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In the Matter of the ORS 656.245 Medical Services Dispute of

**Santa Maria, Pedro, Claimant**

Contested Case No: H03-081

**FINAL ORDER**

March 22, 2004

SEDGWICK CLAIMS MANAGEMENT SERVICES, Petitioner

PEDRO SANTA MARIA, Respondent

Before John L. Shilts, Workers' Compensation Division Administrator

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The petitioner, Sedgwick Claims Management Services (Sedgwick), by and through its attorney Mark Bronstein, timely filed exceptions to Administrative Law Judge (ALJ) Catherine Coburn's November 24, 2003 Proposed and Final Contested Case Hearing Order. Claimant, by and through his attorney Donald Hooton, timely submitted a response. This matter comes before the director for issuance of a final order.

The director may adopt the proposed order as the final order or may modify the proposed order. OAR 137-003-0655(6), 436-001-0275(3). If the director modifies the proposed order in any substantial manner, the agency must identify and explain the modifications. OAR 137-003-0665(3). The director may only modify the ALJ's findings of historical fact if the director determines that the finding is not supported by a preponderance of the evidence in the record. OAR 137-003-0665(4).

The issues raised by Sedgwick are whether the attending physician change from Dr. Walsh to Dr. Verzosa was justified, and whether the ALJ's attorney fee award was excessive. The entire record has been reviewed, including the exhibits received into evidence, the audio recording of the hearing, and the parties' written arguments.

The director adopts the ALJ's findings of fact, with the following changes. On page 3, the references to "Dr. Dirk" in the second paragraph of the findings of fact are replaced with "Madelene Anderson, FNP." (Ex. 3-1). In the third paragraph on page 3, the last sentence is replaced with the following: "On January 16, 2001, Dr. Seymour released claimant to modified work, prescribed medication and referred claimant to Dr. Gerry. (Exs. 5 , 9P)." In the fifth paragraph on page 3, the date of "April 14, 2001" is changed to "March 14, 2001," and the following is added: "On April 20, 2001, claimant sought emergency treatment for back pain from Dennis Grey, FNP. Grey recommended exercises and prescribed medication. (Exs. 3-5, 13, 21P, 22P)."

On page 4, finding of fact (6 ) is replaced with the following:

"6. On July 20, 2002, claimant began treating with Dr. Walsh, chiropractor, and designated him as his attending physician. (Exs. 16, 19, 20). Claimant's twelfth visit with Dr. Walsh occurred on August 12, 2002. (Exs. 16, 19). After claimant's fourteenth visit, Dr. Walsh utilized a consulting exam and treatment plan of Dr. Verzosa. (Ex. 35)."

The references to “Dr. Vervosa” in the ALJ’s order are changed to “Dr. Verzosa.”

### Change of Attending Physician

I adopt and affirm the ALJ’s order, with the following changes and supplementation. In the first full paragraph on page 7, I include claimant’s March 2001 medical services from St. Vincent Hospital’s Emergency Room and find that the services claimant obtained from St. Vincent Hospital’s Emergency Room in February, March and April 2001 do not count as a change of attending physician.

In the second full paragraph on page 7, the second and third sentences are replaced with the following: “Claimant’s twelfth visit with Dr. Walsh occurred on August 12, 2002 (Exs. 16, 19), and at that point, Dr. Walsh was no longer qualified to serve as an attending physician. ORS 656.005(12)(b)(B). After claimant’s fourteenth visit, Dr. Walsh utilized a consulting exam and treatment plan of Dr. Verzosa. (Ex. 35).”

The ALJ’s order is supplemented as follows. At hearing, both parties agreed that Drs. Brown and Seymour constituted claimant’s first choice of attending physician, and that Dr. Gerry was the second attending physician. The ALJ found that Dr. Walsh, a chiropractor, was designated claimant’s third attending physician in July 2002. Claimant’s twelfth visit with Dr. Walsh occurred on August 12, 2002 (Exs. 16, 19), and, at that point, Dr. Walsh was no longer qualified to serve as an attending physician, pursuant to OAR 656.005(12)(b)(B). After claimant’s fourteenth visit, Dr. Walsh utilized a consulting exam and treatment plan of Dr. Verzosa. (Ex. 35). The ALJ relied on OAR 436-010-0220(3)(e), which provides that, when a physician is no longer qualified to serve as an attending physician, the change to a physician who is qualified is not considered a change of attending physician. Because Dr. Walsh was a chiropractor who was no longer qualified as an attending physician after 12 visits, the ALJ concluded that Dr. Verzosa was properly approved as the third attending physician.

Sedgwick argues that the change of attending physician to Dr. Verzosa should not be approved. Sedgwick contends that, at the time Dr. Walsh referred claimant to Dr. Verzosa, Dr. Walsh still qualified as an attending physician. Sedgwick asserts that Dr. Walsh’s referral to Dr. Verzosa and Dr. Verzosa’s completion of the Form 827 were two separate events. Sedgwick relies on *Country Mutual Ins. Co. v. Mendoza*, 148 Or App 397 (1997), and argues that the change to Dr. Verzosa should count as a change of attending physician, rather than a change beyond claimant’s control.

Claimant contends that he was entitled to change his attending physician to Dr. Verzosa when the 30-day period in which Dr. Walsh could act as claimant’s attending physician expired by operation of law. He asserts that Sedgwick is arguing that, by virtue of completing the 827 form, the change of attending physician is transformed as a matter of law from one mandated by statute to one demonstrating active “choice” by claimant. According to claimant, a change of physician is a question of fact and the fact-finder must determine whether a change occurred as a matter of choice, or as a result of statutory requirement or other circumstances beyond the worker’s control. See *Rosemarie Guerra*, 3 WCSR 1 (1998) (status as attending physician is a

question of fact; the filing of Form 829 is not determinative), *aff'd mem Columbia Forest Products, Inc. v. Guerra*, 157 Or App 191 (1998).

ORS 656.245(2)(a) provides, in part:

"The worker may choose an attending doctor or physician within the State of Oregon. The worker may choose the initial attending physician and may subsequently change attending physician two times without approval from the director. If the worker thereafter selects another attending physician, the insurer or self-insured employer may require the director's approval of the selection and, if requested, the director shall determine with the advice of one or more physicians, whether the selection by the worker shall be approved."

OAR 436-010-0220(3) provides that certain actions do not constitute a "change" of physician within the meaning of ORS 656.245(2)(a). Claimant relies on OAR 436-010-0220(3)(c), which provides that "[w]hen workers are required to change physicians to receive compensable medical services, palliative care or time loss authorization because their medical service provider is no longer qualified as an attending physician[,] that is not considered a "change of physician" by choice of the worker.

In *Country Mutual Ins. Co. v. Mendoza*, 148 Or App at 397, the issue was whether a worker changing attending physicians after referral by her current attending physician counted as one of the two changes that ORS 656.245(2)(a) permits without prior director approval. The court explained that, pursuant to *former* OAR 436-10-060(3), certain actions did not constitute a "change" of physicians within the meaning of ORS 656.245(2)(a), one of which was "[c]onsultations or referrals initiated by the attending physician." *Former* OAR 436-10-060(3)(c). The court reasoned that a referral did not necessarily *require* a change of attending physicians. The court found nothing in the rule to suggest that, if a change of attending physicians is preceded by a consultation or referral, the change of physicians did not count as one of the two changes that did not require director approval. In *Mendoza*, there were no findings that the referral to another physician was anything other than a referral for consultation or specialized treatment that did not necessitate a change of attending physicians. Furthermore, there was no evidence that filing the change of physician form was required by the referral for consultation. Rather, they were two separate events. Consequently, the court held that the ALJ erred in concluding that the change of attending physicians did not count as one of the two "changes" in attending physicians allowed without director approval.

Here, unlike *Mendoza*, claimant was statutorily required to change attending physicians. Sedgwick argues that, at the time Dr. Walsh referred claimant to Dr. Verzosa, Dr. Walsh still qualified as an attending physician. The time of "referral" is not dispositive. As of August 12, 2002, Dr. Walsh was no longer statutorily qualified to be claimant's attending physician, pursuant to OAR 656.005(12)(b)(B). (Exs. 16, 19). On August 19, 2002, claimant began treating with Dr. Verzosa and designated her as his attending physician. (Exs. 23, 24). Claimant was required to change physicians because Dr. Walsh was no longer qualified as an attending physician and, therefore, claimant's change to Dr. Verzosa did not constitute a "change" of physician. *See* OAR 436-010-0220(3)(c).

I turn to Sedgwick's argument that claimant must meet one of the requirements of OAR 436-010-0220(7) in order to obtain approval to treat with Dr. Verzosa. Sedgwick contends that claimant has not met those requirements and, therefore, the change of attending physician to Dr. Verzosa should not be approved.

Claimant responds that OAR 436-010-0220(7) contains no provision that would permit a change of attending physician solely because the current attending physician no longer qualifies as an attending physician as a matter of law. Claimant contends that, by arguing that he must meet the requirements of OAR 436-010-0220(7) before an additional change of attending physician can be made, Sedgwick is arguing that he should not be permitted to have an attending physician at all.

OAR 436-010-0220(7) provides:

“After receipt and review, the director will issue an order advising whether the change is approved. The change of attending physician or authorized nurse practitioner shall be approved if the change is due to circumstances beyond the worker's control as described in section (3) of this rule. On a case by case basis consideration may be given, but is not limited to, the following:

“(a) Whether there is medical justification for a change, including whether the attending physician or authorized nurse practitioner can provide the type of treatment that is appropriate for the worker's condition.

“(b) Whether the worker has moved to a new area and wants to establish an attending physician or authorized nurse practitioner closer to the worker's residence.

“(c) Whether such a change will cause unnecessary travel costs and/or lost time from work.”

According to Sedgwick, claimant must meet one of the requirements of OAR 436-010-0220(7) in order to obtain approval to treat with Dr. Verzosa. I disagree. OAR 436-010-0220(7) provides that the change of attending physician “*shall* be approved if the change is due to circumstances beyond the worker's control as described in section (3) of this rule.” (Emphasis supplied). I have determined that the change of attending physician to Dr. Verzosa was due to circumstances beyond claimant's control, pursuant to OAR 436-010-0220(3)(e). OAR 436-010-0220(7) further provides that, “[o]n a case by case basis consideration *may* be given, *but is not limited to*” certain criteria. By its express terms, OAR 436-010-0220(7) does *not* require claimant to meet one of the listed requirements of that rule to obtain approval to treat with Dr. Verzosa. Therefore, I approve the change of attending physician to Dr. Verzosa.<sup>1</sup>

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<sup>1</sup> I also adopt and affirm those portions of the ALJ's order concerning the Motion for Dismissal and Medical Services.

### Attorney Fees

The ALJ awarded claimant's counsel a fee of \$6,750, consistent with his statement of services. Sedgwick argues that the attorney fee award should be reduced. Claimant requests an additional fee of \$1,237.50 for services in response to the exceptions.

In 2003, the legislature amended ORS 656.385. Or Laws 2003, chapter 756, §2 (Senate Bill 620) provides, in part:

“(1) In all cases involving a dispute over compensation benefits pursuant to ORS 656.245, 656.260, 656.327 or 656.340, where a claimant finally prevails after a proceeding has commenced before the Director of the Department of Consumer and Business Services, the director shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant's attorney. In such cases, where an attorney is instrumental in obtaining a settlement of the dispute prior to a decision by the director, the director shall require the insurer or self-insured employer to pay a reasonable attorney fee to the claimant or claimant's attorney. The attorney fee must be based on all work the claimant's attorney has done relative to the proceeding at all levels before the department. The attorney fee assessed by the director, or on appeal from an order of the director, under this section must be proportionate to the benefit to the injured worker. The director shall adopt rules for establishing the amount of the attorney fee, giving primary consideration to the results achieved and to the time devoted to the case. An attorney fee awarded pursuant to this subsection may not exceed \$2,000 absent a showing of extraordinary circumstances.”

Section 3 of Senate Bill 620 (Or Laws 2003, ch 756, §3) provides:

“The amendments to ORS 656.262 and 656.385 by sections 1 and 2 of this 2003 Act apply to all claims for which an order relating to the issue on which attorney fees are sought has not become final on or before the effective date of this 2003 Act, regardless of the date of injury.”

Pursuant to ORS 171.022, an Act of the Legislative Assembly takes effect on January 1 of the year after passage of the Act, “[except as otherwise provided in the Act[.]” Because Senate Bill 620 did not contain an emergency clause, it was effective on January 1, 2004. Here, because the order was not final on or before January 1, 2004, I apply the amended version of ORS 656.385(1) in awarding an attorney fee.

OAR 436-001-0265(1)(b) (WCD Admin. Order No. 03-067) provides that in cases where the director is required to assess an attorney fee under ORS 656.385(1), “[a]bsent a showing of extraordinary circumstances or unless otherwise agreed by the parties, the fee may not exceed \$2,000 nor fall outside the ranges” provided in the matrix, which takes into account attorney time devoted and estimated results achieved. OAR 436-001-0265(1)(c) provides that in cases under ORS 656.245, 656.260, or 656.327, the factors listed in OAR 436-010-0008(13) may also be considered.

OAR 436-001-0265(2) provides:

“Except as provided in section (3), in cases where the administrative law judge or director assesses an attorney fee, the following factors may also be considered:

“(a) The complexity of the issue(s) involved;

“(b) The quality of the legal representation;

“(c) The value of the interest involved;

“(d) The nature of the proceedings;

“(e) The risk in a particular case that an attorney’s efforts may go uncompensated;

“(f) The assertion of frivolous issues or defenses;

“(g) A statement of services, if submitted within seven days of the hearing date, unless the administrative law judge instructs otherwise; and

“(h) Any other relevant consideration deemed appropriate by the administrative law judge or director.”

At the contested case hearing, claimant’s counsel’s statement of services estimated that he had devoted 30 hours preparing for and participating in the hearing. He asserted that the issues were fairly complex and included claimant’s motion to dismiss the employer’s contention that the medical services were not directly due to the accepted condition. Claimant’s counsel calculated that Dr. Walsh’s unpaid bills totaled \$4,959, and Dr. Verzosa’s unpaid bills totaled \$725. Claimant’s counsel said that he ordinarily charged \$150 per hour when billing on an hourly basis and asserted that, because this matter was handled on a contingent basis, an hourly rate of \$225 was reasonable.

Sedgwick objected to the fee request, arguing that claimant’s counsel’s expenditure of 30 hours was excessive and that it was excessive for claimant’s counsel to charge a “risk factor” because he handled the matter on a contingent basis. The ALJ was aware of Sedgwick’s objections, but awarded a fee of \$6,750.

Sedgwick reiterates its argument that the attorney fee award should be reduced. Sedgwick contends that claimant’s attorney’s statement of services did not specifically state the time expended on the services performed and that claimant’s counsel’s estimate of 30 hours is excessive. Sedgwick further argues that: none of the exhibits were submitted by claimant; the ALJ referred to less than half of the 77 exhibits; the hearing was conducted by phone, with no witnesses testifying and only lasted 30 minutes; the issue of change of attending physician was

not complex; the risk of his attorney going uncompensated was reduced because claimant prevailed before the Medical Review Unit; claimant did not prevail on his motion to dismiss; claimant did not prevail on receiving the full reimbursement of services from Dr. Walsh; claimant's counsel's time included calculating medical bills and that time arguably preceded the contested case hearing level; and claimant's counsel's \$150 hourly fee is high enough to take into consideration any contingency factor.

Claimant responds that Sedgwick erred by asserting that claimant did not prevail on his motion to dismiss. Although claimant's counsel acknowledges that he did not submit any of the exhibits, he asserts that it was necessary to review the exhibits on two occasions because Sedgwick asserted an intent to obtain claimant's testimony, which required a postponement. He also asserts that Sedgwick submitted additional exhibits at the original hearing, many of which were duplicative or otherwise objectionable. Claimant's counsel agrees that the hearing was conducted by phone, without witnesses testifying and the hearing only lasted 30 minutes, but he points out that Sedgwick's assertions are incomplete. Because Sedgwick indicated an intent to seek claimant's testimony, claimant's counsel had to prepare claimant for the hearing, which required additional attorney time. Claimant asserts the length of the hearing was not representative of the extended period of representation that was required.

Claimant acknowledges that the issue of change of attending physician was not complex, but he notes that was not the only issue at the contested case hearing. Other issues included the ALJ's jurisdiction to reach the causation issue, Sedgwick's right to raise the issue of causation, and whether chiropractic treatment following the change of attending physician was completed under an appropriate treatment plan. Although Sedgwick argues that claimant did not prevail on receiving full reimbursement of Dr. Walsh's medical services, claimant contends that Sedgwick has not demonstrated that his benefits, considered in totality, were disallowed or reduced as a result of the hearing. Claimant's counsel denies Sedgwick's assertion that the calculation of medical bills preceded the contested case hearing level. Furthermore, claimant's counsel asserts that his normal hourly fee for non-contingent work is \$150, and he disputes Sedgwick's argument that the same hourly fee is sufficient even when the work is contingent. Claimant also requests an additional fee of \$1,237.50 for services in response to the exceptions, based on 5.5 hours devoted to responding to the exceptions. Thus, claimant requests a total attorney fee of \$7,987.50.

In *Schoch v. Luepold & Stevens*, 162 Or App 242, 250 (1999), the court explained that when a claimant or an insurer submits a specific statement of services or a specific objection to a fee award, the agency must explain the reasons why the factors it considered led to its conclusion that a specific fee is reasonable. The agency must explain why its consideration of the various factors caused it to agree or disagree with the specific request or objection a party has presented. *See also Schoch v. Luepold & Stevens*, 325 Or 112, 118 (1997) ("an agency must provide sufficient explanation to allow a reviewing court to examine the agency's action in relation to the range of discretion granted by the legislature, the agency's own 'rule, officially stated agency position, or a prior agency practice,' and other statutory and constitutional provisions").

ORS 656.385(1) provides that an attorney fee "may not exceed \$2,000 absent a showing of extraordinary circumstances." OAR 436-001-0265(1)(b) provides that "[a]bsent a showing of

extraordinary circumstances or unless otherwise agreed by the parties, the fee may not exceed \$2,000 nor fall outside the ranges” provided in the matrix.

I first address whether “extraordinary circumstances” exist in this case. Both parties agree that the issue of the change of attending physicians was not complex. As claimant notes, however, that was not the only issue at hearing. Other issues included the ALJ’s jurisdiction to reach the causation issue, Sedgwick’s right to raise the issue of causation, and whether chiropractic treatment following the change of attending physician was completed under an appropriate treatment plan. Claimant filed a Motion for Order of Dismissal or For Transfer Order, arguing that Sedgwick had failed to raise the issue of whether claimant’s medical services were causally related to the accepted condition before the Medical Review Unit and, therefore, Sedgwick had waived that issue. Alternatively, claimant sought to transfer the causation issue to the Workers’ Compensation Board.

Sedgwick incorrectly asserts that claimant did not prevail on his motion to dismiss. To the contrary, the ALJ granted claimant’s motion and ruled that the insurer was barred from asserting the issue of causation at the contested case hearing. That ruling has not been challenged.

The matrix in OAR 436-001-0265(1)(b) provides a maximum “Attorney Time Devoted” of 12 hours. Claimant’s attorney asserts that he has devoted a total 35.5 hours to this case, nearly three times the maximum provided in the matrix. If I rely only on the matrix in OAR 436-001-0265(1)(b), based on the “estimated results achieved” for claimant (\$5,684; rounded to \$6,000), claimant’s attorney would be allowed a maximum attorney fee of \$1,750, based on 12 hours devoted to the case.

Although Sedgwick contends that claimant’s attorney’s statement of services did not specifically state the time expended on the services performed, there is no such requirement in the administrative rules. Claimant’s counsel’s original statement of services provided sufficient detail of the activities involved in litigating this case.<sup>2</sup> Sedgwick argues that claimant’s counsel’s estimate of 30 hours devoted to the contested case is excessive. However, I find no reason to discount claimant’s counsel’s representation that he devoted 30 hours at the contested case level, particularly in light of the additional issues litigated. I find that claimant’s counsel’s

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Claimant’s counsel’s original statement of services explained, in part:

“I estimate that I expended 30 hours preparing for the contested hearing herein and participating in same, which included review of the 61 exhibits submitted by the Division; review of the 41 exhibits submitted by petitioner and comparing same with the Division’s exhibits for duplicates; researching the statutes and rules set forth in the Administrative Order; conferences with the claimant; researching and preparing Claimant’s Motion for Order of Dismissal or for Transfer Order, including the issues of failure to preserve issues, express waiver, new medical issues, jurisdiction and medical service denials; responding to petitioner’s request for a copy of the record; reviewing and researching argument in reply to petitioner’s response to the motion; reviewing the medical bills and calculating the amounts paid and owing to Dr. Verzosa and chiropractor Walsh; preparing for and participating in the telephone conference hearing of August 29, 2003; and preparing for and participating in the telephone conference hearing of September 2, 2003.”

assertion that he devoted 30 hours at the contested case level is reasonable based on the nature and complexity of the work involved.

Claimant's counsel also asserts that he devoted 5.5 hours responding to the exceptions, as well as considerable additional time spent on the attorney fee issue (none of which was included in the request for an additional attorney fee). Based on the issues raised in Sedgwick's exceptions, I find that claimant's counsel's assertion that he devoted 5.5 hours to respond to the exceptions is reasonable.

In light of the additional issues litigated at hearing and the fact that claimant's attorney had to review the exhibits on two occasions because Sedgwick asserted an intent to obtain claimant's testimony, I find that there are extraordinary circumstances justifying an attorney fee in excess of \$2,000. See *Foster-Wheeler Constructors, Inc. v. Smith*, 151 Or App 155, 158 n4 (1997) ("the more crucial the attorney's role is in the proceeding, the more likely that it will fall under the extraordinary circumstances of ORS 656.308(2)(d)").<sup>3</sup>

I turn to the amount of the attorney fee. ORS 656.385(1) provides that the attorney fee must be based on all work the claimant's attorney has done relative to the proceeding at all levels before the department, and that the fee must be "proportionate" to the benefit to the injured worker. The Director's rules are to give primary consideration to the results achieved and to the time devoted to the case. In his statement of services, claimant's counsel calculated that Dr. Walsh's unpaid bills totaled \$4,959, and Dr. Verzosa's unpaid bills totaled \$725, for a total of \$5,684. I agree with claimant's assertion that Sedgwick has not demonstrated that claimant's benefits, considered in totality, were disallowed or reduced as a result of the hearing. For purposes of awarding an attorney fee, I rely on claimant's representation that the benefit to claimant is \$5,684.

The legislature has not defined "proportionate" for purposes of ORS 656.385(1). In interpreting a statute, we begin with the text and context of the statute, giving words of common usage their plain, natural, and ordinary meaning. *PGE v. Bureau of Labor and Industries*, 317 Or 606, 610-11 (1993). "Proportionate" is defined as "proportional," which means "[p]roperly related in size or other measurable characteristics." *Webster's II New College Dictionary* 887 (1995). "Proportion" means, among other things: "1. A part considered in relation to the whole. 2. A relationship between things or parts of things with respect to relative magnitude, quantity, or degree. 3. A relationship between quantities such that if one varies then another varies in a manner dependent on the first: RATIO. 4. Harmonious relation." *Id.*; see also *Black's Law Dictionary* 1219 (6th ed 1990) (defining "proportionate" as "[a]djusted to something else according to certain rate of comparative relation").

Although ORS 656.385(1) provides that the attorney fee must be "proportionate" to the benefit to the injured worker, the legislature did not describe a particular ratio or type of relationship between those criteria. Furthermore, I am unable to discern from the legislative history what comparative ratio the legislature intended to establish between the benefit to the

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<sup>3</sup> In a similar statutory provision, ORS 656.308(2)(d) provides that an attorney fee for prevailing against a responsibility denial "shall not exceed \$1,000 absent a showing of extraordinary circumstances."

worker and the attorney's time devoted to the case.<sup>4</sup> Here, claimant requests a total attorney fee of \$7,987.50 (based on 35.5 hours of work), whereas the benefit to claimant is \$5,684. In contrast, the matrix in OAR 436-001-0265(1)(b) provides for an attorney fee *less* than the "estimated results achieved," in varying ratios.

Although I have found that this case involves "extraordinary circumstances," I find that it is appropriate to use the matrix in OAR 436-001-0265(1)(b) for guidance in awarding the attorney fee. Based on the aforementioned matrix, in view of the "estimated results achieved" for claimant (\$5,684; rounded to \$6,000), claimant's attorney would be allowed an attorney fee of \$1,750, based on 12 hours devoted to the case. Here, however, claimant's attorney has devoted 35.5 hours to the case, rather than 12 hours, almost three times the "attorney time devoted" in the matrix. For that reason, I find that a reasonable attorney fee is \$5,250 ( $\$1,750 \times 3 = \$5,250$ ).

In reaching this conclusion, I have considered the factors set forth in ORS 656.385(1) and OAR 436-001-0265, as well as claimant's attorney's fee request and Sedgwick's objections. In Sedgwick's original objections to claimant's statement of services, Sedgwick acknowledged that claimant's attorney had provided excellent legal representation. I agree with Sedgwick's assessment. Although the issue of change of attending physicians was of average complexity, I find that the overall complexity of the issues was above average, compared to those generally presented to this forum. I note that Sedgwick's arguments about causation could potentially have been dispositive if claimant had not filed the motion for dismissal. The parties' respective counsels presented their positions in a thorough, well-reasoned and skillful manner. No frivolous issues or defenses were presented. In awarding the attorney fee, I have given primary consideration to the results achieved and the time devoted to the case (as represented by claimant's statement of services and claimant's attorney fee request in his response to Sedgwick's exceptions).

**IT IS HEREBY ORDERED** that the November 24, 2003 Proposed and Final Contested Case Hearing Order is affirmed. Sedgwick is liable for a total attorney fee of \$5,250.

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<sup>4</sup> I note that Randy Elmer, a workers' compensation attorney who represents workers, testified before the Senate Business and Labor Committee on April 9, 2003, and provided an exhibit that stated, in part:

"Both insurers [Liberty Northwest Insurance Corporation and SAIF Corporation] however emphasized that 'proportionality' was absolutely necessary, i.e., the amount of the fees must be proportionate to the amount of effort required and the result gained. Both insurers required some assurance that fees awarded would not be excessive. The insurer's support of SB 563 was made contingent upon putting into place, language in the form of amendments that prohibit excessive fees and guarantee proportionality." April 9, 2003 Senate Business and Labor Committee, SB 563, Exhibit G, page 3-4. (Senate Bill 620 was formerly Senate Bill 563).

Although the text of ORS 656.385(1) and the legislative history are clear that "proportionality" is required, I am unable to discern what comparative ratio the legislature intended to establish between the benefit to the worker and the attorney's time devoted to the case.