at 348.

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[3] We acknowledge Kemper's argument that Dr. Dales' opinion does not appear to evaluate the relative contributions, if any, of claimant's 1992 shoulder complaints or his January 1998 auto accident. In regard to the auto accident (January 1998), we note that the diagnosis two days after the accident was "cervical strain and healing left shoulder strain." (Ex. 45-1). The next and last treatment for the auto accident (about one month later) shows "cervical strain -- resolved," and reports claimant feeling 100 percent recovered. (Ex. 47). In regard to the 1992 complaints of shoulder pain, we note from the chart notes that this episode of shoulder pain was reported in association with chest and back pain. (Ex. 7; 9; 10; 13). Moreover, the complaints of shoulder pain from this episode appear to end in October 1992. Under these circumstances, we are not persuaded that Dr. Dales' failure to directly discuss these items significantly diminishes the persuasiveness of his opinion.

[4] ORS 656.308(1) provides: "When a worker sustains a compensable injury, the responsible employer shall remain responsible for future compensable medical services and disability relating to the compensable condition unless the worker sustains a new compensable injury involving the same condition. If a new compensable injury occurs, all further compensable medical services and disability involving the same condition shall be processed as a new injury claim by the subsequent employer. The standards for determining the compensability of a combined condition under ORS 656.005(7) shall also be used to determine the occurrence of a new compensable injury or disease under this section."

Here, Dr. Dales acknowledged that claimant had ongoing shoulder pain since the December 1997 injury. Nonetheless, Dr. Dales opined that the "reason for the current treatment of his shoulder and operative intervention is" the injury of January 1999. (Ex. 173). From this we conclude that the major contributing cause of claimant's current disability and need for treatment is the January 1999 injury. Consequently, under either ORS 656.308(1) or "the last injury rule," responsibility for claimant's current left shoulder condition rests with Kemper.

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

ORDER

The ALJ's order dated August 31, 2000 is affirmed. For services on review, claimant is awarded a $1,000, attorney fee, payable by Kemper.

In the Matter of the Compensation of
STEPHEN C. BOLING, Claimant
WCB Case No. 00-03304
ORDER ON REVIEW
Jean M. Fisher, Claimant Attorney
Cummins, Goodman, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

The insurer requests review of Administrative Law Judge (ALJ) Spangler's order that: (1) set aside the insurer's denial of claimant's current right foot condition; and (2) set aside the insurer's denial of claimant's claim for scar tissue, right third intermetatarsal space, and persistent right foot pain with metatarsalgia. On review, the issue is compensability.

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

The ALJ set aside the insurer's April 18, 2000 current condition denial as an invalid "preclosure" denial. In so doing, the ALJ noted that the insurer had not accepted a "combined" or "consequential" condition. Thus, the ALJ reasoned that the insurer could not deny pursuant to ORS 656.262(6)(c) or (7)(b) claimant's current right foot condition prior to claim closure. *See Croman Corporation v. Serano*, 163 Or App 136 (1999). The ALJ then concluded that, absent the application of those statutes, the lack of a continuing causal relationship does not permit a "preclosure" denial.

We agree with the ALJ that the insurer was not authorized to issue a "preclosure" denial pursuant to the above statutes. However, we have recognized a carrier's right to issue a "preclosure" denial of a condition that is separate or severable from the accepted condition(s). *See Corinne L. Birrer*, 51 Van Natta 163, *on recon* 51 Van Natta 467 (1999); *Zora A. Ransom*, 46 Van Natta 1287 (1994) (preclosure denial was proper where the medical evidence "unequivocally" indicated that the claimant's current condition was not related to the accepted condition).

Here, we agree with the ALJ's reasoning that claimant satisfied his burden of proving that his current right foot condition is materially related to the compensable May 31, 1994 injury, which was accepted for a metatarsal contusion of the right foot and traumatic Morton's neuroma of the right foot. Thus, we conclude that claimant's current right foot condition is not separate or severable from the accepted conditions. Accordingly, we conclude that the ALJ properly held that the insurer's "preclosure" denial was procedurally invalid. *Cf. Shawn E. Morgan*, 52 Van Natta 2112 (2000) ("preclosure" denial valid where current condition was separate and unrelated to the accepted condition).

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors set forth in OAR 438-015-0010(4) and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,000, payable by the 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 August 29, 2000 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
PEDRO FRIAS, Claimant
WCB Case No. 97-03188
ORDER ON REMAND
Lavis & Dibartolomeo, Claimant Attorney
Alice M. Bartelt (Saif), Defense Attorney

This matter is before the Board on remand from the Court of Appeals. *SAIF v. Frias*, 169 Or App 345 (2000). The court reversed our prior order, *Pedro Frias*, 50 Van Natta 463 (1998), that found that two gaps in claimant's employment constituted "extended gaps" under OAR 436-060-0025(5)(a)(A) (WCD Admin. Order 96-070).[1] Holding that the determination of whether a gap is extended must be made in light of its length and of the circumstances of the individual employment relationship, the court has reversed and remanded for a reevaluation of whether the gaps in claimant's employment were extended.

FINDINGS OF FACT

We adopt the ALJ's findings of fact.

CONCLUSIONS OF LAW AND OPINION

Claimant has an accepted claim for a December 9, 1996 compensable injury. Claimant's temporary disability rate was originally calculated based upon a $12 an hour, 40-hour work week.

In March 1997, SAIF audited claimant's temporary disability benefits and, based upon his actual income during his weeks of employment with the employer, concluded that claimant's average weekly wage was $294.30. This recalculation resulted in a new temporary disability rate of $196.21, whereas claimant's prior rate had been $320.02.

The recalculation was based on 31.6 weeks with gross wages during that period of $9,300. The 31.6 week period included two gaps in claimant's employment from May 25 through June 4, 1996 and from September 7 through September 22, 1996.[2]

Claimant requested a hearing challenging the reduction in his temporary disability benefits. The ALJ concluded that weeks in which claimant did no work for the employer should be excluded when calculating the temporary disability rate. On Board review, we affirmed, finding that the two gaps in claimant's employment constituted "extended gaps" under OAR 436-060-0025(5)(a)(A) and should be excluded when determining claimant's weekly wage. *Pedro Frias*, 50 Van Natta at 463. In determining that the gaps were extended, we added the gaps and determined that the sum of the two gaps was "extended."

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[1] OAR 436-060-0025(5)(a)(A) provides: "Insurers shall use the workers average weekly earnings with the employer at injury for the 52 weeks prior to the date of injury. For workers employed less than 52 weeks or where extended gaps exist, insurers shall use the actual weeks of employment (excluding any extended gaps) with the employer at injury up to the previous 52 weeks."

[2] SAIF has agreed that three weeks of the first gap in employment should be excluded from the calculation because claimant was on vacation and work would have been available.

SAIF sought judicial review of our decision. The court held that our method of evaluating gaps cumulatively did not comport with the language of OAR 436-060-0025(5)(a)(A). *SAIF v. Frias*, 169 Or App at 353. Instead, the court held that the determination of whether a gap is extended must be made in light of its length and of the circumstances of the individual employment relationship itself, including whether the parties contemplated that such gaps would occur when they formed the relationship. On this basis, the court reversed and remanded for a reevaluation of whether the gaps in claimant's employment were extended. We proceed with our reconsideration.

Here, claimant had two gaps in his 28.6 weeks of employment (31.6 weeks minus the 3 week vacation period that SAIF agreed would not be considered in determining the temporary disability rate). The first gap was slightly more than two weeks. The second was a little over two and a half weeks. In accordance with the court's holding, we examine each gap independently to determine whether it was "extended." We also look to the individual employment relationship itself, including whether the parties contemplated that such gaps would occur when they formed the relationship.

The evidence regarding whether such gaps would exist is sparse. Claimant considered himself a permanent employee when he was hired because the employer told him there "were a lot of jobs." (Tr. 8). In contrast, according to the employer's vice president, Mr. Swynenburg, the employer did not have work year round. (Tr. 27). Swynenburg also told claimant that work would be "spotty" and that there would be some "slack time" after completion of the motel job. (Tr. 29).

Given this evidence and the intermittent nature of the employer's construction work, we are not persuaded that, considering claimant's roughly seven month employment period, two gaps of two and two and a half weeks respectively constituted a gap that was extended, *i.e.*, drawn out in length. Although claimant considered himself a permanent employee, Swynenburg indicated he told claimant that work would be spotty and that there would be some "slack time" after the motel job. The record reflects that claimant worked irregular hours, but steadily, for the majority of the employment period and that each of the two gaps (each of approximately two weeks) were not "drawn out in length," particularly considering the nature of the employer's construction business.

Based on the testimony of claimant and Mr. Swynenburg, we recognize that the parties did not come to an exact meeting of the minds regarding how much work would be available. In this regard, as stated above, claimant hoped for full time work without breaks, but given Mr. Swynenburg's testimony that the employer did not always have work available year round and that he informed claimant that there would be some "slack time" after completion of the motel job, claimant's expectations of uninterrupted work were apparently not realistic.

Given the circumstances of this particular employment relationship, we conclude that the gaps in employment were not "extended." Thus, we conclude that SAIF's calculation of claimants temporary disability benefits to include the gaps was appropriate under OAR 436-060-0025(5)(a)(A).

Accordingly, on reconsideration, the ALJ's order dated August 13, 1997 is reversed. SAIF's recalculation of claimant's temporary disability rate is affirmed.

IT IS SO ORDERED.

In the Matter of the Compensation of
EDGAR L. TJADEN, Claimant
WCB Case No. 99-08179
ORDER OF ABATEMENT
Ransom & Gilbertson, Claimant Attorney
Jerald Keene, Defense Attorney

On December 5, 2000, we issued an Order on Review that: (1) reversed an Administrative Law Judge's (ALJ's) order that set aside the self-insured employer's denial of claimant's occupational disease claim for a mental disorder; and (2) reinstated and upheld that denial. Noting that the parties have agreed to settle their dispute, claimant seeks abatement of our order to await their written agreement.

In light of this unrebutted announcement, we withdraw our December 5, 2000 order. On receipt of the proposed agreement, we shall proceed with our review of the settlement. In the meantime, the parties are requested to keep us apprised of any further developments regarding this case.

IT IS SO ORDERED.

In the Matter of the Compensation of
ROBERT A. ASH, Claimant
WCB Case Nos. 00-02599 & 00-00708
ORDER ON REVIEW
Popick & Merkel, Claimant Attorney
Sheridan, Bronstein, et al, Defense Attorney

Reviewed by Board Members Haynes and Biehl.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Black's order that: (1) set aside the insurer's denial of claimant's acromioclavicular (AC) joint condition claim; (2) found that the insurer did not prematurely close a prior claim; and (3) awarded an assessed attorney fee of $1,500 for prevailing over a defacto denial. On review, the issues are compensability, premature closure, and attorney fees. 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 right shoulder strain resulting from an August 24, 1998 industrial injury. Claimant then underwent surgery by his treating orthopedic surgeon, Dr. Teal, for his right shoulder.

After claimant returned to regular duty, on May 19, 1999, he saw Dr. Teal, who found "severe burning" over the right AC joint. (Ex. 32). Dr. Teal eventually recommended surgery for the AC joint. (Ex. 38). The insurer issued a denial for claimant's current right shoulder condition.

After reviewing the medical opinion evidence, the ALJ found that claimant did not prove the compensability of the AC joint condition. In particular, the ALJ found that Dr. Teal's opinion did not satisfy ORS 656.005(7)(a)(B) or 656.005(7)(a)(A). Claimant contends that Dr. Teal's opinion is sufficient to show that the August 24, 1998 injury is the major contributing cause of his current right AC joint condition.

Dr. Teal has indicated numerous times that the August 1998 incident is the major contributing cause of claimant's AC joint condition. On May 1, 1999, Dr. Teal informed claimant's attorney that claimant's "industrial injury continues to be the major contributing cause of his need for medical management." (Ex. 33B). This was followed by a report to the insurer that "changes in the acromioclavicular joint * * * came to my attention after his other shoulder pathology was dealt with and managed" and Dr. Teal suspected that "the major contributing cause to his current need for treatment and surgery continues to be his work injury of 8/24/98." (Ex. 4 1).

Dr. Teal then reported to claimant's attorney that he did not address claimant's AC joint symptoms at the time of the surgery "as his symptoms were primarily a bit lateral to that." (Ex. 5 1 D). According to Dr. Teal, after the surgery, claimant's "symptoms began to worsen over the" AC joint and the AC joint "was involved in his original mishap and now has become symptomatic with the passage of time and correction of the problem on the undersurface of the acromion." (*Id.*)

Finally, Dr. Teal concurred with a report drafted by claimant's attorney stating that, after the surgery, claimant "continued to have pain beneath the AC joint and deltoid insertion" and the symptoms worsened following his return to regular work. (Ex. 57-1). Dr. Teal reiterated his opinion that the August 1998 injury was the major contributing cause of the current need for treatment. (*Id.* at 2).

Dr. Teal's opinion was rebutted first by examining orthopedic surgeon Dr. Baker, who essentially found "no evidence of orthopedic pathology involving the right acromioclavicular joint." (Ex. 44-7). According to Dr. Baker, claimant had "completely recovered from the work injury of August 24, 1998" and any current problems were not related to the work injury. (*Id.* at 10).

Examining orthopedic surgeon, Dr. Tesar, found that claimant's subjective symptoms were "consistent with an acromioclavicular joint abnormality." (Ex. 46-9). According to Dr. Tesar, however, claimant "recovered from his work injury of August 24, 1998, and that * * * injury is no longer the major contributing cause for [claimant's] current condition and need for treatment." (*Id.*) Based on the lack of AC joint symptoms immediately following the injury, Dr. Tesar thought that the AC joint problem "developed after [claimant] recovered from his industrial injury of August 24, 1998" and was "a new condition that is unrelated to the injury of August 24, 1998." (*Id.* at 10).

In assessing medical opinion evidence, we defer to the treating physician absent persuasive reasons to the contrary. *Weiland v. SAIF*, 64 Or App 810 (1983). Here, like the ALJ, we find persuasive reasons not to defer to Dr. Teal's opinion.

First, although Dr. Teal rendered his opinion on numerous occasions, he did not explain why he considered the August 1998 injury to be the major contributing cause of claimant's AC joint condition. Instead, his opinion was summary and conclusory.

We find such an absence of explanation particularly damaging in the face of opposing medical opinions finding that claimant either does not have an AC joint condition or that such condition developed after the industrial injury. In coming to the latter conclusion, Dr. Tesar relied on evidence that, when claimant initially was treated following the August 1998 injury (including his first visit to Dr. Teal), he did not exhibit AC joint symptoms. Dr. Teal does not explain this gap in symptom onset or otherwise respond to Dr. Tesar's opinion.

Similarly, to the extent that Dr. Teal apparently is relying on a history that the onset of AC joint symptoms immediately followed the August 24, 1998 injury, his opinion rests on an inaccurate history.

Thus, because Dr. Teal's opinion is not sufficiently persuasive to carry claimant's burden of proof, we conclude that he did not prove compensability of the AC joint condition. *See* ORS 656.005(7)(a), 656.005(7)(a)(A).[1]

Premature Claim Closure

On January 19, 2000, a Notice of Closure issued for the original accepted right shoulder condition. The Order on Reconsideration rescinded the Notice of Closure on the basis that Dr. Teal indicated that claimant was not medically stationary. The ALJ reversed the Order on Reconsideration and claimant contests this conclusion.

An injured worker is medically stationary when "no further material improvement would reasonably be expected from medical treatment, or the passage of time." ORS 656.005(17). Whether the carrier has prematurely closed the claim depends on whether claimant was medically stationary at the time of the Notice of Closure, without consideration of subsequent changes in his condition. *See Scheuning v. J.R. Simplot & Company*, 84 Or App 622, 625, *rev den* 303 Or 590 (1987). Furthermore, a determination of whether a claim has been prematurely closed must focus only on those conditions accepted at the time of closure; if a condition is found compensable after claim closure, the carrier shall reopen the claim for processing regarding that condition. *James L. Mack*, 50 Van Natta 338 (1998).

Here, on December 29, 1999, Dr. Teal indicated that claimant was not medically stationary. (Ex. 50). Dr. Teal based this opinion, however, on his belief that claimant would benefit from additional treatment of his AC joint. (*Id.*) Because this opinion assessed the status of an unaccepted condition, we find that it does not resolve whether claimant's accepted right shoulder strain is medically stationary. With regard to the accepted right shoulder strain, Dr. Teal indicated as early as March 15, 1999 that claimant was medically stationary. (Ex. 28-1). There is no other contradicting evidence. Thus, we conclude that claimant's accepted right shoulder strain was medically stationary and the insurer did not prematurely close the claim.

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[1] We agree with claimant that there is no medical evidence of a preexisting AC joint condition and that ORS 656.005(7)(a)(B) thus does not apply.

Attorney Fees

Finally, claimant challenges the ALJ's attorney fee award of $1,500 for prevailing over a *de facto* denial of a rotator cuff impingement condition. The ALJ found that claimant's attorney was entitled to "a minimal assessed" fee because claimant had already received the compensation to which he was due for the condition. Claimant argues that the denial was not "an insignificant, trivial event" and setting it aside may result in "additional time loss as a result of the surgery; possible additional permanent disability * * *; and possible future medical treatment, if it later becomes necessary[.]"

In determining a reasonable attorney fee, we consider such factors as time devoted to the case, the complexity of the issues, the value of the interest involved, the skill of the attorneys, the nature of the proceedings, the benefits secured, and risk that an attorney's efforts may go uncompensated. OAR 438-015-0010(4); *see Schoch v. Leupold & Stevens*, 162 Or App 242 (1999) (Board must explain the reasons why the factors considered lead to the conclusion that a specific fee is reasonable).

Here, as the ALJ and claimant suggest, the value of the interest and the benefits secured appear limited in that compensation has been paid, leaving only possible future benefits. Moreover, although claimant's counsel submitted a statement of services, the amount of time specifically devoted to the impingement condition was not indicated. Finally, the complexity of the issue, and the nature of the proceeding concerning this issue, is less than the average case litigated before this forum. Under these circumstances, we consider the ALJ's attorney fee award reasonable.

ORDER

The ALJ's order dated July 19, 2000 is affirmed.

In the Matter of the Compensation of
DAVID E. BELTON, Claimant
WCB Case No. 00-00504
ORDER ON REVIEW
Schneider, et al, Claimant Attorney
Bruce A. Bornholdt (Saif), Defense Attorney

Reviewed by Board Members Haynes and Bock.

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

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

The ALJ determined that the opinions of Drs. Pribnow, Breen and Tahir were insufficient to establish the compensability of claimant's low back condition (strain/herniated disc) as an occupational disease. Claimant contends that those opinions are sufficient to overcome his burden of proof, and that SAIF's denial should be set aside.

Claimant pursued his claim under both injury and occupational disease theories.[1] However, because claimant's low back condition did not arise in a discrete period of time in relation to a specific activity, it should be analyzed as an occupational disease rather than as an injury.[2] *See Mathel v.*

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[1] Claimant has two medical conditions that he alleges are compensable, a low back sprain and a herniated disc at L5-S1. Claimant concedes that because of preexisting degenerative changes, the disc herniation is a "combined" condition. (Tr. 6).

[2] Rather than a specific event, claimant contends that the cause of his low back problem is his last three years of work. (Tr. 4; Ex. 30-2).

Josephine County, 319 Or 235 (1994); *James v. SAIF*, 290 Or 343 (1981). Consequently, he must prove that his work activities are the major contributing cause of the disease itself, not just the major contributing cause of the disability or treatment associated with it. ORS 656.802(2)(a); *Tammy L. Foster*, 52 Van Natta 178 (2000).

To satisfy the "major contributing cause" standard, claimant must establish that his work activities contributed more to the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983). A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disease and deciding which is the primary cause. *Stacy v. Corrections Div.*, 131 Or App 610, 614 (1994); *See Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). Because of the possible alternative causes for his current condition, resolution of this matter is a complex medical question that must be resolved by expert medical opinion. *See Uris v. Compensation Department*, 247 Or 420 (1967).

Claimant relies on the opinion of Dr. Pribnow to establish the compensability of his low back strain. While Dr. Pribnow opined that claimant's work is of the type that might cause strain, he also indicated that he could not say what caused the strain. (Ex. 11). Because Dr. Pribnow's opinion does not attribute claimant's strain to his work activities on the basis of medical probability, Dr. Pribnow's opinion is insufficient to establish the compensability of claimant's low back strain as an occupational disease. *See Gormley v. SAIF*, 52 Or App 1055 (1981).

To establish the compensability of the herniated disc condition, claimant relies on the opinions of Dr. Breen and Dr. Tahir. While both physicians opined that claimant's work as a laborer caused the herniated disc, neither doctor offered any explanation at all to support their opinions. Without such an explanation, their opinions are merely unsupported conclusions, and as such, not persuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

Consequently, on this record, we conclude that claimant has not established the compensability of either his low back strain or his herniated disc condition.

ORDER

The ALJ's order dated September 13, 2000 is affirmed.

December 29, 2000 Cite as 52 Van Natta 2251 (2000)

In the Matter of the Compensation of
GLORIA GARIBAY, Claimant
WCB Case No. 00-03653
ORDER ON REVIEW (REMANDING)
Michael B. Dye, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Members Meyers and Biehl.

Claimant requests review of that portion of Administrative Law Judge (ALJ) Myzak's order that vacated an Order on Reconsideration that set aside a Notice of Closure as prematurely issued. In its respondent's brief, the insurer requests that we remand to the ALJ for further proceedings.[1] On review, the issues are premature closure and remand. We vacate the ALJ's order and remand.

FINDINGS OF FACT

We adopt the ALJ's "Findings of Fact," including the "Finding of Ultimate Fact."

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[1] The Department has participated in this proceeding under ORS 656.726(4)(h), challenging that portion of the ALJ's order that ordered the Director to "continue" the reconsideration proceedings.

CONCLUSIONS OF LAW AND OPINION

On June 28, 1999, claimant injured her mid-back, which resulted in her workers' compensation claim being accepted for compression fractures at T11 and T12. Dr. Pollard has been claimant's treating physician and he recommended on January 3, 2000 that claimant have an insurer-arranged medical evaluation (IME). Drs. Brook and Woodward performed the IME on February 15, 2000 and reported that claimant demonstrated functional overlay on examination and discrepancies in straight leg raising and in hip flexion. The panel also noted that claimant's motion was not valid based on straight leg raising and sacral motion criteria. (Ex. 18-5).

On March 7, 2000, Dr. Pollard noted that he had read the IME report and the report of functional overlay. Dr. Pollard declared claimant medically stationary with "some permanent residuals from the mild compression fracture at T-11 and T-12 with the 15 degrees of gibbus." (Ex. 19). Dr. Pollard also restricted claimant to medium work. In the examination portion of his report, Dr. Pollard specifically noted that claimant was asked to forward bend to touch her toes, but that claimant "goes only a few degrees and stops there due to subjective pain." Dr. Pollard, however, further reported that claimant could fully extend both knees in the sitting position and could reach within 10 inches of her toes without pain. According to Dr. Pollard, this suggested some emotional overlay. *Id.*

The insurer closed the claim by Notice of Closure of March 29, 2000, which awarded claimant 9 percent unscheduled permanent disability for the mid-back. Claimant requested reconsideration, including the appointment of a medical arbiter. (Ex. 23A).

An Order on Reconsideration issued on May 3, 2000. It rescinded the Notice of Closure as having improperly closed the claim for lack of adequate closing information per OAR 436-030-0020(4). Specifically, the appellate reviewer reasoned that Dr. Pollard had not concurred with the February 15, 2000 IME and had not provided thoracic range of motion measurements. The reviewer concluded that, under such circumstances, there was insufficient information to determine impairment. (Ex. 24-2). *See* ORS 656.268(6)(a). The insurer requested a hearing.

The ALJ found that the Department improperly rescinded the insurer's closure notice, concluding that the insurer satisfied all statutory and administrativa prerequisites for issuance of a Notice of Closure. Specifically, the ALJ determined that, while not expressly concurring with the IME report, Dr. Pollard had "in his own words" agreed that claimant's reduced range of motion was attributable, not to the compensable injury, but rather to emotional overlay. The ALJ further reasoned that, where the medical evidence indicated that reduced range of motion was not attributable to the accepted condition, there was no basis for Dr. Pollard to concur with range of motion findings that were not ratable. Furthermore, the ALJ concluded that Dr. Pollard's closing examination contained sufficient information for the insurer to determine impairment. Consequently, the ALJ vacated the Order on Reconsideration and ordered that the reconsideration proceedings "continue" in light of claimant's unfulfilled request for a medical arbiter.

On review, claimant contends that the Department acted within its discretion when it determined that there was insufficient information to determine impairment and rescinded the Notice of Closure. Thus, claimant asserts that the ALJ should not have vacated the Order on Reconsideration and reinstated the insurer's closure notice. The insurer, on the other hand, argues that the ALJ's finding regarding the propriety of its claim closure was correct. However, citing *Vicky Woodard*, 52 Van Natta 796 (2000), it asserts that the claim should be remanded to the ALJ so the parties may proceed to hearing on claimant's other challenges to the Notice of Closure (including consideration of a medical arbiter's examination that it avers occurred on October 3, 2000).

For the following reasons, we agree with the ALJ that the Notice of Closure was properly issued. We also conclude that a remand to the ALJ for further proceedings is appropriate.

Pursuant to ORS 656.268(1)(a), the insurer was entitled to close the claim and determine extent of disability when "[t]he worker has become medically stationary and there is sufficient information to determine permanent impairment." Here, there is no dispute that claimant was medically stationary when the claim was closed. The only issue was whether the insurer had sufficient information to determine permanent impairment when it closed the claim. Although claimant and the Department fault Dr. Pollard's report for not containing range of motion findings, we conclude that, after reviewing the report as a whole (including the results of Dr. Pollard's attempt to measure claimant's range of motion and Dr. Pollard's finding of 15 degrees of "gibbus"), it provided sufficient information to determine permanent impairment.

Claimant asserts that we should review the Department's decision to rescind the insurer's Notice of Closure under an abuse of discretion standard. *See Hadley v. Cody Hindman Logging*, 144 Or App 157 (1996). In *Hadley*, the court interpreted *former* OAR 436-60-025(5)(a), which was adopted by the Director pursuant to ORS 656.210(2)(c), which provides in part:

> "For workers not regularly employed and for workers with no remuneration or whose remuneration is not based solely upon daily or weekly wages, the Director of the Department of Consumer and Business Services, by rule, may prescribe methods for establishing the worker's weekly wage."

The court noted that the statute acted to delegate certain rule-making authority to the Director. Specifically, the court noted that ORS 656.210(2)(c) delegated to the Director broad authority to prescribe by rule "methods" of approximating the wage amount at the time of injury of those workers who are not regularly employed. According to the court, so long as the Director prescribed a method that was within the delegation by the legislature, neither the court nor the Board could substitute its own judgment regarding the method of computation. 144 Or App at 160.

Unlike *Hadley*, where the issue was whether a rule promulgated by the Director was within authority delegated by the legislature, and whether the Board could add an additional requirement to the rule, in this case, the issue does not concern the Director's authority to promulgate administrative rules, but rather concerns whether the insurer properly closed the claim under ORS 656.268(1)(a). *Hadley* does not stand for the proposition that we may only review for abuse of discretion the Department's determination of the propriety of a claim closure.[2]

Having concluded that the ALJ properly decided the claim closure issue, we next examine the portion of the ALJ's order that directed the Director to "continue" the reconsideration proceedings. Although the ALJ's order did not explicitly "remand" to the Department, the ALJ's directive that the Department "continue" the reconsideration proceedings could be interpreted as "remanding" the claim to the Department for a medical arbiter's examination. There is no authority for such a remand. *See Pacheco-Gonzalez v. SAIF*, 123 Or App 312 (1993); *Linda M. Cross*, 45 Van Natta 2130 (1993).

Although we lack the authority to remand this claim to the Department for the appointment of a medical arbiter, claimant is statutorily entitled to a medical arbiter report because she timely disagreed with the impairment findings used to rate her disability. *See* ORS 656.268(7)(a).[3] Under such circumstances, we have previously fashioned a remedy which accommodates both the *Pacheco-Gonzalez* decision and claimant's statutory right to a medical arbiter's report. In other words, the ALJ should have issued an interim order, retaining authority over the case, while directing the parties to seek a medical arbiter examination through the Department. Once that examination was conducted and a report issued, the parties could then notify the ALJ, who could then proceed to review the extent of permanent disability issue. *See Linda M. Cross*, 45 Van Natta at 2131-32.

Here, consistent with the *Cross* rationale, we remand to the ALJ for deferral pending receipt of a medical arbiter's report pursuant to ORS 656.268(6)(f). *See Katherine M. Tofell*, 51 Van Natta 1845 (1998); *Dennis R. Loucks*, 50 Van Natta 1779 (1998). Assuming that a medical arbiter's examination has already occurred, the parties shall be responsible for the submission of the medical arbiter's report to the ALJ. On receipt of the arbiter's report, the ALJ shall conduct further proceedings designed to address the parties' challenges arising from the Notice of Closure. Those further proceedings shall be conducted in any manner that the ALJ deems achieves substantial justice.

ORDER

The ALJ's order dated August 21, 2000 is vacated. This matter is remanded to ALJ Myzak for further proceedings consistent with this order.

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[2] We note our holding in *Estella M. Rogan*, 50 Van Natta 205 (1998), that the Department was not authorized to set aside a carrier's closure notice as premature on the basis that the insurer did not obtain adequate closing information pursuant to OAR 436-030-0020(1) through (4). *See also Ball v. The Halton Company*, 167 Or App 468 (2000). Although *Rogan* applied *former* ORS 656.268(4)(a), we observe that ORS 656.268(1)(a) also does not require a closing examination, only that there be "sufficient information to determine permanent impairment." Dr. Pollard's closing report satisfies that statutory standard.

[3] As previously noted, the insurer states that a medical arbiter's examination has already occurred.

In the Matter of the Compensation of
CLINTON H. PIETSCH, Claimant
WCB Case No. 00-00023
ORDER ON REVIEW
Thomas J. Dzieman, Claimant Attorney
VavRosky, et al, Defense Attorney

Reviewed by Board Members Haynes and Phillips Polich.

The self-insured employer requests review of Administrative Law Judge (ALJ) Brazeau's order that: (1) found that claimant's low back injury claim was not precluded by an earlier Disputed Claim Settlement (DCS); and (2) set aside the employer's denial of claimant's low back injury claim. On review, the issues are claim preclusion and compensability.

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

In setting aside the employer's denial, the ALJ found that claimant sustained an injury during the course of his employment on September 30, 1999. Moreover, relying on the opinion of Dr. Church, the ALJ found that claimant had satisfied his burden of proof on medical causation. Finally, the ALJ found that claimant's claim was not barred by an earlier DCS.

On review, the employer first contends that claimant is not credible, and that he did not sustain an injury in the course and scope of his employment. We disagree.

We generally defer to the ALJ's demeanor-based credibility findings. *See International Paper v. McElroy*, 101 Or App 61 (1991); *Susan M. Backman*, 52 Van Natta 1910 (2000). Here, the ALJ expressly found claimant to be a "completely credible witness" based on both the substance and demeanor of his testimony. (O&O at 3).

Nevertheless, the employer contends that claimant is not credible for several reasons. Specifically, the employer challenges the timeliness of claimant's report of an injury, as well as his version of events involving his report. Fasellon the following reasoning, we do not consider either contention sufficient to overturn the ALJ's demeanor-based credibility finding.

First, the employer notes that claimant did not report an injury to his supervisor or file a claim until October 4, 1999, five days after his injury. However, claimant testified that he did report his injury informally to a secretary on Friday, October 1, 1999. (Tr. 9). Moreover, claimant testified that he did not initially (on Thursday or Friday) file an internal "incident report" or "801" claim form because he did not have immediate symptoms. (Tr. 9, 10). During the weekend, claimant developed increasing back and leg pain, which eventually prompted him to file a claim on Monday, October 4, 1999. (Ex. 17, Tr. 10). On review, we find that claimant provided a reasonable explanation for his failure to report his injury until after the weekend.

Second, the employer contends that claimant's testimony that he reported his injury to the secretary, Ms. Chapin, was disputed by an employer representative, Mr. Huebsch. However, Ms. Chapin did not testify at hearing. Instead, Mr. Huebsch merely testified that Ms. Chapin stated she had not heard of claimant's injury until October 4, 1999. (Tr. 32). We give such indirect testimony less probative weight than claimant's direct testimony, particularly considering the ALJ's express credibility finding.

We also agree with the ALJ that claimant satisfied his burden of proving medical causation. Because claimant has sustained several prior injuries to his back and because he has a preexisting degenerative condition in his lower back, this case represents a complex medical question that must be resolved with expert medical opinion. (Exs. 1, 1D, 2, 4, 11). *Uris v. Compensation Department*, 247 Or 420 (1967). Because claimant's prior injuries and preexisting degenerative condition combined with the effects of his September 30, 1999 injury, claimant must prove that his injury was the major contributing cause of his disability or need for treatment for the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101, *on recon* 149 Or App 309 (1997).

The only medical opinion in the record is that of Dr. Church, who examined claimant at the request of the employer. After taking into account claimant's prior injuries and preexisting conditions, Dr. Church stated that claimant's September 30, 1999 injury was the "primary cause" of his symptoms and need for treatment (at least for several months after the incident). (Ex. 24-16).

Nevertheless, the employer contends that Dr. Church later retracted this opinion in an addendum report. When presented with new information from the employer regarding claimant's injury, Dr. Church found it "quite perplexing" that claimant was able to continue working the day of his injury, assuming trauma to the "L5 nerve root." (Ex. 25-3). Dr. Church characterized such a history as "unusual but not impossible." (*Id.*) However, the reference to an L5 nerve root injury appears nowhere else in the record. As such, Dr. Church's statement on this specific issue in his addendum report lacks context and reasoning and is unpersuasive.

Significantly, in the addendum report, Dr. Church stated that the "real question" was whether claimant's leg was fully extended when he fell off the ladder. (Ex. 25-2). We agree with the ALJ that claimant's testimony (consistent with the "801 " form and the history provided to Dr. Church) confirms that claimant landed with his leg fully extended after falling from the ladder on September 31, 1999. (Exs. 17, 24-15 Tr. 7).

Although Dr. Church initially took an inaccurate history of claimant's wearing a 25-pound tool belt[1] when he fell off the ladder, we are not persuaded that that fact was material to Dr. Church's opinion. Rather, when asked to assume that claimant carried "15 or 20 pounds less weight," Dr. Church still focused on the mechanics of whether claimant's leg was fully extended on impact. (Ex. 25-2).

Moreover, Dr. Church took an accurate history of claimant's injuring his back on September 30, 1999 (although claimant mistakenly referred to this date as a Friday, as opposed to Thursday). (Ex. 24-4). Even if we assume that Dr. Church's history as to the day of the injury was incorrect, there is no indication that that minor inconsistency had any effect on Dr. Church's ultimate opinion on causation. We are therefore satisfied that Dr. Church relied on an accurate history in stating his initial opinion on causation. (Ex. 24-15). *See Miller v. Granite Construction*, 28 Or App 473, 478 (1977).

Finally, we agree with the ALJ that the November 11, 1998 DCS did not bar claimant's claim for a later injury. The doctrine of claim preclusion was described in *Drews v. EBI Companies*, 310 Or 134 (1990):

> " `[A] plaintiff who has prosecuted one action against a defendant through to a final judgment * * * is barred [*i.e.* precluded] * * * from prosecuting another action against the same defendant where the claim in the second action is one which is based on the same factual transaction that was at issue in the first, seeks a remedy additional or alternative to the one sought earlier, and is of such a nature as could have been joined in the first action.' " 310 Or at 140 (quoting *Rennie v. Freeway Transport*, 294 Or 319, 323 (1982)) (brackets in original).

Through the earlier DCS, the employer denied claimant's (then) current neck and back conditions. (Ex. 16-1). Initially, we note that this current claim could not have been "joined in the earlier action" that gave rise to the November 1998 DCS, because claimant's injury occurred several months after the DCS was approved. Moreover, as discussed above, Dr. Church stated that the primary cause of claimant's need for treatment after September 30, 1999 was his on-the-job injury of that date (as opposed to claimant's prior injuries and preexisting conditions). (Ex. 24-16). *See Judy A. Tuttle*, 45 Van Natta 165, 166 (1993) (a claimant may avoid the preclusive effect of a DCS if she establishes that her current need for treatment is for a condition different from the condition at the time of the DCS). Because the earlier DCS did not involve the same "factual transaction" as that arising from claimant's September 30, 1999 injury claim, claimant's claim is not barred by principles of claim preclusion.

Claimant's attorney is entitled to an assessed fee for services on review. ORS 656.382(2). After considering the factors in OAR 438-015-0010(4), and applying them to this case, we find that a reasonable fee for claimant's attorney's services on review is $1,250, payable by the self-insured employer. In reaching this conclusion, we have particularly considered the time devoted to the case (as represented by claimant's respondent's brief), the complexity of the issues, and the value of the interest involved.

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[1] Testimony at hearing proved the tool belt weighed at most elght-and-a-half pounds. (Tr. 19).

ORDER

The ALJ's order dated September 7, 2000 is affirmed. For services on review, claimant's attorney is awarded $1,250, payable by the employer.

December 29, 2000 Cite as 52 Van Natta 2256 (2000)

In the Matter of the Compensation of
RICK PRAIRIE, Claimant
WCB Case No. 98-07984
ORDER ON REVIEW
Starr & Vinson, Claimant Attorney
Jerry Keene, Defense Attorney

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

Claimant requests review of Administrative Law Judge (ALJ) Otto's order that: (1) upheld the insurer's partial denial of claimant's degenerative disc disease and left thoracic scoliosis condition; and (2) upheld the insurer's denial of claimant's current low back condition. On review, the issue is compensability.

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

The ALJ determined that the opinions of Drs. Fuller and Schilperoort, insurer-arranged examiners, were more persuasive than the opinion of Dr. Karasek, the attending physician. Consequently, the ALJ concluded that claimant had failed to establish the compensability of his degenerative disc disease, his left thoracic scoliosis, and his current low back condition.

Claimant suffered a compensable lumbar strain as the result of his work as a mechanic in August 1997. (Ex. 1; 24). Claimant asserts that this injury aggravated and pathologically worsened a preexisting degenerative disc condition at L4-5 and L5-S1 resulting in his current need for a lumbar fusion. (Appellant's Brief, 9). In other words, claimant contends that his August 1997 work injury combined with a preexisting condition necessitating his current need for treatment. Consequently, claimant seeks to establish the compensability of this current "combined" condition.

In order to establish the compensability of claimant's current "combined condition," his compensable injury must be the major contributing cause of the disability or need for treatment of the combined condition. ORS 656.005(7)(a)(B); *SAIF v. Nehl*, 148 Or App 101 (1997), *on recon* 149 Or App 309 (1997), *rev den* 326 Or 389 (1998). To satisfy the "major contributing cause" standard, claimant must establish that his work incident of August 1997 contributed more to the disability or need for treatment of the claimed condition than all other factors combined. *See, e.g., McGarrah v. SAIF*, 296 Or 145, 146 (1983).

A determination of the major contributing cause involves the evaluation of the relative contribution of different causes of claimant's disability or need for treatment of the combined condition and deciding which is the primary cause. *Dietz v. Ramuda*, 130 Or App 397 (1994), *rev dismissed* 320 Or 416 (1995). The fact that a work event precipitated the symptoms or need for treatment of a condition does not necessarily mean that the work incident was the major contributing cause of the condition or its need for treatment. *Dietz*, 130 Or App at 401; *see also Robinson v. SAIF*, 147 Or App 157, 162 (1997); *Elaine M. Baxter*, 51 Van Natta 1898 (1999).

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

The record contains the opinions of four physicians regarding the cause of claimant's current condition. Of those, only the opinion of Dr. Karasek, the current attending physician, supports

compensability.[1] Dr. Karasek does not dispute that claimant had degenerative changes at both L4-5 and L5-S1 that predate the August 1997 work injury. (Ex. 27). However, Dr. Karasek has reasoned that claimant's repetitive extension under load (the mechanism of the accepted lumbar strain) caused a painful annular dysfunction and an inflammatory process in the annulus of the L4-5 and L5-S1 discs. (Ex. 22-1). Based on that reasoning, Dr. Karasek opined that the major contributing cause of claimant's pain and, thus claimant's need for treatment, is the work injury of August 1997. (Ex. 27-2; 27-3).

We interpret Dr. Karasek's opinion as supporting a conclusion that the work incident of August 1997 is the precipitating cause of claimant's present need for treatment, but not necessarily the major contributing cause. We note that Dr. Karasek's opinion offers no evaluation of the relative contributions of the August 1997 work injury and the preexisting degenerative changes which have combined to produce the painful annular dysfunction and the inflammatory process in the annulus of the L4-5 and L5-S1 discs resulting in claimant's need for a lumbar fusion. Without such an evaluation, his opinion that the 1997 work incident is the major contributing cause of claimant's disability or need for treatment for the L4-5 and L5-S1 disc conditions is merely an unsupported conclusion; as such, it is unpersuasive. *Moe v. Ceiling Systems, Inc.*, 44 Or App 429, 433 (1980).

Accordingly, we agree with the ALJ that the record does not establish the compensability of claimant's degenerative disc disease, his left thoracic scoliosis, and his current low back condition. *See* ORS 656.266; ORS 656.005(7)(a)(B).

ORDER

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

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[1] Dr. Karasek became the attending physician in August 1999. (Ex. 21-1).

Board Member Phillips Polich dissenting.

I disagree with the majority that claimant has failed to establish the compensability of degenerative disc disease, his left scoliosis, and his current low back condition. Therefore, I respectfully dissent.

We generally defer to the opinion of the attending physician absent persuasive reasons to the contrary. *See Weiland v. SAIF*, 64 Or App 810 (1983). I find no persuasive reason here to abandon our general practice.

As the majority notes, Dr. Karasek opined that claimant's repetitive extension under load (the result of installing a heavy auto transmission as a part of his work duties) caused a painful annular dysfunction and an inflammatory process in the annulus of the L4-5 and L5-S1 discs. (Ex. 22-1). In making this diagnosis, Dr. Karasek relied on the results of disc stimulation testing, rather than macroanatomy as shown on CT disography. (*Id.*). Dr. Karasek explained that according to medical literature, the most likely cause of this painful annular dysfunction and inflammation is trauma. (*Id.*). Therefore, contrary to the majority's conclusion, Dr. Karasek's opinion is supported; it is supported by actual test results and medical literature.

I find Dr. Karasek's opinion cogent, and I believe that it thoroughly explains the causation of claimant's condition. Consequently, I find it persuasive and sufficient to meet claimant's burden of proof. Therefore, I would reverse the ALJ's order, and set aside the insurer's denials.

In the Matter of the Compensation of
SALLY D. YATES, Claimant
WCB Case Nos. 00-01762, 00-01810 & 98-07460
ORDER ON REVIEW
Welch, Bruun & Green, Claimant Attorney
Terrall & Terrall, Defense Attorney

Reviewed by Board Members Haynes and Bock.

Claimant requests review of those portions of Administrative Law Judge (ALJ) Poland's order that: (1) affirmed an August 28, 1998 Order on Reconsideration that awarded no permanent disability; and (2) reduced claimant's unscheduled permanent disability from 4 percent (12.8 degrees), as awarded by a February 3, 2000 Order on Reconsideration, to 2 percent (6.4 degrees). In addition,, claimant contests that portion of the ALJ's order that admitted Exhibits 34 and 35. The self-insured employer cross-requests review of that portion of the ALJ's order that awarded 2 percent (6.4 degrees) unscheduled permanent disability (whereas an Order on Reconsideration had awarded 4 percent (12.8 degrees)), contending that it should be reduced to zero. On review, the issues are evidence and extent of scheduled and unscheduled permanent disability.

We adopt and affirm the ALJs order with the following supplementation.

Claimant was compensably injured in a February 19, 1997 motor vehicle accident. The employer accepted the following conditions: "cervical/thoracic/lumbar strain, left shoulder contusion, right thumb strain, cerebral contusion, left shoulder strain, left elbow contusion, cephalgia, right knee contusion, pelvic somatic dysfunction, and bilateral thigh contusions." (Ex. 3). Claimant had some preexisting degenerative changes in her lumbar spine. (Exs. 4, 75 8). Her post-injury symptoms included chronic low back pain and right leg radiculopathy. (Ex. 13).

On March 16, 1998, the employer denied claimant's "current condition" on the basis that claimant's injury was no longer the major contributing cause of her current condition. (Ex. 16). Claimant requested a hearing.

An April 9, 1998 Updated Notice of Acceptance at Closure notified claimant that the following were accepted conditions: cervical/thoracic/lumbar strain, left shoulder contusion, right thumb strain, left shoulder strain, cerebral contusion, left elbow contusion, cephalgia, right knee contusion, pelvic somatic dysfunction, bilateral thigh contusions. (Ex. 18). A Notice of Closure that issued the same date awarded no permanent disability. (Ex. 17).

Claimant requested reconsideration, and, on August 11, 1998, Drs. Bald and Farris performed a medical arbiter examination. (Ex. 21). An August 28, 1998 Order on Reconsideration affirmed the Notice of Closure in all respects. (Ex. 22). Claimant requested a hearing, which was deferred in light of the pending compensability litigation.

On January 8, 1999, a prior ALJ found that claimant had a preexisting condition in the low back and right sacroiliac joint with radiation. At hearing, the employer amended its denial to deny that the compensable injury was the major contributing cause of the disability and need for treatment of claimant's current low back lumbar and right sacroiliac/right leg complaints. The ALJ set aside the employer's amended denial and remanded claimant's claim to the employer for processing. The ALJ also concluded that the denials of the accepted conditions that were neither combined nor consequential conditions were improper preclosure denials. The employer appealed.

The Board affirmed, concluding that the medical evidence established that claimant's preexisting condition combined with the accepted conditions of lumbar strain and pelvic somatic dysfunction. *Sally D. Yates*, 51 Van Natta 1336 (1999). The Board also concluded that none of the claimant's other accepted conditions combined with any preexisting condition and that those portions of the employer's denial should be set aside as procedurally invalid. (Ex. 25-3).

The employer reopened claimant's claim and then issued a September 8, 1999 Notice of Closure that awarded no permanent disability. (Ex. 27). Claimant requested reconsideration, and on January 21, 2000, the Department scheduled medical arbiter examinations with Dr. DiPaola and Dr. Lawlor. (Ex. 29). Before these medical arbiter examinations were completed, a February 3, 2000 Order on Reconsideration

awarded 4 percent unscheduled permanent disability, based on Dr. Bald's August 11, 1998 medical arbiter examination findings. (Ex. 33). Dr. DiPaola examined claimant on February 13, 2000 and Dr. Lawlor examined claimant on February 18, 2000. (Exs. 34 and 35).

August 28, 1998 Order on Reconsideration

The ALJ affirmed the August 28, 1998 Order on Reconsideration, reasoning that, when the August 28, 1998 Order on Reconsideration issued, claimant's entire current condition was in denied status and, therefore, under ORS 656.262(7)(c), conditions accepted after claim closure may only be evaluated after the claim has been reopened to process the new or omitted conditions. On review, claimant contends that, because the employer's denial was a nullity, ORS 656.262(7)(c) does not apply and, therefore, impairment of the accepted conditions should be evaluated as of the date of the August 28, 1998 Order on Reconsideration. Specifically, claimant contends that, based on Dr. Bald's August 11, 1998 arbiter report, she should have been awarded both scheduled and unscheduled permanent disability. We disagree.

First, claimant's characterization of the employer's denial as a "nullity" is incorrect. The employer's "current condition" denial was not set aside as a nullity. Rather, the denial of claimant's current combined low back and right sacroiliac joint condition was found to have been proper and the "preclosure" denial of the remainder of claimant's accepted conditions was found to be procedurally invalid, not a nullity. (Exs. 24, 25).

Second, in evaluating claims at closure, the focus is on accepted conditions. *See James L. Mack*, 50 Van Natta 338, 339 (1998). Under ORS 656.262(7)(c), if a condition is found compensable after claim closure, the carrier is required to reopen the claim for processing regarding that condition. *Verna C. Flescher (FKA Lowell)*, 50 Van Natta 1105, 1111 n. 2 (1998), *affd mem* 159 Or App 426 (1999). In *Anthony J. Telesmanich*, 49 Van Natta 49, 51 (1997), *on recon* 49 Van Natta 166 (1997), we held that, where the carrier has accepted additional conditions after issuance of an Order on Reconsideration, the proper procedure at hearing on the Order on Reconsideration is to rate the conditions accepted at the time of the Order on Reconsideration and remand the later accepted conditions to the carrier for processing according to law. *See also* ORS 656.262(7)(c); *Bonnie J Woolner*, 52 Van Natta 1579 (2000); *Bernard G. Hunt*, 49 Van Natta 223 (1997). Therefore, in rating permanent disability under the current statutory scheme, the focus is on accepted conditions at the time,of claim closure and reconsideration. *See Janet R. Christensen*, 50 Van Natta 1152 (1998) (evaluation of conditions ordered accepted after claim closure must await the reopening and processing of the claim for that new condition).

Here, at the time of the claim closure and the August 28, 1999 Order on Reconsideration, all of claimant's accepted conditions were in denied status. Therefore, because there were no accepted conditions at the time of claim closure, the ALJ correctly affirmed the August 28, 1999 Order on Reconsideration that awarded no permanent disabilty.

Evidence

Claimant contends that, even though ORS 656.268(6)(f) allows for medical arbiter reports to be received as evidence at a hearing where the report has not been prepared in time for use in the reconsideration proceeding, this exception applies only to reports or supplementary reports derived from examinations held before the Order on Reconsideration is issued.[1] We disagree.

[1] Claimant relies on *Larry A. Thorpe*, 48 Van Natta 2608 (1997), in which a medical arbiter examined the claimant 10 days before an Order on Reconsideration was issued. Claimant's reliance on *Thorpe* is inapposite. While it is true that the arbiter examination in *Thorpe* was performed prior to the Order on Reconsideration, that case did not turn on that fact. The issue in that case was whether a clarification report that the Department had requested from the medical arbiter during the reconsideration proceeding, but was created and received by the Department subsequent to the issuance of the Order on Reconsideration, was admissible *under* former ORS 656.268(6)(e) (renumbered ORS 656.268(6)(f)), not the timing of the arbiter examination itself.

In *Patricia A. Brown*, 48 Van Natta 1164 (1996), the Department had neglected to schedule an arbiter examination before an Order on Reconsideration issued. We found that the Department retained authority to appoint a medical arbiter and schedule the examination and we concluded that the medical arbiter report (the examination for which would necessarily take place after the Order on Reconsideration) was admissible, "even if the report [was] not prepared in time for use in the reconsideration proceeding," pursuant to *former* ORS 656.268(6)(e) (now numbered ORS 656.268(6)(f)).

Here, because the Department appointed the medical arbiters and scheduled the examinations on January 21, 2000, even if those examinations took place after the February 3, 2000 Order on Reconsideration issued, those medical arbiter reports are admissible pursuant to ORS 656.268(6)(f).[2]

Extent of Unscheduled Permanent Disability

Relying on arbiter Dr. DiPaola's report, the ALJ concluded that claimant's 4 percent unscheduled permanent disability, as awarded by the February 3, 2000 Order on Reconsideration, should be reduced to 2 percent. On review, the employer contends that claimant's award of 2 percent unscheduled permanent disability should be reduced to zero. We disagree.

The employer relies on Dr. DiPaola's report, in which he stated that "claimant's loss of repetitive use of her spinal area was due to pre-existing degenerative disease of the low back," and that "[claimant] does not have partial loss of the ability to use the spinal area due to the accepted conditions." (Ex. 34-4).

However, by virtue of the prior litigation of the employer's "current condition" denial, it has been established that claimant's preexisting low back and right sacroiliac joint conditions are compensable and have combined with the accepted conditions of lumbar strain and pelvic somatic dysfunction. Consequently, claimant's preexisting low back and right sacroiliac joint conditions are included as part of the employer's acceptance and are compensable conditions. As such, they do not constitute "preexisting conditions" for purposes of ORS 656.005(7)(a)(B). *See Raymond J. Suek, Sr.*, 49 Van Natta 706, 707 (1997) (carrier's acceptance for "low back pain" included the degenerative condition at L4-5, which was itself a compensable condition and did not constitute a preexisting condition for purposes of ORS 656.005(7)(a)(B)); *Lee J. Johnson*, 48 Van Natta 2261, 2263 (1996) (since the carrier's acceptance included the osteoarthritis condition, ORS 656.005(7)(a)(B) and 656.262(6)(c) did not apply). Therefore, because the employer has accepted a combined condition (and had not issued a "pre-closure" denial of the combined condition under ORS 656.262(7)(b) prior to its September 8, 1999 Notice of Closure), the entire accepted "combined condition" is to be rated as permanent disability due to the compensable injury. *E.g., Dewey C. Harvey*, 52 Van Natta 1556 (2000).

Because Dr. DiPaola's report states that claimant's loss of repetitive use of her spinal area was due to her preexisting low back condition, and not due to her accepted condition, we do not find that portion of his report persuasive. *See Kuhn v. SAIF*, 73 Or App 768 (1985) (because physician's report conflicted with the law of the case, his conclusion was discounted). Therefore, we affirm the ALJ's award of 2 percent unscheduled permanent disability for reduced lumbar motion.

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 her response to the employer's challenge to the ALJ's 2 percent unscheduled permanent disability award 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 response to the employer's cross-appellant's brief), the complexity of the issue, and the value of the interest involved.

ORDER

The ALJ's order dated July 23, 2000 is affirmed. For services on review, claimant's attorney is awarded a fee of $1,000, to be paid by the self-insured employer.

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[2] ORS 656.268(6)(f) provides: "*Any* medical arbiter report may be received as evidence at a hearing even if the report is not prepared in time for use in the reconsideration proceeding." (Emphasis supplied.)

WORKERS' COMPENSATION CASES

Decided in the Oregon Supreme Court: Page

Robinson v. Nabisco, Inc. (9/28/00) 2262

Decided in the Oregon Court of Appeals:

Benz v. SAIF (9/27/00) 2268
Blamires v. Clean Pak Systems, Inc. (12/6/00) 2308
Harkness v. SAIF (12/6/00) 2314
Kahn v. Providence Health Plan (11/1/00) 2294
Liberty Northwest v. Sparks (11/15/00) 2300
Marvin Wood Products v. Callow (11/22/00) 2302
McTaggart v. Time Warner Cable (10/18/00) 2286
SAIF v. Ekdahl (10/4/00) 2271
SAIF v. Lewis (10/4/00) 2275
Simmons v. Lane Mass Transit District (12/6/00) 2310
Steiner v. E.J. Bartells Co. (11/8/00) 2297
Sutton v. Dennis 7 Dees Landscape (10/11/00) 2284

Cite as 331 Or 178 (2000) September 28, 2000

IN THE SUPREME COURT OF THE STATE OF OREGON

In the Matter of the Compensation of
KATHLEEN A. ROBINSON, Claimant. Petitioner on Review,
v.
NABISCO, INC., Respondent on Review.
(WCB 93-02515; CA A85643; SC S43918)

On review from the Court of Appeals.*

Argued and submitted November 3, 1997. Reassigned February 3, 1998.

Robert Wollheim, of Welch, Bruun, Green & Wollheim, Portland, argued the cause and filed the petition for petitioner on review.

David L. Johnstone, of Vavrosky, Maccoll, Olson & Miller, Portland, argued the cause for respondent on review. With him on the briefs were Karli L. Olson, Portland, and Patric J. Doherty, Portland.

Kimberley Chaput, of Pozzi, Wilson, Atchison, LLP, Portland, filed a brief on behalf of *amici curiae* Oregon Workers' Compensation Attorneys and Oregon Trial Lawyers Association.

David L. Runner, Assistant Attorney General, Salem, filed a brief on behalf of *amici curiae* SAIF Corporation and Max J. Kuney Company.

Before Carson, Chief Justice, and Gillette, Van Hoomissen, Durham, and Kulongoski, Justices.**

DURHAM, J.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

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* Judicial review from the Workers' Compensation Board. 143 Or App 59, 923 P2d 668 (1996).

** Fadeley, J., retired January 31, 1998 and did not participate in this decision. Graber, J., resigned March 31, 1998 and did not participate in this decision. Leeson and Riggs, JJ., did not participate in the consideration or decision in this case.

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331 Or 181> In this workers' compensation case, the issue is whether claimant is entitled to compensation for an injury suffered during a compelled medical examination (CME) under ORS 656.325(1)(a)[1] that her employer requested. The Workers' Compensation Board (Board) upheld employer's denial of compensation, and the Court of Appeals affirmed. *Robinson v. Nabisco, Inc.*, 143 Or App 59, 923 P2d 668 (1996). For the reasons stated below, we reverse the decision of the Court of Appeals and the order of the Board, and remand the case to the Board for further proceedings.

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[1] ORS 656.325(1) provides:

"(a) Any worker entitled to receive compensation under this chapter is required, if requested by the Director of the Department of Consumer and Business Services, the insurer or self-insured employer, to submit to a medical examination at a time reasonably convenient for the worker as may be provided by the rules of the director. However, no more than three examinations may be requested except after notification to and authorization by the director. If the worker refuses to submit to any such examination, or obstructs the same, the rights 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. The provisions of this paragraph are subject to the limitations on medical examinations provided in ORS 656.268.

"(b) The insurer or self-insured employer shall pay the costs of the medical examination and related services which are reasonably necessary to allow the worker to submit to any examination requested under this section. As used in this subsection, 'related services' includes, but is not limited to, child care, travel, meals, lodging and an amount equivalent to the worker's net lost wages for the period during which the worker is absent if the worker does not receive benefits pursuant to ORS 656.210(4) during the period of absence. A claim for 'related services' described in this section shall be made in the manner prescribed by the director."

The facts in this case are undisputed. In 1981, claimant sustained a compensable low back strain and leg radiculopathy, both on her right side, while working. Between 1981 and 1991, claimant aggravated her back condition several times. Claimant received permanent partial disability benefits and was treated at various times during that period. Claimant has not worked since April 1988. In April 1991, claimant and employer entered into a disputed claim settlement in which employer denied an upper-back injury as a new injury or occupational disease, but continued acceptance **<331 Or 181/182>** of claimant's other conditions as an aggravation of her original 1981 claim.

In June 1992, at employer's direction, claimant participated in a CME with Dr. Watson. During the examination, claimant complained of back pain. Watson directed claimant to raise her legs while lying on her back. Claimant stated that she could not raise her right leg. Watson then asked claimant to raise her left leg. When claimant raised her left leg, Watson moved it to a position beyond the point where claimant had moved it. Claimant felt immediate pain in the left low back and hip area. Medical tests indicated that Watson's maneuver had caused a new injury, specifically, a disc herniation on the left side. Doctors recommended surgical treatment for that injury.

Claimant sought workers' compensation for the treatment and surgery. Employer partially denied the claim, and claimant requested a hearing. In March 1993, claimant underwent surgery with another doctor to repair the disc herniation on the left side.

Before the administrative law judge (ALJ), claimant argued that her CME injury was compensable for either of two reasons, which we identify below. Her compensability arguments concern the application of ORS 656.005(7), which provides, in part:

> "(a) 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 **<331 Or 182/183>** cause of the disability of the combined condition or the major contributing cause of the need for treatment of the combined condition."

(Emphasis added.)

First, claimant contended that the CME injury was a new compensable injury and that the injury and her need for treatment arose out of and within the course of employment.[2] ORS 656.005(7)(a). Second, claimant contended that the CME injury was compensable as a consequence of a compensable injury under ORS 656.005(7)(a)(A).

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[2] For that argument, claimant relied on the dissenting opinion of Judge Rossman in *Beardslee v. Diamond Wood Products*, 107 Or App 224, 227, 810 P2d 1352 (1991) (Rossman, J., dissenting). In that opinion, Judge Rossman examined the relationship between the claimant's work and his attendance at an employer-requested medical examination and concluded:

> "* * * I would hold that the relationship between claimant's injury [incurred while traveling to the medical examination] and his employment is sufficiently close to render the injury compensable. Given employer's specific directive -- a directive that was simply being carried out by claimant -- the connection is too strong to ignore."

Id. at 228.

After a hearing in May 1993, the ALJ upheld employer's partial denial of claimant's injury. The ALJ did not analyze the facts to determine whether claimant's CME injury arose out of and in the course of her employment. The ALJ determined that the CME injury was a new injury that was a "consequence" of claimant's original injury. Accordingly, the ALJ applied the major contributing cause standard that governs the compensability of consequential conditions. See ORS 656.005(7)(a)(A) (setting out that standard). The ALJ concluded that claimant's CME injury was not compensable, because the major contributing cause of that injury was Watson's conduct during the CME "or the combination of that injury with some degree of preexisting degenerative disc disease in the spine," not claimant's original 1981 injury.

On review, the Board adopted the ALJ's order. The Board agreed with the ALJ that claimant had not demonstrated that the 1981 compensable injury was the major contributing cause of the 1992 CME injury. As noted, the Court of Appeals affirmed. This court allowed claimant's petition for review.

331 Or 184> On review, petitioner contends that her CME injury is compensable under the following test stated by this court in *Andrews v. Tektronix, Inc.*, 323 Or 154, 162, 915 P2d 972 (1996):

> "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?'"

For the reasons that follow, we conclude that the connection between claimant's 1992 CME injury and her employment is sufficient to justify compensation. In addition, we conclude that the limitation in ORS 656.005(7)(a)(A), regarding a consequential condition, is inapplicable to this case. It follows from those conclusions that claimant's 1992 CME injury is a compensable injury.

Our task is to determine whether claimant's 1992 CME injury is a "compensable injury" under ORS 656.005(7)(a). Because we must construe the statute, the principles set out in *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993), guide our interpretation. We begin by considering the text and context of the statute. *Id.* at 610-11. We also consider, at the first level of analysis, prior case law from this court that interprets the same statutory wording, as well as other related statutes. *State v. Toevs*, 327 Or 525, 532, 964 P2d 1007 (1998).

The text of ORS 656.005(7)(a) describes a series of legal issues that govern the determination whether an accidental injury is compensable. Under that statute, the first question is whether the claim concerns an accidental injury that "aris[es] out of and in the course of employment * * *." If **<331 Or 184/185>** the answer to that question is "yes," then the injury is compensable. ORS 656.005(7)(a)(A) and (B) state the bases, which the statute describes as "limitations," for determining the compensability of injuries and diseases denominated as "consequential" and "combined" conditions. Under the limitation that employer asserts is pertinent here, ORS 656.005(7)(a)(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. The phrase "compensable as a consequence of a compensable injury" indicates that the major contributing cause standard in that limitation applies only if the compensability determination depends on a showing that the injury or disease is a consequence of a compensable condition.

Following the analytical path that the text of ORS 656.005(7)(a) describes, we first inquire under that statute whether claimant's injury "aris[es] out of and in the course of" her employment. This court views the two prongs of that compensability test as two parts of a unitary "work-connection" inquiry that asks whether the relationship between the injury and the employment is sufficiently close that the injury should be compensable. *Krushwitz v. McDonald's Restaurants*, 323 Or 520, 526, 919 P2d 465 (1996); see also ORS 656.012(1)(c) (stating legislative finding that "those injuries that bear a sufficient

relationship to employment * * * merit incorporation of their costs into the stream of commerce"). Thus, although the "arising out of" and "in the course of" prongs provide guidance, the unitary work-connection test does not supply a mechanical formula for determining whether an injury is compensable. We evaluate those factors in each case to determine whether the circumstances of a claimant's injuries are sufficiently connected to employment to be compensable. As this court stated in *Rogers v. SAIF*, 289 Or 633, 643, 616 P2d 485 (1980) quoting *Allen v. SAIF*, 29 Or App 631, 633-34, 564 P2d 1086 (1977):

> "'The statutory phrase "arising out of and in the course of employment" must be applied in each case so as to best effectuate the socio-economic purpose of the Worker's Compensation Act: the financial protection of the worker and his/her family from poverty due to injury incurred in production, regardless of fault, as an inherent cost of the product to the consumer. 1 Larson, Workmen's Compensation **<331 Or 185/186>** Law section 2.20. Various concepts have arisen from attempts to rationalize that purpose, *e.g.*, the going and coming rule, special errands, lunch hour cases, dual purpose trips, impedimenta of employment, horseplay, etc. Each is helpful for conceptualization and indexing, but there is no formula for decision. *Etchison v. SAIF*, 8 Or App 395, 398, 494 P2d 455 (1972). Rather, in each case, every pertinent factor must be considered as a part of the whole. It is the basic purpose of the Act which gives weight to particular facts and direction to the analysis of whether an injury arises out of and in the course of employment.'"

Claimant's injury must satisfy both prongs of the work-connection test to some degree; neither is dispositive. *Krushwitz*, 323 Or at 531. However, if many facts support one element of that test, fewer facts may support the other. *Redman Industries, Inc. v. Lang*, 326 Or 32, 35, 943 P2d 208 (1997).

This court has explained that the "arising out of" prong of the compensability test in ORS 656.005(7)(a) requires that "some causal link exist" between the worker's injury and his or her employment. *Krushwitz*, 323 Or at 525-26. The "in the course of" employment prong requires that the time, place, and circumstances of the injury justify connecting the injury to the employment. *Id.* at 526.

We begin our analysis of the work-connection test by applying the "arising out of" prong to claimant's CME injury. Claimant's injury arises out of employment if employment exposes her to some risk from which the injury originates. *Fred Meyer, Inc. v. Hayes*, 325 Or 596, 601, 943 P2d 197 (1997).

ORS 656.325(1) entitles only three persons or entities to request a CME: the Director of the Department of Consumer and Business Services, an insurer, and a self-insured employer. Only one person is subject to the duty to submit to a CME: a worker entitled to receive compensation. The predicate for any CME is a work-related injury or disease that entitles the worker to receive compensation. Thus, it is a condition of the employment relationship -- specifically, an injury or disease that occurs on the job -- that gives rise to the **<331 Or 186/187>** respective rights and duties of the parties described in ORS 656.325(1).

The injured worker must comply with a request for a CME or face suspension of the right to compensation. In no sense is the worker's participation in a CME a voluntary act carried out for personal reasons.

ORS 656.325(1) does not state explicitly the purpose of a CME but, in context, the purpose is clear. A CME is designed to provide the director, the self-insured employer, or the employer's insurer with information about claimant's condition from a doctor who has no fiduciary relationship with claimant, such as that of an attending physician. See ORS 656.005(12)(b) (defining "attending physician," in part, as "a doctor or physician who is primarily responsible for the treatment of a worker's compensable injury * * *"). An employer or insurer that requests a CME, as in this case, might use the examining doctor's information to protect the employer's legal position on the claim *vis-a-vis* the claimant, for example, by challenging the continuing compensability of the injury or disease, the extent of any resulting disability, or the nature of medical or psychological treatment that the claimant may require.

ORS 656.325(1)(b) obligates the employer's insurer or a self-insured employer to pay the costs of a CME. The costs include the claimant's net lost wages, unless he or she already receives temporary disability benefits under ORS 656.210(4), as well as expenses connected with the examination, including child care, travel, meals, and lodging.

The statute gives claimants no role in selecting the person who performs the CME but, by implication, leaves that matter to the person or entity that requests the examination. In the present case, claimant's employer requested the CME, and the employer's chosen medical examiner, Watson, controlled completely the examination procedures and the conditions that lead to claimant's injury.

The foregoing discussion of the characteristics of a CME, as described in ORS 656.325(1), demonstrates that some causal link does exist between claimant's injury during the CME and a risk connected to a condition of employment. <331 Or 187/188> Claimant's workplace injury was the event that exposed her to the possibility that employer might request a CME. In requesting a CME, employer was exercising a statutory right granted to it because of its status as an employer of a worker with a compensable injury. Claimant faced a loss of her compensation if she failed to submit to the examination. Employer bore the responsibility of paying claimant's costs connected to the examination, including, as appropriate, net lost wage reimbursement. Finally, the purpose of the examination was to aid employer in monitoring its continuing exposure to liability for a work-related injury. The examination was not an activity in which claimant chose to participate to serve her personal interests unconnected to her work.

The characteristics of a CME, summarized above, show how the risk of an injury during a CME is one that is distinctly associated with employment. *Phil A. Livesley Co. v. Russ*, 296 Or 25, 29-30, 672 P2d 337 (1983). Indeed, the fact of employment and the occurrence of a workplace injury are the minimum circumstances that give rise to the use of a CME.

This court has stated that "'[i]njuries sustained by a worker in doing the appointed task are normally compensable, absent self-inflicted injury.'" *Wilson v. State Farm Ins.*, 326 Or 413, 418, 952 P2d 528 (1998), (quoting *Clark v. U.S. Plywood*, 288 Or 255, 261, 605 P2d 265 (1980)). ORS 656.325(1) obligated claimant, by reason of her status as an employee with a compensable injury, to carry out the "appointed task" that employer requested, *i.e.*, submission to a CME administered by Watson. Claimant's fulfillment of that statutory obligation exposed her to the risk that produced her injury. We are satisfied that a sufficient causal link exists between claimant's injury and a risk connected with employment to justify the conclusion that claimant's injury arose out of employment under ORS 656.005(7)(a).

We now turn to the "in the course of" factor of the work-connection test. As explained above, that factor "'point[s] to the time, place and circumstance under which the accident takes place.'" *Rogers*, 289 Or at 639 (quoting *Larson v. State Ind. Acc. Com.*, 135 Or 137, 139-40, 295 P 195 (1931). In *Fred Meyer*, this court stated:

> 331 Or 189> "An injury occurs 'in the course of' employment if it takes place within the period of employment, at a place where a worker reasonably may be expected to be, and while the worker reasonably is fulfilling the duties of the employment or is doing something reasonably incidental to it."

325 Or at 598.

Here, the fact that employer exercised control over claimant at the time of her injury indicates that that injury occurred in the course of employment. As already discussed, employer chose the time, place, and circumstances of claimant's medical evaluation. Employer directed claimant to attend and controlled the circumstances of the CME that lead to claimant's injury. Claimant did not volunteer to participate. But for employer's directive, claimant would not have attended the examination. Claimant's entitlement to compensation for her costs in attending the CME also suggests that the CME injury occurred in the course of employment. *See Adams v. Compensation Department*, 249 Or 530, 532-33, 439 P2d 628 (1968) (fact that deceased worker was compensated for work that occurred during accident supported finding that accident arose in course and scope of employment).

Claimant participated in the CME for employer's benefit. Claimant acknowledges, as she must, that her attendance at the CME was motivated in part by a desire to avoid the suspension of her worker's compensation benefits, as described in ORS 656.325(1)(a). But her desire to avoid that penalty is comparable to the desire of all employees to avoid discipline or discharge by complying with their employer's lawful directives. The proper focus is whether the activity promotes some interest of the employer. As stated above, the CME in this case served the interest of employer by providing employer with pertinent information about claimant's compensable injury.

Applying the criteria identified in *Fred Meyer*, 325 Or at 598-99, we conclude that claimant's CME injury occurred in the course of employment. Because the circumstances of claimant's injury satisfy, at least to some degree, each prong of the test stated in ORS 656.005(7)(a), we also **<331 Or 189/190>** conclude that the relationship between claimant's injury and employment is sufficient to justify compensation. *See Andrews*, 323 Or at 162 (stating analysis).

Because claimant's 1992 CME injury arose out of and in the course of employment, it was, for that reason, a compensable injury under ORS 656.005(7)(a). The Board should have determined, in the first instance, whether the CME injury occurred while claimant was engaged in a work-connected activity. The Board erred in assuming that the CME injury was compensable only as a consequence of a compensable condition. If, as here, the injury is compensable due to its connection to work, the limitation in ORS 656.005(7)(a)(A) is not applicable. ORS 656.005(7)(a) does not require claimant to meet the additional proof requirement that the 1981 injury was the major contributing cause of the 1992 CME injury.

In summary, we conclude that claimant's 1992 CME injury did arise out of and in the course of employment and is a compensable injury under ORS 656.005(7)(a). Because that injury is compensable due to its connection to employment, claimant need not prove that the 1981 compensable injury was the major contributing cause of the 1992 CME injury.

The decision of the Court of Appeals is reversed. The order of the Workers' Compensation Board is reversed, and the case is remanded to the Workers' Compensation Board for further proceedings.

Cite as 170 Or App 22 (2000) September 27, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Marvin H. Benz, Claimant.

MARVIN H. BENZ, Petitioner,
v.
SAIF CORPORATION and BLAZER INDUSTRIES, Respondents.
(WCB No. 98-04562; CA A105703)

Judicial Review from Workers' Compensation Board.
Argued and submitted January 6, 2000.
Greg Noble argued the cause and filed the brief for petitioner.
Jerome P. Larkin argued the cause and filed the brief for respondents.
Before De Muniz, Presiding Judge, and Wollheim and Brewer, Judges.
DE MUNIZ, P. J.
Reversed and remanded for further consideration.

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170 Or App 24> Claimant seeks reversal of an order of the Workers' Compensation Board upholding SAIF's denial of his occupational disease claim for bilateral hearing loss. Claimant asserts that the Board erred by reaching its own medical conclusion that occupational exposure to noise was not the major contributing cause of his hearing loss and that substantial evidence in the record does not support the Board's conclusion. We reverse and remand to the Board for further consideration.

Claimant has worked as an electrician for approximately 40 years. In 1987, he began working for employer Blazer Industries. Claimant was exposed to industrial noise of unknown levels throughout his employment as an electrician but did not have any significant exposure to noise that was not related to his employment. Between 1993 and 1996, claimant noticed increasing hearing loss. Claimant was tested in 1998 by an audiologist, Frink, who concluded, based on history provided by claimant and the degree and configuration of the hearing loss, that the hearing loss was "consistent with a noise induced hearing loss." He ultimately concluded that claimant's work exposure to industrial noise over the course of 40 years was the major contributing cause of his hearing loss.

Another audiologist, Dr. Ediger, examined claimant on behalf of SAIF. Although the results of his examination were quite similar to those of Frink, he concluded that, "for 11 years of work noise to be the major contributing cause in a man 61 years of age, the average noise level would have to exceed 100 dB. It is improbable that Mr. Benz worked in an average noise level of 100 dB at Blazer Industries." He therefore concluded that "work noise at Blazer Industries is not the major contributing cause of his hearing loss."

The administrative law judge (ALJ) evaluated both Frink's and Ediger's reports and concluded that Ediger was more persuasive "on claimant's initial occupational disease theory that his work at Blazer Industries caused his hearing loss." The ALJ then addressed claimant's theory that Blazer Industries was responsible for his hearing loss under the last **<170 Or App 24/25>** injurious exposure rule. Claimant argued, and the ALJ agreed, that Frink was the only expert who addressed the relevant causation question of whether his exposure to noise during his 40 years of work as an electrician was the major contributing cause of claimant's hearing loss. The ALJ concluded:

> "The mere fact that *arguendo* Mr. Frink's opinion is not rebutted does not automatically meet claimant's burden of proof, because I have already ruled that Mr. Frink is not particularly persuasive in his opinion. It is true that, under the first prong of claimant's theory, my task was to determine whether Mr. Frink was more persuasive than Dr. Ediger whereas in regards to claimant's second prong of compensability that expert vs. expert decision does not appear to be the question. However, as I stated above, I have questions regarding Mr. Frink's methodology, and, therefore, I have questions regarding his conclusions, including his conclusion vis a vis claimant's second theory of compensability. It is claimant's burden to establish the elements of his case by a preponderance of the evidence, and I do not find Mr. Frink's opinion has met claimant's burden of proof."

The Board adopted the ALJ's findings of fact but substituted an alternative rationale for concluding that claimant had not met his burden of proof under the last injurious exposure rule:

> "Claimant argues that Dr. Frink's opinion is persuasive because he is the only expert who evaluated the contribution from all prior work activity. While Dr. Frink's opinion is unrebutted, claimant's testimony and the history he gave Audiologist Rheinfelder [who works with Frink] and Dr. Ediger do not support Dr. Frink's assumed history of exposure to harmful noise levels. Thus, we are not persuaded that Dr. Frink's opinion is based on an accurate work history. For this reason, we affirm the ALJ's ultimate conclusion that Dr. Frink's opinion does not establish compensability of claimant's hearing loss under the LIER 'rule of proof.'"

Claimant seeks review of the Board's decision, arguing that the Board's conclusion that Frink's opinion was based on an inaccurate history was not supported by substantial evidence in the record. Claimant further asserts that **<170 Or App 25/26>** the Board's conclusion that he failed to establish a compensable occupational disease claim under the last injurious exposure rule is based on its own medical opinion and is unsupported by the record. We agree and reverse.

In *Roseburg Forest Products v. Long*, 325 Or 305, 309, 937 P2d 517 (1997), the court described the last injurious exposure rule:

> "[The last injurious exposure rule] imposes full responsibility on the last employer, from the time of the onset of the disability, if the claimant was exposed there to working conditions that could have caused the type of disease suffered by the claimant. *Runft v. SAIF*, 303 Or 493, 499, 739 P2d 12 (1987). The last injurious exposure rule is a rule of proof and a rule of assignment of responsibility. *Id.* at 500.
>
> "As a rule of proof, the last injurious exposure rule allows a claimant to prove the compensability of an injury without having to prove the degree, if any, to which exposure to disease-causing conditions at a particular employment actually caused the disease. *Ibid.* The claimant need prove only that the disease was caused by employment-related exposure."

By invoking the last injurious exposure rule, claimant here was required to produce evidence that his hearing loss was caused by employment-related exposure; he was not required to prove what degree of loss was sustained when working for any given employer.

Expert medical opinion is required to establish the relationship, if any, between claimant's occupational noise exposure and his hearing loss. Although the Board may draw reasonable inferences from the medical evidence, it is not free to reach its own medical conclusions about causation in the absence of such evidence. *See SAIF v. Calder*, 157 Or App 224, 227-28, 969 P2d 1050 (1998) ("The Board is not an agency with specialized medical expertise entitled to take official notice of technical facts within its specialized knowledge.").

In this case, the Board rejected the only expert medical opinion that addressed the issue of claimant's hearing **<170 Or App 26/27>** loss over the 40-year course of his employment as an electrician for multiple employers. We address claimant's arguments about why the Board erred together because the factual and legal errors are interrelated. The Board's factual error was its conclusion that "claimant's testimony and the history he gave Audiologist Rheinfelder and Ediger do not support Frink's assumed history of exposure to harmful noise levels." We conclude that substantial evidence does not support that finding.

Rheinfelder's report indicated that claimant "denied significant noise exposure in previous jobs." Ediger's report indicates that claimant reported that "noise levels were lower" at his previous places of employment than at Blazer Industries. Claimant's testimony at the hearing did not include any statement as to the relative amount of noise at his various places of employment. He indicated that drill and saw noise was similar at all of his places of employment but that the earlier places of employment did not have air equipment. Frink concluded: "[Claimant] has worked as an electrician since 1961 and although he states his other jobs were not as noisy as Blazer Industries those jobs also could have

contributed to his hearing loss." There is no inconsistency between Frink's conclusion and claimant's various statements to Rheinfelder and Ediger or his testimony at the hearing. That claimant himself felt his noise exposure at previous employments was not "significant" does not undermine Frink's expert opinion that his noise exposure was, in fact, medically significant. The record indicates that claimant worked for 40 years around similar noise and that his most recent employment at Blazer Industries involved similar but greater noise. Nothing in Frink's report is at odds with the information in the record on which the Board purported to rely in rejecting the expert opinion.

In order to reach its conclusion that claimant had no "history of exposure to harmful noise levels" at his previous places of employment, the Board substituted its own medical opinion about the harmfulness of claimant's previous exposure to noise for the medical opinion of the only expert who addressed the question. The Board's conclusion that claimant had no history of exposure to harmful noise levels is not a **<170 Or App 27/28>** reasonable inference that may be drawn from the available medical evidence in this record.

Reversed and remanded for further consideration.

Cite as 170 Or App 193 (2000) October 4, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Virgillia K. Ekdahl, Claimant.

SAIF CORPORATION and BURLEY DESIGN COOPERATIVE, Petitioners,
v.
VIRGILLIA K. EKDAHL, Respondent.
(98-01337; CA A104246)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 27, 1999.
Julene M. Quinn argued the cause and filed the brief for petitioners.
Kenneth B. Elmore argued the cause and filed the brief for respondent.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
ARMSTRONG, J.
Affirmed.

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170 Or App 195> Employer seeks review of an order of the Workers' Compensation Board that included claimant's patronage dividends in the wages that were used to calculate her temporary disability compensation. We affirm.

Claimant was a member of Burley Design Cooperative (Burley), a manufacturer of bicycles and bicycle accessories. She was injured in a 1996 car accident as she drove home from a work-related seminar. She suffered a cervical and right humerus strain in the accident. Employer accepted her claim and paid her temporary disability benefits. Claimant challenged the rate at which those benefits were paid, arguing that the patronage dividends that she had received during the 52 weeks preceding the accident should be included as part of her wages in the calculation of her time loss benefits.

Burley is a worker-owned cooperative, organized under ORS chapter 62. In addition to its members, who are the owners of the business, Burley also employs a small number of non-members. While non-members are paid only an hourly wage, members of the cooperative receive both an hourly wage and patronage dividends. Patronage dividends are calculated yearly, based on the number of hours a member works and the portion of the profits that is attributable to the efforts of Burley's members.[1] Patronage dividends are declared at some point in the year following the year in which the profits were actually earned; the declaration is made retroactive to January 1 of the year in which it is made. Each member receives a set portion of the dividend (which can vary between 20 percent and 50 percent) some time in the first eight and a half months of the year in which the dividends are declared.[2] The remainder is put into a capital account in the member's name, where it remains for two years as equity.[3] After the two years, the money becomes a **<170 Or App 195/196>** loan to the cooperative upon which the cooperative pays interest to the member. Members are immediately liable for income taxes on the entire amount of the dividend.

The administrative law judge (ALJ) held that the entire patronage dividend was part of claimant's wages and therefore had to be included in the calculation of her time loss benefits. Employer sought review, and the Board affirmed.

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[1] In the years in which the company experiences losses rather than profits, members become liable for a portion of those losses.

[2] In this case, claimant received a lump sum payment for 50 percent of the dividend during the year at issue.

[3] Before April 2, 1996, the portion of dividends held by the cooperative was immediately converted into a loan from the member to the cooperative, on which the cooperative was required to pay interest.

ORS 656.210 governs the calculation of temporary total disability benefits. Subsection (2)(b)(A) of that statute 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." Under ORS 656.005(29),[4] "wages" is defined as "the money rate at which the service rendered is recompensed under the contract of hiring in force at the time of the accident, including reasonable value of board, rent, housing, lodging or similar advantage received from the employer."

The determination of whether claimant's patronage dividends were part of her wages depends on an understanding of the nature of a cooperative. In a case addressing the taxation of cooperatives, the Supreme Court explained that a cooperative is

> "an organization established by individuals to provide themselves with goods and services, or to produce and dispose of the products of their labor. The means of production and distribution are thus owned in common and the earnings revert to the members, not on the basis of their investment in the enterprise but in proportion to their patronage or personal participation in it."

Linnton Plywood v. Tax Com., 241 Or 1, 4, 403 P2d 708 (1965) (citations and internal quotation marks omitted). The *Linnton* court further noted that "income is taxed to the one who produces the income," and that "in the absence of legislation to the contrary, the worker-members of a cooperative are considered [to be] the producers of the income." *Id.* at 7. Finally, it noted that "the earnings of this plaintiff [the cooperative] created by its workers are the earnings of its worker-members and cannot be considered as part of the income of **<170 Or App 196/197>** the corporation." *Id.* at 9. Similarly, William Meade Fletcher has explained that "[t]he tax exclusion or deduction of cooperatives' earnings rests on the theory that such earnings are not profits but rather savings produced for a patron through a pooled effort. The policy behind the tax exemption is not to benefit the cooperative as a business organization but to benefit its member-producers." William Meade Fletcher, 14A *Fletcher Cyclopedia of the Law of Private Corporations* section 7026.1, at 679 (rev ed 2000) (citations omitted).

Based on the definition of "wages" in ORS 656.005(29) and the nature of the cooperative of which claimant was a member, we are persuaded that the patronage dividends that claimant received were wages. As the Supreme Court explained in *Linnton*, the income produced by a cooperative through the efforts of its members is properly considered the income of the members, rather than the profits of the cooperative. Coupled with the fact that the patronage dividends were based on the hours that claimant worked, that feature of a cooperative disposes of employer's argument that claimant's entitlement to patronage dividends was comparable to a stockholder's right to share in a corporation's profits. Furthermore, the fact that the dividends were monetary and based in part on the number of hours that claimant worked means that the dividends were properly considered a "money rate." It also is significant that claimant was entitled to the patronage dividends under the membership agreement that she signed when she became a member of Burley. Thus, the dividends were part of "the money rate at which the service rendered is recompensed under the contract of hiring." ORS 656.005(29). Because patronage dividends fall under the statute's basic definition of "wages," there is no need to analyze the extent to which they qualify as a "similar advantage" under ORS 656.005(29).[5]

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[4] Although ORS 656.005 was amended in 1997, subsection (29) was not affected.

[5] We acknowledge that the Board also suggested that the patronage dividends could be considered a bonus that is included in claimant's wages under OAR 436-060-0025(5)(f) (1996), *renumbered* as OAR 436-060-0025(5)(g) (addressing the circumstances in which bonuses can be considered wages). (Although the rule was amended and some of the subsections were renumbered in 1996, the wording of the subsection addressing bonuses did not change.) Under that provision, "[b]onus pay shall be considered only when provided as part of the written or verbal employment contract as a means to increase the worker's wages. End-of-the-year and other one time bonuses paid at the employer's discretion shall not be included in the calculation of compensation." OAR 436-060-0025(5)(g). We agree with the Board that, because the patronage dividends are not given at the employer's discretion and necessarily occur annually, OAR 436-060-0025(5) does not preclude us from viewing them as wages. However, in light of our conclusion that the dividends fall within the basic statutory definition of "wages," it is unnecessary for us to consider whether the dividends are, in fact, bonuses.

170 Or App 198> Our conclusion that the patronage dividends were wages is buttressed by our decisions in *Emp. Div. v. Surata Soy Foods, Inc.*, 63 Or App 221, 662 P2d 810 (1983), and *Assoc. Reforestation Contractors, Inc. v. State Workers' Comp. Board*, 59 Or App 348, 650 P2d 1068, *rev den* 294 Or 295 (1982). In *Surata Soy Foods*, we held that a cooperative's members were employees and, therefore, that the cooperative was required to pay unemployment insurance premiums for members as well as for nonmember employees. *Surata Soy Foods*, 63 Or App at 225-26. We reached that conclusion in spite of the fact that the members' sole earnings in that case consisted of the patronage dividends that they received. *Id.* at 224. Similarly, in *Assoc. Reforestation Contractors*, we rejected a cooperative's argument that it was not subject to the Workers' Compensation Law because its members received only patronage dividends that were contingent on the corporation earning a profit. We also rejected the cooperative's argument that it functioned as a partnership and therefore should be exempt from the law. *Assoc. Reforestation Contractors*, 59 Or App at 353-54.

We see no reason to deviate from our holdings in *Surata Soy Foods* and *Assoc. Reforestation Contractors* in this case. Although those cases addressed a slightly different issue, namely, whether a cooperative's payment of patronage dividends to its members constituted "remuneration" under ORS 657.015 and ORS 656.005 respectively, we find our reasoning in those cases to be applicable to this case as well.

Moreover, we are not persuaded by employer's argument that the fact that claimant received both an hourly wage and patronage dividends distinguishes this case from *Surata Soy Foods*. Employer argues that we held the patronage dividends to be remuneration in that case because we viewed the employer to be trying to avoid the requirements of the unemployment insurance system by compensating its members solely with patronage dividends. However, nothing in that case indicates that we understood the employer to be **<170 Or App 198/199>** offering its employee-members dividends instead of wages as a ruse to avoid its legal obligations or that our analysis turned on such an understanding. If the payment of patronage dividends for work performed created an employer-employee relationship in *Surata Soy Foods*, we see no reason that the amount earned from patronage dividends for such work should not also be considered part of the employee's wages.

We next address employer's argument that, even if the patronage dividends were wages, the patronage dividends were not wages that the worker was receiving at the time of injury because there was a substantial delay between when the profits were earned and when the member received the dividends. *See* ORS 656.210(2).[6] Because of that delay, employer argues, it was not required to include the dividends in its calculation of claimant's time loss rate under ORS 656.210. We reject that argument as well. Employer bases its theory on the Supreme Court's decision in *Nelson v. SAIF Corp.*, 302 Or 463, 731 P2d 429 (1987). That case addressed whether an employer's payment of medical and dental insurance premiums and its contributions to the claimant's pension were part of the claimant's wages for compensation purposes. The court held that, irrespective of whether those payments could be considered wages, they need not be included in the calculation of the claimant's temporary disability benefits because the worker never *received* the medical and dental premiums at all and would receive the pension payments much later under certain limited conditions. *Id.* at 469.

Nelson is inapposite. Claimant necessarily received her entire portion of the patronage dividends, unlike the premium and pension payments in *Nelson*, and her portion was **<170 Or App 199/200>** calculated according to the number of hours that she worked and the amount of the cooperative's profits that was attributable to the efforts of its patrons. Within a few months after the declaration of the

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[6] ORS 656.210(2) provides in part:

"(2)(a) For the purpose of this section, the weekly wage of workers shall be ascertained by multiplying *the daily wage the worker was receiving* by the number of days per week that the worker was regularly employed.

"(b) For the purpose of this section:

"(A) The benefits of a worker who incurs an injury shall be based on the *wage of the worker at the time of injury*."

(Emphasis added.)

dividend at issue, she received a lump sum check for 50 percent of her share of the dividends for the previous year. Although the cooperative held the rest, it apparently was held in a capital account in claimant's name for two years and then converted into a loan from the claimant to the cooperative, which loan could run for a period of up to 12 years.[7] Claimant was taxed for the whole amount of her patronage dividends for the year in which they were declared and distributed. That situation is fundamentally different from the one in *Nelson*, in which the employer made premium and pension payments on the claimant's behalf, but the claimant never actually received them. Here claimant initially received 50 percent of the dividends in a lump- sum payment. At the same time, she also received a contractual right to the remainder. Moreover, not only was she immediately taxed on the remainder, it was placed in a capital account in her name and then converted to a loan from her to employer. When the note for the loan matures, she will receive the money regardless of whether she is still employed by the company. Unlike the pension payments in Nelson, claimant's receipt of the loan payments in this case is not contingent upon any external circumstances. The money is hers and she is entitled to it, although she may not personally control it until the note becomes due. Accordingly, the Board did not err by including claimant's patronage dividends in the calculation of her average weekly wage for purposes of determining her time loss benefits.

Affirmed.

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[7] The cooperative instituted the two-year period in which the dividends are held as equity on April 2, 1996; before that, the portion of the dividends held by the cooperative was immediately converted into a loan from the member. It is unclear whether the dividends received during the relevant period in this case were distributed under the old or new system.

Cite as 170 Or App 201 (2000) October 4, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Geoffrey R. Lewis, Claimant.

SAIF CORPORATION and OREGON STATE UNIVERSITY, Petitioners,
v.
GEOFFREY R. LEWIS, Respondent.
(97-04909; CA A103052)

En Banc
Judicial Review from Workers' Compensation Board.
Argued and submitted July 19, 1999; resubmitted en banc May 10, 2000.
David L. Runner, Special Assistant Attorney General, argued the cause and filed the brief for petitioners.
Robert J. Thorbeck argued the cause and filed the brief for respondent.
Before Deits, Chief Judge, and Edmonds, De Muniz, Landau, Haselton, Armstrong, Linder, Wollheim and Brewer, Judges.
LINDER, J.
Reversed.
Wollheim, J., dissenting.

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170 Or App 203> Employer seeks judicial review of a Workers' Compensation Board (Board) order concluding that claimant's claim for a "toxic exposure condition" is compensable. The compensability issue centers on the meaning and application of the statutory requirement that the claim must be "established by medical evidence supported by objective findings." ORS 656.005(7)(a); ORS 656.802(2)(d). We conclude that the requirement of "objective findings" is not satisfied if a medical expert merely listens to a patient's description of his or her symptoms and, believing the patient and without any verification process, relies on that description to form a diagnosis. We also conclude that, in this case, claimant failed to present "medical evidence supported by objective findings" to establish his claim. We therefore reverse the Board's order.

The Board found the following facts:

> "Claimant worked as a bioscience research technician for [employer]. On February 11, 1997, claimant's work involved cleaning a building which contained insecticides, herbicides and fungicides in liquid, powder and granular forms. Claimant and his co-workers moved the chemicals and cleaned the room. Claimant also scraped paint from the ceiling and walls to prepare them for repainting. The room was dusty and the work stirred up dust.
>
> "Claimant wore protective clothing, including a charcoal respirator mask. The mask leaked. Claimant also wore goggles part of the time, but he took them off when they became fogged.
>
> "During the job, claimant experienced fatigue and eye irritation. At about 3 p.m., after working, claimant felt 'flat,' disoriented, confused, and 'funny in the eyes.' He experienced eye irritation, tearing, coughing, and wheezing on his way home. That evening, claimant noticed a 'yellowish-whitish' powder in his nostrils. He had difficulty concentrating. By the next morning, claimant had a sore throat, sore neck, fatigue, dizziness, tinnitus, headache, sinus congestion, bright yellow phlegm and sputum, a chemical taste in his mouth, and vision abnormalities."

Claimant did not seek medical attention until three weeks after his February 11, 1997, exposure. On March 3, **<170 Or App 203/204>** 1997, he saw Dr. Huff, who noted that claimant reported "persistent [symptoms] of Tinnitus, [headache] and fatigue primarily." Huff observed that the case was a "difficult one to assess as there's no objective data." He referred claimant to Dr. Stringham, an industrial medicine specialist.

Stringham saw claimant only once, on March 4, 1997. In the "subjective" portion of his report, Stringham recounted claimant's description of his symptoms, which had "mostly subsided" by that time:

> "By the next day [after the exposure], [claimant] had a mild headache, sense of malaise, weakness, and difficulty concentrating. He had a pressure in his head and his sinuses. He noted ringing in the ears. He had a sore throat. He felt like he was disoriented at times. He felt on the morning of 02/12/97 he brought up some yellow sputum and then blood tinged sputum later in the day. On 02/12/97, he returned to the area [where he had been exposed] and painted with spray paint the next day. Over the next few days, he developed fatigue, anorexia, difficulty concentrating. Although he didn't feel well, he presumed the symptoms would subside. He continued to have malaise, tinnitus, headache, sinus ache, through the following week of 02/17/97 through 02/21/97. By 02/21/97, he started to feel more normal, although he still had some tinnitus and still felt some pressure in the back of the head around the right ear. He still had a mild headache."

In the "objective" portion of his report of his examination of claimant, Stringham noted that claimant was "in no acute distress." Claimant's sinuses were "nontender." His hearing was "normal to normal conversation." All laboratory results were normal, except for "an elevated bilirubin total for reasons unclear, but possibly related to the exposure." Stringham's "assessment" of claimant's condition was "[t]oxic exposure to multiple chemicals." Stringham further noted that claimant was "getting better spontaneously."

Later, Stringham reported that, when he saw claimant in early March 1997, claimant was "feeling that he had recovered about 70%." Stringham believed that claimant was "entirely credible." He reported:

> **170 Or App 205>** "On a clinical basis he has an exposure. He developed symptoms in a time frame consistent to the exposure. The symptoms have resolved. In my mind it is far more probable on a medical basis that the exposure, given the chemicals involved and the circumstances of his exposure, is the cause of the symptoms."

Stringham concluded "to a reasonable medical probability" that claimant's symptoms, "including visual changes, malaise, tinnitus, and headache were related to his toxic exposure on February 11, 1997."

In May 1997, claimant saw Drs. Quarum, Berlin, and Burton, all specialists in occupational and environmental toxicology. Quarum directed that an audiogram be performed on claimant, which showed normal hearing in both ears. Quarum concluded that "[t]here [was] no evidence that [claimant] actually had a specific or toxic exposure, and there [was] also no correlation of his tinnitus with any of the chemicals that he was exposed to based on the information provided." Quarum's "best guess" as to the etiology of claimant's tinnitus, "given his negative audiologic history," was "possibly due to Aspirin, which is well known as a salicylate to cause tinnitus." Claimant admitted taking aspirin "on a regular basis," although the amounts he said he took "would not be considered sufficient to cause this condition unless he actually is taking quite a bit more." Burton and Berlin concluded that claimant's complaints were not work-related and more likely were due to some other medical condition that coincided with the possible toxic exposure at work. Quarum and Burton both suggested that any link between claimant's symptoms and his possible exposure to toxic chemicals was based solely on conjecture.

SAIF denied the claim, and claimant requested a hearing. Following the hearing, the administrative law judge (ALJ) concluded that claimant had not proved the compensability of his claim. The ALJ viewed the case as a battle of the experts regarding the causal link between claimant's work and the symptoms that he experienced. The ALJ determined that Stringham's opinion supporting compensability was insufficient because of a "vacuum in the medical literature" regarding the effects of exposure to the multiple chemicals to which claimant was exposed.

170 Or App 206> On review, a divided Board reversed. The Board rejected the ALJ's conclusion that proving compensability necessarily requires support from "medical literature." The Board determined that Stringham's opinion was "more persuasive than those of Drs. Berlin, Burton, and Quarum" because Stringham's "reasoning and conclusions are based on a more accurate history and are more consistent with claimant's clinical course[.]" The Board also rejected employer's contention that claimant had not produced "medical evidence supported by objective findings." ORS 656.005(7)(a); ORS 656.802(2)(d). In rejecting that contention, the Board reasoned:

> "[Employer] argues that claimant's headache, tinnitus, and fatigue symptoms were not verifiable objective findings under ORS 656.005(19). We agree with regard to those symptoms. However, we note that Dr. Stringham reported: 'On a clinical basis, [claimant] has an exposure.' Dr. Stringham's opinion in this regard is supported by claimant's additional symptoms, which included irritated eyes, sinus congestion, and production of bright yellow phlegm and sputum. Because the latter symptoms are observable and verifiable, they are 'objective' under the statute." (Record citations omitted.)

A dissenting Board member maintained that any evidence of the existence of claimant's symptoms was "purely subjective."

> "There are no examination findings which would qualify as objective findings in this record. To the contrary, Dr. Huff, who first examined claimant, reported '[t]his is a difficult one to assess as there's no objective data.'
>
> "Claimant was next examined by Dr. Stringham, who had multiple tests performed. The results of the tests were all normal. Dr. Stringham further noted 'no significant ongoing problems' other than the subjective symptoms previously noted.
>
> "Because no medical expert made findings which were 'reproducible, measurable, or observable,' [see ORS 656.005(19),] claimant's claim must fail for lack of objective findings supporting the medical evidence relating the alleged need for treatment to the work exposure. Based on **<170 Or App 206/207>** this record, claimant's reporting alone is insufficient to satisfy the statute's requirement for objective findings 'in support of medical evidence.'"

(Emphasis in original; record citations omitted.) The dissent also would have concluded that the claim was not compensable because it was not supported by a preponderance of the medical evidence.

On review, employer relies on both of the points made in the Board's dissenting opinion. That is, employer argues that the claim in this case was not "established by medical evidence supported by objective findings" and that the Board erred in relying on Stringham's opinion because it is based on what employer calls "medical speculation of a work-related cause." Because we agree with the first contention, we do not reach the second.[1]

In making its first contention, employer frames the issue as a legal one: whether a claimant's description of his or her symptoms--a description accepted by a physician but not verifiable by the doctor's observations, tests, or measurements--alone can amount to "objective findings" that support medical evidence. So framed, the issue turns on statutory interpretation. Claimant does not respond directly to employer's argument. Without attempting to articulate the applicable legal standard, claimant merely "disagrees with [employer's] characterization of the record" and argues that substantial evidence supports the Board's conclusion that claimant produced "medical evidence supported by objective findings" in this case.[2] We begin by identifying the correct **<170 Or App 207/208>** legal standard and then turn to whether substantial evidence satisfies claimant's burden under that standard.

Both the injury and the occupational disease statutes require that a claim be "established by medical evidence supported by objective findings." ORS 656.005(7)(a); ORS 656.802(2)(d). ORS 656.005(19) defines the term "objective findings."

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[1] The dissent inappropriately assumes the answer to employer's second contention when it weaves into its reasoning "the fact that [claimant's] responses fit a medically recognized pattern." 170 Or App at 217 (Wollheim, J., dissenting). Whether that conclusion can be drawn based on Stringham's support for his opinion is in contention in this case.

[2] The Board considered this to be a claim for occupational disease. Claimant disputes the Board's characterization, arguing that a "sudden, acute physical reaction to exposure to a substance such as chemical dust is analyzed as an injurious event under ORS 656.005(7)(a) as opposed to an occupational disease under ORS 656.802." Recent decisions establish that, in certain circumstances, toxic substance exposure can result in a work "injury." *Jeld-Wen, Inc. v. Molena*, 166 Or App 396, 399, 998 P2d 753, *rev den* 330 Or 363 (2000) ("exposure to fumes, vapors, and the like may result in an injury as well as an occupational disease"); *Weyerhaeuser Co. v. Woda*, 166 Or App 73, 998 P2d 226, *rev den* 330 Or 361 (2000) (same). The distinction ultimately is immaterial for purposes of the issue presented in this case, however. Proof of the compensability of both an occupational disease and an injury requires a claim to be "established by medical evidence supported by objective findings." ORS 656.005(7)(a) (injury); ORS 656.802(2)(d) (occupational disease).

> "'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."

To determine the meaning of the requirement that a claim be "established by medical evidence supported by objective findings" and of the meaning of the definition of "objective findings," we look first to the text and context of the pertinent provisions. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993).

The threshold requirement that a claim must be "established by medical evidence supported by objective findings" itself reveals the statute's emphasis on requiring a degree of certainty and reliability to prove a claim. The word "establish," for example, means "to provide strong evidence for" and to "determine exactly and with certainty."[3] "Evidence" means "an outward sign: indication: * * * something that furnishes or tends to furnish proof."[4] That much is familiar territory, in terms of what those words are readily understood to mean in common parlance. But the words are worth careful examination as a reminder that, in and of themselves, they are infused with the idea that proof to establish a claim must reflect confidence in the diagnosis rather than mere speculation or conjecture.

170 Or App 209> The statute's use of the phrase "objective findings" is less familiar in that it is not commonly used in general day-to-day conversation. The legislature has, however, provided a specific definition for it, declaring that objective findings are "verifiable indications of injury or disease" that include, but are not limited to, "range of motion, atrophy, muscle strength and palpable muscle spasm." That part of the definition is replete with words conveying that the medical evidence must be supported by an empirical confirmation of the existence of an injury or disease. Indeed, a key term in the definition is the word "verifiable," meaning "capable of being verified" and "susceptible to the possibility of being either theoretically or actually proved true or false by reference to empirical facts."[5] In turn, "verify" in this context means "to prove to be true: establish the truth of: * * * to check or test the accuracy or exactness of: confirm the truth or truthfulness of by or as if by comparison with known data or a recognized standard."[6] Similarly, an indication is "something (as a signal, sign, suggestion) that serves to indicate,"[7] that is, "to point out or point to or toward with more or less exactness: show or make known with a fair degree of certainty."[8] Consistent with the statute's insistence on empirical support for proffered medical evidence, the "verifiable indications" listed as examples in the definition (*e.g.*, range of motion, atrophy, muscle strength and "palpable" muscle spasm) all are tangible or quantifiable signs or symptoms with potential diagnostic significance to a medical expert.

The statutory definition does not stop there, however. The second sentence goes on to define "objective findings" by declaring what they do not include. Specifically, they do not include physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable. Again, the standard dictionary definitions of the key terms are telling. All of them have to do with determining, by reliable methods and standards, the existence of a **<170 Or App 209/210>** state or condition through actual testing, scrutinizing, and ascertainment.[9] Thus, by converse implication, the second sentence adds the understanding that objective findings, to provide the

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[3] *Webster's Third New Int'l Dictionary*, 778 (unabridged ed 1993).

[4] *Id.* at 788.

[5] *Id.* at 2543.

[6] *Id.*

[7] *Id.* at 1150.

[8] The definition of "indicate" continues: "to show the probable presence or existence or nature or course of: give fair evidence of: be a fairly certain sign or symptom of: reveal in a fairly clear way * * * <a fever that indicates severe illness> ." *Id.*

[9] To "examine," for example, is to "test by an appropriate method," "to inspect or test for evidence of disease or abnormality," or to "seek to ascertain: attempt to determine." *Id.* at 790 To "reproduce" means "to produce again." *Id.* at 1927. "Observable" is defined as "perceptible directly or indirectly (as by the medium of instruments) through the senses." *Id.* at 1558. Finally, a thing is "measurable" if it is "capable of being measured," and "measure," in this context, is "to ascertain the quantity, mass, extent, or degree of in terms of a standard unit or fixed amount." *Id.* at 1399-1400.

necessary support for medical evidence, must be physical findings or subjective responses to examinations that are verifiable in the sense that they can be objectively or empirically confirmed.

To be sure, laboring through dictionary definitions can seem tedious and at times artificial. But the exercise is worthwhile here because it highlights the consistent nature of the terms that the legislature used to give meaning to the phrase "objective findings." Repeatedly, the legislature chose words that convey precision and reliability in empirically establishing the existence of an injury or disease based on an expert's actual examination and testing of the claimant.[10] That conclusion, moreover, is inescapable considering the broader statutory context. As already described, the starting point of the analysis is the requirement that a claim be "established by medical evidence *supported* by objective findings." ORS 656.005(7)(a) (emphasis added); ORS 656.802(2)(d) (same). Findings cannot logically be described as "supporting" particular medical evidence if the expert providing that evidence did not himself or herself make the findings or reasonably rely on some other qualified individual who did so.

Our conclusions about the statutory language are reinforced by one other aspect of the context. Context includes not only case law, but earlier versions of the statute in question. *SAIF v. Walker*, 330 Or 102, 109, 996 P2d 979 (2000); *PGE*, 317 Or at 611. Based on an earlier version of the **<170 Or App 210/211>** statutory definition of "objective findings," both the Board and this court held that a physician's acceptance of and reliance on a claimant's description of his or her symptoms, without more, could satisfy the "objective findings" standard. *SAIF v. Williamson*, 130 Or App 391, 395, 882 P2d 621 (1994), *rev den* 320 Or 507 (1995); *Georgia-Pacific Corp. v. Ferrer*, 114 Or App 471, 474, 835 P2d 949 (1992); *Suzanne Robertson*, 43 Van Natta 1505 (1991). After those decisions, the 1995 Legislature amended the statutory definition of "objective findings." Or Laws 1995, ch 332, section 1. The 1995 amendment added the requirement that "objective findings" be "verifiable indications of injury or disease." Apparently to place emphasis on the requirement that medically qualified individuals rely on perceptible indications of injury or disease, the 1995 Legislature also specified that a muscle spasm must be "palpable." Finally, the 1995 Legislature also added the sentence excluding physical findings or subjective responses to physical examinations that are not reproducible, measurable or observable from the definition of "objective findings." ORS 656.005(19).[11]

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[10] Indeed, the very term "objective" points to the need for an independent and qualified interpreter of the data or examination. *See id.* at 1556 ("objective," as applied to the "symptoms of disease" is "perceptible to persons other than an affected individual".)

[11] Employer also relies on the history of the 1995 legislative amendment in urging that the statute does not permit findings based only on a claimant's subjective reports, rather than on objective and empirical confirmation of injury or disease. We consider legislative history only if the statutory "language is reasonably capable of more than one construction." *State v. Maxwell*, 161 Or App 468, 473, 984 P2d 361 (1999). Although we do not find that, for our purposes in resolving this case, the statutory language is reasonably capable of more than one construction, we nevertheless agree with employer that the legislative history also supports the conclusion that we reach here. *See State v. Sumerlin*, 139 Or App 579, 587 n 7, 913 P2d 340 (1996) (examination of text and context ended the inquiry but court nevertheless noted that legislative history also supported text and context reading). In particular, the history demonstrates that the 1995 legislature intended to repudiate the Board's *Suzanne Robertson* decision and our similar decisions in *Williamson* and *Ferrer* by requiring, instead, that a medical expert see or otherwise observe or measure some objective indication of injury or disease.

The dissent's reliance on Representative Mannix's statement to the House Labor Committee (*see* 170 Or App at 216 n 3 (Wollheim, J. dissenting)) is misplaced for two reasons. First, it does not support what the dissent would hold--*i.e.*, that the term "verifiable" was understood by the legislature to mean capable of verification in the past rather than at the time of and via a physician's or other medically trained individual's objective examination. To the contrary, the passage cited supports exactly what we hold in this case--that a condition has to be *presently* verifiable and that a process of verification must be engaged in by the medical professional.

The discussion that the dissent quotes undermines the dissent's reasoning in a second way. As an example of the objective verification process in which a medical professional must engage, Representative Mannix cited the possibility that a headache could be verified through brain scans or a claimant's description of a pain pattern that fits with what the medical profession accepts as indicative of a headache. The dissent ignores that the headache is not to be accepted by the medical expert at face value. Here, however, Stringham did the equivalent of that. Stringham asked nothing and did nothing to verify claimant's report of sinus congestion, discolored phlegm, mild headaches, and so on. He accepted those reports as credible and concluded that claimant had an injurious exposure because the symptoms were consistent with an exposure. The dissent accepts that backward reasoning and, in effect, lets the diagnosis serve as the verification. Nothing in the statute's language or its history supports that curious approach.

170 Or App 212> In short, all of the textual and contextual clues point in a single direction: The statutory emphasis is on findings made by a medical expert on the basis of a verification process involving trained observation, examination, or testing that produces results--either physical or subjective responses--that are witnessed, measured, or can be reproduced. For there to be "findings," a process of verification necessarily must take place. The plain import of the language is that the verifiable character of indications of injury or disease are established only if a medical expert engages in a medical examination process that results in their verification. Said another way, to satisfy the statute, the expert must attempt to verify the injury or disease, must succeed in doing so, and must make findings accordingly. Necessarily, then, the indications of an injury or disease must, at the time of the examination, be *presently* verifiable. That much of an understanding of the statutory language is enough to resolve this case.

We turn, then, to the Board's order and its application of the statute in this case. The Board first determined that claimant's "headache, tinnitus, and fatigue symptoms were not verifiable objective findings." The Board then nevertheless concluded that Stringham's opinion in favor of compensability was "supported by claimant's additional symptoms, which included irritated eyes, sinus congestion, and production of bright yellow phlegm and sputum." The Board did not explain how it distinguished between the symptoms that it found were "not verifiable objective findings" and those that it found were. The Board may have determined that Stringham actually observed or otherwise confirmed the existence of those theoretically observable symptoms. Alternatively, the Board may have considered those symptoms to **<170 Or App 212/213>** be "verifiable" indications of injury or disease because, unlike headache, tinnitus, and fatigue, which generally are subjective and must be reported by a patient, irritated eyes, sinus congestion, and discolored phlegm and saliva are at least "capable of verification" even if, in this case, Stringham did not personally observe them.

If the Board's decision rests on the former rationale--*i.e.*, that, factually, Stringham personally observed evidence of claimant's symptoms--the Board's finding is not supported by substantial evidence. *See Garcia v. Boise Cascade Corp.*, 309 Or 292, 295, 787 P2d 884 (1990) ("If a finding is reasonable in light of countervailing as well as supporting evidence, the finding is supported by substantial evidence."). Nothing in the record indicates that Stringham himself--or any other qualified medical expert on whom he relied--observed, measured or reproduced claimant's reported symptoms. Indeed, to the contrary, Stringham's report observed that at the time of his examination, claimant's symptoms had "resolved." The "subjective" portion of Stringham's examination report merely summarized claimant's description of those symptoms. In the "objective" portion of Stringham's report, his only finding was the "elevated bilirubin total," which he could say only was due to "reasons unclear, but possibly related to the [toxic] exposure." Proof of compensability requires more than a speculative possibility. *Paige v. SAIF*, 75 Or App 160, 163, 706 P2d 575 (1985). Stringham's reference to the elevated bilirubin level, therefore, does nothing to prove the compensability of this claim.

Alternatively, the Board may have reasoned that Stringham's medical opinion was based on verifiable indications of injury or disease because the symptoms would have been verifiable when claimant was experiencing them, even though they had resolved by the time he sought medical treatment. If that rationale underlies the Board's finding, then the Board committed legal error because, as we have determined, the statute requires that the indications of disease or injury on which a medical expert relies be verifiable **<170 Or App 213/214>** at the time that the expert examines the claimant. Even setting aside the "reproducible, measurable or observable" requirement, at a minimum, the 1995 version of the statute mandates that there be either "physical findings or subjective responses to physical examinations." That language would be robbed of all meaning if it were deemed to include a claimant's report of once observable symptoms that have never been observable or otherwise objectively perceptible to an examining medical professional. *See* ORS 174.010 (in interpreting statute, court is not "to omit what has been inserted").

More to the point, the "reproducible, measurable or observable" requirement cannot be set aside. A claimant whose symptoms have resolved simply does not--indeed, cannot--present a medical expert with indications of disease or injury that presently are verifiable. Had this claimant sought medical treatment promptly, the symptoms on which the Board relied would have met the statutory requirements, assuming that the medical experts actually confirmed those symptoms and based their opinions on them. Stringham, however, necessarily based his findings on claimant's believability in later reporting those possibly once-verifiable symptoms. The statute simply does not permit such a "finding" to support a medical diagnosis, any more than a physician could find lost range of motion

based only on a claimant's description of his or her physical limitations that, by the time of any medical examination, had resolved and were not then verifiable by the physician.[12]

In sum, the language of ORS 656.005(7)(a), ORS 656.802(2)(d), and ORS 656.005(19), as amended in 1995, compels the conclusion that a claimant's description of his or her own symptoms, including reported past symptoms that no longer are present, cannot alone constitute "objective" findings, even if believed and relied on by a medical expert. **<170 Or App 214/215>** Because no "objective findings" support Stringham's opinion, which is the only medical opinion that favors compensability and the only opinion on which the Board relied, the Board erred in ruling that the claim is compensable.

Reversed.

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[12] The dissent makes no effort to address this point. It is an important one. Based on even the most cursory review of the legislative history, no one could seriously contend that the legislature intended to permit objective findings on such a basis.

WOLLHEIM, J., dissenting.

Because I disagree with the majority's conclusion that ORS 656.005(19) requires that the indications of an injury or disease must be *presently* verifiable at the time of examination, I respectfully dissent.[1]

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." (Emphasis added.)

As the majority explains, the plain language meaning of "verifiable" includes "capable of being verified" and "susceptible to the possibility of being either theoretically or actually proved true or false by reference to empirical facts[.]" *Websters Third New Int'l Dictionary*, 2543 (unabridged ed 1993). Neither meaning requires that verification by the physician take place, only that verification is possible at some time. However, the majority's interpretation of ORS 656.005(19) requires that the findings of injury be *presently* verifiable. That interpretation inserts a term -and consequently, an additional requirement--that the legislature did not expressly include in the language of the statute.[2] That insertion runs counter to the statutory command of ORS 174.010 "not to insert what has been omitted, or to omit what has **<170 Or App 215/216>** been inserted." Contrary to the majority's conclusion, the language of ORS 656.005(19) contains no requirement that the doctor making the diagnosis actually observe or verify the indications of injury during the examination.

The majority's reasoning builds upon clues and implications to reach the conclusion that the legislature intended to require that the indications of an injury or disease be *presently* verifiable at the

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[1] To the extent that the majority's reasoning could also apply to the ORS 656.005(19) terms "reproducible, measurable or observable," I would make the same responding arguments. I limit my discussion here to the term "verifiable" for purposes of clarity.

[2] Presented another way, the majority's conclusion essentially changes the language of ORS 656.005(19) to read: "'Objective findings' in support of medical evidence are *verified* indications of injury or disease * * *."

time of the examination. Unfortunately, the express language of the statute provides otherwise.[3] The plain language of ORS 656.005(19) does not contain a *presently* verifiable requirement. If the legislature in fact intended that indications of injury be *presently* verifiable, then the legislature used the wrong words to convey that intent. *Deluxe Cabinet Works v. Messmer*, 140 Or App **<170 Or App 216/217>** 548, 555, 915 P2d 1053, *rev den* 324 Or 305 (1996) (if the legislature intends to change a statute, it must use language that, reasonably construed, actually changes the statute). We do not have the authority to rewrite a statute to give effect to what we speculate the legislature intended. *See Monaco v. U.S. Fidelity & Guar.*, 275 Or 183, 188, 550 P2d 422 (1976). ("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.").

However, that is what the majority opinion does.

I would affirm the Workers' Compensation Board's order that concludes that claimant's "toxic exposure condition" claim is compensable. The facts before us do not present a suspicious situation where a worker claims that he was injured in an unobserved "accident" at work--no one contests the fact that claimant here was exposed to toxic substances at his workplace. Nor is this an instance where a worker is complaining about lower back pain that has no apparent cause. Claimant was exposed to phenoxyherbicides and Stringham noted that claimant's description of his symptoms, as well as the sudden onset and gradual resolution of those symptoms, is consistent with a case of multiple toxic exposure to chemicals at a low dose. Stringham's conclusion that claimant's claim is compensable was based upon claimant's responses to diagnostic questioning, the fact that those responses fit a medically recognized pattern, and that that pattern was consistent with Stringham's own prior experiences treating workers exposed to multiple phenoxyherbicides. The Board was correct in relying upon Stringham's report in reaching its conclusion.

There is no evidence that claimant is attempting to "milk" the workers' compensation system. Claimant's claim is for a nondisabling injury. He merely seeks recovery of the medical costs he incurred to treat that injury. Claimant makes no claim for permanent or temporary disability. Claimant did not miss any work. In fact, claimant did as many of us would--continue to work expecting that the symptoms would go away. He sought medical attention only when some symptoms did not disappear within a reasonable **<170 Or App 217/218>** time period. Unfortunately for claimant, the majority

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[3] I must also disagree with the majority's comment that the legislative history supports the conclusion that it reaches. My review of the legislative history found that it was not conclusive on the issue before us. However, the following exchange between Representative Brown and Representative Mannix, one of the amendments' sponsors, is enlightening:

> BROWN: "On page three, section 19, being non-medically trained, I would assume that there are conditions that are not, you can't find through x-ray or whatever. But, for example, a headache. Sometimes that is not always determinable. Say I have a headache and I am uncomfortable and I tell that to the doctor. Why isn't that sufficient evidence that I am in pain and that I have a headache?"
>
> MANNIX: "Well, actually the question is whether or not we have objective findings. And the way the physician can evaluate your headache, by the way they can evaluate headaches through brain scans--it's serious in those situations--but they can evaluate through those kinds of technologies and see whether or not there is a pattern that is reproducible. They can also run a variety of tests on your head. *The most simple examination that a physician can carry out, and I am not pretending to be a physician, I'm just speaking off hand here, is, they can ask about the pain pattern. And if the pain pattern that you report, and then they can inquire at another time again, 'Where is the pain pattern?' And the pain pattern that you report is consistent with an accepted form of headache.* They can also do things as evaluate your physical movements, they can inquire, putting it all together. At some point a physician can verify, 'This appears to be a legitimate headache.' And usually that won't be a very serious issue. But if someone says they have chronic headaches, then they could start running MRI scans of the brain and everything else to try to document what the causation is." Tape recording, House Labor Committee, SB 369, March 1, 1995, Tape 38, Side B (emphasis added).

I understand Representative Mannix's comments to explain that subjective responses to diagnostic questioning that fit a medically recognized pain pattern are included within the definition of objective findings. Such responses formed the basis of Dr. Stringham's medical conclusions.

concludes that he waited too long. If claimant had visited his doctor earlier, and the doctor had actually verified claimant's irritated eyes, sinus congestion and bright yellow phlegm and sputum, claimant's claim would have been compensable. But because claimant hesitated, the majority concludes that the workers' compensation system must declare his claim noncompensable.[4] That I cannot accept.

Accordingly, I respectfully dissent.

Deits, Chief Judge, and De Muniz and Armstrong, JJ., join in this dissent.

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[4] Employer's "medical speculation of a work-related cause" argument is merely an attempt at an end-run around the substantial evidence standard. *See SAIF v. Valencia*, 148 Or App 263, 939 P2d 623 (1997) (discussing substantial evidence). Stringham concluded that the symptoms claimant suffered were the result of acute exposure to toxic chemicals at the workplace. The Board expressly found Stringham's reasoning and conclusions more persuasive than those of the other doctors who examined claimant. The Board's decision is supported by substantial evidence. *See Armstrong v. Asten-Hill Co.*, 90 Or App 200, 206, 752 P2d 312 (1988) (in workers' compensation cases, if there are doctors on both sides of a medical issue, whichever way the Board finds the facts will probably have substantial evidentiary support). I see no reason to disturb the Board's causation determination.

Cite as 170 Or App 314 (2000) October 11, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Richard L. Sutton, Claimant.

RICHARD L. SUTTON, Petitioner,

v.

DENNIS 7 DEES LANDSCAPE and LIBERTY NORTHWEST INSURANCE CORP., Respondents.

(WCB No. 97-09186, CA A103883)

Judicial Review from Workers' Compensation Board.

Argued and submitted July 11, 2000.

Patrick K. Cougill argued the cause for petitioner. With him on the brief was Welch, Bruun & Green.

Alexander D. Libmann argued the cause and filed the brief for respondents.

Before De Muniz, Presiding Judge, and Deits, Chief Judge, and Brewer, Judge.

DEITS, C. J.

Affirmed.

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170 Or App 316> Claimant seeks review of an order of the Workers' Compensation Board (Board), asserting that the Board erred in upholding a redetermination order of the Department of Consumer and Business Services (Department) that failed to award claimant additional permanent disability benefits on his aggravation claim. Claimant argues that the Board erred in failing to consider his functional capacity in determining that claimant was not entitled to a redetermination of his permanent disability. He further asserts that the Board erred in considering a medical arbiter's report for the purpose of determining whether claimant had experienced a permanent worsening. We affirm.

The facts are undisputed. Claimant injured his back in 1991, while working for employer as a landscape foreman. His claim for disabling low back strain was accepted and closed by determination order with an award of unscheduled permanent disability. In 1997, following receipt of a doctor's report, employer reopened the claim as an aggravation claim. In June 1997, employer closed the claim, with no additional award for permanent disability, and claimant sought reconsideration. The Department upheld the closure, determining that claimant was not entitled to a redetermination of his permanent disability because he had not suffered a permanent worsening of his condition. The Administrative Law Judge (ALJ) reversed the Department, finding that claimant's condition had worsened, and made an additional award of permanent disability. On employer's appeal, the Board reversed the ALJ, holding that the medical record, including the medical arbiter's report, required the conclusion that claimant had not experienced a permanent worsening since the last arrangement of compensation and that claimant, therefore, was not entitled to a redetermination of the extent of his disability.

We first consider claimant's assertion that the Board erred in referring to the medical arbiter's report in determining whether claimant had experienced a permanent worsening. As claimant points out, ORS 656.268(7)(a) provides for the appointment of a medical arbiter when there is an objection to the impairment used in rating the worker's disability. **<170 Or App 316/317>** Claimant objected to the impairment used in rating his disability, and a medical arbiter was appointed. That report indicated that claimant had not experienced a permanent change in his condition. Claimant does not assert that the arbiter should not have been appointed. *See Sedgwick James of Oregon v. Hendrix*, 130 Or App 564, 883 P2d 226 (1994).[1] Claimant argues only that the medical arbiter's report may be used solely for the

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[1] There, we said:

"In this case, the text of the statute is quite plain. It requires the appointment of a medical arbiter when there is a 'disagreement with the impairment' used to rate claimant's disability. The fact that claimant's disability was rated at zero does not alter the fact that *some* determination of his impairment was made, with which claimant disagrees. Nothing in the text or the context of the statute supports employer's contention that the obligation to appoint a medical arbiter is triggered only by a disagreement with a finding that claimant was impaired to some extent greater than zero, and that claimant's disagreement with that impairment evaluation must be supported by contrary medical evidence. To the extent that there is any ambiguity left unresolved by the text and the context, our review of the legislative history reveals no contrary legislative intent." 130 Or App at 568 (emphasis in original).

purpose of rating disability and only after it has been determined that the worker is entitled to a redetermination of the extent of disability. It is claimant's position that the report may not be used for the purpose of determining whether the worker has experienced a worsening that will entitle him or her to a redetermination.

Claimant does not point to, nor are we aware of, any statutory support for his contention. It is true, as claimant asserts, that the medical arbiter is appointed for the purpose of determining the worker's *level* of impairment. However, there is nothing in the statutes or the case law that prevents the report, once a part of the record, from being referred to by the ALJ and the Board in determining whether the claimant has additional permanent impairment since the last award of compensation, *i.e.*, whether the claimant is entitled to a redetermination of the extent of permanent disability. We conclude that the Board did not err in considering the medical arbiter's report in determining whether claimant had experienced a permanent worsening of his condition.

Claimant also argues that the Board erred in its determination of whether he had experienced a permanent **<170 Or App 317/318>** worsening, because it failed to take into account medical evidence of his reduced functional capacity. Claimant asserts that consideration of functional capacity is an essential component of the determination of loss of earning capacity for the purpose of unscheduled disability and that the evidence of functional capacity here demonstrates his increased disability.

In order to prove a compensable aggravation claim, a claimant must establish an actual worsening of the condition and a diminished earning capacity. *Intel Corp. v. Renfro*, 155 Or App 447, 963 P2d 173 (1998). The Supreme Court has held that a diminished earning capacity alone does not establish an aggravation. The condition must itself be worsened to prove a compensable aggravation. *Stepp v. SAIF*, 304 Or 375, 380, 745 P2d 1207 (1987). Accordingly, although claimant is correct that a reduction in functional capacity may be an appropriate consideration in determining whether a claimant has experienced an aggravation, it is not a necessary consideration under all circumstances. In cases such as this one, where the Board determines that the condition itself has not worsened, for purposes of the aggravation claim, it is not necessary to address whether the claimant has a diminished earning capacity. Consequently, even if claimant were correct that the Board did not address his reduced functional capacity, that would not constitute error.

In any event, contrary to claimant's assertion, it appears that the Board did consider claimant's contention that his functional capacity had diminished. The ALJ specifically found that there had been no change in residual functional capacity from the time of original closure, and the Board adopted that finding.[2] Further, that finding is supported by substantial evidence. Accordingly, the Board did **<170 Or App 318/319>** not err in concluding that claimant is not entitled to a redetermination of the extent of his disability.

Affirmed.

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[2] The ALJ found:

"With respect to adaptability, claimant had a base functional capacity (BFC) of heavy. The medical evidence from Dr. Takacs indicates that claimant cannot now return to the type of work that `he did prior to the time of injury. Claimant suggests that he should be rated at the medium/light level in terms of residual functional capacity. However, there is no specific medical evidence or other evidence which would support that conclusion. Obviously, claimant has lost functional capacity, but on this record I do not believe it is appropriate to conclude that he has deteriorated further than from heavy to medium as was the case at the prior closure."

Cite as 170 Or App 491 (2000) October 18, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation Becky J. McTaggart, Claimant.

BECKY J. MCTAGGART, Petitioner,
v.
TIME WARNER CABLE and TRAVELERS INSURANCE, Respondents.
(98-01802; CA A104295)

Judicial Review from Workers' Compensation Board.
Argued and submitted October 6, 1999.
Holly J. Somers argued the cause and filed the brief for petitioner.
Jerald P. Keene argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
ARMSTRONG, J.
Reversed and remanded for reconsideration.
Kistler, J., concurring.

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170 Or App 493> Claimant seeks review of a decision of the Workers' Compensation Board that upheld employer's[1] denial of her claim for injuries that she suffered when she fell on the way from her car to her work. We reverse and remand for reconsideration.

Claimant works for employer in Portland as a customer service representative.[2] At the time of her injury, she worked four days a week, from 9 a.m. to 8 p.m. When she arrived for work shortly before 9 a.m. on January 9, 1998, she parked on Northeast Sullivan Street, which is a public right of way that runs between the Banfield Freeway and several businesses. Neither the city nor any other entity actually owns the street, but a city ordinance requires adjacent property owners to provide some degree of maintenance. Employer provides parking for its employees, but it has insufficient spaces for all of them. It is aware that some employees park on Sullivan Street when space is available. After claimant parked there on January 9, she began walking eastward toward employer's building, where she intended to enter a door on the lower level to reach her work station.

Before it reaches employer's property, Sullivan Street begins to slope downward, with the slope ending on employer's property; the precise location of the property line is not entirely clear. The surface of the slope is asphalt. The slope leads to a parking area for employer's vehicles and to the delivery area for employer's warehouse. Employer is the primary if not sole vehicular user of the slope. Employer prevents other vehicles from parking on any part of the slope, including the portions that it does not own, in order keep it clear for its purposes. It has filled potholes on the street above the slope and has trimmed bushes on the side of the slope. Claimant fell and suffered the injuries at issue while **<170 Or App 493/494>** she was walking down the slope. She does not know the reason for her fall.[3]

Based on those findings, the Board concluded that claimant's injuries occurred in the course of her employment but that they did not arise from it. It therefore found that the claim is not compensable. The Supreme Court has explained in a number of cases that, in order for an injury to be compensable, it must both occur in the course of the claimant's covered employment and arise out of that employment. The requirement that the injury occur in the course of employment concerns the time, place and circumstances of the injury; the requirement that it arise out of employment requires a causal link

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[1] Travelers Insurance Company is employer's workers' compensation insurer and therefore acted for employer in processing claimant's claim.

[2] In deciding this case, the Board adopted and affirmed the opinion and order of the administrative law judge. We therefore refer to that opinion as the opinion of the Board. Neither party challenges the Board's findings, and we therefore rely on them in describing the facts.

[3] Depending on how the Board construed claimant's testimony, it could have found that claimant believes that she either turned her ankle or tripped over a defect in the asphalt or that she does not know what caused the fall. There is substantial evidence to support its conclusion that claimant does not know the reason.

between the injury and the employment. Although they are stated separately, those requirements are two prongs of what is in fact a single work-connection inquiry. There must be some support for each prong, but neither is dispositive. Strong support for one prong and minimal support for the other may be sufficient to satisfy the test. The basic question is whether the causal connection between the injury and the employment is sufficient to warrant compensation. ORS 656.005(7)(a); *Fred Meyer, Inc. v. Hayes*, 325 Or 592, 596-97, 943 P2d 197 (1997); *Phil A. Livesley Co. v. Russ*, 296 Or 25, 28, 672 P2d 337 (1983).

We begin with the "in the course of employment" prong. Employer cross-assigns error to the Board's conclusion that claimant satisfied that prong. *See* ORAP 5.57.[4] If employer were correct, we would affirm the Board without considering the "arising out of employment" prong. In its order, the Board recognized that, under the "going and coming" rule, an employee's injury that is sustained before arriving at work or after leaving it is generally not compensable. However, it analogized claimant's situation to the parking lot exception to the going and coming rule, under which an **<170 Or App 494/495>** injury may be compensable if it occurs in a parking lot or other off-premises area over which the employer has some control. *See Fred Meyer, Inc.*, 325 Or at 597-98. As the Board explained:

> "[A]s soon as claimant started down [the] slope she, for all practical purposes, was on the employer's premises or an off-premises area over which the employer exercised almost exclusive control. The employer acquiesced in employees parking on the right of way while at work and in the employees walking down the slope to enter the employer's work place through the lower entrance doors. Although there is no evidence that this employer paved the right of way or created the speed bump/water diverter on the slope, the employer's almost exclusive control over the slope is established by the record as a whole and in particular by the following factors: the employer has limited maintenance responsibility for the slope consistent with City ordinance; the employer does not encourage public use of the slope and does not allow parking on the slope so as to maintain ingress/egress to/from the employer's parking lot and warehouse/delivery area; there is no practical reason for the public to use the slope because the slope leads to [the] parking lot and warehouse/delivery area; the slope is extensively used by the employer's vehicles and those coming to the employer's warehouse/delivery area for the employer's business purposes; the employer fixes potholes as needed at the top of the slope; the employer trims the bushes on the side of the slope on a yearly basis."

The Board therefore concluded that the "in the course of employment" prong strongly supports compensability.

Employer argues that claimant's injury occurred only close to claimant's work space, close to claimant's work time, and close to claimant's beginning her work duties, and that closeness is not sufficient to show that the injury occurred in the course of her employment.[5] It notes that the Board stated that it was "almost" as if the fall had occurred on employer's premises or parking lot and suggests that almost is not sufficient. However, in *Cope v. West American Ins. Co.*, 309 Or 232, 785 P2d 1050 (1990), the Supreme Court held that several relevant cases

> **170 Or App 496>** "demonstrate that when an employee traveling to or from work sustains an injury on or near the employer's premises, there is a 'sufficient work relationship' between the injury and the employment only if the employer exercises some 'control' over the place where the injury is sustained."

Cope, 309 Or at 239.[6] Thus, it is possible to satisfy the "occurring in the course of employment" prong when the employer has *some* control over the area where the injury is sustained, even if the area is not a parking lot. Here, employer had essentially exclusive control of the slope where claimant fell, and we therefore agree with the Board's analysis of this prong of the unitary work-connection test.

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[4] ORAP 5.57 expressly refers to cross-assigning error to decisions of a trial court, not of an administrative agency. However, so far as practicable, the procedure in administrative review cases is the same as that for civil appeals. ORAP 4.05. We therefore conclude that ORAP 5.57 applies to this case.

[5] In sporting terms, closeness counts only in horseshoes.

[6] In *Norpac Foods, Inc. v. Gilmore*, 318 Or 363, 867 P2d 1373 (1994), the Supreme Court held that we had incorrectly read Cope as holding that an injury in an employer-controlled parking lot is *per se* compensable without regard to whether it arose out of the employment. That holding does not affect the discussion in *Cope* of the "occurring in the course of employment" prong of the work-related test.

The remaining question is whether the Board correctly concluded that claimant's injury did not arise out of her employment. Claimant must provide at least some limited evidence to satisfy that prong of the unitary work-connection test in order to prove that her injury is compensable. In its opinion, the Board treated the case as one involving an unexplained fall, which it described as a fall where the claimant is unable affirmatively to show a work-related cause for the injuries. It then relied on earlier cases in which the Board had concluded, as a matter of law, that an unexplained fall does not arise out of employment. The basis for those cases was the Board's conclusion that the legislature had overruled the Supreme Court's contrary holding in *Phil A. Livesley Co.*, in which the court held that a truly unexplained fall--one in which among other things, the claimant has eliminated all idiopathic[7] reasons for the fall--arises out the employment. This case presents our first opportunity to consider whether the Board is correct that *Phil A. Livesley Co.* is no longer controlling in this respect.

170 Or App 497> In *Phil A. Livesley Co.*, the claimant fell at work while he was walking from his work station to the time clock in order to punch out. The area where he walked was free from debris or any substance that could account for a slip or trip. The claimant testified that he did not get dizzy, experience vertigo, or lose consciousness before the fall; all that he could remember was falling. 296 Or at 27. The court first noted that the injury satisfied the "in the course of employment" prong of the test. *Id.* at 29. It then turned to the "arising out of employment" prong. It began by pointing out that an employer is not liable for any and all injuries irrespective of their cause; the fact that an employee is injured on the premises during working hours does not in itself establish a compensable injury. The employee must show a causal link between the injury and a risk associated with the employment; the court gave an attack of appendicitis or a self-inflicted injury as examples of noncompensable injuries. *Id.*

The court then considered whether there was a sufficient causal connection between the claimant's unexplained fall and his employment. It noted that an unexplained fall arises from neutral risks of employment--those that are neither peculiar to the employment nor personal to the employee. Both the Board and this court had concluded that the claimant had persuasively eliminated all idiopathic factors of causation. In our decision, we had relied on the elimination of idiopathic factors to hold that the claim arose out of the claimant's employment as a matter of law:

> "[A] sufficient work connection between the injury and the employment has been shown by the fact that the injury occurred in the course of employment, that the employment caused the employe to be at the place where he was injured at the time when he was injured, and that there is no evidence of personal contribution to the injury."

Phil A. Livesley Co. v. Russ, 60 Or App 292, 296, 653 P2d 274 (1982). We emphasized that in reaching that conclusion we had not shifted the burden of proof from the claimant or used an implied presumption; rather, the facts that we described meant that the injury was work related. *Id.*

The Supreme Court expressly agreed with our holding, which it summarized as being that "a truly unexplained **<170 Or App 497/498>** fall that occurs on the employer's premises, during working hours, while the employee is performing required duties is compensable if the employee can eliminate idiopathic causes." *Phil A. Livesley Co.*, 296 Or at 29-30. That express statement appears to treat the question as one of law: if the fall is truly unexplained, it arises out of a neutral risk of the employment and is compensable. However, later statements in the opinion can be read as treating the issue as one of fact, with the unexplained nature of the fall simply allowing a permissible inference that it arose out of the employment. Thus, the court stated that, when the claimant has eliminated idiopathic causes for an unexplained fall, "the inference arises that the fall was traceable to some ordinary risk, albeit unidentified, to which the employment exposed the employee." It then added that, because the course of employment elements were strong, personal elements were eliminated, and the arising out of employment elements were incapable of direct determination, the fact finder could find that the claimant carried his burden of proof of satisfying the unitary work-connection test for compensability. *Id.* at 32.

There is thus at least a superficial ambiguity in the Supreme Court's reasoning. It both held that a truly unexplained fall that occurs in the course of employment arises out of employment as a matter of law and also appeared to suggest that the issue is actually one of an inference for the fact finder. In deciding that the legislature overruled *Phil A. Livesley Co.* when it adopted ORS 656.266, the Board

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[7] Idiopathic reasons are those that are peculiar to the claimant rather than arising out of the work situation, such as a heart attack that occurs at work but whose cause is the claimant's pre-existing, non-work-related heart disease.

focused on the second aspect of the Supreme Court's opinion and ignored the first; it treated the relationship between an unexplained fall and the claimant's work as solely one of fact. We conclude, contrary to the Board, that the court held that an unexplained fall arises out of employment as a matter of law. However, we also conclude that, even if the issue is one of fact, ORS 656.266 does not affect the court's reasoning. Thus, the Board's decision not to follow *Phil A. Livesley Co.* is without support under either approach.

We begin by discussing the case in which the Board first considered the effect of ORS 656.266 on the decision in *Phil A. Livesley Co.* concerning an unexplained fall. ORS 656.266 provides:

> **170 Or App 499>** "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 of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred."

In *Ruben G. Rothe*, 45 Van Natta 369 (1993), the Board concluded from the legislative history that the purpose of the statute was to overrule our decision in *Bradshaw v. SAIF*, 69 Or App 587, 687 P2d 165 (1984).[8] In *Bradshaw* we had found, on *de novo* review, that the claimant's headaches were a consequence of her compensable foot injury. The headaches began while the claimant was hospitalized for a severe infection that resulted from the injury. Neither the claimant's treating physician nor the specialists to whom he referred her were able to determine the cause of the headaches. The treating physician ultimately concluded that the injury and the headaches were related. We agreed with him, noting that "the close connection between [the] onset [of the headaches] and claimant's physical condition, combined with the inability to find any specific cause for them," made it more probable than not that the headaches were caused by the direct effects of the injury. *Bradshaw*, 69 Or App at 590.

In *Rothe*, the Board treated our opinion in *Bradshaw* as holding that the headaches were compensable solely because the claimant had ruled out other possible causes for them. It then quoted a legislator's statement that the purpose for enacting ORS 656.266 was to require the Board and the courts to base decisions on "clearly proven facts instead of deductive reasoning[.]" *Rothe*, 45 Van Natta at 371. Finally, the Board stated that the basis for the holding in *Phil A. Livesley Co.* that an unexplained fall is traceable to an unidentified risk of the employment was an inferential conclusion based on the elimination of other possible causes for the fall. That kind of reasoning, the Board believed, is exactly **<170 Or App 499/500>** what ORS 656.266 prohibits. As a result, according to the Board, the statute effectively overruled that aspect of *Phil A. Livesley Co. Id.* at 372. In this case, employer relies on ORS 656.266 as the Board construed it in *Rothe*. Indeed, employer expands the Board's rationale to argue that the statute requires a worker affirmatively to identify a work-related cause of the injury in order to prove compensability. That argument is based on a misunderstanding of *Phil A. Livesley Co.*

ORS 656.266 is relevant to the compensability of an unexplained fall only if such a fall is compensable solely because the elimination of idiopathic factors leads to an inference that it was work related. Contrary to employer's argument, in the case of an unexplained fall, the issue is not what caused the fall--by definition we cannot know that--but whether it arose out of a risk of the claimant's employment. The foundation of *Phil A. Livesley Co.* is the court's recognition that it is possible to determine that an unexplained fall arose out the claimant's employment without explaining the precise cause of the fall. It was not possible in that case to determine why the claimant fell, but it was clear that he fell while engaged in a work-related activity. The fall was compensable because it was the result of a neutral risk of employment. Recent Supreme Court cases reflect the court's continued insistence that an injury that arises from a neutral risk of employment arises out of the employment. Because that is the foundation for its holding in *Phil A. Livesley Co.*, those cases indicate that its conclusion was one of law, not of fact.[9]

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[8] The claimant in *Rothe* did not seek judicial review, possibly because there was substantial evidence to support the Board's conclusion that he had not ruled out idiopathic causes and, thus, that his fall was not unexplained. Because of that conclusion, the discussion of ORS 656.266 was *dictum*, but the Board followed it without further elaboration in later cases.

[9] That is how we understood *Phil A. Livesley Co.* in a case that we decided shortly after the Supreme Court's decision. *See McAdams v. SAIF*, 66 Or App 415, 417, 674 P2d 80, *rev den* 296 Or 638 (1984) ("if a claimant's fall is unexplained, it is compensable, but if it is idiopathic, it is not").

In *Fred Meyer, Inc.*, the court held that an assault by a third person that occurred in the employer's parking lot after the claimant had finished her shift arose out of the employee's work. It rejected the employer's argument that the place where the employee parked exposed her to no greater risk than those to which the employer's customers were exposed. That argument, the court said, reflected the **<170 Or App 500/501>** largely obsolete "peculiar-risk" and "increased-risk" considerations that it had rejected in *Phil A. Livesley Co.* "Rather, a worker's injury is deemed to 'arise out of' employment if the risk of the injury results from the nature of his or her work or when it originates from some risk to which the work environment exposes the worker." 325 Or at 601. The court then agreed with the Board's conclusion that, by requiring the claimant to park in an unlit fringe of the parking lot, the employer had created the risk that an attack would occur. Id. at 601-02.[10]

In *Redman Industries, Inc. v. Lang*, 326 Or 32, 943 P2d 208 (1997), the claimant was injured when a co-worker assaulted him in retaliation for racially derogatory statements that the claimant had made. In our opinion, we held that the risk of being assaulted for making racially derogatory statements was not sufficiently connected with the worker's employment for it to arise out of that employment. Nothing about the nature of the claimant's employment as a window installer, we said, created or enhanced the risk of an assault by a co-worker for a non-work-related reason. *Redman Industries, Inc., v. Lang*, 142 Or App 404, 407-08, 921 P2d 992 (1996). The Supreme Court rejected our analysis. It believed that we had, at least in part, simply reformulated the discredited "peculiar-risk" or "increased-risk" test. Rather, the issue was whether the risk of injury resulted from the nature of the work or whether the work environment exposed the claimant to the rise of injury. *Redman Industries, Inc.*, 326 Or at 36. The court then reiterated its statement in *Phil A. Livesley Co.* that an injury that arises from a neutral risk of employment is compensable, pointing out that an unexplained injury is a classic example of a neutral risk.

In *Redman Industries, Inc.*, however, the injury was not unexplained, so the court examined the legislature's intent concerning assaults, concluding that it intended an injury from an assault in which the claimant was not an **<170 Or App 501/502>** active participant to be compensable. *Id.* at 36-37. Finally, the court held that an injury arises out of employment if the risk of injury results from the nature of the claimant's work or from the work environment. In *Redman Industries, Inc.*, the work environment exposed the claimant to the risk that a co-worker might lose self-control and assault him. There was no evidence of off-the-job friction that led to the assault.[11] The claim, therefore, was compensable. *Id.* at 39-41.

Finally, in *Wilson v. State Farm Ins.*, 326 Or 413, 952 P2d 528 (1998), the claimant injured herself when she tore her Achilles tendon while "skip-stepping" on her way back to her desk after receiving permission to take the rest of the afternoon off. The Board denied compensation on the ground that the injury did not arise from her employment. According to the Board, skipping was not her usual means for moving around the office, and no condition associated with her work, other than happiness about being able to leave early, caused the injury. *Id.* at 417. We affirmed without opinion. *Wilson v. State Farm Ins.*, 142 Or App 205, 920 P2d 181 (1996). In reversing the Board's decision, the Supreme Court again emphasized its rejection of the "peculiar-risk" and "increased-risk" criteria and held that the injury was compensable. Moving around the office was a work-related activity, and it was irrelevant that the claimant used an unusual method of doing so.[12] The injury arose from her employment. *Id.* at 417-18.

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[10] The court first quoted the Board's reasoning and then stated that it "agree[d] with the Board that claimant's injury 'arose out of' her employment." It did not state that it agreed with all of the Board's reasons for reaching that conclusion. *Id.* at 602.

[11] The requirement that the assault not arise from off-the-job friction is similar to the requirement in *Phil A. Livesley Co.* that there be no idiopathic factors that caused the fall. The purpose of each requirement is to ensure that the injury truly arises from a neutral risk of the employment, not from something that is unrelated to the unemployment.

[12] Thus, if the claimant had been injured while using a normal method of moving around the work place, the injury would have been compensable. That conclusion, again, shows that an unexplained fall that occurs while the claimant is moving around the work place is a compensable injury.

These cases show that the Supreme Court continues to rely on the essential holding of *Phil A. Livesley Co.*: an injury arises out of employment if it arises from a neutral risk of the employment. It is not necessary or, indeed, relevant that work somehow increased the risk of the injury. What matters, rather, is that non-employment risks were not **<170 Or App 502/503>** responsible for the injury. Under those cases, one way of showing that the injury arose from a neutral risk of employment is to show that the claimant was in the course of employment at the time of the injury and that no non-employment risk--an idiopathic condition or an off-the-job dispute with an assaultive co-worker, for instance--was responsible for it. In these cases, the court has reinforced its holding in *Phil A. Livesley Co.* that a truly unexplained fall--one that is not the result of idiopathic factors--is compensable as a matter of law. Its subsequent references in *Phil A. Livesley Co.* to a permissible inference that the cause was work related can best be understood as helping to explain its adoption of that legal rule; those references do not mean that every unexplained fall case depends on what inference the finder of fact chooses to draw.

To require a claimant to show a cause for an unexplained fall is both inconsistent with the lack of explanation that is the essence of such a fall and contradicts the Supreme Court's cases. Because the issue of whether an unexplained fall arose out of the employment is one of law, and because the exclusion of other causes is simply part of showing that the claimant's fall met the legal standard of being unexplained, the prohibition in ORS 656.266 on purely deductive reasoning does not apply. The essential fact to be proved is the lack of explanation; eliminating other causes is a way of proving that fact.

Even assuming that the Supreme Court's decision in *Phil A. Livesley Co.* was based on an inference rather than a rule of law, *Rothe* is incorrect. We begin, as we must, with the words of the statute. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-12, 859 P2d 1143 (1993). ORS 656.266 provides that a claimant may not carry the burden of proving compensability "merely by disproving other possible explanations of how the injury or disease occurred." (Emphasis added.) The crucial word in this context is "merely," which for these purposes means "no more than" and has synonyms that include "barely," "only," "simply," and "solely." *Webster's Third New Int'l Dictionary*, 1413 (unabridged ed 1993). All that the legislature did was to prohibit claimants from doing no more than disproving other explanations. It did not prevent them from disproving other possible explanations as **<170 Or App 503/504>** part of carrying their burden of proof; thus, a claimant may still exclude alternative explanations to assist in proving the claim. *See Bronco Cleaners v. Velazquez*, 141 Or App 295, 298-300, 917 P2d 539 (1996) (dermatologist's evaluation of relationship between claimant's exposures, symptoms, and treatment, including ruling out other possible diagnoses, was sufficient for Board to find that claimant's contact dermatitis was work related, even though dermatologist was unable to identify particular agent that caused claimant's condition).[13]

Here, claimant needs to prove only that the fall arose out of a neutral risk of her employment. Because there is strong evidence that she was in the scope of her employment at the time, she needs to provide only slight evidence of that fact in order to meet the unitary work-connection test. The fact that her fall occurred in the course of employment, while she was engaged in an activity that was essential to performing her job--going to her work station--at the least supports an inference that it arose out of her employment unless there is some non-work-related (in this context, idiopathic) cause for it. Thus, the purpose for eliminating idiopathic causes is not to disprove other possible explanations of how the injury occurred, but, rather, to determine whether the fall--whose precise causation is by definition unknowable--arose out of the employment. ORS 656.266 does not deal with that question.

We conclude, thus, that ORS 656.266 does not affect the Supreme Court's decision in *Phil A. Livesley Co.*, whatever interpretation we give to it. We further conclude that the correct interpretation of that case is that a truly unexplained fall that occurs in the course of employment arises out of the employment as a matter of law. The remaining question is whether claimant has adequately excluded idiopathic factors **<170 Or App 504/505>** so that her fall is truly unexplained. Because of its erroneous legal conclusion, the Board did not consider that issue. It must do so on remand.

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[13] Even if the Board is correct that the legislature, in adopting ORS 656.266, intended to overrule *Bradshaw*, the statute may not have that effect. In *Bradshaw*, the claimant's headaches began when her foot infection was at its worst and while her pre-existing diabetes remained out of control as a result of the infection. Those facts gave rise to an inference that the headaches were related to the compensable injury. The question on *de novo* review was whether we should adopt that inference. The physician's careful exclusion of all other possible explanations led us to do so despite our general reluctance to rely solely on chronological sequence to prove causation. Thus, we used exclusionary reasoning to help us decide what evidence to accept and what inferences to draw, not as a substitute for evidence.

Reversed and remanded for reconsideration.

KISTLER, J., concurring.

I agree with the majority's result but not its reasoning. The majority holds that, under *Phil A. Livesley Co. v. Russ*, 296 Or 25, 672 P2d 337 (1983), a truly unexplained fall--one that is not attributable to idiopathic causes--arises out of work as a matter of law. In my view, the majority reads *Livesley* incorrectly. The court held in *Livesley* that a truly unexplained fall permits but does not require the Workers' Compensation Board to find that the resulting injury arises out of work. 296 Or at 32 (stating the holding).

In this case, the Administrative Law Judge (ALJ) ruled that if a fall were unexplained, he necessarily had to find that the resulting injuries did not arise out of work. The Board adopted the ALJ's opinion and affirmed. That was error under either my or the majority's view of Livesley. Accordingly, I agree that this case should be remanded to permit the Board to apply the correct legal standard, although my view of the correct standard differs from the majority's.

According to the majority, the Supreme Court held in *Livesley* that a truly unexplained fall arises, as a matter of law, out of work and is compensable. The majority draws that conclusion from the fact that the court said "[w]e agree" after describing our reasoning in *Livesley*. At the time we decided *Livesley*, however, we reviewed workers compensation cases *de novo*. To say that the Supreme Court understood that our holding in *Livesley* was based on a legal rather than a factual conclusion and that the court intended to adopt that legal conclusion both reads too much into the phrase, "[w]e agree," and incorrectly discounts the Supreme Court's explicit holding.

After prefacing its opinion with a summary of what we had said, the Supreme Court turned to the task of explaining and distinguishing its cases. *Livesley*, 296 Or at 30-31. The court then reasoned:

> **170 Or App 506>** "In the present case, where idiopathic causes for an unexplained fall have been eliminated, the inference arises that the fall was traceable to some ordinary risk, albeit unidentified, to which the employment premises exposed the employe. *Larsen v. State Ind. Acc. Com.*, 135 Or 137, 140, 295 P 195 (1931).
>
> "Petitioners contend that this result in unexplained fall cases relieves claimants of their burden of proving work-connection. We do not agree. The facts found by the referee and the Court of Appeals permit the reasonable inference that the fall was caused by the employment environment. Claimant has met his burden of eliminating idiopathic causes. There is no finding that any force or condition independent of the employment caused his fall. Claimant was engaged in the duties of his employment, on employer's premises, and exposed to the risks inherent in his work environment. In such a situation, where the 'course of employment' test is so fully met, where the cause-in-fact cannot be directly established, and where claimant has met his burden of eliminating idiopathic causes, we construe the Workers' Compensation Law to allow the inference that the unexplained fall 'arose out of' claimant's employment.
>
> "Because the 'course of employment' elements are strong, because personal risks are eliminated, and because the 'arising' elements are incapable of direct determination, we hold that the administrative agency and the Court of Appeals could find that claimant has carried his burden of proof and that the unitary work-connection test is sufficiently satisfied to allow compensation for this unexplained fall."

Livesley, 296 Or at 32.

The majority's opinion cannot be reconciled with either the Supreme Court's holding or its reasoning. In *Livesley*, the Supreme Court explicitly "h[e]ld that the administrative agency and the Court of Appeals *could* find that claimant has carried his burden of proof" if, among other things, idiopathic causes for an unexplained fall are eliminated. 296 Or at 32 (emphasis added). It did not hold, as the majority does, that the Board must find that the claimant has carried his burden of proof in those circumstances. Were there any doubt about what the court held, the court's explanation eliminates it.

The court explained that it "construe[d] <170 Or App 506/507> the Workers' Compensation Law *to allow the inference* that the unexplained fall 'arose out of' claimant's employment." *Id.* (emphasis added). The court did not construe the workers' compensation statutes to require that inference. Contrary to the majority's conclusion, *Livesley* permits but does not require the Board to find that a truly unexplained fall is sufficiently work-connected to be compensable.[1]

The remaining question is whether a later enacted statute, ORS 656.266, requires a different result. That statute provides:

> "The burden of proving that an injury or an occupational disease is compensable * * * is upon the worker. The worker cannot carry the burden of proving that an injury or occupational disease is compensable merely by disproving other possible explanations of how the injury or disease occurred."

ORS 656.266. If all that *Livesley* required to establish that a claimant's injuries were compensable was proof that the fall was not due to idiopathic causes, the enactment of ORS 656.266 would call *Livesley's* continued vitality into question. As the *Livesley* court explained, however, a claimant does not carry the burden of proving compensability merely by disproving that his or her injuries were due to idiopathic causes. Rather, in order to establish compensability, a claimant must also prove that he or she "was engaged in the duties of his employment, on employer's premises, and exposed to the risks inherent in his work environment." 296 Or at 32. The absence of idiopathic causes is only one factor for the Board to consider in determining whether "the unitary work-connection test is sufficiently satisfied to allow compensation for [an] unexplained fall." *Id.*

The ALJ and the Board, however, acted on the understanding that a truly unexplained fall is necessarily non-compensable. As explained above, that understanding is incorrect. Under *Livesley*, if the Board finds that the fall is <170 Or App 507/508> truly unexplained, it can find that "the unitary work-connection test is sufficiently satisfied to allow compensation for the unexplained fall." Because the Board did not apply the correct legal standard, I would vacate its order and remand for it to apply that standard.

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[1] The majority acknowledges some of what the Supreme Court said in *Livesley*, but it concludes that those statements merely create a "superficial ambiguity." 170 Or App at 509. In my view, there is nothing ambiguous about what the court held in *Livesley*.

Cite as 170 Or App 602 (2000) November 1, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

DEBBIE KAHN, Appellant,
v.
PROVIDENCE HEALTH PLAN, an Oregon non-profit corporation, Respondent.
(9710-08059; CA A103759)

Appeal from Circuit Court, Multnomah County.
Robert P. Jones, Judge.
Argued and submitted January 31, 2000.
Robert Sola argued the cause for appellant. On the briefs was Hank McCurdy.
Paul R. Duden argued the cause for respondent. With him on the brief was Tooze Duden Creamer Frank & Hutchison.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LANDAU, P. J.
Affirmed.

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170 Or App 604> Plaintiff initiated this action for negligence and breach of contract against defendant, based on defendant's failure to authorize medical treatment for injuries arising out of plaintiff's employment. The trial court entered summary judgment in favor of defendant on the ground that plaintiff's exclusive remedy lies under the workers' compensation statutes. We agree and affirm.

The relevant facts are not in dispute. Plaintiff worked for Industrial Indemnity, which, in turn, contracted with defendant, a certified managed care organization (MCO), to provide various services related to the administration of Industrial Indemnity's workers' compensation claims. Among other things, defendant provided "service utilization review" decisions, which involve physician review of a worker's proposed medical procedures to determine whether the proposed procedures are necessary.

In the 1970s, plaintiff compensably injured her back. In the mid-1990s, she began experiencing back pain. In December 1996, her treating physician proposed that she undergo back surgery. In January 1997, defendant performed a service utilization review of the proposed surgery and determined that it was not medically necessary. Several months later, Industrial Indemnity approved the surgery anyway.

Plaintiff then initiated this action against defendant for negligence and breach of contract, claiming damages for the pain and suffering that she endured from the time of defendant's service utilization review until the surgery was completed. Defendant moved for summary judgment on the ground that, among other things, under ORS 656.260, plaintiff's sole remedy was review by the Director of the Department of Consumer and Business Services (DCBS). The trial court agreed and entered summary judgment dismissing plaintiff's claims. On appeal, plaintiff argues that the trial court erred in entering summary judgment for defendant. According to plaintiff, ORS 656.260 does not require that her claims be heard exclusively by the director of DCBS.

170 Or App 605> We review the trial court's entry of summary judgment to determine whether there is a genuine issue of material fact and whether the moving party has demonstrated that it is entitled to judgment as a matter of law. ORCP 47 C; *Jones v. General Motors*, 325 Or 404, 407, 939 P2d 608 (1997).

ORS 656.260(6) provides, in part:

> "Any issue concerning the provision of medical services to injured workers subject to a managed care contract and service utilization review * * * shall be subject solely to review by the director or the director's designated representatives, or as otherwise provided in this section."

Defendant argues, and the trial court held, that, because plaintiff's complaint challenges defendant's service utilization review decision, the sole remedy under the statute is review by the director or one of his or her designated representatives. Plaintiff argues that she is not seeking review of the service utilization review decision, but is instead seeking damages for negligence and breach of contract, which the director is not authorized to award. In any event, she argues, the statute does not limit review to the director but permits her to seek such remedies as are "otherwise provided in this section." According to plaintiff, other subsections of the statute implicitly recognize the possibility of civil actions concerning service utilization review decisions.

Plaintiff's initial argument is easily refuted. Both of her claims depend on whether defendant's decision not to approve the proposed surgery was correct; if defendant correctly disapproved the surgery, she cannot prevail. The statute plainly states that the review of the correctness of a managed care provider's service utilization review decision is "solely" as provided in the statute. The only issue, therefore, is whether the statute itself provides for review other than by the director.

The text of the statute declares that review of service utilization review decisions "shall be subject solely to review by the director or the director's designated representatives, or as otherwise provided in this section." ORS 656.260(6). Nowhere does the section "otherwise provide[]" for direct **<170 Or App 605/606>** review of service utilization review decisions by means of a civil action in court, however. What is "otherwise provided" in ORS 656.260 is a process for obtaining judicial review *of the director's decision.*

Under ORS 656.260(14), if a worker is dissatisfied with an MCO's service utilization review decision, he or she "must first apply to the director for administrative review of the matter." ORS 656.260(15) then requires that, when the director reviews a service utilization review decision or similar medical services decision, there must be prepared "a documentary record sufficient for judicial review." That section further declares that the director's initial decision is "not subject to further review" unless a request for a hearing is filed within a specified number of days of that decision. *Id.* ORS 656.260(16) then provides for a contested case hearing on that documentary record and for review of the resulting decision under the judicial review provisions of the Administrative Procedures Act (APA), ORS 183.310 to ORS 183.550. In addition, ORS 656.260(17) provides that decisions of a managed care organization other than service utilization review, peer review, or quality assurance activities may be subject to a contested case hearing before the director upon request and that the director's decision is subject to review by this court, as provided in the APA.

There is mention of civil proceedings in three subsections of the statute, but in a very limited way. Under ORS 656.260(7):

> "No data generated by service utilization review, quality assurance, dispute resolution or peer review activities and no physician profiles or data used to create physician profiles pursuant to this section or the director's review thereof shall be used in any action, suit or proceeding except to the extent considered necessary by the director * * *."

That section merely guarantees the confidentiality of information generated in the administrative review process. It does not authorize review of the service utilization review decision by means of a civil action.

170 Or App 607> Similarly, ORS 656.260(8) provides:

> "A person participating in service utilization review, quality assurance, dispute resolution or peer review activities pursuant to this section shall not be examined as to any communication made in the course of such activities or the findings thereof, nor shall any person be subject to an action for civil damages for affirmative actions taken or statements made in good faith."

Once again, that section does not authorize a civil action for review of a service utilization review decision. It assures the confidentiality of the administrative review process and, indeed, prohibits actions for civil damages arising out of statements that any person makes in the course of that administrative review process.

Finally, ORS 656.260(9) similarly provides, in part:

> "No person who participates in forming consortiums, collectively negotiating fees or otherwise solicits or enters into contracts in a good faith effort to provide medical or health care services according to the provisions of this section shall be examined or subject to administrative or civil liability regarding any such participation except pursuant to the director's active supervision of such activities and the managed care organization."

That section, like the two preceding it, does not authorize the initiation of a civil action for damages arising out of a service utilization review decision. Instead, it prohibits participants in the MCO review process from being subject to administrative or civil liability, except as expressly permitted by the director.

None of the three subsections that mention civil actions can be read fairly to "otherwise provide[]" for review of a service utilization review decision by means of a civil action for damages. ORS 656.260(6) clearly states that such decisions "shall be subject to review solely" by the director, the director's designee, or the courts as provided in the APA. We therefore conclude that plaintiff's remedy lies exclusively under the workers' compensation statutes and that the trial **<170 Or App 607/608>** court did not err in entering summary judgment for defendant.

Affirmed.

Cite 170 Or App 759 (2000) November 8, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of David A. Steiner, Claimant.

DAVID A. STEINER, Petitioner,

v.

E.J. BARTELLS CO., and SAIF CORPORATION, Respondents.

(WCB TP98003; CA A102725)

Judicial Review from Workers' Compensation Board.

Argued and submitted May 10, 1999.

Meagan A. Flynn argued the cause for petitioner. With her on the brief was Pozzi Wilson Atchison, LLP.

Judy C. Lucas, Assistant Attorney General, argued the cause for respondents. With her on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.

Before De Muniz, Presiding Judge, and Haselton and Wollheim, Judges.

WOLLHEIM, J.

Reversed and remanded.

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170 Or App 761> The question in this workers' compensation case is whether the Workers' Compensation Board (Board) has the authority to order claimant's attorney to pay an unpaid lien amount out of the attorney's personal funds when the attorney had already disbursed the entire third-party judgment proceeds to claimant, SAIF Corporation (SAIF), and to himself for the costs and attorney fees of the third-party judgment. We hold that the Board is not authorized by statute to order such a payment. Accordingly, we reverse and remand to the Board.

The facts are undisputed. Claimant suffered an injury in 1984. SAIF accepted and paid the claim. Claimant also filed a third-party action for damages that resulted in claimant obtaining a judgment in excess of $300,000. The dispute arose because the parties[1]--claimant and SAIF--disagreed on the amount of SAIF's statutory lien. SAIF contended that its lien was $30,465.92. Claimant argued that this amount was too large because it included almost $1,800 in attorney fees paid to claimant out of an award of increased permanent partial disability. In August 1989, claimant's attorney issued three checks from his client's trust account. The first check was to himself for the costs and attorney fees on the third-party claim; the second check was to SAIF for the amount of its lien, less the approximately $1,800 in dispute here; and the third check was to claimant for the balance. After those disbursements, claimant's attorney did not hold any sums from the third-party judgment proceeds.

After claimant's attorney disbursed the proceeds from the third-party judgment, SAIF petitioned the Board to resolve this dispute. In its 1991 third-party distribution order, the Board held that the amount SAIF sought was accurate. The Board explained that, because the disputed attorney fees were payable out of claimant's increased permanent disability award, the attorney fees retained their identity as **<170 Or App 761/762>** compensation. Pursuant to ORS 656.593(1)(c), SAIF was entitled to be reimbursed for "its expenditures for compensation." Therefore, the Board ordered that the disputed amount be paid to SAIF.[2] Claimant petitioned this court for review of the Board's order and we affirmed. *Steiner v. E.J. Bartells Co.*, 114 Or App 22, 833 P2d 1373 (1992).

Nothing happened for several years. In 1995, SAIF requested a status report from claimant's attorney. That response did not satisfy SAIF. In 1996, SAIF argued, for the first time, that claimant's attorney was personally responsible for the disputed amount because the attorney improperly distributed it to claimant. SAIF petitioned the Board for another order. In its June 1998 third-party distribution order, the Board directed claimant's attorney personally to pay the disputed amount to SAIF. Claimant then filed this petition for judicial review.

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[1] ORS 656.005(21) defines "party" as the claimant, the employer, and the insurer, if any. Similarly, OAR 438-005-0040(11) defines "party" as the claimant, the employer, including a noncomplying employer, a processing agent under ORS 656.054, and an insurer.

[2] Neither the Board nor the parties considered that all the proceeds from the third-party judgment had already been disbursed by claimant's attorney.

Claimant argues that, while the Board has authority to resolve disputes concerning the distribution of the proceeds from a third-party judgment, it lacks authority to order claimant's attorney personally to pay SAIF money it is entitled to collect from the proceeds of the third-party judgment. Claimant suggests that the disputed amount be treated as an overpayment. SAIF rejects claimant's arguments on the merits, but it also argues that claim preclusion prevents claimant from making that argument on behalf of his attorney, because claimant failed to do so in the first Board proceeding. SAIF posits that allowing claimant to make such an argument now would constitute an impermissible collateral attack on a final Board order. We disagree with SAIF and conclude that claimant is correct.

As a preliminary matter, SAIF mistakenly describes the preclusion issue before us as claim preclusion. *See Drews v. EBI Companies*, 310 Or 134, 139-45, 795 P2d 531 (1990) (discussing claim and issue preclusion and their application to administrative proceedings). The collateral estoppel SAIF seeks invokes the doctrine of issue preclusion.

170 Or App 763> Issue preclusion does not apply here because, inter alia, one of the essential elements of the preclusion doctrine is not present. The preclusion doctrine--be it issue or claim preclusion--requires that "[t]he party sought to be precluded was a party or was in privity with a party to the prior proceeding." *Nelson v. Emerald People's Utility Dist.*, 318 Or 99, 104, 862 P2d 1293 (1993). *See also Couch v. Couch*, 170 Or App 98, ___ P3d ___ (2000) (generally a judgment will not bind a nonparty unless the nonparty was in privity with a party to the underlying action). Claimant's attorney was not a party in the prior proceeding that resulted in the 1991 third-party distribution order. ORS 656.005(21). Nor was claimant's attorney in privity with claimant for purposes of issue preclusion. Individuals in privity with a named party include those who control the prior action but are not a party to it. *Stevens v. Horton*, 161 Or App 454, 462, 984 P2d 868 (1999). *See also* ORS 43.130(2) and *Restatement (Second) of Judgments* section 34(3) (1982).[3] An attorney does not control a legal action for purposes of privity. *Cf. Caldwell v. Lucas*, 170 Or App 587, ___ P2d ___ (2000) ("The term 'party' for example, commonly refers to the party's attorney, as well, even though, strictly speaking, the attorney is not the party.").

SAIF's brief does not address the issue of privity. Rather, SAIF presumes that the privity requirement is satisfied. On this record, we conclude that the issue preclusion doctrine does not bar claimant's attorney from arguing, via claimant, that he is not required to pay SAIF from his personal funds because he was not a party, or in privity with a party, in the first Board proceeding.

Just as important, claimant's appeal does not amount to a collateral attack on a final Board order. *See Jeld-Wen, Inc. v. Bartz*, 142 Or App 433, 436, 921 P2d 419 (1996) (describing collateral attack on final order). Claimant is not attacking the Board's 1991 third-party distribution **<170 Or App 763/764>** order that concluded that SAIF was entitled to reimbursement of the disputed amount from claimant's third-party judgment proceeds. Rather, claimant attacks the solitary issue, addressed for the first time in the Board's 1998 order, of whether claimant's attorney is *personally* liable for the disputed amount.

We next consider whether the Board had the authority to order claimant's attorney to pay SAIF personally. Recently, in *Gaynor v. Board of Parole*, 165 Or App 609, 996 P2d 1020 (2000), we discussed an agency's statutory authority to act:

> "It is a fundamental principle of administrative law that an administrative body possesses only those powers that the legislature grants, and that it cannot exercise authority that it does not possess. *SAIF v. Shipley*, 326 Or 557, 561, 955 P2d 244 (1998). That principle extends to administrative bodies * * * that perform judicial functions. They do not possess the general jurisdictional powers of a court. Instead, their powers are restricted to those conferred expressly by statute or by necessary implication. *Campbell v. Bd. of Medical Exam.*, 16 Or App 381, 391-92, 518 P2d 1042 (1974)." 165 Or App at 612.

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[3] ORS 43.130(2) provides, in part, that a prior final order is "conclusive between the parties" in any subsequent proceeding. The implication is that a prior final order is not preclusive on nonparties to the prior proceeding.

Restatement (Second) of Judgments section 34(3) (1982) provides that "[a] person who is not a party to an action is not bound by or entitled to the benefits of the rules of res judicata * * *."

Thus, the relevant inquiry is whether the legislature, either expressly or by necessary implication, granted the Board the power to direct a claimant's attorney to comply with a final order and, if so, to what extent. As previously discussed, an attorney is not a party to a proceeding before the Board. ORS 656.005(21); OAR 438-005-0040(11). Nothing in ORS 656.593(1), the statute concerning payment to an insurer of its lien, expressly grants the Board authority to order a nonparty to act. Subsection (1)(d) provides that any dispute between the *worker* and the *insurer* regarding the distribution of a third-party judgment shall be resolved by the Board. Thus, ORS 656.593(1) limits the Board to resolving disputes between the parties. Furthermore, nothing in ORS 656.726, the statute granting the power to the Board to carry out the workers' compensation law, expressly grants the Board authority to order a claimant's attorney to pay money to an insurer.[4] ORS 656.726(5) does grant the Board authority to **<170 Or App 764/765>** make rules that are reasonably required to carry out its duties. However, no Board rule defines an attorney as a party. Thus, there is no express statutory authority for the Board to order claimant's attorney to pay SAIF from the attorney's personal funds.

We next examine whether the Board possesses that authority by necessary implication. The Board does have some authority to enforce its own orders, especially when those orders have become final. What is relevant here is that the Board has the implicit authority to enforce a third-party distribution order. A recent example of that implicit authority is *Legore v. Self-Insured Management Services*, 157 Or App 229, 972 P2d 892 (1998). There, we affirmed a Board order that, to enforce an earlier order awarding the entire proceeds from a third-party settlement to the insurer, directed the claimant's attorney to endorse a third-party settlement check. *Id.* at 231. Significant to the result in *Legore* was the fact that the third-party funds had not yet been disbursed and that the claimant's attorney retained at least partial control, via withholding his endorsement, over the settlement funds. *Id.* at 232. Consequently, the Board's enforcement action in *Legore* was consistent with its express authority to resolve conflicts over the *distribution* of third-party settlement proceeds. In the present instance, the funds at issue were already disbursed and were no longer under the control of claimant's attorney when the Board attempted to enforce its 1991 third-party distribution order. We have never held that the Board has the implicit authority to order a nonparty to make reimbursements from *personal* funds to satisfy a third-party distribution order, and we decline to recognize such authority here. Thus, there is no implied statutory authority for the Board's 1998 order.

We therefore conclude that the Board does not possess the authority to order that claimant's attorney *personally* reimburse SAIF monies due it from the third-party judgment proceeds. Accordingly, we reverse and remand to the Board with instructions to rescind its June 1998 order that **<170 Or App 765/766>** required that claimant's attorney personally pay the disputed funds.

Reversed and remanded.

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[4] The legislature knows how to draft a statute making an attorney liable for the debts of a client. For example, ORS 20.160 provides that an attorney for an out-of-state plaintiff is personally responsible for paying the statutory costs of the client and if such costs are not paid the attorney can be punished by contempt of court.

Cite as 171 Or App 65 (2000) November 15, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Rhonda M. Sparks, Claimant.
LIBERTY NORTHWEST INSURANCE CORPORATION and WESTWOOD SWINERTON CONSTRUCTION, Petitioners,
v.
RHONDA M. SPARKS; JOHNSTON AND CULBERSON, INC.; w/ JOHNSON AND CULBERSON, INC.; DENALI DRYWALL; and DEPARTMENT OF CONSUMER AND BUSINESS SERVICES, Respondents.
(98-04517 and 98-02823; CA A105068)

Judicial Review from Workers' Compensation Board.
Argued and submitted March 17, 2000.
David O. Wilson argued the cause and filed the brief for petitioners.
Judy C. Lucas, Assistant Attorney General, argued the cause for respondents Johnston and Culbertson, Inc., and Oregon Department of Consumer & Business Services. With her on the brief were Hardy Myers, Attorney General, and Michael D. Reynolds, Solicitor General.
No appearance for respondents Rhonda M. Sparks and Denali Drywall.
Before Edmonds, Presiding Judge, and Armstrong and Kistler, Judges.
KISTLER, J.
Affirmed.

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171 Or App 67> Claimant suffered a compensable injury while working at a construction site. The Workers' Compensation Board ruled that the general contractor, not the subcontractor that employed claimant, was responsible for providing coverage for her injury. The general contractor petitions for review of the Board's order. We affirm.

Petitioner Westwood Swinerton was the general contractor on a construction project. It entered into a subcontract with Denali Drywall. As part of the subcontracting agreement, Denali promised to provide appropriate insurance certificates before beginning work on the project. Denali provided petitioner with two certificates for workers' compensation insurance--one with SAIF Corporation, effective from April 1, 1996, to March 31, 1997, and one with Affordable Insurance Concepts, Inc., which showed coverage effective from March 31, 1997, to March 31, 1998.

Contrary to its certification, Denali did not have workers' compensation insurance after March 31, 1997. Work on the project began on April 22, 1997. Claimant suffered a compensable injury while working for Denali on July 16, 1997.

The Workers' Compensation Board ruled that petitioner was responsible for claimant's coverage under ORS 656.029(1).[1] That subsection provides that a general contractor is "responsible for providing workers' compensation insurance coverage for all [nonexempt] individuals * * * who perform labor under the contract unless the person to whom **<171 Or App 67/68>** the contract is awarded provides such coverage for those individuals before labor under the contract commences." The Board determined that, because Denali's coverage ended before work began, responsibility for coverage remained with petitioner under ORS 656.029(1).

Petitioner does not dispute that it remains responsible for providing coverage for claimant unless Denali had "provide[d workers' compensation coverage to its employees] before labor under the contract commence[d]." ORS 656.029(1); *K-Mart Corp. v. Claussing*, 162 Or App 558, 561, 986 P2d 1185 (1999). Petitioner, however, advances two reasons why Denali came within the statutory exception and thus

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[1] ORS 656.029(1) provides, in part:

"If a person awards a contract involving the performance of labor where such labor is a normal and customary part or process of the person's trade or business, the person awarding the contract is responsible for providing workers' compensation insurance coverage for all [nonexempt] individuals * * * who perform labor under the contract unless the person to whom the contract is awarded provides such coverage for those individuals before labor under the contract commences. If an individual who performs labor under the contract incurs a compensable injury, and no workers' compensation insurance coverage is provided for that individual by the person who is charged with the responsibility for providing such coverage before labor under the contract commences, that person shall be treated as a noncomplying employer and benefits shall be paid to the injured worker in the manner provided in this chapter[.]"

relieved it of responsibility for providing claimant's coverage. Petitioner argues initially that the word "provide" can mean "certify" as well as "supply" and that Denali certified that it had workers' compensations insurance when it entered into the subcontract. Petitioner argues alternatively that, even if provide means supply, Denali supplied coverage before work began. Petitioner reasons that Denali had coverage in place when it entered into the subcontract even though the coverage lapsed before work started on the project.

The text of the statute does not support petitioner's first argument. The text uses the same verb form twice in the same sentence; it states that the general contractor is responsible for "providing" workers' compensation coverage unless the subcontractor "provides" that coverage. If petitioner were correct that a subcontractor's certification is sufficient to comply with the requirement of providing coverage, then the same rule would presumably apply to the general contractor as well. *See PGE v. Bureau of Labor and Industries*, 317 Or 606, 611, 859 P2d 1143 (1993). Both the general contractor and the subcontractor could provide coverage merely by certifying that each had coverage regardless of whether either actually had it. Petitioner's interpretation would defeat the purpose of the statute, which is to ensure that either the general contractor or the subcontractor has workers' compensation coverage in force when the workers actually begin work on the job.[2]

171 Or App 69> ORS 656.029(1) is part of a larger statutory scheme that seeks to ensure that workers are, in fact, covered by workers' compensation insurance. *See* ORS 656.017(1). The rule has been that general contractors are responsible for providing coverage to all persons working under the contract. *See Wood v. Dunn*, 109 Or App 204, 211, 818 P2d 979 (1991). The current version of ORS 656.029(1) carves out an exception to that general rule: Unless a subcontractor provides coverage for its own employees when the work on the project begins, the general contractor remains responsible for ensuring coverage of the subcontractor's employees.[3] As we have previously explained, if the general contractor wishes to rely on the subcontractor to provide coverage, "the burden is on the [general contractor] to make sure that the [subcontractor] provides coverage." *Id.* The text of ORS 656.029(1) and its larger statutory context establish that "provide" means "supply" rather than "certify."[4]

Petitioner's second argument is a variation on its first. It argues that because the statute requires only that **<171 Or App 69/70>** Denali provide coverage "*before* labor under the contract commences," it is sufficient that Denali had coverage in force when it entered into the subcontract even though the coverage lapsed before work began. Petitioner's interpretation of the word "before" suffers from the same problem as its interpretation of word "provide." It overlooks the contextual goal of providing coverage. Whether the subcontractor's employees are covered at some other point in time or for other jobs is not relevant under this statute. The legislature's use of the word "before" does not excuse the general contractor from responsibility if the subcontractor's coverage lapses before work under the contract begins.

Affirmed.

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[2] Petitioner observes that not only does the subsection speak of providing workers' compensation coverage in the sense of supplying that coverage, but it also states that "benefits shall be paid to the injured worker in the manner provided in this chapter[.]" Because "provide" clearly has at least two meanings within this subsection, petitioner concludes that it also may have a third--"certify." Although a word may have multiple meanings, the question of which meaning was intended often turns on the context in which the word is used. *See Boyd v. Essin*, 170 Or App 509, ___ P3d ___ (2000). Both clauses in the single sentence at issue here refer to providing workers' compensation coverage. Each has the same direct object and the same purpose. That context demonstrates that the word "provide" should be interpreted the same way in determining the general contractor's and the subcontractor's responsibility for providing coverage.

[3] Petitioners argue that the exception contained in ORS 656.029(1) actually shifts the ultimate burden of providing coverage to the subcontractor. That reading of the statute construes the exception too broadly and overlooks the underlying purpose of the statute as well as our previous holdings. *See, e.g., Wood*, 109 Or App at 211 (holding that the ultimate burden for providing coverage is on the general contractor).

[4] Because the text and context are clear, we need not look to legislative history. Even if we were to reach the legislative history, the history petitioner cites would not change our opinion. Petitioner acknowledges that the legislative history is not particularly useful. It points, however, to a statement made during a House Labor Committee hearing that, if a subcontractor provided coverage to its employees but the policy lapsed after work under the contract commenced, the general contractor should not be responsible. There is a difference, however, between coverage that lapses after work begins and coverage that was never obtained. Indeed, the history petitioner cites cuts against its argument that certification alone is sufficient; the legislative history assumes that the subcontractor's coverage was in force when work began, contrary to the proposition that petitioner advances.

Cite as 171 Or App 175 (2000) November 22, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Patrick J. Callow, Claimant.

MARVIN WOOD PRODUCTS and LIBERTY MUTUAL INSURANCE, Petitioners,
v.
PATRICK J. CALLOW, Respondent.
(WCB 97-08869; CA A103651)

Judicial Review from Workers' Compensation Board.
Argued and submitted June 14, 1999.
Vera Langer argued the cause for petitioners. With her on the brief was Scheminske, Lyons & Bussman, LLP.
Clayton C. Patrick argued the cause and filed the brief for respondent.
Before Landau, Presiding Judge, and Linder and Brewer, Judges.
LINDER, J.
Reversed and remanded.

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171 Or App 177> Employer seeks review of a Workers' Compensation Board (Board) order, seeking to decrease the amount of scheduled permanent partial disability awarded by the Board. On review, employer argues that the Board erroneously assigned it the burden of proof on the extent of claimant's permanent partial disability. Employer also asserts that the Board erroneously rated claimant's disability based on the medical arbiters' findings, even though the medical arbiters expressly reported those findings to be invalid.[1] For the reasons that we explain below, we reverse and remand for further proceedings.

The facts relevant to our review are primarily procedural in nature. Employer accepted claimant's claim for bilateral carpal tunnel syndrome and tendonitis in claimant's wrists and forearms. Upon claim closure, the Department of Consumer and Business Services (DCBS) awarded claimant five percent permanent partial disability for loss of use of each wrist and forearm due to chronic pain. Claimant sought reconsideration by the Appellate Review Unit (ARU) of DCBS, asserting that the disability rating should be based on lost range of motion, lost sensation, and lost strength, in addition to chronic pain. Because employer requested an examination by a three-physician arbiter panel, the record on reconsideration consisted of the report of the arbiter panel, as well as a report by claimant's attending physician, Dr. Warren.

Warren's report concluded that claimant had full range of motion in his wrists but was permanently limited in his ability to perform activities requiring repetitive use of his hands and wrists. Contrary to Warren's report, the medical arbiters made findings that claimant's injury resulted in reduced range of motion in his wrists. Significantly, however, the arbiters also reported that "the panel finds the examination to be invalid." As a result, the arbiters were "unable to set any limitations on the [claimant's] repetitive ability to use **<171 Or App 177/178>** either hand, wrist, or forearm due to the diagnosed chronic and permanent medical condition arising out of the accepted injury." The arbiters did not explain why they found their examination to be invalid.

In the order on reconsideration, the ARU rated claimant's disability using Warren's findings that claimant is limited in his ability to use his hands and wrists repetitively. The ARU also used the arbiters' range of motion findings, noting that, although the arbiter panel found its examination to be invalid, it had not explained that finding. Consequently, the ARU's order on reconsideration increased claimant's scheduled permanent disability award to nine percent for the right wrist and 11 percent for the left wrist.

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[1] Employer also asserts that the Board's extent of disability determination is not supported by substantial evidence. Because of our disposition of the case, we do not reach that contention.

Employer requested a hearing to challenge the increased disability award. The Administrative Law Judge (ALJ) affirmed the ARU's order on reconsideration, and employer sought further review by the Board. The Board affirmed the ALJ's order, largely adopting that order. Employer then sought reconsideration by the Board, which the Board granted. On reconsideration, the Board clarified its decision in certain respects, but it adhered to the increased disability rating determined by the ARU and affirmed by the ALJ.

In its first assignment of error, employer argues that the Board improperly placed the burden of proof on it to establish the extent of claimant's disability. Specifically, employer cites the following portion of the Board's order as impermissibly shifting the burden of proof in the proceeding:

> "[W]e note that this matter involves a request for hearing filed by the insurer to challenge the additional award of permanent disability granted to claimant by the Order on Reconsideration. Claimant did not seek an increased award. Under such circumstances, we have previously held that the employer has the burden of proving that claimant's permanent disability award should be reduced. *See Roberto Rodriguez*, 46 Van Natta 1723 (1994)[.]"

Employer argues that, "[i]n an initial claim for disability compensation, the injured worker has, at all levels of adjudication of that claim, the burden to prove the nature and extent of disability." Claimant takes issue with the premise **<171 Or App 178/179>** of employer's argument--*i.e.*, that the burden of proof on the extent of disability is on claimant throughout all levels of the adjudication of his initial claim for disability compensation. Rather, according to claimant, that burden shifts to the employer when it is the employer, rather than the injured worker, that seeks further review of the disability award. Although we affirm the Board on that point, we write to clarify the role of burden of proof in proceedings of this kind.

As both parties acknowledge, ORS 656.266 places the "burden of proving" the compensability of an injury, together with "the nature and extent of any disability resulting therefrom," on an injured worker. The purpose of the burden of proof in that regard is the same as in other legal contexts: to allocate the risk of nonpersuasion. In effect, assignment of the burden of proof is a way to declare which party loses if the evidence on an issue appears to be equally balanced or if the factfinder cannot say upon which side the evidence weighs more heavily. *See generally Riley Hill General Contractor v. Tandy Corp.*, 303 Or 390, 394-95, 737 P2d 595 (1987) (discussing meaning of burden of proof where burden must be satisfied by preponderance of evidence); *Russell v. Ford Motor Company*, 281 Or 587, 596-97, 575 P2d 1383 (1978) (same). Conceptually, the burden of proof encompasses two distinct burdens: the burden of producing evidence of a particular fact (i.e., the burden of production), and the burden of convincing the trier of fact that the alleged fact is true (i.e., the burden of persuasion). *See generally* McCormick, 2 *Evidence* section 336 at 425 (4th ed 1992).[2]

Logically, the allocation of the burden of proof has its greatest relevance at the stage of the proceeding in which the record is developed and a factfinder initially resolves **<171 Or App 179/180>** the issues in dispute. At that stage, the failure to produce evidence at all, or the failure of the evidence produced to persuade the factfinder, will be fatal to the party with the burden of proof. But at subsequent levels of review, the significance of the burden of proof depends on the nature of the review to be performed. If review is *de novo*--in which case the reviewing body has license to reweigh the facts and reassess the persuasive force of the evidence[3]--the risk of nonpersuasion (and, hence, the burden of proof) potentially can remain a factor in determining which party prevails. When review is not *de novo*, however, the only factual review performed is for the *sufficiency* of evidence pursuant to a standard that essentially tests whether a rational or reasonable factfinder could have been persuaded by the evidence;

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[2] As noted in *State v. Rainey*, 298 Or 459, 464 n 6, 693 P2d 635 (1985), the term "burden of proof" is outmoded for purposes of the Oregon Evidence Code. There, it has been replaced with the more precise concepts of "burden of production" and "burden of persuasion." *See e.g.*, OEC 305 ("A party has the burden of persuasion as to each fact the existence or nonexistence of which the law declares essential to the claim for relief or defense the party is asserting."); OEC 307(2) ("The burden of producing evidence as to a particular issue is initially on the party with the burden of persuasion as to that issue.").

[3] *See, e.g., Hannan v. Good Samaritan Hosp.*, 4 Or App 178, 471 P2d 831 (1970) (*de novo* review is a trial anew in the fullest sense, with the findings of the lower tribunal being given no weight except on issues of credibility).

the reviewing body does not weigh the evidence anew or otherwise decide whether to reach the same result as the initial factfinder.[4] In such a case, no burden remains on the party to *persuade* the reviewing body of the truth of the factual evidence produced, and neither party can be said to bear the risk of factual nonpersuasion in the same way that the risk is borne at the factfinding level.

Review of a disability-extent determination at a hearing before an ALJ and on review before the Board is *de novo*. *See generally* ORS 656.283(7) (ALJ hearing); ORS 656.295(5) (Board review). We therefore agree with employer that, as a general proposition, claimant retains the burden of proof on the nature and extent of disability at the level of Board review. *SAIF v. Schiller*, 151 Or App 58, 63, 947 P2d 1128 (1997), *rev den* 326 Or 389 (1998) (claimant continues to **<171 Or App 180/181>** have burden at Board level to prove that claim is disabling). Thus, if the issues raised by the party seeking an ALJ hearing and Board review trigger the need to review the factual evidence for its weight, the injured worker retains the burden of proof in the sense that, if the ALJ or the Board finds the evidence to be equally balanced and is unable to say upon which side it weighs heavier, the injured worker bears the consequences of nonpersuasion. Indeed, that is how the Board has resolved disputes over extent of disability when the issues have called on the Board to weigh the evidence and the Board has found the evidence equally balanced or simply unpersuasive. *See, e.g., Raymond T. Cox, Jr.*, 47 Van Natta 1628 (1995) (on insurer's request for review, Board modified award of permanent disability, concluding that evidence on certain issues was in equipoise and that claimant therefore did not carry burden of proof); *see also Cynthia R. Deronden-Pos*, 51 Van Natta 1517 (1999) (on insurer's request for review of ALJ's conclusion that condition was compensable, Board reversed, finding the medical evidence "at best, to be in equipoise" and that claimant therefore did not carry her burden of proof).[5]

Here, however, we do not understand the Board to have assigned the burden of proof to employer in that sense. Citing its earlier decision in *Roberto Rodriguez*, 46 Van Natta 1722 (1994), the Board observed that claimant had not sought the ALJ hearing and later Board review; rather, **<171 Or App 181/182>** employer had pursued further review at both levels seeking to have the disability award decreased. In the Board's view, employer, as the party seeking affirmative relief in the form of a modified disability rating, bore the burden of "proving" the basis for the modification. Requiring employer to bear that burden is consistent with ORS 656.283(7), which provides, in part:

> "Evidence on an issue regarding a notice of closure 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."

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[4] Standards for reviewing evidence for sufficiency vary slightly by context but are similar in their formulation. *See, e.g.*, ORS 183.482(8)(c) (factfinding by administrative agency is reviewed for substantial evidence; substantial evidence supports a finding when the record, viewed as a whole, permits a reasonable person to make the finding); *Illingworth v. Bushong*, 297 Or 675, 694, 688 P2d 379 (1984) (to set aside civil verdict, reviewing court must be able to conclude affirmatively that no evidence supports jury's determination of the facts); *State v. Cunningham*, 320 Or 47, 63, 880 P2d 431 (1994), *cert den* 514 US 1005 (1995) (evidence to support criminal conviction is viewed in the light most favorable to the state to determine whether any rational trier of fact could have found the elements of the crime beyond a reasonable doubt).

[5] In practical terms, the likelihood of the medical evidence being in "equipoise" at the Board's level of review on a dispute over extent of disability is not great. By then, at least the claimant will have provided a medical opinion on the extent of disability. The ordinary case pursued to the Board level may also entail a medical arbiter report, prepared in the course of reconsideration by DCBS, as well as possible competing medical evidence submitted by the employer. On a fully developed record where the dispute is extent of disability, the question for the Board on de novo review most often will reduce to which of the medical opinions the Board finds most persuasive. As a matter only of its *de novo* review, the Board would then rate the disability accordingly. Whether the Board in fact does so may depend on other factors, such as what arguments and issues the parties have raised and preserved for the Board's review. *See, e.g., Patricia J. Lei*, 1994 WL 382599 (1994) (ALJ, who erred in finding that claim was closed prematurely, did not reach claimant's argument in favor of increasing disability award; because the record was adequately developed for review, Board reached and decided the issue in the first instance, concluding that claimant's evidence supported a lower extent rating than awarded in the order on reconsideration; Board did not reduce award, however, because employer had not preserved the issue).

(Emphasis added).[6] *See Rodriguez*, 46 Van Natta at 1723-24 (relying on ORS 656.283(7) (1990), to conclude that the party requesting a hearing has the burden to establish that standards for evaluating disability were incorrectly applied).

The language "establish by a preponderance of that evidence" is a holdover from the pre-1995 versions of the statute, which permitted new issues to be raised and new evidence to be considered at the ALJ hearing as well as before the Board. *See* ORS 656.283(7) (1965, 1979, 1981, 1985, 1987, 1990); *see generally Rogue Valley Medical Center v. McClearen*, 152 Or App 239, 244-46, 952 P2d 1048, *rev den* **<171 Or App 182/183>** 327 Or 123 (1998) (discussing significance of 1995 amendment to statute). Under the current statutory scheme, however, the hearing before the ALJ is on the reconsideration record made before DCBS and is limited to the issues raised on reconsideration. The record may be supplemented only with a medical arbiter report that was not prepared in time for use in the reconsideration process, ORS 656.268(6)(f), and the issues may be expanded only to consider those "aris[ing] out of the reconsideration order itself." ORS 656.283(7).

Given the procedural changes brought about in 1995, characterizing the dissatisfied party's burden under the statute as one of "proof" seems off-mark. Apart from possibly supplementing the record with a medical arbiter report, the statute no longer contemplates that a party seeking Board review of a disability award has the ability to introduce new "evidence" showing that the standards were misapplied. Necessarily, then, no burden to convince the factfinder of the "truth" of that new evidence falls on that party. To be sure, the statutes effectively place a burden on the party seeking hearing or review by requiring that party to produce the record made at reconsideration, to identify in what ways the standards for rating the disability were misapplied, and to persuade the reviewing body of the correctness of that proposition. Given the procedural scheme, the statute's reference to the party's obligation to establish that the standards were misapplied "by a preponderance of the evidence" means only that the record made at reconsideration must persuade the ALJ or the Board that there was an error in the disability award. If the evidence does not favor that conclusion--that is, if the ALJ or the Board is not persuaded that there was an error--the party seeking review loses.

Such a requirement is not a "burden of proof" in the true sense of the term (*i.e.*, a burden to produce evidence of a fact and then to persuade the factfinder of the truth of the fact). More accurately, it is a burden of establishing error in the prior resolution. Like a burden of proof, the burden to establish error has two components: first, a burden of going forward by proposing in what way the determination below is erroneous; second, a burden of establishing the correctness of that proposition. Thus, the "burden" on the dissatisfied party **<171 Or App 183/184>** is one traditional to the adversarial process: The party seeking affirmative relief on appeal or review must identify an error in the decision and must do so persuasively. Ordinarily, the party who prevailed at an initial level of adjudication is entitled to rest on that resolution unless and until the opposing party, in a procedurally proper way, seeks review and persuades the reviewing body that the prior resolution should be modified or reversed. Thus, for example, in appeals to this court, *de novo* review does not obviate the necessity for a cross-appeal,[7] for making precise assignments and cross-assignments of error,[8] or for preserving issues in the prior

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[6] The same language appears in substantially the same form in the statute governing Board review of the ALJ's order:

"* * * The board shall apply to the review of the claim such standards for the evaluation of disability as may be adopted by the Director of the Department of Consumer and Business Services pursuant to ORS 656.726. *Nothing in this section shall be construed to prevent or limit the right of a worker, insurer or self-insured employer to present evidence to establish by a preponderance of the evidence that the standards adopted pursuant to ORS 656.726 for evaluation of the worker's permanent disability were incorrectly applied in the reconsideration order pursuant to ORS 656.268.*"

ORS 656.295(5) (emphasis added).

[7] *See Booras v. Uyeda*, 295 Or 181, 188-89, 666 P2d 791 (1983) (even on *de novo* review court will not re-examine aspects of decree that are allegedly erroneous and prejudicial to respondent without a cross-appeal).

[8] Before 1982, assignments of error were not required in equitable appeals. *See former* ORAP 7.20 (*repealed* 1982). Even so, the appealing party had the burden to identify the issues for appeal and to make appropriate references to the record to support the issues raised. *See generally Tidewater v. Wheeler*, 55 Or App 497, 502 n 2, 638 P2d 499, *rev den* 292 Or 722 (1982). Since 1982, the appealing party in a case reviewed *de novo* must assign error, set forth the pertinent portions of the record, and otherwise carry the burden of identifying claims of error. *See* ORAP 5.45 (assignments of error and supporting argument required in all opening briefs).

proceedings.[9] All of those requirements are ways in which, notwithstanding the burden of proof on the underlying merits of an issue, the party seeking affirmative relief after an initial resolution of the merits must persuasively identify the basis for that relief.

Thus, we reject the premise of employer's argument that assigning employer the burden of establishing error in the application of the standards for evaluation of claimant's disability is inconsistent with claimant's burden of proving, under ORS 656.266, the nature and extent of his disability. ORS 656.283(7) merely describes the burden of a party seeking to challenge *DCBS's application of its own standards* after DCBS has determined what amount of disability, if any, to award the injured worker. Requiring the party seeking review to demonstrate persuasively that the standards for **<171 Or App 184/185>** rating disability were misapplied merely places on the dissatisfied party the same obligation that falls on any party seeking affirmative relief on review or appeal: the obligation to propose the basis on which that relief should be awarded and then to establish the correctness of that proposition. The Board's order in this case assigned no other burden to employer and was not error.

We turn to employer's second assignment of error, in which employer challenges whether the ALJ and the Board could rely on the arbiter panel's lost range of motion measurements given the panel's unexplained finding that its examination was invalid. At the time the disability award in this case was made, *former* OAR 436-035-0007(27) (1996) applied. It provided, in part:

> "Validity shall be established for findings of impairment according to the criterion noted in the **AMA Guides to the Evaluation of Permanent Impairment, 3rd Ed., Rev., 1990** * * *. *Upon examination, findings of impairment which are determined to be ratable pursuant to these rules shall be rated unless the physician determines the findings are invalid and provides a written opinion, based on sound medical principles, explaining why the findings are invalid.* When findings are determined invalid, the findings shall receive a value of zero."

(Emphasis added; boldface in original.)[10] Both the parties and the Board assumed below, as the parties do on appeal, that the rule mandates consideration of the arbiter panel's impairment findings despite the finding that the examination was invalid, if the invalidity is not adequately explained. Employer thus asserts that, insofar as the rule does mandate ratings on such findings, the rule conflicts with the ALJ's and the Board's obligations to weigh the persuasiveness of the evidence. Employer further argues that, as a matter of law, unexplained invalid findings cannot be given any weight and, thus, such findings ultimately should not be used.

171 Or App 186> Employer's first argument--that the Board abdicated its responsibility to weigh the medical evidence--simply misunderstands the basis for the Board's adoption of the ALJ's order. In its order on reconsideration, the Board specifically observed: "It is evident from the ALJ's order that the medical opinions were weighed and the ALJ relied on the most persuasive opinion, rather than automatically relying on the arbiters' report." The Board's description of the ALJ's order and reasoning process is accurate.[11] Thus, in adopting the ALJ's order, the Board performed the weighing process that employer believes it must; it did not feel bound by the rule automatically to rate claimant's disability using the impairment findings in the arbiter panel's report. Employer's argument in that regard therefore is without merit.

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[9] *See Duncan v. Liberty Northwest Ins. Corp.*, 133 Or App 605, 610-11, 894 P2d 477 (1995) (party seeking review of disability award must have raised objections to the award at reconsideration); *Gunther H. Jacobi*, 41 Van Natta 1031 (1989) (Board does not consider issues on de novo review that were not raised at hearing before ALJ). *See generally Westendorf and Westendorf*, 165 Or App 175, 178, 996 P2d 523 (2000) (fact that case is subject to *de novo* review does not mean that the preservation rule applies with any less force than in other cases).

[10] The rule was amended in 1997. *See* OAR 436-035-0007(28). The amended--and now differently numbered--rule does not apply to this claim because the claim was closed before the amended rule's effective date. OAR 436-035-0003(1).

[11] In her order, the ALJ specifically compared the treating physician's finding that there was no lost range of motion to the measurements made by the arbiter panel. The ALJ explained that the treating physician did not explain what, if any, measurements he made, whereas the arbiters gave precise measurements that were both specific and closer in time to the reconsideration process. Finding those measurements to be "a better measure of claimant's actual range of motion," the ALJ used them in rating the disability.

The more significant issue raised by employer is whether an arbiter's impairment findings may be used at all in rating the disability when the arbiter concludes that the examination was invalid but does not explain the invalidity. We recently held that *former* OAR 436-035-0007(27) (1996) itself precluded use of invalid impairment findings if the invalidity was based on a determination that an impairment finding does not satisfy AMA criteria. *Roseburg Forest Products v. Clemons*, 169 Or App 231, 9 P3d 123 (2000). When the Board decided this case, it did not have the benefit of that opinion, and it incorrectly understood the rule to require consideration of the arbiter panel's impairment findings, notwithstanding their invalidity, if the invalidity was not explained. *See Justeen L. Parker*, 49 Van Natta 334 (1997) (so holding; cited by the Board in its order in this case). Although employer does not attack that predicate assumption directly, its challenge to the use of the arbiter panel's impairment findings for rating the disability invites us to follow an alternative path to the same conclusion. Correctly, however, the starting point should be whether the rule itself permits the **<171 Or App 186/187>** impairment findings to be used.[12] That is a determination that the Board should make in the first instance, consistent with our decision in Roseburg Forest Products. We therefore reverse and remand to the Board for further consideration under a correct interpretation of former OAR 436-035-0007(27) (1996).

Reversed and remanded.

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[12] *See generally Stull v. Hoke*, 326 Or 72, 77, 948 P2d 722 (1997) (court is responsible for identifying the correct interpretation of a statute); *Bronson v. Moonen*, 270 Or 469, 476-77, 528 P2d 82 (1974) (administrative rules and regulations have the status and effect of law); *State v. Williams*, 161 Or App 111, 116, 984 P2d 312 (1999) (under *Stull*, we are not bound by the parties' formulation of the issues presented if it would force us to misapply or misinterpret a statute).

Cite as 171 Or App 263 (2000) December 6, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Tracey A. Blamires, Claimant.

TRACEY A. BLAMIRES, Petitioner,
v.
CLEAN PAK SYSTEMS, INC., and LIBERTY NORTHWEST INSURANCE CORPORATION,
Respondents.
(98-02326, 98-04194; CA A103926 (Control), A104459) (Cases Consolidated)

Judicial review from Workers' Compensation Board.

Argued and submitted June 2, 2000.

John M. Oswald argued the cause for petitioner. With him on the brief were Gayle A. Shields, and Bottini, Bottini & Oswald.

Leah D. Sideras argued the cause for respondents. With her on the brief was Wallace, Klor & Mann, P. C.

Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Kistler, Judge.

EDMONDS, P. J.

Reversed and remanded for reconsideration.

*Deits, C. J., *vice* Warren, S. J.

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171 Or App 265> This is a workers' compensation case in which claimant seeks review of two orders of the Workers' Compensation Board upholding employer's denials of compensation. He contends that the Board erred in affirming the employer's denials of coverage because its denials were premature under *Croman Corp. v. Serrano*, 163 Or App 136, 986 P2d 1253 (1999). Because the Board did not make a finding as to whether acceptance occurred before the denial in question, we remand for reconsideration.

Claimant was injured while working for employer on October 16, 1997. His work-related injuries were diagnosed as cervical and lumbar strains. A recitation of all of the medical evidence about the nature of his injuries is unnecessary for purposes of review. Claimant was treated for his workplace injury, and in a November 25, 1997, medical examination requested by employer, physicians discovered that he also had a degenerative condition that had combined with his workplace injuries. At that time, his workplace injuries were deemed the major contributing cause of his need for treatment, and claimant's condition was accepted by employer.

The following timeline shows the processing of claimant's claim by employer and is set out at length because it demonstrates the procedural error alleged.

January 5, 1998: Employer accepts claimant's cervical and lumbar strains (first acceptance).

February 25, 1998: The treating physician recommends surgery.

March 11, 1998: Claimant undergoes a second medical examination, where a panel of doctors concludes that claimant's workplace injury is medically stationary, that his work related injury is resolved, and that his pre-existing degenerative condition has become the major contributing cause of his need for treatment.

171 Or App 266> March 17, 1998: Employer issues its first denial of claimant's combined condition (first denial), claimant requests a hearing on the first denial.

March 18, 1998: The claim is closed (first closure).

May 1, 1998: The first denial of March 17 is set aside by the hearings division because employer had not accepted a combined condition before issuing the first denial.

May 21, 1998: The closure of March 18 is also set aside by the hearings division.

May 22, 1998: Employer issues a second denial of the combined condition on the ground that the workplace injury is no longer the major contributing cause of the combined condition.

May 26, 1998: Employer expressly accepts the combined condition.

May 28, 1998: Employer closes the claim; claimant requests a hearing.

June 19, 1998: The second denial is set aside by the hearings division for substantive error.

July 8, 1998: The second closure is set aside by the hearings division; claimant appeals to the Board.

September 24, 1998: The Board reverses the ALJ and reinstates the March 17 denial.

December 1, 1998: The Board reverses the ALJ and reinstates the May 22 denial.

Claimant assigns as error the Board's reinstatements of the March 17 and May 22 denials of his combined condition. He argues that the denials were not authorized under ORS 656.262(7)(b),[1] and that under **<171 Or App 266/267>** ORS 656.262(6)(c),[2] the employer was required to accept claimant's combined condition before it could deny it, relying on our holding in *Croman Corp.*[3]

The rule of *Croman Corp.* is that, under the wording of ORS 656.262(6)(c), the acceptance of a combined condition must precede the denial of a combined condition. Here, the Board did not make *any* finding about whether the January 5, 1998, acceptance was the acceptance of a combined condition. Rather, it did not believe that it was required to do so. The Board concluded,

> "Unlike the proceeding regarding the insurer's first 'pre-closure' denial, the insurer's second 'Updated Notice of Acceptance At Closure,' issued May 26, 1998, indicated that the insurer accepted a combined condition. But, given our determination in the first proceeding, it was not necessary for the insurer [first] to accept the combined condition in order to take advantage of the right to deny claimant's combined condition under ORS 656.262(7)(b)."

That ruling was error under our holding in *Croman Corp.*

Reversed and remanded for reconsideration.

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[1] ORS 656.262(7)(b) provides:

"Once a worker's claim has been accepted, the insurer or self-insured employer must issue a written denial to the worker when the accepted injury is no longer the major contributing cause of the worker's combined condition before the claim may be closed."

[2] ORS 656.262(6)(c) provides:

"An insurer's or self-insured employer's acceptance of a combined or consequential condition under ORS 656.005(7), whether voluntary or as a result of a judgment or order, shall not preclude the insurer or self-insured employer from later denying the combined or consequential condition if the otherwise compensable injury ceases to be the major contributing cause of the combined or consequential condition."

[3] The Board's final decision in this case was made on December 1, 1998, and petitioner sought review on December 2, before *Croman Corp.* was decided.

Cite as 171 Or App 268 (2000) December 6, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of Fredric B. Simmons, Claimant.

FREDRIC B. SIMMONS, Petitioner,
v.
LANE MASS TRANSIT DISTRICT and SAIF CORPORATION, Respondents.
(98-02846, 97-04490; CA A106416)

Judicial review from Workers' Compensation Board.
Argued and submitted May 3, 2000.
Dale C. Johnson argued the cause and filed the brief for petitioner.
James W. Moller argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Linder and Kistler, Judges.
EDMONDS, P. J.
Reversed and remanded.

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171 Or App 270> Claimant seeks review of an order in which the Workers' Compensation Board[1] refused to set aside a "Stipulation and Order" by which he and SAIF had resolved his request for a hearing on SAIF's denial of his claim that his current condition is a new injury. Under the stipulation, SAIF agreed to continue treating his current condition as an aggravation of a previous accepted injury. Claimant argues that the stipulation is invalid both because the law requires the parties to resolve a denied claim by a Disputed Claims Settlement (DCS) rather than a simple stipulation and because there was no consideration for the agreement. We agree with the first ground and therefore reverse without reaching the second.

Claimant is a bus driver who works for respondent Lane Mass Transit District. He began suffering leg cramps in July 1995 after a shift in which he worked for 16 hours without interruption. The cramps eventually went away after he undertook treatment from a physician and a rearranged work schedule that the physician suggested. SAIF initially denied his claim for the leg cramps, and claimant sought a hearing on the denial. In April 1996, after claimant became medically stationary, SAIF agreed to accept his claim as one for "left leg cramp, now resolved." That agreement was reflected in a stipulation and order that an ALJ approved; it left open all unresolved issues concerning the compensation to which claimant was entitled for the injury.

Claimant again experienced left leg cramps in October 1996, after working five consecutive 12 hour shifts. His physician treated the condition in large part by adjusting claimant's work schedule to limit the number of consecutive 12 hour shifts that claimant was working at the time. A notice of claim for a new injury was filed on October 7, and an aggravation claim in the original injury case was filed on November 15. At that time, a number of issues about claimant's right to time loss from the original claim remained unresolved.

171 Or App 271> In January 1997, SAIF denied the claim for a new injury. However, SAIF stated in the letter of denial that it would pay claimant's medical bills under the original claim as an aggravation. Claimant sought a hearing on the denial of the new injury claim, and that hearing was consolidated with the hearing on the unresolved issues from the original claim. In May 1997, claimant's attorney reached a settlement of the new injury claim with SAIF. Under that settlement, the new injury claim remained denied but SAIF agreed to process all issues as an aggravation of the original injury. In addition, SAIF agreed to remove the word "resolved" from its acceptance of the original claim. The statement of the issues that the stipulation resolved was limited to those "raised" at the time of the settlement rather than those "raised and raisable." SAIF paid claimant's attorney $250 in attorney fees as part of the agreement. Claimant signed the stipulation with the understanding that it would not affect his ability to litigate his claims for time loss arising from the 1996 injury.

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[1] Because the Board adopted the opinion and order of the Administrative Law Judge, we refer to the ALJ's opinion and order as that of the Board.

After the ALJ approved the stipulation, claimant changed lawyers. Thereafter, the claim proceeded to a hearing on the unresolved issues arising from both the 1995 injury and the 1996 injury. At the hearing, claimant challenged the validity of the May 1997 stipulated settlement. The Board held that the settlement was valid, and that is the only part of its order that claimant attacks on review. On review, claimant argues that the settlement agreement does not comply with ORS 656.289(4) and OAR 438-009-0010 and should be set aside.

Evaluating claimant's argument requires a consideration of the various mechanisms for settling all or part of a workers' compensation claim. As a general rule, "no release by a worker or beneficiary of any rights under [ORS chapter 656] is valid except pursuant to a claim disposition agreement under [ORS 656.236] or a release pursuant to ORS 656.593." ORS 656.236(8). However, two separate statutes authorize a claimant and an employer to enter into two discrete kinds of settlements that include a release of rights. First, ORS 656.236(1) provides that the parties to a claim may make any disposition of it, except for medical services, that they consider reasonable, subject to whatever terms and conditions the Board prescribes. The disposition is subject to **<171 Or App 271/272>** Board approval by a final order. Unless otherwise specified, a disposition under ORS 656.236(1) could resolve all issues potentially arising out of the claim, other than medical services. Second, ORS 656.289(4) allows the parties to a claim to agree to a disposition of the claim that they consider reasonable where there is a bona fide dispute over compensability. Again, the disposition is subject to approval by an ALJ, the Board, or an appellate court, depending on the stage that the claim has reached in the review process.

The Board has adopted rules to implement these statutes. A "Claims Disposition Agreement" (CDA), as defined in OAR 438-009-0001(1), implements ORS 656.236(1). A CDA is a written agreement in which a claimant agrees to release rights, or to release an insurer or self-insured employer from obligations, except for medical services, in an accepted claim. OAR 438-009-0020 through 438-009-0035 require the parties both to provide information for the Board to review in deciding whether to approve the CDA and also to give the claimant information concerning the effect of agreeing to the CDA.

In contrast to a CDA, a DCS, as defined in OAR 438-009-0001(2), is a written agreement by which the parties agree to make a reasonable disposition of a claim in which there is a bona fide dispute over the compensability of the claim. That rule implements ORS 656.289(4). The applicable administrative rule requires the parties to provide information to the Board, along with assurances that the claimant has been thoroughly informed of the effect of the DCS, before the Board will approve it. OAR 438-009-0010.

One obvious distinction between a CDA and a DCS is that a CDA involves an accepted claim while a DCS involves a denied claim that remains denied. In its decisions, the Board has held that a CDA is proper only when it entirely disposes of an accepted claim, except for medical services. A CDA is not an appropriate way to resolve some but not all of the issues that arise in the processing of a claim. *See, e.g., Jeffrey B. Trevitts*, 46 Van Natta 1767, 1775-76 (1994); *Lynda J. Thomas*, 45 Van Natta 894, 895 (1993). Presumably for that reason, no party suggests that it was possible to implement the settlement in this case by a CDA. On the other **<171 Or App 272/273>** hand, the Board's decisions suggest that, as the rule indicates, a DCS is appropriate primarily when the claimant agrees to keep the claim in a denied status in exchange for the payment of an agreed amount of money. *See, e.g., George M. Brown*, 52 Van Natta 5 (2000); *Forest G. Hull*, 51 Van Natta 1795 (1999).[2]

Because a CDA is proper only when the parties intend to resolve all aspects of a claim other than medical benefits, and because a DCS is proper only when the issue is the resolution of a claim denial and may be limited to situations in which the parties intend the claim to remain denied, neither is suitable for many of the other issues that could arise during the course of a claim. Accordingly, the Board's rules provide for a third category of settlement, a "settlement stipulation," which OAR 438-009-0001(3) defines as

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[2] OAR 438-009-0010(2)(c) provides that a DCS must contain a recital that there is a bona fide dispute as to the compensability of the claim and that the parties have "agreed to compromise and settle the denied and disputed claim[.]" The quoted phrase indicates that the settlement is of the entire claim, which suggests that, after the settlement, it will be entirely resolved. A settlement that contemplates the acceptance and further processing of a formerly denied claim does not appear to fit within those terms.

> "a written agreement, or an oral agreement if made on the oral record of a hearing and approved in writing by a [*sic*] Administrative Law Judge, in which any matter contested between the parties, other than matters resolvable in a claim disposition agreement or disputed claim settlement, are [*sic*] resolved by agreement of the parties."

OAR 438-009-0005 provides the few rules that govern settlement stipulations. Under those rules, the parties may resolve the contested matters at any time. The information that the parties must provide to the ALJ is significantly more limited than the information that must be provided for a CDA or a DCS, and there is no requirement that anyone provide the claimant any specific information about the effect of the stipulation. The rule does not even require that a claimant who is represented by a lawyer sign the stipulation or orally indicate agreement with or acceptance of it. The ALJ must approve any stipulation, but the rule does not provide any criteria for the ALJ to apply in deciding whether to approve it.[3] Those rules do not refer to a "denied" claim.

171 Or App 274> It appears from the Board's cases that parties use settlement stipulations in a wide variety of circumstances. We cite only two examples. In *Carolyn S. Asti*, 51 Van Natta 1706 (1999), the Board noted that the ALJ had approved a settlement stipulation under which the employer withdrew its denial of compensability and agreed to treat the claimant's current condition as compensable under a previous claim, which it agreed to reopen. In *Kenneth F. Plummer*, 51 Van Natta 1239 (1999), the parties had agreed to a settlement stipulation under which the claimant would withdraw a request for sanctions and dismiss his request for a hearing in exchange for the employer's agreement to pay temporary disability until it decided whether to accept or deny the claim, to pay a penalty, and to decide whether to accept or deny the claim within 30 days from the ALJ's approval of the settlement. Neither of those cases involved the ultimate denial of a claim, and in Asti the stipulation resolved the employer's denial of a claim by the employer withdrawing it.

The question, then, is whether a settlement stipulation under OAR 483-009-0001(3) was the proper way to implement the parties' agreement in this case. Because the stipulation did not resolve all issues in the claim, other than medical benefits, a CDA would not have been appropriate. Whether the parties should have used a DCS rather than a "settlement stipulation" depends on what precisely was the "claim" that the settlement attempted to resolve. Claimant argues that because the settlement resulted in the continued denial of a claim, *i.e.*, his claim for a new injury, it falls under the provisions of ORS 656.289(4), which under the rules require a DCS.[4] SAIF argues that the "claim" was claimant's injury, not a piece of paper filed by claimant, and that it agreed in the stipulated settlement to accept that broadly **<171 Or App 274/275>** defined claim as a compensable aggravation of the accepted 1995 injury. Thus, SAIF says, it did not deny the new injury claim, and there was no need for a DCS.

Under ORS 656.005(6), a claim is "a written request for compensation from a subject worker or someone on the worker's behalf, or any compensable injury of which a subject employer has notice or knowledge." Although the portion of the definition that refers to the employer's knowledge of the injury might suggest that the injury itself is the "claim," that suggestion is incorrect. The first part of the definition expressly requires a writing, and even when the employer knows of the injury, ORS 656.265 requires a written request, generally within 90 days, in order to perfect the claim. An injury that is a "claim" under the statutory definition only because the employer has notice of it will become void in the absence of a written request made within the required time. *See McPhail v. Milwaukie Lumber Co.*, 165 Or App 596, 603-05, 999 P2d 1144 (2000). Thus, although an injury creates the basis for a claim, for the purposes of processing the "claim" is the written request for compensation.

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[3] The statutory authority for a settlement stipulation is not entirely clear. Such a stipulation does not appear to fall within the terms of ORS 656.289(4). However, ORS 656.236(1), unlike the rules governing a CDA, does not expressly limit the authority to settle to agreements that resolve an entire claim, although it may contemplate that that will ordinarily be the result of a settlement. The statute is probably sufficient to authorize a settlement stipulation. Another possibility is that such a stipulation is an exercise of the inherent authority of a quasi-judicial body to approve a settlement of issues before it. That possibility may run afoul of ORS 656.236(8).

[4] Although claimant does not directly say so, the premise of his argument appears to be that, because the settlement stipulation maintained his new claim in denied status, it implicated the requirements for a DCS.

In this case, there are two written requests, one for a new injury and one for an aggravation. SAIF denied the first claim and accepted the second. In the stipulation at issue, the parties agreed that the new injury claim would remain denied. Because the new injury claim is distinct from the aggravation claim, the stipulation in effect attempted to dispose of a denied claim under ORS 656.289(4), and the applicable rule requires a DCS to achieve that result.

SAIF relies on *Greenwade v. SAIF*, 41 Or App 697, 598 P2d 1265, *rev den* 288 Or 173 (1979), to support its argument that a stipulation is authorized when a claim remains denied. In *Greenwade*, the claimant agreed to a stipulation to resolve a dispute over a denied claim. Under the stipulation, the claimant received $2,000 and the claim remained denied.[5] Thereafter the claimant sought to set the stipulation **<171 Or App 275/276>** aside. He relied in part on *Schulz v. Compensation Department*, 252 Or 211, 448 P2d 551 (1968), in which the Supreme Court affirmed the Board's decision to set aside a stipulation that determined the amount of compensation that the claimant received as a result of a settlement of an accepted claim. 41 Or App at 700-01. We rejected the claimant's argument, pointing out that there are two issues when a worker makes a claim for compensation: first, whether the injury is compensable and, second, if it is compensable, the amount of benefits to which the worker is entitled. We said that using a case involving a stipulation concerning the extent of compensation to support the setting aside of a stipulation to deny compensability is comparing apples and oranges. *Id.* at 701.

In deciding *Greenwade*, we emphasized that the issue of compensability involves whether the injury arose out of and in the course of the worker's employment. 41 Or App at 701. SAIF argues in this case that there is no dispute over that issue; it agrees that the 1996 injury is compensable, although SAIF believes that it is compensable as an aggravation of the 1995 injury rather than as a new injury. Thus, according to SAIF, because it agrees that the injury is compensable, there is no denied claim that would require a DCS. The problem with SAIF's argument is that it fails to recognize that claimant made two claims arising out of the same injury, that SAIF denied one of those claims, and that the settlement stipulation expressly upholds that denial. The fact that SAIF agrees that the injury is compensable as an aggravation does not affect the fact that SAIF denied it as a new injury. For that reason, our discussion in *Greenwade*, which is correct in the context of that case, is inapplicable to this case. Here, the issue is not whether the claim is compensable at all but whether it is compensable as a new injury. A new injury claim is distinct from an aggravation of an existing accepted claim and can be more beneficial to a claimant than an aggravation claim. Among other things, a new claim provides a new date for measuring the claimant's aggravation rights. *See* ORS 656.273(4). Thus, because there are issues concerning the denial of claimant's new injury claim in this case in addition to whether the injury is compensable in another way, *Greenwade* is not controlling.

171 Or App 277> We conclude that, because the applicable statutes and rules required the parties to implement any settlement that leaves the new injury claim in denied status through a DCS, rather than through a settlement stipulation, the settlement stipulation is void. The settlement does not meet the statutory and rule requirement for the resolution of a denied claim. It follows that the Board erred in upholding the settlement stipulation.

Reversed and remanded.

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[5] So far as the opinion indicates, at the time of *Greenwade* a stipulation was an appropriate method of implementing a settlement of this kind. The Board began adopting the current rules on implementing a settlement in 1984, well after the settlement in *Greenwade*. In any event, no party in *Greenwade* raised any issues about the method of the settlement, and we therefore did not consider the issue that confronts us in this case.

Cite as 171 Or App 329 (2000) December 6, 2000

IN THE COURT OF APPEALS OF THE STATE OF OREGON

In the Matter of the Compensation of John Harkness, Claimant.

JOHN HARKNESS, Petitioner,
v.
SAIF CORPORATION and UNOCAL 76, Respondents.
(97-08467; CA A104207)

Judicial review from Workers' Compensation Board.
Argued and submitted June 2, 2000.
Gayle A. Shields argued the cause and filed the brief for petitioner.
Jerome Patrick Larkin argued the cause and filed the brief for respondents.
Before Edmonds, Presiding Judge, and Deits, Chief Judge,* and Kistler, Judge.
PER CURIAM
Reversed and remanded for reconsideration.
*Deits, C. J., *vice* Warren, S. J.

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171 Or App 330> This is a workers' compensation case in which claimant seeks review of the order of the Workers' Compensation Board upholding SAIF's denial of compensation. He contends that the Board erred in affirming SAIF's denial of coverage because its denial was premature under our holding in *Croman Corp. v. Serrano*, 163 Or App 136, 986 P2d 1253 (1999). Because the Board did not make a finding as to whether acceptance occurred before the denial in question, we remand for reconsideration. *Blamires v. Clean Pak Systems, Inc.*, 171 Or App 263, ___ P3d ___ (2000).

Reversed and remanded for reconsideration.

INDEX CONTENTS

Volume 52

Page

Overview of Subject Index 2316

Subject Index 2318

Citations to Court Cases 2342

Citations to Van Natta's Cases 2356

ORS Citations 2375

Administrative Rule Citations 2383

Larson Citations 2389

Oregon Rules of Civil Procedure Citations 2389

Oregon Evidence Code Citations 2389

Claimant Index 2390

Throughout the Index, page numbers in **Bold** refer to Court Cases.

OVERVIEW OF SUBJECT INDEX

ACCIDENTAL INJURY

ADA CHALLENGE
See CONSTITUTIONAL & ADA ISSUES

AOE/COE

AGGRAVATION CLAIM (PROCEDURAL)

AGGRAVATION (ACCEPTED CLAIM)

AGGRAVATION/NEW INJURY
See SUCCESSIVE EMPLOYMENT EXPOSURES

AGGRAVATION (PRE-EXISTING CONDITION)
See ACCIDENTAL INJURY; MEDICAL CAUSATION; OCCUPATIONAL DISEASE CLAIMS; PSYCHOLOGICAL CONDITION CLAIMS

APPEAL & REVIEW
See OWN MOTION RELIEF; REMAND; REQUEST FOR HEARING (FILING); REQUEST FOR HEARING (PRACTICE & PROCEDURE); REQUEST FOR BOARD REVIEW (FILING); REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE); REQUEST FOR REVIEW--COURTS

ATTORNEY FEES

BACK-UP DENIALS
See DENIAL OF CLAIMS

BENEFICIARIES & DEPENDENTS

BOARD'S OWN MOTION
See OWN MOTION RELIEF

CLAIMS DISPOSITION AGREEMENT
See SETTLEMENTS & STIPULATIONS

CLAIMS FILING

CLAIMS PROCESSING

COLLATERAL ESTOPPEL

CONDITIONS
See OCCUPATIONAL DISEASE, CONDITION OR INJURY

CONSTITUTIONAL & ADA ISSUES

COVERAGE QUESTIONS

CREDIBILITY ISSUES

CRIME VICTIM ACT

DEATH BENEFITS

DENIAL OF CLAIMS

DEPT. OF CONSUMER & BUSINESS SERVICES

DEPENDENTS
See BENEFICIARIES & DEPENDENTS

DETERMINATION ORDER/NOTICE OF CLOSURE

DISCOVERY

DISPUTED CLAIM SETTLEMENT
See SETTLEMENTS & STIPULATIONS

DOCUMENTARY EVIDENCE See EVIDENCE

EMPLOYERS' LIABILITY ACT

EMPLOYMENT RELATIONSHIP
See COVERAGE QUESTIONS

ESTOPPEL

EVIDENCE

EXCLUSIVE REMEDY

FEDERAL EMPLOYEES' LIABILITY ACT

FIREFIGHTERS

HEARINGS PROCEDURE
See REQUEST FOR HEARING (PRACTICE & PROCEDURE)

HEART CONDITIONS
See ACCIDENTAL INJURY; MEDICAL CAUSATION; OCCUPATIONAL DISEASE CLAIMS (PROCESSING); OCCUPATIONAL DISEASE, CONDITION OR INJURY

INDEMNITY ACTION

INMATE INJURY FUND

INSURANCE
See COVERAGE QUESTIONS; EXCLUSIVE REMEDY

INTERIM COMPENSATION
See TEMPORARY TOTAL DISABILITY

JONES ACT

JURISDICTION

LABOR LAW ISSUE

LUMP SUM See PAYMENT

MEDICAL CAUSATION
See also: ACCIDENTAL INJURY; DENIAL OF CLAIMS; EVIDENCE; OCCUPATIONAL DISEASE CLAIMS; PSYCHOLOGICAL CONDITION CLAIMS

MEDICAL OPINION

MEDICAL SERVICES

MEDICALLY STATIONARY
See also: DETERMINATION ORDER/NOTICE OF CLOSURE; OWN MOTION RELIEF

NONCOMPLYING EMPLOYER
See COVERAGE QUESTIONS; DENIAL OF CLAIMS

NONSUBJECT/SUBJECT WORKERS
See COVERAGE QUESTIONS

O.S.H.A. See SAFETY VIOLATIONS

OCCUPATIONAL DISEASE CLAIMS (FILING)

OCCUPATIONAL DISEASE CLAIMS (PROCESSING)
See also: FIREFIGHTERS; PSYCHOLOGICAL CONDITION CLAIMS; SUCCESSIVE EMPLOYMENT EXPOSURES

OCCUPATIONAL DISEASE, CONDITION OR INJURY

OFFSET/OVERPAYMENTS

OWN MOTION RELIEF
See also: ATTORNEY FEES; AGGRAVATION CLAIM (PROCEDURAL); DETERMINATION ORDER/NOTICE OF CLOSURE; JURISDICTION

PAYMENT

PENALTIES

PERMANENT PARTIAL DISABILITY (GENERAL)

PERMANENT PARTIAL DISABILITY (SCHEDULED)

PERMANENT PARTIAL DISABILITY (UNSCHEDULED)
See also: PERMANENT PARTIAL DISABILTY (GENERAL)

PERMANENT TOTAL DISABILITY

PREMATURE CLAIM CLOSURE
See DETERMINATION ORDER/NOTICE OF CLOSURE

PREMIUM AUDIT ISSUE
See COVERAGE QUESTIONS

PSYCHOLOGICAL CONDITION CLAIMS

REMAND

REQUEST FOR HEARING (FILING)

REQUEST FOR HEARING (PRACTICE & PROCEDURE)

REQUEST FOR BOARD REVIEW (FILING)

REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE)

REQUEST FOR REVIEW--COURTS

RES JUDICATA

RESPONSIBILITY CASE
See SUCCESSIVE EMPLOYMENT EXPOSURES

SAFETY VIOLATIONS

SANCTIONS See ATTORNEY FEES

SETTLEMENTS & STIPULATIONS
See also: JURISDICTION; RES JUDICATA

SUBJECT WORKERS
See COVERAGE QUESTIONS

SUCCESSIVE (OR MULTIPLE) EMPLOYMENT EXPOSURES

TEMPORARY TOTAL DISABILITY
See also: JURISDICTION; OWN MOTION RELIEF; PAYMENT

THIRD PARTY CLAIMS

TIME LIMITATIONS
See AGGRAVATION CLAIM (PROCEDURAL); CLAIMS FILING; OCCUPATIONAL DISEASE CLAIMS (FILING); REQUEST FOR HEARING (FILING); REQUEST FOR REVIEW (FILING); REQUEST FOR REVIEW--COURTS

TORT ACTION
See also: EXCLUSIVE REMEDY

VOCATIONAL REHABILITATION

ACCIDENTAL INJURY
See also: AOE/COE; CREDIBILITY; DENIAL OF CLAIMS; MEDICAL CAUSATION; OCCUPATIONAL DISEASE
Burden of proof
"Compensable injury" discussed or defined, **1129**
Generally, 121,238,461,907,1590,2165
Necessity for specific diagnosis, 1921
Preexisting condition
"Combined" condition discussed or defined, 1630,2101,2102
Generally, 330,380,907,963,1014,1286,1348,1383,1599,1610,1652,1915,1944,2196
Major cause defined, 66,397,1014,1383,1521,1845,1944
Major vs. precipitating cause, **518**,702,775,900,936,963,1264,1428,**1704**,1910
Claim compensable
Credible claimant, 174,273,292,1286,1900,1921,2093
Injury to prosthetic appliance, 704
Legal and medical causation established, 180
Material causation test met, 24,174,292,963,1097,1390,1466,1858,1921,2102,2165
Medical services required by exposure, **1129**,1390
No medical evidence on causation, 1900
Objective findings, 911,963,1035,2081
Preexisting condition
Combined with injury
Major cause, need for treatment test met, 479,647,702,871,996,1012,1035, 1065,**1111**,1286,1348,1383,1560,1588,1910,1915,2010,2033,2101,2108
None found, 7,82,1097,1264,2102
Not combined, 1390,1466
Sufficient medical evidence, 31,83,121,400,779,1078,1264,1376,1526
Claim not compensable
Consumption of alcohol or drugs, 1841
Insufficient medical evidence, 17,26,101,227,314,395,469,502,631,639,728,770,905,961,978, 1017,1079,1087,1269,1288,1446,1495,1513,1590,1621,1823,1908,1961,2152,2172,2200
Material causation test not met, 1610,2209
No objective findings, 322
Noncredible claimant, 1,15,66,227,410,469,471,961,1426,1847,1863,2209,2239
Preexisting condition
Combined with injury
Major cause, need for treatment test not met, 39,66,104,307,313,320,330, 380,432,505,**518**,649,665,775,844,907,963,999,1014,1061,1599,1607,1630, 1663,**1704**,1820,1843,1845,1859,2173,2196
Major cause test not met, 2,397,642,821,825,900,926,936,963,1052,1521, 1652,1909,1944,2013
Treatment for non-compensable condition, 172,477
Vs. occupational disease, 27,196,204,**566**,639,882,**1111**,1264,1306,1383,1513,1630,1961,2172,2250

ADA CHALLENGE See CONSTITUTIONAL AND ADA ISSUES

AOE/COE (ARISING OUT OF & IN THE COURSE OF EMPLOYMENT)
See also: ACCIDENTAL INJURIES; COVERAGE QUESTIONS; DENIAL OF CLAIMS; MEDICAL CAUSATION
"Arising out of" and "in the course of" analysis, **534**,760,801,897,1030,1092,1612,1965,2005,**2262**, **2286**
Control over premises issue, 760
Departure from employment activity, 1965
Going and coming rule, **534**,**544**,801,1351
Horseplay, **1174**,1935
Increased hazard, 801,**2286**
Injury during IME, **2262**
Injury during volunteer activity outside job description, 1076
Neutral risk, 2005,**2286**

AOE/COE (ARISING OUT OF & IN THE COURSE OF EMPLOYMENT) (continued)
Paid break, 760
Parking lot rule, **2286**
Personal mission, 739,1612
Prohibited conduct, **1174**
Recreational activity, 1392
Risk assumed by employer, 1870
Special errand, 1351,1870
Syncopal episode, 1830,2005
Traveling employee, 1092,1965
Unexplained fall, 1618,2205,**2286**
Unidentified hazard, 897,1030
Unpaid lunch break, 739

*** Bold Page = Court Case ***

AGGRAVATION CLAIM (PROCEDURAL)
Filing
Form and format requirements challenged, 487
Not perfected, 487,767
Perfected, 716

AGGRAVATION (ACCEPTED CLAIM)
See also: DENIAL OF CLAIMS; MEDICAL CAUSATION; TOTAL TEMPORARY DISABILITY
Burden of proof
Generally, 114,185,716,1018,1050,1086,1102,**1116**,1262,1273,1645,1692,2017,2205
Factors considered
Earning capacity
Diminished, 295,1062
Withdrawal from work force issue, 295
Worsened condition or symptoms issue
"Actual worsening" issue, 270,295,847,1062,1086,**1116**,**1119**,1262,1273,1363,1449, 1904,2017
Due to injury issue, 1018,1050,1645,1692,2017,2205
Lay testimony vs. expert opinion, 1086,1102
Objective findings, 1273
Pathological vs. symptomatic worsening, 295,**510**,1018,**1119**,1262
Waxing and waning symptoms, 1037,1062,**1119**
Vs. new occupational disease claim, 1070
Worsening
Not due to injury, 114,185,402,716,1018,1050,1645,1692,2017,2205
Not proven, 270,847,1037,1086,1102,**1119**,1262,1296,1363,1449,1692
Proven, due to injury, 295,352,1062,1273,1904

AGGRAVATION/NEW INJURY See SUCCESSIVE EMPLOYMENT EXPOSURES

AGGRAVATION (PREEXISTING CONDITION) See ACCIDENTAL INJURY; MEDICAL CAUSATION; OCCUPATIONAL DISEASE CLAIMS; PSYCHOLOGICAL CONDITION CLAIMS

APPEAL & REVIEW See OWN MOTION RELIEF; REMAND; REQUEST FOR HEARING (FILING); REQUEST FOR HEARING (PRACTICE & PROCEDURE); REQUEST FOR BOARD REVIEW (FILING); REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE); REQUEST FOR REVIEW--COURTS (INCLUDES FILING, PRACTICE & PROCEDURE)

ATTORNEY FEES
See also: JURISDICTION; THIRD PARTY CLAIMS
Factors considered
Complexity of case, 128,138,220,353,491,676,835,896,893,1050,1271,1326,1343,1382,1538, 1603,1647,1655,1840,1870,1921,2110,2248
Generally, 667,1326
Hourly rate, 223,2110

ATTORNEY FEES (continued)
Factors considered (continued)
Legal assistant's time, 755,1538
Multiplier, 138,1538,2110
Risk of losing, 128,138,220,223,353,491,747,755,835,1050,1271,1398,1585,1603,1647,1655, 1840,1870,1921,2110
Skill of attorney, 223,353,491,676,835,1382,1398
Time devoted to case, 128,220,223,353,491,676,747,755,835,896,925,983,1050,1271,1326, 1398,1538,1585,1603,1635,1647,1840,1870,1921,2110
Travel time, 1271
Value of interest, 223,676,747,896,925,983,1050,1870,1921,2248
Fee affirmed, awarded or increased
Assessed fee for hearing or rescission of denial
Claimant "ultimately prevails" on Board review, 810
Compensation not reduced, 231,633,660,893,1027
De facto denial
Generally, 257,1398,1540
New medical condition vs. objection to acceptance, 138
"Denied claim" issue, 1398
Extraordinary fee affirmed, 1393
Fee affirmed, 128,138,290,491,1027,1326,1343,1382,1398,1585,1603,1647,1677
Fee increased, 896
Fee not increased, 651
Paid to claimant, 1401
Board review
Basis for, 667,1243,1330,1635,1840
Compensation not reduced, 174,253,676,896,925,1684
Extraordinary fee awarded, 2216
Fee affirmed, 667,983,1655
Fee increased, 1341
Minimal fee, 691
Court of Appeals
Fee for all levels, 1870
Fee for hearing, Board level, 747,1271
Unreasonable conduct
Fee awarded or affirmed
Own Motion case, 634
Unreasonable resistance to payment of compensation, 290
Fee out of, and not in addition to, compensation
Compensation previously paid to claimant, 85,411,1622
None awarded
Own Motion case, 1332,1502,1555,1668,1838,1906,2109
Where PPD reduced, 816
Own Motion case, 151,156,254,269,391,433,455,634,637,822,873,1009,1399,1439,1463,1497, 1893,2009,2023
PPD, 85,711,1926
TTD, 253,294,810,915
Former attorney's fee demand, 154
No fee, or fee reduced
Assessed fee
Compensation reduced, 688,2001,2105,2114
Denial a nullity, 1951,2191
Fee reduced, 43,220,223,353,755,835,1050,1538,1632,1921,2059
No compensation awarded before hearing, 1033
No de facto denial, 383,625,1457,1827
No decision on merits, 1492
No denied claim, 915,2038,2191
No express denial, 903
Post-rescission efforts, 138

ATTORNEY FEES (continued)
No fee, or fee reduced (continued)
Board review
Attorney fee issue, 138,335,651,835,896,1870,2191
Denial moot, 437
No brief submitted, 768
Penalty issue, 651,659,833,835,972,1026,1243,1387
Penalty moot, 437
Unreasonable conduct issue
No separate fee where penalty assessed, 1450
No unreasonable resistance to payment of compensation, 13,653,2038
Responsibility case
Board review
Compensability issue, 56,346,406
Fee limitation, 56,506
No fee, 264
Responsible carrier pays fee, 2097,2207
Hearing
Compensability issue, 691,1333,1677,2157
Extraordinary circumstances warrant fee in excess of limitation, 2127
Fee affirmed; no necessity to take position, 56
Fee limitation, 346,691,1326
Fee sharing issue, 1677
One carrier responsible, other pays fee, 346,438,2161
Responsible carrier pays, 2157
When to request, 1603

BACK-UP DENIAL See DENIAL OF CLAIMS

BENEFICIARIES & DEPENDENTS

BOARD'S OWN MOTION See OWN MOTION RELIEF

CLAIMS DISPOSITION AGREEMENTS See SETTLEMENTS & STIPULATIONS

CLAIMS FILING
Late filing issue
Burden of proof, 911,1577
Employer notification issue, 369,911,1037,1577
New medical condition
Requirements for, 716
Vs. condition omitted from initial acceptance, 45
Withdrawal of claim, employer's attempt, 335

CLAIMS PROCESSING
See also: DETERMINATION ORDER/NOTICE OF CLOSURE; OWN MOTION RELIEF; TEMPORARY TOTAL DISABILITY
Acceptance
Condition in existence prior to, 45,297,1028
Confusing litigation orders; which claim involved, 1883
Following litigation order; effect on appeal, 467
Objection to acceptance: when to process, 257,1900
Objection to updated notice of acceptance at closure, 136
Objection to, vs. new medical condition claim, 136,297,1540
Scope of
Burden of proof, 473
Contemporaneous medical records, 627,1560,2153
Diagnosis vs. procedure, 131
Generally, 346,442,975
No formal acceptance, 2153
Reasonable apprisal, accepted condition issue, 94,191,297,383,473,1342,1393,1540
Symptoms vs. condition, 263,387,497,627,772,1323,2153

CLAIMS PROCESSING (continued)
Classification issue
"Date of injury": occupational disease claim, 25
Disabling vs. nondisabling
Burden of proof, 1094,1396,1659
Generally, 893,1094,1298,1396,1659,1665,1914
When to challenge, 63,1449,1627
Reclassification vs. aggravation claim, 25,63,860
Closure where reopening under Own Motion but while within time to appeal NOC, 1555
New medical condition
Defined or discussed, 1243,1259,1324
New aggravation rights issue, 1285
Reopening requirement, 95,316,531,741,1243,1540,1573,2203
Timely response issue, 1457
Vs. objection to acceptance, 136,1457,1937,2031
When aggravation rights expired, 108,411,682,708,723,730,915,1243,1540,1824,1888,1931, 1986,1993,2081,2212
Penalty issue
Conduct reasonable
Delay in closing claim issue, 1365
Legitimate doubt, 257,1573,1888,2212
No "amounts then due", 903,1026,2038
Timely denial, 1097
Timely response, 1457
Conduct unreasonable
Enforcement, prior order, 2161
Failure to process claim, 1842
Time limitation for raising issue, 1540,2212

COLLATERAL ESTOPPEL
See also: RES JUDICATA

CONDITIONS See OCCUPATIONAL DISEASE, CONDITION OR INJURY

CONSTITUTIONAL AND ADA ISSUES
Due process
Claim classification issue, 25
Permanent disability/limitation on evidence, 561,1953,2024

COVERAGE QUESTIONS
Nonsubject worker issue
Independent contractor, 542,544,1724
Subject worker determination, 2127
Worker not "hired" when injured, 805
Subcontractor without insurance, 2300
Worker leasing company, 2127

CREDIBILITY ISSUES
Failure to call corroborating witness, 1,227
Impeachment of witness: Collateral matter, 792
Medical records
Contemporaneous reporting vs. testimony at hearing, 1426,2008
Referee's opinion
Agreed with, based on de novo review, 1,2081,2093
Deferred to
Claimant an unreliable historian, 961
Generally, 442,1035,1286,1910,2254
Impeachment on collateral matters, 273
Not deferred to
ALJ's speculation unsupported in record, 66
Based on de novo review, 180,1863,2239
Inconsistencies in record, 15,66,1847

CRIME VICTIM ACT
Appeal from denial, timeliness issue, 38,77
Remand to consider additional evidence, 38,77
Standing issue, 38,77

DEATH BENEFITS
Child survivor issue, 2168
In loco parentis discussed, defined, 2168
Widow claims PTD survivor benefits, 1878

DENIAL OF CLAIMS
Aggravation claim; insufficient information, 716
Back-up denial
Burden of proof, 230
Set aside, 230
De facto denial
New medical condition claim vs. objection to acceptance, 136
Noncooperation, **1122**
Penalty issue
Reasonableness question
Conduct reasonable, 149,180,273,307,403,465,704,930,972,1511,1661
Conduct unreasonable, 335,467,1326,2081
Late denial, 467,833,835
"Legitimate doubt" test applied, 149,180,273,403,465,704,1511,1661,2081
No "amounts then due", 157,991,1326,1428
Responsibility case, 346
Preclosure denial
Affirmed, 265,2110
Combined condition claim, **527**
Invalid, 1432,1579,2001,2245,**2308**
Invalid vs. a nullity, 2258
Set aside, 259,918,1432,1579,2001,2245
Valid, 259,265,716,1254,1882,2220,**2314**
Vs. partial denial, 930
Premature, precautionary, prospective
Aggravation claim, 487
Prospective, improper, 781
Set aside as nullity, 487
Scope of
Amended at hearing, 1507,1566
Compensability vs. responsibility, 438
Conditions denied, 1250,1299,1417
Course & scope vs. medical causation, 320,649,1346,1404
Current condition vs. amendment to previous denial, 1380

DEPARTMENT OF CONSUMER & BUSINESS SERVICES

DEPENDENTS See BENEFICIARIES & DEPENDENTS

DETERMINATION ORDER/NOTICE OF CLOSURE
See also: MEDICALLY STATIONARY; OWN MOTION RELIEF
Administrative closure, 810
Medically stationary issue
Ability to return to work, 1544
All (but only) accepted conditions considered issue, 93,112,232,404,796,878,973,1437, 1579,2258
Attending physician's role, 750,1472,1651,1676,1964,1990
Contingent, future surgery recommendation, 371,1478
Date of closure vs. post-closure reports or changes, 1331,1378,1394,1833,1990,2014

*** Bold Page = Court Case ***

DETERMINATION ORDER/NOTICE OF CLOSURE (continued)
Medically stationary issue (continued)
Determinative date: date of closure vs. post-closure changes, 28,61,93,796
Due to injury requirement, 671,1476,1548,2248
Expectation of material improvement issue, 61,93,404,750,787,989,1357,1394,1423,1472, 1676,1832,1853,2140
Future release, 59
Further medical treatment, 147,474,671,715,866,989,1266,1355,1394,1418,1474,1478,1497, 1676,1832,2192
Generality vs. information specific to claimant, 1544
Inappropriate treatment (Director's order final), 1361
New medical condition arises after reopening, 1824,1949,1984
Pain management, 61,1994
Release to modified work, 59
Speculation, 1544,1853
Treatment to improve functional ability vs. condition, 2068,2140,2229
Premature claim closure issue
Burden of proof, 28,112,232,371,377,404,474,671,715,750,796,810,839,878,1266,1357,1367, 1394,1418,1437,1472,1497,1544,1824,1832,1833,1853,1949,1964,2148,2248
Closure affirmed, 59,61,112,147,232,371,404,671,680,715,796,839,866,878,973,1148,1266, 1355,1357,1361,1367,1378,1403,1418,1423,1437,1472,1474,1824,1832,1833,1853,1949,1990, 1994,2014,2148,2192,2229,2248,2251,2258
Closure set aside, 93,474,787,1964,2140
Order on Reconsideration
Mailing requirements, 1739
Validity issue, 417
Who can request, 932
Own Motion closure/new medical condition, 682,730,1540,1573,1824,1949,1984,2148
Reopening under Own Motion but within time to appeal NOC, 1555
Requirements for closure, 1148,2251
Validity issue, 417

DISCOVERY
Evidence in claimant's (not attorney's) possession, 1554
Impeachment potential as basis for avoiding, 2194
Penalty issue, 653,1037

DISPUTED CLAIM SETTLEMENT See SETTLEMENTS & STIPULATIONS

DOCUMENTARY EVIDENCE See EVIDENCE

EMPLOYERS' LIABILITY ACT

EMPLOYMENT RELATIONSHIP See COVERAGE QUESTIONS

ESTOPPEL

EVIDENCE
See also: REMAND
Administrative notice
Agency order, 316,1427,2219
Medical textbook, 2123
Post-hearing backup denial, 1357
Admission of evidence or exhibits issue
Accident reconstruction report, 2119
ALJ's discretion
Abused, 920,2053,2069,2119
Not abused, 161,1546,1607,1915,2036,2219
Late submission
Not timely disclosed, 1607
Post-hearing medical report, 161,1915,2053
Post-hearing request for administrative notice, 2219

EVIDENCE (continued)
Admission of evidence or exhibits issue (continued)
Objection to admission: when to make, 1546
Out-of-state doctor's report, 2086
PPD issue
Arbiter's report, carrier's request, Notice of Closure, 363,932,2181
Arbiter's report; exam after Reconsideration, 2258
Evidence,testimony not part of reconsideration record,107,241,417,1427,2048,2069
PTD issue
Evidence, testimony not part of reconsideration record, 561,2024
Relevancy issue, 2036
Reopening record during closing argument, 1477
Submitted with brief on review: See REMAND
Substitution of document post-hearing, 699
Surveillance video, 1037
"Substantial" discussed or defined, 518,1113

*** Bold Page = Court Case ***

EXCLUSIVE REMEDY
MCO: Suit in civil court against, 2294
Municipality: uninsured motorist insurance vs. workers' compensation, 1151

FEDERAL EMPLOYEES LIABILITY ACT

FIREFIGHTERS

HEARINGS PROCEDURE See REQUEST FOR HEARING (PRACTICE & PROCEDURE)

HEART CONDITIONS See ACCIDENTAL INJURY; MEDICAL CAUSATION; OCCUPATIONAL DISEASE CLAIMS (PROCESSING); OCCUPATIONAL DISEASE, CONDITION OR INJURY

INDEMNITY ACTION

INMATE INJURY FUND

INSURANCE See COVERAGE QUESTIONS; DEPARTMENT OF INSURANCE & FINANCE; EXCLUSIVE REMEDY

INTERIM COMPENSATION See TEMPORARY TOTAL DISABILITY

JONES ACT

JURISDICTION
See also: COVERAGE QUESTIONS
Board
Third party distribution issue, 1410
Board (Own Motion) vs. Hearings Division
Authority to alter Own Motion closure, 1540
Claim closure, 1949,1986
Claim reclassification request more than 5 years after injury, 1627
Compensability, medical services, 160,441,1548
Generally, 160,162,893
New medical condition claim, 108,472,682,708,723,730,734,750,1364,1540,1573,1824,1931, 1949,2145,2212
Responsibility issue, 441
Board vs. Court of Appeals
Incorrect appeal rights, 2020
Noncomplying employer issue, 1924,2020
Order on Reconsideration/Petition for Review, 747

JURISDICTION (continued)
Board vs. D.C.B.S.
Attorney fees, 651
Claim classification, 2187
Compensability, **549**
Medical treatment or fees issue
Generally, 1669,1895
Palliative care, 1006
Reimbursement for prescriptions, 362
Unpaid bill, 1294
Mileage reimbursement, 2125
Penalty issue, 666,886,1934
Board (Own Motion) v. D.C.B.S.
Suspension of TTD for failure to seek treatment, 1405
D.C.B.S.
Authority to abate Order on Reconsideration, **1104,1106**
Subject matter, 1347

LABOR LAW ISSUE
Reinstatement rights/successor business, **1176**
Retaliatory discharge, **1138**
Unlawful employment practices, **555**

LUMP SUM See PAYMENT

MEDICAL CAUSATION
See also: ACCIDENTAL INJURY; DENIAL OF CLAIMS; EVIDENCE; OCCUPATIONAL DISEASE CLAIMS; PSYCHOLOGICAL CONDITION CLAIMS
Burden of proof
"Combined condition" discussed or defined, **1126**,1983
Consequential condition, 954,1094,1097,1440,1579,1940,1957
Major contributing cause defined or discussed, 464,1072,1343,1587,1647,1982,2001,2024
Major vs. precipitating cause, 1566,1587,1988,2256
Necessity for specific diagnosis, 954
Preexisting condition, 170,1097,**1126**,1440,1537,1587,1946,2210,2256
Claim compensable
Consequential condition
Generally, 310,464,1023,1842,1940,2026
Treatment of compensable condition, 37,304
Current condition, 259,287,310,382,392,788,867,872,986,1273,1586,1647,2070
Major cause test met, 1299,1647
Material causation proven, 259,297,442,1246,2059
Preexisting condition
Major cause of combined condition test met, 170
Major cause of, need for treatment test met, 164,191,1072,1330,1343,1528,1537, 1988,1996,2070
Not established, not combined, 1246,2059
Sufficient medical evidence, 254,354,1094,**1132**,1507,1531,1842,1937,2208
Claim not compensable
Consequential condition, 118,157,185,188,193,337,387,431,435,448,701,954,1045,1097,1517, 1579,1900,1957,2024,2248
Current condition, 235,263,339,638,641,716,849,985,1045,1254,1281,1306,1323,1479,1494, 1521,**1707**,1983,2008,2042,2256
Insufficient medical evidence, 131,168,396,500,696,876,991,1267,1318,1440,1460,1481,1632, 1653,1851,1855,2040,2059,2062,2086,2112,2153,2224
Material causation test not met, 270,282,742,1306
New medical condition, 846,1982,2017
Preexisting condition
Major cause, need for treatment not proven, 58,378,385,390,627,745,986,**1126**, 1566,1587,1642,1946,1983,1984,2001,2008,2024,2210,2231
No combining, 1417

MEDICAL CAUSATION (continued)
Direct & natural consequences
Injury during IME, **2262**
Injury during physical therapy, 304

*** Bold Page = Court Case ***

MEDICAL OPINION
Analysis v. conclusory opinion
Conclusory opinion
Conclusory statement, no analysis, 66,79,118,320,322,339,346,385,617,621,745, 825,907,936,938,1065,1099,1333,1460,1494,1590,1621,1639,1915,1940,1943,1958, 2008,2173,2256
Lacks persuasive analysis, 13,20,26,131,174,188,192,227,297,313,346,382,435,448, 649,727,905,985,1258,1273,1357,1368,1383,1443,1521,1601,1843,1844,1861,1937, 1943,1984,2008,2062,2070,2076,2112,2225,2248,2250
Persuasive analysis, 34,39,121,136,164,200,320,382,435,745,843,871,907,963,1035,1072, 1264,1286,1440,1489,1537,1550,1632,1647,2033,2086,2121
Based on
ALJ's taking official notice of technical fact, 1528
"But for" analysis, 780,900,1343,1470,1944,2221
Changed opinion explained, 1072,1466,1489,1501,1676
Complete, accurate history, 4,7,24,82,90,121,164,167,220,266,382,400,442,479,617,63,668, 854,871,1050,1065,1072,1078,1246,1343,1376,1440,1479,1603,1619,1639,1683,1876,1910, 1937,2008,2010,2070,2084,2177,2202,2225,2254,**2268**
Consideration of work, non-work causes, 96,164,170,435,986,1526,1537,1647,1819,1996
Correct understanding of work exposure, 465,676,792,843,1550,2121,2202
Disproving non-work causes, 1050,2121
Expertise: greater/lesser, 2,118,461,701,742,1273,1376,1378,1517,1819,1996
Failure to address relative contributions of work, non-work causes, 114,136,167,318,337, 395,397,431,432,518,649,729,862,907,929,936,1024,1097,1343,1368,1550,1566,1599,1607, 1820,1845,1944,1982,2001,2172,2221,2256
Failure to consider all factors, 2,188,200,238,320,380,387,461,626,742,780,825,954,1079, 1454,1460,1470,1526,1587,1601,1861,1943,1946,2042,2059,2070,2089,2205,2221,2248
First exam long after critical event, 991,1254,2138
General information vs. specific to claimant, 174,977,1035,1368,1489,1661,1819,1980
Inaccurate history, 1,13,17,36,39,66,101,104,122,131,154,185,188,238,266,272,274,288,307, 318,346,378,380,385,410,431,432,445,461,469,502,663,727,728,783,833,844,905,949,954, 959,986,991,999,1002,1014,1050,1061,1306,1318,1454,1470,1489,1494,1495,1550,1566,1619, 1692,1820,1908,1909,1910,1918,2011,2017,2040,2070,2112,2131,2205,2239,2248,2254
Incomplete history or records, 333,395,621,844,872,1008,1017,1246,1286,1299,1333,1376, 1380,1470,1647,1663,1915,1940,1957,2062,2138,2140,2243
Inconsistencies, 7,58,90,114,131,168,288,339,432,448,502,621,660,703,882,923,954,1079, 1116,1246,1264,1296,1306,1318,1348,1363,1494,1530,1566,1594,1607,1630,1647,1845,1855, 1903,2094,2095,2152,2196
Incorrect assumption, 337,385,702,991
Law of the case, 351,660,825,1479
Long term vs. short term treatment, 1378
"Magic words," necessity for, 28,313,344,686,783,843,849,862,999,1367,1437,1528,1853
Opinion of another physician, 378,397
Opinion of another physician about another patient, 2076
Possibility vs. probability, 28,172,192,193,220,237,282,292,318,339,663,728,742,833,996, 1087,1090,1246,1521,1566,2166,2202,2250
Records review vs. exam, 131,320,385,701,1376,1940
Single exam vs. long-term treatment, 96,282,297,1843,1904
Speculation, 7,442,646,1047,1077,1607,1632
Temporal relationship, 185,220,385,775,962,1079,1254,1534,1601,1632,1903,1909,1959, 1980,1984,1996,2177
Treatment before, after key event, 185,227,1296,1588
Written by lawyer, concurred with by physician, 1273

MEDICAL OPINION (continued)
Necessity for
Criteria to determine, 238,961,1446,1900,1905
Impairment issue (PPD), 102
Injury claim
Consequential condition, 131,185,310,954,1940,1957
Current condition, 985,1246,1460,1587
Delay in diagnosis, 1318
Delay in onset of symptoms, 238,461,742,961
Delay in reporting, 15,83,227,238,461,770,961,1446
Delay in seeking treatment, 101,461,2042
Multiple possible causes, 131,188,197,310,330,461,745,770,849,900,926,961,978, 999,1094,1246,1267,1299,1306,1460,1521,1590,1603,1632,1820,2208,2254
Preexisting condition, 83,131,164,227,272,330,380,385,647,986,999,1014,1286,1343, 1348,1383,1521,1599,1630,1647,1663,1845,1909,1915,1944,1982,2001,2013,2173, 2208,2231
Worsened condition, Own Motion case, 254
Occupational disease claim, 114,167,200,213,344,406,859,949,1047,1090,1306,1368,1380, 1459,1470,1661,1943,1998,2062,2076,2121,2225,**2268**
Psychological condition claim, 2131
Responsibility case, 2243
Scope of acceptance issue, 1342
Stress-caused physical condition claim, 1428
Treating physician
Opinion deferred to
Attending physician status challenged, 479
Changed opinion explained, 31,254,663,1042,1050
Generally, 69,121,259,297,464,474,668,702,986,1012,1264,1348,1376,1915,2121,2210
Long-term treatment, 93,96,170,254,282,1383,1588,1904,1937
Surgeon, 164,180,254,297,310,442,479,506,1286,1299,1322,1383,1528,1588,1996, 2208,2243
Treatment before, after key event, 1528,1996,2208
Treatment begun long after key event, 7,15
Opinion not deferred to
Analysis vs. observation, 272,385,387,775,963,999,2221
Generally,193,238,317,337,431,445,505,621,646,647,844,872,926,940,1002,1014, 1079,1566,2095,2205
Inadequate analysis, 200,431,621,729,770,862,978,1024,1368,1861,1944,2248
Inconsistent or contrary opinions, 58,114,131,168,200,288,307,339,390,448,660,849, 882,999,1053,1306,1357,1440,1855,1946,1960,1983,2008,2152
One-time evaluation, 13,114,318,1061,2196
Treatment begun long after key event, 193,272,963,991,996,1045,1061,1440,1632, 2059

MEDICAL SERVICES
See also: JURISDICTION

MEDICALLY STATIONARY
See also: DETERMINATION ORDER/NOTICE OF CLOSURE; OWN MOTION
Defined or discussed, 28,112,232,787,866,2140

NONCOMPLYING EMPLOYER See COVERAGE QUESTIONS; DENIAL OF CLAIMS

NONSUBJECT/SUBJECT WORKERS See COVERAGE QUESTIONS

O.S.H.A See SAFETY VIOLATIONS

OCCUPATIONAL DISEASE CLAIMS (FILING)

OCCUPATIONAL DISEASE CLAIMS (PROCESSING)

See also: FIREFIGHTERS; PSYCHOLOGICAL CONDITION CLAIMS; SUCCESSIVE EMPLOYMENT EXPOSURES

Burden of proof

Generally, 200,465,852,882,946,1024,1306,1368,1380,1470,1576,1661,1861,1943,2084,2121, 2225,2250

Last injurious exposure rule, single claim, 953,1340,1674,**2268**

Major contributing cause defined or discussed, 213,852,862,929,1380,1459,1470,1534,1661, 1861,2221,2225

Necessity for definitive diagnosis, 1069,1077

Objective findings, 687,**2275**

Preexisting condition

Anatomy as, 699

Defined or discussed, 12,1067,1389,1639,1900,2011

Generally, 114,119,178,200,213,344,617,862,924,1047,1090,1389,1943,2011

Symptoms vs. pathological worsening, 119,1047

Symptoms as disease, **1113**,1534,1576,1639

Work exposure, 1980

Claim compensable

Major contributing cause test met, 167,266,387,465,617,663,668,833,843,854,931,977,998, 1050,1077,1264,1322,1470,1489,1550,1639,1661,1819,1998,2084

Objective findings test met, 687,2084

Preexisting condition

Major cause, pathological worsening established, 617,1070,1619

None found, 2177

Sufficient medical evidence, 40,136,676,791,792,881,953,1069,2035,2194,2202,2204

Claim not compensable

Insufficient medical evidence, 20,36,114,192,237,274,314,333,463,621,663,727,859,892,923, 948,962,977,1008,1029,1047,1079,1306,1368,1454,1457,1513,1530,1554,1598,1630,1650, 1903,1905,1943,1958,1959,1960,1978,1980,2062,2076,2094,2095,2100,2180,2225,2250

Major cause test not met, 196,318,626,646,687,729,780,783,838,852,882,929,949,959,1024, 1090,**1113**,1258,1340,1380,1534,1573,1601,1836,1861,1900,1970,2221

Objective findings test not met, 620,**2275**

Preexisting condition

Major cause test not met, 12,178,344,699,749,924,1859,1943

Pathological worsening not established, 119,213,215,344,862,924,1067,1389,2011

Toxic exposure, 1980

"Onset" of disease, 838

Vs. accidental injury, 27,196,204,566,639,882,**1111**,1264,1306,1383,1513,1630,1961,2172,2250

Vs. aggravation, 1070

OCCUPATIONAL DISEASE, CONDITION OR INJURY

ACL tear, 330

Adhesive capsulitis, 94

Arachnoiditis, 949,2086

Aspergilloma, 274

Calcific tendonitis, 178

Carpal tunnel syndrome, 13,20,90,122,167,266,318,465,626,663,668,687,780,783,833,854,929,934, 943,953,977,998,1029,1067,**1113**,1340,1489,1526,1530,1534,1554,**1709**,1819,1828,1903,1943,2035, 1960, 1978,2035,2177,2194,2202

Cellulitis, 2200

Chondromalacia, 442

Chronic pain syndrome, 1531

Chronic regional pain syndrome, 1517

Coccydynia, 963

Costrochondritis, 2013

Cubital tunnel syndrome, 36

Deep vein thrombosis, 701

Dementia, **1132**

OCCUPATIONAL DISEASE, CONDITION OR INJURY (continued)
deQuervain's tenosynovitis, 2231
Epicondylitis, 1957,2084,2231
Ganglion cyst, 843
Headaches, 1980
Hearing loss, 12,406,**536**,838,1258,1619,**2268**
Hepatitis C, 892,2100
Hernia, 926,978,1607,1663,1905
Impingement syndrome (shoulder), 94,193,2062,2204
Lateral epicondylitis, 387,676,941,1601
Latex allergy, 835
Migraine headaches, 1859
Myocardial infarction, 1428
Myofascial pain syndrome, 741
Necrosis, 702
Osteochondritis dissecans, **1126**
PCS, **1707**
Plantar fascitis, 431,729,2221
Post-concussion seizure disorder, 1460
Rotator cuff tear, 2076
Spondylolisthesis, 1267,1306,1566
Substance exposure, 791
Syncope episode, 2005
Tarsal tunnel syndrome, 1550
Taylor's bunionette, 1008
TMJ, 92
Torticollis, 1940
Toxic exposure, **2275**
Trigger-finger or thumb, 1998
Ulnar neuropathy, 387,941,1470,1881

OFFSETS/OVERPAYMENTS
Allowed
TTD vs. PPD, 468
TTD (Own Motion) v. TTD (new condition claim), 1658
Redetermination of PPD following ATP, 222

OWN MOTION RELIEF
See also: ATTORNEY FEES; AGGRAVATION CLAIM (PROCEDURAL); DETERMINATION ORDER/NOTICE OF CLOSURE; JURISDICTION
Consolidation with pending case, 1506,1948
Date of disability, 9,49,50,88,98,162,218,358,370,457,765,1021,1442,1452,1643,1695,1850,1896,2030, 2143
Deferral
Pending compensability litigation, 5,414
Pending Director's review of medical services issue, 52,1321,1448,1634
Pending litigation of aggravation rights, 1868
Dismissal of request for relief issue moot, 478
Enforcement issue, 362
"Futility" discussed or defined, 643,1021
Hospitalization defined or discussed, 452
New medical condition claim, Board's authority, 108,493,682,708,723,730,734,750,1888,1931,1986, 2083,2145,2212,2233
Order designating paying agent (consent)
Allowed, 18,252,645,2116
Allowed for medical benefits only, 1293
Denied, 2037
Postponement until hearing completed (new medical condition claim), 2233
Reconsideration request, 358,827,1364,1628

OWN MOTION RELIEF (continued)
Reconsideration request denied, untimely, 301,761,1899
Referral for hearing, 415,493,648
Relief allowed
*** Bold Page = Court Case ***
Carrier request
Pre-1966 home site modifications, 1256
Pre-1966 medical services, 423
Suspension of TTD, 1405
Claimant request
Closure
Modified, 2009
Set aside, 93,474,750,1325,1331,1394,1497,1964
Medical services, pre-1966 injury, 254,759,769,1021,1611,2015
Penalty, 151,362
Temporary disability
Attending physician's authorization issue, 1009,1898
Burden of proof, 433,457,1468
Change in start date, 145
Due to injury requirement met, 160,254,455,793,820,995,1605,2186
Extended to medically stationary date, 2237
Futile to seek work, 50,1893
In ATP at time of disability, 873
In work force, 271,424,455,498,726,762,820,880,1463,1850,2019,2052
Payroll records, legitimacy of employer questioned, 88
Receipt of Social Security, 994
Receipt of TTD in another claim, 9,269
Self-employment, 823,2160
Surgery, hospitalization criteria met, 1091,1332,1350,1364,1555,1668,1838, 1906,2056
Surgery reasonable, necessary, 1439,2238
Termination of benefits improper, 151
Unemployment benefits, receipt of, 49,367,1442
Willing but unable to work, 98,433,1468,1989,1997,2238
Willing to, and seeking, work, 637,1643,1695
Worsened condition required surgery, 1962,2109
Relief denied
Carrier request
Suspension of TTD, 1483
TTD: claim remains open; issue moot, 1499
Claimant request
Closure affirmed, 51,54,59,61,143,146,147,232,371,377,671,680,708,715,723,730, 734,839,866,878,989,1266,1355,1367,1378,1403,1418,1423,1437,1472,1474,1476, 1478,1544,1548,1824,1832,1833,1920,1925,1949,1977,1986,1990,1994,2014,2068, 2148,2192
Penalty, 634,839,2056
Permanent partial disability, 147,250,878,1403,1474,1994
Pre-1966 injury, medical service, 1919,2016,2055
Temporary disability
Burden of proof, 457,1302,1509,2143
CDA extinguishes right to TTD, 32,1261,1272
Claimant retired, 162
Claimant working full time, 146
Due to injury requirement not met, 74,127,234,393,437,440,441,619,662, 817,819,827,895,974,976,1046,1085,1496,1533,1658,1896,1912,2021,2165
Futility issue, 218,250,262,457,643,765,1021,1452,1896,2030,2143
No surgery, hospitalization, 148,198,301,452,875,1031,1270,1509,1628
Noncompensable surgery, 1280
Not in work force at time of disability, 65,358,370,980,982,1302,1370
Pending claim closure, 839

OWN MOTION RELIEF (continued)
Relief denied (continued)
Claimant request (continued)
Temporary disability (continued)
Receipt of SSD, 1896
Release to return to regular work, 839
Unresolved medical treatment issue, 1372
Willingness to work issue, 2004
Request for hearing denied, 1423
Request withdrawn, 72,81,490
"Surgery" discussed or defined, 52
Temporary disability: inclusive dates, 878

PAYMENT
Attorney fee paid to claimant, 1401
Penalty for late payment issue: Conduct reasonable, 2078
PPD award
Erroneous but not appealed, 1685
Suspended during ATP, 425
Timeliness issue, 2078
Pre-ATP award, post-ATP redetermination, 425

PENALTIES
"Amounts then due" requirement, 13,818,1326
Enforcement issue, 483,2161
PPD award, ATP, new award, enforcement issue, 425

PERMANENT PARTIAL DISABILITY (GENERAL)
Apportionment, **536**
Authority to remand to Director to
Obtain clarification of arbiter's report, 241
Promulgate temporary rule, 889,2178,2241
Vs. requesting abatement of reconsideration order, 1373
Burden of proof, 85,660,909,981,1675,1856,2241,**2302**
DCBS/WCD
Authority to decide issues not raised by parties, **1713**
Objective findings, 673
Penalty issue, 204,425,483,883,1057,1373,1387,1685,2142
Reconsideration request
Carrier's role, Notice of Closure, 363,932
Redetermination, post-ATP, affect on prior award, 425
Standards
No temporary rule needed, 92,2178
When to rate
Generally, 79,85,660,778,876,1579,1656,1867,1926,2028
Worsening after closure, 327,748,1053
Whether to rate
Redetermination following ATP, 222
Surgery, **1700**
Who rates
Arbiter's role in non-impairment questions, 2284
Attending physician
Concurrence with IME vs. arbiter, 660,794,1636,1873
Concurrence with PCE vs. arbiter, 34,79,85,411
Non-concurrence with IME, 2006
Non-concurrence with PCE, 355
Vs. arbiter, 55,57,116,241,275,284,291,327,351,417,673,748,778,976,909,925,1042, 1053,1400,1443,1579,1594,1683,2005
Vs. PCE, where exam before medically stationary, 204
Vs. PCE with concurrence, 932,1081

PERMANENT PARTIAL DISABILITY (SCHEDULED)

Affected body part
- Ankle, 327,446,673,1294,1375,1613,1926
- Arm, 284,925,1679,1683,2156
- Elbow, 703
- Eye, 829,981
- Fingers, 275,291
- Foot, 324,808,1042,1276,1713
- Forearm, 126,714,1100,1443,1549
- Hand, 303,738,1857
- Hearing loss, 343
- Hip, 2048
- Knee,360,411,1877,2028
- Leg, 116,241,1400,1552,1556
- Thumb, 275,939
- Tinnitus, 2178
- Wrist, 1671,1856,2241,**2302**

Factors considered
- Apportionment issue, 343,2048
- Chronic condition
  - Award made or affirmed, 241,303,360,932,1100,1683,1926
  - Award reduced or not made, 116,284,324,446,673,703,939,1294,1400,1549,1679, 1856,1877,2241
  - "Significant" limitation issue, 1856
- Conversion (multiple body parts), 275
- Credibility, 126
- "Direct medical sequelae" issue, **1713**
- Due to injury requirement, 275,714,829,876,1042,1276,1375,1671,1683,1684,**1713**,1877,2028
- Instability/laxity, 324
- Offset for prior award, same claim, 1926
- Permanency requirement, 284,1100
- Range of motion
  - Conformity with standards, 1857
  - Contralateral joint comparison, 275,808,1613,2028
  - Generally, 932
  - Validity issue, 1683,**2302**
- Repetitive use, loss of, 808,1549,1856
- Sensation, loss of, 275,673,1443,1552
- Strength
  - Grip, 303,932
  - Loss of, 126,241,284,925,1552,1556,2156
- Walk/stand limitation, 411,446

PERMANENT PARTIAL DISABILITY (UNSCHEDULED)

See also: PERMANENT PARTIAL DISABILITY (GENERAL)

Apportionment, 711

Back & neck
- No award, 55,355,794,876,909,938,1081,1306,1438,1584,1892,2028,2117
- 1-15%, 34,79,85,99,112,711,778,869,887,1427,1464,1873,2258
- 16-30%, 57,363,417,660,1515,1556,1594,1675,1963
- 33-50%, 485,1053

Body part or system affected
- Abdominal condition, 334
- Facial nerve injury, 2178
- Head injury, 4,349
- Multiple conditions, 1759
- Psychological condition, 351,1289,2206
- Pulmonary condition, 748
- Respiratory injury, 1688

PERMANENT PARTIAL DISABILITY (UNSCHEDULED) (continued)
Body part or system affected (continued)
Shoulder, 102,204,275,635,883,925,1278,1656,1679,**1700**,1953
TMJ, 92
Uterine condition, 889
Factors considered
Adaptability
BFC (base functional capacity) issue, 204,883,1515
Release or return to regular work issue, 99,711,887,1278,1656
RFC issue, 204,485,1053,1953
SVP issue, 363,1053,1953
Impairment
Apportionment issue, 1556,1594
Chronic condition
Award made or affirmed, 275
Award not made or reduced, 102
Multiple body parts, 275
Combined condition, 1556
"Direct medical sequelae," 1464
Due to injury requirement, 55,85,106,112,275,417,778,794,876,907,938,1289,1306,1427, 1579,1584,1656,1675,1873,1892,2028,2258
Law of the case, 351
Objective findings issue, 417,794
Prior award, 1556
Range of motion
Contralateral joint, 204
Due to injury requirement, 106
Validity issue, 34,79,85,417,869,1081,**1713**,**1737**,1892,1963,2117
Strength, loss of, 204,635,925
Surgery, 1278,1556,**1700**
Worsening since last arrangement of compensation requirement, **2284**

PERMANENT TOTAL DISABILITY
Award
Affirmed, 356
Refused, 21,**561**,697,1592,2024
Burden of proof
Odd lot doctrine, 697,2024
Factors considered
Medical issues/opinions/limitations
Due to injury requirement not met, **1707**
Preexisting condition not disabling at time of injury, 2024
Preexisting condition worsens post injury, 1592
Vocational issues, evidence
Futility issue, 21
Non-attending physician's opinion on ability to work, 356
Vocational evidence, 697
Willingness to work issue, 21,697

PREMATURE CLAIM CLOSURE See DETERMINATION ORDER/NOTICE OF CLOSURE

PREMIUM AUDIT ISSUE See COVERAGE QUESTIONS

PSYCHOLOGICAL CONDITION CLAIMS
- Occupational disease claim
  - Burden of proof
    - "Clear and convincing evidence" discussed, 1428
    - Diagnosable mental disorder, 1971
    - Disciplinary actions, **1732**
    - Generally, 2131,2216
    - "Generally inherent" stressors, 494,**523**,**1732**
    - Precipitating vs. major cause, 96
    - Preexisting condition, 96,1626
  - Claim compensable
    - Major cause, combined condition and worsening, 96
    - Real and objective stressors, 2216
    - Stressors not generally inherent, 494,**523**
  - Claim not compensable
    - Insufficient medical evidence, 2131
    - No diagnosable mental disorder, 1971
- Physical condition, stress caused, 1428
- Relationship to physical injury claim
  - Burden of proof, 69
  - Claim compensable
    - Sufficient medical evidence, 69,686,1879
  - Claim not compensable
    - Current condition, 288
    - Major cause test not met, 1844

*** Bold Page = Court Case ***

REMAND
- By ALJ
  - To WCD Director, reversed, 1057
- By Board
  - Motion for, allowed
    - Due diligence test met, 920
    - Post-hearing arbiter's report (causation issue), 1869
    - Post-hearing surgery report, information, 450,763,941
  - Motion for, denied
    - Case not insufficiently developed, 3,657,1953,1984
    - Evidence available with due diligence, 171,654,774,784,960,1257,1431,1653,1673, 1880,1918,1978,2036,2046,2164,2200,2224,2225
    - New information not likely to affect outcome, 3,118,171,230,454,653,774,784,960, 961,1029,1257,1336,1339,1340,1401,1431,1554,1653,1673,1674,1697,1851,1880, 1918,2046,2048,2104,2164,2200,2224,2225
    - No compelling reason for, 469,**1132**,1336,1339,1654,1674,1687,2209
    - Proffered documents (on Board review) not admissible, 107
    - To assign to new ALJ, 1554,2209
    - To DCBS to promulgate rule, 92
    - To join with WCD case, 848
  - To ALJ
    - Order remanding vacated, 1646
    - To complete, correct, order, 1514
    - To consider motion to postpone hearing, 357,946,1303,1670,1907
    - To defer case pending DCBS action (PPD issue), 796,2251
    - To determine
      - Causation issue, aggravation claim, 33
      - Causation, new medical condition, 763,941,1514
      - Compensability, 2119
      - New medical condition claims processing (aggravation rights expired),108
    - To obtain exhibits missing from record, 1505
    - To republish Opinion & Order, 153
    - To take testimony, give rights to unrepresented claimant, 1084

REMAND (continued)
By Board (continued)
To DCBS
Motion for, denied
To obtain further report from arbiter, 748
To promulgate temporary rule, 889
To promulgate temporary rule for deceased worker, 75
By Court of Appeals
To determine
Course & scope, **2286**
PPD, **1737,2302**
TTD rate, extended gaps issue, **1720**
Whether acceptance occurred before denial (combined condition), **2305**
To determine compensability
Aggravation claim, **1116**
Current condition claim, **549**
Hearing loss claim, **2268**
Psychological claim, **1732**
By Supreme Court
To determine whether aggravation proven, **510**
To remand to WCD to promulgate temporary rule, **1700,1970**

REQUEST FOR HEARING (FILING)
Late filing issue
Denial
Good cause issue
Attorney neglect, 1666
Confusion, 1666
Incorrect address on denial, 1837
Mental incapacity, **1132**
Misunderstanding of claims processing, 1566,1690
Reliance on employer's representation, **1717**
Untimely, request for hearing, 1420,1566
Failure to process claim properly, 2145
Order on Reconsideration (D.O. or N.O.C.)
Generally, 60,73,**1106**
"Mailing" discussed, 73,**1739**
Noncooperation denial: necessity to request expedited hearing, **1122**
Sanctions for frivolous appeal
Colorable argument, 487,1420
No basis for, 651
Request denied, 487,651,1250,1420

REQUEST FOR HEARING (PRACTICE & PROCEDURE)
ALJ's role in determining legal standard, 1052
Dismissal, Order of
Affirmed
Attorney requests, *pro se* claimant appeals, 456,657,754,865,1032,1430,1510,1641
Burden of proof, 657, 754,1032
Claim reclassification request, untimely, 1627
Failure to appear, 790,1386,2195
Insurer's failure to appear, 19
No rebuttal of presumption hearing notice mailed, 19
Premature request for hearing, 1259
Unjustified delay, 394
Without prejudice, 1492
Claimant dies pending review, no beneficiary, 636
Jurisdictional issue, 666
"Final, appealable order" discussed or defined, 1978

REQUEST FOR HEARING (PRACTICE & PROCEDURE) (continued)
- Incorrect appeal rights, 2020
- Issue
  - Determination Order or Notice of Closure
    - Raised on reconsideration requirement, 417,698,2218
  - No claim in writing, no agreement to litigate, 45
  - Not raised, 325
  - Not raised; ALJ shouldn't decide, 2161
  - Not ripe, 325
  - Properly raised at hearing, 698
  - Raised at hearing, should be decided, 390,487,1937
  - Raised first in closing argument, not considered, 1326
  - Raised in pleadings, closing argument, 856
  - Untimely raised, 1075
  - Waiver of, or waiver of objection to, 33,856
- Motion to dismiss
  - Denial affirmed: failure to cooperatie allegation, 273
- Motion to reopen record, 1559
- Motion to vacate Opinion & Order, 1357
- Postponement or continuance, motion for
  - ALJ's discretion
    - Abused, 2053
    - Not abused, 1299,1536,1559,1828,1978
  - Denied
    - Failure to act with due diligence, 1828,1978
    - No "surprise", 1299

REQUEST FOR BOARD REVIEW (FILING)
- Dismissal of
  - Claimant dies; no beneficiaries, 1245
  - Compensability issue moot; post-hearing claim acceptance, 467
  - Untimely filing, 1572,2057
- "Filing" discussed or defined, 946,984,2057
- Motion to consolidate cases, denied, 326
- Motion to dismiss
  - Allowed
    - Failure to give timely notice to all parties, 11,1252,2022
  - Denied
    - Necessity for Opinion & Order to be mailed to correct address, 153
    - Timely filed, 946,984
    - Timely mailed to parties, 169
    - Timely notice to all parties, 670,786
    - Unappealed post-hearing denial, same condition, 90
  - Presumption of untimely mailing, 984
- "Party" defined or discussed, 169,830
- Sanctions for frivolous appeal
  - Colorable argument, 60,325,651,904,1373,1491
  - "Frivolous" discussed or defined, 158,651
  - No argument presented, 335
  - Request denied, 60,158,325,335,487,651,784,1373,1491
  - Unrepresented claimant, 784

REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE)
- Board's role in case review, 10,96,940,1560,2124
- Brief (second) not considered, 883
- Consolidation
  - Motion for denied, 1592
  - Two cases, for review, 825,830
- Cross-request, necessity for, 2123,2210

REQUEST FOR BOARD REVIEW (PRACTICE & PROCEDURE) (continued)
En banc review, request for, 940
Findings of fact: necessity for Board to describe, 1255
Issue
Distinguished from legal theory, 2066
Not raised at hearing
Not considered on review, 310,314,335,392,451,482,774,810,846,1053,1072,1254, 1267,1540,1593,1831,1945,1956,1993,2031,2084,2105
Raised at hearing, considered on review, 810,825,828
Raised first in Request for Reconsideration, 25,848
Waiver of right to challenge, 310
Whether raised at hearing: course & scope denial, 320
Motion to allow late filing of brief denied, 936,2075
Motion to extend briefing schedule, 1991
Motion to stay (abate) decision, 1409,1512
Motion to Strike Brief
Allowed
References to evidence not in record, 1431
Untimely, 2026
Untimely, no extraordinary circumstances, 1504,1946
Not allowed
Argument vs. evidence outside record, 118
Issues discussed properly raised, 2231
No prejudice to responding party, 2184
Timely filed, 486,2184
Motion to strike retainer agreement, 1401
Oral argument, request for, 940,1243
Reconsideration request
Denied, untimely filed, 1063,1251,1338,1467
Republication (copy not mailed to party), 789,830
Scope of review, 825

REQUEST FOR REVIEW--COURTS (INCLUDES FILING, PRACTICE & PROCEDURE)
Order on Reconsideration/Petition for review, 747,1697

RES JUDICATA
Prior litigation
Claim or issue litigated or precluded
DCS/current condition denial (same condition), 630
Denial, unappealed/denial, same injury, new conditions, 1566
Partial denial/occupational disease (same condition), 1324
Stipulation/partial denial, 1623
Claim or issue not litigated or precluded
Aggravation claim denial/new medical condition claim, 2086
Aggravation claim (invalid)/aggravation claim, 1956
Case remanded to Director/PPD issue, 2178
CDA/claim for new medical condition, 1318,1507
Claim closure/new medical condition claim, 1993,2212
Claim withdrawn, denied/new claim, same condition, 1677
Classification/compensability, aggravation denials, 316
Current condition denial/claim for condition omitted from acceptance, 45
DCS/new claim, new condition, 2254
Denial, aggravation/denial, aggravation (same facts), 890
Denial, combined condition/denial, preexisting condition, 1281
New medical condition/new medical condition claim, 479
Own Motion denial of reopening/new medical condition claim, 1888
Updated Notice of Acceptance/omitted condition, 1881

RESPONSIBILITY CASE See SUCCESSIVE EMPLOYMENT EXPOSURES

SAFETY VIOLATIONS

SETTLEMENTS & STIPULATIONS

See also: JURISDICTION; RES JUDICATA

*** Bold Page = Court Case ***

Claims Disposition Agreement
- Order disapproving
  - Board's request for addendum ignored, 2045,2047
  - Carrier request for disapproval, 1942
- Order approving
  - Assignment of obligation to make payments, 199
  - Claim processing function not performed, 902,1620,2032
  - Claimant request for disapproval, 1391,1609
  - Higher education fulfills vocational training information, 197
  - Multiple claims, 350
  - Post-submission payment as advance/overpayment, 22
  - Release of non-medical rights, 199
  - Spousal signature as acknowledgement of claimant's release, 430
  - Third party lien waived, 1260,2107
  - Waiver of cooling off period, unrepresented claimant, 23
  - With clarification of typographical error, 62,229,508,661,766,770,799,800,832,1044, 1064,1066,1525,2041
  - With Director's signature line blank, 1839
- Penalty for late payment of proceeds, **1135**
- Reconsideration request
  - Denied: Untimely, 481,1371,1942
- Submission date defined or discussed, 22

Deduction of settlement amount from uninsured motorist award, **573**

DCS
- Assignment of proceeds to third party, 1458,2115
- Limitation of matters approved, 831
- Vs. stipulation, to resolve denied claim, **2310**

Settlement stipulation void, **2310**

SUBJECT WORKERS See COVERAGE QUESTIONS

SUCCESSIVE (OR MULTIPLE) EMPLOYMENT EXPOSURES

Aggravation/new injury or occupational disease
- Burden of proof
  - Generally, 158,506,1296,2236
  - "Involving the same condition," 346,506,**527**,**538**,1333,1521,1560,2243
- First claim responsible, 1296,1560,1603,2236
- Neither claim compensable, 435,639,1494,1500,1521,2112
- New injury proven, 154,506,**527**,911,1333,2138,2243
- New occupational disease proven, 387
- Shifting back to prior employer after acceptance, **527**,**538**

Last injurious exposure issue
- Apportionment issue, **536**
- As defense, 2097
- Initial assignment of responsibility, 122,346,406,932,1535,1677,**1709**,1998,2089,2097,2182
- No carrier responsible, 122
- Onset of disability, 122,406,1998,2182
- Shifting responsibility
  - Burden of proof, 122,406,1535,2182
  - Not shifted, 346,934,1535,1677,**1709**,1998,2097,2182
  - Shifted to earlier exposure, 406
  - Shifted to later exposure, 2089
  - To non-joined carrier, 122
- "Treatment" defined or discussed, **1709**
- Vs. actual causation, 2089,2097

Last injury rule, 2097,2243

Multiple accepted claims, 263,**527**,640,1105,1521,2185

Oregon/out-of-state claim (or vice versa), 479,641,943

TEMPORARY TOTAL DISABILITY (See also: JURISDICTION; OWN MOTION RELIEF; PAYMENT)
Burden of proof, 43,204,1635
Entitlement
ATP plus Own Motion relief; calculation of benefit, 873
Authorization
"Attending physician" issue, 1613,1914
Chiropractor, 1441
Claim denial set aside; open-ended authorization, 1968
Inference of, from records, 688,1635
Necessity for, 43,417,492,688,786,808,1243,1914
Retroactive, 249,417,468,492,688
Substantive vs. procedural, 249,492
Verification of inability to work, 2066
Due to injury requirement, 824,2105
Inappropriate treatment, 1361
New medical condition claim, 253
Own Motion case: inclusive dates, 878
Where closure order not appealed, 2218
Withdrawal from work force issue, 688,1883
Interim compensation
Aggravation claim, 368,401,716,1527,1952
Inclusive dates, 716,1356,1433
New medical condition claim, 294,1243,1354
Original claim
Attending physician authorization issue, 144
Requirements for, 144
Penalty issue
Failure to pay
Conduct reasonable
Generally, 43,824,1243,1527,1540,2174
Legitimate doubt, 129,716,1356,1433
No "amounts then due," 368,400,655,808,1527,2176
Conduct unreasonable
Generally, 174,1433,1450,1613,2227
Legitimate doubt, 1433,2145
Pro rata distribution: two open claims, 269
Rate
52 weeks' earnings, average, 204,655
"Actual weeks" of work, 676,2158
Burden of proof, 655
Extended gaps issue, 655,676,1720,2158,2246
Injury vs. occupational disease: "date of injury," 204
Patronage dividends, 2271
Vacation pay, 2158
Suspension, 1405,1481
Temporary partial disability
Claim denial set aside; open-ended authorization, modified work, 1968
Modified work or offer
Medical approval requirement, 2174
New restrictions require new job offer, 129
Physician's "release" questioned, 2125
Refusal of job because of unrelated problems, 856
Return to regular work followed by modified work release, 2189
Undocumented worker released to modified job, 2103
Worker fired for reason unrelated to work, 1304
Worker quits; no suitable transportation, 692
New limitations imposed after termination (firing), 174,1883
Own Motion case, 839
Terminated worker; cause of termination issue, 105,1450,2174

TEMPORARY TOTAL DISABILITY (continued)
Termination
Failure to receive modified job offer, 2227
Improper: release to modified work, 1613
"Regular work" discussed or defined, 1613
Unilateral, Own Motion case, 839
Two claims; *pro rata* distribution, 1636

*** Bold Page = Court Case ***

THIRD PARTY CLAIMS
Board's authority to order claimant's attorney to pay unpaid lien, **2297**
Distribution issue
Attorney fee, extraordinary, 814
Expenditures of third party, 1637
Paying agency's lien
Anticipated future expenditures, 1088
Burden of proof, 1088
Generally, 1410,1637
"Incurred expenses" issue, 1410
"Paying agency" dispute, 1410
PPD award, including attorney fee paid from, **2297**

TIME LIMITATIONS See AGGRAVATION CLAIM (PROCEDURAL); CLAIMS FILING; OCCUPATIONAL DISEASE CLAIMS (FILING); REQUEST FOR HEARING (FILING); REQUEST FOR REVIEW (FILING); REQUEST FOR REVIEW--COURTS

TORT ACTION
See also: EXCLUSIVE REMEDY
Negligence case; damages must consider workers' compensation benefits, **1168**

VOCATIONAL REHABILITATION
Eligibility determination, **1162**

Case ..... Page(s)

Abbott v. SAIF, 45 Or App 657 (1980) 742,954,1378,1861,1940,1971,1998
Abercrombie v. Hayden Corp., 320 Or279 (1994) 1623
Active Transportation Co. v. Wylie, 159 Or App 12 (1999) 1630,1961
Adams v. Compensation Dept., 249 Or 530 (1968) **2262**
Aetna Casualty Co. v. Jackson, 108 Or App 253 (1991) 653
Agricomp Ins. v. Tapp, 169 Or App 208 (2000) 1998,2089,2182
Agripac v. Kitchel, 73 Or App 132 (1985) 467,893
Albany General Hospital v. Gasperino, 113 Or App 411 (1992) 193,270,282,322,337,435,461,505,742, 882,954,1072,1094,1246,1306,1318,1440,1460,1579,1590,1610,1957
Alcantar-Baca v. Liberty Northwest, 161 Or App 49 (1999) 25,63,65,860,1449,1627
All American Air Freight v. Meissner, 129 Or App 104 (1994) 6
Allen v. SAIF, 29 Or App 631 (1977) 1092,**2262**
Allie v. SAIF, 79 Or App 284 (1986) 272,380,385,387,461,699,742,963,999, 1383,1517,1601,1632,1903,1909,1959,1996,2221
Allied Systems Co. v. Nelson, 158 Or App 639 (1999) 911
Alltucker v. City of Salem, 164 Or App 643 (1999) 1351
Alvarez v. GAB Business Services, 72 Or App 524 (1985) 28,51,54,59,61,93,147,232,371,377,474, 671,680,708,715,723,730,734,750,796,839,866,989,1021,1266,1331,1355,1357,1367,1378,1394,1403,1418, 1423,1437,1472,1474,1478,1497,1544,1824,1832,1833,1853,1925,1949,1986,1994,2140,2148,2192
Amfac, Inc. v. Garcia-Maciel, 98 Or App 88 (1989) 1401
Anderson v. EBI Companies, 79 Or App 345 (1986) 1420
Anderson v. Publishers Paper Co., 78 Or App 513 (1986) 301,358,761,1628,1666,1899
Andrews v. Tektronix, Inc., 323 Or 154 (1996) 704,801,1076,**1174**,1410,1965,**2262**
Aquillon v. CNA Insurance, 60 Or App 231 (1982) 918
Argonaut Ins. v. King, 63 Or App 847 (1983) 11,169,670,946,984,1252,1872,2022, 2057
Argonaut Ins. v. Mageske, 93 Or App 698 (1988) 15,164,170,180,254,297,385,397,442, 479,505,506,843,1014,1286,1299,1306,1322,1383,1528,1588,1910,1996,2070,2196,2208,2243
Argonaut Ins. v. Mock, 95 Or App 1 (1989) 42,401,911,1037,1577
Armstrong v. Asten-Hill Co., 90 Or App 200 (1988) **1116**,**1132**,**1707**,**1737**,**2275**
Armstrong v. SAIF, 67 Or App 498 (1984) 1559
Assoc. Refor. Cont. v. Workers' Cmp. Bd., 59 Or App 348 (1982) **2271**
Astoria Oil Service v. Lincicum, 100 Or App 100 (1990) 425
Atlas Bolt & Screw v. Houck, 151 Or App 200 (1997) 673,687,963
Austin v. SAIF, 48 Or App 7 (1983) 28,51,54,59,61,93,147,232,371,377,474, 671,680,708,715,723,730,734,750,839,866,989,1021,1266,1331,1355,1367,1394,1403,1418,1423,1437,1472, 1474,1478,1483,1497,1544,1824,1832,1833,1920,1925,1949,1977,1986,1994,2009,2140,2148,2192,2237
Bailey v. SAIF, 296 Or 41 (1983) 450,763,774,1029,**1132**,1697,1978,2036
Ball v. The Halton Company, 167 Or App 468 (2000) 1579,1676,2251
Barkley v. Corrections Division, 111 Or App 48 (1992) **1129**
Barnett v. SAIF, 122 Or App 279 (1993) 15,83,101,114,118,131,164,185,188,213, 238,272,297,310,330,380,385,461,477,742,745,770,849,862,900,905,907,926,949,961,999,1014,1090,1246, 1267,1306,1318,1390,1428,1446,1460,1470,1521,1630,1632,1820,1900,1905,1909,1983,2042,2062,2076,2131
Barr v. EBI Companies, 88 Or App 132 (1987) 903
Barrett v. Coast Range Plywood, 56 Or App 371 (1982) 1365
Barrett Business Services v. Hames, 130 Or App 190 (1994) 37,304
Barrett Business Services v. Morrow, 164 Or App 628 (199) 346,**527**,**538**,1521,1560
Bay Area Hospital v. Landers, 150 Or App 154 (1997) 2203
Beardslee v. Diamond Wood Products, 107 Or App 224 (1991) **2262**
Beck v. James River Corp., 124 Or App 484 (1993) 415,648
Benz v. SAIF, 170 Or App 22 (2000) 2042,2076
Berliner v. Weyerhaeuser, 54 Or App 624 (1981) 28,51,54,59,61,93,147,232,371,377,404, 474,671,680,708,715,723,730,734,750,789,796,839,866,989,1266,1331,1355,1367,1378,1394,1418,1423,1437, 1474,1478,1497,1544,1824,1832,1833,1853,1925,1949,1986,1994,2140,2148,2192
Berwick v. AFSD, 74 Or App 460 (1985) **1717**
Beverly Enterprises v. Michl, 150 Or App 357 (1997) 36,297,996,1376,2059
Bi-Mart Corporation v. Allen, 164 Or App 288 (1999) 335,487,1420

Case ..... Page(s)

Bishop v. OBEC Consulting Engineers, 160 Or App 548 (1999) 1420
Blakely v. SAIF, 89 Or App 653 (1988) 385,954,1079,1645,1647
Blamires v. Clean Pak Systems, 171 Or App 263 (2000) 2220,**2314**
Blanchard v. Kaiser Foundation, 136 Or App 466 (1995) 425,1002
Boehr v. Mid-Willamette Valley Food, 109 Or App 292 (1991) 13,157,307,337,502,818,1057,1326,2042
Boeing Co. v. Roy, 112 Or App 10 (1992) 136,621,954,1921
Boise Cascade v. Katzenbach, 104 Or App 732 (1990) 263,442,497,627,772
Boise Cascade v. Starbuck, 296 Or 238 (1984) 122,346,406,943,1677,1998,2182
Boldman v. Mt. Hood Chemical Corp., 288 Or 121 (1979) 1410
Booras v. Uyeda, 295 Or 181 (1983) **2302**
Boyd v. Essin, 170 Or App 509 (2000) **2300**
Boydston v. Liberty Northwest, 166 Or App 336 (2000) 1057,**1104**,1373,2080
Bracke v. Baza'r, 293 Or 239 (1982) 122,406,506,1709,1998,2089,2182
Bradshaw v. SAIF, 69 Or App 587 (1984) **2286**
Bragger v. Oregon Trail Savings, 275 Or 219 (1976) 380,991
Brentano v. Marion County, 150 Or App 538 (1997) **1168**
Brewer v. Dept. of Fish/Wildlife, 168 Or App 173 (2000) **1168**
Bronco Cleaners v. Velasquez, 141 Or App 295 (1996) 892,1050,1980,**2286**
Bronson v. Moonen, 270 Or 469 (1974) **2302**
Brooks v. D & R Timber, 55 Or App 688 (1982) **1704**
Brown v. A-Dec, Inc., 154 Or App 244 (1998) 178,344,1900
Brown v. Argonaut Ins., 93 Or App 588 (1988) 129,149,151,180,257,273,465,704,716, 761,972,1009,**1135**,1428,1433,1450,1511,1527,1573,1613,1661,1685,1888,2078,2081,2145,2174
Brown v. EBI Companies, 289 Or 455 (1980) 301,358,1628,1899
Brown v. J.C. Penney Co., 297 Or 695 (1984) **555**
Brown v. Liberty Northwest, 105 Or App 92 (1990) **1174**
Brown v. SAIF, 51 Or App 389 (1981) 920,1037,1536,1546,1559,1915,2036, 2048
Brown v. SAIF, 79 Or App 205 (1986) 172,292,**1129**
Burke v. Children's Services Division, 288 Or 533 (1980) **1122**
Burkholder v. SAIF, 11 Or App 334 (1972) 1420
Burris v. SAIF, 116 Or App 498 (1992) **1111**
Bush v. SAIF, 68 Or App 230 (1984) 1035,1286,1863,2182
Caldwell v. Lucas, 170 Or App 587 (2000) **2297**
Callan v. Confed. of Oreg. Sch. Adm., 79 Or App 73 (1986) **555**,**1138**
Campbell v. Bd. of Med. Examiners, 16 Or App 381 (1974) **2297**
Carr v. SAIF, 65 Or App 110 (1983) 1405
Carter v. SAIF, 52 Or App 1027 (1981) 1555
Cascade Corporation v. Rose, 92 Or App 663 (1988) **536**
Castle & Cooke v. Porras, 103 Or App 65 (1990) 151,634,1527
Castle Homes, Inc. v. Whaite, 95 Or App 269 (1989) 2127
Cessnun v. SAIF, 161 Or App 367 (1999) 749
Chaffee v. Nolt, 94 Or App 83 (1988) 265,918
Champion International v. Sinclair, 106 Or App 423 (1991) 21,697,1592
Cigna Ins. Companies v. Crawford & Co., 104 Or App 329 (1990) 406
City of Portland v. Bureau of Labor/Ind., 298 Or 104 (1984) **1138**
Clark v. U.S. Plywood, 288 Or 255 (1980) **2262**
Clarke v. SAIF, 120 Or App 11 (1993) 2068,2140,2229
Coastal Farm Supply v. Hultberg, 84 Or App 282 (1987) 15,66,180,200,292,442,1687,1847,1863, 2081,2093,2239
Cogswell v. SAIF, 74 Or App 234 (1985) 301,358,761,1566,1628,1666,1690,1899
Collins v. Hygenic Corp. of Oregon, 86 Or App 484 (1987) **1129**
Colvin v. Industrial Indemnity, 301 Or 743 (1986) 369
Compton v. Weyerhaeuser, 301 Or 641 (1986) 3,107,171,333,450,454,469,653,654,657, 763,774,784,920,941,960,961,1029,1057,**1132**,1257,1336,1339,1340,1401,1431,1554,1653,1654,1673,1687, 1697,1851,1880,1918,1953,1978,1984,2036,2046,2048,2104,2200,2224,2225
Conner v. B & S Logging, 153 Or App 354 (1998) 640,1005,2097

Case ..... Page(s)

Cook v. Workers' Comp. Dept., 306 Or 134 (1988) 73,704
Coombe v. SAIF, 111 Or App 71 (1992) 1914
Coombs v. SAIF, 39 Or App 293 (1979) 1555
Cope v. West American Ins. Co., 309 Or 232 (1990) 801,1351,**2286**
Corona v. Pacific Resource Recycling, 125 Or App 47 (1993) 666,1450
Cottle v. Hayes, 128 Or App 185 (1994) **555**
Cottrell v. EBI, 304 Or 187 (1987) 2168
Couch v. Couch, 170 Or App 98 (2000) **2297**
Counts v. International Paper Co., 146 Or App 768 (1997) **1704**
Croman Corp. v. Serrano, 163 Or App 136 (1999) 168,329,392,482,716,918,930,1254,1373, 1432,1479,1579,1831,1882,2001,2112,2245,**2308**,**2314**
Crowder v. Alumaflex, 163 Or App 143 (1999) 417
Crowe v. Jeld-Wen, 77 Or App 81 (1985) 27
Cutright v. Weyerhaeuser Co., 299 Or 290 (1985) 457,1883
Cy Investment, Inc. v. N.C.C.I., 128 Or App 579 (1994) **1724**,2127
D & D Company v. Kaufman, 139 Or App 459 (1996) 1318,1623
Daquilante-Richards v. Cigna Ins., 149 Or App 682 (1997) 810
Davidson v. Rogers, 281 Or 219 (1978) **1168**
Davies v. Hanel Lumber Co., 67 Or App 35 (1984) 15,66,2239
Davis v. Kendall Ford, 144 Or App 192 (1996) 1566
Dawes v. Summers, 118 Or App 15 (1993) 2078
Dawkins v. Pacific Motor Trucking, 308 Or 254 (1989) 9,49,50,81,88,98,162,218,250,262,271, 367,370,424,433,455,457,493,498,637,643,726,762,765,823,873,880,980,982,994,1021,1302,1370,1442,1452, 1463,1468,1506,1509,1643,1695,1850,1883,1893,1896,1948,1989,1997,2004,2019,2030,2052,2083,2143,2160, 2238
Dean Warren Plumbing v. Brenner, 150 Or App 422 (1997) 1326
Deaton v. Hunt-Elder, 145 Or App 110 (1996) 1033
Degrauw v. Columbia Knit, Inc., 118 Or App 277 (1993) 63
Deluxe Cabinet Works v. Messmer, 140 Or App 548 (1996) 1373,**2275**
Dennis Uniform Mfg. v. Teresi, 115 Or App 349 (1992) 56,346,406,691,1333,2138
Dennis Uniform Mfg. v. Teresi, 119 Or App 447 (1993) 56,346,406,691,1333,2138
Denton and Denton, 326 Or 236 (1998) **1176**
Deschutes County v. Scott, 164 Or App 6 (1999) 690
Destael v. Nicolai Co., 80 Or App 596 (1986) 223,1560,2210
Dibrito v. SAIF, 319 Or 244 (1994) 96,297,1052,1306,1513,1560,1630,1909
Dickson v. Carolina Casualty, 108 Or App 499 (1991) 1971
Dietz v. Ramuda, 130 Or App 397 (1994) 39,66,96,114,154,164,167,170,188,200, 213,238,259,292,307,318,330,337,378,380,382,385,390,395,397,461,464,**518**,621,631,649,665,745,775,844, 852,862,900,907,929,936,963,986,999,1014,1035,1047,1072,**1111**,1264,1286,1322,1343,1348,1368,1376,1380, 1383,1454,1459,1460,1470,1521,1534,1537,1550,1560,1566,1587,1599,1607,1647,1661,1663,1820,1845,1861, 1910,1915,1940,1943,1944,1946,1958,1982,1984,1988,1996,2008,2013,2024,2070,2166,2173,2196,2221,2225, 2231,2250,2256
Dilworth v. Weyerhaeuser Co., 95 Or App 85 (1989) 406
Doe v. American Red Cross, 322 Or 502 (1995) **1138**
Donald Drake Co. v. Lundmark, 63 Or App 261 (1983) 1454,1630
Don't Waste Oregon v. Energy Siting, 320 Or 132 (1994) **1162**,**1713**
Dotson v. Bohemia, 80 Or App 233 (1986) 138,170,223,257,290,322,335,353,467, 491,651,659,676,702,835,893,896,972,983,1401,1677,1870,2110,2191
Drew v. PSRB, 322 Or 491 (1996) **1116**
Drews v. EBI Companies, 310 Or 134 (1990) 33,215,316,890,1281,1324,1956,2033, 2086,2254,**2297**
Duncan v. Liberty Northwest, 133 Or App 605 (1995) **2302**
Duran v. SAIF, 87 Or App 509 (1987) 2216
Eastman v. Georgia Pacific Corp., 79 Or App 610 (1986) 810,1405,2174,2227
EBI Companies v. Chandler, 112 Or App 275 (1992) 1483
EBI Companies v. Horton, 157 Or App 397 (1998) 265,918
EBI Companies v. Hunt, 132 Or App 128 (1994) 356

Case ..... Page(s)

EBI Companies v. Lorence, 72 Or App 75 (1985) 1666,1899
Elder v. Rosboro Lumber Co., 106 Or App 16 (1991) 1592
Eli v. Selectemp, 140 Or App 644 (1996) 1566
Emmons v. SAIF, 34 Or App 603 (1978) 1592
Emp. Div. v. Surata Soy Foods, Inc., 63 Or App 221 (1983) **2271**
Erck v. Brown Oldsmobile, 311 Or 519 (1991) 200,238,442,461,905,991,1687
Erickson v. Grande Ronde Lbr. Co., 162 Or App 556 (1939) **1176**
Errand v. Cascade Steel Rolling Mills, 320 Or 509 (1995) **1151**
Estes v. Lewis & Clark College, 152 Or App 372 (1998) **1138**
Etchison v. SAIF, 8 Or App 395 (1972) **2262**
Evanite Fiber Corp. v. Striplin, 99 Or App 353 (1989) 781
Evanhoff v. S.I.A.C., 78 Or 503 (1915) **1151,1168**
Fairlawn Care Center v. Douglas, 108 Or App 698 (1991) 810,1405,2174
Farrimond v. Louisiana-Pacific Corp., 103 Or App 563 (1990) **555**
Ferland v. McMurty Video Productions, 116 Or App 405 (1992) 1924,2020
Finch v. Stayton Canning Co., 93 Or App 168 (1988) 172,**1129**
Finley v. SAIF, 34 Or App 129 (1978) **1135**
First Interstate v. Morris, 132 Or App 98 (1994) 1914
First Interstate Bank v. Clark, 133 Or App 712 (1995) 897
Fischer v. SAIF, 76 Or App 656 (1985) 9,269,301,680,708,723,730,734,750,789, 873,1063,1338,1364,1544,1628,1636,1824,1899,2148
Fister v. South Hills Health Care, 149 Or App 214 (1997) 335,846,1053,**1148**,1267,1593,2066,2105
Fleetwood Homes v. Vanwechel, 164 Or App 637 (1999) 95,682,741,973,1540,1573,2203
Food Services of America v. Ewen, 130 Or App 297 (1994) 1914
Forney v. Western States Plywood, 297 Or 628 (1984) 264,667,915
Foster-Wheeler Constr. v. Smith, 151 Or App 155 (1997) 56,691
Fox v. Country Mutual Ins. Co., 327 Or 500 (1998) **1151**
Franke v. Lamb-Weston, Inc., 165 Or App 517 (2000) 867
Fred Meyer, Inc. v. BOLI, 152 Or App 302 (1998) **555**
Fred Meyer, Inc. v. Bundy, 159 Or App 44 (1999) 249,468,492,688,808,1009,1243,1613, 2174
Fred Meyer, Inc. v. Crompton, 150 Or App 531 (1997) 1842
Fred Meyer, Inc. v. Hayes, 325 Or 592 (1997) **534**,897,1030,1092,1351,**2262,2286**
Fred Meyer, Inc. v. Hofstetter, 151 Or App 21 (1997) 392,848,**1162**
Freightliner Corp. v. Arnold, 142 Or App 98 (1996) 401,686,739,783,843,849,862,897,949, 999
Freightliner Corp. v. Christensen, 163 Or App 191 (1999) 263,497,**538**,627,772,1281
Freres Lumber Co. v. Jegglie, 106 Or App 27 (1991) **1739**
Fuls v. SAIF, 321 Or 151 (1995) **523,566**
Gallino v. Courtesy Pontiac-Buick-GMC, 124 Or App 538 (1993) 241,1057,1373,2178,2241
Ganer v. Sisters of Providence, 164 Or App 177 (1999) 69
Garcia v. Boise Cascade Corp., 309 Or 292 (1990) **518,549,1113,1135,2275**
Garibay v. Barrett Business Services, 148 Or App 496 (1997) 943
Gaynor v. Board of Parole, 165 Or App 609 (2000) **2297**
Geer v. SAIF, 121 Or App 647 (1993) 2178
George v. Richard's Food Center, 90 Or App 639 (1988) 10,1255,2105,2124
Georgia-Pacific v. Awmiller, 64 Or App 56 (1983) 1365
Georgia-Pacific v. Ferrer, 114 Or App 471 (1992) **2275**
Georgia-Pacific v. Kight, 126 Or App 244 (1994) 1299
Georgia-Pacific v. Piwowar, 305 Or 494 (1988) 263,387,442,497,627,772,1281,1323, 2153
Georgia-Pacific v. Warren, 103 Or App 275 (1990) **1113**,1534
Gerber v. S.I.A.C., 164 Or 353 (1940) 425
Gevers v. Roadrunner Construction, 156 Or App 168 (1998) 75,126,241,1679,2078,2241
Givens v. SAIF, 61 Or App 490 (1983) 385,1014
Gonzalez v. Schrock Cabinet Co., 168 Or App 36 (2000) 1677
Good Samaritan Hosp. v. Stoddard, 126 Or App 69 (1994) 1623

Case ..... Page(s)

Goodyear Tire v. Tualatin Tire, 322 Or 406 (1995) **566,1151**
Gormley v. SAIF, 52 Or App 1055 (1981) 28,36,192,193,237,282,287,318,339,406, 477,502,663,742,833,849,996,1090,1343,1521,1534,1544,1566,1853,2042,2166,2250
Gossett v. Simonson, 243 Or 16 (1966) **544**
Graham v. State of Oregon, 164 Or App 747 (2000) **1151**
Granner v. Fairview Center, 147 Or App 406 (1997) 263,435,442,497,627,772,**1713**
Gray v. SAIF, 70 Or App 313 (1984) 174,2189
Green Thumb v. Basl, 106 Or App 98 (1991) 781
Greenwade v. SAIF, 41 Or App 697 (1979) **2310**
Groshong v. Montgomery Ward, 73 Or App 403 (1985) 108
Guerrero v. Stayton Canning Co., 92 Or App 209 (1988) 1882
Gwynn v. SAIF, 304 Or 345 (1987) **510,1119**
Hadley v. Cody Hindman Logging, 144 Or App 157 (1996) **1720**,2251
Hale v. Port of Portland, 308 Or 508 (1990) **1151,1168**
Hammon Stage Line v. Stinson, 123 Or App 418 (1993) 60
Hammons v. Perini Corp., 43 Or App 299 (1979) 272,381,385,461,742,963,999,1267,1460, 1517,1590
Hanna v. SAIF, 65 Or App 649 (1983) 425,1053
Hannan v. Good Samaritan Hosp., 4 Or App 178 (1970) **2302**
Harmon v. SAIF, 54 Or App 121 (1981) 28,51,54,59,61,93,112,147,232,371,377, 474,671,680,708,715,723,730,734,750,787,839,866,878,989,1021,1266,1331,1355,1367,1394,1403,1418,1423, 1437,1472,1474,1478,1483,1497,1544,1824,1832,1833,1853,1920,1925,1949,1977,1986,1994,2009,2140,2148, 2192,2237
Harris v. SAIF, 292 Or 683 (1982) 657,660,810,1032,1042,1430,1510,1635
Harsh v. Harscho Corp., 123 Or App 383 (1993) 6,1573,2212
Haskel Corporation v. Filippi, 152 Or App 117 (1998) 747,1697
Havlik v. Multnomah County, 164 Or App 522 (1999) 494
Hays v. Tillamook Co. General Hosp., 160 Or App 55 (1999) 223,335,1677
HDG Enterprises, Inc. v. N.C.C.I., 121 Or App 513 (1993) **1724**
Heide/Parker v. T.C.I. Incorporated, 264 Or 535 (1973) **544**,801,1351
Heinzel v. Backstrom, 310 Or 89 (1990) **1135**
Hempel v. SAIF, 100 Or App 68 (1990) 790,**1132**,1566,1666,1690
Henderson v. Jantzen, Inc., 79 Or App 654 (1986) **1138**
Henn v. SAIF, 60 Or App 587 (1982) **1724**
Hensel Phelps Const. v. Mirich, 81 Or App 290 (1986) 346,943,2243
Hewlett-Packard Co. v. Leonard, 151 Or App 307 (1997) 425,**1148**
Hewlett-Packard Co. v. Renalds, 132 Or App 288 (1995) 96,1052
Hickey v. Union Pacific Railroad, 104 Or App 724 (1990) 1351
Hill v. Oland, 52 Or App 791 (1981) 666
Hill v. Stuart Andersons, 149 Or App 496 (1997) 716
Hix v. SAIF, 34 Or App 819 (1978) 805
Holcomb v. Sunderland, 321 Or 99 (1995) **1151**
Holien v. Sears, Roebuck & Co., 298 Or 76 (1984) **555**
Holzapfel v. M. Duane Rawlins, Inc., 127 Or App 208 (1994) 703
Hurlburt v. Tecton Laminates Corp., 135 Or App 202 (1995) **1707**
Hutcheson v. Weyerhaeuser, 288 Or 51 (1979) 83,907
Iliaifar v. SAIF, 160 Or App 116 (1999) **534**,1092,1351,1870
Illingworth v. Bushong, 297 Or 675 (1984) **2302**
Independent Paper Stock v. Wincer, 100 Or App 625 (1990) 147,198,250,730,878,1403,1474,1573, 1824,1878,1994,2212
Industrial Indemnity v. Kearns, 70 Or App 583 (1984) 506,640,1005,1500,2097,2185
Industrial Indemnity v. Weaver, 81 Or App 493 (1986) 1535,2089
Intel Corp. v. Renfro, 155 Or App 447 (1998) 185,1037,1102,1645,**2284**
International Paper v. Hubbard, 109 Or App 452 (1991) 823,2160
International Paper v. Huntley, 106 Or App 107 (1991) 149,180,704,716,1243,1354,1433,1450, 1511,1573,1661,1685,2078,2081,2145
International Paper v. McElroy, 101 Or App 61 (1990) 1,15,66,180,1910,2209,2254

Case ..... Page(s)

International Paper v. Miller, 151 Or App 131 (1997) 1262
International Paper v. Riggs, 114 Or App 203 (1992) 406
International Paper v. Wright, 80 Or App 444 (1986) 301,358,789,1063,1338,1364,1628,1697, 1899
J.R. Simplot Co. v. Dept. of Rev., 321 Or 253 (1995) **538,1126**
Jackson Co. S.D. #5 v. Dawson, 160 Or App 700 (1999) 649
Jahnke v. US West, 161 Or App 44 (1999) **531**
James v. Cook, 290 Or 343 (1981) 1094
James v. Kemper Ins. Co., 81 Or App 80 (1986) 52
James v. SAIF, 290 Or 343 (1980) 196,**566**,882,1037,1383,2250
James River Corp. v. Green, 164 Or App 649 (1999) 343
Jeld-Wen, Inc. v. Bartz, 142 Or App 433 (1996) **2297**
Jeld-Wen, Inc. v. Molena, 166 Or App 396 (2000) 1513,**2275**
Jenkins v. AAA Heating, 245 Or 382 (1966) **544**
Jenkins v. Carman MFG. Co., 79 Or 448 (1916) 2216
Jenkins v. Continental Baking Co., 135 Or App 436 (1997) 45
Jensen v. Liberty Northwest, 161 Or App 198 (1999) 856
Johansen v. SAIF, 158 Or App 672 (1999) 95,108,138,253,259,297,472,723,915, 1243,1324,1573,1926,1931,1949,1993,2145,2148,2212
Johansen v. SAIF, 160 Or App 579 (1999) 108,253,472,1926,1931,1993,2145,2148, 2212
John N. Sheagren, M.D., v. Albrecht, 123 Or App 553 (1993) 273
Johnsen v. Hamilton Electric, 90 Or App 161 (1988) **1129**
Johnson v. Beaver Coaches, Inc., 147 Or App 234 (1997) 649
Johnson v. SAIF, 78 Or App 143 1878
Johnson v. Spectra Physics, 303 Or 49 (1987) 918,2038
Jole v. Bredbenner, 95 Or App 193 (1989) **555**
Jones v. Emanuel Hospital, 280 Or 147 (1977) 716,1433
Jones v. General Motors Corp., 139 Or App 244 (1996) **1138**
Jones v. General Motors Corp., 325 Or 404 (1997) **544,1138,2294**
K-Mart v. Claussing, 162 Or App 558 (1999) **2300**
K-Mart v. Evenson, 167 Or App 46 (2000) 1097
Kaiel v. Cultural Homestay Institute, 129 Or App 471 (1994) **1724**
Kammerer v. United Parcel Service, 136 Or App 200 (1995) 739,**1174**,1935
Kassahn v. Publishers Paper, 76 Or App 105 (1985) 66,101,114,167,200,227,254,859,954, 1077,2121,2123
Kelso v. City of Salem, 87 Or App 630 (1987) 31,254,288,307,310,339,457,502,663, 703,849,882,978,1042,1050,1072,1286,1331,1440,1489,1494,1630,1647,1676,1845,1903,1937,1946,1983,2008, 2086,2152
Kempf v. Carpenters & Joiners Union, 229 Or 337 (1961) 25,63,1627
Kempf v. SAIF, 34 Or App 877 (1978) 2168
Kepford v. Weyerhaeuser, 77 Or App 363 (1986) 890,1264
Kessen v. Boise Cascade, 71 Or App 545 (1984) 1495
Kienow's Food Stores v. Lyster, 79 Or App 416 (1986) 3,107,154,185,227,454,469,653,657,784, 848,960,961,1246,1262,1296,1299,1383,1401,1431,1528,1554,1588,1653,1851,1880,1918,1953,1957,1996, 2046,2200,2208,2209,2225
Kilminster v. Day Management Corp., 323 Or 618 (1996) **1151**
Kimberly Quality Care v. Bowman, 148 Or App 292 (1997) 903
King v. Building Supply Discount, 133 Or App 179 (1995) 1281
Kinross Copper v. State of Oregon, 163 Or App 357 (1999) **573**
Knapp v. City of North Bend, 304 Or 34 (1987) **555**
Knapp v. Weyerhaeuser Co., 93 Or App 670 (1988) 60
Koitzsch v. Liberty Northwest, 125 Or App 666 (1994) 57,102,116,204,327,351,355,**531**,660, 748,778,794,876,909,925,1042,1081,1289,1443,1594,1683,2006
Kordon v. Mercer Industries, 308 Or 290 (1989) 231
Koskela v. Willamette Industries, 159 Or App 229 (1999) 25,107,**561**,883,1953,2024,2069
Krieger v. Just, 319 Or 328 (1994) 425,**566**

Case ..... Page(s)

Krushwitz v. McDonald's Restaurants, 323 Or 520 (1996) **534**,**544**,801,1351,1612,**2262**
Kuhn v. SAIF, 73 Or App 768 (1985) 131,351,1002,1357,2153,2258
Labor Force of Oregon v. Frierson, 169 Or App 573 (2000) 1656,1892,1963,2117
Labor Ready, Inc. v. Mann, 158 Or App 666 (1999) 108,294,716,1243
Lamm v. Silver Falls Timber Co., 133 Or 468 (1930) 805
Lane County v. State of Oregon, 104 Or App 372 (1990) **555**
Lane Co. Public Works v. Lane Co., 118 Or App 46 (1993) **1138**
Lankford v. Copeland, 141 Or App 138 (1996) 2020
Larson v. S.I.A.C., 135 Or 137 (1931) **2262**,**2286**
Lasley v. Ontario Rendering, 114 Or App 543 (1992) **561**
Lebanon Plywood v. Seiber, 113 Or App 651 (1992) 146,839,1613,1685,2009,2218,2237
Leedy v. Knox, 34 Or App 911 (1978) 425
Legord v. Self-Insured Management, 157 Or App 229 (1998) **2297**
LeMasters v. Tri-Met, Inc., 133 Or App 258 (1995) 1915,1978,2048
Lenox v. SAIF, 54 Or App 551 (1981) 1087
Lepage v. Rogue Valley Medical, 166 Or App 627 (2000) 1018,1037,1062,1262,1363
Lester v. Weyerhaeuser Co., 70 Or App 307 (1984) **1135**,1365
Lewis & Clark College v. Bureau of Labor, 43 Or App 245 (1979) **555**,**1138**
Liberty Northwest v. Allenby, 166 Or App 331 (2000) **1106**,2080
Liberty Northwest v. Bird, 99 Or App 560 (1989) 1566
Liberty Northwest v. Bowen, 152 Or App 549 (1998) 1623
Liberty Northwest v. Church, 106 Or App 477 (1991) 805
Liberty Northwest v. Cross, 109 Or App (1991) 1367,1437
Liberty Northwest v. Gordineer, 150 Or App 136 (1997) 2127
Liberty Northwest v. Johnson, 142 Or App 21 (1996) 1935
Liberty Northwest v. Koitzsch, 155 Or App 494 (1998) 682
Liberty Northwest v. McKellips, 100 Or App 549 (1990) 893
Liberty Northwest v. Noble, 153 Or App 125 (1998) 330,2108
Liberty Northwest v. Noble, 159 Or App 426 (1999) 716
Liberty Northwest v. Rector, 151 Or App 693 (1997) 1566
Liberty Northwest v. Shotthafer, 169 Or App 556 (2000) 1971
Liberty Northwest v. Verner, 139 Or App 165 (1996) **1116**
Lindamood v. SAIF, 78 Or App 15 (1986) 2178
Linnton Plywood v. Tax Comm., 241 Or 1 (1965) **2271**
Little Donkey Enterprises v. SAIF, 107 Or App 400 (1991) **544**
Long v. Argonaut Insurance Co., 169 Or App 625 (2000) 2187
Lopez v. Agripac, Inc., 154 Or App 149 (1998) 808,1613,1683,2006
Lough v. S.I.A.C., 104 Or 313 (1922) 425
Lucas v. Clark, 106 Or App 687 (1991) **510**
Luckhurst v. Bank of America, 167 Or App 11 (2000) 1097,1630,2101,2166
Lyday v. Liberty Northwest, 115 Or App 668 (1992) **1106**,2178
Maarefi v. SAIF, 69 Or App 527 (1984) 51,61,147,671,715,866,989,1266,1418, 1472,1676,1832,1853,1994,2192
Marconi v. Guardian Management, 149 Or App 541 (1997) **1138**
Marcum v. City of Hermiston, 149 Or App 392 (1997) 352
Marshall v. Boise Cascade Corp., 82 Or App 130 (1986) 702
Martelli v. R.A. Chambers & Assoc., 310 Or 529 (1990) 805
Martinez v. Dallas Nursing Home, 114 Or App 453 (1992) 634
Marvin Wood Products v. Callow, 171 Or App 175 (2000) 2241
Mathel v. Josephine County, 319 Or 235 (1994) 196,**566**,882,1094,1306,1630,1961,2250
McAdams v. SAIF, 66 Or App 415 (1984) **2286**
McCall v. Dynic USA Corp., 138 Or App 1 (1995) **1138**
McClendon v. Nabisco Brands, 77 Or App 412 (1986) 28,313,333,344,401,843,926,1367,1437, 1528,1853
McGarrah v. SAIF, 296 Or 145 (1983) 66,200,213,382,435,494,626,665,699, 775,852,936,1035,1072,1094,**1151**,1286,1299,1343,1348,1368,1380,1383,1459,1587,1603,1647,1661,1663, 1845,1861,1915,1940,1943,1944,1982,1998,2001,2024,2221,2231,2250,2256

Case ..... Page(s)

McGill v. SAIF, 81 Or App 210 (1986) 2216
McIntyre v. Standard Utility Contr., 135 Or App 298 (1995) 7,15,185,792,963,991,996,1045,1440, 1632
McKeown v. SAIF, 116 Or App 295 (1992) 1870
McPhail v. Milwaukie Lumber Co., 165 Or App 596 (2000) **2310**
McPherson v. Employment Division, 285 Or 541 (1979) **1132**
McQuary v. Bel Air Convalescent Home, 69 Or App 107 (1984) **555**
McTaggart v. Time Warner Cable, 170 Or App 491 (2000) 2005,2100
Medford Corp. v. Smith, 110 Or App 486 (1992) 838
Mell v. W.C. Ranch, Inc., 108 Or App 105 (1991) 2168
Mellis v. McEwen, Hanna, Gisvold, 74 Or App 571 (1985) 897,1030
Menashe Corp. v. Crawford, 164 Or App 174 (1999) 1243
Mendoza v. SAIF, 123 Or App 349 (1993) **1717**
Messmer v. Deluxe Cabinet Works, 130 Or App 254 (1994) 479,1566
Metro Machinery Rigging v. Tallent, 94 Or App 245 (1988) 454,469,653,654,657,763,774,784,960, 961,1029,1401,1554,1673,1880,1918,2036,2046,2048,2200,2225
Miller v. Granite Construction, 28 Or App 473 (1977) 1,13,31,66,101,122,131,272,307,330, 395,410,469,502,663,702,727,783,833,843,872,949,954,978,986,999,1008,1012,1017,1050,1061,1072,1286, 1299,1306,1318,1376,1380,1440,1454,1489,1494,1495,1521,1566,1599,1647,1663,1692,1820,1836,1847,1908, 1915,1940,1957,1971,2011,2017,2042,2070,2140,2205,2208,2239,2243,2254
Miller v. Spencer, 123 Or App 635 (1993) 1924,2020
Million v. SAIF, 45 Or App 1097 (1980) 1324
Miltenberger v. Howard's Plumbing, 93 Or App 475 (1988) 65,147,198,254,301,362,472,680,682, 827,873,878,1009,1405,1544,1948
Mischel v. P.G.E., 89 Or App 140 (1987) 425
Mission Ins Co. v. Dundon, 86 Or App 470 (1987) 346,1005
Miville v. SAIF, 76 Or App 603 (1985) 479,943
Mobley v. SAIF, 58 Or App 394 (1982) 893
Moe v. Ceiling Systems, 44 Or App 429 (1980) 66,167,200,320,770,825,1343,1348,1531, 1587,1590,1603,1855,1861,1940,1943,2001,2221,2250,2256
Monaco v. U.S. Fidelity & Guar., 275 Or 183 (1976) **2275**
Montgomery v. S.I.A.C., 224 Or 380 (1960) 801
Morrow v. Pacific University, 100 Or App 198 (1990) **1111**
Mosley v. Sacred Heart Hospital, 113 Or App 234 (1992) 11,169,670,946,1252,2022,2057
Multifoods Specialty Dist. v. McAtee, 164 Or App 654 (1999) 157,263,346,**527**,1097,**1126**,1373,1521, 1560,1630,2097,2101,2102,2166,2243
Mustoe v. Career Management, 130 Or App 679 (1994) 75,85
Myers v. Cessna Aircraft, 275 Or 501 (1976) **1168**
Neely v. SAIF, 43 Or App 319 (1979) 33
Neher v. Chartier, 319 Or 417 (1994) **1168**
Nelson v. Douglas Fir Plywood Co., 260 Or 53 (1971) 801
Nelson v. Emerald P.U.D., 318 Or 99 (1993) **2297**
Nelson v. SAIF, 43 Or App 155 (1979) 425
Nelson v. SAIF, 302 Or 463 (1987) 2158,**2271**
Nesselrodt v. State Compensation Dept., 248 Or 452 (1967) 1926
Nethercott v. SAIF, 126 Or App 210 (1994) **510**
Newell v. SAIF, 136 Or App 280 (1995) 1372
Newport Seafood v. Shine, 71 Or App 119 (1984) 805
Nike, Inc. v. Barajas, 166 Or App 237 (2000) 716
Nix v. SAIF, 80 Or App 656 (1986) 335,1387
Noffsinger v. Yoncalla Timber Products, 88 Or App 118 (1987) 1883
Nomeland v. City of Portland, 106 Or App 77 (1991) **536**,1556
Norby v. SAIF, 303 Or 536 (1987) 1926
Nordstrom, Inc. v. Windom-Hall, 144 Or App 96 (1996) 497
Norpac Foods, Inc. v. Gilmore, 318 Or 363 (1994) 760,801,897,1030,1092,1351,1392,1965, **2286**
North Clackamas Sch. Dist. v. White, 305 Or 48,468 (1988) 215,316,890,1324,2086

Case ..... Page(s)

Northwest Reforest. v. Summit Forests, 143 Or App 138 (1996) **531**
Norton v. Compensation Dept., 252 Or 75 (1968) 19,1420,1483
Nyre v. F & R Leasing, 106 Or App 74 (1991) 1592
O'Neal v. Sisters of Providence, 22 Or App 9 (1975) 196,**566**
O'Neall v. Tewell, 119 Or App 329 (1993) 1433
Offill v. Greenberry Tank & Iron Co., 142 Or App 351 (1986) 1926
Ogden Aviation v. Lay, 142 Or App 469 (1996) 790,**1132**,1666,**1717**
Oldham v. Plumlee, 151 Or App 402 (1997) 2020
Oregon Boiler Works v. Lott, 115 Or App 70 (1992) 122,406,1677,2089
Oregon Drywall Systems v. N.C.C.I., 153 Or App 662 (1998) **1724**
Oregon Occu. Saf. v. Don Whitaker Log., 123 Or App 498 (1993) 241,**1162**,1410
Oremus v. Ore. Pub. Co., 11 Or App 444 (1972) 805
Orman v. SAIF, 131 Or App 653 (1994) 1405,1573,2212
OSCI v. Bureau of Labor/Ind., 98 Or App 548 (1989) **1138**
Owens v. Maass, 323 Or 430 (1996) **510**,**1151**,**1176**
P & C Construction v. American Diversified, 101 Or App 51 (1990) 1623
Pacheco-Gonzalez v. SAIF, 123 Or App 312 (1993) 241,796,2178,2251
Pacific Power & Light v. Jacobson, 121 Or App 260 (1993) 1092
Paige v. SAIF, 75 Or App 160 (1985) **2275**
Paniagua v. Liberty Northwest, 122 Or App 288 (1993) 810,1405
Papen v. Willamina Lumber Co., 123 Or App 249 (1993) 25,**536**,860
Parmer v. Plaid Pantry #54, 76 Or App 405 (1985) 763,941
Parker v. Fred Meyer, Inc., 152 Or App 652 (1998) **555**
Perez v. Employment Dept., 164 Or App 356 (1999) **1174**
Perry v. SAIF, 307 Or 654 (1989) **510**
Peterson v. SAIF, 78 Or App 167 (1986) 2216
Petshow v. Portland Bottling Co., 62 Or App 614 (1983) 9,269,1636
PGE v. Bureau of Labor & Ind., 317 Or 606 (1993) 138,204,363,425,**510**,**527**,**531**,**566**,704, 1033,**1129**,1387,1410,**1713**,1931,2078,2168,**2262**,**2275**,**2286**,**2300**
Phil Livesley Co. v. Russ, 60 Or App 292 (1982) **2286**
Phil Livesley Co. v. Russ, 296 Or 25 (1983) 801,897,1030,1351,1830,2005,2100, **2262**,**2286**
Philpott v. S.I.A.C., 234 Or 37 (1963) 1351
Pollock v. Tri-Met, Inc., 144 Or App 431 (1996) 1623
Popoff v. Newberrys, 117 Or App 242 (1992) 1566
Precision Castparts Corp. v. Lewis, 115 Or App 732 (1992) 1560
Precision Castparts Corp. v. Plummer, 140 Or App 227 (1996) 1427
Price v. SAIF, 296 Or 311 (1984) 2178
Proctor v. SAIF, 123 Or App 326 (1993) 1092,1965
Progress Quarries v. Vaandering, 80 Or App 160 (1986) 943
Quillen v. Roseburg Forest Products, 159 Or App 6 (1999) **1138**
Racing Commission v. Multnomah Kennel Club, 242 Or 572 (1996) 1033
Randall v. Liberty Northwest, 107 Or App 599 (1991) 13,157,307,502,818,1057,1326,2042
Redman Industries v. Lang, 326 Or 32 (1997) 649,897,1030,1351,**2262**,**2286**
Reinwald v. Dept. of Employment, 148 Or App (1997) **1151**
Rennie v. Freeway Transport, 294 Or 319 (1982) 1956,2254
Reynolds Metals v. Rogers, 157 Or App 147 (1998) 122,**1709**,1998,2089,2097,2161,2182
Riley Hill Gen. Contract. v. Tandy Corp., 303 Or 390 (1987) 1428,2131,**2302**
Ring v. Paper Distribution Services, 90 Or App 148 (1988) 273
Roberts v. SAIF, 18 Or App 590 (1974) 1619,1863
Robinson v. Nabisco, Inc., 143 Or App 59 (1996) **2262**
Robinson v. SAIF, 147 Or App 157 (1997) 193,**518**,907,929,936,1576,1587,1819, 1845,1859,1982,2001,2024,2256
Rogers v. SAIF, 289 Or 633 (1980) **534**,760,805,1351,**2262**
Rogers v. Tri-Met, 75 Or App 470 (1985) 671,1437,1476,1497
Rogue Valley Med. Center v. McClearen, 152 Or App 239 (1998) 454,1953,**2302**
Roller v. Weyerhaeuser, 67 Or App 583 (1984) 918

Case ..... Page(s)

Roller v. Weyerhaeuser, 68 Or App 743 (1984) 918
Roseburg Forest Products v. Clemons, 169 Or App 231 (2000) **1737**,1963,2117,**2302**
Roseburg Forest Products v. Glenn, 155 Or App 318 (1998) 266,1273
Roseburg Forest Products v. Long, 325 Or 305 (1997) 406,892,1340,2089,2097,2182,**2268**
Roseburg Forest Products v. Wilson, 110 Or App 72 (1991) 856
Rosell v. S.I.A.C., 164 Or 173 (1940) 425
RSG Forest Products v. Jensen, 127 Or App 247 (1994) 144,1243,1433,1914
Runft v. SAIF, 303 Or 493 (1987) 2097,**2268**
Russell v. Ford Motor Co., 281 Or 587 (1978) **2302**
Russell v. SAIF, 281 Or 353 (1978) **1700**
S-W Floor Covering Shop v. N.C.C.I., 318 Or 614 (1994) 805,**1724**,2127
Safeco Ins. Co. v. Christensen, 248 Or 550 (1968) **1151**
Safeco Ins. Co. v. Laskey, 162 Or App 1 (1999) **531**
Safeco Ins. Co. v. Victoria, 154 Or App 574 (1998) 346,1005,2089,2097
Safeway Stores, Inc. v. Hayes, 119 Or App 319 (1993) 346,1677
Safstrom v. Reidel, Inc., 65 Or App 728 (1983) 918
SAIF v. Allen, 320 Or 192 (1994) 264
SAIF v. Avery, 167 Or App 327 (2000) 1674
SAIF v. Balcom, 162 Or App 325 (1999) 636,1245
SAIF v. Belden, 155 Or App 568 (1998) **527**,1556
SAIF v. Blakely, 160 Or App 242 (1999) 9,49,81,88,98,162,218,250,367,424,457, 493,498,637,643,726,762,765,823,873,880,980,982,994,1021,1302,1442,1452,1463,1468,1506,1509,1695,1850, 1893,1896,1948,1989,1997,2004,2019,2030,2052,2083,2143,2160,2238
SAIF v. Britton, 145 Or App 288 (1996) 313,1333,1560,2243
SAIF v. Brown, 159 Or App 440 (1999) **1737**
SAIF v. Burke, 145 Or App 427 (1996) 1076
SAIF v. Calder, 157 Or App 224 (1998) 204,241,397,635,781,949,999,1065,1278, 1306,1464,1528,1531,2042,2076,2123,**2268**
SAIF v. Carey, 63 Or App 68 (1983) **1709**
SAIF v. Cessnun, 161 Or App 367 (1999) 12,344,617,838,943,949,953,1067,1258, 1389,1639,2011
SAIF v. Cline, 135 Or App 155 (1995) 2142
SAIF v. Coburn, 159 Or App 413 (1999) 222,425,483
SAIF v. Condon, 119 Or App 194 (1993) 290,1026,1037,2038
SAIF v. Danboise, 147 Or App 550 (1997) 85,275,714,829,909,981,1042,1306,1464, 1584,1671,1684,2006
SAIF v. Drews, 318 Or 1 (1993) 154,**527**,**538**,1296
SAIF v. Edison, 117 Or App 455 (1992) 1483
SAIF v. Ekdahl, 170 Or App 193 (2000) 2158
SAIF v. Falconer, 154 Or App 511 (1998) 1428
SAIF v. Fisher, 100 Or App 288 (1990) 747,**1106**,1697
SAIF v. Fitzsimmons, 159 Or App 464 (1999) 655,676,**1720**
SAIF v. Fortson, 155 Or App 586 (1998) 1612
SAIF v. Frias, 169 Or App 345 (2000) 2246
SAIF v. Fuller, 159 Or App 426 (1999) **1739**
SAIF v. Gaffke, 152 Or App 367 (1998) 1306
SAIF v. Glubrecht, 156 Or App 339 (1998) 1256,2015
SAIF v. Hart, 162 Or App 297 (1999) 1613
SAIF v. Hernandez, 155 Or App 401 (1998) 79
SAIF v. January, 166 Or App 620 (2000) 991,1018,1062,**1119**,1262,1363
SAIF v. Kelly, 130 Or App 185 (1994) 122,**1709**,1998,2089,2182
SAIF v. Kurcin, 160 Or App 489 (1999) 230,1828
SAIF v. Ledin, 149 Or App 94 (1997) 680,682,1380
SAIF v. Lewis, 170 Or App 201 (2000) 1980,2081,2084
SAIF v. Mize, 129 Or App 636 (1994) 90,467

Case ..... Page(s)

SAIF v. Nehl, 148 Or App 101 (1997) 39,114,164,330,344,378,390,**518**,**549**, 900,924,936,986,996,1012,1014,1035,1061,1072,1094,1343,1348,1376,1440,1528,1610,1647,1663,1859,1910, 1915,1944,1946,1996,2031,2101,2102,2108,2196,2231,2254,2256
SAIF v. Nehl, 149 Or App 309 (1997) 39,114,164,330,344,378,390,**518**,**538**, **549**,900,924,996,1014,1061,1286,1376,1383,1440,1528,1610,1647,1663,**1704**,1819,1859,1910,1915,1944,1946, 1996,2031,2101,2102,2108,2196,2231,2254,2256
SAIF v. Parker, 61 Or App 47 (1982) 1410
SAIF v. Paxton, 154 Or App 259 (1998) 406
SAIF v. Reddekopp, 137 Or App 102 (1995) 682,1357,1948
SAIF v. Robertson, 120 Or App 1 (1993) 810,1405
SAIF v. Roles, 111 Or App 597 (1992) 425,483,**1162**,1357
SAIF v. Schiller, 151 Or App 58 (1997) 1094,1396,1665,**2302**
SAIF v. Shipley, 326 Or 557 (1998) **2297**
SAIF v. Simpson, 88 Or App 638 (1987) 2024
SAIF v. Stephen, 308 Or 41 (1989) 21,697,1592
SAIF v. Strubel, 161 Or App 516 (1999) 28,90,292,397,**518**,631,649,686,699,849, 862,900,926,949,991,999,1100,1521,1819,2070,2166
SAIF v. Sweeney, 115 Or App 506 (1992) 425,483
SAIF v. Sweeney, 121 Or App 142 (1993) 425,483
SAIF v. Tull, 113 Or App 449 (1992) 346,627,975,1560,1873
SAIF v. Valencia, 148 Or App 263 (1997) **1113**,**2275**
SAIF v. Walker, 145 Or App 294 (1996) 114,270,295,**510**,847,1018,1086,1262, 1363
SAIF v. Walker, 330 Or 102 (2000) 716,847,1018,1037,1062,1086,1102, **1116**,**1119**,1262,1273,1296,1363,1449,1639,1692,1904,2017,2205,**2275**
SAIF v. Whitney, 130 Or App 429 (1994) 346,1326
SAIF v. Williamson, 130 Or App 391 (1994) **2275**
SAIF v. Wolff, 151 Or App 398 (1997) 2203
SAIF v. Wright, 312 Or 132 (1991) 1410
SAIF v. Yokum, 132 Or App 18 (1994) **538**,943,**1709**,2097
Salem Tent & Awning v. Schmidt, 79 Or App 475 (1986) **542**
Sanford v. Balteau/SAIF, 140 Or App 177 (1996) 346,**538**,2097,2243
Saunders v. Preston Petty Products Co., 133 Or App 602 (1995) 2075
Savin Corp. v. McBride, 134 Or App 321 (1995) 1092,1965
Saxton v. SAIF, 80 Or App 631 (1986) 149,180,257,335,403,467,651,659,676, 755,833,835,854,883,972,983,1026,1387,1398,1450,1685,2081,2110,2194,2227,2236
Schmitt v. Towne Center Tire, 164 Or App 536 (1999) 316
Schoch v. Leupold & Stevens, 144 Or App 259 (1996) 138,2110
Schoch v. Leupold & Stevens, 162 Or App 242 (1999) 138,220,223,651,667,676,755,835,983, 1330,1343,1382,1398,1538,1585,1603,1635,1647,1677,1840,1921,2001,2248
Schoch v. Leupold & Stevens, 325 Or 112 (1997) **1116**
Schram v. Albertson's, 146 Or App 415 (1997) **555**
Schuening v. J.R. Simplot & Co., 84 Or App 622 (1987) 61,93,112,474,796,878,**1148**,1331,1357, 1378,1394,1478,1833,1990,2014,2248
Schuler v. Beaverton Sch. Dist. 48J, 164 Or App 320 (1999) 963
Schultz v. Springfield Forest Products, 151 Or App 727 (1997) 73,425,1556
Schulz v. Compensation Dept., 252 Or211 (1968) **2310**
Sedgwick James of Oregon v. Hendrix, 130 Or App 564 (1994) **2284**
Seitz v. Albina Human Resources, 110 Or App 665 (1990) **1138**
Sekermestrovich v. SAIF, 280 Or 723 (1977) 1666,**1717**,1899
Severy v. Board of Parole, 318 Or 172 (1993) **1162**
Shaw v. Doyle Mining Co., 297 Or 251 (1984) **1138**
Shaw v. PACCAR Wagner Mining, 161 Or App 60 (1999) 25,63,65,860,1449
Shaw v. Steinfelds Products, 160 Or App 77 (1999) 75
Shelley v. Portland Tug/Barge, 158 Or 377 (1938) **555**
Sherman v. Western Employer's Ins., 87 Or App 602 (1987) 1489,1661,2076
Shoulders v. SAIF, 300 Or App 606 (1986) 893

Case ..... Page(s)

Shubert v. Blue Chips, 151 Or App 710 (1997) 889,**1700**,1970
Shubert v. Blue Chips, 330 Or 554 (2000) 1970
Shurman v. Bureau of Labor, 36 Or App 841 (1978) **1162**
Silveira v. Larch Enterprises, 133 Or App 297 (1995) 479,943,1500
Sisters of Providence v. Ridenour, 162 Or App 467 (1999) 640
Slaughter v. SAIF, 60 Or App 610 (1982) 1965
Smith v. Ed's Pancake House, 27 Or App 361 (1976) 346,2243
Smith v. Multnomah Cty. Bd. of Comm., 319 Or 302 (1994) 2187
Smith v. SAIF, 302 Or 396 (1986) **510**
Smurfit Newsprint v. DeRosset, 118 Or App 368 (1993) 346,**538**,2097,2243
Snyder v. Barrett Business Services, 147 Or App 619 (1997) 85
Somers v. SAIF, 77 Or App 259 (1986) 15,24,66,79,114,131,164,167,171,185,188,213,238,272,288,292,307,310,314,320,322,330,333,337,380,385,387,397,442,448,461,474,502,621,638,668,742,745,770,849,854,862,882,900,907,926,949,954,963,986,996,1012,1014,1042,1050,1053,1072,1079,1094,1246,1264,1267,1273,1286,1296,1299,1306,1322,1343,1348,1368,1376,1380,1383,1428,1440,1460,1470,1472,1528,1550,1590,1601,1603,1619,1632,1639,1647,1650,1833,1836,1855,1861,1910,1915,1937,1940,1946,1953,1957,1960,1971,1990,1996,1998,2006,2008,2013,2033,2059,2086,2121,2131,2140,2205,2208,2221,2225,2231,2243,2256
South Benton Ed. v. Monroe U. High, 83 Or App 425 (1987) 178
Southwest Forest Industries v. Anders, 299 Or 205 (1985) 1347
Spaur v. Ashenberner Lumber, 121 Or App 684 (1993) 1433
Spivey v. SAIF, 79 Or App 568 (1986) 1026,1356,2176
Springfield Ed. Assn. v. School Dist., 290 Or 217 (1980) 704,**1132**
Spurlock v. International Paper Co., 89 Or App 461 (1988) 1535,2097
Stacy v. Corrections Division, 131 Or App 610 (1994) 1368,1380,1459,1861,1943,2221,2250
Stan v. Constitution State Service Co., 168 Or App 92 (2000) 1076
Stanfield v. Laccoarce, 284 Or 651 (1978) **544**
Stanich v. Precision Body & Paint, 151 Or App 446 (1997) **1138**
Stark v. S.I.A.C., 103 Or 80 (1922) **1174**
State v. Burton, 114 Or App 84 (1992) 2187
State v. Cook, 163 Or App 578 (1999) **1713**
State v. Cunningham, 320 Or 47 (1994) **2302**
State v. Maddox, 165 Or App 573 (2000) **573**
State v. Maxwell, 161 Or App 468 (1999) **2275**
State v. Meyers, 153 Or App 551 (1998) **1138**
State v. Moyle, 299 Or 691 (1985) 383
State v. Pratt, 316 Or 561 (1993) 425
State v. Preston, 103 Or 631 (1922) 2187
State v. Rainey, 298 Or 459 (1985) **2302**
State v. Sumerlin, 139 Or App 579 (1996) **2275**
State v. Toevs, 327 Or 525 (1998) **510**,**2262**
State v. Vasquez-Rubio, 323 Or 275 (1996) **531**
State v. Webb, 324 Or 380 (1996) **1151**
State v. Williams, 161 Or App 111 (1999) **2302**
State v. Ysasaga, 146 Or App 74 (1997) **573**
State ex rel Hall v. Riggs, 319 Or 282 (1994) **1106**,1931
State ex rel Juv. Dept. v. Ashley, 312 Or 169 (1991) 704
State ex rel Kilian v. City of West Linn, 112 Or App 549 (1992) **1168**
State Farm Insurance v. Lyda, 150 Or App 554 (1997) 1479
Steiner v. E.J. Bartells Co., 114 Or App 22 (1992) **2297**
Stephen v. Oregon Shipyards, 115 Or App 521 (1992) 50,433,1468,1893,1989,1997,2004,2238
Stephens v. Bohlman, 314 Or 344 (1992) **566**
Stephenson v. Meyer, 150 Or App 300 (1997) 264,915,1951,2038,2191
Stepp v. SAIF, 304 Or 375 (1987) **510**,1062,**2284**
Stevens v. Horton, 161 Or App 454 (1999) **2297**
Stevenson v. Blue Cross of Oregon, 108 Or App 247 (1991) 310,335,451,482,774,846,973,1026,1053,1070,1072,1254,1387,1433,1540,1573,1943,1945,1956,1993,2031,2056,2066,2084,2105,2145

Case ..... Page(s)

Stoddard v. Credit Thrift Corp., 103 Or App 283 (1990) 1256,2015
Strazi v. SAIF, 109 Or App 105 (1991) 1033,1492
Stull v. Hoke, 326 Or 72 (1997) **2302**
Sullivan v. Argonaut Ins., 73 Or App 694 (1985) 28,51,54,59,61,93,112,147,232,371,474, 671,680,708,715,723,730,734,750,787,839,866,878,989,1021,1266,1331,1355,1367,1378,1394,1403,1418,1423, 1437,1472,1474,1478,1497,1544,1824,1832,1833,1853,1925,1949,1986,1994,2140,2148,2192
Sweeden v. City of Eugene, 95 Or App 577 (1989) 1677
Taal v. Union Pacific Railroad, 106 Or App 488 (1991) **1116**
Tattoo v. Barrett Business Services, 118 Or App 348 (1993) 649,1299,2038
Taylor v. Cabax Saw Mill, 142 Or App 121 (1996) 630,1623
Taylor v. Liberty Northwest, 107 Or App 107 (1991) 153
Taylor v. SAIF, 75 Or App 583 (1985) 742
Tee v. Albertsons, Inc., 314 Or 633 (1992) 704
Terlouw v. Jesuit Seminary, 101 Or App 493 (1990) 1492
Tektronix, Inc. v. Nazari, 117 Or App 409 (1992) 649,1346
Tektronix, Inc. v. Nazari, 120 Or App 590 (1993) 1346
Tektronix, Inc. v. Watson, 132 Or App 483 (1995) 57,204,355,748,1081,1289,1443,1594, 1656
Teledyne Wah Chang v. Vorderstrasse, 104 Or App 498 (1990) 1534
The New Portland Meadows v. Dieringer, 153 Or App 383 (1998) 479,943,1639
The New Portland Meadows v. Dieringer, 157 Or App 619 (1998) 479,943
Thomas v. Liberty Mutual Ins. Corp., 73 Or App 128 (1985) 742
Thomas v. SAIF, 8 Or App 414 (1972) 2168
Thomas v. SAIF, 64 Or App 193 (1983) 310,1254,1566,1573,1888
Tidewater v. Wheeler, 55 Or App 497 (1982) **2302**
Timberline Equip. v. St. Paul Fire, 281 Or 639 (1978) 1623
Timm v. Maley, 125 Or App 396 (1993) 122,406,934,1535,**1709**,1998,2089,2097, 2182
Tinh Xuan Pham Auto v. Bourgo, 143 Or App 73 (1996) 241,2048,2069
Torkko v. SAIF, 147 Or App 678 (1997) 760
Trabosh v. Washington County, 140 Or App 159 (1996) **542**
Trevitts v. Hoffman-Marmolejo, 138 Or App 455 (1996) 32,344,**1135**,1261,1272,1318,1540,1623
Tripp v. Ridge Runner Timber Services, 89 Or App 355 (1988) 37,136,621,954,1069,1077
Trout v. Umatilla Co. Sch. Dist., 77 Or App 95 (1985) **1151**
Turnbow v. K.E. Enterprises, Inc., 155 Or App 59 (1998) **1168**
U-Haul of Oregon v. Burtis, 120 Or App 353 (1993) 1367,1437
Uris v. Compensation Dept., 247 Or 420 (1967) 66,114,118,164,167,185,188,200,213, 227,238,254,272,292,297,310,330,344,380,385,406,461,477,**518**,647,742,745,770,849,859,862,900,905,907, 926,949,954,963,978,986,999,1012,1014,1035,1072,1090,1094,1246,1267,1286,1299,1306,1318,1339,1342, 1343,1348,1380,1383,1428,1459,1460,1470,1521,1587,1590,1599,1603,1610,1630,1632,1647,1663,1820,1845, 1855,1905,1909,1915,1940,1943,1944,1957,1982,1983,1998,2001,2013,2024,2042,2062,2076,2095,2121,2131, 2173,2208,2221,2231,2243,2250,2254,2256
Urness v. Liberty Northwest, 130 Or App 454 (1994) 1088,1637
Valtinson v. SAIF, 56 Or App 184 (1982) 196,313,639,1037,1306,1383,1630,1961
Van Blokland v. O.H.S.U., 87 Or App 696 (1987) 52,1256,2015
Vaughn v. Pacific NW Bell, 289 Or 73 (1980) 425,**1138**
Vega v. Express Services, 144 Or App 602 (1996) 1685,2078
Vogel v. Liberty Northwest Ins. Corp., 132 Or App 7 (1994) 2056
Volk v. American West Airlines, 135 Or App 565 (1995) 85,411,915,**1162**,1552,1622
Voorhies v. Wood, Tatum, Moser, 81 Or App 336 (1985) 1666,**1717**
Wacker Siltronic Corp. v. Satcher, 91 Or App 654 (1988) 634
Warner v. SAIF, 63 Or App 280 (1983) **1132**
Washington Cty. Police v. Wash. Cty., 321 Or 430 (1995) 316
Watkins v. Fred Meyer, Inc., 79 Or App 521 (1986) 425
Wausau Ins. Companies v. Morris, 103 Or App 270 (1990) 9,49,50,88,98,162,218,250,271,301,358, 370,424,433,452,455,457,498,643,765,823,994,1442,1452,1463,1628,1643,1695,1850,1893,1896,2019,2030, 2052,2143,2160

Case ..... Page(s)

Way v. Fred Meyer, Inc., 126 Or App 343 (1994) 856
Weckesser v. Jet Delivery Systems, 132 Or App 325 (1995) 102
Weiland v. SAIF, 64 Or App 810 (1983) 7,13,15,21,26,31,93,96,112,114,121,131, 164,168,170,180,185,188,193,200,204,238,272,282,288,297,307,310,314,318,320,322,337,344,371,385,396, 397,431,442,448,461,464,620,621,642,646,647,649,663,668,729,742,745,750,770,843,844,849,854,862,872, 876,882,907,926,940,949,963,978,986,996,1002,1012,1045,1061,1079,1094,1246,1264,1296,1306,1322,1348, 1355,1368,1376,1380,1383,1440,1472,1479,1513,1528,1550,1566,1577,1590,1601,1619,1639,1650,1656,1836, 1855,1861,1908,1909,1910,1915,1937,1940,1944,1946,1957,1983,1990,1996,1998,2008,2010,2013,2094,2095, 2121,2140,2196,2205,2208,2210,2221,2225,2243,2248,2256
Welch v. Banister Pipeline, 70 Or App 699 (1984) 697,2024
Weller v. Union Carbide, 288 Or 27 (1980) 1534
West v. SAIF, 74 Or App 317 (1985) 52
Westendorf and Westendorf, 165 Or App 175 (2000) **2302**
Westfall v. Rust International, 314 Or 553 (1992) 60,904
Westmoreland v. Iowa Beef Processors, 70 Or App 642 (1984) 273,792
Wetzel v. Goodwin Bros., 50 Or App 101 (1981) 52
Weyerhaeuser Co. v. Bryant, 102 Or App 432 (1990) 649,1346,1566,1888,1937
Weyerhaeuser Co. v. Kepford, 100 Or App 410 (1990) 9,49,50,88,98,162,218,271,358,370,424, 433,455,457,643,765,823,994,1021,1370,1442,1452,1463,1643,1695,1850,1883,1893,1896,2019,2030,2052, 2160
Weyerhaeuser Co. v. Knapp, 100 Or App 462 (1990) 1590
Weyerhaeuser Co. v. Woda, 166 Or App 73 (2000) **1111**,1513,**2275**
Whipple v. Howser, 291 Or 475 (1981) 1878
Whitlock v. Klamath Co. Sch. Dist., 142 Or App 137 (1996) 494,**523**
Whitlock v. Klamath Co. Sch. Dist., 158 Or App 464 (1999) 494,**523**,**1732**
Willamette Industries, Inc. v. Titus, 151 Or App 76 (1997) 2089,2097
Williams v. American States Ins. Co., 163 Or App 179 (1999) **573**
Williams v. SAIF, 31 Or App 1301 (1977) 1365
Williams v. Wise, 139 Or App 276 (1996) 1623
Wilson v. State Farm Ins., 326 Or 413 (1998) 649,897,1030,1935,**2262**,**2286**
Wilson v. Steel Tank & Pipe, 152 Or 386 (1936) **544**
Wilson v. Weyerhaeuser, 30 Or App 403 (1977) 697
Winnett v. City of Portland, 118 Or App 437 (1993) **555**,**1138**
Winters v. Woodburn Carcraft Co., 142 Or App 182 (1996) 651,1373,1491
Wise v. Gary-Adams-Trucking, 106 Or App 654 (1991) 1492
Wojcik v. Weyerhaeuser Co., 89 Or App 561 (1987) 1378
Wood v. Dunn, 109 Or App 204 (1991) **2300**
Woody v. Waibel, 276 Or 189 (1976) **1724**
Wooten v. Viking Distributing Co., 136 Or App 56 (1995) **555**
Wootton v. Stadeli Pump & Constr., 108 Or App 548 (1991) 943
Worldmark The Club v. Travis, 161 Or App 644 (1999) 28,90,**518**,631,649,862,926,949,999, 1100,1273,1428,1819
Wright v. Bekins Moving & Storage Co, 97 Or App 45 (1989) 1420
Wright Schuchart Harbor v. Johnson, 133 Or App 680 (1995) 33,204,856,1387
Young v. State of Oregon, 161 Or App 32 (1999) **531**,**1713**
Younger v. City of Portland, 305 Or 346 (1988) **518**
Zerba v. Ideal Mutual Ins. Co., 96 Or App 607 (1989) **555**
Zurich Ins. v. Diversified Risk Management, 300 Or 47 (1985) 11,670,1252,2022,2057

Case ..... Page(s)

Abbott, Douglas G., 50 Van Natta 1156 (1998) 2203
Abel, Thomas L., 44 Van Natta 1039, 1189 (1992) 634
Abel, Thomas L., 45 Van Natta 1768 (1993) 362,1405
Abshire, Anthony W., 52 Van Natta 204, 635 (2000) 925,1679
Adkins, John P., 52 Van Natta 708 (2000) 2148
Akins, Linda M., 44 Van Natta 108 (1992) 335
Albro, Gail A., 48 Van Natta 41 (1996) 15,66
Allen, Anthony G., 49 Van Natta 460 (1997) 1260
Allen, Denise L., 50 Van Natta 2357 (1998) 325
Allen, Larry D., 52 Van Natta 430 (2000) 1878
Allenby, George L., 50 Van Natta 1844 (1998) 417,2080
Alm, Gerald C., 52 Van Natta 456 (2000) 754
Alvarado, Alfonso S., 43 Van Natta 1303 (1991) 1409
Amstutz, Lynn, 50 Van Natta 1436 (1998) 1246,1318
Andersen, Christopher S., 52 Van Natta 85 (2000) 2006
Anderson, Joan D., 50 Van Natta 1817 (1998) 497
Anderson, Kim S., 48 Van Natta 1876 (1996) 1679
Anderson, Neal S., 49 Van Natta 1 (1997) 118,960
Anderson, Robert E., 52 Van Natta 151 (2000) 1405,1483
Andre, Marlene J., 48 Van Natta 404 (1996) 50,433,1468,1893,1989,1997,2004,2238
Andrews, Edward J., 51 Van Natta 226, 377 (1999) 1690
Angstadt, Lisa R., 47 Van Natta 981 (1995) 174,2189
Armstrong, Robert L., 47 Van Natta 1399 (1995) 1828
Asbury (Shaffer), Constance A., 48 Van Natta 1018 (1996) 833
Asti, Carolyn S., 51 Van Natta 1706 (1999) 2310
Asti, Janenne R., 48 Van Natta 2575 (1996) 2006
Atkins, Gorden L., 52 Van Natta 284 (2000) 939,1294
Avery, Albert D., 51 Van Natta 814 (1999) 467
Azorr, Steven R., 52 Van Natta 2145 (2000) 2212
Babury, Orfan A., 48 Van Natta 1687 (1996) 327,351,660,794,876,925
Backman, Susan M., 52 Van Natta 1910 (2000) 2254
Bade, Anita A., 36 Van Natta 1093 (1984) 2066
Baker, Mark A., 50 Van Natta 2333 (1998) 45,138,257,297,1540
Baker, Peggy J., 49 Van Natta 40 (1997) 105,2174
Baker, Virginia L., 44 Van Natta 217 (1992) 2209
Bakke, Daniel R., 44 Van Natta 831 (1992) 918
Balcom, Gerald, 49 Van Natta 659 (1997) 636
Baldie, Julie M., 47 Van Natta 2249 (1995) 2127
Balogh, Donna J., 52 Van Natta 1057 (2000) 1373,1867
Banks, Robert W., 51 Van Natta 1707 (1999) 2182
Barabash, William J., 50 Van Natta 1561 (1998) 1376
Barajas, Gustavo B., 51 Van Natta 613, 732 (1999) 716
Barbeau, Valerie, 49 Van Natta 189 (1997) 467
Barbee, Jack L., 48 Van Natta 1855 (1996) 1566
Bard, Anthony N., 47 Van Natta 2016 (1995) 425
Bardales, Victor M., 52 Van Natta 925 (2000) 1679
Barklow, Georgia, 49 Van Natta 1261 (1997) 112
Barlow, Michael S., 46 Van Natta 1627 (1994) 1867
Barnes, Lynette D., 44 Van Natta 993 (1992) 506
Barrett, William B., 51 Van Natta 286 (1999) 138
Barrs, Connie J., 51 Van Natta 1338, 1500 (1999) 1576,2166
Bates, Jean M., 43 Van Natta 2280 (1991) 90
Batori, Michael C., 49 Van Natta 535 (1997) 50,218,358,370,424,433,498,765,994,1452,1463, 1850,1893,1896,2052,2143
Baxter, Elaine M., 51 Van Natta 1898 (1999) 936,1343,1587,1845,1982,2001,2256
Baxter, Gary D., 50 Van Natta 634 (1998) 58
Beairsto, Elizabeth, 47 Van Natta 750 (1995) 977

Case ..... Page(s)

Beardsley, William M., 48 Van Natta 2210 (1996) 1409
Beatty, Robert L., 49 Van Natta 860 (1997) 1348
Becker, William C., 47 Van Natta 1933 (1995) 1677,1956
Bent, William E. II, 48 Van Natta 1560 (1996) 946
Bentley, Darlene K., 45 Van Natta 1719 (1993) **1713**
Bergeron, Glen A., 51 Van Natta 900 (1999) 651
Berhorst, Janet F., 50 Van Natta 1578 (1998) 457
Berhorst, Janet F., 51 Van Natta 464, 1008 (1999) 634,1009
Bergmann, Michael T., 52 Van Natta 1931 (2000) 2145,2148,2212
Bergquist, Larry J., 46 Van Natta 2397 (1994) 1677
Bergrud, Brian A., 50 Van Natta 1662 (1998) 506
Bird, Harold T., 43 Van Natta 1732 (1991) 2119
Birrer, Corinne L., 51 Van Natta 163, 467 (1999) 241,339,918,1254,1882,2112,2245
Bisceglia, Eugene I., 52 Van Natta 404 (2000) 1357
Black, Rodney A., 52 Van Natta 1632 (2000) 1903
Blackburn, Gary L., 52 Van Natta 1373 (2000) 1867
Blamires, Tracey A., 50 Van Natta 1793, 2273 (1998) 1373,1432,1579
Blankenship, John W., 52 Van Natta 406 (2000) 1544,1677
Bliss, Jerry L., 49 Van Natta 1471 (1997) 497
Board, James E., 52 Van Natta 442 (2000) 2081
Boldway, Jamie J., 52 Van Natta 755 (2000) 1538,2110,2227
Bolin, Verna M., 51 Van Natta 1949 (1999) 627,1560
Bollinger, Edwin, 33 Van Natta 559 (1981) 304
Bond, Arlene J., 50 Van Natta 2426 (1998) 60,158
Bonham, Olive M., 51 Van Natta 1710 (1999) 45,1324,1566,1888,1993,2212
Booker, Sandra L., 48 Van Natta 2533 (1996) 2053
Boone, Cheryl A., 51 Van Natta 616 (1999) 55,417
Bounds, Annie L., 51 Van Natta 358 (1999) 810,1405,2078
Boydston, Jenny L., 50 Van Natta 691 (1998) 60,1057
Bradburry, Bobby, 52 Van Natta 1560 (2000) 2243
Bradford, Jacqueline D., 49 Van Natta 236 (1996) 1351
Bradley, Maureen E., 49 Van Natta 2000 (1997) 291
Brickey, Cordy A., 44 Van Natta 220 (1992) 423,1611
Bridwell, Joseph E., 49 Van Natta 1061,1452 (1997) 174
Briggs, Terri A., 52 Van Natta 1009 (2000) 1898
Briggs-Tripp, Terri A., 51 Van Natta 21, 456 (1999) 1009
Brimblecom, Lois, 48 Van Natta 2312 (1996) 51,61,147,715,866,989,1266,1418,1472,1676, 1832,1994,2192
Britton, Judy A., 37 Van Natta 1262 (1985) 171,454,774,784,960,1257,1294,1401,1654,1673, 1880,1918,1978,2036,2225
Brizendine, William D., 50 Van Natta 21 (1998) 7
Brodigan, Todd M., 45 Van Natta 438 (1993) 275
Brokenshire, Victoria A., 50 Van Natta 1411 (1998) 814
Bronson, June E., 51 Van Natta 928 (1999) 138,747,835,1271,1870
Brooks, Douglas H., 48 Van Natta 736 (1996) 438
Brown, Denise N., 51 Van Natta 836 (1999) 2210
Brown, Earl M., 41 Van Natta 287 (1989) 1273
Brown, Gilbert R., 43 Van Natta 585 (1991) 873
Brown, George M., 52 Van Natta 5 (2000) **2310**
Brown, Patricia A., 48 Van Natta 1164 (1996) 2258
Brown, Shirley M., 40 Van Natta 879 (1988) 768,1100,1560
Brown, Vicki F., 51 Van Natta 1961 (1999) 775
Browne, Howard L., 49 Van Natta 485 (1997) 160,455,793,995
Broyles, Joanne C., 51 Van Natta 1250 (1999) 1944,2221
Brusseau, James D., 43 Van Natta 541 (1991) 1559,2036
Bryant, Carol A., 51 Van Natta 1827 (1999) 1845
Bucknum, David W., 47 Van Natta 2055 (1995) 1070

Case ..... Page(s)

Buitron, Elizabeth M., 51 Van Natta 1768 (1999) 780,1534,1958,1984
Bundy, Kenneth P., 48 Van Natta 2501 (1996) 249,1009,1613
Burke, Richard O., 50 Van Natta 1177 (1998) 1679
Burrow, Linda R., 44 Van Natta 71 (1992) 810
Bursell, Bonnie L., 50 Van Natta 2323 (1998) 1276
Burson, Nga H., 52 Van Natta 860 (2000) 1627
Burt, William A., 46 Van Natta 270 (1994) 2161
Burton-Berg, Verna, 39 Van Natta 665 (1987) 873
Bush, Frank L., 48 Van Natta 1293 (1996) 1423
Butcher, Lenne, 41 Van Natta 2084 (1989) 452
Bye, Wendy R., 49 Van Natta 636 (1997) 1534
Byrne, Robyn, 47 Van Natta 213 (1995) 18,2116
Calhoun, Donna J., 47 Van Natta 454 (1995) 467
Calise, Dena M., 45 Van Natta 783 (1993) 1477
Callahan, Teri S., 49 Van Natta 548 (1997) 869,1683
Calles, Ana J., 46 Van Natta 2195 (1994) 1401
Caouette, Teri L., 52 Van Natta 767 (2000) 1952
Carman, Karen S., 49 Van Natta 637 (1997) 538
Carper, Robert E., 48 Van Natta 1160 (1996) 1899
Carr, Glen A., 52 Van Natta 1405 (2000) 1483
Carter, Daniel L., 50 Van Natta 1145 (1998) 85,2178
Carter, Lura F., 51 Van Natta 1226 (1999) 19,654
Carter, Lura F., 51 Van Natta 2038 (1999) 655
Carter, Randy L., 48 Van Natta 1271 (1996) 227,432
Casperson, Robert, 38 Van Natta 420 (1986) 169
Castaneda, Mario R., 49 Van Natta 2135 (1997) 108,682,708,723,730,750,1824,2148
Caywood, Charles N., 39 Van Natta 83 (1987) 118,960
Cazares, Rosa, 48 Van Natta 1007 (1996) 1665
Ceballos, Robert S., 49 Van Natta 617 (1997) 657,754,865,1032,1430,1510
Cecil, Dale F., 51 Van Natta 1010 (1999) 940
Centurion, Antonio, 51 Van Natta 2017 (1999) 1088
Cervantes, Victor J., 51 Van Natta 1343 (1999) 273
Cessnun, Michael D., 51 Van Natta 1737 (1999) 2304
Chambers, Robert B., 48 Van Natta 1113 (1996) 768
Chavez, Ricardo, 50 Van Natta 90 (1998) 174
Chittim, Charles L., Jr., 51 Van Natta 764 (1999) 487,1956
Chorney, Oreste A., 50 Van Natta 498, 818 (1998) 1097
Chrisman, Jan M., 48 Van Natta 2225 (1996) 101
Christensen, Janet R., 50 Van Natta 396 (1998) 263,497
Christensen, Janet R., 50 Van Natta 1152 (1998) 316,1427,1579,1592,1867,1869,1926,2258
Christian, Cindy K., 50 Van Natta 1729 (1998) 1318
Church, Lori, 46 Van Natta 1590 (1994) 118,960
Cilione, Joseph L., 50 Van Natta 1828 (1998) 36
Clark, Harvey, 47 Van Natta 136 (1995) 869,1081
Clark, Ronald L., 50 Van Natta 2352 (1998) 371,1361
Clark, Ronald L., 51 Van Natta 1365 (1999) 371,1361
Clarke, Trisha, 48 Van Natta 505 (1996) 2020
Clift, Susan K., 51 Van Natta 646 (1999) 472,682,973,1285
Clifton, Anita L., 43 Van Natta 1921 (1991) 946,984,1654,2022
Clunas, William M., 51 Van Natta 765 (1999) 953
Cobian, Carlos S., 45 Van Natta 1582 (1993) 204,778,1053,1926
Coburn, Robert W., 49 Van Natta 1778 (1997) 222
Cody, Sheri L., 44 Van Natta 2254 (1992) 1637
Coffman, Beverly J., 51 Van Natta 1736 (1999) 880
Coldiron, Debby R., 51 Van Natta 905 (1999) 946
Coleman, Bill D., 48 Van Natta 2154 (1996) 1347
Coleman, Marti J., 51 Van Natta 819 (1999) 1623

Case ..... Page(s)

Colerick, Karen M., 46 Van Natta 930 (1995) 523
Collado, Jeffrey V., 50 Van Natta 2075 (1998) 355
Collins, David E., 49 Van Natta 561 (1997) 1299
Collins, Linda J., 51 Van Natta 1901 (1999) 1446
Colombo, Marie L., 51 Van Natta 1872 (1999) 316
Conaway, Carol L., 43 Van Natta 2267 (1991) 49,367,1442
Cone, Garnette D., 51 Van Natta 848 (1999) 760
Conner, Arthur A., 52 Van Natta 649 (2000) 1346
Conradi, Clifford L., 46 Van Natta 854 (1994) 432,1559
Conradson, Ben E., 51 Van Natta 851 (1999) 128,164
Conradson, Ben E., 52 Van Natta 893 (2000) 1033
Coon, Oliver F., 42 Van Natta 1845 (1990) 2119
Cooper, George T., 44 Van Natta 492 (1992) 2026
Cordiero, Mary E., 48 Van Natta 1178 (1996) 425
Cornett, Clifford D., 51 Van Natta 1430 (1999) 856
Cornett, Robert E., 45 Van Natta 1567 (1993) 634
Countryman, Fred R., 50 Van Natta 2202 (1998) 85
Courtright, Carol D., 50 Van Natta 1770 (1998) 1674
Couture, David L., 50 Van Natta 1181 (1998) 275,1464
Cox, Raymond T., Jr., 47 Van Natta 1628 (1995) 2302
Coyle, Laura, 52 Van Natta 1254 (2000) 1432
Crawford, Mark A., 46 Van Natta 725, 873 (1994) 1357
Crawford, Murlaine, 51 Van Natta 1783 (1999) 1026
Crews, Leslie A., 50 Van Natta 193, 317 (1998) 1859
Criss, Donald M., 48 Van Natta 1569 (1996) 651,1491
Crockett, Eleanor I., 51 Van Natta 950 (1999) 346,1333
Crompton, Dustin L., 50 Van Natta 1206 (1998) 1372
Crompton, Jody, 48 Van Natta 1183 (1996) 2109
Crook, James C., Sr., 49 Van Natta 65 (1997) 357,1303,1670,1907
Cross, Linda M., 45 Van Natta 2130 (1993) 2251
Crowley, Mary A., 51 Van Natta 1829 (1999) 313,926
Cuellar, Elloy, 48 Van Natta 814 (1996) 755
Culp, Elsie M., 47 Van Natta 760 (1995) 1342
Culver, Melba J., 50 Van Natta 2028 (1998) 1666
Cuniff, Barbara J., 48 Van Natta 1032 (1996) 1063,1338
Currie, Lloyd G., 45 Van Natta 492 (1993) 510
Dahl, Gerald J., 47 Van Natta 1055 (1995) 467
Dahl, Lorraine W., 52 Van Natta 1576 (2000) 1903
Dalton, Gene C., 43 Van Natta 1191 (1991) 346
Danboise, Kim E., 47 Van Natta 2163, 2281 (1995) 1042
Daniel, Minnie A., 35 Van Natta 681 (1985) 425
Darr, Bruce C., 45 Van Natta 305 (1993) 19
Dart, Ronald R., 49 Van Natta 1027 (1997) 897
Davila, Jeffrey N., 50 Van Natta 1687 (1998) 630
Davis, Ben L., 47 Van Natta 2001 (1995) 250,2143
Davis, Bill H., 47 Van Natta 219, 1448 (1995) 371,1361,1405
Davis, Bill H., 49 Van Natta 337 (1997) 1405
Davis, Donald D., 49 Van Natta 2100 (1997) 231
Davis, Donald D., 50 Van Natta 357, 682 (1998) 1464
Davis, Earl W., 51 Van Natta 1347 (1999) 356
Davis, John R., 52 Van Natta 1278 (2000) 1528
Davis, Randall, 48 Van Natta 369 (1996) 1566
Davis, Robert P., 49 Van Natta 2139 (1997) 1859
Davis, Vicki L., 49 Van Natta 603 (1997) 45
Davis, William F., 51 Van Natta 257 (1999) 223,1603
Dawkins, Roland L., 42 Van Natta 1 (1990) 295
Dawson, Robert L., 50 Van Natta 2110 (1998) 649,897,1030

Case ..... Page(s)

Day, Charles C., 49 Van Natta 511 (1997)..... 1548
Declue, Jeffrey S., 50 Van Natta 2315 (1998)..... 1588
Deel, Carrie L., 50 Van Natta 2311 (1998)..... 991
Delatorre, Jesus M., 51 Van Natta 728 (1999)..... 1559
Delfel, Adam J., 50 Van Natta 1041 (1998)..... 1683
Demagalski, Michael D., 51 Van Natta 1043 (1999) 457,1997
Dennis, Jeffrey D., 43 Van Natta 857 (1991) 151,835,1009
Dennis, Jeffrey L., 52 Van Natta 344 (2000)..... 924,1540,2084
Denton, John, 50 Van Natta 1073 (1998)..... 452
DePaul, Ralph B., 44 Van Natta 92 (1992) 890
Derderian, Robert, 45 Van Natta 1042 (1993) 22,2107
Deronden-Pos, Cnythia R., 51 Van Natta 1517 (1999) **2302**
Dickson, Ronald V., 42 Van Natta 1102 (1990) 1971
Dionne, Frank M., 50 Van Natta 2290 (1998)..... 1323
Dipolito, Michael A., 45 Van Natta 1776 (1993)..... 755
Dixon, Robert E., 48 Van Natta 46 (1996) 692,2227
Dobbs, Fred L., 50 Van Natta 2293 (1998)..... 56,263,346,538,627,1521,1560,1873
Dobson, Thomas G., 50 Van Natta 2390 (1998)..... 1094,1396,1659
Dobson, Thomas G., 51 Van Natta 297 (1999) 1396,1659
Dodgin, Donald R., 45 Van Natta 1642 (1993) 63,65,860
Dominiak, Raymond J., 48 Van Natta 108 (1996)..... 886
Doolin, Clifford C., 50 Van Natta 99 (1998)..... 12
Dorman, James I., 50 Van Natta 1649, 1773 (1998)..... 99,887
Douglas, Frank M., 46 Van Natta 1445 (1994)..... 2068,2140,2229
Drennen, Vincent C., 48 Van Natta 819, 969 (1996) 887
Drevenchuk, Yekaterina, 49 Van Natta 1016 (1997) 169
Drew, Oscar L., 38 Van Natta 934 (1986) 425
Drew, Shawn M., 50 Van Natta 925 (1998)..... 487
Drushella, Denice K., 52 Van Natta 621 (2000)..... 785
Duede, Jerry W., 48 Van Natta 413 (1996)..... 1512
Duncan, Ragie D., 52 Van Natta 1 (2000) 1619
Duncan, Steve, 50 Van Natta 987 (1998)..... 936
Durette, L.C., 52 Van Natta 410 (2000)..... 1847
Dyer, Ken T., 49 Van Natta 2086 (1997)..... 676,2158
Dylan, David L., 50 Van Natta 276, 852 (1998)..... 487,716,767,1347,1952
Easley, David L., 50 Van Natta 2112 (1998)..... 1900
Eberhart, Bonnie L., 45 Van Natta 800 (1993) 918
Ebert, Edward F., 47 Van Natta 2170 (1995)..... 883
Ebert, Edward F., 48 Van Natta 37 (1995)..... 883
Eichensehr, Douglas A., 44 Van Natta 1755 (1992)..... 52
Egbert, Mary A., 52 Van Natta 1457 (2000)..... 1827
Eggman, Brian M., 49 Van Natta 1835 (1997)..... 1427,1592
Eggman, Brian M., 51 Van Natta 398 (1999) 295,316
Eli, Roger, 47 Van Natta 1938 (1995)..... 1566
Elizalde, Jeff R., 50 Van Natta 2229 (1998)..... 1383
Elizondo, Richard R., 47 Van Natta 377 (1997)..... 1243
Emerson, Kenneth W., 51 Van Natta 654 (1999)..... 714,829,1306,1671
Enriquez, Anselmo, Jr., 51 Van Natta 304 (1999)..... 1676
Enriquez, Yolanda, 50 Van Natta 1507 (1998)..... 1489,1661
Eubank, Robert, 51 Van Natta 669 (1999)..... 1009
Evans, James M., 51 Van Natta 1046 (1999) 457
Fagin, Robert W., 50 Van Natta 1680 (1998)..... 144
Fair, Ronnie C., 51 Van Natta 1860 (1999)..... 505,907
Fairchild, Judy D., 45 Van Natta 421 (1993)..... 90
Falls, Neal, 49 Van Natta 465 (1997) 784
Falsetto, Sharon K., 49 Van Natta 1202, 1573 (1997) 1088
Farnsworth, Annette E., 48 Van Natta 508 (1996) 848

Case ..... Page(s)

Felix, Rosario, 45 Van Natta 1179 (1993) 241,2048
Felton, Kenneth C., 48 Van Natta 194, 725 (1996)..... 50,52,218,358,370,424,433,498,765,994,1452, 1850,1893,1896,1899,2052,2143
Ferdig, William R., 50 Van Natta 442 (1998) 978,986,1008,1012,1017,1072,1286,1299,1380, 1647,1663,1915,1957,2140,2243
Field, Daniel S., 47 Van Natta 1457 (1995)..... 96,297,320,1052,1306,1630,1909
Field, Paul D., 50 Van Natta 1731 (1998) 60
Fischbach, William L., 48 Van Natta 1233 (1996) 1679
Fisher, Joan L., 51 Van Natta 959 (1999) 2218
Fisher, Joseph, 45 Van Natta 2112 (1993)..... 452
Fitzgerald, Gayle L., 52 Van Natta 1400 (2000)..... 1656
Fitzsimmons, Brian M., 50 Van Natta 433 (1998)..... 676
Flaherty, Christine M., 51 Van Natta 1971 (1999)..... 275
Fleming, Michal A., 52 Van Natta 383 (2000) 473,1540
Flescher, Verna C. (fka Lowell), 50 Van Natta 1105 (1998)..... 1579,2258
Fleshman, Tamara J., 52 Van Natta 1918 (2000)..... 2225
Fletes, Jesus, 48 Van Natta 197 (1996)..... 25
Flores, Richard, 51 Van Natta 411 (1999)..... 1326
Foil, Brenda, 51 Van Natta 345 (1999)..... 196
Forrest, Johnny J., 45 Van Natta 1798 (1993)..... 1566
Fortado, Lorraine F., 52 Van Natta 446 (2000)..... 1549,1856
Foster, Anthony, 45 Van Natta 1997 (1993)..... 983
Foster, Susan R., 49 Van Natta 2026 (1997)..... 487
Foster, Tammy L., 52 Van Natta 178 (2000)..... 344,924,948,959,1368,1380,1459,1470,1550, 1576,1639,1661,1861,1903,1943,2221,2225,2250
Fountain, Loretta K., 52 Van Natta 213 (2000) 326
Fountain, Loretta K., 52 Van Natta 213 (2000) 2204
Fountain, Loretta K., 52 Van Natta 215 (2000) 326
Fournier, Larry E., 47 Van Natta 786 (1995)..... 1828
Fowler, Leroy R., 41 Van Natta 1468 (1989) 9
Fox, Gary S., 51 Van Natta 60 (1999)..... 425
Fox, Gary S., 52 Van Natta 425 (2000)..... 483
Frank, Leroy, 43 Van Natta 1950 (1991)..... 510
Frank, Pamela G., 50 Van Natta 219 (1998)..... 196
Franklin, Merry E., 46 Van Natta 1637 (1994) 2178
Frazier, Charmaine A., 39 Van Natta 148 (1987)..... 410
Fredrickson, Tom, 45 Van Natta 211 (1993)..... 699
Free, Kenneth R., 47 Van Natta 1537 (1995)..... 2032
French, Ronald L., 48 Van Natta 773 (1996) 1934
Frias, Pedro, 50 Van Natta 463 (1998)..... 676,2246
Frias, Silverio, Sr., 49 Van Natta 1514 (1997) 657,1430,1510,1641
Friend, Leroy A., 44 Van Natta 775 (1992)..... 2178
Frolander, Tamera, 45 Van Natta 968 (1993) 148,452
Fuller, Ronald D., 50 Van Natta 1023, 1483 (1998) 73
Gabbard, Marilyn S., 47 Van Natta 1362 (1995)..... 360
Gabriel, Daryl R. II, 48 Van Natta 137 (1996)..... 1347
Gale, Billie W., 52 Van Natta 192 (2000) 2202
Gale, George H., 52 Van Natta 339 (2000) 1946,1983,2166
Ganer, Jackie T., 50 Van Natta 2189 (1998) 1368,1632,1819
Ganer, Jackie T., 51 Van Natta 116 (1999)..... 69
Garcia, Manuel G., 48 Van Natta 1139 (1996)..... 778,876
Garcia, Margie L., 46 Van Natta 1028 (1994)..... 2024
Garcia-Caro, Julio C., 50 Van Natta 160 (1998) 1464
Garcia-Guerroero, Nicolas, 50 Van Natta 513 (1998)..... 85
Garcia-Ortega, Gilberto, 48 Van Natta 2201 (1996) 657,754,865,1032,1430
Garner, Troy M., 48 Van Natta 1594 (1996) 1677
Gates, Mary J., 42 Van Natta 1813 (1990)..... 789

Case ..... Page(s)

Geddes, Robert, 47 Van Natta 2388 (1995) 666
Gentry, Pamela J., 52 Van Natta 918 (2000) 1882
Gerber, Joseph A., 51 Van Natta 278 (1999) 178,1931
Gesner, John G., 49 Van Natta 2147 (1997) 673
Gevers, Peter, 51 Van Natta 32 (1999) 241,2241
Gibson, Van M., 41 Van Natta 2182 (1989) 805
Gilcher, Stephen L., 43 Van Natta 319 (1991) 371,1361,1405
Gildea, Andrea M., 45 Van Natta 2293 (1993) 112,878
Gilmore, William F., 46 Van Natta 999 (1994) 936,1494,1656
Glenn, David L., 49 Van Natta 1251 (1997) 778
Gnatiuk, Antonina, 50 Van Natta 976 (1998) 790,1504,1946,2075
Gomez, Marta I., 46 Van Natta 1654 (1994) 621,649
Gomez-Martinez, Leodegario, 51 Van Natta 1251 (1999) 889
Gonzalez, Eugenio, 45 Van Natta 921 (1993) 1433
Gonzalez, Janice K., 49 Van Natta 638 (1997) 2127
Gooding, David L., 47 Van Natta 1468 (1995) 146
Goodson, Sandra M., 50 Van Natta 1116 (1998) 649,1346
Gordineer, Harley J., 47 Van Natta 2138 (1995) 839
Gordineer, Harley J., 50 Van Natta 1615 (1998) 486
Gould, Debra A., 47 Van Natta 1072 (1995) 1666
Graham, John R., 50 Van Natta 1508 (1998) 108
Graham, John R., 51 Van Natta 1740 (1999) 95,108,198,414,472,493,682,708,730,750,915, 1243,1285,1354,1364,1506,1540,1573,1888,1931,1949,2145,2148,2212
Graham, John R., 51 Van Natta 1746 (1999) 108,414,493,682,708,730,750,1364,1506,1573, 1888,1949,2145,2148
Graham, John R., 51 Van Natta 1858 (1999) 1964
Grant, Donald L., 49 Van Natta 250 (1997) 673
Grasham, Paul R., 52 Van Natta 385 (2000) 1079,1910
Green, Cresencia, 50 Van Natta 47 (1998) 699
Green, Kenneth L., 50 Van Natta 132 (1998) 343
Green, Richard W., 44 Van Natta 152 (1993) 369
Greenslitt, Linda V., 48 Van Natta 24 (1996) 2168
Grenbemer, David L., 48 Van Natta 195 (1996) 147
Griffin, Jacqueline J., 51 Van Natta 1806 (1999) 263
Grimes, Catherine M., 46 Van Natta 1861 (1994) 1863
Gross, Catherine, 48 Van Natta 99 (1996) 149
Grossetete, Mark, 50 Van Natta 2235 (1998) 755,1271
Gutierrez, Eva F., 51 Van Natta 2028 (1999) 1510
Guyse, Lester, 51 Van Natta 180 (1999) 2216
Hadley, Mark L., 47 Van Natta 725 (1995) 1870
Hakes, Daniel L., 45 Van Natta 2351 (1993) 172,292,477
Halbrook, William L., 46 Van Natta 79 (1994) 9,269,1636
Hale, Gilbert T., 43 Van Natta 2329 (1991) 118
Haley, Betti A., 51 Van Natta 1786 (1999) 1639
Hall, Dennis D., 51 Van Natta 1537 (1999) 326,640
Hall, Dennis D., 52 Van Natta 1993 (2000) 2145,2212
Hall, Glenn E., 48 Van Natta 1452 (1996) 105
Hall, Patti, 51 Van Natta 620 (1999) 417
Halvorsen, Donald L., Jr., 50 Van Natta 284, 480 (1998) 417
Hambrick, Kenneth V., 43 Van Natta 1636 (1991) 1401
Hamel, Ellen L., 40 Van Natta 1226 (1988) 742
Hamilton, Claudia I., 42 Van Natta 600 (1990) 890
Hamilton, LaToy E., 51 Van Natta 724 (1999) 625
Hamilton, Paul D., 52 Van Natta 1063, 1251 (2000) 1338
Hamilton, Ramona E., 48 Van Natta 2438 (1996) 2038
Hamilton, William F., 41 Van Natta 2195 (1989) 1677
Hankel, Darrell, 45 Van Natta 2056 (1993) 1878

Case ..... Page(s)

Hansen, Cassandra J. 50 Van Natta 174 (1998) 626,699
Hanson, James A., 50 Van Natta 23 (1998) 291
Haragan, Kim L., 42 Van Natta 311 (1990) 676
Harbison, Glen A., 50 Van Natta 2157 (1998) 394
Hardenbrook, Michael W., 48 Van Natta 529 (1992) 1392
Hardy, Fred T., 50 Van Natta 1076 (1998) 946
Hargadine, Dale A., 51 Van Natta 428 (1999) 2236
Haron, Louis L., 52 Van Natta 1833 (2000) 2140
Harp, Corrie M., 50 Van Natta 212 (1998) 2026
Harper, Brent, 50 Van Natta 499 (1998) 357,946,1303,1670
Harper, Brent, 51 Van Natta 1002 (1999) 107,1654
Harris, Dorothy M., 49 Van Natta 1348 (1997) 1594
Harrit-Diaz, Marysol, 52 Van Natta 1903 (2000) 1996
Harry, Diann C., 51 Van Natta 1540 (1999) 1426,2008
Hart, Douglas R., 51 Van Natta 1856 (1999) 468,808,1613
Hartley, Rob R., 49 Van Natta 2011 (1997) 15,66,2093
Harvey, Dewey C., 52 Van Natta 1556 (2000) 1594,2258
Hasty, Timothy, 46 Van Natta 1209 (1994) 975,1540
Havlik, Vicki L., 51 Van Natta 98 (1999) 494
Headding, Teena M., 51 Van Natta 789 (1999) 1856
Heck, William M., 48 Van Natta 1072 (1996) 1651
Hedinger, James M., 49 Van Natta 1797 (1997) 1267
Heitz, Kathy J., 51 Van Natta 1023 (1999) 1639
Helzer, Gary W., 47 Van Natta 143 (1995) 523
Henderson, Jeffrey E., 50 Van Natta 2340 (1998) 42,911,1037,1577
Henry, James W., 51 Van Natta 1822 (1999) 663
Henwood, Andrea E., 52 Van Natta 943 (2000) 1500
Hernandez, Alfredo R., 51 Van Natta 71 (1999) 2103
Hickman, Jerrin L., 51 Van Natta 1022 (1999) 223,1306
Hidy, Daniel J., 49 Van Natta 527 (1997) 118,960
Hight, Carl, 44 Van Natta 224 (1992) 423,1611
Hill, Diane S., 48 Van Natta 2351 (1996) 716
Hill, James D., 49 Van Natta 308 (1997) 2022
Hillard, Vickie, 51 Van Natta 1994 (1999) 1690
Hinkle, Brenda, 40 Van Natta 1655 (1988) 1365
Hinson, Thomas L., 51 Van Natta 1942 (1999) 1005,2097,2185
Hirsch, Willard A., 49 Van Natta 1311 (1997) 12,344
Hittle, Rhonda L., 47 Van Natta 2124 (1995) 904
Ho, Tuan A., 45 Van Natta 2413 (1993) 1666
Hoag, Kenneth, 43 Van Natta 991 (1991) 1260
Hobbs, Leonard C., 46 Van Natta 171 (1994) 943
Hockett, Terry, 48 Van Natta 1297 (1996) 92,334,2178,2241
Hodgen, Frederick W., 51 Van Natta 1490 (1999) 438
Hofrichter, Kathleen L., 45 Van Natta 2368 (1993) 102,360
Holbert, Marvin D., 51 Van Natta 843 (1999) 932
Holcomb, Donald, 50 Van Natta 874 (1998) 666,1934
Holder, Anthony R., 50 Van Natta 1760 (1998) 2227
Holland, Ronny G., 50 Van Natta 2240 (1998) 446,932,1856
Hollander, Susan R., 51 Van Natta 1502 (1999) 1637
Hollified-Taylor, Kelly R., 50 Van Natta 286 (1998) 1062
Holmsten, Kara, 50 Van Natta 194 (1998) 790
Holzapfel, Rae L., 45 Van Natta 1748 (1993) 102,703
Honeywell, Ancil R., 46 Van Natta 2378 (1994) 438
Hooper, Jack B., 49 Van Natta 669 (1997) 651,1491
Horton, David E., 50 Van Natta 514, 795 (1998) 265,918
Houck, Tony D., 48 Van Natta 2443 (1996) 673,687,963
Houck, Tony D., 51 Van Natta 1301 (1999) 1357,1361,1427

Case ..... Page(s)

Houston, Deborah D., 50 Van Natta 1547 (1998)..... 892
Hoyt, James A., 52 Van Natta 346 (2000)..... 1005,2097,2243
Hubbs, Tabbatha G., 51 Van Natta 1906 (1999)..... 410
Huddleston, Paul R., 48 Van Natta 4, 203 (1996)..... 56,2127
Hueng, Tat, 50 Van Natta 2205 (1998)..... 810,1683
Huff, Joseph R., 48 Van Natta 731 (1996)..... 2095
Huizar, Alexander, 52 Van Natta 390 (2000)..... 1946
Hulke, Jan M., 50 Van Natta 1393 (1998)..... 1278,1528
Hull, Forest G., 51 Van Natta 1795 (1999)..... **2310**
Humpage, Lloyd A., 49 Van Natta 1784 (1996)..... 1037,2038
Humphrey, Dave A., 51 Van Natta 1003 (1999)..... 723
Hunt, Bernard G., 49 Van Natta 223 (1997)..... 1579,1869,2258
Hussey, Alan L., 47 Van Natta 1302, 1460 (1995)..... 477
Huston, Brett S., 51 Van Natta 1790 (1999)..... 506,1677
Hyatt, Robert D., 48 Van Natta 2202 (1996)..... 498,994
Inman, Cathy A., 47 Van Natta 1316 (1995)..... 1365
Jacobi, Gunther H., 41 Van Natta 1031 (1989)..... 335,2105,**2302**
James, Barbara J., 44 Van Natta 888 (1992)..... 1072
January, Edward M., 49 Van Natta 1477 (1997)..... 1363
Jenkins, Shannon E., 48 Van Natta 1482 (1996)..... 45
Jensen, Glenda, 50 Van Natta 346, 1074 (1998)..... 856
Jesse, Charles E., 52 Van Natta 1504 (2000)..... 1946,2075
Jett, John J., 46 Van Natta 33 (1994)..... 943
Jimenez-Menera, Maria E., 48 Van Natta 2139 (1996)..... 1400,1656
Jobe, Roger D., 41 Van Natta 1506 (1989)..... 52,452
Johansen, Paul D., 49 Van Natta 2013 (1997)..... 253,1949
Johanson, John R., 46 Van Natta 2463 (1994)..... 9,49,50,88,162,218,271,358,370,424,433,455, 457,498,823,994,1442,1452,1463,1643,1695,1850,1893,1896,2019,2052,2143,2160
Johnson, Arnold R., 41 Van Natta 2199 (1989)..... 873
Johnson, Barbara M., 50 Van Natta 882 (1998)..... 1989
Johnson, Connie M., 48 Van Natta 239 (1996)..... 856
Johnson, Grover, 41 Van Natta 88 (1989)..... 786
Johnson, Lee J., 48 Van Natta 2261 (1996)..... 2258
Johnson, Richard E., 49 Van Natta 282 (1997)..... 1383,1619
Johnson, Robert E., 50 Van Natta 7 (1998)..... 1951,2191
Johnson, Willie C., 48 Van Natta 2451 (1996)..... 1554
Johnson, William T., 51 Van Natta 1750 (1999)..... 1918
Johnston, Donna M., 51 Van Natta 1414 (1999)..... 2097
Johnstone, Michael C., 48 Van Natta 761 (1996)..... 9,269,1636
Jones, Blaine M., 42 Van Natta 869 (1990)..... 356
Jones, Charles M., 47 Van Natta 1546 (1995)..... 147
Jones, Eston, 49 Van Natta 1841 (1997)..... 1084
Jones, Eston, 50 Van Natta 1407, 1582 (1998)..... 716
Jones, Fred L., 52 Van Natta 318 (2000)..... 996
Jones, Margaret R., 45 Van Natta 1249 (1993)..... 1566
Jones, Rebecca L., 49 Van Natta 553 (1997)..... 911
Jordan, Paul M., 49 Van Natta 2094 (1997)..... 49,88,98,162,218,271,358,370,424,455,457,498, 643,765,823,994,1452,1463,1695,1850,1896,2030,2052,2143,2160
Joy, Mitchell D., 50 Van Natta 824 (1998)..... **538**
Judish, Walter E., 51 Van Natta 189 (1999)..... 630
Kaler, Herbert C., 47 Van Natta 1607 (1995)..... 1926
Kaleta, Daniel S., 51 Van Natta 309 (1999)..... 506
Kamasz, Imre, 47 Van Natta 332 (1995)..... 425
Kamp, David A., 46 Van Natta 389 (1994)..... 703
Karr, Gregg A., 50 Van Natta 2434 (1998)..... 1450
Karr, Larry P., 48 Van Natta 2182 (1996)..... 301,358,761,1628,1899
Karr, Larry P., 48 Van Natta 2183 (1996)..... 362,1405

Case ..... Page(s)

Keeland, Audrey, 50 Van Natta 2041 (1998) 114,1018
Keener, Marilyn E., 49 Van Natta 110 (1997) 755,835,911,1271,1538,2110
Kelley, Wanda, 47 Van Natta 146 (1995) 941
Kellow, Beverly J., 49 Van Natta 741 (1997) 1534
Kelly, Robert E., 52 Van Natta 25 (2000) 417,483,860
Kendall, Marie E., 46 Van Natta 2520 (1994) 2078
Kendall, Marie E., 47 Van Natta 335 (1995) 2078
Kennedy, John R., 50 Van Natta 837 (1998) 726,762,880
Kimball, Lorenzo K., 52 Van Natta 411, 633 (2000) 810,1683
King, James M., 51 Van Natta 1534 (1999) 262
King, Judith R., 48 Van Natta 2303, 2403 (1996) 50,433,1439,1468,1893,1989,1997,2004,2238
King, Randolph, 51 Van Natta 82 (1999) 984
Kister, Phillip A., 47 Van Natta 905 (1995) 626,1047
Klouda, Mark A., 51 Van Natta 265, 823 (1999) 290,915
Knauss, Elmer F., 47 Van Natta 826, 949, 1064 (1995) 1867
Kneeland, Betty L., 51 Van Natta 1334 (1999) 2084
Knodel, Carol, 45 Van Natta 426 (1993) 148
Knox, William L., 45 Van Natta 854 (1993) 1515
Knudson, Jeffrey T., 48 Van Natta 1708 (1996) 151,362,1009,1405,1893,1898
Knupp, Patricia M., 46 Van Natta 2406 (1994) 1472,1483
Kosmoski, Camilla S., 52 Van Natta 1573 (2000) 1888,1931,2145,2148,2212
Kowalewski, Lori L., 51 Van Natta 13 (1999) 55,327,883,909,1579,1635,2117
Kreier, Darrell L., 51 Van Natta 1478 (1999) 2189
Kristensen, Tonya L., 50 Van Natta 1372 (1998) 1828
Krueger, Josephine, 51 Van Natta 1407 (1999) 161
Kruger, Jack L., 52 Van Natta 627 (2000) 772,1873
Krushwitz, Timothy H., 45 Van Natta 158 (1993) 1472,1483
Kubik, Bradley R., 50 Van Natta 989 (1998) 655
Kunsman, John, 50 Van Natta 2299 (1998) 859
Kyle, Jeffrey A., 49 Van Natta 1331 (1997) 9,49,50,88,98,162,218,271,358,370,424,433,455, 457,498,765,823,994,1442,1452,1463,1643,1850,1893,1896,2019,2052,2143,2160
Lacey, Paul N., 52 Van Natta 13 (2000) 1836
LaFrance, Richard, 48 Van Natta 427 (1996) 425,1053
LaFrance, Richard, 48 Van Natta 306 (1996) 481,1371
Lamb, Cheryl A., 52 Van Natta 676 (2000) 2158
Lambert, Cody L., 48 Van Natta 115 (1996) 1061
Lamerson, Norma L., 52 Van Natta 1086 (2000) 1296
Lamping, Bethel A., 50 Van Natta 883 (1998) 1989
Land, Wayne J., 51 Van Natta 442 (1999) 1915
Langston, Kima L., 52 Van Natta 15 (2000) 238,272,461
Larson, Jeana, 48 Van Natta 1278 (1996) 869
Lascari, James J., 51 Van Natta 965 (1999) 911
Lay, Randy S., 51 Van Natta 649 (1999) 327,748
Ledbetter, Nellie M., 43 Van Natta 570 (1991) 346,911
Ledbetter, Ronald L., 47 Van Natta 1461 (1995) 1246
Ledin, Larry L., 50 Van Natta 115 (1998) 680,682
Ledin, Larry L., 51 Van Natta 471 (1999) 680,682
Ledin, Larry L., 52 Van Natta 680 (2000) 708,723,730,734,750,1824,1949,1986,2148
Ledin, Larry L., 52 Van Natta 682 (2000) 708,723,730,734,750,915,1540,1573,1824,1888, 1931,1949,1986,1993,2145,2148,2203,2212
Lejeune, Theodule, Jr., 40 Van Natta 493 (1988) 1458,2115,2235
LeMasters, Rose M., 46 Van Natta 1533 (1994) 363,920,932,1037,1536,1546,1607,1915,1978, 2048,2219
Lemley, Sharron D., 49 Van Natta 1365 (1997) 1828
Leonetti, Diane C., 50 Van Natta 2060 (1998) 99,887
Levya, Martha E., 49 Van Natta 1177 (1997) 698,810,2066
Lewis, Geoffrey R., 50 Van Natta 1352 (1998) 791,867,911

Case ..... Page(s)

Lewis, Lester B., 51 Van Natta 778 (1999) 1094,1396
Lim, Michael V., 51 Van Natta 1777 (1999) 325
Lincicum, Theodore W., 40 Van Natta 1953 (1988) 425
Link, Arline F., 52 Van Natta 1032 (2000) 1430
Link, Terri, 47 Van Natta 1711 (1995) 105
Livesay, David S., 48 Van Natta 1732 (1996) 169
Lockett, Herbert L., 50 Van Natta 154 (1998) 2194
Long, Ed, 51 Van Natta 748 (1999) 417
Lopez, Cupertino A., 50 Van Natta 1452 (1998) 45
Lopez, Gaspar, 48 Van Natta 1774 (1996) 326,1357,1592,1869
Lopez, Julio P., 38 Van Natta 862 (1986) 11,1252,1872,2022,2057
Lopez, Petronilo, 45 Van Natta 1136 (1993) 2123
Lore, Billie L., 51 Van Natta 1957 (1999) 716
Loucks, Dennis R., 50 Van Natta 1779 (1998) 241,796,2251
Lowry, Donald E., 45 Van Natta 749, 1452 (1993) 102
Luby, Georgina F., 49 Van Natta 1828 (1997) 284,748
Lucas, Edward D., 41 Van Natta 2272 (1989) 510
Luehrs, Danny G., 45 Van Natta 889 (1993) 42,220,223,667,1343,1603,2001
Luttrell, Lawrence, 51 Van Natta 2030 (1999) 463
Lutz, Brian K., 49 Van Natta 2009 (1997) 151,371
Lutz, Brian, 50 Van Natta 1421 (1998) 1009
Lyda, Harry L., 48 Van Natta 1300 (1996) 1479
Lyda, Harry L., 52 Van Natta 21 (2000) 697
Mack, James L., 50 Van Natta 338 (1998) 112,404,796,878,973,1357,1579,1592,1926,2248
Mack, James L., 51 Van Natta 1681 (1999) 688
Maderos, Laura, 48 Van Natta 538, 838 (1996) 1632
Magby, Walter H., 51 Van Natta 436 (1999) 1333
Magill, Judy L., 51 Van Natta 926 (1999) 295
Mahon, John, 47 Van Natta 1647 (1995) 1
Maldonado, Karren S., 47 Van Natta 1535 (1995) 1659,1914
Mangiofico, Christopher F., 51 Van Natta 1881 (1999) 273
Mangum, Harold G., 52 Van Natta 1824 (2000) 2148
Mangum, Vicki L., 52 Van Natta 1006 (2000) 1294,1669
Mann, Joe E., 50 Van Natta 62 (1998) 294
Manning, Martin N., 40 Van Natta 374 (1988) 153
Mariels, Karen T., 44 Van Natta 2452 (1992) 371,1361
Marion, Teresa, 50 Van Natta 1165 (1998) 357,946,1303,1670,2195
Marks, Lou E., 52 Van Natta 118 (2000) 2076
Markum, Richard L., 48 Van Natta 2204 (1996) 346,435,2153
Markuson, Elizabeth, 52 Van Natta 781 (2000) 1579,1951
Marlatt, Brent L., 50 Van Natta 2369 (1998) 856,1512
Marrs-Johnston, Mary, 49 Van Natta 1757 (1997) 975
Marsden, Candice, 50 Van Natta 1361 (1998) 2218
Marshall, Deana F., 51 Van Natta 415 (1999) 747,1271
Marshall, Harvey W., 42 Van Natta 517 (1990) 873
Martin, Connie A., 42 Van Natta 495, 853 (1990) 1338
Martin, Gary L., 48 Van Natta 1802 (1996) 160,441,455,793,878,995,1548,1912
Martin, Terry W., 52 Van Natta 161 (2000) 2069
Martin, William A., 46 Van Natta 1704 (1994) 456,657,754,1032,1510
Martinez, Alfredo, 49 Van Natta 67 (1997) 2218
Martinez, Ana M., 51 Van Natta 800 (1999) 784
Martinez, Nestor P., 51 Van Natta 2033 (1999) 1081
Martushev, Zinaida I., 46 Van Natta 1601, 2410 (1994) 482
Matlack, Kenneth W., 46 Van Natta 1631 (1994) 34,57,116,241,284,327,351,660,794,876,925, 1042,1306,1443,1675,1683,2006,2048
Mathews, Shannon L., 48 Van Natta 1839,2406 (1996) 223,676,835
Mathews, Zebedee, 52 Van Natta 1594 (2000) 1873

Case ..... Page(s)

Mayfield, Ilene A., 48 Van Natta 550 (1996) 1515
Mayfield, Julie, 42 Van Natta 871 (1990) 890,1492
Mayo, Patricia J., 44 Van Natta 2260 (1992) 301
Mazza, Richard M., 52 Van Natta 28 (2000) 1853
McAdams, Billy J., 41 Van Natta 2019 (1989) 223
McAtee, David E., 50 Van Natta 649 (1998) 1373
McClain, Darlynda J., 48 Van Natta 542 (1996) 1351
McClung, Jerry M., 42 Van Natta 400 (1990) 301
McCollum, John D., 44 Van Natta 2057 (1992) 2056
McConnell, John, 45 Van Natta 1197 (1993) 1613
McCormick, William H., 52 Van Natta 1599 (2000) 2013
McDaniel, Ivan R., 51 Van Natta 967 (1999) 790
McDowell, Durwood, 47 Van Natta 2370 (1995) 1962,2109
McFadden, Trever, 48 Van Natta 1804 (1996) 482,1945
McGarvey, Michael A., 52 Van Natta 1014 (2000) 1588
McIntosh, Colin J., 47 Van Natta 1965 (1995) 1626
McKellips, Darius, 51 Van Natta 2047 (1999) 1432
McKenzie, Mary J., 48 Van Natta 473 (1996) 425
McKinzey, Patricia M., 51 Van Natta 1933 (1999) 1326,2042
McLain, Darlynda J., 48 Van Natta 542 (1996) 1092
McMurrin, Margo E., 50 Van Natta 1167 (1989) 178
McVay, Patricia L., 48 Van Natta 317 (1996) 231,633,810
Meagher, Sherena M., 52 Van Natta 1479 (2000) 1983
Mecham, Jeffrey S., 51 Van Natta 638 (1999) 655,676
Mecone, Kathleen A., 43 Van Natta 166 (1991) 1092
Melton, Donald L., 47 Van Natta 2290 (1995) 830
Mendez, Amador, 44 Van Natta 736 (1992) 128,164,1326,1870
Mendoza, Carmen, 51 Van Natta 1956 (1999) 2219
Mercer, Ernest W., 50 Van Natta 2354 (1998) 232,234
Meredith, Raymond, 42 Van Natta 816 (1990) 630
Merriman, Richard R., 51 Van Natta 167 (1999) 19
Merwin, Ron L., 49 Van Natta 1801 (1997) 178,382,1639
Merwin, Ronald L., 51 Van Natta 1678 (1999) 1264
Meyer, Darrell A., 51 Van Natta 135 (1999) 926
Meyer, Kenneth A., 50 Van Natta 2302 (1998) 2036,2164
Meyers, Kenneth W., 41 Van Natta 1375 (1989) 1853
Michael, Philip G., 46 Van Natta 519 (1994) 2209
Miller, Jerry R., 44 Van Natta 1444 (1992) 830
Miller, Kurt C., 41 Van Natta 1899 (1989) 796
Miller, Richard M., 49 Van Natta 1239 (1997) 1492
Miller, Sean W., 45 Van Natta 2337 (1993) 810
Millsap, Lawrence E., 46 Van Natta 2112 (1995) 856,1546,2145,2161
Miner, Bertha J., 40 Van Natta 518 (1987) 1540
Minor, Vernon L., 52 Van Natta 320 (2000) 649,1346,1404
Minter, James, 48 Van Natta 979 (1996) 761
Minton, Ted B., 50 Van Natta 2423 (1998) 716,767,1952,1956
Mitchell, Sandra K., 51 Van Natta 1837 (1999) 2084
Mitchell, Thurman M., 47 Van Natta 1971 (1995) 2125
Mohrbacher, Cheryl, 50 Van Natta 1826 (1998) 220,667,755,1343,1538,1603,2001,2227
Montgomery, John L., 52 Van Natta 1318 (2000) 1436
Montgomery, Kristin, 47 Van Natta 961 (1995) 122
Montgomery, Leo A., 50 Van Natta 2237 (1998) 2174
Moody, Eul G., 45 Van Natta 835 (1993) 657
Moon, Robert A., 51 Van Natta 242 (1999) 714
Moon, Virgil E., 42 Van Natta 1003 (1990) 1365
Moore, Dana K., 49 Van Natta 2045 (1997) 1053
Moore, Daniel P., 46 Van Natta 2490 (1994) 452

Case ..... Page(s)

Moore, Edmund D., 49 Van Natta 1426 (1997) 2218
Moore, Jonna M., 52 Van Natta 1984 (2000) 2173
Moore, Melba D., 49 Van Natta 631 (1997) 368
Moore, Terrance L., 49 Van Natta 1787 (1997) 241,284
Moore, Walter, 45 Van Natta 2073 (1993) 911
Morales, Ricardo, 47 Van Natta 1394 (1995) 146
Morgan, Margaret, 49 Van Natta 1934, 2072 (1997) 99,887
Morgan, Shawn E., 52 Van Natta 2112 (2000) 2245
Morris, Arthur R., 42 Van Natta 2820 (1990) 50,433,1468,1893,1989,1997,2004,2238
Morris, Ralph L., 50 Van Natta 69 (1998) 45,1900,2038
Morrison, Gerald D., 51 Van Natta 295 (1999) 351
Mortenson, Anton V., 40 Van Natta 1171, 1702 (1988) 19
Muldrow, Gregg, 49 Van Natta 1866 (1997) 33
Mundell, Rebecca S., 52 Van Natta 106 (2000) 1892
Murray, Donald J., 50 Van Natta 1132 (1998) 657,754,1032,1430,1510,1641
Murray, Donald J., 51 Van Natta 2052 (1999) 1836
Mustoe, Kelly D., 46 Van Natta 285 (1994) 75,85
Myers, Clarence A., 45 Van Natta 1471 (1995) 1842
Nagmay, Michelle T., 47 Van Natta 1952 (1995) 450
Nease, Phyllis G., 49 Van Natta 195,301,494 (1997) 284,748,1053
Neeley, Dennis J., 50 Van Natta 2127 (1998) 973
Neeley, Ralph A., 42 Van Natta 1638 (1990) 75
Nelson, Karel L., 42 Van Natta 1206 (1990) 2145
Nesvold, William K., 43 Van Natta 2767 (1991) 102
Nevett, Daralynn, 52 Van Natta 1856 (2000) 2241
Newell, William A., 35 Van Natta 629 (1983) 254,415,423,759,769,1021,1256,1611,1919,2055
Newman, Steven H., 47 Van Natta 244 (1995) 1863
Newton, Carrie, 50 Van Natta 1750 (1998) 755
Nicholson, Lawrence L., 51 Van Natta 1977 (1999) 1819
Nielsen, Nancy A., 52 Van Natta 333 (2000) 1674
Noble, Gregory C., 49 Van Natta 764 (1997) 330,2108
Noble, Gregory C., 50 Van Natta 1469 (1998) 716
Nordyke, Caroline S., 52 Van Natta 61 (2000) 1676
Nott, Randy L., 48 Van Natta (1996) 394
O'Campo, Eduardo, 48 Van Natta 432 (1996) 2174
O'Donnell, Hugh J., 51 Van Natta 1394 (1999) 238,649
O'Neal, Charlotte A., 47 Van Natta 1994 (1995) 1964
O'Reilly, Allasandra W., 40 Van Natta 1180 (1988) 670
Oakes, Rebecca M., 52 Van Natta 119 (2000) 295
Odell, Donald L., 49 Van Natta 1872 (1997) 204
Oetken, Glen D., 52 Van Natta 1528 (2000) 2123
Olsen, Richard H., 41 Van Natta 1300 (1989) 1918
Olson, Albert H., 51 Van Natta 685 (1999) 506,1005,2097
Olson, Gloria T., 47 Van Natta 2348 (1995) 114,185,627,716,1018,1050,1273,1645,1692, 2017,2205
Olson, Jason O., 47 Van Natta 2192 (1995) 241,2069
Olson, Robert A., 52 Van Natta 1540 (2000) 1573,1888,1931,1993,2145,2148,2212
Olson, Robert A., 52 Van Natta 1544 (2000) 1888
Olson, Ronald B., 44 Van Natta 100 (1992) 335
Olson, Ronald P., 51 Van Natta 354 (1999) 151,839
Olson, William H., Jr., 45 Van Natta 85 (1993) 1830
Opdenmeyer, Katie J., 52 Van Natta 92 (2000) 2178,2241
Orazio, George B., 49 Van Natta 1982 (1997) 1883
Orn, Benino T., 46 Van Natta 254 (1994) 38
Osborn, Bernard L., 37 Van Natta 1054 (1985) 1880
Osborne, Thomas K., 51 Van Natta 1262 (1999) 12,1440
Osbourne, Clive G., 47 Van Natta 2291 (1995) 1326

Case ..... Page(s)

Ostermiller, Mark, 46 Van Natta 1556, 1785 (1994) 1863
Oxford, Fredrick D., 42 Van Natta 476 (1990) 634
Padilla, Salvador, 51 Van Natta 1693 (1999) 1576
Parker, Justeen L., 49 Van Natta 334 (1997) 1713,2117,**2302**
Parker, Russell D., 49 Van Natta 83 (1997) 401
Parks, Darlene E., 48 Van Natta 190 (1996) 1063,1338
Parsons, Kathyron D., 45 Van Natta 954 (1993) 883
Partible, John L., 48 Van Natta 434 (1996) 1318,1507
Paxton, Conrid J., 50 Van Natta 1709 (1998) 406
Paul, Steve L., 50 Van Natta 1987 (1998) 865,1430
Pauley, William H., 49 Van Natta 1605 (1997) 1042,1276
Pedraza, Jorge, 49 Van Natta 1019 (1997) 10,1255,1438,1653,1851,2105,2124
Pelayo, Ramiro, 52 Van Natta 363 (2000) 932,2181,2219
Pendergast-Long, Nancy, 48 Van Natta 2334, 2517 (1996) 630
Penturf, Cindy M., 50 Van Natta 1718 (1998) 2145
Peppler, Christopher H., 44 Van Natta 856 (1992) 1070
Perkins, Jay D., 51 Van Natta 970 (1999) 45
Perry, Darold E., 50 Van Natta 788 (1998) 1296
Peterson, Dana M., 50 Van Natta 1554 (1998) 1081,1892,2117
Peterson, Frederick M., 43 Van Natta 1067 (1991) 1620
Peterson, Llance A., 50 Van Natta 1808 (1998) 218,433
Petty, Patricia J., 51 Van Natta 1688 (1999) 368
Pfeiffer, Jennifer, 52 Van Natta 903 (2000) 1398
Phillips, Mary K., 50 Van Natta 519 (1998) 320,649,1346
Pickrell, Rick J., 51 Van Natta 453 (1999) 2097
Piper, Randal W., 49 Van Natta 543 (1997) 241,303,1552
Plumlee, Carl F., 52 Van Natta 185 (2000) 380,1440,1645
Plummer, Kenneth F., 51 Van Natta 1239 (1999) **2310**
Plummer, Kenneth F., 52 Van Natta 19 (2000) 1483
Poe, Mika T., 49 Van Natta 495 (1997) 2053
Porras, Maria R., 42 Van Natta 2625 (1990) 704,1450
Pottorff, Donald L., 50 Van Natta 2247 (1998) 430
Potts, William B., 41 Van Natta 223 (1989) 761
Power, Douglas D., 52 Van Natta 107 (2000) 1654
Prater, Terry W., 43 Van Natta 1288 (1991) 75
Preece, Betsy A., 45 Van Natta 2320 (1993) 1070
Prettyman, Earl J., 46 Van Natta 891, 1137 (1994) 250,1962,2109,2143
Preuss, Sandy K., 50 Van Natta 1028 (1998) 946
Prewitt, Ronda G., 49 Van Natta 831 (1997) 401
Prince, Craig J., 52 Van Natta 108, 1658 (2000) 198,414,472,493,680,682,708,723,730,734,750, 1506,1540,1573,1824,1888,1931,1949,1986,2083,2145,2148,2165,2212
Prince, Wallace M., 52 Van Natta 45 (2000) 1566,1881,1900
Pringle, Ralph I., 47 Van Natta 2155 (1995) 2125
Pritchard, Oliver E., 50 Van Natta 202 (1998) 896
Privatsky, Kenneth, 38 Van Natta 1015 (1986) 2123
Prociw, Lynda C., 46 Van Natta 1875 (1994) 264,896,1326
Propper, Edwin W., 51 Van Natta 1531 (1999) 55,1579
Provost, Deborah J., 52 Van Natta 1389 (2000) 2011
Puglisi, Alfred F., 39 Van Natta 310 (1987) 11,1252,1872,2022,2057
Purdy, Richard C., 49 Van Natta 1272 (1997) 1537
Quintero, Efren, 50 Van Natta 86 (1998) 2109
Quintero, Lidia A., 51 Van Natta 1221 (1998) 903
Radich, Angelo L., 45 Van Natta 45 (1993) 15,66
Ramberg, Stephen G., 51 Van Natta 1461 (1999) 2109
Ramirez, Marjorie A., 52 Van Natta 1998 (2000) 2089
Randolph, John G., 48 Van Natta 162 (1996) 665
Rankin, William G., 47 Van Natta 975 (1995) 90

Case ..... Page(s)

Ransom, Zora A., 46 Van Natta 1287 (1994) 339,918,1254,1882,2112,2245
Rasmussen, Terry J., 51 Van Natta 1287, 1397 (1999) 1005,1677,2097
Rassum, Joan K., 51 Van Natta 1511 (1999) 697
Ray, Joe R., 48 Van Natta 325, 458 (1996) 107,883,1427,2024
Readye, Margo A., Jr., 50 Van Natta 177 (1998) 75,2156
Real, Patrick W., 49 Van Natta 2107 (1997) 494,**523**
Reddin, Michael A., 50 Van Natta 1396 (1998) 112,2097
Reed, Kenneth R., 49 Van Natta 2129 (1997) 1556,1594
Renno, David A., 51 Van Natta 1730 (1999) 273
Retlinger, Joseph H., 51 Van Natta 87 (1999) 465
Reynolds, Ronald D., 51 Van Natta 1552 (2000) 1514,1869
Rice, John J., 46 Van Natta 2528 (1994) 463
Rice, Kimberly R., 52 Van Natta 138 (2000) 257,1259
Richter, Ernest C., 44 Van Natta 101, 118 (1992) 138
Riley, Lisa, 51 Van Natta 1703 (1999) 1449
Riordan, Michael D., 50 Van Natta 2375 (1998) 1390
Rios, Jose I., 52 Van Natta 303 (2000) 932,1552
Roberts, Melvin O., 44 Van Natta 33 (1992) 2119
Roberts, Vincent S., 48 Van Natta 15 (1996) 324
Robertson, Suzanne, 43 Van Natta 1505 (1991) **2275**
Robinson, Ronald D., 44 Van Natta 2500 (1992) 1492
Rocha, Felipe A., 44 Van Natta 797 (1992) 2145
Rocha, Richard J., 49 Van Natta 1411 (1997) 456,754
Rock, Rachelle M., 50 Van Natta 1168 (1998) 1641
Rodgers, Robert A., 52 Van Natta 1243 (2000) 1354,1450
Rodriguez, Jose D., 49 Van Natta 703 (1997) 781,1579
Rodriguez, Roberto, 46 Van Natta 1722,2233,2530 (1994) 28,43,85,660,909,1042,1635,1856,**2302**
Rogan, Estella M., 50 Van Natta 205 (1995) **1148**,2251
Rogers, Bonnie, 48 Van Natta 1211 (1996) 936
Rogers, Ronald E., 49 Van Natta 267 (1997) 2161
Rogers, Ronald E., 51 Van Natta 937 (1997) 2161
Rohde, Karl G., 41 Van Natta 1837 (1989) 918
Roles, Glen D., 43 Van Natta 278 (1991) 1697
Roles, Glen D., 45 Van Natta 282 (1993) 344,425,1243
Rose, Howard L., 47 Van Natta 345 (1995) 438
Rose, Rena L., 49 Van Natta 2007 (1997) 284,703,1294
Rossiter, Steven M., 47 Van Natta 34 (1995) 18,2116
Rossum, Joan K., 51 Van Natta 1409 (1999) 932
Rothe, Ruben G., 45 Van Natta 369 (1993) 344,897,1540,**2286**
Rowe, David J., 47 Van Natta 1295 (1995) 778,876,1053
Roy, Jack B., 50 Van Natta 1029 (1998) 1594
Roy, Robert E., 42 Van Natta 2000 (1990) 1069
Rule, Steven K., 47 Van Natta 83 (1995) 241
Rusch, Jeanne C., 45 Van Natta 163 (1993) 118,960,1899
Ruvalcaba, Guillermo, 51 Van Natta 313 (1999) 918
Sabin, Nancy L., 51 Van Natta 2035 (1999) 112,878
Saint, John J., 46 Van Natta 2224 (1994) 346,2097,2243
St. Jean, Rustee R., 49 Van Natta 2161 (1997) 144
Salber, Michael, 48 Van Natta 757 (1996) 1260
Salsbury, Kenneth D., 41 Van Natta 565 (1989) 824
Sanchez, Antonio E., 50 Van Natta 967 (1998) 1246
Sanchez, Gilbert M., 51 Van Natta 248 (1999) 1540
Sanders, William E., 43 Van Natta 558 (1990) 1559
Sanford, Archiel F., 49 Van Natta 122 (1997) **538**
Santamaria, Wilson O., 52 Van Natta 657 (2000) 754,1641
Santibanez, Carlos C., 43 Van Natta 2685 (1991) 823
Santos, Benjamin G., 46 Van Natta 1912 (1994) 1892

Case ..... Page(s)

Saunders, Darwin K., 50 Van Natta 934 (1998) 107
Saunders, Lester E., 46 Van Natta 1153 (1994) 790,1504,1946,2075
Schell, Janet L., 52 Van Natta 2140 (2000) 2229
Schiller, Gerard R., 48 Van Natta 854 (1996) 904
Schmitt, Brian L., 48 Van Natta 295 (1996) 984
Schmitt, Brian L., 51 Van Natta 393 (1999) 316
Schoch, Lois J., 49 Van Natta 170 (1997) 223
Schoch, Lois J., 49 Van Natta 788 (1997) 2110
Schofield, Edward R., 50 Van Natta 979 (1998) 1505
Schreiner, Gerry L., 51 Van Natta 1998 (1999) 497,716,1432
Schrick, Timothy O., 51 Van Natta 890 (1999) 352
Schrock, Errol L., 52 Van Natta 1888 (2000) 2212
Schultz, Kathleen S., 48 Van Natta 2518 (1996) 126
Schultz, Mary M., 45 Van Natta 571 (1993) 1666
Schunk, Victor, 50 Van Natta 2049 (1998) 148
Schutte, Larry L., 45 Van Natta 2085 (1993) 2161
Scott, Cameron D., 44 Van Natta 1723 (1992) 2123
Scott, Charles, 48 Van Natta 2592 (1996) 943
Scott, Florence L., 44 Van Natta 2454 (1992) 131
Scott, Iris K., 50 Van Natta 2271 (1998) 690
Scott, Jeffrey L., 49 Van Natta 503 (1997) 1057,1373
Scrum, Jackson R., 51 Van Natta 1062 (1999) 250,457,643,765,1021,1896,2030,2143
Seiber, John T., 43 Van Natta 136 (1991) 49,367,1442
Semeniuk, Olga G., 46 Van Natta 152 (1994) 357,394,1303,1670,1907
Senay, Daniel P., 49 Van Natta 1966 (1997) 926
Senger, Eugene J., 52 Van Natta 1324 (2000) 1566,1881
Sepull, Mike, 42 Van Natta 470 (1990) 1348
Serpa, Patricia L., 47 Van Natta 747, 2386 (1995) 482,941
Sharp, Jennifer, 50 Van Natta 829 (1998) 897
Shaw, John B., Sr., 52 Van Natta 63 (2000) 860,1627
Shaw, Trevor E., 46 Van Natta 1821,2168 (1994) 151,839
Sherman, Douglas, 51 Van Natta 1213 (1999) 263
Shinn, Herbert K., 50 Van Natta 243 (1998) 254
Shipman, Peggy, 51 Van Natta 827 (1999) 1639
Shirk, James D., 41 Van Natta 90 (1989) 66,1318
Shores, Phillip L., 49 Van Natta 341 (1997) 497
Shubert, Milan F., 47 Van Natta 1297 (1995) 1970
Sica, Frank, 50 Van Natta 2092 (1998) 273,792
Sigfridson, Lanny K., 49 Van Natta 1433 (1997) 85
Silva, Kevin J., 52 Van Natta 66 (2000) 1830
Simpson, Grace B., 43 Van Natta 1276 (1991) 1006
Sizemore, Jack W., 46 Van Natta 1571 (1994) 295
Smalling, Joey D., 50 Van Natta 1433 (1998) 339
Smith, Fred E., 42 Van Natta 1538 (1990) 52,148,452
Smith, Gary D., 45 Van Natta 298 (1993) 1613
Smith, George D., 50 Van Natta 1485 (1998) 984
Smith, Harold E., 47 Van Natta 703 (1995) 169
Smith, Lisa M., 51 Van Natta 777 (1999) 314
Smith, Marietta Z., 51 Van Natta 324, 731 (1999) 325,747
Smith, Pamela T., 50 Van Natta 2162 (1998) 2236
Smith, Paul E., 52 Van Natta 730 (2000) 1824,1949,1986,2148
Snyder, Alec E., 47 Van Natta 838 (1995) 1944,2221
Solis, Nozario N., 52 Van Natta 335 (2000) 1387,2084,2105
Somers, Ted, 51 Van Natta 1223 (1999) 814
Soriano-Garcia, Lorenzo, 51 Van Natta 1493 (1999) 1935
Sosa, Lori A., 42 Van Natta 1745 (1991) 1077
Sowell, Timothy R., 52 Van Natta 112 (2000) 878,1579

Case ..... Page(s)

Spears, Candace L., 47 Van Natta 2393 (1995) 755,1538,2110
Spencer, Samantha L., 49 Van Natta 280 (1997) 1687
Spencer House Moving, NCE, 44 Van Natta 2522 (1992) 1924,2020
Spillers, Synndrah R., 52 Van Natta 714 (2000) 889,1671
Spino, Trudy M., 52 Van Natta 626 (2000) 699
Spivey, Robin W., 48 Van Natta 2363 (1996) 112,1594
Sprueill, Konnie, 45 Van Natta 541 (1993) 994,1896
Starkey, David L., 50 Van Natta 906 (1998) 649,897
Steece, Leroy W., 52 Van Natta 482 (2000) 1831,1945
Steele, Edward C., 48 Van Natta 2292 (1996) 481,1371
Stephens, Sharon D., 40 Van Natta 105 (1988) 2022
Stephenson, Robert W., 48 Van Natta 2287 (1996) 2191
Stevens, Rickey A., 48 Van Natta 1444 (1997) 227
Stewart, Jack F., 51 Van Natta 22 (1999) 32,1261,1272
Stimler, Nancie A., 47 Van Natta 1114 (1995) 497
Stock, Ronald A., 43 Van Natta 1889 (1991) 886
Stockwell, Rhonda P., 46 Van Natta 446 (1994) 692
Stone, Karen M., 51 Van Natta 1560 (1999) 138,1870
Stone, Timothy W., 50 Van Natta 909 (1998) 1892
Stone, Timothy W., 50 Van Natta 2421 (1998) 1245
Stonier, Chad H., 52 Van Natta 380 (2000) 1983
Storns, Linda M., 51 Van Natta 876 (1999) 1883
Strahon, Guy R., 51 Van Natta 1418 (1999) 122
Stransky, Josepy M., 51 Van Natta 143 (1999) 911,963
Stromer, Christine M., 51 Van Natta 1824 (1999) 333
Suby, Thomas E., 50 Van Natta 718 (1998) 1361,1372
Suby, Thomas E., 50 Van Natta 1088 (1998) 1361,1372
Suek, Raymond J., 49 Van Natta 706 (1997) 2258
Sullivan, Diane E., 43 Van Natta 2791 (1991) 118,960
Sullivan, Mike D., 45 Van Natta 900 (1993) 657
Surina, Robert D., 40 Van Natta 1855 (1988) 1458,2115,2235
Swan, Ronald L., Sr., 47 Van Natta 2412 (1995) 438
Sweem, Clifton L., 51 Van Natta 884 (1999) 1828
Tackett, Charles C., 31 Van Natta 65 (1981) 425
Talevich, Janice A., 48 Van Natta 2318 (1996) 1267,1593
Taschereau, Brian J., 49 Van Natta 1760, 1846 (1997) 149
Taylor, Debra L., 51 Van Natta 676 (1999) 1847
Taylor, George T., 43 Van Natta 676 (1991) 22
Taylor, Richard F., 40 Van Natta 384 (1988) 153
Taylor, Wanda, 44 Van Natta 2117 (1992) 282
Tebbetts, Gary A., 52 Van Natta 307 (2000) 1061
Tedrow, Charles, 48 Van Natta 616 (1996) 1423,1948
Teeters, Susan K., 40 Van Natta 1115 (1988) 873,2123
Telesmanich, Anthony J., 49 Van Natta 49, 166 (1997) 1579,2258
Telfer, Georgia, 50 Van Natta 1658 (1998) 1035
Templeton, James E., 51 Van Natta 975, 1061 (1999) 45,479,1259
Terranova, Rashell A., 51 Van Natta 1496 (1999) 859
Terrible, Leonard M., 51 Van Natta 1375 (1999) 288,2216
Terry, James D., 44 Van Natta 1663 (1992) 356
Thiesfeld, Cynthia J., 51 Van Natta 984, 1264 (1999) 297,383,473,1540
Thomas, Debbie S., 52 Van Natta 7 (2000) 699
Thomas, Leslie, 44 Van Natta 200 (1992) 2145
Thomas, Lynda J., 45 Van Natta 894 (1993) 1620,2310
Thomas, Verna F., 51 Van Natta 1317 (1999) 1483
Thompson, Burton I., 48 Van Natta 866 (1996) 406
Thorpe, Larry A., 48 Van Natta 2608 (1996) 241,738,2048,2258
Thurman, Rodney J., 44 Van Natta 1572 (1992) 873,2123,2219

Case ..... Page(s)

Timmel, Raymond H., 47 Van Natta 31 (1995) 2097
Tipton, Ronald L., 48 Van Natta 2521 (1996) 204,411,1594,2117
Toedtemeier, Gary A., 48 Or App 1014 (1996) 1423
Tofell, Katherine M., 51 Van Natta 1845 (1998) 796,1357,2251
Tolman, Ezra J., 52 Van Natta 310 (2000) 1254,1573
Tomlinson, Greg V., 47 Van Natta 1085 (1995) 213,215,326,824,825,848
Totaro, Mark, 49 Van Natta 69 (1997) 19
Trevino, Alejandra R., 50 Van Natta 2302 (1998) 1304
Trevitts, Jeffrey B., 46 Van Natta 1767 (1994) 32,344,1261,1272,1540,**2310**
Trujillo, Timothy W., 52 Van Natta 748 (2000) 2069
Trump, Robert L., 39 Van Natta 314 (1987) 873
Trussell, Kelly J., 47 Van Natta 121 (1995) 2068,2140,2229
Tsirimiagos, Gerasimos, 50 Van Natta 1627 (1998) 1094,1396,1659,1665
Turnbull, Bonnie L., 49 Van Natta 139, 470 (1997) 1548
Tuttle, Judy A., 45 Van Natta 165 (1993) 2254
Uhing, Richard N., 50 Van Natta 1611 (1998) 452
Valencia, Daniel M., 48 Van Natta 1524 (1996) 2142
Valencia, Rosendo M., 51 Van Natta 1034, 1293 (1999) 2140
Valenzuela, Ricardo O., 51 Van Natta 1852 (1999) 2219
Valero, Tina M., 50 Van Natta 1475 (1998) 1061
Vanderzanden, Dorothy, 48 Van Natta 1573 (1996) 1280
VanHorn, Frederick W., 48 Van Natta 956 (1996) 204,483
VanHorn, Jill C., 44 Van Natta 1523 (1992) 324
VanLanen, Carole A., 45 Van Natta 178 (1993) 1697
Vaughn, Ernest L., 40 Van Natta 1574 (1988) 789
Velasquez, Raul R., 52 Van Natta 1072 (2000) 1940
Verschoor, Karen L., 52 Van Natta 275 (2000) 981
Vick, Marlys M., 52 Van Natta 1944 (2000) 2221
Vieke, Barbara, 50 Van Natta 1447 (1998) 790
Villa-Acosta, Lino, 51 Van Natta 211 (1999) 174,655,1883
Villagrana, Francisco, 45 Van Natta 1504 (1993) 1472,1483
Villanueva, Amelia, 50 Van Natta 1577 (1998) 66,1910
Vinci, Charlene L., 47 Van Natta 1919 (1995) 57,241,411,778,2117
Vinson, Clara S., 52 Van Natta 200 (2000) 1264
Vinson, Darrel W., 47 Van Natta 356 (1995) 896
Vinyard, Pamela, 48 Van Natta 1442 (1996) 151
Vioen, Fred, 48 Van Natta 2110 (1996) 9,49,50,88,98,162,271,358,370,424,433,455,457, 498,643,765,823,994,1442,1452,1643,1695,1893,2019,2030,2052,2143,2160
Voeller, Paul E., 42 Van Natta 1962 (1990) 1497
Volk, Jane A., 46 Van Natta 681, 1017 (1994) 85,411,915,1552,1622
Voorhies, Peter, 50 Van Natta 2051 (1998) 1483
Voorhies, Peter, 51 Van Natta 920 (1999) 1483
Waasdorp, David L., 38 Van Natta 81 (1986) 362,1405
Wagner, Tricia C., 51 Van Natta 755 (1999) 856
Walker, Jesse R., 45 Van Natta 974 (1993) 2123
Walker, Michael D., 46 Van Natta 1914 (1994) 79,869,1053
Walker, Roland A., 52 Van Natta 1018 (2000) 1062,1262,1273,1363,1692
Wall, Melvin L., 51 Van Natta 23 (1999) 452
Walter, Steven L., 48 Van Natta 1532 (1996) 1685
Ward, Melody R., 52 Van Natta 241 (2000) 748,1373,1552,2069
Washington, Billy W., 52 Van Natta 734 (2000) 1540,1658,2145
Washington, James K., 50 Van Natta 223 (1998) 346
Watkins, Dean L., 45 Van Natta 1599 (1993) 218,250
Way, Sandra J., 45 Van Natta 876 (1993) 856
Wegesend, William F., III, 50 Van Natta 1612 (1998) 505
Weich, David F., 39 Van Natta 468 (1997) 2184,2203
Wells, Everett G., 47 Van Natta 1634 (1995) 52

Wells, Susan D., 46 Van Natta 1127 (1994) 92,2178,2241
Wendler, Richard C., 47 Van Natta 87 (1995) 510
Westenberg, Marsha E., 49 Van Natta 2178 (1997) 666,1084
Westlake, Donald A., 50 Van Natta 1213 (1998) 1464
Weymiller, Tobin E., 50 Van Natta 2184 (1998) 946,2195
Wheeler, Phyllis J., 44 Van Natta 970 (1992) 2119
Whisenant, Donald J., 52 Van Natta 808 (2000) 2028
White, Michael A., 43 Van Natta 582 (1991) 1942
Whitton, Loris D., 49 Van Natta 2183 (1997) 11,1252
Widby, Julie A., 46 Van Natta 1065 (1994) 778
Wiedle, Mark N., 43 Van Natta 855 (1991) 15
Wilbourne, Constance D., 51 Van Natta 1541 (1999) 1296,1440,1960
Wilbur, Glen E., 50 Van Natta 1059 (1998) 699
Wiley, Gloria J., 50 Van Natta 781 (1998) 883
Willenburg, Robert, 51 Van Natta 643 (1999) 918
Williams, Charles J., 49 Van Natta 601 (1997) 2203
Williams, Linda J., 51 Van Natta 1528 (1999) 763,941
Williams, Loy W., 52 Van Natta 754 (2000) 1641
Williams, Marcia D., 49 Van Natta 313 (1997) 55
Williams, Nevada J., 48 Van Natta 998 (1996) 828
Williams, Ruby J., 49 Van Natta 1550 (1997) 897
Williams, Sherri L., 51 Van Natta 75 (1999) 1035,1286,1863
Williams, Timothy L., 46 Van Natta 2274 (1994) 467
Wilmarth, Cecil L., Jr., 48 Van Natta 325 (1996) 2048
Wilson, Douglas L., 51 Van Natta 1473 (1999) 1677,2236
Wilson, Georgia E., 47 Van Natta 387, 627 (1995) 241,2048
Wilson, Lawrence E., 43 Van Natta 1131 (1991) 1857
Wilson, Robert K., 45 Van Natta 1747 (1993) 430,1878
Wing, Vickie L., 49 Van Natta 1468 (1997) 85
Wiseman, John, 52 Van Natta 1666 (2000) 1690
Witt, Ralph L., 46 Van Natta 1902 (1994) 430
Wolford, Robert E., 46 Van Natta 522 (1994) 1458,2115
Wood, Kim D., 48 Van Natta 482 (1996) 263,346
Woodraska, Glenn L., 41 Van Natta 1472 (1989) 890
Woods, John R., 48 Van Natta 1016 (1996) 151,1009
Woodward, Vicky L., 52 Van Natta 796 (2000) 973,1357,2251
Woolner, Bonnie J., 52 Van Natta 1579 (2000) 1869,1926,2258
Wright, Charles R., 50 Van Natta 1150 (1998) 1002
Yang, Sueyen A., 48 Van Natta 1626 (1996) 1368,1632,1863,2209
Yates, Sally D., 51 Van Natta 1336 (1999) 2258
Ybarra, Stella T., 52 Van Natta 1252 (2000) 2022,2057
Yeager, Gary W., Sr., 48 Van Natta 2293 (1996) 18,2116
Yekel, Stuart C., 49 Van Natta 1448 (1997) 346
Yorek, Richard R., 43 Van Natta 1401 (1991) 98
Young, William K., 47 Van Natta 740 (1995) 227,304,432
Youngstrom, Dennis, 47 Van Natta 1622 (1995) 1637
Yowell, Jay A., 42 Van Natta 1120 (1990) 301,358,761,1628,1899
Zabuska, Lorinda L., 52 Van Natta 191 (2000) 1342
Zambrano, Natalie M., 48 Van Natta 1812 (1996) 425
Zamora, April F., 52 Van Natta 865 (2000) 1430
Zanni, Kelly J., 50 Van Natta 1188 (1998) 411,1594,1683,1873,2117
Zapata, Gabriel, 46 Van Natta 403 (1994) 154
Zarifi, Mohammad, 42 Van Natta 670 (1990) 1401
Zarling, Eula M., 50 Van Natta 296 (1998) 655
Zarling, Eula M., 50 Van Natta 1189 (1998) 1357
Zeller, Gerald A., 48 Van Natta 501, 735 (1996) 1968
Zeller, Lynda J., 47 Van Natta 1581 (1995) 1971
Ziebert, Debbie K., 44 Van Natta 51 (1992) 902,2032

Statute
Page(s)

10.095
1863

10.095(8)
1619

18.160
301,358,761,1628,
1717,1899

20.160
2297

30.020
1168

30.020(1)
1168

30.020(2)(a)-(e)
1168

30.050
1168

30.160
1168

30.260
1151

30.265(3)(a)
1168

30.282
1151

40.065(2)
316,1357,1427,1592,
2219

43.130(2)
2297

62 et seq.
2271

105.655 to 105.680
1168

105.685 to 105.697
1168

135.905
38

147.005-.375
38,77

147.005
38

147.005(1)
38

147.005(1)(b)
77

147.005(11)
77

147.005(12)
38

147.135
77

147.145
38,77

147.155
38

147.155(1)
38,77

174.010
178,425,**527,531,538,**
1126,1162,1410,**1713,**
2078,2168,**2275**

174.020
204,1410,1931,2022,
2168

174.120
946

183.310 to 183.550
2294

183.413
1084

183.415(2)
38

183.450(2)
810

183.482
1162

183.482(6)
1697

183.482(7)
523,538,1132

183.482(8)
527,531,534,538,549,
1129,1132,1713,1732

183.482(8)(b)
1717

183.482(8)(c)
518,549,1113,1116,
1700,1707,1709,2302

187.010(1)(a)
946,2022

243.672
1151

243.672(1)(g)
1151

276.598
1151

278.200
1151

278.205
1151

278.205(1)-(4)
1151

278.215
1151

278.215(1)
1151

278.215(2)
1151

278.215(3)
1151

426.005 to 426.223
1132

426.241 to 426.380
1132

654.305 to 654.335
1151

656.005
1428,**2271**

656.005(3)
542

656.005(5)
2168

656.005(6)
555,1931,2191,**2310**

656.005(7)
114,178,213,259,344,
363,**527,538,566,**716,
924,1050,1276,1296,
1389,1470,1479,1556,
1560,1594,1639,1692,
1700,2017,2097,2205,
2243,**2262,2308**

656.005(7)(a)
7,15,114,174,178,185,
238,273,282,292,297,
314,320,322,461,**527,**
534,538,566,627,649,
704,716,742,801,867,
882,897,911,985,1014,
1018,1037,1078,1092,
1094,1097,**1129**,1264,
1288,1346,1351,1390,
1446,1460,1495,1526,
1590,1610,1645,**1704,**
1823,1858,1859,1935,
1957,1965,2040,2042,
2059,2081,2166,2248,
2262,2275,2286

656.005(7)(a)(A)
37,69,193,270,304,
310,337,387,392,435,
448,464,500,640,949,
954,1005,1045,1094,
1097,1318,1333,1440,
1517,1579,1632,1842,
1900,1940,2024,2026,
2097,2185,2200,2248,
2262

656.005(7)(a)(B)
1,7,17,39,66,83,114,
121,164,167,170,178,
188,193,196,227,235,
259,272,288,297,307,
313,320,330,344,378,
380,382,385,390,392,
397,432,448,461,479,
482,497,500,505,**518,**
527,538,549,566,627,
647,649,665,702,745,
775,810,844,867,900,

656.005(7)(a)(B)-cont.
907,924,926,936,963,
986,999,1012,1014,
1035,1037,1052,1061,
1072,1078,1094,1097,
1126,1246,1250,1281,
1286,1299,1306,1333,
1343,1348,1376,1383,
1390,1417,1440,1470,
1479,1500,1507,1521,
1526,1528,1560,1579,
1587,1588,1599,1607,
1610,1626,1630,1632,
1647,1652,1663,**1704**,
1820,1845,1858,1859,
1873,1900,1909,1910,
1915,1937,1944,1946,
1983,1988,1996,2001,
2010,2013,2017,2024,
2031,2033,2040,2042,
2070,2097,2101,2102,
2108,2172,2173,2196,
2210,2231,2248,2254,
2256,2258,**2262**

656.005(7)(b)
566

656.005(7)(b)(A)
1495

656.005(7)(b)(C)
1841

656.005(7)(c)
893,1094,**1129**,1396,
1659,1665,1914

656.005(8)
423,1033,1611

656.005(8)(a)
1129

656.005(9)
241,2078

656.005(11)
241

656.005(12)(a)(B)
1441

656.005(12)(b)
1613,**2262**

656.005(12)(b)(A)
479

656.005(12)(c)
1483

656.005(17)
28,51,54,59,61,93,
112,147,232,371,377,
404,474,671,680,708,
715,723,730,734,750,
787,796,839,866,878,
883,893,973,989,1266,
1331,1355,1357,1367,
1378,1394,1403,1418,
1423,1437,1472,1474,
1478,1483,1497,1544,
1824,1832,1833,1853,
1920,1925,1949,1977,
1986,1994,2009,2068,
2140,2148,2192,2229,
2237,2248

656.005(19)
149,**510**,673,687,704,
821,911,963,1018,
1086,1262,2081,2084,
2275

656.005(21)
153,169,670,**2297**

656.005(24)
12,178,200,213,617,
699,943,963,1052,
1264,1470,1639,1900,
1943,2210

656.005(28)
1724

656.005(29)
2158,**2271**

656.005(30)
88,805,**1724**,2127

656.005(31)
1724

656.012
479,943

656.012(1)(b)
1151

656.012(1)(c)
2262

656.012(2)(a)
903,1410

656.012(2)(b)
903

656.012(2)(c)
692,1405

656.017
2020,2127

656.017(1)
1151,**2300**

656.018
534,**1151**

656.018(1)(a)
1151

656.018(1)(c)
1151

656.018(2)
1151

656.018(6)
1151

656.018(7)
1151

656.027
805,**1724**

656.027(2)
2020

656.027(3)
2020

656.027(3)(b)
25

656.027(7)
1724

656.027(7)(b)
542,**1724**

656.029
1724

656.029(1)
2300

656.054
2127,**2297**

656.054(1)
1433

656.156(1)
2216

656.204
636,**1168**,1245,1878,
2168

656.204(1)
430

656.204(3)(a)
2168

656.204(3)(b)
2168

656.204(4)
2168

656.204(4)(a)
2168

656.206(1)(a)
704,1592,**1707**,2024

656.206(3)
21,**561**,697,1592

656.208
430,1878,2233

656.208(1)
1878

656.210
105,129,146,692,1914,
2009,2237,**2271**

656.210(1)
204,**1720**

656.210(2)
1720,**2271**

656.210(2)(a)
2271

656.210(2)(b)(A)
204,**1720**,**2271**

656.210(2)(c)
204,2251

656.210(4)
2262

656.211
1720

656.212
105,129,146,692,1304,
1450,1914,2189

656.212(2)
1914,2103

656.214
425,1685,1926

656.214(2)
425,536,829,981,1441,
1556,1877,2028,2048

656.214(3)
425,1556

656.214(4)
425,1556

656.214(5)
99,112,425,711,887,
1306,1556,1656,1688

656.214(7)
510,1119

656.218
75,636,1245

656.218(3)
2219

656.222
1926

656.225
510,1126,1276

656.225(1)
510,1126

656.225(2)
510

656.226
2168

656.234
1458,2115,2235

656.236
335,481,1135,1371,
2310

656.236(1)
22,23,32,62,151,197,
199,229,350,430,508,
661,766,771,799,800,

656.236(1)--cont.
832,839,902,1044,
1064,1066,1246,1260,
1261,1272,1318,1405,
1525,1620,1839,1898,
1920,1942,2032,2041,
2107,2310

656.236(1)(a)
335,1318,1620,1942

656.236(1)(a)(C)
23

656.236(1)(b)
23,1942

656.236(1)(c)
1391,1609,1942,1992

656.236(2)
481,1371,1942

656.236(8)
2310

656.245
32,52,65,72,81,108,
148,160,162,218,250,
254,362,415,423,441,
452,455,457,549,643,
651,759,765,769,793,
875,980,982,995,1006,
1021,1031,1256,1272,
1294,1302,1318,1452,
1509,1611,1912,1919,
2015,2030,2055,2187,
2192,2233

656.245(1)
157,1895

656.245(1)(a)
1704

656.245(1)(b)
1256

656.245(1)(c)
1006

656.245(1)(c)(L)
52,1116,1119,1363,
1439

656.245(2)(b)(B)
57,85,102,204,355,
356,417,673,909,1081,
1289,1443,1594,1683,
1914,2006

656.245(3)(b)(B)
356,869

656.245(6)
1026,1372

656.248
549,2187

656.248(12)
1294

656.260
108,160,441,445,549,
651,793,995,1006,
1347,1912,2187,2233,
2294

656.260(6)
2294

656.260(7)
2294

656.260(8)
2294

656.260(9)
2294

656.260(14)
2294

656.260(15)
2294

656.260(16)
2294

656.260(17)
2294

656.262
108,472,497,531,682,
708,716,723,730,734,
750,903,915,1122,
1132,1243,1364,1420,
1540,1573,1620,1824,
1888,1931,1968,1993,
2145,2212,2233

656.262(1)
465,1613

656.262(2)
1135

656.262(4)
335,1009,1433,1527,
1613,1968

656.262(4)(a)
108,144,417,1243,
1356,1433,1527,1613,
1914,1926

656.262(4)(d)
1433,1846,2066

656.262(4)(e)
151,1405,1433,1483

656.262(4)(f)
249,492,688,1009,
1433

656.262(4)(g)
43,249,417,688,786,
808,1009,1257,1433,
1613,1893,1968,2066,
2174

656.262(4)(h)
417,1613,1914

656.262(5)
335

656.262(5)(d)
1365

656.262(6)
63,467,1483,1931

656.262(6)(a)
835,903,1281,1420,
1590

656.262(6)(b)
1931

656.262(6)(b)(A)
1931

656.262(6)(b)(F)
1931

656.262(6)(c)
259,392,497,527,538,
627,716,930,1281,
1479,1579,1882,1931,
2001,2070,2220,2245,
2258,2308

656.262(6)(d)
45,138,257,259,297,
383,625,682,846,975,
1259,1299,1342,1457,
1464,1504,1540,1566,

656.262(6)(d)--cont.
1873,1881,1900,1931,
1937,2017,2031,2212

656.262(7)
108,1931,2203

656.262(7)(a)
45,94,95,138,191,257,
289,294,297,383,473,
716,846,1243,1259,
1285,1299,1324,1342,
1393,1457,1464,1540,
1566,1573,1881,1931,
1937,1993,2017,2031,
2145,2212

656.262(7)(b)
168,259,392,482,497,
527,538,549,716,918,
930,1254,1276,1281,
1432,1556,1579,1594,
1873,1882,1931,2001,
2112,2220,2245,2258,
2308

656.262(7)(c)
95,108,138,198,316,
404,414,472,493,**531**,
680,682,708,723,730,
734,741,750,796,846,
915,973,1243,1285,
1357,1506,1540,1544,
1573,1579,1658,1824,
1881,1888,1931,1949,
1986,1993,2042,2083,
2145,2148,2165,2203,
2212,2218,2233,2258

656.262(8)
1483

656.262(9)
1420

656.262(10)
886,**1129**,1373

656.262(11)
314,337,368,401,666,
704,833,915,1026,
1037,1057,**1135**,1326,
1373,1428,1540,1590,
2038,2081,2145,2148,
2174,2176,2227

656.262(11)(a)
114,129,149,151,180,
188,257,362,465,634,

656.262(11)(a)--cont.
655,666,716,818,835,
839,846,856,886,903,
972,1009,**1135**,1243,
1326,1354,1365,1373,
1433,1450,1511,1527,
1613,1661,1685,1888,
2078,2212

656.262(14)
223,**1122**

656.262(15)
1122,1303

656.265
66,**555**,911,1037,1880,
2310

656.265(1)
555,911,1037,2093

656.265(2)
555,911

656.265(3)
911

656.265(4)
911,1577

656.265(4)(a)
42,911,1037

656.265(4)(b)
911

656.265(5)
911

656.266
55,79,83,92,112,146,
192,200,204,238,259,
271,322,330,380,390,
410,457,461,655,701,
852,869,892,897,907,
961,1014,1045,1050,
1053,1061,1087,1288,
1446,1460,1470,1481,
1587,1590,1599,1610,
1618,1628,1823,1830,
1845,1847,1863,1883,
1958,1971,1980,1982,
1984,2001,2005,2055,
2100,2121,2178,2225,
2256,**2286,2302**

656.268
25,43,75,95,108,129,

656.268--cont.
138,241,363,414,417,
472,483,492,**561**,682,
692,708,723,730,734,
750,808,860,915,1009,
1106,1243,1257,1364,
1506,1540,1555,1573,
1613,1627,1635,1658,
1672,**1713**,1824,1888,
1893,1898,1931,1949,
1968,1986,1993,1993,
2024,2066,2083,2145,
2148,2165,2189,2212,
2233,2241,**2262,2302**

656.268(1)
28,51,54,59,61,93,
147,232,371,377,474,
671,680,708,715,723,
730,734,750,810,839,
866,989,1021,1266,
1331,1355,1367,1378,
1394,1418,1423,1437,
1472,1474,1478,1497,
1544,1824,1832,1833,
1853,1925,1949,1986,
1994,2140,2148,2192

656.268(1)(a)
265,2251

656.268(1)(b)
417,810

656.268(1)(c)
1433

656.268(3)
839,1070,1405

656.268(3)(a)
151,839,1405,1613

656.268(3)(b)
151,839,1405

656.268(3)(c)
151,692,839,856,
1405,2125,2174,2227

656.268(3)(d)
151,1009,1405

656.268(4)
839,**1148**,1405,1544,
2189

656.268(4)(a)
363,698,1009,**1148**,
1405,1613,1898,1920,
2251

656.268(4)(b)
75,363,1009,**1148**,
1405,1613,**1739**,1898,
1920

656.268(4)(c)
1009,**1405**,1613,1898,
1920,2125,2227

656.268(4)(d)
1009,1405,1483,1613

656.268(4)(e)
241,363,932

656.268(4)(f)
1573

656.268(4)(g)
204,483,883,1387,
2142

656.268(5)
425,873,**1148,1713**

656.268(5)(a)
1713

656.268(5)(b)
73,363,417,425,**1713**,
2218

656.268(5)(d)
1573,2212

656.268(5)(e)
883,1387,2142

656.268(6)
363,**1148,1713**

656.268(6)(a)
4,363,**1713**,2251

656.268(6)(b)
241,425,**1106,1713**

656.268(6)(d)
1057,**1104,1106**

656.268(6)(e)
2048,2258

656.268(6)(e)(A)
363

656.268(6)(e)(B)
363,417

656.268(6)(f)
241,303,363,796,**1106**,
2069,2251,2258,**2302**

656.268(6)(g)
60,363,425,1654

656.268(7)
57,102,204,241,355,
363,417,909,1081,
1106,**1148**,1289,1443,
1594,1683,2006

656.268(7)(a)
241,363,673,796,**1148**,
1737,2251,**2284**

656.268(7)(b)
673,**1148**,2181

656.268(7)(f)
241

656.268(7)(g)
107,241,748

656.268(7)(h)
883,1654

656.268(8)
204,417,**1713**,2048,
2218

656.268(9)
222,425,873,1053

656.268(14)
973,1387,1464

656.268(16)
303,796,973,1464,
1713

656.271
510

656.273
25,63,65,108,138,213,
253,254,**510**,699,860,
1018,1062,**1122**,1243,
1261,1262,1264,1272,
1363,1410,1627,1926,
2210,2233

656.273(1)
114,185,254,270,295,
368,402,**510**,627,716,
847,1018,1037,1050,
1062,1086,1102,**1116**,
1119,1262,1273,1296,
1338,1363,1449,1639,
1645,1692,1904,2017,
2205

656.273(1)(a)
2109

656.273(1)(b)
2109

656.273(3)
401,487,**510**,716,767,
1037,**1116**,**1119**,1449,
1692,1952

656.273(4)
387,**2310**

656.273(4)(a)
6,147,160,250,441,
455,793,827,873,878,
995,**1119**,1270,1403,
1474,1912,1994

656.273(4)(b)
63,65,147,827,873,
1119

656.273(6)
368,716,1527

656.273(8)
510,847,1018,1037,
1062,1086,1102,**1119**,
1262,1363,1665

656.277
25,63,253,417,860,
1627

656.277(1)
25,63,860,1627,2187

656.277(2)
25,63,65,860,1449,
1627

656.278
18,52,108,138,151,
160,252,254,362,414,
441,455,472,490,493,
645,680,682,708,723,
726,730,734,750,761,
793,873,878,982,995,
1009,1261,1270,1272,
1293,1364,1405,1410,
1483,1506,1540,1544,
1555,1573,1603,1658,
1672,1824,1850,1888,
1893,1898,1912,1931,
1949,1986,2016,2037,
2083,2109,2116,2145,
2148,2165,2212,2233

656.278(1)
6,51,61,145,160,198,
254,377,423,441,455,
708,723,730,734,750,
759,769,793,989,995,
1009,1256,1266,1270,
1355,1372,1405.1418,
1474,1478,1540,1611,
1824,1919,1949,1986,
2015,2148

656.278(1)(a)
6,9,18,49,50,52,72,74,
81,88,98,108,127,145,
147,148,160,162,198,
218,234,250,252,254,
269,271,301,358,367,
370,371,387,393,424,
433,437,440,441,452,
455,457,472,498,619,
634,637,643,645,662,
680,682,708,723,726,
730,734,750,762,765,
793,817,819,820,823,
827,873,875,878,880,
895,915,974,976,980,
982,994,995,1009,
1031,1046,1085,1091,
1261,1266,1270,1272,
1280,1293,1302,1332,
1350,1372,1403,1405,
1439,1442,1452,1463,
1468,1474,1496,1499,
1502,1509,1533,1540,
1544,1555,1573,1605,
1628,1643,1668,1695,
1824,1838,1850,1893,
1896,1906,1912,1920,
1948,1949,1962,1977,
1989,1994,1997,2004,
2019,2021,2030,2037,
2052,2056,2109,2116,
2143,2148,2160,2186,
2233,2238

656.278(1)(b)
162,198,254,415,648,
1021,1405,2015,2055

656.278(2)
6,1009

656.278(4)
680,708,723,730,734,
750,1824,1949,1986,
2148

656.278(5)
873

656.278(6)
108,198,254,680,708,
730,734,750,1405,
1544,2148

656.283-.295
108,160,441,455,793,
995,1912,2233

656.283
63,108,198,363,414,
493,682,708,723,730,
734,750,**1162**,1420,
1506,1573,1824,1986,
2148,2187,2233

656.283(1)
63,160,455,793,995,
1347,1948,2125,2187

656.283(2)
1162,2187

656.283(2)(d)
1162

656.283(4)
2053

656.283(7)
21,55,75,79,107,204,
241,275,291,324,327,
349,351,415,417,425,
561,660,673,682,711,
763,778,794,876,883,
920,925,932,941,1037,
1042,1053,1057,1361,
1427,1536,1540,1546,
1559,1579,1635,1654,
1656,1683,1697,**1713**,
1931,1953,1978,2024,
2028,2036,2048,2053,
2069,2117,2145,2218,
2241,**2302**

656.289(1)
1106

656.289(2)
153

656.289(3)
11,153,169,670,890,
946,984,1252,1483,
1872,2022,2057

656.289(4)
163,**2310**

656.291
1122

656.291(1)
1122

656.291(2)
1122

656.291(2)(a)
1122

656.291(2)(b)
1122

656.295
11,169,670,946,984,
1252,1338,1685,1872,
2022,2057

656.295(2)
11,169,670,946,1252,
1872,2022,2057

656.295(3)
346

656.295(5)
3,33,75,107,171,223,
275,324,450,454,469,
653,654,657,763,774,
784,848,856,920,941,
960,961,984,1029,
1084,**1132**,1257,1336,
1339,1401,1431,1505,
1514,1554,1653,1654,
1673,1674,1687,1697,
1851,1869,1880,1918,
1953,1978,2036,2046,
2053,2104,2119,2200,
2225,**2302**

656.295(6)
10,1560

656.295(7)
789

656.295(8)
747,789,890,1063,
1338,1483,1697

656.298(1)
1697

656.298(6)
920,**1132**

656.298(7)
527,**534**,**538**,**1129**,
1707

656.307
18,56,108,127,252,
264,438,**536**,645,896,
1122,1293,1326,2037,
2116,2186,2233

656.307(1)
154

656.307(1)(b)
1293,2037

656.307(5)
264,896,1326

656.308
108,154,157,346,**527**,
538,943,2097,2182

656.308(1)
154,157,346,387,506,
527,**538**,639,943,**1126**,
1296,1333,1427,1521,
1560,1603,1606,**1709**,
2097,2138,2185,2236,
2243

656.308(2)
346,1333,2127

656.308(2)(c)
2127

656.308(2)(d)
56,506,691,1005,1326,
1560,1585,1603,1677,
2127,2207,2236

656.310(1)(b)
2216

656.310(2)
1423,2119

656.313(1)(a)
2078

656.313(4)(b)
1458,2115,2235

656.313(4)(c)
1458,2115,2235

656.319
3,890,**1132**,1347,1420,
1483,1566,2187

656.319(1)
1132,1420,1666,1677,
1717

656.319(1)(a)
60,**1132**,1420,1483,
1566,1599,1690

656.319(1)(b)
790,**1132**,1566,1690,
1717

656.319(2)
1132,1420

656.319(3)
1132

656.319(4)
1654

656.319(6)
1540,1573,1993,2145,
2212

656.325
1405,1483,**1732**

656.325(1)
2262

656.325(1)(a)
527,1483,**2262**

656.325(1)(b)
2262

656.325(4)
1492

656.325(5)(a)
129,692

656.325(5)(b)
105,129,174,1450

656.325(5)(c)
2103

656.327
52,108,160,441,455,
549,651,793,995,1280,
1321,1362,1372,1439,
1448,1634,1912,2187,
2233

656.327(1)
1895

656.327(1)(a)
1372

656.327(2)
38,52

656.340
425,**549**,651

656.340(6)(a)
1162

656.340(6)(b)(A)
1162

656.382
651

656.382(1)
114,129,188,290,314,
337,401,467,625,634,
653,886,915,1026,
1037,1326,1365,1387,
1428,1450,1573,2038,
2078,2161,2212

656.382(2)
7,24,27,31,34,37,43,
56,57,83,95,96,121,
126,128,136,149,158,
170,174,191,220,222,
230,231,249,253,259,
273,287,310,316,329,
335,346,352,354,356,
360,363,369,378,382,
387,392,400,403,439,
442,464,465,467,479,
491,497,633,640,647,
651,654,659,660,663,
667,668,676,686,687,
688,691,698,702,738,
760,768,779,781,787,
791,792,810,816,833,
835,843,854,871,872,
881,883,887,893,896,
915,918,925,932,934,
943,953,963,972,977,
986,996,998,1012,
1023,1026,1033,1035,
1050,1062,1065,1069,
1070,1072,1077,1078,
1092,1094,1100,1264,
1273,1278,1286,1299,
1322,1326,1330,1343,
1348,1351,1354,1382,
1383,1387,1390,1427,
1432,1441,1466,1477,
1479,1492,1507,1512,
1526,1528,1531,1535,
1537,1540,1556,1573,
1577,1586,1588,1603,
1612,1613,1619,1632,
1635,1639,1647,1661,
1665,1675,1676,1677,

656.382(2)--cont.
1679,1683,1684,1685,
1688,1819,1840,1842,
1856,1858,1876,1879,
1888,1900,1904,1910,
1915,1921,1931,1940,
1951,1956,1963,1968,
1988,1993,1996,1998,
2001,2006,2010,2026,
2035,2059,2066,2070,
2081,2084,2093,2101,
2105,2108,2114,2123,
2127,2138,2140,2145,
2166,2174,2177,2181,
2191,2194,2202,2204,
2208,2212,2216,2227,
2236,2245,2254,2258

656.382(3)
651

656.385(2)
651

656.385(4)
651

656.385(5)
651

656.386
438,651,667,848,915,
2127

656.386(1)
45,56,69,138,164,170,
174,180,223,253,266,
290,292,295,297,304,
335,346,383,438,440,
447,461,617,625,651,
667,691,702,704,755,
835,897,903,911,915,
963,1037,1050,1097,
1246,1326,1343,1376,
1489,1540,1550,1579,
1585,1603,1647,1655,
1677,1870,1900,1937,
1951,1993,2033,2038,
2059,2084,2105,2121,
2127,2191,2207

656.386(1)(a)
138,667,915,1398

656.386(1)(b)
138,625,915

656.386(1)(b)(A)
438,903,915,1398,
2038

656.386(1)(b)(B)
138,257,383,846,1342,
1457,1827,1900

656.386(1)(b)(C)
138,846,915,1342

656.386(1)(c)
915

656.386(2)
85,253,411,417,633,
711,741,810,915,1926

656.388
2127

656.388(1)
253,747,1271,1870

656.390
60,158,325,651,904,
1250,1373,1387,1491

656.390(1)
487,651,784,904,1373,
1420,1491

656.390(2)
60,158,487,651,904,
1373,1420,1491

656.407
2127

656.576 to .595
814,1410

656.576
1410,1637

656.578
1410,1637

656.580
1637

656.580(2)
1088,1410

656.587
1410

656.591
1410,1637

656.593
1410,1637,**2310**

656.593(1)
1088,1410,1637,**2297**

656.593(1)(a)
1637

656.593(1)(c)
1088,1410,**2297**

656.593(1)(d)
2297

656.593(2)
1410

656.593(3)
1088,1410,1637

656.593(6)
1410

656.593(6)(a)
1410

656.593(6)(b)
1410

656.593(6)(c)
1410

656.593(6)(d)
1410

656.593(6)(e)
1410

656.593(6)(f)
1410

656.593(6)(g)
1410

656.593(7)
1410

656.625
423,682,1611

656.704
1410

656.704(3)
447,**549**,831,848,1006,
1410

656.704(3)(b)
160,441,455,793,995,
1006,1294,1669,1912,
2125

656.704(3)(b)(A)
1006,1347

656.704(3)(b)(B)
1006,1026,2125

656.704(3)(b)(C)
1006,2125

656.704(3)(b)(D)
1006

656.704(4)
1006

656.718(3)
940

656.724(1)
2178

656.726
75,425,893,1635,**1713**,
2241,**2297**,**2302**

656.726(2)
549

656.726(3)
73

656.726(3)(a)
75

656.726(3)(f)(A)
204,425,711

656.726(3)(f)(B)
79,85,102,204,275,
324,673,1053,2028

656.726(3)(f)(C)
75,241,1396,**1700**,
2241

656.726(3)(f)(D)
99,1278

656.726(3)(f)(D)(i)
99,711,887

656.726(3)(f)(D)(ii)
711

656.726(3)(f)(D)(iii)
711

656.726(3)(g)
73,**1739**

656.726(3)(h)
738

656.726(4)(f)
1688,1700

656.726(4)(f)(A)
1688,1700

656.726(4)(f)(B)
1306,1443,1656

656.726(4)(f)(C)
1700,1970,2178

656.726(4)(f)(D)(i)
1688

656.726(4)(f)(D)(ii)
1656

656.726(4)(h)
1057,1433,2178,2251

656.726(5)
2297

656.740
1924,2127

656.740(1)
1924

656.740(2)
2127

656.740(3)
1924

656.740(3)(c)
1924

656.740(4)
1924

656.740(4)(c)
1924,2020

656.740(6)(c)
2127,2207

656.745
1373

656.802
136,196,200,266,344,
494,566,620,862,1024,
1306,1428,1470,1513,
1576,1619,1630,1900,
1961,1978,2062,2084,
2275

656.802(1)
566

656.802(1)(a)
566

656.802(1)(a)(A)
566,1111

656.802(1)(a)(B)
566

656.802(1)(a)(C)
196,566

656.802(1)(b)
566,1428

656.802(1)(c)
566

656.802(2)
237,646,929,1047,
1113,1340,1980

656.802(2)(a)
13,96,178,196,200,
213,318,333,344,465,
494,523,621,626,663,
699,727,783,838,843,
852,882,924,943,948,
949,977,1047,1050,
1067,1090,1113,1264,
1306,1368,1380,1454,
1459,1470,1489,1550,
1576,1601,1639,1650,
1661,1836,1858,1861,
1903,1943,2011,2062,
2070,2076,2084,2121,
2131,2216,2221,2225,
2250

656.802(2)(b)
96,114,119,178,196,
200,213,344,382,566,
617,620,663,699,749,
838,843,862,924,943,
949,953,1067,1090,
1306,1383,1389,1454,
1470,1550,1619,1639,
1639,1858,1943,2011,
2062,2070,2084,2204,
2236

656.802(2)(c)
178,344,924

656.802(2)(d)
114,314,344,617,1113,
2084,2216,2275

656.802(2)(e)
200,1368,1380,1459,
1661,1943

656.802(3)
494,1428,1971

656.802(3)(a)
1732,2131,2216

656.802(3)(b)
494,523,747,1732,
2131,2216

656.802(3)(c)
2131,2216

656.802(3)(d)
2131,2216

656.804
25

656.807
555,1070

656.807(1)
555

656.850
2127

656.850(1)(b)
2127

656.850(3)
2127

657.015
2271

657.155(1)(c)
2174

659.030(1)(f)
555

659.121
1138

659.121(1)
1138

659.400(1)
1138

659.400(2)(a)
1138

659.410
105,555,1138

659.410(1)
555,1138

659.415
105,1176

659.415(1)
1176

659.420
105

659.425
1138

659.425(1)
555,1138

659.425(1)(a)
1138

659.425(1)(c)
1138

670.600
1724

670.600(1)
1724

677.100 to .228
1613

677.805 et seq.
1613

701.035
1724

736.317
1151

742.317(3)
1151

742.500 to 742.504
1151

742.500(2)
1151

742.500(2)(b)
1151

742.504
1151

742.504(1)(a)
1151

742.504(2)(a)
1151

742.504(2)(a)(C)
1151

742.504(2)(b)(A)&(B)
1151

742.504(2)(c)
1151

742.504(2)(i)
1151

742.504(2)(k)
1151

742.504(4)(c)
1151

742.504(7)(a)
1151

742.504(7)(b)
1151

742.504(7)(c)(A)&(B)
1151

742.504(9)(a)
1151

742.504(9)(b)
1151

742.504(9)(c)
1151

742.504(7)(c)(B)
573

742.504(10)
1151

742.520 to 742.542
1151

743.786 to 743.792
1151

743.786(2)(b)
1151

743.789
1151

743.792
1151

743.800
1151

743.805
1151

801.355
1151

803.430
1151

806.070
1151

ADMINISTRATIVE RULE CITATIONS

Rule
Page(s)

137-003-0001
38

430-001-0015
1162

430-001-0015(1)(a)
1162

430-001-0015(1)(a)(A)
1162

430-001-0015(1)(a)(B)
1162

430-001-0015(1)(b)
1162

430-001-0015(1)(b)(A)
1162

430-001-0015(1)(b)(B)
1162

430-001-0015(1)(e)
1162

436-005-0007(23)
1613

436-009-0020(30)
204,1053,1953

436-010-0005
204,1053,1953

436-010-0008(4)
1006,1294

436-010-0008(6)
1006,1294

436-010-0100
1483

436-010-0230(10)
704

436-010-0250
52,1365,1439

436-010-0280
85,204,1148

436-030-0005(5)
73

436-030-0005(7)
204

436-030-0009(2)
363

436-030-0015
810,1148,1739

436-030-0015(2)
1148

436-030-0015(2)(c)
1148

436-030-0015(3)
1148

436-030-0020
810,1739

436-030-0020(1)
1579,2251

436-030-0020(2)
1579,2251

436-030-0020(3)
1579,2251

436-030-0020(3)(b)
810

436-030-0020(4)
1579,2251

436-030-0020(4)(a)
1148

436-030-0020(6)
1148

436-030-0020(8)
1739

436-030-0020(9)
1739

436-030-0020(9)(a)
1739

436-030-0020(9)(b)
1739

436-030-0020(9)(c)
1739

436-030-0020(9)(d)
1739

436-030-0020(11)
1739

436-030-0030
810

436-030-0030(10)
417

436-030-0034
810

436-030-0034(1)
810

436-030-0034(1)(a)
810

436-030-0034(4)
1579

436-030-0034(4)(a)
112,1579

436-030-0035
810

436-030-0035(1)
1676

436-030-0035(2)
1676

436-030-0035(3)
1676

436-030-0035(4)
1676

436-030-0035(5)
1676

436-030-0036(1)
688

436-030-0036(2)
1613

436-030-0045
2187

436-030-0045(10)(b)
893

436-030-0045(10)(c)
893

436-030-0055
1276,1873,2024

436-030-0055(2)
2024

436-030-0115
417

436-030-0115(1)
417

436-030-0115(5)
363

436-030-0135(1)
417

436-030-0135(1)(e)
1057

436-030-0135(3)
417

436-030-0135(5)
1057

436-030-0135(5)(a)
1373

436-030-0135(7)
810

436-030-0145(2)
73

436-030-0145(3)(b)
241

436-030-0155(4)
241

436-030-0175(2)
204,483

436-030-0175(3)
2142

436-30-360(2)
1556

436-030-0580
1373

436-030-0580(2)
2187

436-035-0001 thru -0500
1594

436-035-0001
75

436-035-0003(1)
1713,2302

436-035-0003(2)
102,204,241,1042

436-035-0003(3)
204,241

436-35-005(5)
102

436-035-0005
1594

436-035-0005(1)
1594

436-035-0005(14)
1594

436-035-0005(16)
711,887

436-035-0005(17)(c)
99,887

436-035-0007
1276,1594,1676

436-035-0007(1)
241,284,1276,1289,
1594,1873,1877,2048

436-035-0007(2)
711,1556,1594

436-035-0007(2)(a)
711

436-035-0007(2)(b)
711

436-035-0007(2)(d)
241

436-035-0007(4)
1594,1873,2048

436-035-0007(4)(a)
1276

436-035-0007(4)(b)
1276

436-035-0007(4)(c)
1276,1556,1594,2048

436-035-0007(5)
1276,1594,1873,2048

436-035-0007(6)
1926

436-035-0007(6)(b)
1556,1926

436-035-0007(6)(c)
1556

436-035-0007(6)(c)(D)
1556

436-035-0007(8)(b)
1053

436-035-0007(7)
869,1688

436-35-007(9)
85

436-035-0007(9)
1926

436-035-0007(9)(a)-(c)
1926

436-035-0007(12)
102,673,1926

436-035-0007(13)
102,673,869,909,**1148**,
2006

436-035-0007(14)
34,55,57,79,85,116,
204,241,275,284,411,
417,869,876,938,1042,
1053,1081,1289,1306,

436-035-0007(14)-cont
1400,1443,1579,1594,
1656,1675,1683,1873,
1892,2006,2028,2048

436-035-0007(15)
204,275,711,1556,
1594,1873

436-035-0007(18)
275,673

436-035-0007(18)(a)
241

436-035-0007(19)
204,241,635,1552,
1556,1679

436-035-0007(19)(a)
204,241,284,925,932

436-035-0007(19)(b)
204,376,635,925,1679

436-035-0007(20)
1552

436-035-0007(22)
1373

436-035-0007(22)(b)
275,303

436-035-0007(23)
204,275,808,2028

436-035-0007(23)(a)
275

436-035-0007(27)
1713,1737,2117,**2302**

436-035-0007(28)
79,349,869,1656,1671,
1737,1892,1963,2117,
2302

436-035-0010
673

436-035-0010(2)
1877

436-035-0010(3)
284

436-035-0010(5)
116,241,284,324,360,
446,703,932,939,1100,
1294,1396,1443,1552,
1679,1856,2241

436-035-0010(5)(a)
241,673,1926

436-035-0010(5)(b)
241,1400,1877

436-035-0010(5)(c)
284,303,703,939,1549,
1856

436-035-0010(5)(d)
284,703

436-035-0010(6)
102

436-035-0020(3)
275

436-035-0050(1)
275

436-035-0050(8)
275

436-035-0060(1)
275

436-035-0060(4)
275

436-035-0060(7)
275

436-035-0070(1)
275

436-035-0070(2)
275

436-035-0070(3)
275

436-035-0075(1)
275

436-035-0075(2)
275

436-035-0075(5)
275

436-035-0080
932

436-035-0090
275

436-035-0110(1)
275

436-035-0110(1)(a)
275,673

436-035-0110(1)(c)
275

436-035-0110(8)
126,932

436-035-0110(8)(a)
126,284

436-035-0115(3)
356

436-035-0130(2)
673

436-035-0200
673

436-035-0200(1)
673

436-035-0200(3)(a)
324

436-035-0200(3)(b)
324

436-035-0200(3)(c)
324

436-035-0200(4)
1042

436-035-0200(4)(a)
324,446

436-035-0230(5)(b)
2028

436-035-0230(8)(a)
1552,1556

436-035-0230(9)(a)
241

436-035-0230(10)
241

436-035-0230(16)
411

436-035-0250
343,536

436-035-0270(2)
355,417,1289

436-035-0270(3)(a)
99

436-035-0270(4)(a)
711

435-035-0280
79,711,1289,1679

436-035-0280(1)
1289

436-035-0280(2)
1289

436-035-0280(3)
1289

436-035-0280(4)
275,1289,1594

436-035-0280(5)
1289

436-035-0280(6)
204,275,1053,1289,
1594,1953

436-035-0280(7)
204,1053,1289,1953

436-035-0290
711

436-035-0290(2)
204,485,711,1289,
1594

436-035-0300
711,1289

436-035-0300(2)(a)
204,1289

436-035-0300(2)(b)
485,711,1594

436-035-0300(3)
485,711,883,1053,
1289,1594

436-035-0300(3)(b)
204,1953

436-035-0300(3)(b)(A)
883

436-035-0300(3)(b)(B)
1053

436-035-0300(4)
204,883,1053,1289,
1594,1953

436-035-0310
711,887,1289

436-035-0310(1)
1289

436-035-0310(2)
204,1053,1289,1594

436-035-0310(3)
883

436-035-0310(3)(a)
1515

436-035-0310(3)(b)
485

436-035-0310(3)(e)
204,1953

436-035-0310(3)(g)
1053,1594

436-035-0310(3)(l)(C)
887

436-035-0310(4)
883

436-035-0310(4)(a)
204,883,1515,1892

436-035-0310(4)(c)
883

436-035-0310(5)
204,485,1053,1953

436-035-0310(5)(a)
204,1053,1953

436-035-0310(5)(b)
204,1053,1953

436-035-0310(6)
204,485,1053,1289,
1594,1953

436-035-0320(1)
355

436-035-0320(2)
1656

436-035-0320(3)
85,417,1679

436-035-0320(5)
275

436-035-0320(5)(a)
275

436-035-0330(5)
204

436-035-0330(9)
204

436-035-0330(11)
204

436-035-0330(13)
204,1278

436-035-0330(17)
204,635,1679

436-035-0330(19)
635,1679

436-035-0350(1)(a)
1713

436-035-0350(2)
79

436-35-350(3)
126

436-35-350(5)
126,1679

436-035-0360
34

436-035-0360(13)
275,417,1594

436-035-0360(14)
275,417,1594

436-035-0360(15)
275,417,1594

436-035-0360(16)
275,417,1594

436-035-0360(19)
417,869

436-035-0360(20)
417,869

436-035-0360(21)
417,869

436-035-0360(22)
869

436-035-0360(23)
869

436-035-0375
334

436-035-0385
1688

436-035-0385(1)(a)-(d)
1688

436-035-0385(2)
1688,2178

436-035-0385(4)
748

436-035-0390(6)
2178

436-035-0390(7)(b)
2178

436-035-0400(5)
1289,2006

436-035-0400(5)(a)
1289

436-035-0400(5)(a)(A)
1289

436-035-0400(5)(b)
351

436-035-0430(7)
889

436-060-0020(4)(b)
688

436-060-0020(6)
688

436-060-0020(8)
9,269,1636

436-060-0020(9)
269,1636

436-060-0020(11)
1968

436-060-0025
1720

436-060-0025(5)
204,**2271**

436-60-025(5)(a)
2251

436-060-0025(5)(a)
204

436-060-0025(5)(a)(A)
204,655,676,**1720**,
2158,2246

436-060-
0025(5)(a)(B)(ii)
655

436-060-0025(5)(f)
2271

436-060-0025(5)(g)
2271

436-060-0025(5)(m)
1720

436-060-0030
2105

436-060-0030(2)
856,1968

436-060-0030(5)
692,856,2174

436-060-0030(5)(a)
692,856

436-060-0030(5)(b)
692,856,2174

436-060-0030(5)(c)
692,856

436-060-0030(6)
692

436-060-0030(7)
692

436-060-0030(8)
692,2189

436-060-0030(9)
2189

436-060-0030(9)(a)
2189

436-060-0030(9)(b)
2189

436-060-0030(9)(c)
2189

436-060-0030(9)(d)
2189

436-060-0040(2)
425

436-060-0040(3)
425

436-060-0095
1483

436-060-0095(1)
1483

436-60-095(2)(b)
1483

436-060-0095(5)
1483

436-060-0095(5)(a)-(h)
1483

436-060-0095(12)
1483

436-060-0105(13)
1492

436-060-0140(7)
1943

436-060-0150(4)(i)
2045,2047

436-060-0150(5)(h)
1968

436-060-0150(5)(k)
1391,1609,1992

436-060-0150(6)(e)
2045,2047

436-060-0150(7)
2078

436-060-0150(7)(a)
2078

436-060-0150(7)(b)
2078

436-060-0150(7)(c)
2078

436-060-0150(7)(d)
425,2078

436-060-0150(7)(e)
2078

436-060-0150(10)
1135

436-060-0180
18,252,438,645,1293,
2037,2116

436-060-0180(13)
1293,2037

437-004-0240
2127

438-005-0040(11)
2297

438-005-0046
1006

438-005-0046(1)(a)
169,670,946,984,2026,
2057

438-005-0046(1)(b)
11,946,984,1252,1654,
1872,2022,2057

438-005-0046(1)(c)
486,2026

438-005-0046(2)
2203

438-005-0046(2)(b)
2184

438-005-0065
1420

438-005-0070
1599

438-006-0031
33,223,335,1380

438-006-0036
903,1380

438-006-0071
19,273,790,2195

438-006-0071(1)
394,946,2195

438-006-0071(2)
19,357,946,1303,1386,
1670,1907,2195

438-006-0081
946,1978,2053

438-006-0081(3)
1697

438-006-0081(4)
1978

438-006-0091
1828,1978,2053

438-006-0091(2)
1828

438-006-0091(3)
335,1299,1828

438-006-0091(4)
1978

438-006-0095(2)
2209

438-007-0015
1554,1607,2119

438-007-0015(2)
333

438-007-0015(4)
1554

438-007-0015(8)
1697

438-007-0016
2119

438-007-0018
333,2119

438-007-0018(4)
1607,1978

438-007-0023
1423

438-007-0025
920,2219

438-007-0025(2)(b)
2219

438-007-0095(2)
1554

438-009-0001(1)
1246,1318

438-009-0001(2)
2310

438-009-0001(3)
2310

438-009-0005
2310

438-009-0008(2)(b)
1006,1294

438-009-0008(2)(d)
1006,1294

438-009-0010
2310

438-009-0010(2)(c)
2310

438-009-0010(2)(g)
1458,2115

438-009-0015(5)
163,831

438-009-0020(1)
1620

438-009-0020(4)(b)
2045,2047

438-009-0020(4)(e)
197

438-009-0022(3)(k)
23

438-009-0025(2)
22

438-009-0030(7)
1135

438-009-0035
22,62,197,199,229,
350,430,508,661,766,
771,799,800,832,902,
1044,1064,1066,1525,
1620,1839,2032,2041,
2107

438-009-0035(1)
481,1371,2045,2047,
2167

438-009-0035(2)
481,1371,2167

438-011-0015(2)
344,940,1243,1540

438-011-0020
1603

438-011-0020(1)
775

438-011-0020(2)
486,775,883,936,1504,
1946

438-011-0020(3)
1504

438-011-0030
790,887,936,1504,
1673,1946,2075

438-011-0031(2)
940

438-011-0031(3)
940

438-012-0016
834,1548

438-012-0020(3)(b)
634

438-012-0030
5,1370,2014

438-012-0030(1)
5,634

438-012-0032
18,252,645,1293,2037,
2016

438-012-0035
151

438-012-0035(1)
1009,1893,1898

438-012-0035(4)
151,839,1009,1405,
1483,1898,1920

438-012-0035(4)(a)
151,839,1405

438-012-0035(4)(b)
151,839,1405

438-012-0035(4)(c)
151,839,1405

438-012-0035(5)
151,371,1405,1483

438-012-0037
254,759,769,1256,
2015,2055

438-012-0037(1)(a)
1021

438-012-0040
415,2016

438-012-0040(3)
1948

438-012-0050
108,414,2233

438-012-0050(1)(a)
680,708,723,730,734,
1824,1949,1986,2148

438-012-0050(1)(b)
634,680,708,723,730,
734,1824,1949,1986,
2148

438-012-0050(1)(c)
680,708,723,730,734,
1824,1949,1986,2148

438-012-0055
6,9,49,50,88,93,98,
108,145,147,151,160,
250,254,269,271,367,
411,415,423,424,433,
455,474,498,634,637,
726,750,759,762,769,
794,820,823,827,839,
873,880,995,1009,
1021,1091,1256,1325,
1331,1332,1350,1394,
1403,1405,1439,1442,
1463,1468,1474,1497,
1499,1502,1555,1605,
1643,1668,1672,1695,
1824,1838,1850,1868,
1893,1898,1906,1919,
1962,1989,1994,1997,
2015,2016,2019,2052,
2056,2148,2160,2186,
2233,2238

438-012-0055(1)
28,51,54,59,61,147,
371,377,474,671,680,
708,715,723,730,734,
750,839,989,1266,
1355,1367,1403,1418,
1423,1437,1472,1474,
1478,1544,1824,1832,
1920,1925,1949,1977,
1986,1994,2009,2148,
2192,2237

438-012-0060(1)
377

438-012-0060(5)
1423

438-012-0065(2)
301,358,761,827,1628,
1899

438-012-0065(3)
301,358,761,1499,
1628,1899

438-013-0010(1)
1122

438-013-0010(1)(c)
1122

438-013-0025
1122

438-013-0040(1)
1122

438-015-0005(2)
1401

438-015-0010
223,1343

438-015-0010(1)
269,1091,1332,1401,
1502,1555,1668,1838,
1906

438-015-0010(4)
7,24,27,31,34,37,43,
45,50,56,57,69,83,88,
93,95,96,121,126,128,
136,138,149,151,158,
160,164,167,170,174,
180,191,220,222,223,
230,231,253,254,259,
266,273,287,292,295,
297,304,310,316,329,

438-015-010(4)-cont.
346,352,353,354,356,
360,363,369,378,382,
387,392,400,403,406,
424,433,438,439,442,
455,464,465,474,479,
491,497,617,633,634,
637,640,647,651,654,
659,660,663,667,668,
676,686,687,691,698,
702,704,738,747,750,
755,760,779,781,787,
791,792,793,810,820,
833,835,843,854,871,
872,873,881,883,893,
896,897,911,915,918,
925,931,932,934,943,
953,963,972,977,983,
986,996,998,1009,
1012,1023,1026,1033,
1035,1037,1050,1062,
1065,1069,1070,1072,
1077,1078,1092,1094,
1097,1243,1246,1264,
1271,1273,1286,1299,
1322,1326,1330,1331,
1333,1341,1348,1350,
1351,1354,1376,1382,
1383,1390,1398,1427,
1432,1439,1441,1463,
1466,1468,1477,1479,
1489,1497,1507,1512,
1526,1528,1531,1535,
1537,1538,1540,1550,
1556,1573,1577,1579,
1585,1586,1588,1603,
1605,1612,1619,1632,
1635,1639,1643,1647,
1655,1661,1665,1675,
1676,1677,1683,1684,
1685,1688,1695,1819,
1840,1842,1850,1858,
1870,1876,1879,1888,
1893,1900,1904,1910,
1915,1921,1931,1937,
1940,1956,1962,1963,
1988,1989,1993,1996,
1998,2001,2006,2009,
2010,2019,2026,2033,
2035,2059,2070,2081,
2084,2093,2097,2101,
2108,2110,2121,2123,
2127,2138,2140,2145,
2166,2174,2177,2181,
2186,2191,2194,2202,
2204,2208,2212,2216,
2227,2237,2243,2245,
2248,2254,2258

438-015-0010(4)(a)
755

438-015-0010(4)(g)
138,755,835,1538,
1870,2110

438-015-0010(4)(h)
2227

438-015-0029
1603

438-015-0029(1)
223

438-015-0029(2)(b)
1603

438-015-0029(3)
983

438-015-0045
253

438-015-0052(1)
229,508,800,1066

438-015-0055
417,711,1926

438-015-0055(1)
85,633,810

438-015-0080
50,88,93,151,156,160,
254,296,391,424,433,
455,474,634,637,750,
793,820,822,873,1009,
1091,1331,1332,1350,
1399,1439,1463,1468,
1497,1502,1553,1555,
1605,1643,1668,1695,
1838,1850,1893,1906,
1962,1989,2009,2019,
2023,2186,2237

438-015-0095
814

734-075-0035(2)(a)
544

734-075-0035(10)
544

839-006-0105(2)
555

839-06-240(1)
1138

839-06-240(3)
1138

839-007-0550
555

LARSON CITATIONS

Larson
Page(s)

1 Larson WCL, 2.20
2262

1A Larson, WCL, 23.00
739

1A Larson, WCL, 25.00 at 5-275 (1990)
1092

1A Larson, WCL, 43.52 (1973)
1724

1B Larson, WCL, 41.31 (1973)
566

1C Larson, WCL, 44.33(b) (1978)
1724

4 Larson, WCL, 95.12 (1976)
346,2243

OREGON RULES OF CIVIL PROCEDURE CITATIONS

Rule
Page(s)

ORCP 10A
946,2022

ORCP 47
1151

ORCP 47C
1138,1151,2294

ORCP 71B(1)
301,358,761,790,**1132**,
1566,1628,1666,1690,
1899

OREGON EVIDENCE CODE CITATIONS

Code
Page(s)

OEC 305
2302

OEC 307(2)
2302

Claimant (WCB#) ..... Page(s)

Abah, Peter (99-07692) 2104
Abshire, Anthony W. * (99-01443) 204,376,635
Acevedo, Aurelio (99-09280) 1396
Acevedo, Noe (99-00717) 849
Adams, Finis O. (97-0181M) 1990
Adams, Finis O. (99-0118M) 1989
Adamson, Virgil, Jr. (00-02964) 2078
Adkins, John P. (99-0121M) 708
Affolter, Karen E. (00-0063M) 873
Aguila, Ana M. (00-00265 etc.) 2038
Ahrendt, Christine J. (C002709) 2041
Allee, Terry R. (98-0454M) 974
Allee, Terry R. (99-0215M) 976
Allee, Terry R. (99-04555 etc.) 975
Allen, Larry D. (C000606) 430
Allen, Willard R. * (99-00791) 818
Allenby, George L. (97-02663; CA A103780) 1104,2080,2230
Alltucker, Scott (97-03007; CA A101436) 534
Alm, Gerald C. (99-05869) 456
Ambriz, Octavio (98-09572) 83
Andersen, Christopher S. (99-02676) 85,231
Anderson, Arthella D. (99-02602) 1079
Anderson, Bau T. (98-08148 etc.) 163
Anderson, Robert E. (97-0438M) 151,1977
Anderson, Roger K. (99-0354M) 32
Anderson, Roger K. (99-0385M) 819
Anderson, Roger K. (99-0386M) 820
Anderson-Nixon, D'Ann (99-01723) 1517
Andrew, Pamela (98-10122) 257
Anonuevo, Luzviminda P. (99-08839) 1656
Anson, James R. * (99-04319) 483
Anthoney, Terry L. (99-08306) 1587
Anthony, Margaret A. (98-04017) 445
Antilla, Gerald L. (99-10149) 1843
Ardito, Joseph M. (99-08358) 2174
Artman, Larry S. * (99-03834 etc.) 631
Asana, Edet E. * (99-04072) 923
Ash, Robert A. (00-02599 etc.) 2248
Ashton, Deana M. (99-08274) 978
Astorino, Sheri M. (99-03124) 287
Atkins, Gorden L. * (99-04079) 284
Avery, Albert D. (96-01975 etc; CA A99912) 1132
Avery, Harold L. (66-0475M) 1611
Aviles, Gerardo (99-06972) 1081
Ayala-Ramirez, Camilo (99-07923) 768
Azorr, Steven R. (00-0119M) 2148
Azorr, Steven R. (00-02760) 2145
Babcock, John (99-06533) 1534
Bachman, John G., Jr. (99-09258) 1450
Bachman, John G., Sr. (99-01994) 99
Backman, Susan M. (99-02538 etc.) 1910
Baker, Keith G. (98-08272) 2062
Baker, Mary L. (99-08899) 1398
Balcom, Gerald R. (95-09867) 636
Ball, Dianna R. (00-02235) 1951
Ball, Donald V. (00-00392) 1819
Ball, Jon E. (99-00312; CA A107202) 1148

Claimant (WCB#) ..... Page(s)

Ball, Jon E. * (98-06366) 322,396,476
Ball, Jon E. * (99-10202) 1491
Ballinger, Donald E. (99-09473) 1588
Balogh, Donna J. * (99-01547) 1057
Ban, John J. (97-08233) 2110
Bardales, Victor M. (99-08365) 925
Barnes, Douglas R. (99-08756 etc.) 2097
Barnes, Raymond D. (99-05929) 1844
Barr, Reginald G. (99-07220) 821
Barrow, Gerald (99-0149M) 866
Bartruff, Donna L. (99-04273) 1489
Basmaci, Metin * (98-10143) 337
Baszler, Joan L. * (97-09089) 170
Batson, James L., Sr. (99-01559) 79,283,454
Battin, Sharon M. * (99-02619) 1340,1469,1674
Bauman, Franklin D. (99-00579) 24
Bean, Stephen A. (99-07287) 1845
Beard, John D. (98-05209) 325
Beaver, Joshua D. * (99-01967) 801
Becker, William (00-01978) 2081
Bedard, Donald W. (99-0239M) 72
Beer, Rimm L. (00-03910) 2156
Bell, Judy A. * (99-03656 etc.) 1440
Belton, David E. (00-00504) 2250
Beltran, Hector M. * (99-03538) 711
Benavides, Jorge L. (98-08336) 101
Benfield, Warren L. (99-0201M) 88
Bennett, Richard L. (00-0123M) 1372
Benz, Marvin H. (98-04562; CA A105703) **2268**
Benzel, Rebecca (99-05040) 497
Berdahl, Robin B. * (98-04216) 237
Bergmann, Michael T. (00-01126 etc.) 1931
Bergmann, Michael T. (99-0177M) 493,2083
Bernloehr, Teri L. (99-03995 etc.) 144
Bertrand, Gary A. (00-0210M) 1091
Bielby, Jody R. (99-02063) 55
Bigelow, Audrey J. (99-0391M) 1280,1362
Bingley, Joseph D. (99-0444M) 2009
Birrer, Corinne L. (98-0279M) 59,240,1423
Bisceglia, Eugene I. (98-08367 etc.) 404
Bittle, James L. (00-02965) 2227
Bitz, Steve R. (00-00989) 1991
Bixel, Judy (99-0427M) 498
Bjur, Julia (Klinger) (99-0462M) 441
Bjur, Julia A. (00-0202M) 1912
Black, Rodney A. (99-03659 etc.) 1632
Blackburn, Gary L. * (00-00495) 1867
Blackburn, Gary L. * (97-08691) 1373
Blamires, Tracey A. (98-02326 etc.; CA A103926 etc.) **2308**
Blanchard, Jeffrey T. (98-09313) 786
Blankenship, John W. (98-07177 etc.) 406
Blaske, Gary F. (99-00738) 259
Blystone, Edward D. (C002428) 1992
Board, James E. (99-02118) 442
Bock, Janice K. (00-0021M) 1266
Boggs, Patrick R. (99-04731) 829,981
Bogle, Melinda J. (99-09313) 1877

Boldway, Jamie J. (98-07321) 755
Boling, Stephen C. (00-03304) 2245
Bowers, Wayne W. (98-08977) 963
Boydston, Jenny L. (97-03081; CA A102008) 1106
Brach, Charles W. (99-05052 etc.) 1084
Bradburry, Bobby A. (99-07212 etc.) 1560,1606
Bradford, Cathleen A. (99-0421M) 1261
Bradshaw, Keely M. (99-03455 etc.) 56
Brady, Gary R. (98-07478 etc.) 263
Brena, Maria T. (99-00018) 876
Brenner, Troy D. * (00-00644) 1618
Brenton, Anthony C., Sr. (99-0289M) 1350
Brewster, Charles E. (00-0178M) 982
Bridges, Genevieve K. (99-0072M) 671
Briggs, Terri A. (94-0730M) 1009
Brong, Sherryl A. (99-01868) 617,782,881
Brooke, Teresa (98-08782) 663
Brown, Claudia J. (99-0256M) 127
Brown, George M. (99-0335M) 5,619
Brown, George M. (99-04980) 1250
Brown, Gerard (CA A100218) **544**
Brown, Vicki F. (00-00606) 2033
Brown, Victor L. (98-09451) 329
Brozene, Stephen T. (00-0225M) 1463
Bruffet, Charlotte A. (99-02306) 465
Buchanan, Patrick (98-0517M) 478
Buckley, Darren D. (00-03846) 2177
Bundy, Kenneth P. (95-07510) 249
Burroughs, Bruce W. (99-06219) 1505,1646
Burson, Nga H. (98-08574) 860
Burton, Keith R. (99-01047) 1869
Bushman, Lisa D. (98-08647) 10
Butler, James L. (00-01812) 1510
Calkins, Richard H. (0001048) 1641
Callahan, Richard P. (99-0429M) 250
Callow, Patrick J. (97-08869; CA A103651) **2302**
Camp, Donald R. (00-00497 etc.) 2180
Can, Daniel M. (99-06890) 1348,1501
Caouette, Teri L. (99-00623) 767
Carlow, Buddy S. (99-0055M) 1403
Carman, Sandra R. (98-05278) 770
Carolus, Johnny J. * (99-03345) 862
Carr, Glen A. (00-0026M) 1405
Carter, Craig A. (98-0400M) 1046
Carter, Craig A. (98-07929) 1045
Carter, Sidney F. (00-00798) 1878
Carter, Troy W. (98-05457 etc.) 2124
Cashell, William M. (99-06120) 2121
Cashmere, Willie D., III (99-02499) 1619
Caward, Thomas D. (99-0454M) 9,715,834,1325
Cawley, Kathy J. (99-00954) 2184
Cervantes, Victor J. (99-07541) 2176
Challburg, Eric M. (98-09534 etc.) 972
Chaney, Orvel L. (99-0250M) 457
Charleboix, Patrick K. (00-01033) 1946
Charles, Carl L. (97-07790) 316
Charles, Carl L. (99-01918) 787
Charpentier, Anita (00-04117) 2200
Chartrand, Shirley (99-0330M) 2192

Claimant (WCB#) ..... Page(s)

Chavez, Rosa M. (99-02636) 833,983
Cheney, Gary L. (99-02593) 1554
Chiccino, Gary A., Jr. (99-03111) 1409
Chipman, Dale W. (97-02766; CA A100859) 1113
Chrastil, Judith L. (99-05329) 1404
Christman, Pamela M. * (99-04174 etc.) 122
Churchill, Carla K. (99-09760) 2239
Ciaramella, Alexander (00-02031 etc.) 1996
Cilione, Joseph L. * (97-08921) 789
Clark, Paul E. * (99-02738) 739
Clark, Stephen T. (99-03809 etc.) 1267
Clemons, James E. (97-00968; CA A101296) 1713
Coburn, Robert W. (96-10496) 222
Cole, Shelly (99-08462) 2194
Cole, Todd E. * (99-00333) 227
Coleman, Laurie E. (00-03369) 2152
Collins, Rebecca R. (99-03788) 2123
Collman, Rita K. (99-03738) 1978
Colouzis, Nicholas J. (TP00001) 1410
Connell, Janice K. (98-0271M) 1331
Connell, Kevin (99-09846) 1417
Conner, Arthur A. (98-08640) 649
Conner, Colleen M. (99-06765) 1464
Conner, David L. (66-0455M) 1021
Conradson, Ben E. * (99-06301) 893
Contreras, Trevor A. (99-06343) 790
Cooper, Albert V. (99-08057) 1028
Cooper, Barbara F. (00-04164) 2241
Cooper, Barbara F. (99-07161 etc.) 1029
Cooper, Benjamin J. (00-03146) 1837
Cooper, Steven M. (00-00044 etc.) 2035
Cooper, Steven M. (99-09605 etc.) 1521
Corriea, Stewart C. (00-0239M) 1442
Corthell, Darlene (99-05138) 126
Corum, James R. * (97-10164) 984,1621,1823
Cotan, John (C001646) 2045
Cotter, Diane K. (99-0209M) 472
Covert, Daniel B. (00-01535) 1635,1846,2066
Cox, Fred A. (00-01542) 1659,1914
Cox, Larry B. (00-01016 etc.) 1879
Coyle, Lara (99-02706) 1254
Craft, James E. (00-02012) 2048
Craig, Carolyn M. (00-0058M) 252
Crawley, Kim K. (98-10029) 171
Criswell, Kent W. * (98-09964) 158
Crowe, Scott P. (99-07378) 653
Cruz, Donald J. (99-04344) 620
Cruz-Lopez, Jorge (99-05316) 1035
Cuellar, Vikki A. (99-09215) 1679
Culp, Kenneth G. (66-0066M) 1256
Dahl, Lorraine W., * (99-04622) 1576
Dale, Joe R. (C000201) 197
Davidson, Bethany * (99-09504) 1351
Davis, Caroline D. * (99-01421) 102
Davis, Jerry L. (99-09432 etc.) 1023
Davis, John R. * (99-07458) 1278
Davis, Ronald M. (99-0299M) 162

Davis, Terry L. (00-0054M) 645,2186
Davis, Terry L. (00-02088 etc.) 2185
Davis, William F., Jr. * (99-07705) 915
Dawson, Lillie M. * (99-05558) 998
Dean, Dale F. (99-01247) 742
DeHart, Emmett G. (99-04686 etc.) 2243
DeHaven, Deborah L. (99-05191) 1061
Delgado, Sheila C. (99-04266 etc.) 1047
Deming, Jimmy G. (99-07707 etc.) 1281
Dennis, Jeffrey L. (98-06329) 344
DePaolo, Linda M. (98-0269M) 148
Despois, Gary S. * (99-01913) 953
Diaz, Eduardo (00-0298M) 1838
Dick, Dell D. (99-05490) 999
Diekman, Bettina M. (99-07722) 907
Dillon, Jame P. (99-06308) 939
Dionne, Frank M. (99-03057) 485
Dolan, Michael S. (C992898) 22
Dorry, Scott D. (00-03773 etc.) 2178
Drashella, Denice K. *See* Drushella, Denice K.
Drennan, Jeffery A. * (98-09892) 73
Drew, Charles R. (98-0491M) 51
Droppa, Robert E. (99-0379M) 1085
Drum, Bruce A. (99-01274) 2005
Drushella, Denice K. * (99-03676 etc.) 621,785,940
Dubose, Jodie M. (97-01993; CA A103853) **1122**
Dugger, Linda M. (99-02996 etc.) 1915
Duncan, Cecil (C001982) 1525
Duncan, Ragie D. (99-00020) 1
Dunn, Dale A., Sr. (00-00969) 2010
Dunn, Tara R. (98-08369) 654
Durette, L.C. (99-04382) 410,664,764
Eames, Janis L. (98-09045) 1303
Earnest, James G. (00-0130M) 2056
Earnest, James G. * (99-04497) 1354
Easdale, Michael (99-04894) 360
Edelbach, Tim (00-01415) 1935
Edwards, Robert A. (98-06984) 104
Egbert, Mary A. (99-09160) 1457
Ehr, Allen B. (00-00244) 2209
Eichamer, Ellen B. * (99-06330) 1820
Ekdahl, Virgillia K. (98-01337; CA A104246) **2271**
Eller, Carrie L. (99-05499) 625
Emerson, Kenneth W. (99-04247) 941
Enfield, Kenneth M. (99-00403) 11,153
Entgelmeier, John (99-03769) 369
Escalera, Debra J. (00-01552) 2011
Etcher, David F. (99-08021) 1304
Evans, James M. (99-0152M) 1355,1520,1868
Eveland, Arthur R. (99-07883 etc.) 1537
Evenson, Patsy J. (97-07020; CA A103326) **1129**
Fagin, Gary L. (99-00609) 1458
Fairchild, Joseph A. (C001712) 1391
Fasching, Bill D. (00-00726) 1675
Fawcett, Gerald H. (00-01322) 1847
Ferero, Debbie J. (97-07250) 831
Ferguson, Kenneth V. (00-0260M) 1502,1553
Ferren, Duane A. (99-0258M) 1899
Fiester, Kathleen C. (00-00034) 1900

Claimant (WCB#) ..... Page(s)

Fimbres, Filbert M. * (98-07427) 772
Fisher, Lynn E. (99-05212) 1492
Fitzgerald, Gayle L. (99-09256) 1400
Fleming, Michal A. * (99-04637) 383
Fleming, Michelle E. (98-05214) 962
Fleshman, Tamera J. (99-08074 etc.) 1918
Fletcher, Denise G. (00-02017 etc.) 2204
Fletcher, Russell D. (99-06067) 882
Flickinger, Marilyn J. (99-00239) 128
Flohr, Shawn W. (99-03843) 1346
Flowers, Timmy L. (00-00443) 2084
Flynn, Mary L. (99-09099) 1880
Follett, Justin T. (99-06110 etc.) 1566
Forrister, Lisa M. (00-0144M) 822
Forsythe, Tommy A. (99-06610) 783
Fortado, Lorraine F. (99-02227) 446
Foster, Allan W. (00-0038M) 875
Foster, Christina A. * (98-09971) 1623
Foster, Tammy L. * (98-08327) 178
Fountain, Blair (CA A102804) 1176
Fountain, Loretta K. (98-05293) 213
Fountain, Loretta K. (99-03369) 215
Fowler, Mark (C000218) 229
Fox, Gary S. * (99-01031) 425
Francisco, Mary A. (00-01086) 1645
Franke, Laura R. (96-04464; CA A102043) 549,867,971,1271
Franz, James (99-0195M) 895
Franz, James (99-04212 etc.) 896
Frazier, John R. (98-03515) 500
Fredrickson, Arthur E. * (99-06104) 897,1030
Frias, Pedro (97-03188; CA A101756) 1720,2246
Frierson, Stacy (98-03225; CA A105758) 1737
Frost, Phillip W. (99-08634) 2125
Fullbright, Christopher W. (98-09532) 39
Fuss, Bradley P. (99-00723) 448
Gaage, Gerald S. (66-0136M) 1919
Gaddis, John K. (99-00832) 368
Gage, Darlene L. * (99-01974) 288
Gainer, Antoinette (00-02165) 2013
Gale, Billie W. (99-03944) 192
Gale, George H. * (99-00743) 339
Gallagher, Lonny W. * (99-00300 etc.) 12
Gallagher, Venita A. * (99-02177 etc.) 716,809,930
Gallardo, Amador R. (00-02293) 1956
Gallardo, Amador R. (99-02506) 487
Garcia, Antonio R. * (99-07397) 655
Gardner, Gloria L. (00-0251M) 1948
Gardner, Larry R. (99-01714) 265
Gardner, Myrna (99-07634 etc.) 1375,1539,1653,1851
Garibay, Gloria (00-03653) 2251
Gassner, Thomas R. (99-03525) 2
Gatchell, Cheryl M. (00-00301) 1514,2205
Gates, Angela L. (99-07790 etc.) 1037
Gavlik, Christina R. (00-02540) 2210
Gentry, Pamela J. (99-01975) 918
Gilbert, William L. (99-09439) 2086
Gill, Karen L. (99-02766) 774

Glass, James H. (99-02561) 129
Gomes, Sherry A. (99-07107) 1670,1930,2022
Gong, Ark O. (99-07194) 1511
Gonzales, Elvira (99-08874 etc.) 954
Gonzalez, Benjamin R., Jr. (99-05763) 1526
Gonzalez, David (CA A99970) **1162**
Good, Robert J. (99-08765) 1376
Goodmanson, Earl F. (99-05936) 1347
Goodrich, Donna R. (00-00934 etc.) 2089,2157
Gotthardt, Deborah L. (00-00620 etc.) 1957
Grabenhorst, Steven N. (99-06346) 749
Grant, Gaylynn (99-0129M) 52,1439
Grasham, Paul R. (98-04820) 385
Green, Douglas K. (99-0311M) 54
Green, Kenneth L. (97-02171; CA A101134) 343,**536**
Green, Renee E. * (00-00117) 1572
Green, Robert G., Jr. (00-00622) 1937
Greenhill, Kara S. (98-07056 etc.) 843
Grell, Tonya R. (98-0312M) 1418
Groff, Josephine A. (99-06786) 792
Grover, Leroy J. (C000930) 799
Guevara-Morales, Salvador (99-06605) 1427
Gugliotta, Betty O. (99-02017) 1459
Guillen, Dolores M. * (98-04412) 131
Guritz, Elyata J. (99-09213) 1958
Guyse, Lester (00-02492) 2006
Hailey, Larry L. (00-00340) 1959
Hall, Charlotte E. (99-08158) 985
Hall, Dennis D. (00-00824) 1993
Hall, Donna J. (99-01485) 745
Hall, Jon S. * (99-03316) 1607
Hallgarth, Leah M. (99-04974 etc.) 1610
Hambleton, James H. (00-00057) 1466
Hamilton, Paul D. * (99-05803) 844,1063,1251,1467
Hammond, Mary C. * (98-09732) 467
Hammond, Mary C. * (99-09566) 1512
Hampton, Darla (99-04361) 846
Haney, Charles M. (98-0360M) 1478,1660,2014,2171
Hanna, Kevin E. (00-01337 etc.) 2057
Hanson, James A. * (00-01150) 1671
Hardie, Dorothy (CA A99826) **1138**
Hardin, William (TP00007) 1637
Harding, Christopher K. * (99-07198) 1285
Hari, Hidi L. * (99-05101) 1626
Harkness, John (97-08467; CA A104207) **2314**
Haron, Louis L. (66-0195M) 759,1833
Harper, Susan E. (00-0043M) 1850
Harris, Raymond L. (99-09033) 1357,1516,1583
Harrison, Elizabeth W. (99-03620) 852
Harritt-Diaz, Marysol (99-05778) 1903
Harsha, Greg (00-0216M) 1468,1636
Hart, Carter G. (97-07993) 1245
Hart, Leslie J. * (98-04496) 395
Hartung, Gerald W. (00-01107) 1683
Harvey, Dewey C. * (99-06867) 1556
Haskins, Dale L. (99-06795) 1538
Hatfield, Richard J. (99-03963) 1642
Hauser, Lavonne L. (99-08417) 883
Havlik, Vicki I. * (98-00608; CA A105086) 494,**523**,747

Claimant (WCB#) ..... Page(s)

Hayward, Karen K. (99-02656) 266
Heatley, Terrie L. (99-05372) 1960
Heffley, Rick D. (98-0479M) 437
Heffley, Rick D. * (98-09784 etc.) 435
Heffley, Teri (98-06550 etc.) 387
Heffley, Teri L. (98-0335M) 393,662
Hembree, Deborah C. (99-01306) 931
Hemings, Susan M. (00-02034) 1904
Henderson, Dixie J. (C001143) 1260
Hendrickson, Barry M. * (99-00923) 397
Henwood, Andrea E. * (99-06187) 943
Herrmann, Emmett L. (99-06415) 986
Hess, Oskar (99-06658) 1428
Hewitt, Vivian K. (99-08581) 1684
Hickman, Jerrin L. (99-06796) 869
Hickmon-William, Rosalyn * (99-06453) 1527
Hilby, Gene A. * (99-03399) 105
Hill, Kathleen E. (00-00262) 1676
Hiner, Lisa A. (00-00492) 2203
Hinkley, Richard J. (00-02534) 2229
Holbrook, Mikel T. (99-03861) 838,942,1258
Holte, Daniel A. (00-00690) 1661
Horton, David E. (99-03497) 60
Houchens, Sebulah A. (99-03315 etc.) 934
Houck, Tony D. * (99-06589) 1361
Howard, Christopher H. (98-02728) 164
Howell, Charles E. (00-0325M) 2052
Howell, Jack L. (99-06699) 900
Hoyt, James A. * (99-03257 etc.) 346
Hubbard, James C. (99-02437) 1286
Hublitz, Gregory P. * (99-04481) 673,816
Huff, Larry D. * (99-07085) 791
Huizar, Alexander * (98-08580) 390
Hulse, Joseph A. (99-07427 etc.) 2127,2207
Humphrey, Dave A. (00-02887) 2212
Humphrey, Dave A. (99-0332M) 723
Hunter, Gregory C. (99-06237) 2231
Huntington, Jack R. (00-0057M) 269,296
Huynh, Van V. * (99-09391) 1443
Hval, Virginia L. * (99-08836) 1024
Hyatt, John W. (99-01329 etc.) 1050,1305,1503
Icenhower, Lushona K. * (98-10087) 886
Ilg, Dale L. (99-04012) 775
Iliaifar, Mir (96-05052) 1870
Ilsley, James P. (99-03346 etc.) 154,264
Ingallinero, Nancy (C002354) 1942
Inmon, Quincy J. (99-04546) 400
Jackson, Tricia M. (99-07076) 1426
James, Richard J. (99-06602 etc.) 1677
James, Sherrie J. * (99-04340) 349
Jamieson, Clifford M. (99-09920) 1470
January, Edward M. (96-08893; CA A100221) 1116,1363
Jaramillo, Donna K. (C000506 etc.) 350
Jarvis, Francis L. (99-03501) 871
Jeli, Scott L. (99-07131) 1647
Jensen, Gabriel S. (99-06408) 959
Jensen, Michael C. (98-02785) 665

Jesse, Charles E. (99-08069) 1504
Johansen, Paul D. (96-05209) 253
John, Judith A. (99-10078) 1673
Johnson, Bryan E. (99-07576) 1365
Johnson, Deborah M. (99-0085M) 160
Johnson, Donald C. (98-08935) 1257
Johnson, Karen L. (99-09441) 1430
Johnson, Karen M. (98-06528) 270
Johnson, Lee J. (99-08305) 1685
Johnson, Matthew W. (99-0326M) 989
Johnson, Michael J. (99-01535) 1052
Johnson, Stephen H. (00-01335 etc.) 2024
Johnson, Toni L. (00-0068M) 637
Johnson, Verna J. (99-08233) 1288
Johnson-Slone, Anita E. (98-06102) 1087
Jones, Fred L. (99-04311) 318
Jones, Gary R. (99-08363 etc.) 2216
Jones, Richard L. (98-02826) 701
Jones, Walter, Jr. (66-0356M) 2055
Jordan, James W. (00-0051M) 271,391
Jordan, Jason A. (98-09888) 326
Kaeo, Jaunene R. (99-04103 etc.) 1333
Kaesemeyer, Clifford L. (99-01741) 638
Kahn, Debbie (CA A103759) **2294**
Kanehl, William J. (99-07697) 1853
Keel, Richard J. (99-08409) 1840
Keith, Larry W. (00-0257M) 1506,2165
Keller, David W. (99-06413) 1559
Keller, Joseph H. * (98-09663) 42
Kelly, Marjorie F. (99-04489) 1259
Kelly, Robert E. (98-07668 etc.) 25
Kennaday, Gary F. (00-00106) 2008
Kennedy, Patrick J. (99-09988) 1390
Kester, Dwight D. (99-07165) 1446
Keys, Clarinda S. (98-0461M) 1472,1644,2068
Killian, Ken, Jr. (99-0443M) 370
Killion, Albert E. * (99-02409) 94,289,473
Kimball, Lorenzo K. (99-06601) 411,633
Kimble, Carl H. (99-09828) 1549
King, James M. (99-0248M) 262
King, James, Jr. (99-09878) 2166
Klutsenbeker, Charles F., Jr. (98-06559 etc.) 2153
Knieriem, Richard (99-05147) 686
Knudsen, Richard A. (00-0206M) 1031
Kolibaba, Teresa J. (98-00825) 960
Korsmo, Lester L. (66-0389M) 769
Kosmoski, Camilla S. (99-0414M) 198
Kosmoski, Camilla S. * (99-09855) 1573
Kreger, Michael A. (99-07471) 2101
Kruger, Jack L. * (99-01692 etc.) 627
Kucera, Alan (00-0268M) 1555,1672,2233
Kucera, Alan T. (98-0498M) 878
Kulczyski, Alice Z. * (99-05744) 1431
Lacey, Paul N. (98-06173) 13
Lalley, Omar (00-0235M) 1496
Lamb, Cheryl A. (98-08100) 676
Lamb, Donald L. (99-06228) 2094
Lambie, Douglas J. (C001446 etc.) 1064
Lamerson, Norma K. (99-01965) 1086

Claimant (WCB#) ..... Page(s)

Lance, Robert E. (99-00944) 1432,1572,1913
Lang, San N. (C000847) 766
Langley, Jean M. (99-03547) 991
Langley, Rose L. (98-09539) 136
Langston, Kima L. (98-07374) 15
Lantz, Mark A. * (99-04948 etc.) 639
Larson, Kris P. (98-05863) 2093
Larson, Robert K. (99-0397M) 1367
Lasley, Earnest E. (94-03312; CA A95509) 561
Lasure, Brent A. (99-01779) 291
Laughlin, Susan (97-0536M) 362
Lavin, James P., Jr. (99-08348 etc.) 784
Lawrence, Monica A. * (99-05641) 1590
Le, Cat (99-01141) 1980
Le, Cuong V. (99-04996) 317
Leach, Everett L. (00-0170M) 880,994
Ledin, Larry L. (93-0486M) 680
Ledin, Larry L. * (99-03403) 682
Lee, James T. (98-06593) 1441
Lee, Richard A. (99-04640) 431
Lefors, Sheila A. * (99-07460) 909,1041,1438
Lemus, Abraham * (99-08679) 887
Leon, Raul G. (99-03940) 847
LePage, Ryan T. (98-03638 etc.; CA A106615) 1119
Leslie, Gilbert T. (99-02922 etc.) 911
Lewis, Geoffrey R. (97-04909; CA A103052) 2275
Lightner, William M. (C002753) 2107,2167
Lim, Michael V. * (98-09487) 3
Lima, Robert M. (00-0023M) 145
Linerud, Jeff (99-09856) 1940
Link, Arline F. (99-05347) 1032
Little, Larry L. * (99-05373 etc.) 640,788
Littlefield, Michael D. (99-0428M) 1321
Lloyd, Dyane L. (99-0022M) 74
Logsdon, Terry G. * (99-00431) 226
Lohonyay, J. Peter (98-03510) 238
Lommel, Sandy J. (99-01983) 193
Long, Ed (98-02853; CA A106544) 1739
Loomis, Carol J. (99-06430 etc.) 1943
Lopez, Juana M. * (99-09380) 1654,1895
Lopez, Michael E. (99-05856) 778
Lougher, Sherry A. * (99-06817) 760
Luckhurst, Dustin (97-03907; CA A102856) 1126
Lueker, Randy L. (98-04287) 196
Lusk, Bryan W. (99-02559 etc.) 290
Luther, Kurt W. (99-02608) 292
Lutz, Brian K. (94-0392M) 371,656,1378
Lux, Melvin J. (00-0191M) 1499
Lux, Melvin J. (99-0243M) 1497
Lyda, Harry L. * (98-04115) 21
Mabray, Andrew C. (00-03468) 1908
Macedonio, Salvador (00-00347) 1934
Macias, Carmen O. (99-02440) 450
Macias, Juan G. (99-08178) 1982
Maciel, Ruben R. (99-04833) 327
Mack, Curtis J. (99-09486) 1392
Maden, Richard M. (00-0143M) 793

Madriz, Anna B. * (98-03837) 282,447,848
Magill, Judy L. * (99-00277 etc.) 48,295
Mangum, Harold G. (98-0486M) 1824
Mangum, Vicki L. (99-08729) 1006
Manion, Mark A. (99-07833) 1380
Manley, Leo R. * (99-04915) 973
Mann, Joe M. (96-01194) 294
Mann, Joe M. (98-06650) 1393
Mann, Joe M. * (99-06806) 1592
Marks, Lou E. * (98-09254) 118
Markuson, Elizabeth (99-05117) 781
Marlatt, Brent L. (99-03277 etc.) 728
Marsing, Charles (00-03086) 2218
Martin, Barbara L. (98-03892) 1012
Martin, Donna R. (99-02795) 2026
Martin, Michael C. (99-02901) 1663
Martin, Pamela A. (00-0127M) 726
Martin, Terry W. * (98-00466) 161
Martinez, Francisco J. (99-08537) 666
Martinot, Robert F. (99-02696) 90,2115
Massey, Jimmy L. (99-0442M) 1452,1543,1893
Massey, Robert V. (99-08236) 1584
Masters, William (00-02201) 1855
Mathews, Jacalyn A. * (99-01214 etc.) 1500
Mathews, Zebedee (99-05021) 1594
Mattson, Robert W. (99-06271) 469
Mattson, Thomas L. (98-09642) 330
Maxfield, Dennis (99-01500) 180
May, Judith R. * (99-06575) 889
May-Arthur, Cindy (99-09069) 1289
Mayberry, Michael D. * (98-05561) 69
Mazza, Richard M. (97-08021) 28
McArdle, John E. (C993098) 199
McAtee, David E. (97-01943; CA A101980) 538
McCausland, Cathy A. (00-0166M) 1474
McCord, Clinton L. (97-0060M) 474
McCormick, Dennis E. (98-01720) 17
McCormick, William H., Sr. * (00-01706 etc.) 1599
McCutchen, Randy (00-01233) 2181
McGarity, Edward A. (99-07429 etc.) 468
McGarvey, Michael A. (98-07764) 1014,1269
McGeehan, Patrick C. (99-09543) 1342
McHenry, Jeffrey J. (00-04314) 2187
McKinley, David H. * (99-02415) 890
McKown, Eric C. (00-0318M) 2019
McLain, John J. (99-06832) 1053
McPhail, Don (CA A98729) 555
McQueen, Robert W. II (98-08439) 667
McTaggart, Becky J. (98-01802; CA A104295) 2286
Mead, Frances M. (98-03153) 646,815,948
Meagher, Sherena M. (99-08360) 1479
Medley, Kathleen A. (99-04561) 727
Mefford, James S., Sr. (00-02268) 1983
Meithof, Rosita M. (99-07293) 1062
Melick, John C. (98-0635) 401
Mendenhall, Every * (99-06923 etc.) 95
Mercer, Ernest W. (96-0253M) 232
Mercer, Ernest W. (98-0372M) 234
Merriman, Richard R. (99-03859 etc.) 1336

Claimant (WCB#) ..... Page(s)

Mickola, Thea M. (00-00585 etc.) 1881
Miller, Marline D. (99-10158) 2069
Miller, Ronald S. (96-03652) 1262
Miller, Truman (99-08237) 1968,2105,2114
Mills, Craig B. (98-0358M) 377
Minor, Anglee (99-02403) 172,389,477
Minor, Vernon L. * (99-00420) 320
Minton, Christine (C001136) 902
Minton, Ted B. * (99-03039) 402
Moen, Betty J. (00-01854 etc.) 2070
Mohl, Barbara (99-04677) 2095
Mohl, Barbara A. * (98-07027 etc.) 961
Mohr, Billy M. (97-04178; CA A103884) **1704**
Molena, Darlene J. (97-08181; CA A105255) **1111**
Molz, Kenneth C. * (99-08189 etc.) 1306
Monroe, Marilyn D. (99-00203) 43
Montez, Audencia * (99-06577 etc.) 805,830
Montgomery, Bernard (00-0347M) 2160
Montgomery, John L. (99-03372) 1318,1508,1687
Moon, Leslie (00-0228M) 1293
Mooney, Allen (99-00987) 2208
Moore, Dean M. (00-00582) 1550,1655
Moore, Georgia (99-0435M) 18
Moore, Jonna M. (99-06285) 1984
Mootz, Gwendolyn A. (99-04695) 167
Morgan, Larry J. (98-09689 etc.) 4
Morgan, Shawn E. (99-04725 etc.) 2112
Morrison, Gerald D. * (99-03424) 351
Morrow, Daral T. (96-06161 etc.; CA A100632) **527**
Mullen, Julieta M. (99-09226 etc.) 1339
Mundell, Rebecca S. (99-03761) 106
Munro, Judith C. White (98-09202) 2100
Munson, Rebecca A. * (99-04393) 741
Murray, Lynn L. (99-06215) 630
Mustafa, Nabeeh (99-09689) 2202
Myers, Torie M. (TP-00003) 1088
Nagai, Eleanor (98-07355) 1971,2067
Nasery, Rabia S. (99-05507) 502
Nathan, Barbara A. (99-04501) 1092
Navarro, Martha (00-02528) 2103
Neeley, Dennis J. (99-01678) 1460
Neighbors, James (CA A102041) **1135**
Nelson, Kevin R. (99-09731) 1841
Nelson, Michael A. (99-07959 etc.) 2235
Nelson, Nancy J. (99-07561) 1650
Nevett, Daralynn (99-07228) 687
Nevett, Daralynn (99-09461) 1856
Nevin, Frieda M. (00-00699) 1882
Newby, Luana J. (99-04639) 1017
Newton, Alexander (00-0264M) 1896,1997
Nguyen, Kerry (99-06526) 688
Nicholas-Jimenez, Eleazar J. (99-01015) 926
Nickel, James E. (99-09624) 1454
Nielsen, Nancy A. * (98-05915) 333
Niswender, Kimberly M. (98-08348 etc.) 2059
Nordyke, Caroline S. (97-0429M) 61
Nored, Gary (99-05211) 920

Norman, Brad J. (99-09078) 2172
Norris, Donald B. (99-04673) 659
Norstadt, Jon O. * (99-10123) 1627
Norwalk, Marshall H. (99-05632) 491
Nowotny, Vauda E. (00-0189M) 1448,2021
Nuckolls, Joseph J. (00-02700) 1872
O'Hallaran, Linda K. (99-06679) 1387
Oakes, Rebecca M. (98-06423 etc.) 119
Oetken, Glen D. (99-08825) 2219
Oetken, Glen D. * (99-04823) 1528
Olds, Byron K. (99-03869) 168
Olds, Harold G. (00-02084) 2036,2164
Olsen, Rodney E. (98-07606 etc.) 924
Olson, Robert A. (99-0065M) 1544
Olson, Robert A. * (99-09253) 1540
Olson, Ronald P. (98-0119M) 1920
Olson, Thomas (C992617) 23
Opdenweyer, Katie J. (98-08728) 92
Osler, Debra D. (99-07845) 977
Ouzounian, Dave R. (99-09951) 1688
Owens, Bill (00-0222M) 1332,1399
Oxley, Heather (00-0177M) 980
Pantoja, Ismael (98-09601 etc.) 1585
Papajack, Anthony W. * (99-05618) 432
Papke, Duane J. (99-01727) 1065
Parent, Darrell F. (99-04289) 451
Parker, Alan J. (99-03784) 392
Parker, Barry E. (99-03097) 352
Parker, Peter F. (98-02710) 1090
Parks, Jerry L. (98-05646 etc.) 691
Parks, Kristina L. (99-09218) 2108
Parnell, Henry M. (99-06167 etc.) 1094,1298
Patino, Javier H. (99-08656) 2028
Peacock, Pamela J. (99-01081) 835
Pearce, Ronald V. (98-07657) 1273
Peckham, Hazel (99-00531) 353
Pedersen, Randy M. (99-07412) 1433
Peek, Paul (C001674) 2047
Pelayo, Ramiro (99-01601) 363
Pena, Gilberto M. (99-02871) 1857
Pendergast-Long, Nancy L. (95-0408M) 146
Penn, Kimberly K. (98-09414) 149
Pense, Jason C. (99-05916) 779
Perera, Pedro L. (00-05451 etc.) 2236
Perez, Fidel H. (99-03654) 647
Perkins, Lee A. * (99-04274) 1002
Perkins, Michele A. (99-09174) 1368
Perrin, Claudia M. (98-07391) 1858
Perry, Darold (00-00444) 1401
Peterson, Dale A. (99-05829) 641
Peterson, Llance A. (99-0376M) 218,315,433
Peterson, Rosemary (99-09469) 1552,1622
Peterson, Thomas L. (99-04101 etc.) 1494
Petrie, James W. * (99-01904 etc.) 936
Pewonka, Steve E. (98-08608) 272
Pfeiffer, Jennifer * (99-05613) 903
Phelps, Reuben J. (99-07615) 1026
Phillips, Byron (99-07172 etc.) 1294
Phillips, Gerald (99-0449M) 81

Claimant (WCB#) ..... Page(s)

Pierce, Kenneth F. (00-0048M) 367
Pierson, Jon L. (C000880) 771
Pietsch, Clinton H. (00-00023) 2254
Pixler, Duane J. (99-10090) 1665
Platt, Gary R. (97-09977) 1102
Plumlee, Carl F. (98-07275) 185
Plummer, Kenneth F. (98-07991) 19
Plummer, Richard L. (00-02195) 2102
Poelwijk, James A. (92-0427M) 1634
Post-Booze, Ladawna L. * (99-03864 etc.) 1322
Potter, Dyona J. (97-0556M) 1994
Power, Douglas D. (99-02694) 107
Prairie, Rick (98-07984) 2256
Presnell, Raymond L. (00-0035M) 1949
Price, Carl M. (66-0218M) 2015
Price, Ralph E. (99-04230) 1382
Price, Robert L. (C000343) 481
Prince, Craig J. (99-0186M) 108,1658
Prince, Doyce G. (00-02142 etc.) 1883
Prince, Wallace M. * (98-00458) 45
Prociw, Jeffrey L. (98-08108) 297,453,632
Proud, Daniel B. (00-03833) 2189
Provost, Deborah J. (99-04168) 1389
Pugh, Daniel G. (99-03946) 403
Pulver, Steven K. (00-0071M) 414
Raber, Francesca R. (00-02185) 2220
Ragel, Ralph J. (99-09088) 1530
Ramirez, Jewell F. (99-06550) 854
Ramirez, Marjorie A. (99-08314 etc.) 1998
Ramsey, Wayne (99-05134) 354
Rasmussen, Myron O. * (00-01698) 1827
Ratliff, Linda (00-0209M) 1302,1465,1643
Redding, Dora R. (98-07922) 1067
Reuter, Glenn S. (98-0391M) 301
Reyes, Deborah L. (99-06622) 932
Reynolds, Gladys J. (99-01194) 169
Reynolds, Ronald D. * (98-04171) 1033
Rhinehart, Steven L. (99-05257) 492
Rhoades, Shawn L. (97-08354; CA A104640) 1717
Rhoten, Robert J. (99-05094) 486
Rice, Kimberly R. (99-00425) 138
Richey, Johnny R. * (99-02426) 461
Richey, Robert S. (98-0521M) 839
Ricker, Carolyn S. * (99-08594) 1027
Rider, Vickey L. * (98-08939) 378
Riggs, Christy (00-0077M) 452
Riggs, Edward D. (99-0028M) 93
Riley, Chris R. * (99-08876) 1593
Rios, Jose I. (98-09859) 303
Rios, Jose L. (99-08252) 1873
Robbins, David A. (99-06641) 1323
Robbins, Michael L. * (99-01544) 479
Robertson, Jesse F., Sr. (00-00059) 2221
Robinson, Kathleen A. (93-02515; CA A85643; SC S43918) **2262**
Rockwell, Samuel H. (98-08331) 223
Rodgers, Robert A. (00-0031M) 156
Rodgers, Robert A. * (99-09641) 1243,1356

Claimant (WCB#)..... Page(s)

Rodrigues, Pauline O. (99-06159)..... 2040
Rodriguez, Angel J. (00-0175M)..... 1270,1628
Rogers, Gary W. (99-04707)..... 905
Rogers, Ronald E. (99-09834 etc.)..... 2161
Ronald, Dorothy A. (99-01159 etc.)..... 121
Rookhuizen, Earl W. (00-01175)..... 1831,1936,2031
Rose, Juanita C. (00-0004M)..... 455
Rosera, Moureen J. (99-09315)..... 1343
Roten, Carl C. (00-00570)..... 2158
Rothauge, Edward T. (66-0410M)..... 415,648,2016
Routon, James D. (98-06603)..... 696
Roy, Peter A. (00-02361)..... 2075
Ruddock, David A. (99-03581)..... 1630
Ruiz, Marcelino (99-06823)..... 946
Russell, Donna M. (99-05129)..... 1690
Saenz, Argelio C. (00-00043 etc.)..... 2053
Sage, D.A. (99-07130)..... 1546
Salazar, Steve H. (99-0268M)..... 490
Salisbury, Steven P. (CA A103039)..... 1151
Salustro, Tracie L. (99-09527)..... 1420
Salveta, Christine * (99-05697)..... 1069
Sampson, Darrell H. (00-0345M)..... 2037,2116
Sanchez, Amelia (99-03110 etc.)..... 1097
Sanchez, Ana Rosa L. (98-07619)..... 1921
Sanders, Jaye E. (99-07869)..... 1513
Sanders, Kathleen (99-10137)..... 2224
Sanetel, Kathleen A. * (99-02456)..... 1008
Santamaria, Wilson O. (99-03288)..... 657
Saputo, Harrison S. (99-02630)..... 417
Saunders, Richard L. (99-0471M)..... 49
Schell, Janet L. (00-02401)..... 2140
Schell, Janet L. (99-08997)..... 1601
Scherer, Connie L. * (99-06720)..... 856
Schichtel, Deborah L. (99-05465)..... 1828
Schmidt, Gregory M. (C000035)..... 62
Schriber, John P. (98-0490M)..... 147
Schrock, Errol L. (99-09897)..... 1888
Schuler, Melissa R. (97-01397; CA A101276)..... 518
Schultz, Ralph A. (00-0136M)..... 762
Schunk, Victor (98-0383M)..... 6,2237
Schuster, Danny R. (99-04182)..... 304
Scott, Iris K. (97-10026)..... 690
Scurlock, Clara J. (98-08394)..... 1926
Seaman, Michael D. (99-0108M)..... 440
Seaman, Michael D. (99-03985 etc.)..... 438
Seeley, Martha K. * (99-05193)..... 892
Seifert, Ellis L. (98-09066)..... 1070,1341
Senger, Eugene J. (99-09137)..... 1324
Senz, Edward A. (99-06170 etc.)..... 157
Sessums, Wes J. (00-0157M)..... 823
Seward-Douglas, Lela (00-0275M)..... 1668
Shannon, Michelle L. (99-06106)..... 668
Shaw, John B., Sr. (96-0277M)..... 65
Shaw, John B., Sr. (96-10371)..... 63
Shaw, Stanley M. (97-08533)..... 75
Shaw, Vicky C. * (99-03061)..... 1077
Shay, Delbert (99-06917 etc.)..... 1924,2020

Claimant (WCB#)..... Page(s)

Sheldon, Barry M. (00-00231)..... 1830
Sheldrick, Dennis A. (00-0079M)..... 761
Shelnutt, Sharon L. (C002125)..... 1620
Sherman, Wayne R. (00-0084M)..... 424
Sherrell, Casey R. (99-02150)..... 26
Sherrick, Bryce A. (99-03724)..... 334
Shinall, Linda N. (99-05512)..... 729
Shinn, Herbert K. (66-0117M)..... 254
Short, Marjorie M. (99-05642)..... 324
Shostak, David L. (99-00575)..... 31
Shotthafer, Susan M. (98-01697; CA A105289)..... **1732**
Shubert, Milan F. (94-08858; CA A89283; SC S45040)..... **1700,1970**
Shumaker, Sandra L. (98-08409)..... 33
Shumway, Douglas L. (99-0310M)..... 1986,2126
Silva, Heriberto (99-03988)..... 1692
Silva, Kevin J. (99-03050)..... 66
Simmons, Fredric B. (98-02846 etc.; CA A106416)..... **2310**
Sims, James E. (99-04357)..... 355
Sires, Gary * (99-06088)..... 692
Skowron-Gooch, Annette (99-02418)..... 34
Slaughter, John H. (99-01260)..... 463
Smetana, Manfred M. (00-03196)..... 2173
Smirnoff, George D. (99-06222)..... 1961
Smith, Ellen M. (99-03606)..... 188
Smith, Greg T. (98-06651)..... 273
Smith, Karen * (99-05405)..... 929
Smith, Kenneth L. (98-06222)..... 356
Smith, Mavis (99-08711)..... 670
Smith, Mike D. (98-0107M)..... 358
Smith, Paul E. (99-0130M)..... 730
Smith, Paula T. * (99-00322)..... 704
Smith, Robert W. (99-04007)..... 763
Smith, Vernon T. (99-00865)..... 2168
Solis, Nazario N. (99-00410)..... 335
Soots, Matthew J. (99-03153)..... 1383
Sosnoski, Dennis (00-00867)..... 1965
Sotelo, Amado T. (98-0449M)..... 1832
Sowell, Timothy R. (99-03285)..... 112
Sparks, Rhonda M. (98-04517 & 98-02834; CA A105068)..... **2300**
Spencer, Michael L. (99-05588)..... 1481
Spillers, Synndrah R. (99-05069)..... 714
Spino, Trudy M. (99-05314)..... 626,780
Spratt, Nancy S. (C002667)..... 2032
Spurling, Edwin B. * (99-06294)..... 651
Squire, Erla F. (00-01932)..... 1988
Stackhouse, Timothy J. (99-03807)..... 471
Stalnaker, Forest C. (00-0308M)..... 2238
Stamp, Roy L. (CA A102274)..... **1724**
Stan, Florian D. (98-01004; CA A105650)..... **1174**
Steece, Leroy W. (99-06217)..... 482
Steele, Dugald L. (98-09583)..... 825
Steele, Dugald L. (99-03417)..... 824
Steiner, David A. (TP-98003; CA A102725)..... **2297**
Steiner, Jim M. (99-0198M)..... 827
Stevens, James D. (TP00004)..... 814
Stevens, Robin L. (98-03511)..... 82
Stevens, Teresa L. * (99-05820)..... 1859

Stewart, Christopher (99-03292) 27
Stewart, Michael (99-0199M) 1437,1476,1548
Stewart, Steven P. * (98-06193 etc.) 1326
Stiennon, Richard E. (00-0055M) 1364
Stigall, Beverly B. (99-08379) 1892
Stiles, Douglas W. (99-09929) 1876
Stoaks, Albert R. (99-07281) 1836
Stonier, Chad H. (99-00451) 380
Storm, Nancy J. (CA A99618) **1168**
Strackbein, Veronica M. (96-08239 etc.; CA A99635) **1707**
Strode, Cynthia K. * (99-05689) 794
Struble, David R. (98-07942) 2195
Sullivan, Rodney D. (96-0269M) 1394,1565,1964
Suter, James P. (99-0106M) 1925
Sutton, Richard L. (97-09186; CA A103883) **2284**
Sweet, Jack L. (99-0071M) 50
Talachian, Monireh (99-10026) 1909
Tannenbaum, Vera (00-0229M) 1962,2109
Tapp, James E. (97-07116 etc.; CA A102426) **1709**
Tate, Leticia R. (99-09723) 1952
Taylor, Christian (99-02208) 36
Taylor, Danny O. (99-06801) 1449
Taylor, Ruth (99-09291) 1477
Teague, James P. (00-00695) 2196
Teasley, Lowell R. (99-04500) 1905
Tebbetts, Gary A. (99-04294) 307
Templeton, James E. (00-01389) 2117
Tew, Ralph H. (66-0096M) 423
Therriault, William G. (99-03585) 702
Thomas, Debbie S. (99-02822) 7
Thomas, Lori M. (99-07861) 938
Thomas, Verna F. (95-0456M) 143
Thompson, Kevin E. (00-00375) 1651
Thompson, Kevin E. (99-05300) 642
Thornburg, Gordon D. (99-03075) 904
Thorson, Thomas M. (99-07930) 2119,2242
Thurston, Diann K. (99-06544) 859
Timby, Bruce W. (99-04392) 697
Tjaden, Edgar L. (99-08179) 2131,2247
Todd, Aaron D. (99-0423M) 817
Tofell, Laddie R. (00-0195M) 995
Tolman, Ezra J. (99-02009) 310
Tompkins, Terry L. * (99-08281) 1100
Tompos, Teresa A. * (99-01291) 382
Toney, William C. (98-07540 etc.) 230,439
Torralba, Enrique (99-05478) 357
Toth, Laszlo (99-04198) 2042
Tranmer, Paula K. * (99-06946) 660
Trapp, Michael L. * (98-10097) 949
Trujeque, Carlos (99-05933) 505
Trujillo, Timothy W. * (99-00534) 748
Tucker, Larry V. (00-0332M) 2030
Tucker, Quina F. (99-08144) 1246,1385,1507,1669
Turmaine, Jennifer D. (99-03353) 996
Ulledahl, Joel H. (99-04625) 699
Underhill, Thelma L. (00-0096M) 765
Usinger, John D. (99-0119M) 750
Valdivia, Charlotte L. (00-0018M) 643,807,1370
Valdivia, Charlotte L. (00-0234M) 1695

Claimant (WCB#) ..... Page(s)

Valencia, Rosendo M. (00-01501) 1953
Van Arnam, Alvin (C001879) 1609
Vanderpool, Brian L. (99-02032) 174
Vanortwick, Dale A. (99-08650) 1531
VanWechel, Daniel I. (97-06406; CA A102189) 531
Vaquera, Juventino (00-01049) 1945
Vaughn, Christina E. (99-05470 etc.) 2138
Vaughn, Richard (99-0254M) 1533
Vega, Robert J. (99-00670 etc.) 828,979,1255
Velasquez, Raul R. (99-05249) 1072
Vergeson, Lina Q. (C001451) 1066
Verschoor, Karen L. (99-01890) 275
Vestal, Michael W. (96-11164; CA A100974) 542
Vichas, Mark A. (00-0066M) 634
Vick, Marlys M. (98-07096) 1944
Vinson, Clara S. (98-08506) 200
Virnig, Donna M. (99-05675) 2191
Viscaino, Cindy M. * (99-02288) 57
Vistica, Christine M. (C000730) 661
Volner, Carl E. (99-04224 etc.) 114
Voorhees, Carl G. * (99-01316 etc.) 313
Voorhies, Peter (97-0530M) 1483
Vosburg, Jeff A. (99-03164) 116
Wachtrup, Arthur (00-0217M) 1272
Wagner, John F. (99-07738) 872
Walker, Roland A. (93-07081; CA A89100; SC S44116) 510,1018,1338
Walker, Terri L. (99-08815) 1075
Walston, Terrance C. (00-03418) 2142
Ward, Melody R. (98-09972) 241
Warneke, George (99-07604) 1078
Warren, Barbara J. (99-06401) 1042,1276
Warren, Charles E. * (98-03210) 274
Washington, Billy W. (96-0512M) 734
Waterman, Ginny D. (98-07952) 96
Watkins, Donald (99-04550) 703
Watkins, Jerry J. (99-03487) 20
Watkins, Marilyn J. (99-08963 etc.) 1296
Weathers, Enedina * (99-02287 etc.) 506
Weaver, Keith R. (00-0336M) 2143
Weaver, Melvin J. * (98-07807) 1861
Webb, Donald L. * (99-07552 etc.) 1005
Weideman, Loren E. (99-0259M) 1605
Weideman, Loren E. (99-08376 etc.) 1603
Weiss, Darleen J. (99-10012) 1612
Wendt, Nita C. (99-09970) 1598
Werner, Maybelle M. (99-09820) 2076
West, Robert (00-0293M) 1906,2023
West, Robert * (99-00951) 235
Westenberg, Marsha E. * (00-00195) 1386,1697
Westman, Christine M. (99-04027) 698
Weston, Michael W. (99-03421) 2001
Whaley, Billy G. (99-09331 etc.) 2182
Whisenant, Donald J. (99-07729) 808,935,1613
White Munro, Judith C. (98-09202) 2100
Whiteley, Raymond P. (99-07190) 1863
Whitted, Ronald W. (98-07685) 394
Whitton, Robert (00-0262M) 1509

Whitton, Robert C. (99-01464) 464
Whitty, Janet E. (99-07693) 1652
Whitus, Dawn C. (99-02417) 1639
Wickdal, Troy R. (99-07622) 1076
Wilcoxen, Darren J. (99-04073) 58
Williams, Glenette R. (99-07100 etc.) 1535
Williams, Greg (99-10069) 1495
Williams, Harvey L. (99-01007) 37
Williams, Henry (00-0300M) 2004,2130
Williams, Jeannie (C001391) 1044
Williams, John A. (99-08657) 1264
Williams, Larry A. (C000946) 800
Williams, Lorna D. (99-05773) 738
Williams, Loy W. (99-07972) 754
Williams, Patricia A. (CV-99002) 38
Williams, Robert L. (CV-99002) 77
Williams, Thomas (CA A102719) 573
Willis, Laurie D. (99-05186 etc.) 314
Willis, Robert (C000679) 508
Wilson, Leland J. (99-09755) 1963
Wilson, Robert A. (00-00026) 2225
Wilson, Toni A. (00-00012) 2017
Wimsatt, Duane (99-05508) 2046
Wirfs, Judy A. (99-07447) 810
Wiseman, John J. (99-06689) 1666
Woda, Melvin C. (96-11475; CA A101658) 566
Woodard, Vicky L. (99-06153) 796
Woolner, Bonnie J. * (99-04302 etc.) 1579
Wrobel, Alan P. (99-04348) 1907
Wroot, Scott R. (C970428 etc.) 1371
Wyllie, Carl J. (C002201) 1839
Yates, Sally D. (00-01762 etc.) 2258
Ybarra, Stella T. (99-07856) 1252
Yekel, Stuart C. (98-05313) 220
Yeoman, Thomas M. (99-09148) 1515
Yorek, Richard R. (99-0161M) 98,1898
Young, Wilma J. (C000963) 832
Zabuska, Lorinda L. (99-00781) 191
Zamora, April F. (99-08782) 865
Zaragoza, Ramona (00-01512) 1842
Zeigler, Joshua G. (99-08633) 1536
Zimmerman, John H. (99-01164) 1330,1475,1586
Zwingraf, Joseph R. * (99-04299) 1299

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* Appealed to Courts as of 10/31/00

Cite as 52 Van Natta ____ (2000)